

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid
Services 7500 Security Boulevard,
Mail Stop S2-01-16 Baltimore,
Maryland 21244-1850



CMCS Informational Bulletin

DATE: March 7, 2024

FROM: Daniel Tsai, Deputy Administrator and Director
Center for Medicaid and CHIP Services

SUBJECT: Strategies to Improve Delivery of Tobacco Cessation Services

Smoking is the leading preventable cause of disease and death in the United States, causing about 480,000 deaths annually and costing more than \$600 billion each year in direct medical care and lost productivity.^{1,2,3,4} Tobacco use is particularly salient for the populations enrolled in Medicaid. In 2021, approximately one in five (21.5%) adults enrolled in Medicaid smoked cigarettes, compared to about one in nine (8.6%) adults with private health insurance and about one in ten (11.5%) adults overall.⁵

The purpose of this informational bulletin is to highlight strategies that states have used to improve the delivery of tobacco cessation services to help more Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries quit smoking.

- Section I summarizes the burden of smoking and smoking-related diseases in the Medicaid and CHIP population, outlines the benefits of helping beneficiaries quit smoking, and provides an overview of the evidence-based treatment services and opportunities available to help this population quit smoking.
- Section II provides an overview of state tobacco cessation coverage requirements and authorities in Medicaid and CHIP.
- Section III highlights state strategies for improving delivery of cessation services and provides state examples of each strategy.

¹U.S. Department of Health and Human Services, 2014. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. U.S. Department of Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, Atlanta.

² Xu X, Shrestha SS, Trivers KF, Neff L, Armour BS, King BA. U.S. Healthcare Spending Attributable to Cigarette Smoking in 2014. *Preventive Medicine* 2021 (150): 106529.

³ Shrestha SS, Ghimire R, Wang X, Trivers KF, Homa DM, Armour BS. Cost of Cigarette Smoking Attributable Productivity Losses, United States, 2018. Forthcoming at *Am J Prev Med* 2022.

⁴ Max W, Sung HY, Shi Y. Deaths from secondhand smoke exposure in the United States: economic implications. *American Journal of Public Health* 2012;102(11): 2173–80.

⁵ Cornelius ME, Loretan CG, Jamal A, Lynn BC, Mayer M, Alcantara IC, Neff L. Tobacco Product Use Among Adults—United States, 2021. *Morbidity and Mortality Weekly Report*. 2023 May 5;72(18):475.

- Section IV provides an overview of quality measures that state Medicaid and CHIP agencies can use to measure and drive improvement in their delivery of tobacco cessation services.
- Finally, the Appendix includes several resources that can support states in their drive for improvement.

While e-cigarettes have surpassed conventional cigarettes as the most commonly used tobacco product among youth, conventional cigarettes remain the most commonly used tobacco product among adults.^{6,7} Additionally, the evidence base for tobacco cessation treatments is strongest for cigarette smoking cessation, since most of the studies on cessation treatments were conducted on adults with this form of tobacco use.⁸ As a result, this informational bulletin is focused on cigarette cessation treatments for adults.

Section I: Health Burden and Costs of Smoking, Healthy Equity Implications, Proven Treatment Services, and Opportunities for Quitting

Helping Beneficiaries Quit Smoking Cigarettes Improves Health and Lowers Costs

Overall smoking rates have decreased among adults in recent years, but at a slower pace among adults enrolled in Medicaid.⁹ The high smoking rate among Medicaid beneficiaries results in a heavy burden of smoking-related disease, disability, and death. Cigarette smoking is known to cause heart disease, stroke, chronic obstructive pulmonary disease, diabetes, many types of cancer, adverse reproductive health effects, and numerous other chronic diseases, in addition to triggering acute episodes such as asthma attacks.¹⁰ Smoking-related disease is also a major driver of Medicaid costs, accounting for an estimated 20.3% of Medicaid spending in 2010-2014 -- \$68.3 billion in 2014.¹¹ An economic evaluation estimated a 1% reduction in smoking prevalence could save an estimated \$2.5 billion, with a median state savings of \$26 million annually.¹² Quitting smoking has enormous health benefits regardless of age, reducing the risks of diseases associated with smoking as well as improving health status and adding as much as 10 years to life expectancy.¹³

A much-studied effort undertaken by the Massachusetts Medicaid program demonstrates the rapid dividends that robust Medicaid cessation coverage can yield. Starting in 2006, Massachusetts sought to improve cessation coverage, reduce barriers to accessing covered

⁶ Park-Lee E, Ren C, Cooper M, Cornelius M, Jamal A, Cullen KA. Tobacco Product Use Among Middle and High School Students – United States, 2022. *MMWR Morb Mortal Wkly Rep* 2022;71:1429-1435.

⁷ Creamer MR, Wang TW, Babb S, Cullen KA, Day H, Willis G, Jamal A, Neff L. Tobacco Product Use and Cessation Indicators Among Adults -- United States, 2018. *MMWR Morb Mortal Wkly Rep*. 2019; 68:1013-1019.

⁸ “Commercial tobacco” means harmful products that are made and sold by tobacco companies. It does not include “traditional tobacco” used by Indigenous groups for religious or ceremonial purposes.

⁹ Jamal A, Phillips E, Gentzke AS, et al. Current Cigarette Smoking Among Adults -- United States, 2016. *MMWR Morb Mortal Wkly Rep*. 2018; 67(2):53-59.

¹⁰ https://www.cdc.gov/tobacco/basic_information/health_effects/

¹¹ Xu, *supra* footnote 2.

¹² Glantz SA. Estimation of 1-Year Changes in Medicaid Expenditures Associated With Reducing Cigarette Smoking Prevalence by 1%. *JAMA Netw Open*. 2019;2(4):e192307.

