

LETTERS TO THE EDITOR

Letters intended for publication should be a maximum of 500 words, 10 references, and one table or figure, and should be sent to Simon Chapman, deputy editor, at the address given on the inside front cover. Those responding to articles or correspondence published in the journal should be received within six weeks of publication.

Tobacco treatment services should be covered under Medicaid

EDITOR.—In 1997 the National Conference of State Legislatures in the United States conducted a survey of state Medicaid agencies for the Robert Wood Johnson Foundation to determine the extent to which states covered nicotine addiction treatment as a routine benefit under Medicaid (the government programme that provides health care to the poor). Only 22 states and the District of Columbia reported coverage for nicotine addiction treatment services under Medicaid, including only 19 of the 40 states with lawsuits against the tobacco industry to recoup Medicaid costs of smoking. These 22 states were California, Colorado, Delaware, Florida, Louisiana, Maine, Maryland, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, Vermont, and Wisconsin. A repeat survey is now underway to obtain more detailed information on these benefits and to update the findings.¹

We estimate that Medicaid provides health insurance coverage for five million or more smokers, including about 70% of all pregnant smokers. Like their counterparts covered under private health insurance, Medicaid smokers need access to readily available, evidence-based nicotine addiction treatment resources and services. Treatment for nicotine addiction is more cost-effective than many other medical interventions that are routinely covered under Medicaid. Brief quit-smoking advice and counselling from a primary-care provider combined with transdermal nicotine are estimated to cost only \$263 per successful quitter.²

At the time of the 1997 survey, many states were in the process of moving their Medicaid beneficiaries into fully capitated managed care. Almost half of all Medicaid beneficiaries (47.8%) were in some type of managed care in June 1997—up from 23.1% in 1994.³ This shift to managed care represents a unique “window of opportunity” for states to mandate coverage for tobacco treatment services for their Medicaid enrollees. Contracts negotiated between the State Medicaid agency and private health plans offer an important mechanism for building the assessment and treatment of nicotine dependence into standard basic health care services provided for all Medicaid beneficiaries. In addition, these contracts can establish systems of quality assurance and performance measure-

ment. Such efforts are particularly important because of the high prevalence of smoking among Medicaid beneficiaries, including those enrolled in managed care. A survey of adult Medicaid members of five health maintenance organisations in Michigan showed a smoking prevalence of 44%.⁴

Therefore, we urge the tobacco control and public health communities to work with their state Medicaid agencies to incorporate explicit language in their managed-care contracts, policy briefs, lawsuit provisions, and Medicaid formularies to ensure nicotine treatment coverage under Medicaid. In states with actual or potential revenues from tobacco excise tax increases or litigation settlements or awards, it is important to seize available opportunities to designate funds to help support Medicaid coverage of tobacco treatments.

At a minimum, the standard benefit for nicotine addiction treatment under Medicaid should cover: (a) health plan or provider payment for “basic” tobacco treatment interventions for all who use tobacco products, including brief provider quitting advice and counselling along with pharmacotherapies approved by the US Food and Drug Administration as appropriate; and (b) health plan or provider payment for the delivery of more specialised or intensive treatments for the smokers who require them.

These recommendations are consistent with the US Agency for Health Care Policy and Research (AHCPR) guideline⁵ and with recommendations recently set forth by the Center for the Advancement of Health.⁶

Preliminary interviews with tobacco control advocates in several states in March 1998 indicated that state Medicaid agencies can use their purchasing power, regulatory authority, and convening capacities to encourage healthcare systems to deliver evidence-based nicotine addiction treatment for all smokers. In Oregon, for example, state Medicaid contracts with managed-care plans include participation in selected prevention provisions. Medical directors participating in the Oregon Health Plan, the state’s Medicaid managed-care programme, adopted tobacco cessation as their prevention priority in December 1997 and are now implementing a modified version of the AHCPR guidelines throughout their plans. In Michigan, a recently issued Medicaid policy brief lists nicotine treatment replacement therapies that are covered under Medicaid beginning in 1998. We urge that others explore these programmes as models for their own states.

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This letter presents the views of the authors as individuals, and does not necessarily reflect the views of their employers.

