



Improving Tobacco Cessation Coverage through Medicaid Managed Care Contracting: An Issue Brief

This Issue Brief provides guidance for state tobacco control programs to collaborate with their state Medicaid agency to improve coverage for tobacco cessation through the Medicaid Managed Care procurement process when possible, or through additional administrative mechanisms to expand coverage if participating in procurement is not feasible.

Introduction

Medicaid enrollees are twice as likely to smoke tobacco as the general population¹, placing them at a higher risk for smoking-related diseases. While Medicaid enrollees want to quit at rates identical to those with private insurance², the smoking disparity still persists. Research shows that Medicaid coverage of tobacco cessation treatment, including tobacco cessation medication and counseling, leads to reduced smoking rates³ and fewer smoking-related healthcare costs.⁴

On February 14, 2020, the Centers for Disease Control and Prevention (CDC)'s Morbidity and Mortality Weekly Report (MMWR) published [State Medicaid Coverage for Tobacco Cessation Treatments and Barriers to Accessing Treatments – United States, 2008 – 2018](#). This article used the American Lung Association's tobacco cessation Medicaid coverage data comparing two snapshots of state coverage in 2008 and 2018. It found substantial improvements in state coverage of tobacco cessation treatments, especially coverage of medications over this ten-year period. However, the article also found room for improvement in coverage of counseling and removal of barriers to access tobacco cessation treatments in state Medicaid programs.

The increase in the number of states covering all nine tobacco cessation treatments likely resulted in part from the Patient Protection and Affordable Care Act (ACA), passed in March 2010. The ACA included three provisions that introduced new requirements for state Medicaid cessation coverage. The first provision, which took effect in October 2010, requires state Medicaid programs to cover cessation counseling and FDA-approved cessation medications for pregnant women with no cost-sharing. The second provision, which took effect in January 2014, barred state Medicaid programs that participate in the Medicaid drug rebate program from excluding FDA-approved cessation medications from coverage. With the exception of pregnant Medicaid enrollees, the ACA does not require standard state Medicaid programs (non-expansion) to cover cessation counseling or to remove barriers that impede access to cessation counseling and medications. The third provision requires Medicaid expansion, unlike standard coverage, to include coverage without cost-sharing of preventive services receiving an "A" or "B" rating from the U.S. Preventive Services Task Force (USPSTF). Tobacco cessation intervention,

Comprehensive Tobacco Cessation Benefit:

Seven FDA-Approved Medications:

- NRT Gum
- NRT Patch
- NRT Lozenge
- NRT Inhaler
- NRT Nasal Spray
- Bupropion
- Varenicline

Three Forms of Counseling:

- Individual
- Group
- Phone



including both counseling and pharmacotherapy, for non-pregnant adults has an “A” rating from USPSTF.

Although the progress reported in the MMWR is encouraging, state Medicaid cessation coverage still lags behind the Healthy People 2020 objective of comprehensive cessation coverage in all 50 states and DC.⁵ Smokers enrolled in Medicaid are just as likely as those enrolled in private insurance to want to quit and to have made a past-year quit attempt, but they are less likely to succeed in quitting.⁶ Compared with smokers with private health insurance, Medicaid smokers are more likely to have chronic diseases and to experience severe psychological distress.⁷ The high smoking prevalence among Medicaid enrollees imposes a substantial health burden and is a major driver of federal and state health care expenditures.⁸ State Medicaid programs can help reduce these burdens by covering all evidence-based tobacco cessation treatments, removing barriers to coverage, and promoting utilization of covered benefits to Medicaid enrollees and providers.⁹

Background: Medicaid Managed Care Organizations

As state tobacco control programs consider how to work with their state Medicaid program on expanding tobacco cessation benefits, they will realize quickly that the discussion is largely influenced by the presence of Medicaid managed care. [Medicaid.gov](https://www.medicicaid.gov) defines managed care as a:

“health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs).”¹⁰

According to the Kaiser Family Foundation’s [10 Things to Know about Medicaid Managed Care](#), “as of 2019, 40 states, including Washington DC, contract with comprehensive risk-based MCOs to provide care to at least a portion of their Medicaid beneficiaries.” This means the MCO gets a fixed payment regardless of how many services its enrollees use and takes on the financial risk of enrollees using services and treatments in excess of the fixed monthly payment. States have pursued risk-based contracting with managed care plans for different purposes, however states can and do require their MCOs to cover specific treatments (such as tobacco cessation) to ensure the health of the enrollees.¹¹

