Medicaid Cessation Coverage Roundtable Report
July, 2014

Medicaid Administrative Match for Quitline Services: A Worthwhile Endeavor?

BACKGROUND

Tobacco Cessation Quitlines as an Allowable Medicaid Administrative Activity

In a letter to State Medicaid Directors on June 24, 2011, the Centers for Medicare and Medicaid Services (CMS) provided guidance on tobacco cessation quitlines as an allowable Medicaid administrative cost expenditure.[1] This decision allows states to claim the 50 percent federal administrative match rate for quitline services to Medicaid beneficiaries. State tobacco control programs viewed, and continue to view, the CMS quitline guideline as 1) a tool for building new relationships with their state Medicaid agencies or strengthening existing ones; 2) a window of opportunity in which to engage their state Medicaid agencies in a broader discussion of comprehensive cessation benefits for the Medicaid population of tobacco users; and 3) a way to further build quitline sustainability efforts through public-public cost-sharing partnerships, especially considering some tobacco programs report that 30-40% of all callers to their state quitline are Medicaid-insured.

Implementing the CMS Quitline Guideline

Developing the Memorandum of Understanding[1]

State Medicaid agencies are the only entity that may submit claims to CMS to receive Federal Financial Participation (FFP) for allowable Medicaid costs. Additionally, federal CMS funds can *only* flow to a state Medicaid agency. Therefore, in order to take advantage of the CMS quitline guideline and draw down federal funds to support quitline services to Medicaid enrollees (and to support quitline sustainability) a state tobacco control program MUST have a formal relationship with their state Medicaid agency and a Memorandum of Understanding (MOU), contract, or Interagency

[1] Adapted from NAQC's *Advice to Guide You: Building a Strong Memorandum of Understanding to Secure Medicaid Administrative Match for Quitline Services*, June 2013.

Agreement (IA) is the mechanism by which this happens.[2] Working out the details of the MOU, contract or IA becomes the heart of the work between the two partners and the first step toward implementing the quitline guideline.

An MOU or interagency agreement is a document describing a mutual agreement between parties (i.e., the state Medicaid agency and the state health department's tobacco control program). Critical components of any MOU or interagency agreement include a clearly defined purpose, a detailed scope of the relationship or agreement and distinctly outlined roles and responsibilities for each party. In addition to these essential components, MOUs related to the CMS quitline guideline outline assurances for both partners, including:

- Assurance that costs submitted do not duplicate costs claimed under any other federal grant, or duplicate costs included in the indirect cost pool. For example, existing CDC grants for quitline expenditures cannot be used as the state share for Medicaid quitline claims.
- Assurance that the state tobacco control program has sufficient state match for the Medicaid-related expenditures, and that the state match on quitline expenditures claimed as Medicaid-related is not being used as state match for any other federal grants.
- Assurance that the state Medicaid agency will distribute the match as a transfer of federal revenue from the Medical Care Programs to an account designated by the tobacco control program.
- Assurance that the state Medicaid agency will serve as a pass-through agency, as they are not required to pass claimed quitline administrative expenditures through to state tobacco control programs.

<u>Amending the Public Assistance Cost Allocation Plan (CAP)[3]</u>

Working out the details of the MOU, contract or interagency agreement is most often the first step in the process to implement the CMS quitline guideline. However, it is followed closely by the need to develop an amendment to the state Medicaid agency's CAP. Medicaid administrative claiming is the payment of FFP, at different matching rates, for amounts "found necessary for the proper and efficient administration of the state Medicaid plan" (Section 1903(a)(7) of the Social Security Act). State and local governments allocate these administrative costs to the Medicaid program in accordance

[2] There are states in which the tobacco control program and the state Medicaid program are within the same state agency or department. For these "umbrella" agencies, an Interagency Agreement (IA) would be needed, not an MOU.

[3] Adapted from NAQC's *Advice to Guide You: Building a Strong Cost Allocation Plan Amendment for Medicaid Administrative Match for Quitline Services*, June 2013.

with the Public Assistance Cost Allocation Plan (CAP). CAPs are approved by the U.S. Department of Health and Human Services (DHHS), Division of Cost Allocation (DCA) after CMS reviews and comments on the fairness of the allocation methods.

A CAP is the tool by which a state Medicaid agency describes the procedures and methodologies used to identify, measure, and allocate specific administrative costs to claim federal grant award funds. When a state Medicaid agency plans to begin claiming new administrative costs, such as those associated with providing quitline services to Medicaid enrollees, they must amend their CAP to show the method(s) used to estimate claimable costs. The CAP amendment must also describe how the state Medicaid agency will ensure that only costs associated with Medicaid enrollees will be claimed.

