



Learning More About Medicaid Reimbursement for Tobacco Cessation Quitline Activities

Part One in a Series of Webinars Dedicated to Tobacco Cessation Services for Medicaid Beneficiaries

Medicaid Reimbursement for Tobacco Cessation Quitline Activities

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After brief comments of welcome by the webinar's co-sponsors (the North American Quitline Consortium, the Tobacco Control Network and the CDC, Office on Smoking and Health) Sharon Brown began her presentation on the new CMS guideline that regards tobacco quitlines that follow the evidence-based protocols set forth in the PHS Guideline as an allowable Medicaid administrative activity. The content of this webinar was limited to this particular type of federal reimbursement and did not address reimbursement of medications dispensed through quitlines to Medicaid beneficiaries. Future webinars will be hosted that address the policy on reimbursement of medications.

CMS issued a State Medicaid Director Letter on June 24, 2011, on tobacco cessation services that, in part, announced a new policy allowing costs related to "tobacco telephone quitline" activities that are provided to Medicaid beneficiaries to be claimed to Medicaid as an administrative expenditure. **Allowable costs** are limited to those directly related to implementing and operating a tobacco cessation quitline (e.g., personnel and salary costs) and **do not** include costs related to tobacco cessation medications, either over-the-counter or prescription-based, that are dispensed through quitlines.

Allowable administrative activities are defined as those necessary for the "proper and efficient" administration of the State Medicaid plan under 1903(a)(7) of the Social Security Act and includes a wide variety things such as Medicaid eligibility determinations; outreach; utilization review; prior authorization; MMIS; transportation activities; translation services; and tobacco cessation quitlines.

Quitline claiming by states is an **OPTION** and is not required or mandated by Medicaid however, CMS is strongly encouraging states to pursue this option. Any costs claimed as administration have to be done so in accordance with applicable cost principles under OMB Circular A-87. State Medicaid programs do have flexibility to design their own quitline counseling benefit based on beneficiary needs, other existing resources, available State Medicaid funding, etc.

The effective date of this new administrative claiming policy is the date of issuance of the SMD letter; that is, June 24, 2011. Because it is a policy and not a regulation, it is effective on the date of issuance. This means that if states can't immediately begin claiming for allowable expenditures, June 24th begins a 2-year window to go back to submit claims. As noted, the matching rate is 50% and states do not have to submit an amendment to their State Medicaid plan in order to claim quitline expenditures as administration.

If quitlines serve Medicaid and non-Medicaid eligibles alike, there must be a cost allocation methodology in place to isolate costs that benefit Medicaid. Only *that* portion of the overall quitline costs would be claimable. However, if quitline services are made available only to Medicaid beneficiaries, for instance as a part of Medicaid managed care program, costs would not need to be allocated amongst multiple programs and can be claimed in their entirety at the 50 percent matching rate.

CMS recognizes that quitlines are often operated by independent entities that have contracts with states. If the state contracts are with the health department or some other state agency that is not the Medicaid agency, there will need to be an Inter-agency agreement between the sister state agencies in order for related costs to be claimed. **Only claims from state Medicaid agencies are accepted.** Such interagency agreements are typically included in the State's Public Assistance Cost Allocation Plan on file with the U.S. Department of Health and Human Services.

A lot of independent quitline vendors may have already negotiated contracts with Medicaid managed care (MMC) entities. There are regulations specific to MMC contracts and these contracts are considered to include everything that the managed care entity provides. In this case, quitlines are included as part of the capitation rate that the state Medicaid agency pays to the managed care entity. In this case, one would not be able to break out quitline expenditures to be eligible for separate reimbursement as an administrative cost. However, states do have the option to carve out the quitline costs from the capitated rate and develop a contract separately for these costs - then reimbursement is possible.

CMS will not require individual authentication of Medicaid beneficiaries in order for costs to be claimed. However, states will need to come up with a way to properly allocate costs related to quitlines and Medicaid callers. Two examples include:

- A survey of callers to determine Medicaid eligibility, or
- The calculation of a Medicaid eligibility ratio to determine the approximate percentage of Medicaid eligibles in the total universe of callers served by the quitline

Given the nature and volume of questions, CMS has the goal to continue to provide information through webinars and FAQ documents.

