



Current Treatment Programs: What are states doing now on cessation?

State Investment In Tobacco Control:

The evidence shows that tobacco prevention and cessation programs work; investments in these programs save lives and money. Unfortunately, most states are not gaining the maximum benefits available because they are not investing in tobacco control programs at the most efficient levels. The total investment in state tobacco control from state and federal sources averages about 56 percent of the minimum recommended funding in CDC's Guidelines, *Best Practices for Comprehensive Tobacco Control Programs*.²⁷ In eighteen states, the combined funding from state and federal sources provides less than 33 percent of the minimum recommended funding. In 2003, only four states invested in tobacco control programs at the minimum recommended funding level.²⁸ These funding levels illustrate a missed opportunity when compared with the increased benefits possible from the recommended funding levels. More can be done, and coverage for cessation services under Medicaid is the perfect place to start.

Services Covered Under State Medicaid:

States have been working to increase the number of cessation programs, but historically large state budget deficits have led to a reduction in services covered by Medicaid. Federal law does not yet mandate states to provide cessation services to Medicaid beneficiaries. Many Medicaid smokers are unaware that they can obtain financial and medical assistance to stop smoking (only 11 states that offer cessation benefits under Medicaid inform recipients of this option).²⁹

The Early and Periodic Screening, Detection and Treatment Program (EPSDT), requires states to provide specific preventive services for youth (under 21), including tobacco dependence treatment. In 2000, when surveyed, seven states covered smoking cessation counseling for children and four states covered counseling for their parents under EPSDT. Sixteen state Medicaid programs covered some form of pharmacotherapy for children and their parents through EPSDT. BupropionSR was the most commonly covered drug.³⁰ Fifteen state programs, under EPSDT, explicitly required providers to screen youths for tobacco use, while only six states explicitly required screening parents.

States are encouraged to make all of their Medicaid enrollees and providers aware of the EPSDT coverage in order to ensure that Medicaid beneficiaries receive cessation services when it is covered. Achieving patient and provider awareness is a key component of maximizing a return on investment. Two-thirds of states that offer EPSDT coverage do not adequately inform their enrollees of this benefit.³¹

Status of Services Covered:

(See Appendices B and C for detailed state coverage data)³²

- Eleven states (Alabama, Alaska, Connecticut, Georgia, Idaho, Iowa, Massachusetts, Missouri, Nebraska, South Carolina and Tennessee) did not cover any of the recommended cessation services under Medicaid in 2002. More than half of these provide statewide quitline services for any resident seeking help to quit, however neither face-to-face counseling nor pharmacotherapy options were available for Medicaid beneficiaries in these states in 2002.
- Nineteen states (Colorado, Florida, Indiana, Kansas, Kentucky, Maine, Minnesota, Mississippi, New Jersey, New Hampshire, North Dakota,

Oregon, Pennsylvania, Rhode Island, Utah, Virginia, Washington, West Virginia and Wisconsin) covered at least one form of adult face-to-face cessation counseling under Medicaid in 2002. However, seven of these states limited access to the available benefit by covering pregnant smokers eligible for Medicaid only (Colorado, Kentucky, Mississippi, New Hampshire, Utah, Virginia and Washington).

- Thirty-seven states currently have quitlines available for smokers to obtain telephone counseling.³³ In a study published by the *New England Journal of Medicine*, an evaluation of the effectiveness of the California tobacco quitline showed that telephone counseling doubled abstinence rates.
- Thirty-seven states offered Medicaid coverage for at least one form of pharmacotherapy in 2002. As with the counseling benefits, coverage in one state (Utah) limited the available benefit to pregnant smokers eligible for Medicaid only.
- Only ten states (Florida, Kansas, Maine, Minnesota, New Jersey, Oregon, Pennsylvania, Utah, West Virginia and Wisconsin) offered comprehensive cessation services for their Medicaid covered smokers in 2002, with some face-to-face counseling, telephone counseling and pharmacotherapy. Due to recent budget shortfalls, several states were forced to cut or suspend funding for quitlines and counseling services in 2003, including Florida and Oregon.

2002 Treatment Data¹

FDA APPROVED MEDICATION	# OF STATES WITH COVERAGE
BupropionSR	36
Nicotine Nasal Spray	28
Nicotine Inhaler	28
Nicotine Patch	27
Nicotine Gum	26
Nicotine Lozenge	Data not available

Many states offer limited pharmacotherapy and telephone quitlines but not counseling services or the recommended combination of comprehensive therapies. Experts agree that effective cessation requires the option to combine various forms of pharmacotherapy and counseling to enable customization of the most effective treatment for each smoker. Medicaid officials have a unique opportunity to help their states' beneficiaries end their addiction to tobacco while utilizing these cost-effective strategies to gain the highest return of investment. While offering coverage for some services is an important step, more can be done to help people who want to quit and save money for the state by offering all of the recommended treatments.

Case Study

Comprehensive Coverage in Maine

The State of Maine is a pioneer in tobacco cessation. The state allocated \$22.3 million for its comprehensive state tobacco treatment program from a combination of Maine's master settlement (MSA) funds and Medicaid funds.³⁴ MaineCare, the state's Medicaid program, covers recommended behavioral and pharmacotherapy treatments for tobacco dependence for all members. Members have pharmacy benefits for the nicotine patch and gum, as well as for the prescription drug bupropionSR. The Bureau of Medical Services (BMS), the state agency responsible for the MaineCare program, pays an additional \$20 to a MaineCare provider who counsels a tobacco user to quit smoking during a clinical visit. Providers are required to document this counseling in the patient's medical record, and use CPT code 99402, ICD-9 diagnosis code 305.1 (tobacco use disorder) for billing. This additional \$20 payment is available for up to three visits per patient per calendar year per provider. If the patient is seen only for tobacco dependence, only the \$20 reimbursement can be claimed. Dentists may also recoup the same additional reimbursement one time per year to provide smoking cessation counseling to MaineCare members under the age of 21 when they are seen for other dental services. In addition, the BMS is working in collaboration with the Bureau of Health to provide smoking cessation support for MaineCare members who are interested in quitting. The BMS has distributed consumer posters and a guideline outlining the U.S. Public Health Service recommendations for tobacco cessation counseling to providers' offices. The statewide quitline, called the Maine Tobacco HelpLine, provides free telephone counseling six days per week. Maine residents who have no insurance are eligible for eight weeks of nicotine replacement therapy through the HelpLine. This service can augment tobacco cessation services offered by providers. In addition, Maine's tobacco control program supports a sophisticated media campaign to raise awareness of the dangers of smoking and to promote statewide tobacco treatment services. From January 2000 to November 2002, Maine's Medicaid costs for cessation pharmacotherapy reached \$3.8 million for about 2.1 million prescriptions. With 26,100 users, the average cost per patient was \$149 during this same time period.³⁵