Survey of State Quitline Efforts to Build Relationships and Cost-Sharing Strategies with State Medicaid Agencies

Current Landscape and Critical Questions for the Work Ahead

September 2015
INTRODUCTION

In a letter to State Medicaid Directors on June 24, 2011, the Centers for Medicare and Medicaid Services (CMS) announced its approval of tobacco cessation quitlines as an allowable Medicaid administrative cost expenditure. ¹ This announcement signified CMS encouragement of efforts to strengthen tobacco cessation support for Medicaid members and formally recognized that costs associated with tobacco cessation quitline activities are "proper and efficient" for the administration of state Medicaid plans. The CMS guidance made allowable quitline expenditures, such as personnel and salary costs associated with operating a quitline, claimable as administration at the 50 percent Federal Medicaid matching rate, but only to the extent that these costs serve Medicaid members.

Since the CMS guidance was released (including a November 11, 2011 CMS information bulletin offering further detail on the quitline guideline), there has been an increase in state quitlines actively claiming administrative expenditures for quitline services provided to Medicaid members and many state tobacco control programs have prioritized cost-sharing partnership with their state Medicaid agency to increase the capacity and sustainability of the state quitline. In order to support quitlines in these efforts, NAQC has provided technical support to states and convened Medicaid-related workgroups to help focus dialogue, technical assistance and resource development.² In fact, after nearly three years of delivering technical assistance to state quitlines on securing Federal Financial Participation (FFP) for quitline services, the NAQC Medicaid Cessation Coverage Roundtable identified a need to elevate many of the structural, operational and policy barriers that hinder implementation of comprehensive cessation coverage to Medicaid members.

The Roundtable developed recommendations for accelerating progress on implementation of a variety of Medicaid-related activities, including claiming FFP for allowable quitline expenditures, and recommended that NAQC be able to provide up-to-date data on progress toward quitline cost-sharing agreements with state Medicaid agencies. This report signifies NAQC’s commitment to the Roundtable’s recommendation and offers the most recent information available on funding mechanisms for tobacco treatment services for Medicaid members via quitlines.

SURVEY METHODOLOGY

In April 2015, NAQC fielded a survey to 50 state and three U.S. territory tobacco control programs (TCP) to gather updated information on efforts to build quitline cost-sharing agreements with state Medicaid agencies. Specifically, NAQC wanted to learn more about the provision of state quitline services to Medicaid members, the degree to which states/territories are implementing cost-sharing agreements to support the delivery of quitline services to this priority population of tobacco users, and the successes and challenges encountered in efforts to increase and improve tobacco treatment for Medicaid members.
A total of 46 responses (45 states and one territory) were received. In order to gather more detailed information on specific topics of interest, a follow-up telephone survey was conducted with 12 state quitlines. Four interviews were conducted with those claiming FFP, four with those intending to claim FFP in the next 12 months and four with those not claiming and not intending to claim in the next 12 months. Interview respondents were selected based on the state’s FFP claiming status, how claimed funds were being used, and the barriers experienced in implementing FFP. The interviews provided critical insight into the concerns, roadblocks and limitations experienced by states as they worked to ensure sustainable provision of quitline services to Medicaid members.

**KEY FINDINGS**

Considering smoking prevalence is significantly higher among adult Medicaid members than the general population (30.1% of adult Medicaid members smoke, compared with 18.1% of U.S. adults), and cigarette smoking is one of the greatest drivers of adverse health outcomes and state Medicaid costs, a continued focus on ensuring access to tobacco treatment for this population of smokers must be a public health priority. Because tobacco treatment is one of the most cost-effective preventive services, and can provide substantial short- and long-term return on investment, many state and territorial tobacco control programs focus their attention and resources on increasing access to evidence-based tobacco treatment, including quitline services, for Medicaid members. Additionally, states and territories are encouraged by federal agencies such as the Centers for Disease Control and Prevention (CDC) and CMS to ensure comprehensive Medicaid coverage for tobacco dependence treatments and to use Medicaid administrative funding to enhance and sustain quitlines.