Discussion, Feedback and Questions Noted from the Webinar

GENERAL QUESTIONS/COMMENTS

While I read the letter from CMS, I understand this is still an optional service right now and I am somewhat unclear as to how this works! So, if those out there working on the amendment for their Medicaid state plan will share their knowledge on this one, that would be a big help!

My understanding is that we need to file a state plan amendment, and that this can be effective anytime after June 24 when the letter was sent. Is there assistance in creating a model state plan amendment? This would help expedite this!

Folks will be happy to hear that States do not need to file a plan amendment in order to claim quitline expenditures. The State plan amendment requirement is specific to the other provision discussed in the Director's letter (Section 4107) in order to come in to compliance with amendments related to that regulation.

SERVICE PROVIDER-RELATED DETAILS

It appears that Medicaid offices will be able to contract directly with quitline vendors to gain the 50% match. Will Medicaid offices be required to use the same vendor as the State Tobacco Control Program offices or can

they break off and go with the vendor of their choice? Will this be a CMS decision or will it be left up to the states?

It is absolutely left up to the states. CMS is not dictating the vendors chosen.

If state Medicaid programs are allowed to use a vendor other than the official state vendor then who will own 1-800-QUIT-NOW? This could create a LOT of confusion as we move towards national advertising and the FDA cigarette packaging requirements.

SERVICE OFFERINGS DETAILS (COUNSELING AND PHARMA)

The 50% match is intended to cover up to 5 calls. We are uncertain about meds coverage.

This question will be addressed in a future webinar.

REPORTING AND AUTHENTICATION

There may need to be individual authentication of Medicaid eligibility. The reports are supposed to be easy (list from the Quitline we have heard)??

There WILL NOT be a requirement for individual authentication. However, states will need to come up with a way to properly allocate costs related to quitlines and Medicaid callers. In addition, States need to adhere to federal reporting and documentation guidelines that are codified in OMB circular 87.

Will there be a national **recommendation** on how to document and report Medicaid participation in Quitline activities? Or will it be totally state option on how to document and pay for those services?

No, CMS will not make a national recommendation on how to document and report. Again, states need to adhere to federal reporting and documentation requirements.

PAYMENT/REIMBURSEMENT-RELATED ISSUES

I am hoping that payment will be covered and clarified for all levels (provider & patient) during this presentation. I am involved in all areas that involve Medicaid patients and providers. As I do my work in the field with MCOs, Providers, Employers and Organizations I always let them know how fortunate we are to have such incredible comprehensive coverage for Medicaid patients. Time after time I am told about nonpayment/coverage for both providers and patients. In fact I recently received a follow-up from a major MCO telling me that their research had shown that they do not cover patches, gum and any items that can be purchased over the counter. We are also hearing from patients that their pharmacy does not honor payment for NRT even if they have a prescription. If I was hearing this from a few, I would feel that these were isolated incidences. However, I am hearing similar stories throughout the state on a weekly basis.

I realize that communication may also be a problem. Because of the sheer size and workload of so many of these entities communication and perception is difficult.

These issues will be addressed in a future webinar.

We've been discussing this with the Wisconsin Medicaid Program, and while they (including the Medicaid Director) are supportive of offering the quitline as a benefit for Wisconsin Medicaid members (and amending the state plan to change the benefit and take advantage of the 50% federal match for quitline services), they likely will not do so until our next biennial budget in July 2013. Our 2011-2013 budget just passed and our state Medicaid Program took a large cut (\$500 million dollars) on top of a similar cut 2 years ago and they do not have the financial resources to pay for the state's 50% portion of quitline services. I'm guessing many state

Medicaid Programs are in the same dire fiscal situation and it is what is stopping this from going forward in Wisconsin. On a related note, our state tobacco program received a 22% cut for 2011-2013.

CMS recognizes this predicament. Making the reimbursement available is something we are glad to be able to offer but we recognize that needing to come up with the additional 50% can be a barrier for states. I do want to emphasize that any permissible funding source under our statutes can be used to fund the state's share of these expenditures. In terms of flexibility in this regard, I'm not a funding expert, but we can certainly help with answering questions and providing information around permissible funding sources for the state match. We have staff dedicated to answering these questions.