The CAP amendment must make explicit reference to the methodologies, claiming mechanisms, MOUs, and other relevant sources that will be used for submitting Medicaid administrative claims and appropriately allocating costs. Allowable quitline expenditures are limited to personnel and salary costs associated with implementing and operating a tobacco cessation quitline to the extent it serves Medicaid enrollees. While the 2011 letter to state Medicaid directors offers guidance and details, a November 11, 2011 information bulletin provides further details about allowable costs and claiming methodologies.

Since 2011, the North American Quitline Consortium (NAQC) has provided state tobacco control programs with technical assistance, tools and resources to support securing cost-sharing partnerships with their state Medicaid agencies via the CMS quitline guideline. Over the past three years there have been several lessons learned, challenges strategized and success realized by some. While challenges to implementation of the CMS quitline guideline have been time-intensive and difficult to maneuver for state tobacco control programs, most still believe that working to establish public-public partnerships with Medicaid is critical to ensuring access to evidence-based cessation treatment by a population disparately impacted by tobacco's harm; to encouraging comprehensive cessation coverage by Medicaid for ***all*** of its covered lives; and to supporting the sustainability and success of quitlines.

While the Medicaid administrative match for quitline services has served as critical leverage for some state tobacco programs to engage state Medicaid agencies in cessation-related efforts, it is important to note two important developments that are negatively impacting on current progress: 1) many states are shifting from a primarily fee-for-service Medicaid population to coverage primarily through managed care organizations, which means a shrinking proportion of enrollees covered by the CMS administrative match; and 2) state tobacco control programs taking advantage of the

CMS match still has them paying for 50% of quitline counseling services and 100% of any medications provided to Medicaid enrollees, which is not ideal, especially in light of the Affordable Care Act.

These developments, coupled with nearly three years of lessons learned by state tobacco control programs engaging their state Medicaid agencies in securing the match, require us to consider whether or not the time and energy required to secure the match is a worthwhile endeavor for state tobacco programs and if so, how the process can be better streamlined to support implementation. In its second meeting, the NAQC Medicaid Cessation Coverage Roundtable considered this important issue with the purpose of providing guidance to state health officials and tobacco control program staff, state Medicaid Directors, and CMS so that the CMS quitline guideline may better serve its intended purpose: to increase access to an evidence-based cessation treatment among those most impacted by tobacco's harm.

ROUNTABLE RATIONALE AND PURPOSE

The North American Quitline Consortium (NAQC) Medicaid Cessation Coverage Roundtable is a result of over two years of dialogue, technical assistance and resource development aimed at tobacco control programs working to secure cost-sharing partnerships with their state Medicaid agencies. The impetus of this early work was the June 2011 letter from the Centers for Medicare & Medicaid Services Director (CMS), Cindy Mann, to State Medicaid Directors announcing tobacco cessation telephone quitlines as allowable Medicaid administrative activities and thus, eligible for the 50 percent Federal Medicaid matching rate.[2]

After nearly three years of providing support to state quitlines on securing the Federal Medicaid matching rate for quitline services, it has become clear to NAQC that, in addition to technical support to states working to take advantage of the CMS guideline on quitlines and the ACA, there is **a need to elevate many of the structural, operational and policy barriers** that hinder implementation of comprehensive cessation coverage to Medicaid enrollees to those who are most able to influence change. In order to openly discuss specific topics, identify barriers and make targeted recommendations for addressing them, NAQC determined that a roundtable of leaders from state tobacco control, state Medicaid, CDC's Office on Smoking and Health, and national advocacy organizations who work to ensure access to comprehensive cessation coverage among those who are publicly ensured would be extremely useful. The specific aims of the Roundtable are:

- To work across systems to **improve understanding** of the Medicaid cessation policy landscape in light of the Affordable Care Act (ACA), as well as general changes to Medicaid, that may impact on partnership-building efforts focused on tobacco cessation-related cost sharing and benefit design;
- To clearly articulate to the tobacco control community how specific aspects of the Medicaid policy landscape **impact positively and negatively on efforts** to improve coverage for cessation;
- To **develop targeted recommendations** to decision-makers within HHS, CMS and CDC for addressing identified structural, operational and policy barriers to successful implementation of comprehensive cessation coverage for Medicaid enrollees; and
- To provide **a forum for strategizing and sharing information** on both national and state Medicaid cessation policy priorities.