Standardizing tobacco cessation coverage by having all managed care organizations cover all proven cessation treatments with minimal barriers can maximize Medicaid enrollees’ access to proven cessation treatments while minimizing confusion about coverage among enrollees and providers. Standardizing coverage in this way is particularly important because states are increasingly moving to managed care coverage.¹²

* Managed Care Organizations (MCOs) are sometimes referred to as managed care plans (MCPs). The meaning is the same but different terms are used in different states.



Procurement of Medicaid Managed Care Organizations

Options to improve coverage will depend on where the state is in its procurement process. Government procurement, also known as government purchasing, is the procurement of goods and services by government agencies. This is a very formal, time intensive process required by law, in which government agencies issue bid proposals and seek responses from companies following strict rules and procedures. The strict requirements can make a procurement cycle take several years. Typical steps in a Medicaid MCO procurement process include those illustrated below. Understanding the general process and timing in your state will highlight potential opportunities for improving tobacco cessation coverage.

State Medicaid Managed Care Procurement Steps	Description
1. MCO contracting process begins	If the Medicaid agency already has MCO contracts it will typically conduct its own internal evaluation of program changes desired to improve past Medicaid MCO results.
2. Develop a Request for Information (RFI)	This optional process allows the Medicaid agency to gather stakeholder feedback and further refine priorities before they finalize a Request for Proposal (RFP) or Request for Application (RFA).
3. Evaluate feedback	The Medicaid agency weighs the input received from the RFI.
4. Develop an RFP/RFA	Input from stakeholders may shape questions and requirements in the managed care RFP or RFA.
5. Post RFP/RFA	The Medicaid agency will post the request and provide adequate time for MCOs to respond. Because there are often data that must be analyzed and evaluated, network contracting requirements to meet with letters of intent or contracts, and other detailed work, the posting timeframe may last for several months.
6. Evaluate proposals	Medicaid agencies may receive a few or a few dozen proposals depending on the geography, the dollar amount of the opportunity and the requirements. Evaluation will likely take a month or more and follow strict rules for participation, scoring and documentation.
7. Select successful bidders	When successful bidders are notified, there is often an opportunity for unsuccessful bidders to protest their failure to be selected. A formal process allows them to find out why they weren't selected, usually through sharing scoring documentation. This can also add months to the process.



8. Contract effective date	After all inquiries are settled, the state Medicaid agency issues contracts to the successful bidders.
9. Start-up and implementation period	Typical implementation periods may be from six to twelve months to enable the successful MCOs to implement their systems, processes and policies to serve Medicaid beneficiaries.
10. Contract “goes-live”	After the contracts are effective, they may have a term of three to five years, often with the potential for a one or more yearlong extensions.

Opportunities for Influencing the Procurement Process

There are multiple points during the procurement process when a state tobacco control programs can work with the Medicaid agency to achieve better tobacco cessation coverage. Because the procurement cycle can take a few years and then is not repeated again for at least three to five years, identifying where the state Medicaid agency is in the cycle is important. Each of the opportunities noted below can be used consecutively if timing allows the state tobacco control program to be involved from the start of the process. While involvement at the beginning is ideal, the state examples that follow show it is always worth trying to become involved at any point in the process.

An example of a real-life Medicaid managed care procurement and contracting cycle is playing out in Ohio at the time of this writing. Governor DeWine called on the Medicaid agency to ensure the best value in quality care from the state’s MCPs in early 2019. The agency released its first RFI in June 2019, followed by a second RFI which closed in March 2020. Ohio Medicaid is currently working on developing an RFA that reflects stakeholder input; the best-case scenario would have new MCPs providing services to beneficiaries in late 2021– three years after the process began.

Developing Request for Information (RFI): If a state tobacco control program already has a working relationship with the Medicaid agency, they might be able to influence the inclusion of questions about the different aspects of an evidence-based tobacco prevention and cessation program. This can include the MCOs experience and plans for the areas of:

- Tobacco cessation coverage
- Provider training and support for cessation including reimbursement
- Identification and engagement of members who use tobacco
- Quality measures or other Quality Improvement (QI) strategies that involve tobacco cessation
- Population health as a broad strategy and specifically whether it includes tobacco use prevention and cessation



Responses to these questions can guide priorities for the Request for Proposal that will be developed in the next step.

