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Medicaid Reimbursement for Screening and Brief Intervention: Massachusetts' Preparations

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Introduction

SBIRT Background

Early detection of health risk behaviors is important to both improving patients' health outcomes and to containing health care costs. Screening and Brief Intervention (SBI) is the term used to describe the identification of risky substance use behaviors, including alcohol use at the binge drinking level, and immediate feedback when a patient's behaviors may contribute to injury or to illness. Screening, brief intervention, and referral to treatment (SBIRT) is the process to systematically screen (S) for substance use risk and dependence in a medical setting and then intervene at the time of screening (BI) and to refer for subsequent treatment if the identified level of risk warrants (RT). As evidenced in a Massachusetts (MA) pilot project and in other studies, about 20 percent of those presenting for all health care services 'screen positive' for use of alcohol and drugs in unhealthy ways.[1] Of this 20 percent, most need brief intervention only, with between 1 and 5 percent of those who screen positive warranting referral to further treatment. This "RT" group represents a larger proportion among those patients screened in emergency departments and inpatient settings.[2]

The SBIRT model is based in part on an Institute of Medicine recommendation that called for community-based screening for health risk behaviors including substance use with appropriate assessment and referral activities.[3] SBIRT is a patient safety and quality measure and a service that is appropriate for inclusion in medical home and coordinated care models. A designated person in health care settings, including but not necessarily a physician, can administer a few pre-screening questions, do further screening of those for whom the prescreening yields a positive result, do a brief intervention for those whose scores suggest a level of risky use and refer to assessment and treatment the small number whose scores indicate possible dependence.

Substantial literature supports the clinical and cost effectiveness of SBIRT to assist people who are not dependent or addicted, but who use alcohol and drugs in risky ways that contribute to poor health outcomes. Additionally, SBIRT assists the early identification of those with substance use disorders at a lower level of addiction severity that may be receptive to lower cost outpatient treatment. SBIRT can reduce alcohol and drug misuse/abuse and has been shown to be effective in a range of healthcare settings including emergency departments[4], physicians' offices[5], and community health clinics[6]. Further the Motivational Interviewing (MI) techniques employed during BI sessions are useful for modifying many kinds of health risk behaviors.[7] While pregnant women, adolescents, and youth are among the special populations for whom SBIRT is recommended as an early intervention strategy, universal screening is

[1] Madras BK. Alcohol and Drug Abuse Weekly 2007; 19:8. Online ISSN 1556-7591.
[2] Madras BK. Alcohol and Drug Abuse Weekly 2007; 19:8. Online ISSN 1556-7591.
[3] Institute of Medicine, Committee on Quality of Health Care in America (IOM). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC, 2001.
[4] Désy PM, Perhats C. Alcohol screening, brief intervention, and referral in the emergency department: An implementation study. Journal of Emergency Nursing 2008; 34:11-9.
[5] Fleming MF, Mundt MP, French MT et al. Brief physician advice for problem drinkers: Long term efficacy and benefit-cost analysis. Alcoholism: Clinical Experimental Research 2002; 26:36-43.
[6] Madras BK, Compton WM, Avula D et al. Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: Comparison at intake and six months later. Drug and Alcohol Dependence 2009; 280-295.
[7] Antiss T. Motivational Interviewing in Primary Care. Journal of Clinical Psychology in Medical Settings 2009; 87-93.

recommended[8] since unhealthy and binge alcohol use is often hidden in adult moderate users of all age groups.

