Joint_MD_SB798_Medicaid Coverage for Cessation Tes

Uploaded by: Aleks Casper

Position: FAV

Joint Testimony Senate Bill 798
Finance Committee
Budget and Taxation Committee
March 10, 2026
Support

Chair Beidle, Chair Guzzone, Vice-Chair Hayes, Vice-Chair Rosapepe and Members of the Committees:

Thank you for the opportunity to provide comments on Senate Bill 798, Public Health- Maryland Medical Assistance Program – Tobacco Cessation sponsored by Senator Lam. The American Lung Association, American Heart Association and the American Cancer Society Cancer Action Network **support** this bill as a way to ensure that all Maryland Medicaid enrollees have access to the fully array of evidence-based treatments to quit tobacco.

Tobacco use remains the leading cause of preventable death in the United States, killing an estimated 490,000 Americans and 7,490 Marylanders each year.[1] However, nearly seven out of ten people who smoke want to quit.[2] Senate Bill 798 would ensure that people who smoke who are enrolled in Medicaid would have access to a comprehensive, barrier-free quit smoking benefit including all Food and Drug Administration (FDA) approved medications and all three forms of counseling proven to help people quit.

Nearly 25% of Marylanders enrolled in Medicaid smoke[3] and according to the American Lung Association's State of Tobacco Control[4] healthcare costs attributed to smoking is $2.7 billion annually.

Quitting smoking is effective at reducing the risk of death and disease, and most Medicaid enrollees who smoke want to quit. Healthcare coverage of all evidence-based quit tobacco treatment without barriers to access leads to higher rates of quitting and saves money. Maryland could save $53.6 million in Medicaid costs the year following a one percent decrease of the smoking rate.[5]

Maryland's current Medicaid coverage of quit tobacco treatments varies and some enrollees face barriers to access including prior authorizations and step-therapy requirements. All ten treatments are considered first line treatments, with many people who use tobacco going through either or more quit attempts before they quite for good – often having to try different treatments to ultimately find the one that will be successful. Senate Bill 798 seeks to remedy gaps in coverage and ensure all Maryland enrollees have barrier-free access to all FDA-approved medications and all three forms of counseling proven to help people quit tobacco.

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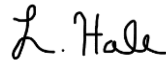
The American Lung Association, American Heart Association and the American Cancer Society Cancer Action Network thanks the Maryland General Assembly for their continued commitment to the health and wellbeing of the residents of Maryland. The American Lung Association, American Heart Association and the American Cancer Society Cancer Action Network support Senate Bill 798 which will ensure barrier free access to all FDA-approved treatments to quit tobacco. We encourage swift action to move the bill out of committee and passage by the General Assembly.

Sincerely,



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[1] U.S. Department of Health and Human Services. Eliminating Tobacco-Related Disease and Death: Addressing Disparities—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, 2024.
[2] VanFrank B, Malarcher A, Cornelius ME, Schecter A, Jamal A, Tynan M. Adult Smoking Cessation — United States, 2022. MMWR Morb Mortal Wkly Rep 2024; 73:633–641. DOI: http://dx.doi.org/10.15585/mmwr.mm7329a1
[3] 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. doi:10.1001/jamanetworkopen.2019.2307
[4] American Lung Association, State of Tobacco Control Report. 2026. Maryland | State of Tobacco Control | American Lung Association
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Public Health Law Clinic_SB798_FAV.pdf
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Testimony in Support of Senate Bill 798

Public Health - Maryland Medical Assistance Program - Tobacco Cessation

Before the Senate Finance Committee: March 10, 2026

Tobacco use remains the leading cause of preventable disease and death in the United States, responsible for more than 490,000 deaths each year and over $600 billion in annual health care expenditures and productivity losses nationwide.[1] In Maryland alone, tobacco use causes more than 7,500 deaths each year and results in billions of dollars in annual health care costs.[2] Ensuring access to effective tobacco cessation treatment remains a major public health priority.

Tobacco use also remains disproportionately concentrated among Medicaid enrollees. Recent estimates indicate that approximately 19% of adult Medicaid enrollees in Maryland report daily tobacco or nicotine use, roughly one in five beneficiaries.[3] By comparison, tobacco use among the overall adult population in Maryland is substantially lower. This disparity reflects longstanding patterns in which tobacco companies have heavily targeted low-income communities through marketing and product promotion. While most Medicaid enrollees do not use tobacco, the higher prevalence within the Medicaid population means a significant portion of beneficiaries may benefit from cessation support.[4] Federal data also consistently shows that smoking prevalence among Medicaid enrollees is significantly higher than among privately insured adults.[5] Thus, it makes sense for Maryland to target tobacco cessation support to Medicaid enrollees.