If the state tobacco control program does not have an established relationship with the Medicaid agency, they may be able to provide a written response to the RFI and stress the importance of evidence-based tobacco cessation programs.

Developing the Request for Proposal (RFP) or Request for Application (RFA): As with the RFI, if the state tobacco control program and the state Medicaid agency have a positive relationship, the state tobacco control program may be able to suggest specific questions about tobacco cessation coverage and other member and provider support options. Specific questions may be influenced by the responses to the RFI, but if the state tobacco control program did not have the opportunity to provide input to the RFI, similar topics can be proposed at this stage of the process. RFP questions should be framed in a manner that is easy to “score” or evaluate. Medicaid RFPs are very long, and the evaluation process is difficult, so the easier it is to include content the more likely the state tobacco control program will be successful.

A second opportunity associated with developing the RFP is in influencing the base MCO contract which is often part of the RFP. Contract terms such as reporting requirements and QI measures can provide information and send a strong signal to MCOs of the importance that Medicaid is placing on tobacco cessation.

Evaluating Proposals: Many states seek interagency representatives on the RFP or RFA evaluation team. The state tobacco control program can seek to join the team to provide feedback on tobacco cessation coverage proposal responses, depending on the state procurement rules. State tobacco control program participants may be asked to sign non-disclosure documents and provide formal written feedback to be used in scoring. The scoring can be time intensive and must take place within a limited period of time, so the state tobacco control program must be prepared to make this investment.

Contracting: Input on the contract terms is usually determined prior to development of the RFP or RFA, since a proposed contract is usually shared as part of the request. However, it may be possible to add contract terms after the RFP or RFA response evaluation, depending on state procurement rules.

State Examples of Improving Cessation Benefits During Procurement

The procurement process described above highlights several opportunities for state tobacco control programs to influence tobacco cessation benefits in the Medicaid program: during the development of the MCO bid documents, during evaluation of responses, or during the development of the contract language. Examples of states that have used these approaches are detailed, below.

Michigan: Using the Contracting Process to Ensure Coverage

The Michigan Department of Health and Human Services Tobacco Program has had a long and successful relationship with their Medicaid agency, resulting in strong requirements for tobacco cessation coverage, provider education support and reporting in their Medicaid managed care plan (MCP)s. It started in 2004 when state tobacco control program staff found Consumer Assessment of Health Care Providers and Systems (CAHPS) data indicating low rates of medical assistance with smoking and tobacco use cessation. Using the data, staff raised the concern with the Medicaid director who had a quality improvement focus and quickly became a champion for voluntary managed care plan participation with the state quitline. Half of the Medicaid MCPs and two commercial plans agreed to participate, and the overall quitline call rate increased sharply.

In 2008, a new Chief Medical Executive joined Michigan Medicaid and became another champion for tobacco cessation coverage. His team required all MCPs to have a state tobacco control program-approved quitline and cover nicotine replacement therapy patch and gum or lozenge. State tobacco control program staff continued to assess CAHPS results and shared data on success rates with medication, noting that flexibility was a key to success in this phase. Rather than insist on “all or nothing” in the tobacco cessation coverage, they compromised where it made sense to keep the coverage improving incrementally. They also partnered with Medicaid on paid advertising to promote tobacco cessation benefits.

The final phase of the relationship in Michigan started in January 2015 when language was included in the state’s new RFP for MCPs. Starting then, Michigan’s standard contract¹³ included the following language:

1. *Contractor must not place prior authorization requirements on tobacco cessation treatment or limit the type, duration or frequency of tobacco cessation treatments included in this section.*
2. *Contractor must provide tobacco cessation treatments that includes, at a minimum, the following services:*
 - a. *Intensive tobacco cessation treatment through a Michigan Department of Health and Human Services (MDHHS)-approved telephone quitline;*
 - b. *Individual tobacco cessation counseling/coaching in conjunction with tobacco cessation medication or without;*
 - c. *Non-nicotine prescription medications;*
 - d. *Prescription inhalers and nasal sprays;*
 - e. *The following over the counter agents;*
 - i. *Patch*
 - ii. *Gum*
 - iii. *Lozenge*
 - f. *Combination therapy – the use of a combination of medications, including but not limited to the following combinations*