Multiple stakeholders including federal agencies and professional organizations support SBIRT use. The Center for Medicare and Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC) and the US Preventive Services Task Force have all promoted SBIRT nationally. The American College of Surgeons, Committee on Trauma (ACS-COT) has issued a mandate that both Level I and II trauma centers screen for alcohol misuse/abuse. The Joint Commission (formerly the Joint Commission on the Accreditation of Healthcare Organizations, JCAHCO) has undertaken the development of standards for screening and brief intervention for alcohol and other drugs. The National Commission on Prevention Priorities ranked alcohol screening and brief counseling for adults among its top five prevention priorities, ahead of 20 other effective services including colorectal cancer screening, hypertension screening and treatment, and influenza immunization.[9] Yet the actual diffusion of alcohol screening activities that are identified as a formal SBIRT model in healthcare practice has been low. Lack of familiarity with SBIRT standards, factors constraining time with patients, and low confidence in skills needed to provide a BI are among the barriers that practitioners cite to implementing SBIRT.[10] Structural barriers also exist. A recent survey of 36 states conducted by Oregon Health & Science University[11] indicates that while there is interest among state health authorities in implementing the service as a paid benefit, confusion remains about many aspects of this change in policy and practice, including confusion about the choice of billing codes that could facilitate reimbursement. Massachusetts, an identified leader in many areas of healthcare reform, seeks to understand how SBIRT may be adopted as part of its Medicaid program and so looks to learn from those other state Medicaid programs that have already done so.

Massachusetts experience with SBIRT

The Substance Abuse and Mental Health Services Administration (SAMHSA) monitors binge drinking behavior via its National Survey on Drug Use and Health (NSDUH). SAMHSA publishes state level information regularly as a supplement to its national profile. Estimates currently available (www.oas.samhsa.gov/2k6state/2k6state.pdf) indicate that nationally 22.8 percent of all persons aged 12 or older participated in binge use of alcohol in the past month. At the same time, less than half -- 41.7 percent -- of all persons aged 12 or older perceived a great risk of binge drinking. In Massachusetts according to the NSDUH, some 25 percent of the population aged 12 or older engaged in binge drinking, while only 34.66 percent of the same group perceived a great risk in this behavior. These percentages indicate that while a greater proportion of the Massachusetts population over the age of 12 reports binge drinking behavior than the national average, a smaller proportion of the Massachusetts population perceives risk in engaging in this behavior. Health policymakers, however, are well aware of the health risks associated with heavy alcohol use.

Substance misuse/abuse results in poor health outcomes and in substantial health care costs related to illness, hospitalizations, motor vehicle injuries, and premature deaths. Intoxication is a leading factor for injury, particularly in a binge drinking episode when a person consumes more alcohol than the body can process. Indeed, the roots of SBI as a service arose from practitioners' desire to prevent injury. Unhealthy alcohol use can also complicate existing chronic diseases including diabetes, hypertension, cardiovascular diseases and depression. It can counteract the benefits of medications and affect most organ systems. According to the National Center on Addiction and Substance Abuse, Massachusetts

[8] Babor TF, Higgins-Biddle JC. Brief intervention for hazardous and harmful drinking: A manual for use in primary care. Geneva: World Health Organization 2001; WHO/MSD/SMB/01.6b.

[9] Solberg, LI, Maciosek MV, Edwards NM. Primary care intervention to reduce alcohol misuse: Ranking its health impact and cost effectiveness. American Journal of Preventive Medicine 2008; 34:2:143-152

[10] Cherpitel CJ. Screening and brief intervention for alcohol problems in the emergency room: Is there a role for nursing? Journal of Addictions Nursing 2006; 17:79-82.

[11] Fussell HE, Rieckmann T, Gilpin M (2009) Medicaid reimbursement for screening and brief intervention of substance use: A mixed methods study. Oregon Health & Science University. Presentation of study funded by the Robert Wood Johnson Foundation Substance Abuse Policy Research Program (grant ID: 64378).

spends more than $4.5 million dollars annually on substance abuse related expenditures. Of that, more than $3 million is spent every year on health care costs related to hazardous substance use.[12] Multiple studies have shown that an investment in SBIRT can result in health care cost savings, with amounts noted ranging from $3.81[13] to $5.60[14] for each $1.00 invested. It should be noted that the time period for realizing the return on the initial "investment" referenced in these studies also varies. Time durations varied from 12 to 48 months, much longer than a fiscal quarter.