Senate Bill 798 strengthens access to tobacco cessation treatment for those covered by the Maryland Medical Assistance Program (Maryland Medicaid). The bill requires coverage of individual and group counseling for tobacco cessation, subject to state budget limitations and federal law, and prohibits prior authorization requirements for tobacco cessation medications and services. SB 798 builds on existing Medicaid cessation coverage by ensuring access to both individual and group counseling and by removing prior authorization barriers that can delay or

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[1] Campaign for Tobacco-Free Kids, The Toll of Tobacco in the United States, https://www.tobaccofreekids.org/problem/toll-us.
[2] Campaign for Tobacco-Free Kids, The Toll of Tobacco in Maryland, https://www.tobaccofreekids.org/problem/toll-us/maryland.
[3] Urban Inst., *Treatment for Tobacco and Nicotine Use Disorder in Medicaid* tbl. 6 (2025), https://www.urban.org/sites/default/files/2025-04/Treatment_for_Tobacco_and_Nicotine_Use_Disorder_in_Medicaid.pdf.
[4] Andrea DiGiulio et al., *State Medicaid Coverage for Tobacco Cessation Treatments and Barriers to Accessing Treatments — United States*, 2018-2022, *73 MMWR* 301 (2024).
[5] Id.

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discourage evidence-based treatment. In doing so, the bill improves access to cessation services for Medicaid beneficiaries.

Federal law already establishes a baseline for tobacco cessation coverage in Medicaid. First, Medicaid must cover tobacco cessation counseling and pharmacotherapy for pregnant beneficiaries and may not impose cost-sharing for those services.[6] Second, since January 2014, federal law has prohibited state Medicaid programs from excluding FDA-approved tobacco cessation medications from coverage.[7] However, federal law permits states to apply utilization management tools such as prior authorization and quantity limits for these medications.[8] Thus, while cessation medications cannot be categorically excluded, states retain discretion regarding administrative requirements.

Maryland is a Medicaid expansion state. Adults eligible through expansion receive coverage through Alternative Benefit Plans ("ABPs"), which must include the Essential Health Benefit category of preventive and wellness services.[9] Tobacco cessation interventions for adults carry a U.S. Preventive Services Task Force Grade A recommendation, meaning there is high certainty of substantial net benefit.[10] Because ABPs must include preventive and wellness services, and tobacco cessation interventions fall within that preventive services category, cessation services must be included for expansion adults. However, federal law does not require coverage of specific counseling formats (such as individual or group counseling), nor does it prohibit prior authorization, session limits, or other utilization controls for nonpregnant adults. These design choices are left to the states. In other words, federal law establishes a coverage floor—cessation services must be covered—but it leaves states discretion over how those services are structured and accessed unless state law provides otherwise.

SB 798 addresses this gap. While federal law establishes that cessation medications cannot be excluded and that preventive services must be covered in expansion plans, it does not require states to eliminate administrative barriers or explicitly codify individual and group counseling coverage in Medicaid statute. SB 798 would ensure that counseling is clearly

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[6] Social Security Act §§ 1905(bb), 1916(b)(2)(B), 42 U.S.C. §§ 1396d(bb), 1396o(b)(2)(B).
[7] 42 U.S.C. § 1396r-8(d)(2)(D).
[8] 42 U.S.C. § 1396r-8(d)(1)(A); 42 C.F.R. § 440.230(d).
[9] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001(a)(1), 124 Stat. 119 (2010) (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)); 42 U.S.C. § 1396u-7; 42 C.F.R. § 440.347(a)(9).
[10] U.S. Preventive Servs. Task Force, *Tobacco Use in Adults and Pregnant Women: Counseling and Interventions* (Jan. 19, 2021), https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions; see also U.S. Preventive Servs. Task Force, *Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Persons*: U.S. Preventive Services Task Force Recommendation Statement, 325 JAMA 265 (2021), https://jamanetwork.com/journals/jama/fullarticle/2775287.

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available and that prior authorization does not function as a barrier to accessing cessation treatment.