- 1 Orleans CT, Schauflier HH, Barker DC, et al. 1997 survey of state policy on nicotine addiction treatment. Paper presented at the 1998 Annual Meeting of the Society for Research on Nicotine and Tobacco, New Orleans, 27–29 March 1998.
- 2 Cromwell J, Bartosch WJ, Fiore MC, et al. Cost-effectiveness of the clinical practice recommendations in the AHCPR Guideline for Smoking Cessation. *JAMA* 1997; 276:1759–66.
- 3 US Health Care Financing Administration (HCFA), Center for Medicaid and State Operations, Data and Systems Group. *National summary of Medicaid managed care programs and enrollment, managed care trends*. Baltimore, Maryland: HCFA, 30 June 1997.
- 4 US Centers for Disease Control and Prevention. Health risk factor surveys of commercial plan- and Medicaid-enrolled members of health-maintenance organizations—Michigan, 1995. *MMWR* 1997;46:923–6.
- 5 Fiore MC, Bailey WC, Cohen SJ, et al. *Smoking cessation*. Clinical Practice Guideline No 18. Rockville, Maryland: US Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, April 1996. (AHCPR Publication No 96-0692.) <http://text.nlm.nih.gov/frs/tocview>
- 6 Center for the Advancement of Health. *Treating tobacco dependence in the U.S.: ad hoc group findings and recommendations*. Washington, DC: Center for the Advancement of Health, 11 February 1998.

Errors in using tobacco withdrawal scale

EDITOR.—Several scientists and clinicians have used a tobacco withdrawal scale either received from us or based on our published work. We would like to make some suggestions about use of our scale to minimise misinterpretation.

First, the name we prefer is the “Minnesota Nicotine Withdrawal Scale.” Second, total withdrawal scores are often reported; however, there is some variance in which symptoms are included and thus scores across studies are not comparable. Many researchers include drowsiness, fatigue, gastrointestinal complaints, headaches, and somatic complaints as scale items because we measured them in our earlier articles. Although a few studies have found evidence of these as withdrawal phenomena, most work indicates these are not valid measures of nicotine withdrawal.^{1,2} Many also omit depression, which was not included in our 1986 study but data collected since then show depression to be a valid withdrawal symptom for some smokers.^{2,3} Some include craving and some do not. Craving was included in our original scale as it was included in the versions of nicotine withdrawal in the third edition and revised third edition of *Diagnostic and statistical manual of mental disorders*. Craving has been dropped in the fourth edition (DSM-IV).⁴ We believe that if craving is queried, it should not be included when calculating a total withdrawal summary score so that the total score represents a sum of DSM-IV items and because there is evidence that craving behaves differently from other withdrawal items.⁵

In summary, we believe the most appropriate scale is one that includes only seven DSM-IV items: depression, insomnia, irritability/frustration/anger, anxiety, difficulty concentrating, restlessness, and increased appetite/weight gain (the eighth item, decreased heart rate, is not detectable on a self-report scale). Items can be rated on an ordinal scale with 0 = not present, 1 = mild, 2 = moderate, and 3 = severe, or on a 0–4

scale with the additional descriptor of "slight" between not present and mild, or using a 100 mm visual analogue scale. The last measure is probably the most sensitive but cannot provide an adjective descriptor to any given value. Whether or not researchers use only the DSM-IV items, we suggest they report which items they have included and the mean score across symptoms rather than a total score. This will improve comparability across reports.

Finally, researchers can obtain our scale and further tips on its use from one of us (JH: fax +1 802 656 9628; john.hughes@uvm.edu; DK: fax +1 612 626 5168; hatsu001@tx.umn.edu).

Other withdrawal scales can be obtained from Doug Jorenby (fax: +1 608 265 3102; dej@ctri.medicine.wisc.edu), Nina Schneider (fax: +1 310 478 6349; ngs@ucla.edu), or Saul Shiffman (fax: +1 412 687 4855; shiffman@pinneyassociates.com).

- 1 Hughes JR, Higgins ST, Hatsukami DK. Effects of abstinence from tobacco: a critical review. In: Kozlowski LT, Annis H, Cappell HD, et al, eds. *Research advances in alcohol and drug problems, vol. 10*. New York: Plenum Press, 1990:317-98.
- 2 Patten CA, Martin JE. Measuring tobacco withdrawal: a review of self-report questionnaires. *J Substance Abuse* 1996;8:93-113.