The Massachusetts Department of Public Health (MDPH) Bureau for Substance Abuse Services (BSAS) has been instrumental in making SBIRT more broadly known among health care providers and more widely used through its MASBIRT project. With both SAMHSA and BSAS funds, SBIRT projects currently exist in emergency departments and primary care clinics around the state, including the Emergency Department at Boston Medical Center, nationally known for the development and expansion of SBIRT services. While Brandeis University's Florence Heller Graduate School conducts a comprehensive evaluation of the MASBIRT pilot, recently released preliminary statistics show that in 2 years of the MASBIRT operation more than 57,898 patients were screened, with 8,184 (14%) screening positive and receiving a BI and 1,674 (2.9%) being referred to treatment. Knowing both the benefits of SBIRT as a service and the success of the MASBIRT pilot, members of the Executive Leadership Team at MassHealth, the Massachusetts Medicaid Authority, engaged the University of Massachusetts Medical School (UMMS) Commonwealth Medicine (CWM) Center for Health Policy and Research (CHPR) in a multiple year project to implement SBIRT as a member benefit.

MassHealth initiative for SBIRT implementation

Early in 2009 the MassHealth Office of Behavioral Health (MHBH) and CHPR began a multi-phased project that seeks to: (1) prepare a set of evidence-based recommendations for integrating standardized SBIRT protocols into MassHealth's service delivery package, (2) operationalize the selected benefit implementation option, and (3) design and conduct an evaluation of the benefit's roll-out. Phase I, currently underway, involves building the necessary partnerships among key stakeholders, including federal and state government agencies and health care providers; building a sustainable SBIRT project infrastructure; and obtaining MassHealth leadership approval to move forward with service reimbursement under SBI specific billing codes. Staff from MassHealth, CHPR, and BSAS meet regularly as a project team, often initiating activities that inform early decision points in the project.

The MassHealth Office of Acute and Ambulatory Care (OAAC) oversees service delivery through the state Medicaid plans. OAAC has a pivotal role in the adoption of an SBI benefit. During a project meeting, OAAC senior managers expressed interest in the experience of other state Medicaid programs. CHPR subsequently undertook an environmental scan conducted with officials of other states where the Medicaid Authority has implemented SBI as a covered benefit. In conducting the environmental scan, CHPR sought to better understand the states' experiences both before and after the implementation of SBIRT as a covered benefit. We chose to define states as SBIRT adopters if the state had open billing codes specific to SBI reimbursement. These SBI codes are discussed below. It should be noted that no "RT" codes exist, therefore billing codes are referred to as SBI codes, while the services are referred to as "SBIRT". We chose to focus on these states alone to seek guidance from their experiences of implementation. Based on both preliminary findings from an Oregon Health & Science University study as well as our own information gathering, we identified eleven states with open billing codes related to SBIRT in September 2009.

The four questions of interest for our work were:

[12] http://www.jointogether.org/getinvolved/state/massachusetts/massachusetts-state-page.pdf
[13] Gentilello LM, Ebel BE, Wickizer TM et al. Alcohol interventions for trauma patients treated in emergency departments and hospitals: A cost benefit analysis. Annals of Surgery 2005; 24(4) 541-550.
[14] Fleming MF, Mundt MP, French MT et al. Benefit-cost analysis of brief physician advice with problem drinkers in primary care settings. Medical Care 2000; 38(1) 7-18.

(1) What led each state to implement SBIRT and how did the state prepare for implementation?

(2) What billing codes did states decide to open?

(3) Who performs SBIRT, in what settings, and with which screening tools?

(4) What happened once the billing codes were opened for reimbursement?

Methods

We elected to employ qualitative methods, using telephone interviews conducted with a semi-structured interview guide. We developed the guide based on some preliminary conversations with colleagues in other states and on findings from the scientific literature. For example, with regard to what led each state to implement SBIRT, we asked what motivated the state to do so, as well as whether the state Medicaid and Substance Abuse Authorities worked together to jointly roll out the benefit. We also asked whether SBIRT was implemented as part of a broader policy initiative such as the implementation of a Medical Home of primary care. The interview guide invited respondents to offer recommendations in light of the lessons they learned and their ongoing planning for future enhancements to billing and training efforts. A copy of the interview guide is included in the Appendix of this document.

