

| CASE STUDY |

A Case Study to Support Gaining Federal Medicaid Match for State Tobacco Cessation Quitlines: Maryland

OVERVIEW

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. This decision allows states to claim the 50 percent federal administrative match rate for quitline services to Medicaid beneficiaries. State tobacco control programs viewed the new 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.

In less than a year, eight states (Arkansas, Colorado, Louisiana, Maryland, Massachusetts, Montana, North Carolina and Oklahoma) have executed Memorandums of Understanding that allow the state tobacco control program to claim the 50 percent federal matching rate for allowable quitline expenditures and four more states are well on their way (Arizona, California, Delaware and Indiana). However, there are many barriers to successful implementation of the new CMS guideline (e.g., cost allocation methodology approval) that have hindered these states, as well as those who are just beginning their partnership efforts with Medicaid.

Despite the challenges and the intensity of effort, working to establish a public-public partnership 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. With the goal to inspire, support, encourage and direct states in their cost-sharing efforts, *A Case Study to Support Gaining Federal Medicaid Match for State Tobacco Cessation Quitlines*, offers quick-to-read yet detailed guidance from one successful state, with broader lessons learned through NAQC's Medicaid Learning Community woven throughout. This case study includes the following sections:

- 1. Background**
- 2. Building the Relationship**
- 3. Challenges to the Relationship**
- 4. Building the Agreements: Memorandum of Understanding and Cost Allocation Plan**
- 5. Building the Infrastructure**
- 6. Challenges to the Process**
- 7. Final Thoughts**
- 8. Resources**

Throughout the document readers will find important things to consider before moving forward in partnership with state Medicaid partners in **blue font** and building blocks for success in text boxes.

BACKGROUND

Maryland has a current smoking prevalence of 15.2% or 672,000 smokers and dedicates approximately 1 million per year to their quitline budget. All Maryland residents who are 18 or older are eligible to receive up to four quitline counseling sessions and four

weeks of nicotine replacement therapy (patch or gum). In State Fiscal Year (SFY) 2011, 30% of callers (1,800) to the quitline were Medicaid beneficiaries.

Roughly 1 in 6.5 Marylanders are covered by Medicaid including those with full benefits, partial benefits and dual-eligibles. 82% of Medicaid beneficiaries are served through seven Managed Care Organizations (MCOs), the majority of whom are children. 18% of beneficiaries are fee-for-service (FFS) and these are mostly dual-eligibles, individuals in spend-down categories, in nursing homes or in long-term care.

What do you know about your state's Medicaid population? Who are they? How are they covered (managed care or fee-for-service)? What percentage are tobacco users and how many call the quitline? What cessation benefits do they have? How many MCOs does your state have? What is the relationship between your state Medicaid agency and the MCOs they contract with?

BUILDING THE RELATIONSHIP

Beginning in 2009 and armed with an analysis of quitline costs for serving the Medicaid population, the Maryland Tobacco Control Program (TCP) started to reach out to state Medicaid staff to gather information. Cessation benefits for those covered by Medicaid, as well as private insurers, was vague up to this point so the TCP began to explore cessation benefits covered under Medicaid Managed Care plans specifically. They began to have conversations with their state Medicaid agency about potential collaboration and these conversations resulted in an American Recovery and Reinvestment Act (ARRA) -funded project that examined all tobacco cessation benefits in Maryland, including Medicaid.

Fast-forward to April 2011 and the TCP was asked to collaborate with the state Medicaid agency to develop Maryland's application for the Medicaid Incentives for the Prevention of Chronic Disease grant program. The [Medicaid Incentives for the Prevention of Chronic Disease grant program](#) (MIPCD), which will provide a total of \$85 million over five years, is intended to test the effectiveness of providing incentives directly to Medicaid beneficiaries of all ages who participate in MIPCD prevention programs, and change their health risks and outcomes by adopting healthy behaviors.

Even though Maryland's application was not funded, the process resulted in increased understanding between the partners, a specific focus by Medicaid on tobacco cessation, and strengthened relationships between staff members. Additional support for the partnership between the TCP and Medicaid came in June of 2011 with the new CMS guideline on quitlines. Together the partners developed a plan to submit a cost allocation methodology to CMS for approval. The methodology was submitted to CMS in October 2011 and approved in December 2011. The programs finalized the MOU in March 2012.