Maryland's current approach is more restrictive than the policies adopted by several leading states, particularly for the standard (traditional) Medicaid population. Federal law requires Medicaid expansion enrollees to receive coverage for evidence based tobacco cessation interventions as part of the preventive services included in ABPs.[11] Coverage and access policies for standard Medicaid enrollees are governed by different federal rules and therefore vary substantially across states.[12] Nationally, approximately 80 percent of Medicaid enrollees are covered under standard Medicaid eligibility categories rather than the expansion group.[13]

In the most recent CDC analysis of standard Medicaid benefits, based on state policy verification conducted by the American Lung Association, 20 states were reported to provide comprehensive tobacco cessation coverage for standard Medicaid enrollees, and Maryland is not currently among those states.[14] The same analysis found that three states (Kentucky, Missouri, and Wisconsin) reported no access barriers such as prior authorization or duration limits.[15] Some states have addressed these barriers directly through legislation. For example, Ohio law prohibits prior authorization requirements for tobacco cessation medications under its Medicaid program, helping ensure that beneficiaries can access treatment without administrative delay.[16]

Maryland covers cessation medications and offers counseling, but gaps and barriers remain, particularly around group counseling and prior authorization. For example, Maryland's Medicaid fee-for-service system covers individual counseling but does not list group counseling as a covered service. Coverage of group counseling also varies across managed care plans, and prior authorization requirements still apply to certain cessation medications.[17]

SB 798 moves Maryland toward the more comprehensive, lower-barrier model by explicitly requiring both individual and group counseling and by preventing prior authorization from functioning as a barrier to cessation medications and services.

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[11] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001, 124 Stat. 119 (2010); see also 42 U.S.C. § 1396u-7(b)(5) (requiring Alternative Benefit Plans to include preventive and wellness services consistent with Essential Health Benefits).
[12] U.S. Preventive Servs. Task Force, *Interventions for Tobacco Smoking Cessation*.
[13] DiGiulio et al., *State Medicaid Coverage*, 73 MMWR at 301-02.
[14] Id. at 301. The report also defines "comprehensive" coverage for standard Medicaid as coverage of the seven FDA-approved tobacco cessation medications together with individual, group, and telephone counseling.
[15] Id. at 304-05.
[16] Ohio Rev. Code Ann. § 5164.10.
[17] Maryland Medicaid Tobacco Cessation Treatment Coverage Review, University of Maryland School of Medicine Tobacco Control Research Center (2025).

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Tobacco cessation treatments are strongly supported by decades of public health research. The USPSTF concludes with high certainty that behavioral counseling and FDA-approved pharmacotherapy substantially improve tobacco cessation outcomes for adults who smoke.[18] Evidence also shows that combining counseling with medication substantially increases quit rates compared with minimal treatment or usual care.[19] SB 798 therefore represents a modest but meaningful step that strengthens access to evidence-based cessation treatment for Maryland Medicaid beneficiaries.

For these reasons, the Public Health Law Clinic respectfully urges a favorable report on Senate Bill 798.

This testimony is submitted on behalf of the Public Health Law Clinic at the University of Maryland Carey School of Law and not by the School of Law; the University of Maryland, Baltimore; or the University of Maryland System.

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[18] U.S. Preventive Servs. Task Force, *Interventions for Tobacco Smoking Cessation*.
[19] Patnode, C. D. et al., *Behavioral Counseling and Pharmacotherapy Interventions for Tobacco Smoking Cessation*, USPSTF Evidence Review (Jan. 19, 2021), https://www.uspreventiveservicestaskforce.org/uspstf/document/final-evidence-summary/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions.

Patient 1.pdf
Uploaded by: Janaki Deepak
Position: FAV

2/27/2026

I, Alfred Beads, Jr., am testifying as a citizen in my individual capacity.

Alfred Beads, Jr. spoke to us in support of Senate Bill 798 and agreed to have his name and words shared here today. He has Medicaid. He said he was lucky to not have trouble getting his tobacco treatment medications covered, but emphasized that patients with Medicaid should be free to try a variety of medications in pursuit of the one that works best for them. His experience is a great example of why coverage should not be limited to one or two of the FDA-approved medications for tobacco treatment – what works for one person might not work for the next.