With the interview guide completed we set out to develop a list of state officials to interview. We enlisted the aid of the SAMHSA SBIRT Office and colleagues from other state substance abuse authorities to identify initial contacts by state for recruitment. In each of the eleven states, we identified Medicaid and Substance Abuse Authority staff with knowledge of SBIRT. We contacted all potential respondents, and successfully scheduled 30-minute telephone interviews with staff in ten of the eleven states. We assured respondents that the information that they shared with us would be kept confidential. We explained that our interest is in developing common themes across all states that implemented SBIRT as a covered benefit to guide the Massachusetts policy decision. We agreed not to name the states, so for purposes of this report, specific states are referred to with Roman numerals.

In September 2009, we completed the interviews in ten states. Often multiple calls were needed to identify the person(s) in each state who could provide us with a complete description of the state's experience. Respondents included six Medicaid staff members, one of whom was the Medicaid Medical Director; three staff from Substance Abuse Authorities, and one from a governor's institute on substance abuse. Responses were recorded in writing by the interviewer, then transcribed and analyzed using Atlas TI software version 6.0.

Results

What led each state to implement SBIRT and how did the state prepare for implementation?

States were motivated to implement SBIRT as a covered benefit for a variety of reasons and with varying levels of planning. State IV simply decided it was the right thing to do, and opened the billing codes within months of first considering it. Other states, such as State I, VI, VII, and X specifically mentioned benefitting from the efforts of "SBIRT champions" at state agency and provider levels who engaged multiple policy makers and providers over time to build support. In State I, SBIRT adoption has been a part of a decades-long process that began with physician education efforts in the 1980s. Collaboration among funders and medical societies lent momentum to this state's efforts in recent years to open billing codes, implement, and track performance of the service. Most states in our census launched implementation of SBIRT in early 2008 when the American Medical Association approved two Common Procedural Terminology codes related to SBI. State VI launched its efforts a year earlier when the Center for Medicare and Medicaid Services (CMS) first approved use of SBI codes in early 2007. Some states noted that SBI services may have already occurred in various ways across a variety of medical settings prior to CMS approval. Formal tracking of the service via billing codes is a relatively new development made possible in these states by the use of codes specific to the SBI services.

Cost containment was cited as a motivator for SBIRT adoption. Managed care organizations (MCOs) acted as early promoters. The respondent from State VIII characterized it this way:

> *"Because managed care organizations can recognize the high costs of behavioral health and medical costs for untreated substance abuse, it is easy for them to see how helpful, useful, and cost effective SBIRT is."*

SBIRT's embodiment of harm reduction and injury prevention strategies also motivated states toward implementation. The respondent from State III talked about the need to address general attitudes among state residents that drinking to excess is okay. Policy makers and providers in two states talked about the difficulty in changing lax attitudes toward risky use of alcohol among state residents. One stated that the state could not afford an "abstinence only approach." Both were interested in identifying risky use as soon as possible and in intervening immediately.

States III and IX recalled being contacted by the White House's Office of National Drug Control Policy (ONDCP) in the fall of 2007, promoting the use of soon-to-be-approved SBI billing codes. While the ONDCP contact was not the only reason these states opened the codes, each recalled that this contact occurred prior to its implementation of SBIRT in the state.

State agencies approached collaboration for SBIRT implementation in various ways. The Medicaid and Substance Abuse Authorities in States I, VII, VIII, and X worked to jointly launch the implementation of SBIRT in their state. The other six reported varying degrees of collaboration.