Critical elements to building relationship with your state Medicaid agency include:

- *Understanding where Medicaid is housed within your state administration.*
- *Meeting with Medicaid to gather information on the specific structure of Medicaid in your state.*
- *Ensuring that you have a solid understanding of how Medicaid works in your state.*
- *Understanding and appreciating that the Medicaid staff are most likely as busy as you are!*
- *Providing an overview of quitline services including how many of their members are served, cost savings projections, and quit and satisfaction rates.*
- *Asking Medicaid to provide an overview/presentation of how the Medicaid infrastructure works in your particular state, and how it differs from other states.*
- *Involving key influencers and leveraging their support of the work.*
- *Knowing what your "ask" is and what the benefit is to **them**.*

CHALLENGES TO THE RELATIONSHIP

Having a positive, trusting relationship with your state's Medicaid agency is a critical element to success. As is the case with most systems-change efforts, an internal champion for cessation can be extremely helpful. Often this person serves as conduit,

translator and convener. Unfortunately, there are state tobacco programs that find it nearly impossible to build relationship with their state Medicaid agency – either due to historical mistrust, political and budget climate, or the simple fact that tobacco cessation is not on the very-full Medicaid radar. To move forward in drawing down federal funds to support quitline services to Medicaid beneficiaries (and to support quitline sustainability) a tobacco program MUST have a relationship with their state Medicaid agency, as federal CMS funds can *only* flow to a state Medicaid agency. The MOU is the mechanism by which the state Medicaid agency agrees to transfer those funds to the state tobacco program. Working out the details of the MOU becomes the heart of the work between the two partners.

While the MOU is the mechanism by which the state Medicaid agency agrees to transfer funds to the tobacco program, an amendment to the Medicaid agency’s cost allocation plan is the document that outlines exactly how they will develop and document administrative claims for quitline services and becomes the second big hurdle for tobacco programs in this effort. Public Assistance Cost Allocation Plans (PACAPs) are under the purview of the Division of Cost Allocation (DCA) in the U.S. Department of Health and Human Services. In accordance with Subpart E of 45 CFR Part 95 and OMB Circular A-87, a state’s cost allocation plan must be amended and approved by DCA before federal funds would be available for the cost of quitline administrative activities claimed through an MOU and cost allocation methodology.

However, CMS (regional *and* central offices) works directly with DCA in the PACAP review and approval process. Under this process, DCA will not approve a PACAP without CMS review and approval of the cost allocation methodologies. The PACAP must make explicit reference to the methodologies, claiming mechanisms, interagency agreements/MOUs, and other relevant issues that will be used for submitting Medicaid administrative claims and appropriately allocating costs. **Further details on MOUs and CAPs in Building the Agreements: Memorandum of Understanding and Cost Allocation Plan.*

What some states have learned is that 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, is difficult. One state tobacco program reports that their state Medicaid partner is creating roadblocks to cost allocation methodology development, due in part to reports of prior and current difficulties with their CMS regional office. The state tobacco program has been told that while CMS will initially agree to a simple methodology format, the Medicaid agency cites prior problems that cause them to distrust CMS instructions on the methodology. While a tobacco program has little control over the relationship between their Medicaid partner and the CMS regional office, remember that knowledge is power! The more the partners know and understand about quitlines and how they are operated and evaluated, the better. Their confidence in your understanding and tracking of the numbers behind the proposed dollar amounts goes a long way.

BUILDING THE AGREEMENTS: MEMORANDUM OF UNDERSTANDING AND COST ALLOCATION PLAN

A memorandum of understanding (MOU) is a document describing a mutual agreement between parties. It most often indicates an intended common line of action and many government agencies use MOUs to define a relationship between departments or agencies. Critical components of any MOU include a clearly defined purpose, a detailed scope of the relationship or agreement and distinctly outlined roles and responsibilities for each party.

What is Maryland’s best advice when starting work on an MOU with Medicaid? Be clear about its purpose. For example:

“To establish procedures for claiming Title XIX Federal Fund match on allowed Medicaid-related administrative costs expended in the operation of the quitline.”

In their MOU, Maryland used existing CAP language and stated that CMS had approved Maryland’s methodology for allocating a Medicaid share of certain allowed administrative costs in the operation the quitline (*most other states do this process in opposite order: first execute the MOU; include language in the MOU that it is dependent on an approved CAP methodology; and then work to get the CAP methodology approved*). Maryland’s MOU language needed to include:

- Assurance that costs submitted do not duplicate costs claimed under any other Federal grant, or duplicate costs included in the indirect cost pool.

- Assurance that it has sufficient State match for the Medicaid-related expenditures, and that the State match on expenditures claimed as Medicaid-related is not being used as State match on any other Federal grants.
- Assurance that Medicaid would distribute the match as a transfer of Federal revenue from the Medical Care Programs to an account designated by the Program. Assurance that Medicaid would serve as a pass-through agency.