**State Quitline Focus on Medicaid**

*Medicaid members continue to be a population that states/territories prioritize for quitline services, though the level of support for tobacco treatment services and cost-sharing varies.* Forty-five quitlines report serving Medicaid members and one quitline reports that it does not provide services to Medicaid members (N=46). On average, 39% of callers to quitlines are Medicaid members (range: 0 – 65%, N=45).

When asked about TCP support for providing tobacco treatment services and resources to Medicaid members, 37 quitlines report their TCP is highly supportive, five report their TCP is somewhat supportive, and the remaining four quitlines report either little to no support or that they simply do not know if there is support (N=46).

When asked about receiving funds from the state Medicaid agency to cover the cost of tobacco treatment services and resources (i.e., quitline services) for Medicaid members, 30 TCPs are highly supportive and seven are somewhat supportive of receiving such funds. It is important to note that the nine remaining quitlines report little to no support, or that they do not know what level of support exists (N=46).

**State Medicaid Coverage of Cessation**

The structure of state Medicaid agencies varies from state to state, as do TCP efforts to partner with their state Medicaid agency. State quitlines participating in the follow-up telephone interviews (N=12) reported a variety of Medicaid agency structures and plan models such as fee-for-service (i.e., traditional Medicaid), managed care and coordinated care, or a combination of these models. States reported wide variation of Medicaid benefits and services for tobacco cessation and very little consistency on coverage between plans. Several of the 12 states reported that it is difficult to find information about benefits and services because it is not clearly communicated.
by the Medicaid agency in writing or on websites. States with multiple Managed Care Organizations (MCOs) or Coordinated Care Organizations (CCOs) also report wide variability in coverage between plans. These variations and state-specific nuances contribute to the challenges associated with TCPs developing relationship with state Medicaid agencies and working together to improve coverage.

All 12 follow-up states reported some level of counseling coverage for Medicaid members, with some state Medicaid agencies only covering counseling for pregnant women, and some covering only one form of counseling (group or individual). Four of the 12 states reported telephone counseling as a covered cessation benefit paid for by the state Medicaid agency at some level. Medication coverage also varies widely across states and across Medicaid plans, and in many cases policies such as co-pays, prior authorizations or requirements to attend counseling create barriers to accessing cessation medications. **Follow-up states reported that while most plans promote quitline services to Medicaid members, the majority of quitline services to Medicaid members are paid for by the state tobacco control program.**

Learn more about state Medicaid coverage of smoking cessation treatments [HERE.](#)  

**Securing Federal Financial Participation for Quitline Services: the Current Landscape**

**Since the CMS guidance for quitlines was released in June, 2011, there has been a steady increase in states actively claiming FFP for quitline administrative expenditures and many states have prioritized partnership with state Medicaid agencies in order to eventually do so.** In a [2011 NAQC report](#), only 3 states were claiming FFP for quitline administrative expenditures. Today, that number has risen to 16. These states include Alabama, Arizona, California, Colorado, Connecticut, Georgia, Iowa, Indiana, Kansas, Louisiana, Massachusetts, Maryland, Montana, North Carolina, Oklahoma and Texas. An additional 10 states intend to claim FFP within the next 12 months. The remaining 20 states report either not intending to claim FFP within the next 12 months (n=14) or not knowing (n=6).
During follow-up interviews with four states currently claiming FFP, respondents were asked if they anticipate any potential changes to their claiming status. All four states reported that they do not foresee any changes in the near future, as having the claiming process in place creates stability in the funding stream. However, one state that reported actively claiming FFP in the survey noted during the follow-up interview that while they have the FFP claiming processes approved and in place (and have claimed FFP funds in the past), they are currently unable to do so because they do not have any state dollars to serve as the required state match (see box at right).

The types of allowable administrative expenditures for quitline services to Medicaid members claimed by states vary. Fifteen states responded that they claim quitline counseling services provided to Medicaid members for FFP, though FFP is reserved for administrative costs only, not direct services-related costs to administer quitlines. Some states are also successfully “claiming Medicaid match” for other quitline-related expenses such as evaluation of quitline services to Medicaid members, and quitline promotion and outreach directed to Medicaid members. States who reported “other quitline-related costs” specified quitline staffing and operating costs as claimable expenses.