Two of the ten states rolled out SBI as part of larger initiatives. State X did so as part of a Medical Home model of primary care. Tier 3 physicians in that state are required to conduct SBI activities as well as behavioral health screens. State I also rolled out SBI as part of a Medical Home Initiative, and noted that its implementation was strengthened and informed by the efforts of a recently formed partnership of state agencies and funders to promote the integration of behavioral health screenings into primary care. In the remaining eight states, SBI was not rolled out as part of a larger initiative. State IX indicated that Medicaid rolled out SBI as conversations were underway about Medical Home, integration of care, and state health reform. It is important to note that none of the ten states amended their Medicaid state plan in order to open codes for and roll out the implementation of SBI as a covered service. All of the states that we contacted found support in their existing Medicaid state plans or state plan Waivers that allowed for SBI code initiation and roll out of the benefit.

The ways in which states went about adapting their state policy to reimburse providers by opening SBI codes vary widely. Some states opened the SBI codes as a matter of routine update in billing codes. Other states looked upon the change as adoption of something new and did so because it was assessed as the right thing to do. In some cases, the state's Medicaid and Substance Abuse Single State Authorities (SSAs) mentioned working together to roll out SBI as a paid benefit. Having decided to make payment, a second consideration was the selection of a billing protocol.

What billing codes did states decide to open?

CMS approved Health Care Procedural Code Set (HCPCS) Level II codes H0049 and H0050 in January, 2007. These codes allow health care providers to bill Medicaid specifically for screening (H0049) and for brief intervention sessions (H0050) related to alcohol and other drug disorders (AOD). One year later the American Medical Association (AMA) approved HCPCS Level I Common Procedural Terminology (CPT) codes 99408 and 99409. Health care providers can bill private payers and Medicaid for screening and brief intervention for sessions of 15 minutes to 30 minutes (99408) or more than 30 minutes (99409). CMS also approved reimbursement for Medicare recipients under HCPCS Level II codes G0396 and G0397 for screening and brief intervention sessions defined as CPT 99408 and 99409 respectively. These approvals provide an important step in State Medicaid programs' adoption of SBIRT as a paid benefit, but leave many decisions for state policymakers to consider. Should AOD screening be tracked independently of brief interventions and of other types of screenings? Since the H codes are contained in the HCPCS behavioral health section, will health care providers use them?

Nine of the ten states interviewed chose to open CPT codes 99408 and 99409. Respondents indicated that these codes were selected because CPT codes are widely used in medical settings. State II opened both CPT and G codes. State III opened CPT, H, and G codes but noted that H codes are not being used.

State VI elected to forgo the CPT codes in favor of H codes. It had previously opened CPT code 96151, a code for health and behavioral health screening and intervention, but providers were unsure how to use this code as part of existing billing procedures. So, prompted by CMS' guidance, this state went ahead and opened the H codes.

Who performs SBIRT, in what settings, and with which screening tools?

Practitioners

While all states designate physicians and the majority of states include nurse practitioners as professionals who shall perform SBI, states make use of a variety of other practitioner levels and types, including addiction/mental health counselors, licensed clinical social workers, physician assistants, psychologists, and midwives. A respondent from one state would like to see Medicaid approve paraprofessionals -- such as emergency medical technicians – to perform SBI as well.

Some states have developed specific guidance for health care professionals other than the physician who will perform SBI with patients. For example, the Medicaid Authority of one state clarified that health care professionals who are provisionally licensed and "incident to" (supervised by) a physician could perform SBI and then consult with the physician with regard to next steps, including referral to treatment if necessary. This approach freed up the physician to see other patients while a staff member conducted a BI with the patient.

Settings

All ten states approved implementation of SBI in physicians' offices. In addition, SBI occurs across a range of medical care settings. States I, III, IV, and IX, have also approved implementation in emergency rooms, while States VI and VIII plan to approve emergency rooms in the near future. States IV, IX, and X designated Federally Qualified Health Centers (FQHCs) as approved settings while States I and VIII seek to pilot SBIRT in FQHCs as a first step. State IV approved most every type of primary care provider and setting, including rural health clinics and outpatient hospital settings. State VII also included mental health settings. State V makes no restriction on where SBIRT is performed, and the SBI codes are set up to be billable by physicians or nurse practitioners.