¹³ https://www.cdc.gov/tobacco/quit_smoking/how_to_quit/benefits/index.htm

cessation treatments, and widely promote the new benefit.^{14,15,16} Within three years of this undertaking, 37% of Medicaid beneficiaries who smoked used the benefit, the smoking rate in the state Medicaid population fell from 38% to 28%, and heart attack hospitalizations fell by almost half among Medicaid smokers who used the benefit.^{17,18} Every dollar spent was associated with more than \$3 in medical savings.¹⁹

Health Equity

Improved tobacco cessation will advance health equity by addressing disparities associated with cigarette smoking, secondhand smoke exposure, and access to treatment, ultimately reducing the burden of smoking-related disease. These disparities are driven by social and structural factors which may make it easier for someone to start smoking or harder to quit. For example, stress related to issues like discrimination or poverty, or tobacco product marketing targeted to specific population groups, contribute to tobacco-related disparities. These disparities may be compounded by lack of access to tobacco cessation services and smoke-free air. For example, Hispanic individuals who smoke cigarettes are less likely to receive advice to quit, and are less likely to use cessation treatments, despite having the same rates of quit attempts as non-Hispanic white adults.²⁰ Additionally, Black adults and children are more likely to be exposed to secondhand smoke than those of other racial groups.²¹ While multiple upstream interventions are needed to prevent and eradicate these tobacco-related disparities, ease of access and effective delivery for tobacco cessation services may help reduce these disparities. Additionally, successful quitting may require tailoring of services and supports to be culturally and linguistically adapted for cultural competence.

Proven Tobacco Cessation Treatment Services

Most adults want to quit smoking,²² and there are evidence-based tobacco cessation treatments to support that goal.²³ These treatments are both clinically effective and cost-effective, and include individual, group, and telephone behavioral counseling and seven FDA-approved medications. The U.S. Preventive Services Task Force (USPSTF) has given all these treatments a “Grade A”

¹⁴ <https://www.mass.gov/info-details/about-the-massachusetts-tobacco-cessation-and-prevention-program-mtccp>

¹⁵ <https://www.mass.gov/doc/fact-sheet-providerspdf/download>

¹⁶ Email from Massachusetts Medicaid staff to Jessica Lee. October 18, 2023.

¹⁷ Land T, Warner D, Paskowsky M, et al. Medicaid coverage for tobacco dependence treatments in Massachusetts and associated decreases in smoking prevalence. *PLoS One*. 2010; 5(3):e9770-e9770.

¹⁸ Land T, Rigotti NA, Levy DE, et al. A Longitudinal Study of Medicaid Coverage for Tobacco Dependence Treatments in Massachusetts and Associated Decreases in Hospitalizations for Cardiovascular Disease. *PLOS Medicine*. 2010; 7(12):e1000375.

¹⁹ Richard P, West K, Ku L. The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts. *PLoS One*. 2012; 7(1):e29665.

²⁰ Lindson N, Chepkin SC, Ye W, Fanshawe TR, Bullen C, Hartmann-Boyce J. Different doses, durations and modes of delivery of nicotine replacement therapy for smoking cessation. *Cochrane Database of Systematic Reviews*. 2019; (4).

²¹ Chaiton M, Diemert L, Cohen JE, et al. Estimating the number of quit attempts it takes to quit smoking successfully in a longitudinal cohort of smokers. *BMJ Open*. 2016; 6(6):e011045-e011045.

²² Babb S, Malarcher A, Schauer G, Asman K, Jamal A. Quitting Smoking Among Adults — United States, 2000–2015. *MMWR Morb Mortal Wkly Rep*. 2017; 65(52):1457-1464.

²³ Department of Health and Human Services. Smoking Cessation. A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2020

recommendation for their use in the adult population.^{24,25} A combination of counseling and medication gives adults who smoke the best chance to quit.²⁶ A combination of nicotine replacement therapies (NRT) – a patch together with a short-acting form such as gum or lozenges – can also improve a person’s chances of quitting smoking.²⁷ Strategies to increase quit attempts and use of evidence-based treatments include covering proven cessation treatments with minimal barriers, and promoting use of covered treatments to beneficiaries who smoke and their health care providers.²⁸ Individuals may try to quit smoking as many as 30 times or more before succeeding.²⁹ Tobacco use and dependence is a chronic, relapsing condition that often requires repeated intervention and long-term support.³⁰

Opportunities to Help Medicaid and CHIP Beneficiaries Quit Smoking

Although adults enrolled in Medicaid who smoke are just as likely as those with private health insurance to want and to try to quit, they are less likely to succeed in quitting.³¹ This suggests that Medicaid beneficiaries could benefit from increased access to and use of cessation counseling and medications. One study found that state Medicaid coverage of the combination of cessation counseling and medications was associated with a mean increase in past-year quitting of 3 percentage points in covered Medicaid beneficiaries relative to lower income individuals not covered by Medicaid.³²

Opportunities exist for state Medicaid and CHIP programs to partner with the Centers for Medicare & Medicaid Services (CMS) to help more beneficiaries quit smoking. Specifically, state programs can:

- Support quitting by covering proven cessation treatments, minimizing barriers to accessing these treatments, and promoting use of covered treatments,^{33,34,35,36}

²⁴ Krist, Alex H., et al. "Interventions for tobacco smoking cessation in adults, including pregnant persons: US Preventive Services Task Force recommendation statement." *JAMA* 325.3 (2021): 265-279.

²⁵ A “Grade A” recommendation indicates the USPSTF recommends the services and there is a high certainty that the net benefit is substantial. For pregnant individuals, the USPSTF has concluded that the current evidence is insufficient to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation, a “Grade I” recommendation.

²⁶ Patnode CD, Henderson JT, Melnikow J, Coppola EL, Durbin S, Thomas R. Interventions for tobacco cessation in adults, including pregnant women: an evidence update for the US Preventive Services Task Force.

²⁷ Lindson, *supra* footnote 20.

²⁸ Department of Health and Human Services, *supra* footnote 23.

²⁹ Chaiton, *supra* footnote 21.

³⁰ Fiore MC, Jaén CR, Baker TB, et al. *Treating Tobacco Use and Dependence: 2008 Update*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service; 2008.

³¹ Babb S, *supra* footnote 22.

³² Kostova D, Xu X, Babb S, McMenamin SB, King BA. Does State Medicaid Coverage of Smoking Cessation Treatments Affect Quitting? *Health Serv Res.* 2018; 53(6):4725-4746.

³³ Department of Health and Human Services, *supra* footnote 23.

³⁴ Kostova, *supra* footnote 32.

³⁵ Land, *supra* footnote 17.

³⁶ Greene J, Sacks RM, McMenamin SB. The Impact of Tobacco Dependence Treatment Coverage and Copayments in Medicaid. *Am J Prev Med.* 2014; 46(4):331-336.

