HMA

HEALTH MANAGEMENT ASSOCIATES

Review of Maryland Screening Brief Intervention Referral to Treatment (SBIRT) State Reimbursement

PRESENTED TO
PEER ASSISTANCE SERVICES AND
THE COLORADO DEPARTMENT OF HUMAN SERVICES,
OFFICE OF BEHAVIORAL HEALTH

FEBRUARY 14, 2017

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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Purpose and Approach to Maryland SBIRT Research

HMA Community Strategies engaged in research to understand the specific billing and reimbursement policies for Screening Brief Intervention and Referral to Treatment (SBIRT) in Maryland. Colorado SBIRT and Peer Assistance Services were particularly interested in understanding two features of Maryland's SBIRT program. Reimbursement for interventions that were shorter in duration (e.g., 3-20 minute intervals) than the Federally developed Centers for Medicare and Medicaid Services (CMS) procedural codes reimbursed in 15-30 minute intervals and SBIRT reimbursement as a separate billing code in Federally Qualified Health Centers (FQHCs). The following is an overview of the Maryland model and the process by which the Department of Health and Mental Hygiene (DHMH, Maryland Medicaid agency) as part of Maryland SBIRT developed the policies and coding structures.

HMACS initiated the research by interviewing Marla Oros, President of the Mosaic Group, to understand their role and involvement in Maryland SBIRT and informing the reimbursement policy. HMACS also interviewed Susan Tucker, Executive Director of Maryland's Office of Health Services Medical Care Programs at DHMH. Following the interviews, the team reviewed the official Medicaid Transmittals (Appendix A) regarding the new SBIRT billing policies as well as other Maryland SBIRT documentation.

Maryland Reimbursement of SBIRT

In early June 2016, DHMH disseminated two General Provider Transmittals (N. 82 and No.7) regarding SBIRT reimbursement in Maryland. One transmittal was specific to FQHC billing while the other was more broadly disseminated to primary care and medical providers. These transmittals address the development of local procedural codes created by DHMH to support greater provider flexibility when billing SBIRT services. A local procedural code is separate from Federal procedural codes released by CMS and requires State level design, policy development and State based rate setting. Local procedural codes are only applicable to the specific State that created them. Not all State Medicaid departments utilize the option of local procedural codes.

General Provider Transmittal No. 82 (released June 6, 2016) was disseminated to dental providers, FQHCs, general clinics, hospitals, local health departments, managed care organizations, nurse midwives, nurse practitioners, and physicians covered various Medicaid updates including billing for SBIRT.

Important highlights from this transmittal (see Appendix A) include:

- Screening and brief interventions are reimbursable under Maryland Medical Assistance Program (Medicaid), when provided by, or under the supervision of, the following health care professionals:

Table 1. Maryland SBIRT Providers and Billers (copied from Transmittal)

Provider Type	SBIRT Provider	SBIRT Biller
Physician*	✓	✓
Nurse Anesthetists-Individual-Group*	✓	✓
Nurse Midwife-Individual-Group*	✓	✓
Nurse Practitioner-Individual-Group*	✓	✓
Clinic, Federally Qualified Health Center	✓	✓
Physician Assistant**	✓	✓
Behavioral Health Provider in a Primary Care Setting (i.e., Licensed Certified Social Worker, Licensed Clinical Professional Counselor, etc.)	✓	

*These providers may delegate the provision of SBIRT services to any other provider if those services are within the provider's scope of practice. The billing provider does not need to be physically present in the room when the delegated provider performs SBIRT services.

** Physician Assistants must have a Board of Physicians-approved delegation agreement with a physician that authorizes the rendering and supervision of other SBIRT providers before they may provide those services.

- Screening, discussing the screening results, and providing recommendations to an individual are considered billable activities.
- DHMH recommends providers receive training in SBIRT and requires providers to use evidence based screening tools identified by the Substance Use Mental Health Services Administration (SAMHSA).
- In creating these local codes, Maryland is making the Federal SBIRT procedural codes (99408 and 99409) inactive.
- SBIRT will be reimbursed for a maximum of one screening and four interventions annually per recipients ages 12 and up.
    - Providers cannot bill more than one screening code on the same claim (e.g., self-administered and provider-administered).
    - Screening and intervention provided on the same day can be included on the same claim.
- Providers do not need to bill for an E&M services on the same days as performing an SBIRT intervention service for reimbursement.
- SBIRT services provided by a behavioral health provider outside of primary care settings will not be reimbursed.
- The SBIRT codes are not eligible for reimbursement from Beacon Health Options which is a managed care organization responsible for payment of primary behavioral health services. Reimbursement for primary care through other MCOs in the Maryland are eligible for reimbursement.
- FQHCs have separate codes and a separate transmittal (described below).