The MOU also includes clearly defined responsibilities of both the tobacco program and the state Medicaid partner based on the assurances above, including requiring the tobacco program to provide quarterly reports identifying the Medicaid-related administrative costs of the quitline.

Building Block: Understanding *their* Concerns

Know the specific barriers to financial support from your Medicaid agency's perspective and address these first. It goes without saying that you will need to be prepared to explain and defend costs associated with quitline services and your expected return on investment (ROI). However, if pushback from your Medicaid agency has little to do with ROI and is instead rooted in concern about your program's ability to maintain your assurance of the state match requirement, you'll need to shift your strategy a bit!

Medicaid administrative claiming is the payment of Federal Financial Participation (FFP), at different matching rates (the matching rate for quitlines is 50%), for amounts "found necessary by the Secretary for the proper and efficient administration of the state plan". State and local governments allocate these administrative costs to the Medicaid program in accordance with a cost allocation plan (CAP) approved by the Department of Health and Human Services, Division of Cost Allocation (DCA) after CMS reviews and comments on the fairness of the allocation methodologies. Federal regulations (45 CFR § 95.507) require that cost allocation plans conform to the accounting principles and standards in Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments" (A-87).

Administrative claiming must be directly related to Medicaid program administration and payment may only be made for the percentage of time actually spent on Medicaid-eligible individuals. A CAP is the tool by which the state describes the procedures used to identify, measure, and allocate administrative costs among benefiting Federal and State programs. Claims for administrative costs must be made in accordance with a state's cost allocation plan.

Maryland's CAP, based on an existing template provided to the tobacco program by the regional CMS office, includes language assuring that:

- the state quitline serves both a Medicaid and non-Medicaid population;
- upon intake to the quitline counseling program, callers are asked their insurance status and name of insurance;
- monthly client utilization data is compiled from this intake survey;
- the survey data indicates 30% of callers were Medicaid enrollees; and
- the state will use intake survey data and the compilation of resultant client data to determine the quarterly percentage of Medicaid callers to total callers as the Medicaid allocation factor against claimable quitline expenditures.

In the CAP, be clear about the source document(s) / tracking data that will serve as 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. For example, be sure to highlight the estimated Federal fund reimbursement and any estimated growth in the next five years. When projecting growth in the next five years remember to take into account changes coming as a result of healthcare reform!

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 Maryland's approach, the intake survey provides the source data for the quarterly allocation ratio.

Building Block: Cost Allocation Plan

Development of the Cost Allocation Plan (CAP) methodology is a team effort. It is likely that the tobacco program staff does not speak “Medicaid” and the Medicaid program staff does not speak “quitline.” Clarity is essential so that NOTHING is assumed in the development of the CAP (or the MOU for that matter!). Feel free to pass along the [summary of the NAQC webinar on the quitline guideline](#) featuring Sharon Brown of CMS to your state’s Medicaid team to increase their understanding of the guideline. Determine if your state Medicaid agency has an existing CAP that could be utilized as a template for the CMS application. If an existing CAP template can be utilized, request a sample and work with Medicaid budget personnel to fill it out appropriately. Be sure to use reports from your quitline service provider to help build the CAP methodology!

BUILDING THE INFRASTRUCTURE

Establishing a relationship with Medicaid, arriving at a decision to implement the guideline, reaching agreement on the terms and conditions of the MOU, writing the CAP methodology and receiving approval from DCA are steps in the sometimes-lengthy process to draw down Federal funds for quitline administrative expenditures. However, once this work is complete, the infrastructure that supports the drawdown of the funds must be developed and implemented. This often means that even more new partners from within Medicaid must be engaged (e.g., Office of Health Services, Office of Finance, and Medicaid Pharmacy Program staff). Together with your partners you will have to define and develop the reimbursement processes, reporting methods and timelines, invoicing functions, tracking systems and how internal challenges will be addressed.

Using intake surveys and the compilation of client data from their service provider, Maryland takes the quarterly percentage of Medicaid callers to total callers as the Medicaid allocation factor against claimable quitline expenditures. The State Quitline Coordinator then reviews the invoices developed by their service provider, prepares a tracking sheet that outlines costs for quitline counseling services and gathers additional supporting documents such as a monthly report of all self-reported Medicaid callers and sends them to the Medicaid program as a claim. The claim is then approved and submitted by Medicaid Office of Finance to CMS Regional Offices. Medicaid is then reimbursed and the funds are placed into the tobacco program’s account through the State Fiscal Management System.