- Leverage the 50% administrative match offered by CMS for tobacco cessation counseling provided by state quitlines that follow evidence-based protocols set forth in the Public Health Service Guideline and are offered to Medicaid beneficiaries;^{37,38} and
- Undertake quality improvement initiatives, drawing from a wide array of state success stories.

Section II. Medicaid and CHIP Tobacco Cessation Services Coverage Requirements and Authorities

All recommended tobacco cessation services -- including individual, group and telephone counseling and all seven FDA-approved cessation medications -- are Medicaid or CHIP-coverable services. CMS has previously released guidance on which cessation services are required and optional for certain enrollment groups. To summarize previous guidance:

- States are required to cover both counseling and pharmacotherapy with no cost-sharing for pregnant women enrolled in Medicaid. For more information on this requirement, see [New Medicaid Tobacco Cessation Services - Link](#),” (June 24, 2011). States have the option of continuing these services under 12-month postpartum coverage extensions.
- States must cover medications that meet the definition of Covered Outpatient Drug pursuant to Section 1927 of the Social Security Act (the Act) and are approved by the Food and Drug Administration (FDA) for tobacco cessation if the manufacturer of the medication has entered into a Medicaid drug rebate agreement. For more information on coverage of cessation medications, see [Coverage of Barbiturates, Benzodiazepines and All Drugs Used for Smoking Cessation - Link](#),” (September 12, 2013).
- State Medicaid programs are generally not required to cover over-the-counter (OTC) drugs and Medicaid federal financial participation (FFP) (the portion of Medicaid expenditures paid by the federal government) generally would not be available for OTC drugs dispensed without a prescription. However, states may cover and receive FFP for OTC drugs, such as some NRT, when prescribed by professionals authorized to do so under state laws and regulations. States are required to cover over-the-counter and prescription tobacco cessation medications for pregnant women.³⁹
- As a USPSTF “grade A” recommended preventive service, tobacco use counseling and cessation medications must be covered under the Essential Health Benefits requirement for Medicaid beneficiaries enrolled in Alternative Benefit Plans, including beneficiaries in the adult group.⁴⁰ See [“Alternative Benefit Plan Coverage” on Medicaid.gov](#) for more information.

³⁷ Centers for Medicare and Medicaid Services. State Medicaid Director Letter: New Medicaid Tobacco Cessation Services. Baltimore, MD: 2011. SDL # 11-007.

³⁸ Centers for Medicare and Medicaid Services. CMCS Informational Bulletin: Tobacco Cessation Telephone Quitlines. Baltimore, MD: 2011.

³⁹ Centers for Medicare and Medicaid Services, *supra* footnote 38.

⁴⁰ A summary of USPSTF recommended tobacco cessation services is included in the Appendix.

- Section 4106 of the Affordable Care Act established a one percentage point increase in the federal medical assistance percentage (FMAP) effective January 1, 2013 for states that cover, without cost-sharing, certain services, including preventive services assigned a grade of A or B by the USPSTF. The one percentage point FMAP increase applies to state expenditures for certain services, including clinical preventive services assigned a grade of A or B by the USPSTF (described in section 1905(a)(13)(A) of the Act) and tobacco cessation services for pregnant people (described in section 1905(a)(4)(D) of the Act).
 - Of note, effective October 1, 2023, statutory amendments made by the Inflation Reduction Act (IRA) modified both the requirements for the one percentage point FMAP increase and the expiration time frame of the increase for vaccination services described in section 1905(a)(13)(B). States that opt to cover preventive services described in section 1905(a)(13)(A) of the Act without cost sharing and the tobacco cessation services for pregnant individuals described in section 1905(a)(4)(D) of the Act can continue to receive that FMAP increase even after September 30, 2025 (the expiration of the enhanced FMAP for vaccination services). See [Affordable Care Act Section 4106 \(Preventive Services\) - Link](#) and [Mandatory Medicaid and Children’s Health Insurance Program Coverage of Adult Vaccinations under the Inflation Reduction Act - Link](#) for more information.
- For eligible adolescents (up to age 21) who use tobacco, cessation counseling and pharmacotherapy, if indicated, must be covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.
- All separate CHIP programs must cover tobacco cessation services in accordance with section 2105(c)(5) of the Act and recommendations from USPSTF (both “grade A” and “grade B”) and the American Academy of Pediatrics’(APP) Bright Futures as applicable to children and pregnant women.⁴¹ For additional information on this CHIP requirement, please see [Access to Mental Health and Substance Use Disorder Services for Children and Pregnant Women in the Children’s Health Insurance Program - Link](#) (March 2, 2020).
- Finally, CMS regards properly allocated state expenditures for tobacco cessation quitlines that follow the evidence-based protocols set forth in the Public Health Service Guideline⁴² as an allowable Medicaid administrative activity, to the extent that the quitline provides support to Medicaid beneficiaries, and states have the option to claim FFP for expenditures in accordance with applicable rules. For more information on this option, please see [CMCS Informational Bulletin, “Tobacco Cessation Telephone Quitlines.”](#) (Nov18, 2011).

Section III. Strategies to Improve Delivery of Cessation Services and Increase Quit Rates

⁴¹ Jenssen, Brian P., et al. "Protecting children and adolescents from tobacco and nicotine." *Pediatrics*. May 2023 1;151(5):e2023061804.

⁴² Fiore MC, *supra* footnote 30.

While coverage of tobacco cessation services is a necessary condition for the delivery of high-quality, effective cessation treatments, effective delivery of tobacco cessation services requires other key components for success. CMS offers [quality improvement \(QI\) technical assistance](#) to help states improve coverage and utilization of their tobacco cessation services for beneficiaries of Medicaid and CHIP.⁴³ These resources include guidance on how to start a QI project, examples of evidence-based interventions, and case studies from promising state QI projects (known as state stories). This section highlights five strategies that state Medicaid and CHIP programs have used to improve access to, and delivery and use of, cessation services covered in their state:

1. Standardize and communicate covered cessation benefits
2. Reduce barriers that make it difficult for specific populations to access cessation services
3. Use managed care contracts and tools to improve delivery of tobacco cessation services
4. Partner with tobacco cessation quitlines and providers such as pharmacists to increase access to cessation treatments
5. Establish partnerships to promote coverage and encourage utilization of covered cessation services

Strategy 1: Standardize and Communicate Covered Cessation Services

Variation in coverage of and limits on cessation treatments across managed care organizations (MCOs) and fee-for-service delivery systems may create disparities and gaps in treatment access. This variation can also create confusion among Medicaid and CHIP beneficiaries and their providers regarding benefits (*e.g.*, what medications are covered) and reimbursement (*e.g.*, billing for provider-delivered counseling). Several states have worked with their MCOs to ensure a consistent, comprehensive, evidence-based cessation benefit across plans and to communicate with providers about covered services and how to bill for them. These states have also shared information with beneficiaries about what services are covered by each MCO.