Table 2. Maryland Local SBIRT Reimbursement (copied from Transmittal)

Procedure Code	Description	Reimbursement
W7000	Alcohol and/or substance (other than tobacco) use disorder screening; self-administered	$5.14
W7010	Alcohol and/or substance (other than tobacco) use disorder screening; provider-administered structured screening (e.g., AUDIT, DAST)	$17.13
W7020	Alcohol and/or substance (other than tobacco) use disorder intervention; greater than 3 minutes up to 10 minutes	$5.71
W7021	Alcohol and/or substance (other than tobacco) use disorder intervention; greater than 10 minutes up to 20 minutes	$11.42
W7022	Alcohol and/or substance (other than tobacco) use disorder intervention; greater than 20 minutes	$22.36

Maryland Reimbursement of SBIRT in Federally Qualified Health Centers

As part of the development of local codes for SBIRT in Maryland, DHMH incorporated feedback from FQHCs about the need for a separate billing code for SBIRT that is outside of the Prospective Payment

System (PPS) rate. The PPS rate is a national rate for FQHCs that can be adjusted by the local State agency and the rate incorporates the services provided by the FQHC. DHMH incorporated SBIRT billing codes into local readjustments to the PPS rate for FQHCs in Maryland as part of a more comprehensive readjustment process. DHMH also felt that by having a separate billing code for SBIRT, they could capture utilization and data on the use and importance of screening for substance use.

On June 8, 2016, DHMH released Transmittal No. 7 (see Appendix A) which is specific to SBIRT reimbursement in FQHCs. The details follow the provision described above for other primary care settings. Important highlights from this transmittal include:

- Effective July 1, 2016, FQHCs could begin to bill for SBIRT services in conjunction with an encounter visit.
- Screening for SBIRT had two separate codes (self-administered and provider administered).
- Interventions for SBIRT had three codes corresponding to the duration of the intervention.
- FQHCs could bill for one unit of screening (either self-administered or provider-administered) and if the intervention occurred the same day, could bill for one unit of intervention (based on duration used) per encounter.
    - The specific SBIRT codes for the FQHC are the same as described above in Table 2.
    - Additional interventions did not need to be billed in conjunction with an encounter visit (and should not be billed as a separate encounter).
    - An FQHC cannot bill for more than one intervention code on the same claim
    - An FQHC cannot bill for a SBIRT screening or intervention with a behavioral health exam on the same claim.
- Services could be billed when provided by Physicians, Nurse-Practitioners and Physician Assistances employed by the FQHC.
    - A physician or nurse-practitioner could delegate the SBIRT service to any other provider if those services are within the provider's scope of practice (including a behavioral health provider in the FQHC).
    - Behavioral health providers cannot provide reimbursed SBIRT services outside of a primary care setting.
    - The billing provider does not need to be physically present in the room when the delegate provides the SBIRT services.
    - Physician Assistants must have a Board of Physicians-approved delegation agreement with a physician that authorizes the delivery and supervision of other SBIRT providers before they can provide those services.
- DHMH encouraged FQHC providers to obtain training in SBIRT and required the use of evidence-based screening tools (as identified by SAMHSA).

Important Process Elements in the Design of Maryland SBIRT Reimbursement

The focus on addressing SBIRT reimbursement within the Maryland SBIRT project came from data from a testing model phase of SBIRT in Maryland prior to the SAMHSA grant. Billing and reimbursement were raised as barriers by some providers within the test implementation of SBIRT throughout the State. Additionally, DHMH had feedback from providers who were doing SBIRT and the feedback indicated that the timeframes were limiting factors for some to fully embrace the model. The Federal procedure codes were viewed restrictive in allowing providers to engage in best practice brief intervention. The goal was to emphasize short and brief intervention and the 15 minute minimum limited how providers perceived or engaged in brief intervention.

Maryland SBIRT was also specifically interested in promoting the use of billing codes as a way to expand provider utilization of SBIRT and thus needed to address some of the perceived challenges. The success in Maryland to expand reimbursement to a three minute intervention in primary care settings, including FQHCs, and to include reimbursement for behavioral providers in primary care settings, can be attributed to four interconnected factors. The identified variables for success were:

1. A foundation of a successful test model for SBIRT implementation;
2. Strong Statewide reputation with providers for the test model;
3. State Behavioral Health Authority and Medicaid as the SBIRT grantee and engagement of the right people at the right time who understood the SBIRT value proposition;
4. A Medicaid Department with capacity and interest in local reimbursement codes to incorporate best practice and engagement of providers.

