Maryland's Story Securing Federal Financial Participation for Quitline Services

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Maryland's Timeline

- June 2006
  - The Maryland Tobacco Quitline was launched.
  - Provided counseling services for all residents age 18 years and older.
  - Data base for referral for additional cessation services and medication for Medicaid/other insurance was vague.
- 2007
  - NRT (patch and gum) was added to contract for all residents.
- 2008
  - Outreach to promote the Quitline as effective service for Medicaid participants with pregnant woman as the focus.

Maryland's Timeline

- 2009
  - Quitline costs were analyzed for Medicaid populations
    - Over 30% of callers were Medicaid participants.
    - Annual cost were over $300,000.
  - Started to explore cost share, additional services, and medications that were covered under Medicaid plans.
  - Asked for meetings to collaborate.
  - ARRA project for MDQuit (Maryland's Resource Center) to examine all tobacco benefits in Maryland.

Maryland's Timeline

- June/July 2010
  - Started to submit briefs and talking points for expanding Medicaid cessation and cost share based on the Patient Protection and Affordable Care Act.
  - Used many resources, ALA, NAQC, CDC/OSH, and other states
  - NAQC's Medicaid toolbox was helpful.
- August 2010
  - Held meeting with our Quitline provider to gain information on cost share models with Medicaid.

Maryland's Timeline

- September 2010
  - Meeting was held to discuss the QL and cessation coverage under Health Care Reform with Medicaid. Challenges that existed:
    - Current Medicaid benefits include coverage for smoking cessation services (tobacco use cessation counseling and pharmacotherapy) for all enrollees not just pregnant women and therefore exceed what is required under health care reform.
    - The Medicaid Free Care Rule and Third Party Liability posed a problem for Medicaid support of quitline services.
    - Free Care Rule and Third Party Liability The Free Care Rule says that Medicaid funds may not be used to pay for services that are available without charge to everyone in the community.

Maryland's Timeline

- March 2011
  - Continued writing briefs.
- April 2011
  - Approached to apply for Medicaid incentive grant, and sought other states for ideas how they worked with Medicaid.
  - Applied for grant
- October 2011
  - Submitted cost allocation plan to CMS and held follow-up meeting with Medicaid.
- December 2011
  - CMS approved cost allocation plan for quitline match.
- January 2012
  - Working on finalizing MOU with Medicaid.

Maryland's Story

- Maryland has an estimated 655,586 smokers (BRFSS 2010).
- The QL handles on average over 10,000 calls per year.
- Yearly evaluations show consistent quit rates of > 30% for 30 day quit.
- Yearly budget is a little over 1 million dollars with mix of federal, state, and MSA dollars.
- Match will likely net about $100,000 per year for QL services.

Key Lessons Learned

- Leverage existing relationships with Medicaid within your State Health Department.

- Utilize influential personnel to support and further the partnership between the two groups.
  - Find out if team members have an existing relationship or other collaborative opportunity with Medicaid and utilize that relationship to set up a meeting.

  - Maryland had the opportunity to work on Medicaid Incentive Grant that was supported both by the Deputy Secretary for Public Health and the Deputy Secretary for Medicaid Services. This collaboration increased an understanding of Medicaid and Quitline services for both parties. Also provided opportunity to get to know staff that work in Medicaid.

Key Lessons Learned

- Make partnership opportunity known to Health Secretary and leverage support of the Health Secretary to assist in facilitating communication between the two teams.
- Key messages:
  - How this collaboration will earn reimbursement dollars for the state (have your figures researched ahead of time and available),
  - Save the state money in healthcare expenditures,
  - Achieve state health improvement.
  - Used talking points, ALA, NAQC, other states, cost savings, etc.

Key Lessons Learned

- Understand where Medicaid is housed in your state administration.
  - DHMH is comprised of five divisions: Health Care Financing, Operations, Regulatory Programs, Behavioral Health and Disabilities, and Public Health Services.
  - Maryland Medicaid is located within the Health Care Financing division. The Office of Planning, a division within Health Care financing works closely with Medicaid.
  - Tobacco Control Program is located under Public Health Services.

Key Lessons Learned

- Meet with Medicaid to gather information on the specific structure of Medicaid in your state.
  - Ensure that you have a solid understanding of how Medicaid works in your state.
  - Understand that the Medicaid staff are most likely as busy as you! In Maryland, our structure is quite large and serves many residents.
  - Provide an overview of Quitline services showing how many of their members are served, along with cost savings, and quit and satisfaction rates.
  - Ask Medicaid to provide an overview/presentation of how the Medicaid infrastructure works in your state, and how it differs from other states.