For example, in South Carolina, tobacco cessation services varied across the state's five Medicaid MCOs.⁴⁴ Variations existed in:

- duration of tobacco cessation treatments,
- number of counseling sessions covered,
- stepped care therapy requirements for cessation medications,
- prior authorization requirements for tobacco cessation medications, and
- copayment amounts charged to beneficiaries.

South Carolina chose to standardize coverage to eliminate confusion and increase access to the covered services. On July 1, 2017, South Carolina's Medicaid agency released a policy change ensuring a comprehensive and consistent tobacco cessation benefit without copayments or prior authorization across its fee-for-service Medicaid program and five Medicaid MCOs. The state

⁴³ <https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/tobacco-cessation/index.html>

⁴⁴ American Lung Association. Improving Medicaid Tobacco Cessation Coverage in South Carolina: A Case Study in Partnership. Chicago, IL: 2018.

Medicaid and public health agencies worked together to conduct outreach promoting the new coverage to providers and Medicaid beneficiaries.^{45,46}

Several other states have issued communications to providers and MCOs to clarify coverage requirements and billing procedures to eliminate confusion expressed by providers as a barrier to delivering appropriate cessation services. For instance, California issued [All-Plan Letter 16-014](#) to “provide additional information and explanation regarding requirements for comprehensive tobacco cessation services.”

Strategy 2: Reduce Barriers that Make It Difficult for Specific Populations to Access Cessation Services

Certain Medicaid and CHIP beneficiaries, such as people with mental health or substance use disorders and pregnant individuals, are disproportionately likely to smoke and/or to suffer additional consequences from tobacco usage. It is particularly important to reduce barriers to access cessation services for these populations. Some states have successfully addressed specific populations through policy changes and partnerships with other agencies and organizations to improve access to cessation services.

People with Mental Health and Substance Use Disorders

People with mental health and substance use disorders are more likely to smoke than people without such conditions, and also tend to smoke more heavily.^{47,48,49,50} People with these conditions want to quit smoking, are able to quit successfully, and are more likely to quit when they use cessation counseling and medication, although they may need more intensive cessation treatment.^{51,52} In addition to reducing the risk of developing smoking-related diseases, quitting

⁴⁵ American Lung Association, *supra* footnote 44.

⁴⁶ Seeff LC, McGinnis T, Heishman H. CDC's 6|18 Initiative: A Cross-Sector Approach to Translating Evidence Into Practice. *J Public Health Manag Pract.* 2018; 24(5):424-431.

⁴⁷ Prochaska JJ, Das S, Young-Wolff KC. Smoking, Mental Illness, and Public Health. *Annu Rev Public Health.* 2017; 38:165-185.

⁴⁸ Compton W. The need to incorporate smoking cessation into behavioral health treatment. *Am J Addict.* 2018; 27(1):42-43.

⁴⁹ Substance Abuse and Mental Health Services Administration. Results from the 2015 National Survey on Drug Use and Health: Detailed Tables. Rockville, MD: 2016.

⁵⁰ Glasheen C, Hedden SL, Forman-Hoffman VL, Colpe LJ. Cigarette smoking behaviors among adults with serious mental illness in a nationally representative sample. *Ann Epidemiol.* 2014; 24(10):776-780.

⁵¹ Centers for Disease Control and Prevention. Vital signs: current cigarette smoking among adults aged ≥ 18 years with mental illness -- United States, 2009-2011. *MMWR Morb Mortal Wkly Rep.* 2013; 62(5):81-87.

⁵² Richter KP, Arnsten JH. A rationale and model for addressing tobacco dependence in substance abuse treatment. *Subst Abuse Treat Prev Policy.* 2006; 1:23-23.

smoking could also improve – and does not jeopardize -- mental health and substance use recovery outcomes.^{53,54,55,56}

As the single largest source of funding for mental health and substance use treatment and services,⁵⁷ Medicaid plays an important role in providing access to evidence-based, cost-effective treatments for this population. In an effort to ensure that cessation services are available to people with mental health and substance use disorders, some states have opted to remove or reduce limitations on service utilization, such as copays, limits on the duration of medication use, and the number of quit attempts allowed annually.

For example, New York’s Medicaid program wanted to increase utilization of covered treatment benefits by people who use tobacco, especially among individuals with mental health and substance use disorders. They sought to accomplish this through the following actions:

- eliminating the limit on the number of treatments per year for this population;
- ensuring all FDA-approved medications are covered without prior approvals if used according to labeling (exceptions would apply for brand name medications with generics available); and
- allowing concurrent prescriptions to be written for long- and short-acting medication regimens, a guideline-recommended approach.

New York instituted these changes for all Medicaid fee-for-service and managed care members.⁵⁸ The state used health communications and media to increase awareness of the available benefit and services among people enrolled in Medicaid.⁵⁹ An evaluation of this campaign approach showed that awareness of these messages was strongly associated with a higher likelihood of using evidence-based quitting methods at the most recent quit attempt.⁶⁰ In 2019, while not Medicaid-specific, New York also launched a campaign to remind health care providers of their important role in tobacco cessation treatment.⁶¹

⁵³ Prochaska, *supra* footnote 47.

⁵⁴ Centers for Disease Control and Prevention, *supra* footnote 51.

⁵⁵ Weinberger AH, Platt J, Esan H, Galea S, Erlich D, Goodwin RD. Cigarette Smoking Is Associated With Increased Risk of Substance Use Disorder Relapse: A Nationally Representative, Prospective Longitudinal Investigation. *J Clin Psychiat*. 2017; 78(2):e152-e160.

⁵⁶ Taylor G, McNeill A, Girling A, Farley A, Lindson-Hawley N, Aveyard P. Change in mental health after smoking cessation: systematic review and meta-analysis. *BMJ*. 2014; 348:g1151-g1151.