Another issue that we've been discussing and are curious how other states will address is the statement bolded and underlined below from page 6 of the June 24, 2011 letter. Could you raise this on the July 27 webinar and ask the CMS presenter how we should interpret and address the statement? Does it pertain to not duplicating state funding for quitlines?

*"For these reasons, CMS will regard tobacco quitlines that follow the evidence-based protocols set forth in the PHS Guideline as an allowable Medicaid administrative activity necessary for the "proper and efficient" administration of the State plan under its authority under section 1903(a)(7) of the Act, to the extent that the quitline provides support to Medicaid beneficiaries under the auspices of the State Medicaid agency. Therefore, States can claim FFP for expenditures on such quitlines in accordance with the applicable cost principles under Office of Management and Budget, Circular A-87. In order for States to claim expenditures related to quitlines as administration at the 50 percent Federal Medicaid matching rate specified at 42 CFR 433.15(b)(7), **such claims may not duplicate costs that have been, or should have been, paid through another source.** Allowable costs must also be allocated in accordance with the relative benefits received by the Medicaid program. We encourage States with questions to contact CMCS."*

This statement is a general cost principle that applies throughout Medicaid as we are generally viewed as the payer of last resort. You can't replace one funding source with another unless it is permissible. There are certain offsets that must be applied to determine allocable costs. If there are other grant sources that are made available for quitlines, those should be used first.

I'm not a funding expert, but we can certainly help with answering questions and providing information around permissible funding sources for the state match. We have staff dedicated to answering these questions.

I have a couple of questions in regard to Medicaid and how we would be able to utilize the 50% match within our state.

1. Would only participants in the Medicaid state plan be eligible for the 50% match or would it also include individuals with waivers (as you know we have different categories of Medicaid)?

It would be for anyone served through Medicaid either via the state plan or waiver service as long as those covered under a waiver are not served by a Medicaid managed care entity - in which case the quitline costs may be bundled in the capitated rate and therefore unable to be separated out and claimed.

2. What other states are utilizing the 50% match with their Quitlines?

Will there be an additional contract between Medicaid and the Quitline for the administrative match to be possible? (As opposed to utilizing our existing contract.)

I want to emphasize that we are not requiring a redevelopment of existing contracts. If there is a contract with a state agency that is not the Medicaid agency there would need to be an inter-agency agreement between the

Medicaid agency and the state agency that holds the contract with the quitline vendor in order to define roles and responsibilities. This would not impact the vendors, only the state entities.

Is it possible for a state quitline to secure CMS reimbursement without the direct involvement of the state Medicaid program?

No. All claims for federal Medicaid reimbursement must come from the single state Medicaid agency. It cannot come indirectly from another source. This is where quitlines will need the engagement and involvement with the state Medicaid agency to be sure that they are willing to submit claims on behalf of other parties.

Can MCOs be reimbursed? How?

Typically the capitated rate paid to Medicaid managed care is intended to be all inclusive. You can't separately claim certain costs unless you remove it from the development of the rate that is paid. In this case, you could claim expenditures as administrative as long as they are not duplicative.

What is the status of medications – are they covered, are prescriptions required, how is reimbursement secured?

I want to make sure that the audience understands that we in no way want to dissuade the provision of medications. It is just that under our statutes, the cost of medications are simply not allowed as a part of the administrative claim. Now, whether they will be an allowable service expenditure, that is still unknown at this time.

This question will be addressed in a future webinar.

Is it possible for CMS to prepare a comprehensive FAQ document on how reimbursement will work and make it available to states?

CMS is actively working to develop additional guidance on quitline reimbursement.

Are there CMS constraints on how the 50% match funds are used by the state? The state directors were interested in whether the Medicaid match funds could be used as a policy lever for chronic diseases.

No. States are able to use federal funds received as reimbursement as they choose. There is a lot of flexibility here but the states can also choose to retain those funds rather than give them to a third party. These are the types of details that should be outlined in an interagency agreement or contract.

In reference to the caveat that medications through quitlines cannot be reimbursed via the administrative funds: why would a state want to use administrative funds for medications, which only pull a 50% reimbursement from the feds - instead of paying for it through normal pharmacy benefits, which in most cases would pull more than a 50% match? Perhaps that is why this issue is still undecided.

Very good point. Certainly states have options and various matching rates are available, many of which are higher than the 50% administrative matching rate.