**The Road to Sustainability**

The total amount of FFP claimed in FY14 (July 2013 to June 2014) is approximately $3.5 million and so far in FY15 (July 2014 to March 2015) is approximately $3.85 million. In FY14, individual states claimed from $25,000 to $2,743,024 and the median amount claimed was $140,026 (N=14). In FY15, individual states claimed from $18,600 to $2,002,638 and the median amount claimed was $119,641 (N=14). It is notable that some of the 16 states actively claiming FFP as of April 2015 may have not been claiming funds for the full FY14 or FY15, and two states did not know the amount of FFP claimed by their states.

*The majority of TCPs actively claiming FFP and receiving reimbursement from their state Medicaid agency are reinvesting these dollars in their quitline services.* TCPs are using funds received as a result of securing federal matching funds for quitline administrative services for multiple purposes, such as quitline service delivery, medications support, evaluation and outreach. Reimbursed funds also are used generally by the TCPs (including support of the quitline) in two states. It is worth noting that in four states, the reimbursed funds are allocated exclusively to the state general fund rather than to the quitline, tobacco control program or health department budgets.

<table>
<thead>
<tr>
<th>Utilization of FFP Funds by States*</th>
<th>Number of States (N=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quitline services</td>
<td>10</td>
</tr>
<tr>
<td>Quitline medications including NRT</td>
<td>4</td>
</tr>
<tr>
<td>Quitline evaluation</td>
<td>2</td>
</tr>
<tr>
<td>Quitline media/promotion</td>
<td>2</td>
</tr>
<tr>
<td>Quitline outreach</td>
<td>2</td>
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<tr>
<td>State Tobacco Control Program</td>
<td>2</td>
</tr>
<tr>
<td>Medicaid benefits or costs (i.e. in-person or group counseling not provided by quitline)</td>
<td>2</td>
</tr>
<tr>
<td>State General Fund</td>
<td>4</td>
</tr>
</tbody>
</table>

*Respondents were able to indicate multiple ways funds are utilized, if applicable (i.e., quitline services and state tobacco control program).*
“Since Medicaid is housed within our state health department it has made for a good relationship. For FY15, because the quitline coordinator is now state funded, we can claim administrative match for salary.” - Respondent

Facilitating Factors for Success

According to survey respondents currently claiming FFP, the effort is “very much worth it” and the successes outweigh the challenges. There are common factors that have bolstered success, including:

- Successfully building and maintaining strong relationships with the state Medicaid agency
- Using the process to secure FFP as a foot in the door with the state Medicaid agency in order to also address or improve other tobacco cessation initiatives, such as benefit design and comprehensive coverage
- Having champions and problem solvers within both state agencies
- Having the formal guidance letter from CMS stating that quitline administrative expenditures are eligible for administrative matching funds in hand
- Building strong partnerships with budget and fiscal staff in both state agencies

During follow-up interviews with four of the states currently claiming FFP, respondents were asked about the value of their efforts to claim administrative match, especially given the numerous challenges identified in the claiming process. While time-consuming and challenging, respondents agree that the work is worthwhile. One respondent stated, “It’s a win-win...no reason not to do it. We’ve got agreement and buy-in and that brings sustainability for us, and also creates buy-in for Medicaid to make tobacco cessation a priority.”

A state in which reimbursed funds are allocated directly to the state general fund was asked about the value of their efforts to claim FFP despite not being able to use the funds for tobacco control efforts. “There have been some benefits. We have partnered with Medicaid to do promotion of the quitline...to one million participants. Now we’re meeting more often and we’re reporting to them on FFP and checking in on our MOU to make sure that things continue to work properly. Looking back, we might have been better off working with them as a health plan to get NRT paid for rather than trying to get match dollars.”