⁵⁷ Soni A. Healthcare Expenditures for Treatment of Mental Disorders: Estimates for Adults Ages 18 and Older, U.S. Civilian Noninstitutionalized Population, 2019. Statistical Brief # 539. February 2022. Agency for Healthcare Research and Quality. https://meps.ahrq.gov/data_files/publications/st539/stat539.pdf

⁵⁸ New York Department of Health. Update on the Smoking Cessation Benefit in Medicaid Fee-for-Service and Medicaid Managed Care; https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-03.htm#smokingcess

⁵⁹ The following links are examples of these targeted ads: [Cigarettes Are Eating you Alive](#) and [Medicaid Can Help You Quit Smoking](#).

⁶⁰ Hayes KA, Olson LT, Brown EM, Battles HB, Juster HR. Medicaid coverage for tobacco dependence treatment: Enrollee awareness and use. *Prev Med Rep*. 2021 Aug 2;24:101509.

⁶¹ Hayes KA, Brown EM, Nonnemaker J, Juster H, Ortega-Peluso C, Farrelly MC, Davis K. Effectiveness of a media campaign promoting health care provider tobacco dependence treatment. *Prev Med Rep*. 2023 Sep 7;36:102403. doi: 10.1016/j.pmedr.2023.102403. PMID: 37753382; PMCID: PMC10518602.

Using Medicaid member profile data, New York documented increases in reported quit attempts, provider recommendations to quit, and use of the Medicaid smoking cessation benefits over the past several years.⁶² In 2017, New York began tracking data specific to the population enrolled in their Medicaid managed care plan for adults with significant mental health or substance use disorders. The state found that, of the beneficiaries in that plan who smoked, more than half used tobacco cessation services, the highest proportion of any Medicaid managed care population in the state.⁶³

Pregnancy

Medicaid and CHIP cover nearly half of all births in the United States annually.⁶⁴ People covered under Medicaid are three times more likely to smoke during the last trimester of pregnancy than those with private insurance.⁶⁵ Smoking during pregnancy is associated with several poor health outcomes for both birthing parent and child, including a higher likelihood of preterm birth, lower birth weight, and delivery complications.⁶⁶

While state Medicaid and CHIP programs are required to cover tobacco cessation services for pregnant individuals, utilization of these services varies, and beneficiaries and their providers do not always know that tobacco cessation services are covered by Medicaid and CHIP. State Medicaid programs have successfully partnered with public health agencies and local nonprofits to address this challenge by promoting tobacco cessation services to individuals who are pregnant or of reproductive age, and making providers aware of Medicaid tobacco cessation services for individuals who are pregnant.

For instance, Wisconsin's First Breath program, which is operated by the nonprofit Wisconsin Women's Health Foundation and funded in part by Wisconsin's Division of Public Health, took a multipronged approach to providing tobacco cessation support to pregnant and postpartum individuals. The program works with providers to refer pregnant patients, and household members who smoke, to the Wisconsin Women's Health Foundation, where specially-trained coaches provide telephone-based and in-person cessation counseling.^{67,68} With a [Medicaid Incentives for the Prevention of Chronic Diseases Model \(MIPCD\)](#) award, Wisconsin tested the impact of incentives on utilization of tobacco cessation services by Medicaid-eligible individuals in the First Breath program. Wisconsin found that participants receiving incentives

⁶² Seeff, *supra* footnote 46.

⁶³ New York State Department of Health. Smoking cessation benefit utilization in New York State's Medicaid Managed Care Program 2015-2017.

https://health.ny.gov/health_care/managed_care/reports/smoking_cessation_in_mmc.htm

⁶⁴ CMS. 2023 Medicaid and CHIP Beneficiary Profile. April 2023.

<https://www.medicaid.gov/sites/default/files/2023-04/beneficiary-profile-2023.pdf>

⁶⁵ Tong VT, Dietz PM, Morrow B, et al. Trends in Smoking Before, During, and After Pregnancy -- Pregnancy Risk Assessment Monitoring System, United States, 40 Sites, 2000-2010. *Morbidity and Mortality Weekly Report Surveillance Summaries*. 2013; 62(6):1-19.

⁶⁶ U.S. Department of Health and Human Services, *supra* footnote 1.

⁶⁷ Mundt P, Fiore M, Piper M, Adsit R, Kobinski K, Alaniz K, Baker T (2022). Cost-effectiveness of stop smoking incentives for Medicaid-enrolled pregnant women. *Preventive Medicine*, 153.

⁶⁸ Baker T, Fraser D, Kobinsky K, Adsit R, Smith SS, Khalil L, Alaniz K, Sullivan T, Johnson M, Fiore M (2018). A randomized controlled trial of financial incentives to low-income pregnant women to engage in smoking cessation treatment: Effects on post-birth abstinence. *J Consult Clin Psychol*. 86(5), 464-473.

were more likely to use cessation services and were also more likely to achieve biochemically verified cessation.^{69,70}

Strategy 3: Use Managed Care Contracts and QI activities to Improve Delivery of Tobacco Cessation Services

MCOs cover more than 75% of Medicaid beneficiaries,⁷¹ and there are multiple ways states can improve delivery of tobacco cessation using MCO contracts and QI activities. States can use managed care contracts to deploy strategies such as including tobacco cessation metrics in value-based purchasing, requiring coverage of all FDA-approved cessation treatments and counseling without barriers to access covered treatments, and including performance improvement projects (PIPs) to improve tobacco cessation delivery. States conduct several mandatory quality oversight activities within their managed care programs: developing a quality strategy to articulate the state's vision and priorities for managed care, including quality improvement goals and objectives; requiring managed care plans to establish ongoing Quality Assessment and Performance Improvement (QAPI) programs; and implementing an annual External Quality Review (EQR) to assess managed care plan performance.⁷² QAPI programs include the performance measures that plans will report to the state and the PIPs that plans will implement. States can mandate a specific PIP topic, identify an area of focus, or allow plans to select their own PIPs.