What happens when a state's quitline is funded 100% by CDC (federal funds) - do they have the option for administrative match? Can states target administrative match for the Medicaid enrolled pregnant callers only (exclude Medicaid enrolled/not pregnant)?

To your first question, I'm not the expert but would remind you that there are rules related to claiming reimbursement from Medicaid when other funding sources exist.

To your second questions, yes, states can target their quitline services (e.g., to pregnant callers only) and claim related costs. The quitline does not have to be offered statewide in order for costs to be allocated to Medicaid.

What keeps a managed care organization that has a contract with the state Medicaid office from requesting claims for cessation "help-lines" that they use with their members that are less than standard for how we operate state quitlines?

The letter states that only costs for quitlines that adhere to the PHS Guideline are eligible for administrative match. If expenditures are claimed for services that do not adhere to the guideline we may not find out about this until an audit. However, it is in the best interest of the state to do the right thing from the start and they are at risk for any claims that do meet those guidelines.

What are "outreach" activities that are considered allowable administrative activities?

Quitline outreach costs that are targeted to Medicaid enrollees may be permissible, although they would not be considered a quitline expenditure per se. Rather, such costs would simply be categorized as outreach, and would need to be authorized and approved by the State Medicaid agency and developed in coordination with the State to ensure they are not duplicative and are indeed "proper and efficient" for the administration of the State plan.

Examples of outreach include: (1) Informing Medicaid eligible and potential Medicaid eligible children and families about the benefits and availability of services provided by Medicaid, including services provided through the EPSDT program, tobacco cessation services and quitline activities; (2) Developing and/or compiling materials to inform individuals about the Medicaid program and how and where to obtain those benefits; and (3) Distributing literature about the benefits, eligibility requirements, and availability of the Medicaid program.

Does reimbursement go back two years from the policy enactment to June 2009 or is it just back to the date of policy enactment in June 2011?

The starting point is June 24, 2011 so you can incur costs today and the state has two years in which to claim allowable costs.

In many states, 80% or more of Medicaid enrollees received their healthcare through a managed care organization. In that CMS is not mandating person-specific data for reimbursement, if a survey documents that, for example, 30% of quitline callers are from Medicaid members, can a state claim all the Medicaid callers, irrespective of proportion of fee for service vs. managed care enrollees?

Generally, the survey that shows 30% would suffice, as long as costs for any medications are removed from the cost basis. Where the quitline overlaps with managed care, it is still doable but there might need to be a correction applied to that 30% that shows a breakdown of the eligibility ratio.

As a follow up, in some states 80% of enrollees are in managed care contracts. Are you suggesting that states can only claim that 20% who are in fee for service contracts?

No but for those in managed care world a separate approach is needed to break out the quitline costs from the capitated rate beforehand.

Would they still be part of that single line item under other administrative expenses that you mentioned?

You are right. All the costs would ultimately be lumped together and reported on line 29 for “other financial participation,” but the cost documentation would still need to be maintained separately.

In that most capitated contracts currently don't have a provision for quitlines, this may be a non-issue.

Yes, for those capitated rates that don't currently include quitline, this is a non-issue.

Would you please talk more about working with Medicaid Managed Care Organizations? Would the state Department of Health who manages the quitline initiate discussions with the MCOs rather than the state agency what oversees Medicaid?

I think it could be a little of both. This isn't something that we dictate. Certainly the state Medicaid agency has to agree to submitting claims on others' behalf so it may be a good entry point.

Thank you for your presentation. I have two questions. First, there are some states where an independent foundation (or other non-governmental agency) funds quitline services for the state, including for Medicaid enrollees. You mentioned that if the state health department funds the quitline, an interagency agreement is required. What process/documentation is required in this instance, when the state health department does not fund the quitline?

The need for an inter-agency agreement only exists if the quitline is operated by a state agency other than the Medicaid agency.

Second, if we can calculate the exact counseling service costs for Medicaid enrollees, can we simply provide this information to the state and then the state can claim the 50% administrative match.

If the state is able to compile this information and then determine allowable costs, this might suffice, but all federal documentation requirements still apply.

Is a mechanism being developed that would allow NRT to be covered as a medical expense? When will we get guidance on how to bill NRT as a medical expense? We would like some guidance from CMS on the options.

These questions will be addressed during a later webinar.