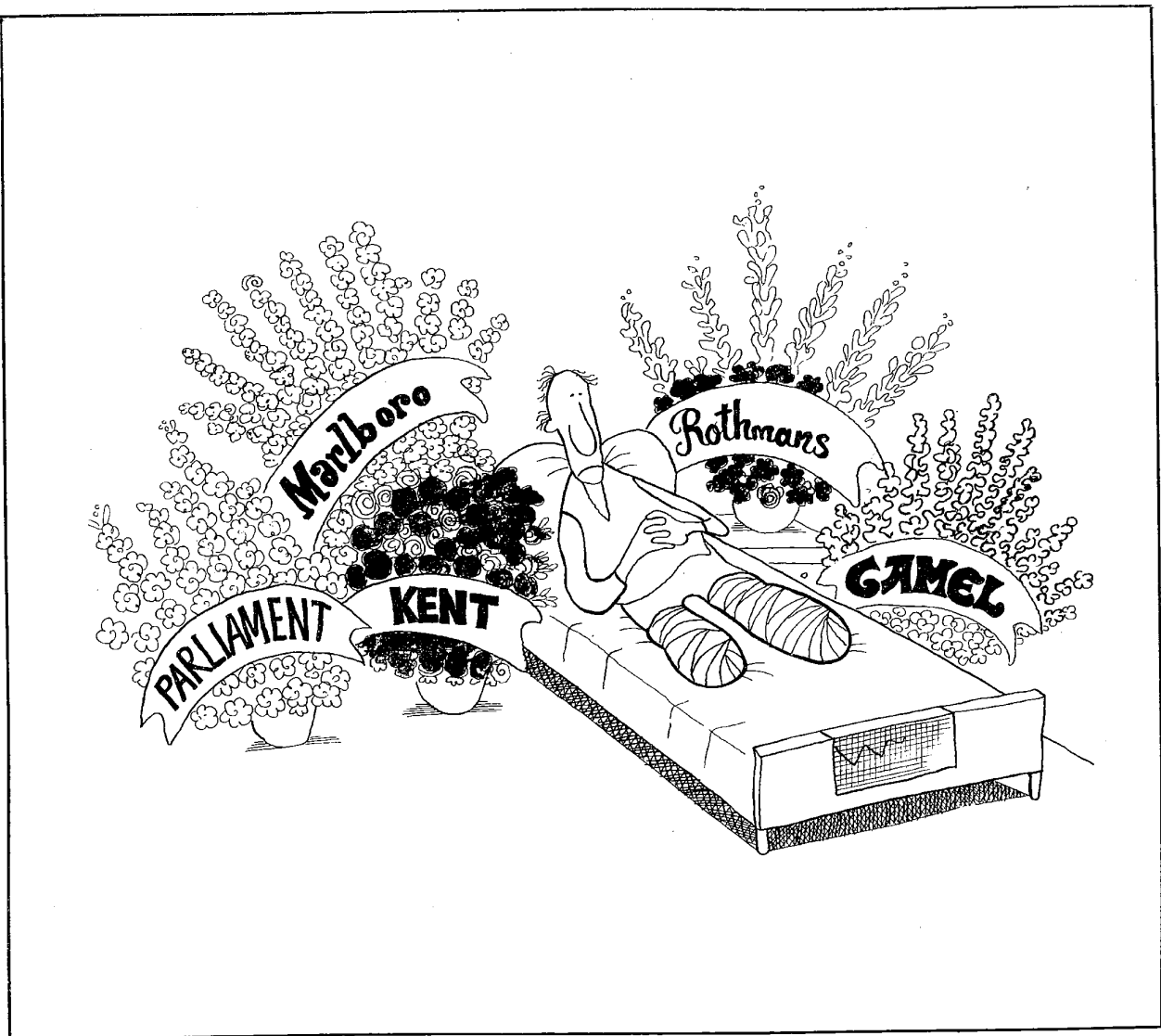
- 3 Covey LS, Glassman AH, Stetner F. Depression and depressive symptoms in smoking cessation. *Comprehensive Psychiatry* 1990;31:350-4.
- 4 American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*. 4th ed. Washington, DC: APA, 1994.
- 5 Hughes JR. Craving as a psychological construct. *Br J Addict* 1986;82:38-9.

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