Success Element #1: A Foundation of a Successful and Tested model for SBIRT Implementation

Prior to the SAMHSA grant award in Maryland, there was a grass roots effort to pilot and implement SBIRT in community health centers. From 2010 to 2012, Behavioral Health System Baltimore and the Mosaic Group received two grants from the Open Society Institute—Baltimore to study the feasibility of providing SBIRT services at community health centers. The project implementation was led by the Mosaic Group, a Baltimore-based consulting firm, and resulted in SBIRT services being implemented in four community health centers. The first grant was a one-year planning grant, allowing them to design and test the feasibility of their SBIRT approach. As a result of the successful planning process, they received additional funding and expanded to 24 sites. This expansion occurred at the same time as many providers across the State were implementing Patient Centered Medical Homes (PCMH) and SBIRT became a good fit within that model.

The model leveraged existing practice staff to incorporate SBIRT into patient workflows to make it a fully integrated routine part of care including documenting services within practices' electronic health record (EHR). Because of the focus on using existing practice staff, the model was unlike the traditional SAMHSA SBIRT grantee model which utilized health educators or health navigators to implement SBIRT services. This also fit with the broader context in Maryland with PCMH implementation and other efforts to integrate behavioral health providers in primary care. Federal procedure codes (99408 and 99409) were active codes within Maryland for reimbursement of SBIRT at the time of these pilot projects. However, one of the challenges was that behavioral health providers could not bill Medicaid for SBIRT in primary care because they were not a delegated provider. Similarly, the FQHCs in the project were not receiving a separate billing code for SBIRT because it was considered to be part of their PPS encounter

rate. Although many FQHCs were not complaining about this reimbursement process it made tracking their use of SBIRT more difficult. Behavioral Health System Baltimore and the Mosaic Group were interested in addressing billing issues around SBIRT and these were important issues identified in the test model phase. The partners began to work on these issues with DHMH in Maryland during the test model implementation

As an effort to expand this model, Maryland applied for a SAMHSA SBIRT grant proposing to use the Behavioral Health System Baltimore/Mosaic Group model being implemented and expanding on their evaluation data. In 2014, SAMHSA awarded a $9.8 million, five-year grant to the Maryland DHMH to implement SBIRT services in health care organizations across Maryland. DHMH partnered with Behavioral Health System Baltimore to serve as the administrative and fiscal agent of the grant while the Mosaic Group continues to provide on-site technical assistance and training for the clinical sites engaged in the project.

Building on the foundation of the work done by Behavioral Health System Baltimore and the Mosaic Group in Maryland, the SAMHSA grant allowed the model to grow to 71 community health settings, including hospitals, Community Health Clinics (CHCs), FQHCs, family planning clinics, and Sexually Transmitted Infection clinics. These sites span 15 Maryland jurisdictions and Maryland SBIRT anticipates reaching 90,000 individuals during the five-year rollout ending in 2020.

As part of the focus on scaling the success of the approach regionally, Maryland SBIRT began to focus on ensuring behavioral health providers could bill for their work in primary care. Additionally, Maryland SBIRT wanted to address SBIRT reimbursement within FQHCs as this was another important way to track the utilization of SBIRT specifically and it encouraged the use of the intervention to have a separate billing code. DHMH as the State grantee and key partner in Maryland SBIRT was in the process of examining the FQHC adjusted rate anyway and so looking at SBIRT coding fit in that analysis.

The momentum in the State from the test model phase as well as the fact that the State was engaged with Behavioral Health System Baltimore and the Mosaic Group in incorporating the lessons learned in that early SBIRT implementation paved the way for a strong state model and existing relationships among key stakeholders working on the ground to promote SBIRT.

Success Element #2: Strong Statewide Reputation with Providers Willing to the Test Model

The SAMHSA grant phase built on the momentum and reputation of Statewide awareness of SBIRT following the testing model. The Behavioral Health System Baltimore and the Mosaic Group had worked closely with providers in the test phase; delving into one-on-one practice change to identify needs and challenges. This included providing resources and support on how to integrate SBIRT into routine practice and how to develop workflows that were effective and efficient. This reputation for practice level support built buy-in for providers and a level of trust in the technical assistance effectiveness.

Maryland SBIRT built on this technical assistance reputation with practices to ensure that each grant site's Electronic Health Record (EHR) was capable of collecting SBIRT information, including utilization of SBIRT Medicaid procedure codes. An evaluation of the effort relied on utilization of SBIRT codes. Once a site was showing that approximately 75% of its patients were screened for alcohol based on SBIRT billing code utilization, it was assumed that practice transformation had occurred and SBIRT was integrated routine part of care. This allowed Maryland SBIRT to use EHR data to show outcomes and the extent to which the practice has adopted SBIRT.

This reputation also promoted engagement from key stakeholders and facilitated some of the work needed to adjust reimbursement. For example, DHMH found that survey data from providers on SBIRT and its challenges were helpful in identifying and prioritizing barriers, such as specific factors within reimbursement. With a strong reputation for problem solving with providers and having feedback incorporated into the Maryland SBIRT project, there was greater connectivity between the grass roots implementation and policy adjustments to promote SBIRT implementation statewide.

