July 27, 2010

Donald Berwick, MD, MPP
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Dr. Berwick:

On behalf of the North American Quitline Consortium (NAQC), I would like to congratulate you on your appointment as Administrator of the Centers for Medicare & Medicaid Services (CMS). Your work on health care improvement has been and will continue to be critical to the nation. NAQC looks forward to your leadership at CMS and offers whatever support and resources will be helpful to you.

I also am writing to request your help and assistance on a major challenge facing the nation’s tobacco cessation quitlines. Specifically, I request your assistance in beginning a dialogue at a national level regarding the issue of reimbursement of state operated tobacco cessation quitlines by the Medicaid program for services provided to its members.

As you may know, every state and two territories in the United States have a tobacco cessation quitline that provides evidence-based services to smokers who want to quit. These quitlines are most often embedded in the state health department’s tobacco control program. While figures vary from state to state, Medicaid members typically constitute 10-40 percent of quitline callers seeking help in their attempts to quit using tobacco. Other populations served by state quitlines include Medicare members, the uninsured and individuals with private health insurance. In most states, the uninsured and individuals on government-sponsored insurance (including Medicaid) account for approximately two-thirds of all callers. Currently, the state quitline budget covers the cost of Medicaid members, with no contribution from the federal Medicaid program. With Medicaid representing the single largest line item in every state budget, and treatment of tobacco-related illnesses accounting for 10-15 percent of all Medicaid expenditures, it is a fiscal and health care imperative that we work collaboratively to cover the costs of care that will reduce the number of tobacco users in the United States, including those eligible for Medicaid.

State quitlines and tobacco control programs have a long history of partnership with state Medicaid agencies, primarily on three issues:
* Expanding coverage (and decreasing barriers) for tobacco cessation services to Medicaid members;
* Promoting existing cessation coverage and the availability of free quitline services to Medicaid members; and
* Gaining some level of funding and/or reimbursement for delivery of quitline services to Medicaid members.

These partnerships have led to gains in the level of coverage for tobacco cessation benefits. Currently, six states provide cessation coverage that meets the Public Health Services Clinical Guideline for Treating Tobacco Use and Dependence (2008 update) and another 21 state Medicaid agencies cover most, but not all, cessation treatments.

A number of state Medicaid offices have expressed an interest in paying quitlines for services to Medicaid members, however only two states, Oregon and Utah, have succeeded in their efforts. Even in these states, the payment arrangements may not be as efficient as they could be if CMS headquarters provided consistent rules for reimbursement. Many state Medicaid agencies have been obstructed in paying quitlines due to one or more of the challenges listed below:

1. Quitlines are not viewed as qualified providers for payment by Medicaid. Most state Medicaid agencies agree that quitlines may not be reimbursed because they are not on the plan B provider list. A number of states have identified ways to overcome this challenge, most often for quitline service providers that are located within the state or that are located within an institution that has a relationship with Medicaid.

2. Medicaid does not reimburse for telephonic counseling. Medicaid officials have voiced concern that if they reimburse quitlines for telephonic counseling, other providers will want to be reimbursed for advice over the phone. There may be an opportunity to overcome this challenge; Medicaid does reimburse for telemedicine and video-conferencing (when the health care provider is visible). It may be possible to restrict reimbursement for telephonic counseling to interventions with documented effectiveness such as quitlines. State Medicaid officials have suggested that in developing parameters for payment of telephonic counseling, they should be restrictive, well-defined and easy to implement by state agencies.

3. Medicaid requires a prescription for over-the-counter and prescription medications, and the medications may not be sent by mail order. In some states, such rules have been set aside if an agency analysis shows that it would be cost-saving to allow payment without a prescription and to distribute by mail order. NAQC raises this issue for consideration. It would facilitate quitline services to Medicaid members to have a national solution to this challenge.

4. A few state Medicaid agencies believe they are authorized to use administrative funds to pay for quitline services, however there is inconsistency across the federal regions in opinions on whether administrative funds may be used to pay for quitline services. It would facilitate quitline service delivery to allow payment via administrative or other funds and to have consistency across the regions.
5. Medicaid agencies have been reluctant to pay for a service that may be available free-of-charge to other tobacco users in the state. This is a challenge in some state Medicaid agencies and not in others. As state quitline budgets have been cut during the recession and as health care reform pushes payers to treat tobacco cessation as a regular part of health care, more and more quitlines have approached private and public health care payers to discuss reimbursement of quitline services to their members. In at least two of the states NAQC talked to, non-Medicaid health plans had agreed to bear some or all of the costs for quitline services to their members. State Medicaid officials viewed these paying arrangements as an incentive for them to find a way to reimburse the quitline for Medicaid members.

6. In at least one state, tobacco cessation services are billed to Medicaid using substance abuse codes rather than tobacco cessation codes (which are available, but not open). For this state, there are additional restrictions on who can provide the service, certification requirements, and supervision requirements. It may be helpful to have consistency across the regions on codes that should be used for billing tobacco cessation services.

NAQC asks CMS to begin a dialogue to discuss these challenges and strategies for addressing them. We would like to know under what circumstances is reimbursement permissible and if there are statutory and/or regulatory barriers to reimbursement what those prohibitions are and why they are applicable to tobacco cessation quitlines? Secondly, we would like to request your assistance in identifying ways in which tobacco cessation quitlines and Medicaid can collaborate more effectively that are appropriate and consistent with current laws and policy. Further, we would like to suggest that CMS help to convene a panel of federal and state Medicaid officials, along with state health department/quitline program managers, to identify potential areas for collaboration, including discussion of potential reimbursement scenarios. Our organizations stand ready to help CMS in facilitating outreach to quitlines and in serving as a technical resource in this effort. We hope these efforts will increase the delivery of high quality cessation services for Medicaid members who smoke.

Thank you for your time and consideration of this request. If you have any questions regarding this inquiry, please contact me at (602) 279-2719, extension 7, or by e-mail at lbailey@naquitline.org. I look forward to hearing from your office.

Best wishes for your tenure at CMS.

Sincerely,

[Signature]

Linda Bailey, JD, MHS
President and CEO