Rethinking SBIRT

Lessons from the Past 10 Years, Strategies for the Next 10

Speakers:
Margarita Pereyda, MD, Principal, HMA
Gina Lasky, PhD, Project Manager, HMA Community Strategies

Moderator:
Carl Mercurio, HMA Information Services

October 29, 2015
Why this webinar?
Overview of the Spread of a Practice Innovation

SBIRT - HISTORY AND STATUS
Sample of SBIRT Initiatives

• SAMHSA
  ✓ 17 Medical Residency Cooperative Agreements
  ✓ 32 State Cooperative Agreements
  ✓ 12 Targeted Capacity Expansion Campus Screening and Brief Intervention Grants
  ✓ 14 SBIRT Medical Professionals Training Grants

• HRSA ACA Mental Health Service Expansion-Behavioral Health Integration (BHI) Expansion Grants

• National Council of Behavioral Health

• Conrad N. Hilton Foundation
  ✓ 3,545,000 through June 30, 2015 in SUD screening and early intervention including SBIRT
SAMHSA State Cohorts

Cohort 1 Cook Inlet Tribal Counsel, AK
Cohort 2 Tanana Chiefs Conference, AK
Cohort 4 American Samoa
Cohort 2 and 4 Colorado
Cohort 1 and 6 New Mexico
What has changed with ACA?

• Service delivery and payment reforms that incentivize rapid screening and access to treatment
• Provides an opportunity to offer substance use services to more people with varied substance use histories:
  o Harmful Users vs. Abuse or Dependence
  o Substance Users with multiple chronic health conditions
Service Delivery Changes

Substance Use treatment and prevention services are a key component of new health care environment

- ACA includes substance use disorders as one of the ten elements of essential health benefits.
- Coverage expansion that includes mental health and substance use disorders.
- Under ACA- preventative services with a US Preventative Task Force grade of A or B will be covered with no cost sharing requirement.
Reimbursement Opportunities

• Commercial
• Medicare
• Medicaid
• EPSDT
Reimbursement codes for screening and brief intervention services

• Medical procedures are coded using Common Procedure and Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes.
• Virtually all payers use AMA’s Evaluation and Management (E & M) CPT codes to pay physicians' services.
• Many payers reimburse for independent licensed health practitioners such as advance practice nurses, psychologists, and masters-level social workers.
• Move is to pay for service provided by health professionals under the supervision of a physician/licensed provider.
### Commonly Used Codes

<table>
<thead>
<tr>
<th>Payer</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Insurance, Medicaid</td>
<td>99408</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min</td>
</tr>
<tr>
<td>Commercial Insurance, Medicaid</td>
<td>99409</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min</td>
</tr>
<tr>
<td>Medicare</td>
<td>G0396</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min</td>
</tr>
<tr>
<td>Medicare</td>
<td>G0397</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min</td>
</tr>
<tr>
<td>Medicare</td>
<td>G0442</td>
<td>Prevention: Screening for alcohol misuse in adults including pregnant women once per year. No coinsurance; no deductible for patient</td>
</tr>
<tr>
<td>Medicare</td>
<td>G0443</td>
<td>Prevention: Up to four, 15 minute, brief face-to-face behavioral counseling interventions per year for individuals, including pregnant women, who screen positive for alcohol misuse; No coinsurance; no deductible for patient</td>
</tr>
<tr>
<td>Medicaid</td>
<td>H0049</td>
<td>Alcohol and/or drug screening (code not widely used)</td>
</tr>
<tr>
<td>Medicaid</td>
<td>H0050</td>
<td>Alcohol and/or drug service, brief intervention, per 15 min (code not widely used)</td>
</tr>
</tbody>
</table>
SBIRT Billing Codes: Medicaid

• Each State must activate or unlock the HCPCS codes. In other words, the State Medicaid agency (and/or Medicaid managed care plans) must agree to reimburse for the services.

• This process of unlocking codes varies by state. State Medicaid systems are complex, and sustained effort is required to effect change in these systems.