- i. *Long term (>14 weeks) nicotine patch and other nicotine replacement therapy (gum or nasal spray)*
- ii. *Nicotine patch and inhaler*
- iii. *Nicotine patch and bupropion SR*

The state tobacco control program assisted with enforcement of the contract requirements by taking complaints and questions from local health departments and other funded partners who heard from tobacco users when they could not get a prescription filled, passing information along to Medicaid contract managers. This work was time intensive but ultimately addressed most issues so that the plans are now covering the required products.

The relationship between the state tobacco control program and the Medicaid agency has been consistent and collaborative for over 15 years; both programs are fortunate to have had minimal staff turnover. The Tobacco Dependence Treatment Coordinator noted the importance of staying in touch with Medicaid colleagues even when there are no current projects under development or implementation – she sends resources, webinars, and information that can be shared with the MCPs monthly – making sure that she is “giving rather than just asking” along the way.

New Hampshire: A Comprehensive Approach

New Hampshire’s efforts to expand tobacco cessation coverage in Medicaid included both RFP language and contract language to address coverage, performance measures, and reporting. In early 2018, New Hampshire Medicaid prioritized reducing tobacco use and dependence in the state Medicaid population, which created an opportunity for collaboration with the state tobacco control program. Prior to 2018, the programs had not worked together, but fortuitously, a consultant that had worked with the state tobacco control program and was a champion for tobacco cessation treatment went to work at Medicaid, offering a new opportunity for a relationship and influence.

The CDC’s 6|18 Initiative connects healthcare purchasers, payers, and providers with CDC researchers, economists, and policy analysts to find ways to improve health and control costs with the 6|18 interventions.

The Medicaid-state tobacco control program collaboration focused on developing cessation benefits model language for the Medicaid MCO procurement process. In addition, New Hampshire applied to participate in the third cohort of the Centers for Disease Control and Prevention’s (CDC) 6|18 Initiative for the purpose of assessing the impact of prior authorizations on tobacco cessation efforts (and successful abstinence). Together, the 6|18 team created the workplan for the Medicaid-state tobacco control program collaboration. Later, Medicaid asked the state tobacco control program to provide draft language for the Medicaid MCO RFP.

The state tobacco control program requested technical assistance from the American Lung Association, the CDC and states participating in North American Quitline Consortium’s Public-Private Partnership workgroup. These subject matter experts assisted with development of requirements. The proposed language was accepted by New Hampshire Medicaid, embedded in



the RFP and then finalized in the Medicaid MCO contract document *under Scope of Services 4.9.5 – Collaboration with the New Hampshire Tobacco Cessation Program*. This section of the scope of services specifies that the MCO shall promote and utilize the state tobacco control program-approved tobacco treatment quitline (QuitNow-NH) and tobacco cessation program, provide comprehensive treatment including coaching, counseling and pharmacotherapy, and report on tobacco cessation activities.

Further clarification is found in a guidance document created by the state tobacco control program which explicitly describes each component. This document was approved by Medicaid and the state tobacco control program has begun working with MCO Compliance Officers. Over the next three to six months, the state tobacco control program expects to learn about Medicaid managed care workflows for meeting the performance measures set forth in the contract, which include:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS): Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit
- CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications
- CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies
- Adult and Youth Community Mental Health Program (CMHP) Eligible Members: Smoking Status

While the work has been delayed due to the COVID-19 pandemic, state tobacco control program staff is optimistic about presenting to the additional MCO Compliance Officers and finalizing plans to ensure all Medicaid smokers have access to expanded benefits.

Florida: Leveraging a Signature Program in the MCO Contract

The Florida state tobacco control program reached out to Medicaid in the time leading up to a new procurement cycle in 2017 but had not yet made their case for expanded benefits before the Invitation to Negotiation (ITN) (similar to an RFP) was released. They were pleased that the ITN included language on smoking cessation but responding MCOs' tobacco cessation benefits and programs were not fully described in the responses. Because they had not been able to find a way to engage in drafting the Invitation to Negotiate, Laura Corbin, Bureau Chief of Florida's state tobacco control program, felt they had "missed their golden opportunity."