Success Element #3: State Behavioral Health Authority and Medicaid as SBIRT Grantee and Engagement of Right People at the Right Time who understood the SBIRT Value Proposition

One of the strengths of the Maryland SBIRT approach is that unlike many states the SAMHSA grantee was the State department that includes both Medicaid and the Behavioral Health Authority for Maryland. This combination of expertise underscored the State's strong commitment and valuation of SBIRT and provided opportunities for creative methods to promote and scale the use of SBIRT across provider settings. Added to this internal State expertise was the strong partnership with the community partners (Behavioral Health System Baltimore and the Mosaic Group) to bring grass roots practice transformation to the State department to inform policy and changes such as the reimbursement codes.

Early in the process, Maryland SBIRT was able to initiate a meeting with DHMH personnel, including the Deputy Secretary who oversees Medicaid, people from the Behavioral Health administration, and the state health secretary medical director. It was a high level meeting with individuals who recognized the value of SBIRT in achieving the governor's priorities to address the State's opioid overdose crisis. Maryland SBIRT provided a clear ask for the group: to create a new Medicaid transmittal for SBIRT. Ideally, the new transmittal would better explain the billing including eligible provider types and provider settings. They also requested that behavioral health providers be named as a provider who could bill independently within primary care and that the State consider allowing SBIRT billing in FQHC settings that were separate from the PPS set rate. Previous experience collaborating with one another and strong relationships allowed Maryland SBIRT to bring practice level concerns directly to invested State department personnel who had the expertise to address key policy barriers to implementation.

According to the interviews, other stakeholders brought important support to the process. Maryland SBIRT was significantly supported by the work of a Policy Steering Committee, which promotes and guides Maryland's SBIRT project to meet the goals and objective. Additionally, a physician adviser (a practicing Primary Care Provider) who worked with Maryland SBIRT and DHMH provided important assistance to making the coding changes. The advisor provided immediate feedback on how to make the changes most relevant to providers and support day-to-day practice utilization.

Having all the right people engaged in the process to brainstorm and inform the process was instrumental to addressing policy and practice level changes. The shared vision among the stakeholders was that SBIRT had significant value to offer the State and was worth investment in paving a path forward to enhance provider utilization.

Successful Element #4: Medicaid Department with Capacity and Interest in Local Reimbursement Codes to Incorporate Best Practice and Engagement of Providers.

Maryland SBIRT provided DHMH with research and practice level feedback about the important factors to consider in billing and reimbursement in the State. However, DHMH also engaged in additional research on best practice in screening and brief intervention as well as working with the physician advisor to consider day-to-day practice needs. DHMH leveraged their capacity within their State plan to create local Medicaid codes to consider alternative timeframes and reimbursement structures for SBIRT. The research on brief interventions and experience of providers in Maryland indicated that a three minute intervention was an important consideration. In part this was based on the research and evidence that informed the Medicare tobacco procedural codes. This code is based on a three minute intervention which was determined to support more utilization and deemed effective in the research.

DHMH also examined the Washington State SBIRT transmittal that has reduced timeframes and modeled their guidance after this approach. The specific rates set in Maryland was also a thoughtful and planned process with a rate methodology starting with Medicare rates and then using specific analysis to determine the right rate for Maryland. These rates were then tested and verified.

The decision to examine separate reimbursement in FQHCs came from an overall evaluation of the PPS rate in the State and a need for readjustment (a process that States undergo periodically). The determination that this may support SBIRT implementation as well as tracking the use of SBIRT provided the momentum for creating a separate code.

DHMH and Maryland SBIRT are tracking the implementation of these new codes with evaluation. They are interested in evaluating how billing and reimbursement changes impact the use of SBIRT and whether this shift in policy promotes greater utilization.

Take-Away's for Colorado SBIRT

The Maryland example of implementation is interesting in a number of ways from the model chosen to the coordination among State personnel. The strong evaluation of the model may support Colorado as the SBIRT implementation continues outside of the SAMHSA grant requirements. It may be useful for Peer Assistance Services to more closely examine the model used in Maryland and to share data on this approach with Colorado providers. Leveraging existing staff rather than health navigator may be a more efficient and immediate method for expansion of SBIRT now that that the SAMHSA grant has ended.

The opportunity to create local reimbursement codes is less likely in Colorado. At this point, the Colorado Department of Health Care Policy and Financing (HCPF) does not engage in development of local codes. However, the evaluation and impact of the local codes in Maryland may provide useful data for Colorado and certainly if the results are strong, prompt consideration of adjustments. SAMHSA is also tracking the outcomes of the Maryland grant process (including the coding utilization) closely and this may inform Federal procedure codes in the future.

Peer Assistance Services and the Office of Behavioral Health are encouraged to track these outcomes to share them with key state stakeholders but also to continue to evaluate whether payment is an important factor in enhancing provider use of the health prevention approach.