"I was very fortunate when I got Chantix since the other medications (nicotine replacement therapy) hadn't been as effective for me. When those meds didn't work, I felt discouraged. They weren't taking the cravings away. I would have loved to be able to go cold turkey but I couldn't. Chantix almost immediately started to have an impact. It's a tiny pill but it took away the desire and cravings and my whole mindset changed. Cigarettes didn't even taste the same because Chantix took away the enjoyment of the cigarette. I have not smoked in over two years and now I can be around people who smoke. I have no temptation to smoke – I just don't think like that anymore. I would recommend Chantix to anyone who is serious about stopping smoking. My appetite increased, my food tastes better, and my health is a lot better now. I have gained a little weight but I'd much rather that than lung cancer. Chantix should be given to people trying to stop smoking unless the other meds work better for them.

I have friends and neighbors who did not get the medications covered and I feel very lucky that I did. Two days before I was supposed to have neck surgery due to spinal compression in February of this year, my insurance said they wouldn't cover it. I don't see how the insurance company could make a call like that when they don't even know me. My doctor has known me for years. The insurance company is outside the room. I feel like I'm just a name or a number on a piece of paper. What's the point of my doctor making a recommendation if insurance isn't going to cover it? Is it motivated by money? The patient's best interest should always be our priority.

I'd hoped to get my surgery several years ago but I didn't have anyone to help me during recovery. Now I have a significant other who I met a year ago. She doesn't smoke – she really dislikes smoking! Now I am ready for my surgery and I have the support I need to

succeed. My doctor has appealed the insurance company's decision and I pray that my surgery will be covered."

Patient 2.pdf
Uploaded by: Janaki Deepak
Position: FAV

3/2/26

I, Sheila Thompson, am testifying in my capacity as a citizen.

Sheila Thompson spoke to us in support of Senate Bill 798 and agreed to have her name and words shared here today. She has Medicaid and Medicare. In 2011, she tried to stop smoking cigarettes by using patches and gum. She said the medications were expensive and weren't working well for her at that time, so she tried vaping and instantly stopped smoking. She vaped consistently until the fall of 2024 when she stopped completely with the help of nicotine patch, Nicotrol inhalers, and counseling. The inhalers weren't covered by her insurance so she obtained them with the help of Pfizer Patient Assistance Program and samples purchased by the Nicotine Health Clinic from Kea Health. The patches were not covered either so she has relied on clinic samples and the Quitline to provide patches.

"I went from regular cigarettes to electronic cigarettes in 2011 to try to stop smoking. I stopped smoking regular cigarettes entirely. Before trying the electronic cigarettes, I had tried the gum and patch. I didn't do it consistently and I was removing the patches to smoke. I'm sure those meds were good, I just don't do well with new medicines sometimes. Gum and lozenges helped my grandson a lot. But when I was introduced to e-cigarettes, I didn't know the harm I was doing to myself until Dr. Deepak showed me that the vapes were hurting my body.

It was very hard to fight nicotine dependence along with insurance not covering medication because everything was so expensive out of pocket. The patches alone were very expensive. Same with the lozenges and gum. You have to put out so much money for the medications try to stop smoking and then you don't have any money left to spend when you need more medicine, so you're back to square one. When I found out that Nicotrol was going away (discontinued by Pfizer), I was really disappointed and a little shaky. Unrestricted access to Nicotrol was fantastic. Patches and Nicotrol and counseling are what really did it."

patient 3.pdf
Uploaded by: Janaki Deepak
Position: FAV

3/2/26

I, Alvin Carroll, am testifying in my capacity as a citizen.

Alvin Carroll spoke to us in support of Senate Bill 798 and agreed to have his name and words shared here today. He has Medicaid. Mr. Carroll stopped smoking in 2022 with the help of the nicotine patch and nicotine inhaler. The inhaler wasn't covered by his Medicaid plan so he participated in the Pfizer Patient Assistance Program, which sent him free Nicotrol inhalers. That program ended in 2023 and Mr. Carroll relied on the remaining Nicotrol, the Nicorette Inhalators (available in Europe, Canada, Australia, and New Zealand) from Kea Health, and lozenges which he said did not compare to Nicotrol but usually helped in a pinch. His dependence is very high and he has struggled to wean. In 2025, we had no more inhalers to give him. Mr. Carroll tried his best but relapsed about two months ago.

"I feel hurt that I did pick it up again. I thought I had this thing under control but the devil got me again. I…feel like I smoke too much. Smoking causes all kinds of cancer to the body. Everybody got different triggers. My trigger was that I like to have something to hold in my hand. I'm always trying to stay busy. When I wasn't smoking, my body was feeling good, I was picking up weight. Now my appetite is starting to act funny again. If insurance companies could just come up with something that meets people halfway, that'd be fine. These insurance companies are cutting a lot of stuff, including one of my medications that helps my appetite.

