



July 22, 2016

Commissioner Stephen Miller
Department for Medicaid Services
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Dear Commissioner Miller:

We appreciate this opportunity to provide comment on the proposed 1115 Medicaid waiver as it relates to tobacco cessation. Our work at the University of Kentucky College of Nursing BREATHE program is focused on promoting healthy environments, with particular expertise in tobacco prevention and treatment for the people of the Commonwealth.

Tobacco cessation is a critical component of reducing Kentucky's health and economic burdens from smoking-attributable disease. However, we have several concerns with the plan to address tobacco dependence in the current language of the waiver. Our concerns are easily fixable and will ultimately save Kentucky healthcare costs. We urge you to consider the following changes:

- The waiver selects just some components of CMS-recommended tobacco cessation treatment. Counseling is "limited to telephonic and online health coaching" for tobacco cessation, despite the fact that "A" and "B" services recommended by the United States Preventive Services Task Force (USPSTF) cover all forms of behavioral counseling support. CMS is very clear about covering evidence-based tobacco treatment which includes all forms of counseling, thus extending the reach and access that will measurably improve tobacco cessation rates in Kentucky.¹ Expanded coverage of these treatments through our current Medicaid expansion has very likely helped to reduce adult smoking rates in recent years, moving Kentucky in the right direction. Let's not "fix" what is not broken. **We recommend that all forms of counseling (i.e., individual, group, telephonic, online) and all 7 FDA-approved medications, as per the USPSTF "A" and "B" recommendations, be covered to help Medicaid patients quit smoking and using tobacco.**
- The waiver creates new barriers to the access and use of evidence-based cessation treatment, clearly promoting a "dis"-incentive. Specifically, access to over-the-counter (OTC) medications (e.g., nicotine replacement therapy [NRT]) is through My Rewards account dollars. As currently worded, people will not have access to the basics (e.g., NRT) until they earn enough money to pay for it in their My Rewards accounts. Tobacco use is not a simple behavior that can be easily controlled and changed; it is a complex addiction to nicotine that nearly universally starts in youth. We know that 90% of people who use tobacco start before age 18, and the majority are addicted before they are adults. Tobacco use is a chronic, highly addictive condition, characterized by relapse.² There is simply no evidence that incentives are effective in low income populations; a recent study found that surcharges had a net effect of *reducing* cessation.³ Behavior modification alone is not best-practice for addiction. Just as we would not expect diabetics or those with hypertension to "earn their medication" through volunteer or work activities, we should not require those activities to treat the disease of addiction. Earning the right to have your addiction treated is not ethical, practical, nor effective. Such a strategy does not save lives from diseases such as cancer and cardiovascular disease. Nor does it provide employers and all levels of government the immediate healthcare savings that result from reduced smoking rates.⁴ **We recommend that OTC**

medications be covered outright, without prior authorization, and without using My Rewards account dollars. Incentives should not replace evidence-based treatment.

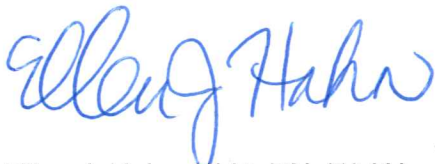
- This story from a family member dealing with lung cancer from the effects of smoking illustrates the critical importance of covering quit methods that work and reducing all barriers to tobacco cessation:

Last October, my husband of almost 50 years was told he had lung cancer. He also learned that he has vascular problems affecting his ability to walk without pain. His addiction to nicotine is a sad yet familiar story, beginning with occasional smoking in high school followed by a strong addiction after two tours of duty on aircraft carriers during the Vietnam conflict. He attempted to quit in the 1980s and he is still struggling today. I stopped counting his attempts to quit smoking when he had tried 20 times. He has used every resource at his disposal (2 series of cessation classes, individual counseling, many kinds and combinations of NRT). He is now taking Chantix because his vascular condition prohibits NRT...which is WORKING for him. During the first 3 months after his lung cancer was discovered our insurance paid at least \$30,000 in diagnostic work. The cost of effective cessation treatment pales in comparison to the ongoing costs of my husband's health care. Carol A. Riker, RN

In summary, we recommend the following changes to the proposed 1115 Medicaid waiver:

1. Cover all 7 FDA-approved medications and all forms of counseling as per the USPSTF "A" and "B" recommendations to help patients quit tobacco products without having to use My Rewards account dollars to pay for OTC medications.
2. Remove prior authorization requirements for FDA-approved cessation medications.

Sincerely,



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