Barriers Facing Quitlines Currently Working Toward FFP

The lack of prioritization of the effort, communication roadblocks and implementation of the required fiscal processes top the list of barriers cited by the ten state quitlines reporting an intent to claim FFP within the next 12 months (N=46). The respondents reported a high level of focus on building relationships with the state Medicaid agency, and a few respondents reported they are in the midst of developing Memorandum of
Understanding (MOU) and/or cost allocation plan (CAP) methodology. NAQC has developed specific guidance for states developing MOUs and CAPs.

When asked about specific challenges or barriers that have been encountered or are anticipated during this phase of the process, the following common barriers were noted:

- Leadership not prioritizing this work
- Lack of a direct line of communication with the Medicaid agency
- Breakdowns in communication between agencies
- Lack of cost allocation plan methodology examples
- Getting fiscal processes in place

“Barriers are two-fold. Our state Medicaid program experienced a turnover in staff, and a temporary position is now in place. The main obstacle however has been the billing and invoicing between our program and the state Medicaid program for reimbursement. We also lacked access to examples of a cost allocation methodology that could be used as a proxy for our own...this may exist, but with the other issues, everything is on hold.” - Respondent

Why Quitlines Are Not Working Toward FFP

Fourteen state quitlines reported not actively claiming FFP and that they do not intend to do so within the next 12 months. When asked why, respondents reported common reasons including:

- Lack of state funding
- Lack of knowledge about FFP
- Medicaid program structure complexities (e.g., multiple Managed Care Organizations (MCO))
- New and/or unsupportive administrations
- State focus is monopolized by Medicaid expansion
- State budget constraints on the Medicaid program

“Ninety percent of Medicaid recipients are in managed care in our state. Since we cannot claim the match on managed care, it is not a good use of time to claim the match on just 10%.” - Respondent

Lack of state funding allocated to the quitline was a barrier noted among respondents working toward FFP. However, just because the tobacco program does not have the required state funds to serve as the 50% match, does not mean the work is over. The state Medicaid agency could provide the required state portion of the match! In this case, it would be less about cost-sharing between Medicaid and the TCP, and more about the TCP supporting Medicaid in taking full advantage of accessible federal funds to help Medicaid smokers quit.

During follow-up interviews with four state quitlines not currently claiming FFP and not intending to within the next 12 months, three states reported that they do not anticipate any changes to their status in the near future. Two states identified having multiple MCOs or CCOs in the state as a reason for not pursuing FFP. It was reported that determining whether MCOs would be eligible for, or interested in, claiming FFP would be complicated and time-consuming and is not a priority at this time. One state reported “We will be working...
toward claiming FFP for quitline services in the next 12 months but do not anticipate being able to actually claim such funds during that time period. As our state has no state funding allocated for quitline services, at this point there are no funds that are eligible for the match.” Another state reported that persistent staff vacancies and changes in leadership have been barriers to claiming and “they are not likely to change any time soon.”

**Allocating State Medicaid Funds to Tobacco Control Program Activities**

While the FFP funds drawn down by 16 states are substantial ($3.5M in FY14 and $3.8M in FY15), they represent federal funding. Extremely few state Medicaid agencies are allocating state funds to tobacco control program activities. State quitlines were asked if their state Medicaid agency allocates state Medicaid funds (i.e., funds allocated directly from the state Medicaid budget to the state tobacco control program) for state quitline services, other state quitline-related costs, or other state tobacco control program costs. Only four states reported allocation of state Medicaid agency funds for state quitline or tobacco control program costs (N=46). State Medicaid funds were used for quitline services to fee-for-service Medicaid members, Medicaid provider education initiatives, in-person and group counseling, pharmacotherapy, and tobacco control program costs such as quitline services, grants, contracts, evaluation, and administration.

State quitlines were also asked if their state Medicaid agency provides funding for private quitline services or costs (N=46). Only three states reported Medicaid agency funding for private quitline costs. These Medicaid funds were used to cover costs for quitline services paid for by either the Medicaid agency or by multiple MCOs.

