

RATIONALE FOR TOBACCO CONTROL AND MEDICAID PARTNERSHIPS

Each state Medicaid program is both complex and unique making it difficult to offer generalized recommendations or advice for making changes. Rather, when changes are being considered for any Medicaid program, they need to be uniquely designed to fit into an individual state Medicaid system. Knowledge of the system and a patient timetable are needed to work through the complexities of each Medicaid system in order for any change to be successful.

Medicaid programs typically lack leadership and staff with tobacco cessation expertise. Or, if there is staff with tobacco expertise, their responsibilities may prevent them from devoting the necessary time to program development and oversight. Without that expertise, tobacco cessation benefits, which work best when they are designed to be as barrier-free as possible and regularly promoted, are often designed instead with the same cost controlling and access limiting features as typical benefits. Assumptions may be made that the demand for the benefit will be high, since smoking rates are high, and little effort is made to let anyone know the benefit exists. These steps make sense for benefits in a Medicaid program for which demand IS high. But, they do not help effectively increase access and use of tobacco cessation benefits and services.

The solution lies in the quality of the partnership between tobacco control programs, that have the tobacco cessation expertise, and state Medicaid programs that can facilitate the integration of a comprehensive benefit into their complex system.

DEFINITION OF PARTNERSHIPS

1. An active role for the state tobacco control/cessation program contributing technical support and expertise in the development of Medicaid covered services (e.g. participating in task forces, working groups, training programs).
2. An ongoing role for the state tobacco control/cessation program contributing expertise and technical support and assisting Medicaid staff to develop shared expertise for the sustainability of services.
3. Mutual shared capacity for and completion of data gathering and review for quality improvement purposes (e.g. collaboration of evaluation teams).
4. Shared quality improvement goals that could help lead to (or sustain) services that comply more closely with the PHS Clinical Practice Guidelines with reduced barriers to access.
5. Development of shared strategies for promotion of Medicaid services.
6. Contractual and/or funding relationships.

Definition of “ideal”, PHS compliant, reduced-barrier services:

- Coverage of all FDA approved medications.
- Coverage of multiple options for counseling/coaching (including quitlines)
- Access to several (2-3) courses of medication per year
- Access to multi-session counseling/coaching per year
- Low or no co-pay for services
- As free of restrictions as possible including eliminating: 1) requirements for prior authorization; 2) enrollment in programs to receive medications; 3) stepped care approach – failing on one medication before access to another; 4) limiting duration of pharmacotherapy and counseling and; 5) prescribing only one medication at a time (restricting use of combination medications).