Source: Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment; Technical Assistance Publication Series (TAP 33); SAMSHA (2013)
EPSDT Overview

- Medicaid program’s benefit for children and adolescents
- Provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under age 21
- Benefit is more robust than the Medicaid benefit for adults
- Designed to assure that children receive early detection and care
- Individuals have to meet Medicaid eligibility requirements
EPSDT Screening

• Eligible individuals are entitled to periodic screening services (well-child exams) as defined by the statute.

• Expectation from CMS is that assessment includes an age-appropriate behavioral health screening.

• Eligible children are additionally entitled to inter-periodic screenings in order to identify a suspected illness or condition not present or discovered during the periodic exam.
**EPSDT Reimbursement**

- States establish their own fee schedules for screening services.
- States may develop a *bundled payment rate* to pay for health screening components under one billing code.
- States may also recognize each component of the EPSDT screening separately.
  - For example, one state pays for the visit itself with one code and pays separately for each individual screening service delivered during the visit.
  - Encourages providers to perform every component of an EPSDT exam and provides information on whether the elements of the EPSDT guidelines were met.
EPSDT and SBIRT

EPSDT activities could serve as the program (and funding) vehicle for SBIRT for children
Reimbursement of SBIRT

The Institute for Research, Education and Training in Addictions (IRETA) administers the National SBIRT ATTC, a federally funded program.

http://my.ireta.org/sbirt-reimbursement-map
Despite Progress…
Lesson 1: The Flexibility of SBIRT

• Choice of Screening Tool is Flexible
• Do not need BH providers on the team
• Brief Interventions can be BRIEF!
• Engage the full care team
• SBIRT fits into the full continuum of care
Lesson 2: The Key Barriers to SBIRT Implementation

• Protocol is Too Complex
• Universal Screening is Unnecessary
  – “We already know who needs services.”
• Focus on Screening and Referral to Treatment — Where’s the Brief Intervention?
• View of SUD as a behavioral health problem rather than a health problem.
• Tendency to Re-Silo SBIRT as Behavioral Health Specialty Service
• Challenge of incorporating into workflow
• Provider Resistance to SUD
• Inadequate Referral Network
• Provider Reimbursement (?)
Lesson 3: Treatment of SUD as Chronic Disease Using Stepped Care

Substance Use Prevalence

- Very Serious Use
  - In Treatment ~ 2,300,000
  - Addiction ~ 23,000,000
- Harmful – 40,000,000 Use
- Little/No Use
  - Little or No Use
Chronic Illness Model

Chronic Illness Model:

- **Chronic Diabetes Specialty Care**
  - Controlled Diabetes Primary Care Provider/Integrated Care Team
  - Risk Factors for Diabetes Primary Care Staff/Provider

- **Addiction Specialty Care**
  - Moderate Substance Use Primary Care/Integrated Care Team
  - Risk Factors for Use Primary Care Staff/Provider

*Peer Assistance Services, SBIRT Colorado*
Integration and Stepped Care

- Screening and Brief Intervention
- Enhanced Brief Intervention
- Specialty Care
Lesson 4: Overcoming Myths

• Culture Change
• Conversations in our daily lives and in our health care system about alcohol and substance use

• Tool:

https://www.youtube.com/watch?v=tbKbq2lytC4
Lesson 5: Expanding SBIRT’s Reach

- SBIRT is already moving into Schools, County Jails, Public Health Departments
- What are the places of the future?
  - Supported Housing?
  - Food Non-profits?
  - Other Human Service Organizations?
The Next Phase of Climbing

• Debunking the Myths
• Continued Education and Exposure to:
  – Brief Intervention
  – Flexibility of the Model
  – Engagement of All disciplines
• Hard Conversations about the Role of Alcohol in our Lives and Education for All
• Continued Culture Change for Providers
• Use Chronic Disease Models to Step Care for Substance Use
Q & A

Margarita Pereyda, MD, Principal, HMA
mpereyda@healthmanagement.com

Gina Lasky, PhD, Project Manager,
HMA Community Strategies
glasky@healthmanagement.com

October 29, 2015