Oregon, for example, incorporated a tobacco cessation-related incentive metric into the Coordinated Care Organizations (CCOs) Quality Incentive Program.⁷³ After this metric was introduced, CCOs began offering comprehensive cessation benefits and beneficiaries subsequently reported increased cessation assistance from their providers. Ultimately, the state saw a decline in smoking rates among Medicaid beneficiaries.⁷⁴

North Carolina also increased support of tobacco cessation through MCO contracts, with the aim of advancing health equity and eliminating disparities. Standard and tailored plans for behavioral health providers are required to cover evidence-based tobacco treatment services to Medicaid recipients in tobacco-free settings. North Carolina requires its health plans to submit annual quality measures on tobacco cessation efforts including a yearly Tobacco Cessation Plan. Plans also will provide their networks care management training on tobacco use assessment and exposure, brief interventions, and [cessation standard of care](#). Health plans under contract must promote and adopt tobacco-free campuses; ensure screening and assessment of all tobacco use and exposure; and provide treatment (both counseling and medications) at all inpatient and outpatient facilities. The health plans will also increase use of smoking cessation CPT codes, as

⁶⁹ Hoerger T, Boland E, Acquah JK, et al. Medicaid Incentives for Prevention of Chronic Disease. RTI International; 2017.

⁷⁰ Alaniz K, Christiansen B, Sullivan T, Khalil L, Fiore MC (2019). Addressing postpartum smoking relapse among low-income women: a randomized control trial. *J Patient Cent Res Rev* (6), 233-242.

⁷¹ CMS, *supra* footnote 64.

⁷² CMS. Managed Care Quality Improvement. [Managed-care-quality-improvement Link](#)

⁷³ CCO Metrics Program (2023). CCO Metrics Performance Dashboard. Interactive display accessed [10/30/2023]. Portland, OR: Oregon Health Authority. [CCO Performance Metrics Dashboard Link](#)

⁷⁴ Livingston, Catherine J., et al. "Peer Reviewed: Reducing Tobacco Use in Oregon Through Multisector Collaboration: Aligning Medicaid and Public Health Programs." *Preventing Chronic Disease* 17 (2020).

appropriate; use of incentives for members and providers; and offer provider training on the smoking cessation CPT codes. Starting April 1, 2024, almost all providers reimbursed by Medicaid, as well as other state-funded facilities, will be required to develop a tobacco-free campus policy.⁷⁵

Strategy 4: Partner with Tobacco Cessation Quitlines and Providers Such as Pharmacists to Increase Access to Cessation Treatments

It is important that Medicaid and CHIP beneficiaries can access cessation services at times and locations that are convenient for them. Some states have expanded the list of provider types who can be reimbursed for tobacco cessation services to increase access opportunities. For example, states may reimburse additional provider types such as community health workers, community treatment teams, social workers, therapists, and pharmacists to screen for and provide tobacco cessation services. For instance, pharmacies can be a convenient option for obtaining cessation treatments as pharmacies are broadly available, including in rural settings. States can also contract with quitlines, which are also a convenient way to receive cessation services, as they can be accessed anywhere a person is able to use a telephone and are often open in the evenings and on weekends.

Partner with Pharmacists

Several states have authorized pharmacists to provide tobacco cessation medication and counseling services. Research indicates that pharmacist-delivered cessation medication and counseling is effective in helping individuals quit smoking. Additionally, brief interventions (e.g., “Ask, Advise, Refer”) provided at community pharmacies has effectively increased the number of people who contact the tobacco quitlines.^{76,77}

As of 2022, 18 states were in the process of allowing pharmacists prescriptive authority for tobacco cessation medications. Of the subset of 16 states with fully delineated protocols, eight include all FDA-approved medications for tobacco cessation, and eight include only NRT.^{78,79} Although the protocols vary by state, most require pharmacists to conduct a health screening and tobacco use assessment prior to providing cessation medication(s), and they must refer beneficiaries to the tobacco quitline or provide individualized tobacco cessation counseling that addresses both medication use and behavioral support. Additionally, some states require pharmacists to contact the beneficiary’s primary care provider to inform them of the individual’s quitting plan.

⁷⁵ [North Carolina Standard Plan, Tailored Plan and LME/MCO Tobacco-Free Policy Requirement](#)

⁷⁶ Hudmon KS, Corelli RL, de Moor C, Zillich AJ, Fenlon C, Miles L, Prokhorov AV, Zbikowski SM. Outcomes of a randomized trial evaluating two approaches for promoting pharmacy-based referrals to the tobacco quitline. *Journal of the American Pharmacists Association*. 2018 Jul 1;58(4):387-94.

⁷⁷ Dent LA, Harris KJ, Noonan CW. Tobacco Interventions Delivered by Pharmacists: A Summary and Systematic Review. *Pharmacotherapy: The Journal of Human Pharmacology and Drug Therapy*. 2007; 27(7):1040-1051.

⁷⁸ <https://naspa.us/resource/tobacco-cessation/> accessed November 28, 2023.

⁷⁹ Hilt KE, Corelli RL, Vernon VP, Hudmon KS. Update and recommendations: Pharmacists’ prescriptive authority for tobacco cessation medications in the United States. *Journal of the American Pharmacists Association*. 2022 Sep 1;62(5):1531-7.

In 2016, California changed its regulations to allow pharmacists to furnish NRT products.^{80,81} These pharmacists follow a statewide protocol and receive training and continuing education on tobacco cessation counseling and NRT. They can bill Medi-Cal, California’s Medicaid program, for the smoking cessation services provided. However, about two years after this regulation change, a University of California at San Francisco (UCSF) study found that few pharmacists were furnishing NRT to Medi-Cal beneficiaries, likely because the payment for these services had not been implemented.⁸² In response to these findings, UCSF conducted educational outreach to community pharmacies in counties with high prevalence of adult smoking and at least 100 beneficiaries enrolled in Medi-Cal. This outreach sought to increase the number of pharmacists furnishing NRT and providing cessation services to Medicaid beneficiaries in these counties. Within 12 months of the mailing, total claims for NRT had increased 18.6% in the counties with pharmacy outreach compared to 9% in all other counties.⁸³

Partner with Tobacco Cessation Quitlines

Tobacco cessation quitlines are evidence-based and effective at helping people quit smoking. Quitline interventions typically include behavioral counseling and provision of FDA-approved cessation medications (typically a “starter” amount) and increasingly include other services such as text messaging support.⁸⁴ In some states, the Medicaid and public health programs have worked together to promote, enhance, and increase use of quitline services for Medicaid beneficiaries, including claiming FFP for quitline expenditures to the extent that the quitline provides support to Medicaid (See Section II). For example, Oklahoma’s Medicaid agency and state health department collaborated to revise tobacco cessation policies and increase access to tobacco cessation services.^{85,86} The agencies also increased referrals to the state quitline by creating an automated referral database and training Medicaid care management staff to integrate the new system into their daily work processes.⁸⁷

In North Carolina, the Division of Health Benefits (NC Medicaid) and the Division of Public Health partnered to increase quitline services access for Medicaid beneficiaries. In its transition from fee-for-service to managed care, North Carolina required all Medicaid managed care plans to contract with the state quitline vendor. NC Medicaid and Public Health teams worked together to expand access to evidence-based tobacco treatment through QuitlineNC.⁸⁸ These teams coordinated promotion to maximize provider referrals and increase beneficiaries’ access to

⁸⁰ In California, “furnish” is the term for prescribing done by anyone other than MDs.