Medicaid enrollees accounted for 25% of tobacco users served by U.S. quitlines in FY2012.[3] For state tobacco control programs, guaranteeing that smokers insured by Medicaid have access to a comprehensive cessation benefit that includes quitline counseling *and* receiving reimbursement for the evidence-based treatment that quitlines provide to Medicaid enrollees has become a cornerstone of their work. This report aims to bolster these important efforts by states by providing a summary of the NAQC Roundtable's discussion of six questions and recommendations that NAQC believes will accelerate progress toward truly comprehensive cessation coverage, including quitline counseling, for all Medicaid enrollees. With opportunities such as the CMS quitline guideline, the Affordable Care Act and Medicaid Expansion, tobacco users should have more support and options to quit and stay quit than ever before – the question for us is, *How can we most effectively maximize the impact of the CMS quitline guideline and decrease the burden of implementation on state tobacco control programs?*

THE ROUNDTABLE'S VIEW

In this final section of the report, the questions posed to the roundtable, highlights from the discussion and recommendations for accelerating progress are presented.

What is the current status of implementation of the CMS quitline guideline among states?

There are three primary ways in which NAQC has historically captured information related to state efforts to implement the CMS quitline guideline:

1) technical assistance requests by NAQC members;

2) listserv post requests for information and assistance among NAQC members; and
3) NAQC's Annual Survey of Quitlines.

Three questions to assess state Medicaid-related efforts were added to the FY 2012 Annual Survey of Quitlines and the same questions appeared in the FY 2013 survey in order to capture progress. According to results from the FY 2012 survey, 22 states intend to claim (or already claim) Federal financial participation (FFP) for quitline administrative expenditures for Medicaid beneficiaries. A subsequent FY 2012 survey question asks states to note their stage of action as of January 1, 2013 with respect to claiming Federal financial participation (FFP) for quitline administrative expenditures for Medicaid beneficiaries.[3]

Status of State Tobacco Control Programs Regarding Medicaid Match for Quitlines as of January 1, 2013

Stage of Action	Number of States
No action	4
Building relationship	6
Working on MOU	4
Executed MOU	1
Working on CAP	1
MOU executed & CAP approved	1
Invoicing	5

Source: NAQC FY 2012 Annual Survey of Quitlines

Based on NAQC's technical assistance efforts to, and information requests from, members, the following state tobacco control programs have an approved memorandum of understanding (MOU) with their state Medicaid agency to draw down federal matching funds and transfer the federal funds to the tobacco program; or both an executed MOU and approved CAP, but are not yet invoicing; or an invoicing process underway with their state Medicaid agency according to the MOU and cost allocation methodology:

Alabama, Arizona, Arkansas, California, Colorado, Indiana, Louisiana, Maryland, Massachusetts*, Montana, North Carolina, Oklahoma and Texas.

*In Massachusetts, federal matching funds must go to the state general fund and are not allowed to be transferred to a specific program/agency.

ACCELERATING PROGRESS ON ASSESSING CURRENT STATUS OF IMPLEMENTATION

1. How success of the CMS quitline guideline is being measured by CMS or by the tobacco control community remains undefined. Developing a goal for implementation, and at the very least defining a standard measure of success is critical. However, it is important that the measure is focused on implementation, as well as the longer-term impacts on quitline sustainability. For instance, we are unsure of the real-dollar value of the matching funds to state tobacco programs and how these funds are being used to increase access, use and effectiveness of state quitlines.
2. NAQC should continue to gather Medicaid-related data via the Annual Survey of Quitlines. In addition, NAQC should request up-to-date data on implementation efforts quarterly. This requires state tobacco control programs to respond to requests for information in order to have the most accurate, up-to-date picture of implementation of the guideline.

What difference has the match made to tobacco programs and quitline sustainability efforts? To Medicaid tobacco users?

Two roundtable members were pleased with the opportunity to share perspectives on how implementation of the CMS quitline guideline has impacted positively on their work.

Montana has taken time to assess quitline utilization by Medicaid enrollees before and after implementation of the CMS quitline guideline. In 2010, Medicaid enrollees accounted for 7% of all calls to the quitline and in 2013, this percentage rose to 11%. The savings the state tobacco program has realized as a result of the matching funds has allowed them to increase their outreach activities to target populations.

For Maryland, one of the first states to implement the guideline, the relationship with their state Medicaid agency is in many ways the most important outcome of the work. Medicaid enrollees account for approximately 36% of all calls to the Maryland quitline, their state Medicaid agency partners understand that the quitline is effective and that they must continue working together to reduce barriers to tobacco treatment. Certainly, matching funds have helped to defray costs associated with administering the quitline.