**Priorities for the Work Ahead**

*Given the significant variation of Medicaid-related partnership and cost-sharing activities across states, understanding state TCP priorities for increasing tobacco treatment access and utilization among Medicaid members is critical.* States reported a variety of priorities related to Medicaid and tobacco cessation. Common priorities and activities include:

**Relationship-Building**

- Improving the relationship between the state Medicaid agency and TCP
- Seeking payment by state Medicaid agency for quitline services and/or getting quitline payment into MCO contracts

**Increasing Knowledge**

- Understanding what benefits and services are covered for tobacco treatment
- Accessing data and evaluating cessation coverage utilization and return on investment (ROI) over time (similar to the Massachusetts case study)

**Increasing Access**

- Improving Medicaid benefits for cessation to include medication and counseling, removing prior authorization and copays, and addressing inconsistencies in coverage across plans
**Increasing Utilization**

Increasing the number of Medicaid callers to the quitline and increasing FFP claims for quitline services  
Increasing healthcare provider referrals to the quitline, including expanding eReferral work  
Increasing promotion of tobacco treatment services and quitline to Medicaid members (includes broader priority population efforts such as outreach to low-socioeconomic smokers, pregnant women, and behavioral health populations)  
Increasing provider awareness, provision of, and billing for, tobacco treatment services, and expanding provider eligibility or billing to include tobacco cessation. One state identified working with their Medicaid agency to allow Tobacco Treatment Specialists (TTS) and other healthcare providers to be eligible to deliver and bill for tobacco counseling.

Additionally, states identified the need to dedicate staff to efforts to engage Medicaid on a variety of tobacco treatment initiatives, and noted that state leadership often recognizes the potential opportunity that the Affordable Care Act (ACA) may offer to reinvigorate attention to cessation and quitlines.

**DISCUSSION**

The 2015 NAQC Medicaid Survey provides an up-to-date view of implementation of the 2011 CMS guidance on quitlines as an allowable administrative activity eligible for 50% federal match, and provides details on the successes and ongoing challenges TCPs are encountering in their work to increase and improve cost-sharing agreements for quitline services to Medicaid members. The 16 states already claiming FFP indicate that their work to partner with their state Medicaid agency to claim the 50% federal match was worth the effort, though there were, and continue to be, challenges in doing so.

While the focus on securing FFP for quitline services to Medicaid members is an important one for ensuring sustainable access to cessation support via quitlines, and one supported by ample training and technical assistance to TCPs, it should not be the sole focus, nor the sole responsibility, of TCPs to drive the effort. We know that Medicaid callers make up over one-third of all calls to quitlines and FFP currently accounts for only $3.5-$3.8M per year in reimbursement to TCPs. This is far less than one-third of the total funding for quitlines in fiscal year 2013 (which would amount to $41.8M) and the limitations of FFP as an adequate funding mechanism to leverage has become clear over the past four years.

The federal dollars now augmenting many state tobacco control program budgets as a result of FFP are just that – federal dollars. Cigarette smoking is one of the greatest drivers of adverse health outcomes and costs for state Medicaid programs. Is it time to reconsider our strategy and instead of viewing FFP as the sole TCP/quitline sustainability tactic for serving Medicaid members, encourage state Medicaid agencies to invest state Medicaid dollars as the required state portion of the match (rather than TCP funds)? Should we use our knowledge of FFP as a tool to assist state Medicaid agencies in meeting the intent of the ACA’s approach to comprehensive cessation as a regular and vital part of health care coverage? How are we possibly disincentivizing our state Medicaid agencies from stepping up to the cessation plate by continuing to serve their members at no cost to them? How can we do a better job of supporting CMS’s call to state Medicaid agencies to:

- Use Medicaid administrative funding to enhance quitlines;
- Implement mandatory coverage of tobacco cessation counseling for pregnant women and provide cessation services for all other Medicaid beneficiaries; and
- Ensure coverage of all FDA-approved tobacco cessation medications?[^7]
These and other questions are in need of full discussion and deliberation among NAQC members and our national partners in order to build a solid foundation of quitline sustainability, yes, and as importantly, to ensure comprehensive coverage for cessation is included as a regular cost of health care for all Medicaid members.
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REFERENCES