In 2019, a new hire at the state tobacco control program who had a personal relationship with a deputy secretary at Medicaid reached out to explore ways to further develop the relationship between the state tobacco control program and Medicaid. In this process they learned that the state Medicaid agency had included a requirement for the MCOs to develop programs to reduce Potentially Preventable Events (readmissions, hospitalizations and emergency department visits that add costs and are correlated with low quality outcomes) as a central feature of their new



contracts. They also learned that the MCOs had to submit quarterly reports on health behaviors. The state tobacco control program saw an opportunity to highlight the role that tobacco plays in many of the preventable events. Medicaid allowed the state tobacco control program to field a comprehensive survey of the MCOs regarding tobacco coverage, provider and enrollee support, member identification and knowledge of available programs and resources. It took persistence but eventually all 13 MCOs responded. The information was aggregated and shared with Medicaid, which gave the state tobacco control program permission to share it with the MCOs. The state tobacco control program reached out to the MCOs and offered to share their results to benchmark against the aggregate results. To date, eight of thirteen have agreed. These sessions created a vehicle for information sharing and opened the doors to a number of different opportunities for the state tobacco control program to support the MCOs.

The relationship with Medicaid is much stronger because of this work and has created opportunities for other programs, such as Chronic Disease Management, to engage with the Potentially Preventable Events initiative to promote their programs.

Non-Procurement Cycle Options

Procurement is an ideal time to encourage MCO cooperation with the state tobacco control program's cessation recommendations because MCOs are highly motivated to offer competitive programs during the bidding process. However, since there are years between procurement opportunities, other options to influence Medicaid and MCO support for tobacco cessation also are important. These options typically start with educating Medicaid about the impact of tobacco use and cessation and then leveraging that knowledge into administrative action. If the procurement timeline precludes addressing tobacco cessation coverage through the bid and contracting process, development of a Medicaid bulletin (formal publications that inform MCOs or providers of Medicaid news or policy changes) and administrative rule-making present additional options.

South Carolina: Medicaid Bulletin

The South Carolina Medicaid agency and the state tobacco control program participated in the CDC's 6|18 initiative and built a partnership between the two agencies. These efforts led to successful standardization of tobacco cessation treatment coverage across MCOs, modification of Medicaid payment policies in fee-for-service and managed care and additional financial support for the South Carolina Tobacco Quitline through a 50% federal administrative match for services offered to Medicaid beneficiaries. This process was documented in an American Lung Association [case study](#).

In South Carolina, five Medicaid MCOs cover approximately 70% of the Medicaid population and have a high proportion of tobacco users. Depending on the MCO, between 33% and 40% of enrollees smoke.¹⁴ The Medicaid agency engaged its actuaries to analyze the fiscal impact of an enhanced tobacco cessation benefit on the Medicaid capitation (the monthly price paid to the MCOs for each enrollee). The state tobacco control program presented the case for coverage of all tobacco cessation medications and counseling without barriers as recommended by the CDC to the Medicaid MCO medical directors. South Carolina Medicaid and its MCOs deemed the costs reasonable and on July 1, 2017, Medicaid formally unveiled the [policy change](#). It provided a comprehensive tobacco cessation benefit without copayment or prior authorization to South Carolina Medicaid enrollees in fee-for-service and managed care settings. Communication included the release of a [Medicaid bulletin](#) to all state Medicaid MCO providers. A communication plan was developed to engage providers and Medicaid members to bolster use of the enhanced benefit.

The CDC's 6|18 initiative strives to create working partnerships between State Medicaid programs and public health programs. Twenty different states included a tobacco component in their 6|18 work, which has provided additional insights into successful partnerships to improve tobacco cessation services.

Oklahoma: Rule Making and Staffing Strategy

Oklahoma has not yet implemented Medicaid expansion and was not a Medicaid expansion state at the time of the administrative actions mentioned below[†]; the state also does not use MCOs. However, integrating evidence-based tobacco cessation coverage and support was a priority for the state Tobacco Prevention program in the Oklahoma State Department of Health and the Tobacco Settlement Endowment Trust. The Trust was established with Master Settlement Agreement funds and is required to spend only the earnings from its endowment on health. The Trust's founding Executive Director came from the state tobacco control program and had deep experience in tobacco cessation and an established relationship with the Medicaid agency. The Trust leveraged its resources and its relationships to gain coverage of cessation services and to embed a staff person in the Medicaid agency. The Medicaid agency hired an individual who "spoke insurance" and then the tobacco program taught the individual about tobacco and cessation.