ACCELERATING PROGRESS ON THE GUIDELINE'S IMPACT

1. As healthcare reform continues to take shape, the responsibility for paying for quitline services must shift from solely that of the public sector to a shared-cost

model in which the cost of quitline services are borne by the health plans, including Medicaid, responsible for covering the care of particular populations. As recommended in NAQC's Quitlines in the U.S.: An Exploration of the Past and Considerations for the Future, Executive Summary and Recommendations, state tobacco control programs should take a leadership role in establishing cost-sharing partnerships with state Medicaid agencies. These partnerships should go beyond the CMS quitline guideline and should have a very clear link to both comprehensive coverage of tobacco cessation for all Medicaid enrollees (fee-for-service and managed care) and increasing quitline sustainability.

2. Due to the link between the CMS quitline guideline and efforts to increase quitline sustainability, NAQC should develop a mechanism for states to report annually on the percentage of quitline budget that FFP specifically accounts for and real-dollar value of the match, as well as where those funds have been directed. In addition, NAQC should gather data related to percentage of quitline budget that other cost-sharing and/or reimbursement agreements with Medicaid (including Medicaid managed care entities) account for. Together, these figures will help us to gather a national-level view of the overall impact of the guideline, and cost-sharing and reimbursement partnerships with Medicaid.

What are the challenges to implementation of the quitline guideline?

Challenges to implementation fall into four broad categories.

Relationship

- Unfortunately, there are state tobacco programs that find it nearly impossible to build relationship with their state Medicaid agency due to:
    - historical mistrust
    - difficult political and budget climates
    - tobacco cessation either not being on the very-full Medicaid radar or not being a priority on the radar
    - the 50% match representing a very small fraction of the overall Medicaid agency budget which serves as a barrier when tobacco control programs are working to build the case for quitlines and/or leverage the guideline as a "foot in the door" with their state Medicaid agencies
    - communication barriers (e.g., the tobacco control program manager is not allowed to contact anyone within Medicaid without approval from leadership and/or leadership making first contact. It is often not a priority to do so and the effort stalls.)
- There is lack of understanding about Medicaid among tobacco program staff and a lack of understanding about cessation/quitlines among Medicaid staff.

- There is a lack of understanding or different understanding about the CMS quitline guideline among state Medicaid agency staff and/or CMS regional office staff. For instance, state tobacco programs report that their state Medicaid agency partners believe that there is a requirement for individual verification of Medicaid eligibility at quitline intake in order to claim the matching funds.

According to roundtable members, the only guidance to state Medicaid agencies and to regional CMS related to the quitline guideline has been the initial letter to state Medicaid directors and the information bulletin published months later in response to questions from state Medicaid agencies.

In April, 2014, CMS launched a new Medicaid.gov feature, Policy in Practice, to focus attention on important health policy issues and the role the Medicaid program can play in addressing them. Policy in Practice brings both internal and external resources about a specific issue, explores promising state implementation strategies and highlights provider perspectives and consumer voices.

The first Policy in Practice highlighted Medicaid support for tobacco cessation activities and featured Maryland's Quitline at http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/State-Highlights/state-highlights.html. The full Policy in Practice is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Tobacco.html.

Less is known among roundtable members about how CMS communicates with regional CMS offices, though regular meetings with regional offices are held.

- Staff turnover. It is often the case that efforts are completely derailed because the state Medicaid "quitline champion" leaves or takes a new position. There have also been cases where changes in state health department leadership have resulted in stalled or derailed collaboration with Medicaid.

<u>Memorandum of Understanding/Inter-Agency Agreement</u>

- Reaching agreement on the terms and conditions of the MOU moves smoothly so long as there is a clearly defined purpose of the MOU, a detailed scope of the relationship or agreement and distinctly outlined roles and responsibilities for specific *positions* within each agency/department and not specific *people*.
- The state Medicaid agency must agree to serve as a pass-through for the administrative funds – this is not an automatic assurance.

- A transfer of spending authority is sometimes required, which can be extremely time intensive and may involve the legislature. In addition, this process is different for different states and therefore, a national approach to a solution is impossible.