Maryland Medicaid Key Terms

- In Maryland, Medicaid is also called Medical Assistance
- Within Federal parameters (State Plan or Waiver approved by CMS), Maryland can design its own:
  - Eligibility standards
  - Benefits package
  - Provider requirements
  - Payment rates

Maryland Medicaid Key Terms

- State Plan
- Waiver Applications with Terms and Conditions
- State Regulations
- Transmittals and Procedure Guidelines
- Public Notice is Important

Maryland Medicaid Programs

- Traditional Medicaid
  - Families and Children (FAC)
  - Aged, Blind, Disabled (ABD)
- Pregnant Women and Maryland's Children's Health Program (MCHP)
- MCHP Premium
- Primary Adult Care Program (PAC)
- Family Planning Waiver Program
- Kidney Disease Treatment Program
- Home and Community-Based Waiver programs (9)
- Breast and Cervical Cancer Treatment Program
- Employed Individuals with Disabilities Program
- Money Follows the Person (MFP)

Medicaid Enrollment

- Thus far in FY 2011, there are an average of 870,000 enrollees with full benefits (18% increase)
  - 82% in Managed Care Organizations (MCOs)
  - 18% fee-for-service (FFS) - mostly dual eligibles, individuals in spend-down categories, in nursing home or long term care
- Currently, there are more than 922,000 people enrolled
  - Roughly 1 in 6.5 Marylanders - includes: full benefits, partial benefits, Medicare cost sharing)

Fee-For-Service Program

- Some populations receive all of their services on a fee-for-service basis:
  - Dually-eligible (Medicaid/Medicare)
  - Institutionalized
  - Spend-down
  - Model waiver
  - Family planning program waiver
  - New Medicaid eligibles
  - Enrollees in rare and expensive case management (REM)

What is a Medicaid Waiver?

- A waiver gives states permission to waive certain federal rules that would otherwise apply
- Waivers are often used to authorize large-scale managed care programs, expand coverage populations, and provide home and community-based services (HCBS) as an alternative to institutional care
- Maryland operates two types of waivers
  - 1115 Waiver – HealthChoice managed care
  - 1915(b)(4) – Limit recipient's choice of providers
  - 1915 (c) – 9 different HCBS waivers

HealthChoice Managed Care Program

- In 1997, Managed Care Organizations (MCOs) became responsible for providing the majority of Medicaid services, including dental
- Currently, 7 MCOs serve over 715,000 enrollees, the majority of whom are children (about 476,000 or 67%)

Key Lessons Learned

- Send appropriate information/correspondence to Medicaid office pertaining to CMS match and ask about existing template to be utilized.
  - Send the CMS correspondence to Medicaid team. Determine if they have an existing cost allocation plan that could be utilized as a template for the CMS application.
  - If existing cost allocation plan template can be utilized, request a sample and work with Medicaid budget personnel to fill it out appropriately for CMS match opportunity.
  - Utilize quitline vendor reports to help with cost allocation plan.

Development of the CAP (Cost Allocation Plan)

- Be clear about the source document(s) / tracking data that is the basis for the Medicaid / non-Medicaid allocation, how that data is gathered, and how it will be applied.
- If at all possible, base the allocation on data that is updated quarterly, and can be readily audited.
- Be clear on the financial impact to CMS; i.e., the estimated Federal fund reimbursement, and any estimated growth in the out years.

Language in CAP (Cost Allocation Plan)

- QL serves both a Medicaid and non-Medicaid population.
- Upon intake to the program, callers are asked their insurance status and name of insurance.
- Monthly client utilization data is compiled from the intake survey.
- SFY2011, survey data indicates 30% of callers were Medicaid enrollees.

Language in CAP (Cost Allocation Plan)

- The state will use intake surveys and compilation of resultant client data, using the quarterly percentage of Medicaid callers to total callers as the Medicaid allocation factor against claimable Quitline expenditures.
- Federal guidance specifically provides for allocation methods that may include a survey of callers or a calculation of a Medicaid eligibility ratio in the total universe of callers. In our approach, the survey provides the source data for the quarterly allocation ratio.

Example of CAP (Cost Allocation Plan)

- Estimate of claimable Quitline costs for SFY 2012, allocation to Medicaid and resultant Federal share, is as follows:

Quitline contractor, entire program	$X	
Quitline Coordinator, salary & fringe	$X	
Total costs	$X	
Estimated Medicaid allocation	X%	
Medicaid claimable costs	$X	
Times 50% Federal match	$X	Federal share

CAP (Cost Allocation Plan)

- Indirect cost allocation:

Quitline Coordinator's salary	$X
Estimated Medicaid allocation	X%
Medicaid portion	$X
Times IDC rate X% of salary	$X
Times 50% Federal match	$ X Federal share

Key Lessons Learned

- Ask Medicaid team to join tobacco cessation team to sit in on NAQC informational calls or other related calls.
- MOU Agreement will be needed and signed by both internal offices.
- Work with Medicaid budget personnel to determine how reimbursement process will function.
- Determine additional ways to partner with Medicaid on an ongoing basis in a manner that will benefit Medicaid participants.