Even with the benefit of funding and relationships, they faced barriers in convincing Medicaid to expand coverage, as the first entity in the state to do so. The Trust's Executive Director at the time described a four-step process to convince Medicaid:

1. Because there was no Medicaid tobacco use data for Oklahoma, they used general BRFSS data to calculate the cost of doing nothing.
2. They then showed Medicaid what it would cost to provide a benefit

[†] Oklahoma expanded Medicaid through a ballot initiative on June 30, 2020



3. Using the ROI tool developed by Kaiser Center for Health Research and showcased on America's Health Insurance Plans (AHIP) website <http://www.businesscaseroi.org/roi/default.aspx>, they demonstrated the potential for savings.
4. On a parallel track they shared the results of the Massachusetts' Medicaid programs investment in tobacco cessation and brought in a respected subject matter expert for additional education and influence. Together, the results were very eye opening.

To allay Medicaid's fear of a program with runaway costs and utilization, they agreed to some limits on the benefits, including a prior authorization requirement. The Executive Director indicated that it probably would not have been approved without prior authorization and that it was exceedingly difficult to eventually remove the requirement.

Recommendations

Several common themes and recommendations emerge across the state examples described in this issue brief and other cross-sectoral efforts such as 6|18. These recommendations are important for state tobacco control programs interested in expanding Medicaid tobacco cessation coverage, no matter the stage in the procurement cycle:

1. Develop a relationship with the Medicaid agency staff. The CDC's 6|18 program helped facilitate these relationships in several states, but regardless of how it occurs, it is critical. One important piece of advice is to recognize that Medicaid staff are as busy and under-resourced as health department staff.
2. Stay focused on how important the Medicaid population is in order to fulfill the mission of public health. Remembering that this is a high-needs population relative to tobacco use can help you keep prioritizing relationship-building even when progress seems slow.
3. Find a champion for tobacco cessation coverage in Medicaid. This can be achieved through long-standing relationships such as Michigan's experience or funding a position in the state Medicaid program such as Oklahoma's initiative. Sometimes, staff move from one agency to the other as in New Hampshire, and in those instances, it is important to capitalize on that existing relationship. In Florida there were staff members from the tobacco control program who had moved to Medicaid, as well as the prior relationship between a new person and a Medicaid deputy secretary.
4. Use existing tools and language developed by other states and for other initiatives as a starting point. There are many different examples of initiatives that require collaboration between Medicaid agencies and state health departments. By-products of those initiatives include case studies, model language, educational webinars and peer resources. Several states indicated these resources were invaluable and, in some instances, even provided

Sally Herndon with North Carolina Public Health said prior to their work on tobacco cessation the relationship they had with Medicaid was simply "on paper ...we have now developed relationships with our sister agencies that can serve us down the road".



insight that they did not yet realize they needed.

5. Simplify the processes for plans and providers to work with your Quitline program so that once the MCO has agreed to provide coverage, it is easy to engage them in using the Quitline.
6. Stay connected with the Medicaid agency staff – even when you are not working on a joint project. Share material and resources so that there is value for all parties. Florida’s willingness to help Medicaid with their Potentially Preventable Events program on an ongoing basis has been invaluable.
7. Know the language that Medicaid and their MCOs speak. Oklahoma hired people with health systems expertise and trained them in tobacco. Florida benefited from the prior experience of a staff person who came from the hospital industry and was able to navigate the MCO world.

Conclusion

Many state tobacco control programs have had success working with individual MCOs, whether commercial or Medicaid, on shared initiatives to promote tobacco cessation. Yet, understanding ways to leverage the Medicaid MCOs’ relationship with the state Medicaid program and how those MCOs interact with the state during the procurement process adds critical information for creating partnerships that can expand, improve and standardize tobacco cessation coverage. These partnerships can be most impactful if contractually embedded during the procurement process, but state tobacco control programs should not hesitate to use the other options described in this brief if procurement cycle timing is not in sync with tobacco cessation coverage expansion goals.

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