When my insurance wouldn't cover Nicotrol, I got real scared. Then Nicotrol was discontinued by Pfizer and it made me feel hurt, like I lost a best friend. It was like a stab in the back. I feel real disappointed. The inhaler kept me motivated, people was complimenting me! People would ask me how I quit. I said I went to the doctor, got some meds, and boom! When that worked for me, it made me feel so good. I don't want to keep smoking. I want to quit forever. I just hope and pray that something will come through for people that are really trying to quit smoking."

SB798 Maryland Medical Assistance Program - Tobac
Uploaded by: Kathryn Feeley
Position: FAV

March 6, 2026

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis, Maryland 21401

RE: Senate Bill 798 Public Health - Maryland Medical Assistance Program - Tobacco Cessation

Dear Chair Beidle:

The Maryland State Council on Cancer Control (Council) respectfully submits this letter of support for Senate Bill 798 (SB 798), which would require the Maryland Medical Assistance Program, subject to budget limitations and federal law, to provide individual and group tobacco cessation counseling and would prohibit prior authorization requirements for tobacco cessation products and services.

SB 798 represents a critical and evidence-based step toward reducing tobacco use, preventing cancer, and improving health outcomes for Maryland residents who rely on Medicaid coverage.

Strengthening Access to Evidence-Based Tobacco Cessation Services

Tobacco use remains the leading preventable cause of cancer incidence and cancer-related mortality. Comprehensive tobacco cessation services—including behavioral counseling and pharmacotherapy—are well established as the most effective approach to helping individuals quit successfully. SB 798 strengthens Maryland's tobacco control framework by ensuring Medicaid enrollees have access to both individual and group counseling, services that are proven to improve quit rates and long-term abstinence.

Removing Barriers That Undermine Quit Attempts

Prior authorization requirements create unnecessary delays and administrative barriers that can disrupt quit attempts at the moment individuals are most motivated to stop using tobacco. SB 798 appropriately removes these barriers by prohibiting prior authorization for tobacco cessation products and services, allowing clinicians and cessation providers to respond immediately to patient readiness.

Supporting Face-to-Face Counseling and Community-Based Support

Research consistently demonstrates that face-to-face tobacco cessation counseling, including one-on-one coaching and group-based interventions, improves quit success - particularly when combined with pharmacotherapy. In-person and group-based services provide accountability, peer support, skill-building, and culturally responsive engagement.

Advancing Health Equity and Cancer Prevention

Medicaid enrollees experience higher rates of tobacco use and tobacco-related disease. By expanding cessation counseling benefits and removing utilization barriers, SB 798 directly addresses disparities in access to preventive services.

Aligning With Maryland's Comprehensive Cancer Control Goals

The Council supports policies that advance prevention, early intervention, and risk reduction across the cancer continuum. SB 798 aligns with Maryland's comprehensive cancer control priorities by strengthening tobacco cessation infrastructure.

For these reasons, the Maryland State Council on Cancer Control strongly supports SB 798 and respectfully urges the Senate Finance Committee to give the bill favorable consideration.

Thank you for your leadership and continued commitment to public health and cancer prevention in Maryland.

Sincerely,

Taofeek Owonikoko, MD
Chair
Maryland State Council on Cancer Control

Joint_MD_SB798_Medicaid Coverage for Cessation Tes

Uploaded by: Lance Kilpatrick

Position: FAV

Joint Testimony Senate Bill 798
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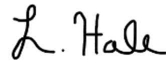

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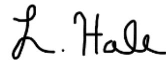

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[1] U.S. Department of Health and Human Services. Eliminating Tobacco-Related Disease and Death: Addressing Disparities—A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2024.
[2] VanFrank B, Malarcher A, Cornelius ME, Schecter A, Jamal A, Tynan M. Adult Smoking Cessation — United States, 2022. MMWR Morb Mortal Wkly Rep 2024; 73:633–641. DOI: http://dx.doi.org/10.15585/mmwr.mm7329a1
[3] 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. doi:10.1001/jamanetworkopen.2019.2307
[4] American Lung Association, State of Tobacco Control Report. 2026. Maryland | State of Tobacco Control | American Lung Association
[5] 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. doi:10.1001/jamanetworkopen.2019.2307

NCADD-MD - 2026 SB 798 FAV - Tobacco Cessation - S

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Position: FAV

Senate Finance Committee
March 10, 2026

Senate Bill 798 - Public Health - Maryland Medical Assistance Program - Tobacco Cessation
Support

NCADD-Maryland supports Senate Bill 798. Nicotine addiction substantially increases the risk of cancer, stroke, and heart attacks among other negative health impacts. According to NIH's National Cancer Institute, Medicaid enrollees have a higher smoking prevalence than the general population. This means that Medicaid pays for the health care services related to smoking.

