

Medicaid Match for State Tobacco Cessation Quitlines

Quitlines are available throughout the United States,^{1,2} and are linked through one electronic portal, 1-800-QUIT-NOW, which automatically connects callers to their state's quitline. Quitlines offer information, direct support, and ongoing counseling—all proven strategies for decreasing smoking rates. In 2007, an American Legacy Foundation study found that Medicaid costs could be lowered by 5.6 percent (cost savings of \$10 billion) if Medicaid enrollees were to quit smoking.³

On June 24, 2011, the Centers for Medicare and Medicaid Services (CMS) sent a [letter](#) to state Medicaid directors outlining how the Patient Protection and Affordable Care Act could help reduce tobacco use. CMS provided guidance that would allow states to claim tobacco cessation quitline expenditures as a Medicaid administrative cost and receive a 50 percent administrative match rate for services provided to Medicaid beneficiaries.⁴ The letter covered three areas: (1) comprehensive coverage for pregnant women; (2) coverage for individuals who are not pregnant, including children; and (3) tobacco cessation telephone quitlines as allowable Medicaid administrative activities.

The letter stated that “CMS will regard tobacco quitlines that follow the evidence-based protocols...as an allowable Medicaid administrative activity necessary for the ‘proper and efficient’ administration of the State plan...to the extent that the quitline provides support to Medicaid beneficiaries under the auspices of the State Medicaid agency.” However, for states to claim these expenditures, they cannot be duplicate costs that have been or should be paid by another source and the allowable costs must be in accordance with the benefits received through the Medicaid program. CMS has encouraged states to offer comprehensive, evidence-based telephone quitline services to all Medicaid beneficiaries, allowing them to claim the administrative match. CMS posted an [information bulletin](#) following this letter. Together, these two documents comprised the only guidance for state Medicaid agencies.

Current State Status

As of February 2015, 12 states (Alabama, Arizona, Arkansas, Colorado, Georgia, Indiana, Louisiana, Maryland, Massachusetts, Montana, Oklahoma, and Texas) are drawing down federal matching funds for quitline administrative services (North American Quitline Consortium (NAQC), personal communication, May 27, 2015).¹ To do so, these states execute a memorandum of understanding (MOU), approve a cost allocation plan (CAP) claiming methodology, and the state tobacco control program invoices its state Medicaid partner. The state Medicaid agency and the state tobacco control program must have a MOU to transfer the federal matching funds to the state tobacco control program because federal matching funds can only be provided from CMS to a state Medicaid agency.

The HHS Division of Cost Allocation (DCA) is responsible for approving CAP amendments, including their claiming methodologies. However, CMS regional and central offices work directly with DCA in the review and approval process. Under this process, DCA will not approve claiming methodologies without CMS review and approval.

Other states, such as California, have made progress toward implementing the quitline guideline, but are still working for approval on CAP amendments. Meanwhile, North Carolina has completed the MOU and has an approved CAP, but is unable to draw down because it does not contribute state funds to its quitline service.

¹ At the time of publication, NAQC was surveying states on their drawdown status and activities. An update will be available in fall 2015.

Barriers to Successful Implementation

There are several barriers that have delayed states' implementation of the new CMS guideline. A 2012 NAQC case study outlined some of the common challenges and lessons learned.^{5,6} Specific barriers states have encountered, as well as guidance based on the lessons learned from other state health agencies for overcoming these potential obstacles, are provided below.

1. **Relationship between tobacco program and Medicaid agency.** Some state tobacco programs do not have a strong relationship with their Medicaid agency due to historical mistrust, political and budget climate, tobacco cessation not being on the Medicaid radar, and lack of communication or opportunities. This creates a potential challenge because only a state Medicaid agency can receive the federal CMS funds.

Lesson Learned: State health official (SHO) leadership is critical to building relationships at the programmatic level that will connect key staff and facilitate conversation about collaborative partnerships. Tobacco program staff should be encouraged to participate in cross-training opportunities because specialized knowledge and language are key to engaging with Medicaid. For example, cessation programs must understand that Medicaid is concerned with a specific population, not the population as a whole. A strong alliance between the program and its Medicaid agency can also help both parties agree on the legal language used in the MOU, ensuring development continues through a change in leadership.

2. **Unfamiliarity with the Medicaid rule and quitline guidance.** There may be a difference in or lack of understanding about the full range of internal state processes that are needed to implement the CMS guideline and begin drawing down federal matching funds. Review and approval processes, as well as MOU, CAP, and infrastructure development, can present barriers to progress if not properly planned. These processes may take longer than expected if they require using policy and administrative levers that fall outside the state Medicaid office and state health agencies (e.g., statutory language to allow transfer of spending authority). In addition, the review process can add additional delays when the Medicaid agencies do not communicate to programs the level of detail that they require in a claiming methodology.

Lesson Learned: Tobacco programs need to understand the language, policies, and procedures of internal state processes to properly engage with their Medicaid agencies and implement the CMS guideline. Information is available to states on the [NAQC website](#), which has resources such as webinar series and conferences that outline successful cases, including an example from [Maryland](#). Flexible timelines also help with the unexpected barriers that can occur when working with a large, heavily regulated agency like Medicaid.