CHALLENGES TO THE PROCESS

Aside from challenges stemming from a lack of understanding about Medicaid and partners, there are process-related challenges that can impact negatively on progress toward implementation of CMS’s quitline guideline. For instance, it is important to understand the full range of internal state processes that may need to take place in order to implement the CMS guideline on quitlines and begin drawing down federal matching funds. There may be processes that fall outside of the administrative realm of operations that can take time (e.g., legislated transfer of spending authority). Knowing what these are ahead of time is critical to planning efforts.

Communication processes also pose a potential threat to progress. For example, there are state tobacco programs in health departments that are not allowed to communicate with Medicaid agency staff directly and instead must work through agency directors. If the health department director does not view implementation of the quitline guideline as critical, communication stops or is difficult at best. Often tobacco program staff find themselves first having to “sell” the importance of the effort to health department leadership before even setting off to build a relationship with Medicaid.

Once the work begins to develop the MOU, staying in constant contact with Medicaid staff is essential – to answer questions, to provide data, to ensure proper cost projections. If the tobacco program staff person must either work through someone else to communicate with Medicaid or must have all communication reviewed and approved, the process is slowed considerably.

There are also process-related barriers that neither the tobacco or Medicaid partners have control over. Seemingly endless staff turnover and under-staffed programs are often reported as challenges by state tobacco programs engaged in Medicaid-related efforts. For example, one state successfully executed an MOU to draw down federal matching funds for quitline administrative expenditures but the health department’s budget office made it clear that they would not be able to process any new invoices

from the tobacco program to Medicaid for six months!

FINAL THOUGHTS

As everyone knows, once a partnership is developed you must also work to maintain it. Continuing the partnership with Medicaid should go beyond the monthly or quarterly invoices for federal funds. Routinely invite your Medicaid partners to join tobacco-related calls or webinars that they may find useful to their work; promote the partnership to other state agencies, highlighting that together you were able to draw down additional funds for the state's health; make the quitline "real" for Medicaid staff by letting them know about the successful quit attempts made by the people they serve. Keeping state Medicaid agencies engaged in tobacco control beyond drawing down the federal match for quitline services becomes a key strategy for ensuring a comprehensive approach to the quality of, and access to, tobacco cessation treatment in a state.

In just over a year, eight states have successfully executed an MOU with their state Medicaid partner to secure federal matching funds for quitline services to Medicaid beneficiaries. Several additional state tobacco programs are in various stages of partnership building and even more are starting to consider how public-public partnerships may lend to the sustainability of their quitline – especially as some tobacco programs are seeing 30-40% of all callers reporting that they are Medicaid-insured. While there are certainly challenges to implementation of the CMS guideline, it serves as a critical step toward broader dialogue with Medicaid on the issue of comprehensive cessation coverage, an example of successful partnering to highlight in future cost-sharing efforts, and a state tobacco program's commitment to ensuring quality and accessible cessation treatment options building a working relationship with new for a population of tobacco users most impacted by its harm.

Building Block: Final Words of Wisdom from NAQC's Medicaid Learning Community

You will be working with a very large agency with many regulations. You might get different answers from different people at different times throughout the process. Be sure to keep a paper trail of decisions made and agreed upon.

You must be able to communicate the importance of a short-term investment for long-term savings.

This process will take you a long time and there are a lot of details to manage and communicate! Do not box yourself in to a specific timeline.

Throughout the process you will likely have different people at the table due to turnover. You will need to constantly bring new people up to speed. While this takes time away from implementation, it is a critical step to bringing everyone along.

There are so many internal contracting and budget issues on both sides – some you will be able to anticipate and others you will not.

RESOURCES

Below are links to resources that will prove useful in Medicaid-related partnership efforts, especially as they pertain to securing Federal matching funds for quitline services to beneficiaries.

- [Final CMS Announcement, June 24, 2011](#)
- [Medicaid Resource Repository](#): an electronic collection of documents and links on topic areas such as Medicaid 101, promotion of cessation benefits to beneficiaries, and partnering with Medicaid.
- [Efforts to Claim Federal Financial Participation for Quitline Administrative Expenditures: A Review of the Landscape, December 2011](#): a NAQC report highlighting results from an assessment of states' Medicaid-related efforts. The report includes details on state strategies, current challenges and links to helpful resources.
- [Kaiser Family Foundation's Medicaid/CHIP Web page](#): a one-stop-shop for Medicaid-related background, updates, reports and fact sheets. 🌟

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