In our state, we already collect insurance status and provider, so we get a monthly reporting of Medicaid callers. Will those monthly reports be sufficient for purposes of reimbursement from the Medicaid agency? Or do we need to develop a formula (e.g. a percentage of total calls)?

Certainly, where there is a willingness and ability to provide more detail, these types of reports are welcome.

It is my understanding that mail-order medications of any kind are not eligible for reimbursement by Medicaid and this is the traditional method of medication delivery for quitlines.

Again, medications-related questions will be addressed in the future.

If it's accurate that Medicaid pays for NRT already, what tier are the different drugs in and how much does the federal government match/what is the formula?

We will address this question on a future webinar.

Are there any states on this call that have done this?

This is a new guideline so not likely that states have already submitted claims.

Any match available for online services where people?

We would entertain this if proposed by a state but it was not considered as part of the June 24th letter.

We have met with our Medicaid staff and are hoping to move forward with Medicaid reimbursement for Quit Line services. A major question is, does the quit line have to be an authorized Medicaid provider?

No. The quitline does not have to be a Medicaid provider in order for related costs to be claimed as administration.

We (the Medicaid agency) are working with our sister agency (Dept of Public Health and Environment) on exploring our capacity and the logistics of claiming Medicaid administrative match for the quitline. As the Medicaid agency, we would like to have the specific identifiers of the Medicaid clients who use the quitline so that we can (a) compare their health care costs and utilization patterns before and after receiving quitline services, and (b) compare their “after intervention” costs and utilization patterns with other Medicaid clients who smoke but did not use the quitline. We are thinking about claiming using this individual client count multiplied by the quitline’s average cost per client (all clients, regardless of Medicaid status) minus the cost of the medication (since we learned that that is not allowable). If this per-client cost includes costs for counselor’s salaries plus quitline infrastructure, program evaluation, etc., can that full amount (including these other “cost centers” in addition to the counselor’s compensation) be included in the administrative claiming? Would this be an appropriate methodology to use for claiming?

We would need additional information regarding the other cost centers (e.g., quitline infrastructure, program evaluation) in order to determine if they can be included in the per-client cost used to calculate the Medicaid administrative claim.

Using a client-specific indicator that identifies Medicaid enrollees and an average cost per client (regardless of eligibility) that subtracts out the cost of medications as the baseline for developing claims sounds appropriate, as the cost of quitline services for Medicaid beneficiaries versus non-Medicaid beneficiaries is not likely to vary significantly.

We’d like additional guidance on the issue of outreach/media campaigns to encourage Medicaid clients’ use of the quitline. Would we be able to claim administrative match for billboards, flyers, PSAs, in zip codes with high proportions of Medicaid clients? Or for mailings targeted to specific Medicaid clients for whom claims data shows tobacco dependence? Could CMS provide some examples of allowable outreach that can be claimed using MAM within the guidelines of OMB A-87?

Quitline outreach costs that are targeted to Medicaid enrollees may be permissible, although they would not be considered a quitline expenditure per se. Rather, such costs would simply be categorized as outreach, and would need to be authorized and approved by the State Medicaid agency and developed in coordination with the State to ensure they are not duplicative and are indeed "proper and efficient" for the administration of the State plan.

Examples of outreach include: (1) Informing Medicaid eligible and potential Medicaid eligible children and families about the benefits and availability of services provided by Medicaid, including services provided through the EPSDT program, tobacco cessation services and quitline activities; (2) Developing and/or compiling materials to inform individuals about the Medicaid program and how and where to obtain those

benefits; and (3) Distributing literature about the benefits, eligibility requirements, and availability of the Medicaid program.

For the next webinar or FAQs on claiming for the NRT provided by the quitline to Medicaid clients: If the Medicaid agency was allowed to and able to allow/develop a mail order policy for NRT to be submitted on a medical claim from the quitline vendor, could the agency restrict reimbursement of mail order NRT only to the quitline vendor and only for NRT (for instance, disallow mail order claimed by pharmacies – except in specific circumstances (homebound, etc) – and disallow any other types of medications), or would this fall under the “any willing provider” requirements? Or could we say that the provider qualifications for billing this service include having a contract with the state health department for provision of the statewide quitline services?

Thank you for these questions and we will address them at a later date. This issue has not been decided and pertains to direct service costs, not administration.