3. **Set communication processes within the health department.** Chain of command often prohibits tobacco programs from communicating directly with Medicaid. Program staff must work through their agency directors, who may already be negotiating with Medicaid to support multiple programs that are competing for limited resources. Therefore, it is critical for staff to promote the importance of tobacco programs to their directors and build the necessary relationships with Medicaid. Working through multiple channels of communication can slow down the process considerably, and if quitline implementation is not a priority, can stop it prematurely.

Lesson Learned: A chain of command is vital to direct and manage priorities across different health programs, but supportive management is also essential to elevate tobacco cessation priorities. A paper trail of decisions provides clarity when different answers are supplied by various staff, and is useful for remembering internal contracting and budgeting details on both sides.⁷ Program staff must be able to communicate how this short-term investment contributes to savings in the long-term by gathering data to build the case, which should have its basis in return-on-investment and their CAP.⁸ Oregon developed a [cost-savings estimates spreadsheet](#) that clearly identifies the financial impact.⁹

Once development of an MOU begins, maintaining relationships with Medicaid staff by involving them in work beyond the federal match for quitline services will keep them informed of successes and motivate ongoing support.¹⁰ The Georgia MOU requires the state public health department to provide evaluation reports to the state Medicaid program each year, which outline the total number of Medicaid participants per quarter, tobacco quit rates, and cessation service utilization patterns specific to Medicaid beneficiaries, as well as referral patterns among Georgia Medicaid providers.

- 4. Infrastructure barriers exist on both sides.** Both the state Medicaid agency and state tobacco programs must define processes to support the draw-down of funds for quitline services. Barriers that currently exist include high staff turnover, understaffed programs, and a lack of infrastructure to support invoicing and payment. For example, progress can be undermined when the state Medicaid “quitline champion” resigns, such as during a change in leadership at the SHO level.

Lesson Learned: Learning about Medicaid’s infrastructure and language will give program staff a clear sense of requirements, such as where federal requirements end and Medicaid requirements begin.¹¹ Keeping a paper trail of decisions is useful for remembering internal contracting and budgeting details on both sides.¹²

¹ Cummins SE, Bailey L, Campbell S, et al. “Tobacco cessation quitlines in North America: a descriptive study.” *Tob Control*. 2007; 2007;16:i9-i15 doi:10.1136/tc.2007.020370. Available at: http://tobaccocontrol.bmj.com/content/16/Suppl_1/i9.abstract. Accessed 9-19-2014.

² North American Quitline Consortium (NAQC). Quitline Map. Available at: <http://map.naquitline.org/>. Accessed 6-8-2015.

³ American Legacy Foundation. “Saving Lives, Saving Money II: Tobacco-Free States Spend Less on Medicaid.” Washington, DC: American Legacy Foundation; 2007. Available at: <http://archive.tobacco.org/news/255963.html>. Accessed 9-19-2014.

⁴ NAQC. “A Case Study to Support Gaining Federal Medicaid Match for State Tobacco Cessation Quitlines: Maryland.” Phoenix, AZ: North American Quitline Consortium; 2012. Available at: http://c.ymcdn.com/sites/naquitline.site-ym.com/resource/resmgr/Case_Studies/MedicaidCaseStudyMaryland201.pdf. Accessed 9-19-2014.

⁵ *Ibid.*

⁶ NAQC. “Medicaid Administrative Match for Quitline Services: A Worthwhile Endeavor?” Phoenix, AZ: North American Quitline Consortium; 2014. Available at: http://c.ymcdn.com/sites/naquitline.site-ym.com/resource/resmgr/medicaid/July212014May_Roundtable_Rep.pdf. Accessed 9-29-2014.

⁷ *Ibid.*

⁸ NAQC. “Efforts to Claim Federal Financial Participation for Quitline Administrative Expenditures: A Review of the Landscape, December 2011.” 2011. Available at: <http://c.ymcdn.com/sites/www.naquitline.org/resource/resmgr/medicaid/MedicaidReviewofLandscape.pdf>. Accessed 1-16-2015.

⁹ NAQC. “Oregon Medicaid Cost Savings by Plan; 2012.” Available at: http://www.naquitline.org/resource/collection/01BB4985-72E1-4536-AD93-E7887B830BC3/Oregon_Medicaid_Cost_Savings_by_Plan_-_Jan_2012_Update.xls. Accessed 1-16-2015.

¹⁰ NAQC. “A Case Study to Support Gaining Federal Medicaid Match for State Tobacco Cessation Quitlines.” Maryland. Phoenix, AZ: North American Quitline Consortium; 2012. Available at: http://c.ymcdn.com/sites/naquitline.site-ym.com/resource/resmgr/Case_Studies/MedicaidCaseStudyMaryland201.pdf. Accessed 9-19-2014.

¹¹ NAQC. “Efforts to Claim Federal Financial Participation for Quitline Administrative Expenditures: A Review of the Landscape, December 2011.” Available at: <http://c.ymcdn.com/sites/www.naquitline.org/resource/resmgr/medicaid/MedicaidReviewofLandscape.pdf>. Accessed 1-16-2015.

¹² *Ibid.*