⁸¹ See [SPA 18-0039](#).

⁸² Medi-Cal. In the Pharmacy: Pharmacists Furnishing Nicotine Replacement Products. 2018.

⁸³ Email from California Department of Health Care Services staff, November 15, 2023.

[DUR Board Meeting Minutes Sept 15 2020.pdf](#)

⁸⁴ Community Preventive Services Task Force. Reducing Tobacco Use and Secondhand Smoke Exposure: Quitline Interventions. [Tobacco use and secondhand smoke exposure quitline interventions on thecommunityguide.org](#).

⁸⁵ Email from Oklahoma Health Care Authority staff to Jessica Lee. August 28, 2023.

⁸⁶ <https://oklahoma.gov/ohca/individuals/tobacco-cessation-individuals.html>

⁸⁷ American Lung Association. Medicaid Tobacco Cessation Coverage in Oklahoma: A Case Study in Leveraging Systems and Partnerships. 2015.

⁸⁸ <https://quitlinenc.dph.ncdhhs.gov/>

quitline services.⁸⁹ North Carolina also implemented a standing order for medication offered through the quitline. When Medicaid beneficiaries enroll with QuitlineNC, they receive a no-cost two-week starter kit of combination NRT and a standing order prescription for an additional twelve weeks of medication that can be used at any pharmacy accepting Medicaid.

Strategy 5: Establish Partnerships to Promote Coverage and Encourage Utilization of Covered Cessation Services

As many states have discovered, policy changes alone are insufficient to increase access to and improve delivery of cessation treatments. Several states have partnered with state public health agencies and other stakeholders to proactively provide information to beneficiaries and providers regarding Medicaid cessation coverage and encourage utilization of covered services.

For example, Vermont successfully increased access to and utilization of a Medicaid cessation benefit through partnerships and promotion. The Vermont Tobacco Control Program (VTCP) collaborated with the state Medicaid agency to update Vermont's Medicaid cessation benefit to be more comprehensive.⁹⁰ They then worked together to promote the new cessation coverage and services to both Medicaid beneficiaries and health care providers through mailings, digital ads, and other means.⁹¹ They found that, among Medicaid-insured adults, cigarette smoking decreased from 29% to 28% from 2018 to 2021, translating to an estimated \$2.3 million Medicaid cost savings in 2022.⁹² Vermont renewed these efforts by adding financial incentives for Medicaid members enrolled in the state quitline cessation services in 2021, and sending a provider advisory highlighting available cessation benefits in 2023.

Kentucky has also experienced success with forming partnerships that lead to the promotion of Medicaid benefits. The Kentucky Tobacco Prevention and Cessation Program (KTPC) worked strategically with Kentucky Medicaid and the Medicaid MCOs to ensure that MCOs covered cessation counseling and all FDA-approved cessation medications. To make cessation coverage information more accessible to providers, the KTPC developed and disseminated laminated charts describing cessation services covered by each MCO and common tobacco treatment billing codes. In 2017, Kentucky formalized these efforts by requiring Medicaid to cover all USPSTF recommended tobacco cessation services and medications.^{93,94,95}

Section IV. Measuring Success

⁸⁹ Hashim S. 6|18 Initiative a Win-Win for Medicaid and Public Health: A Conversation with North Carolina on Tobacco Cessation. Center for Health Care Strategies; 2018.

⁹⁰ Email from Vermont Department of Health staff to Jessica Lee. October 20, 2023.

⁹¹ Williams RK, Brookes RL, Singer ER. A Framework for Effective Promotion of a Medicaid Tobacco Cessation Benefit. *Health Promot Pract.* 2020 Jul;21(4):624-632.

⁹² [Tobacco Medicaid ROI infographic_2022_2023_09_FINAL.pdf](#) accessed November 2023.

⁹³ <https://www.bhthechange.org/wp-content/uploads/2018/06/Medicaid-Billing-slides-Final.pdf> accessed Nov2023.

⁹⁴ Email from staff from Department of Medicaid Services, Kentucky Cabinet for Health and Family Services to Jessica Lee. October 27, 2023.

⁹⁵ <https://www.chfs.ky.gov/agencies/dph/dpqi/cdpb/hpdocs/MedicaidandMCOTobaccoCessationBenefits.pdf> accessed November 2023.

States are encouraged to review data on utilization of covered cessation services, relevant quality measures, and other metrics to identify, focus, and monitor efforts to improve the delivery and use of those services. There are many health care quality measures related to tobacco cessation that are used in a variety of health care settings and programs and are specified for reporting at different levels, including state, MCO, and facility (including hospitals). State Medicaid and CHIP agencies should work with their MCOs, provider, and public health partners to select measures of tobacco cessation on which they would like to see improvement and where they, collectively, can have an impact. CMS technical assistance includes guidance on [how to build a tobacco cessation family of measures](#) for QI initiatives.

States are encouraged to use the Child and Adult Core Sets of quality measures to monitor and improve the quality of health care provided to people enrolled in Medicaid and CHIP (see <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/index.html>). The Adult Core Set includes the “Medical Assistance with Smoking and Tobacco Use Cessation” measure, identified under the CMS Measures Inventory Tool (CMIT) as CMIT #432. This measure is drawn from Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey questions about respondents’ use of tobacco and whether their doctor or other health care provider advised them to quit and discussed quitting strategies including medications. For the 28 states that reported performance on that measure in 2022 Core Set reporting, 73% of adult Medicaid beneficiaries who use tobacco reported being advised by their doctor to quit, but only 50% reported discussing use of cessation medications with their doctor and only 44% reported discussing other cessation strategies with their doctor.^{96,97} These results point to an opportunity to improve clinicians’ delivery of medical assistance with tobacco cessation.⁹⁸ States with MCOs can also requiring tobacco cessation measures in QAPI programs and report tobacco cessation measures in their annual EQR technical report. EQR is the analysis and evaluation of quality, timeliness, and access to the health care services provided by managed care plans.⁹⁹ An External Quality Review Organization summarizes EQR findings in an annual EQR technical report that must include performance measure findings, PIP findings, and recommendations for quality improvement.