Providing people who smoke with greater access to tobacco cessation treatments can reduce myriad Medicaid costs, and also reduce morbidity and mortality from cancers and other tobacco-related diseases. But as of 2024, only 26 states provided comprehensive insurance coverage of evidence-based cessation treatments for people enrolled in Medicaid. Maryland is not among them.

Just as Maryland covers treatment of other substance use disorders for Medicaid enrollees, it should cover and provide the greatest access possible to tobacco cessation tools. These treatments are highly cost-effective and evidence-based, resulting in reduced long-term health care costs and lower mortality rates.

We urge a favorable report on Senate Bill 798.

NCADD-Maryland
410-625-6482 · www.ncaddmaryland.org

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DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

March 10, 2026

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401-1991

RE: Senate Bill 798 – Public Health – Maryland Medical Assistance Program – Tobacco Cessation – Letter of Information

Dear Chair Beidle and Committee Members:

The Maryland Department of Health (the Department) respectfully submits this letter of information for Senate Bill (SB) 798 – Public Health – Maryland Medical Assistance Program – Tobacco Cessation. The bill requires the Maryland Medical Assistance Program (Medicaid), subject to the State budget and federal law, to provide coverage for individual and group tobacco cessation counseling and prohibits Medicaid and managed care organizations (MCOs) from requiring prior authorization (PA) for any product or services used to treat tobacco dependence, effective October 1, 2026.

Tobacco cessation counseling and medications are already covered under Medicaid. Specialty mental health (MH) and substance use disorder (SUD) services, including treatment for nicotine dependence when provided as part of covered behavioral health service, are administered through the behavioral health administrative services organization (ASO) and are automatically authorized when medical necessity criteria are met.[1,2] These regulations establish covered services, provider participation, and medical necessity standards for treatment of nicotine dependence as part of covered behavioral health services.

In practice, routine specialty MH and community-based SUD services, including counseling and medication management for tobacco cessation, do not require separate-service level PA. However, primary behavioral health services delivered by a participant's primary care provider or federally qualified health center (FQHC) are the responsibility of the MCO when rendered within the provider's scope of practice and may be subject to MCO prior authorization.[3,4] In contract, tobacco cessations, including nicotine replacement therapy and other medications, are

[1] Code of Maryland Regulations. *COMAR 10.09.59 - Speciality mental health services; COMAR 10.09.80 - Community-based substance use disorder services.*
[2] Maryland Department of Health. 2023. *Provider Transmittal (PT) 17-24 - Billing Reminder for Hospitals Seeking Reimbursement for Carved-Out Behavioral Health Services*
[3] Code of Maryland Regulations. *COMAR 10.69.08.02 - Primary Behavioral Non-Capitated Covered Services.*
[4] Maryland Department of Health. 2024. *Provider Transmittal (PT) 75-24 - Clarification of Reimbursement for Primary Care Services with Carved-Out Diagnosis Codes in FQHCs*

reimbursed through the Medicaid fee-for-service pharmacy benefit, and some medications currently require PA.

The Department estimates that eliminating PA would result in a 15% increase in utilization across affected services to reflect improved access. This is projected to increase annual Medicaid expenditures by approximately $258,000 in total funds ($155,000 federal funds and $103,000 general funds) for tobacco cessation counseling services, and approximately $1.2 million in total funds ($727,000 federal funds and $485,000 general funds) for tobacco cessation medications. Over five years, the total fiscal impact of the bill is estimated at approximately $7 million in total funds ($4.2 million federal funds and $2.8 million general funds) over five years.

If you would like to discuss this further, please do not hesitate to contact Meghan Lynch, Director of Government Affairs at meghan.lynch@maryland.gov

Sincerely,

Meena Seshamani, M.D., Ph.D.
Secretary of Health