Cost Allocation Plan (CAP)/Methodology

- Without a positive, trusting relationship between the state Medicaid agency and their CMS regional office the work to develop an approved cost allocation methodology, without requirements for overly burdensome data and reporting, has been difficult for tobacco programs.
- The approval of the CAP methodology is where the tobacco program loses control of the process and new partners (regional and central CMS and DCA) become involved. For state tobacco programs, very little is known about who is involved in the CAP methodology approval, the questions that are being asked by new partners, how those questions are being answered by state Medicaid agency partners and where in the approval process the CAP methodology is. (For example, one state submitted their CAP methodology in July and after responding to an initial set of questions in August, the tobacco program was asked by CMS to share the entire quitline service contract as part of the approval process in December. They are still waiting for approval six months later.)
- There seems to be different requirements from regional CMS offices for different states (e.g., individual verification of Medicaid enrollment) that are in conflict with guidance provided by CMS.

Infrastructure to Support Invoicing and Payment

- The state Medicaid agency and state tobacco program must define and develop the reimbursement processes, reporting methods and timelines, invoicing functions, tracking systems and how internal challenges will be addressed. This often takes time and once again requires new partners who often speak yet another "Medicaid" language.

ACCELERATING PROGRESS ON ADDRESSING BARRIERS

1. NAQC has developed guidance for state tobacco programs in addressing many of the barriers above. However, the barriers that seem to have the most impact on implementation stem from a lack of understanding of the CMS guideline among state Medicaid agency staff and regional CMS offices. State tobacco program staff spend a great deal of time educating state Medicaid agency staff on the CMS quitline guideline, not to mention the time spent educating on cessation and quitlines. States that have been successful implementing the guideline have been gracious in sharing examples of their MOUs and their cost

allocation methodologies and states working toward implementation have found these useful in proving to their state Medicaid agency partners that it can be done without stipulations like individual identification of Medicaid enrollees. NAQC will continue to gather these examples and disseminate them to members upon request.

2. Addressing the *full* list of barriers above requires the complete support of federal CMS, state Medicaid directors, CMS regional administrators, and the appropriate CMS regional consortium administrator(s). CDC and NAQC should work together to present information related to the guideline's implementation and barriers in meetings, conferences and webinars at which these audiences are present.

What opportunities for change and strategies for progress exist? What should our focus be moving forward?

In order to influence efficient, streamlined implementation of the CMS quitline guideline, roundtable members suggested **encouraging states to dedicate staff** to efforts to engage Medicaid on various tobacco treatment initiatives, especially considering the specialized knowledge that it requires.

Roundtable members noted the importance of integrating tobacco treatment into current delivery systems already being utilized by Medicaid enrollees, as well as the importance of **working with the Medicaid managed care organizations**, as these entities are becoming more and more responsible for if and how enrollees have access to evidence-based services.

National tobacco cessation partners should work with CMS (federal and regional offices) to **reinvigorate attention to cessation and the quitline guideline** and to **ensure consistent communication and guidance** related to the guideline. **Direction from state Medicaid directors** that their staff should prioritize implementation of the quitline guideline would not only improve the likelihood of success, but limit the burden on state tobacco control programs that are spending time and effort educating Medicaid on Medicaid policy.

The CMS quitline guideline may become less relevant over time as it only covers 50% of the administrative costs of quitline services and does not include costs associated with cessation medications. While the match has been a tremendous opportunity, state tobacco control programs need to **carefully and strategically consider the rest of the healthcare coverage and service delivery landscape** in order that decisions about

where to place resources are in alignment with overall program and sustainability priorities.

Ensure that the tobacco control community stays up-to-date on **Medicaid incentive grants and their lessons learned** over the past five years. There may be some important information garnered that could prove useful in moving cessation forward.

Remember that cessation coverage, even comprehensive coverage, does not mean the same thing as utilization or even high-quality delivery of service. There is a critical need for us to **better promote what is covered** in order to ensure that services are used!

ROUNDTABLE MEMBERS

State Agency Teams

California

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Centers for Medicare & Medicaid Services
Observer: *Stephen Cha, MD, MHS,* Chief Medical Officer, Center on Medicaid and CHIP Services
Additional representatives from CMS will join meetings as needed for specific discussion topics.

American Lung Association
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REFERENCES

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[2] Centers for Medicare and Medicaid Services. June 24, 2011. New Medicaid Tobacco Cessation Services. Retrieved from http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd11-007.pdf

[3] North American Quitline Consortium. 2013. Results from the 2012 NAQC Annual Survey of Quitlines. Retrieved from http://c.ymcdn.com/sites/www.naquitline.org/resource/resmgr/2012_annual_survey/final1oct23pptnaqc_2012_fina.pdf