Section V. Conclusion

Quitting smoking is one of the most important steps that individuals can take to improve their health. Every state Medicaid and CHIP program covers treatments that can help beneficiaries quit successfully. States are encouraged to use the strategies discussed in this Information Bulletin to improve delivery of tobacco cessation services to Medicaid and CHIP beneficiaries and to help more beneficiaries quit smoking. Many resources are available from CMS, CDC, and

⁹⁶ [Annual Reporting on the Quality of Health Care for Adults Enrolled in Medicaid on Medicaid.gov](#)

⁹⁷ In the last National Adult Medicaid (NAM) CAHPS data from 2014-2015, 27% of adult Medicaid beneficiaries reported smoking or using tobacco. While 74% of those beneficiaries who use tobacco reported being advised by their doctor to quit, only 44% reported discussing use of cessation medications with their doctor and only 39% reported discussing other cessation strategies with their doctor.

⁹⁸ Ku L, Bruen BK, Steinmetz E, Bysshe T. Medicaid Tobacco Cessation: Big Gaps Remain In Efforts To Get Smokers To Quit. *Health Aff (Millwood)*. 2016; 35(1):62-70.

⁹⁹ CMS. CMS External Quality Review (EQR) Protocols. February 2023. <https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf>

other organizations to support state efforts, including several listed in the Resources section below. For additional information about this Information Bulletin or to inquire about technical assistance, please contact Jessica Lee, Acting Chief Medical Officer, at Jessica.Lee@cms.hhs.gov.

Appendix A. Tobacco Cessation Resources Available to States

Centers for Medicare & Medicaid Services:

CMS recently released [new technical assistance resources](#) to support state quality improvement efforts related to tobacco cessation. Questions or requests for technical assistance related to driving quality improvement can be submitted to MedicaidCHIPQI@cms.hhs.gov. These resources include ideas for tobacco cessation QI activities and illustrative state examples of successful tobacco cessation programs. CMS also created resources on getting started with QI and how to use data for QI. In addition, CMS offers technical assistance focused on improving tobacco cessation for specific populations, such as individuals who are pregnant and individuals with mental health or substance use disorders.

CMS provides technical assistance and analytic support to states to increase the number of states collecting, reporting and using Medicaid and CHIP Core Set measures. This includes technical assistance to help states collect and report the “Medical Assistance with Smoking and Tobacco Use Cessation” (CMIT #432) quality measure. Questions or requests for technical assistance related to the Medicaid and CHIP Core Sets can be submitted to MACqualityTA@cms.hhs.gov.

Surgeon General:

Published in 2020, [Smoking Cessation: A Report of the Surgeon General](#) provides a comprehensive summary of the latest evidence on the health benefits of cessation. The report also describes the evidence supporting treatment with smoking cessation medications, NRT, and behavioral counseling.

Centers for Disease Control and Prevention:

As part of the [National Tobacco Control Program](#) (NTCP), the CDC Office on Smoking and Health (OSH) provides funding and technical assistance to states to implement comprehensive state tobacco control programs. One of the four goals of the NTCP is promoting quitting of tobacco use among adults and youth. This includes supporting efforts by state tobacco control programs to work with their state Medicaid programs to help Medicaid beneficiaries quit smoking. These programs have expertise and can also connect to additional resources and tools to assist Medicaid programs. The [OSH website](#) includes a section on “Cessation Materials for State Tobacco Control Programs,” which includes several Medicaid-specific case studies and other relevant resources.

In addition to funding states, OSH funds a cooperative agreement that supports tracking of state Medicaid cessation coverage. This includes reporting information on the cessation treatments that each state Medicaid program covers as well as coverage barriers to accessing these treatments such as copayments and prior authorization. Quarterly reports on states’ cessation activities can be accessed in CDC’s [State Activities Tracking and Evaluation \(STATE\) System](#).

OSH also funds separate cooperative agreements that provide technical assistance to states and partners on proven population-level cessation interventions, including health systems change, cessation insurance coverage, and state quitlines. With CDC funding, the American Lung Association has developed Medicaid-specific technical assistance in its [online resource library](#).

Through the 6|18 Initiative (<https://www.cdc.gov/sixeighteen/>), the CDC partners with health care purchasers, payers, and providers to improve health and control health care costs.

Specifically, CDC is providing these partners with rigorous evidence about six high-burden health conditions, including tobacco use, and eighteen interventions that have been found to be effective in addressing these conditions, including three interventions to reduce tobacco use: increasing access to evidence-based tobacco cessation treatments, removing barriers to accessing these treatments, and promoting increased use of covered treatments. All three of these interventions are directly relevant to the Medicaid population. The 6/18 Initiative aligns evidence-based preventive practices with emerging value-based payment and delivery models.

Center for Health Care Strategies (CHCS):

CHCS has developed an [online resource center](#) to help state Medicaid programs and Medicaid MCOs work with state health departments to implement CDC’s 6|18 interventions. The resource center includes a collection of materials, tools, state examples, and other practical resources.

USPSTF Recommendations Related to Tobacco:

Population	Recommendation	Grade	Year of Recommendation
Adults who are not pregnant	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to nonpregnant adults who use tobacco.	A	2021
Pregnant persons	The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.	A	2021
Pregnant persons	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant persons.	I	2021
All adults	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of electronic cigarettes (e-cigarettes) for tobacco cessation in adults, including pregnant persons. The USPSTF recommends that clinicians direct patients who use tobacco to other tobacco cessation interventions with proven effectiveness and established safety.	I	2021
School-aged children and adolescents who have not started to use tobacco	The USPSTF recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents.	B	2020
School-aged children and adolescents who use tobacco	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of primary care--feasible interventions for the cessation of tobacco use among school-aged children and adolescents.	I	2020

Note: All these recommendations are subject to periodic updates. See the [USPSTF’s website](#) for the most recent final recommendations. Grade A = The USPSTF recommends the service. There is high certainty that the net benefit is substantial. Grade B = The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. Grade I = The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.