FQHCs are widely acknowledged as important sites for implementing SBIRT. Several respondents stated that FQHCs are strategically positioned for implementing SBIRT given their high utilization rate by Medicaid members, and by the fact that FQHCs can integrate behavioral health, primary care, and linkages to other community resources under the same roof. As the respondent from State IX stated,

> *"[FQHCs] are on the forefront and the early adopters. Getting a clinic to code the procedure is a trick, since they don't get paid more for doing so."*

That state now allows FQHCs to submit as many codes as they need in order to accurately report all services they are performing.

Tools

None of the states require providers to use a particular screening tool, however three states recommend use of the AUDIT[15] and DAST[16], and provide internet-based information regarding these tools. One state recommends the ASSIST[17]. Screening tools used in the remaining six states vary. In some states, managed care organizations (MCOs) provide guidance to providers about the use of screening tools, while in other states MCOs leave it up to the physician to decide.

One state Medicaid authority engaged in a three year process with providers and other stakeholders to develop a combined health risk assessment (HRA) tool that screened not only for risky alcohol and drug use, but also for depression and domestic violence. The combined HRA continues to be used today, but the Substance Abuse Authority is now promoting the use of validated SBI tools alongside other behavioral health screens such as that on the HRA.

What happened once the billing codes were opened for reimbursement?

A low volume of claims

A simple answer seems to be, "Not much." Medicaid Authorities reported an unsubstantiated fear that they would be flooded with claims once they opened the billing codes. Even though the literature indicates cost savings in the long run, SBI adopting states were concerned prior to implementation that they would incur high costs in the short term as providers submitted a high volume of claims. Their fears were not realized, however. Provider claims were low in all ten of the states interviewed. This was true not only for states that opened the codes with minimal planning (for example, as a matter of annual code updates) but also for those that engaged in years of pre-planning with providers and agencies. The state that engaged in a three-year process with providers and other stakeholders to develop a combined HRA, looked at claims submitted for SBI code 99408 (session 15-30 minutes reimbursed at $28.07) and SBI code 99409 (session greater than 30 minutes reimbursed at $55.04). For the 15 month period from January 2008 to March 2009, six physicians billed for 191 unduplicated instances of service for a total of $5,623 in claims. State VII, another state that engaged in planning with multiple stakeholders, experienced claims totaling $1,545 over the 12 months from January 2008 to January 2009. When a state engaged in minimal planning prior to implementation, they experienced even a lower claims volume. From January 2008 to August 2009, one such state counted three claims totaling $139. When state respondents did not have specific claims figures, they responded that claims were low.

The respondent from State IX accounted for the slow rate of uptake / reporting this way:

> *"Codes are not being used for a variety of reasons. The main reason is that codes don't automatically translate into utilization. Practice patterns need to change…It requires physicians to do something different in their flow of practice, such as the use of physician extenders [health professionals other than the physician]."*

Concerns about reimbursement rates

Several respondents observed that the low rates of billing may be also related to the low reimbursement rates for performing the service. As one observed,

> *"Physicians may not bill if the rate doesn't make it worth their while. If it's not financially rewarding, we can't expect physicians to do it."*

[15] Babor TF, Higgins-Biddle JC, Saunders JB, Monteiro MG. AUDIT: The alcohol use disorders identification test: Guidelines for use in primary care. Geneva: World Health Organization 2001; WHO/SMB/01.6a.
[16] Skinner HA. The drug abuse screening test. Addictive Behavior 1982; 7:363-371.
[17] WHO ASSIST Working Group. The alcohol smoking and substance involvement screening test (ASSIST): Development, reliability, and feasibility. Addiction 2002; 97:1183-1194.

Another respondent believed that it is unlikely that other physicians would implement SBIRT without reimbursement, and observed,

"If it's not covered, why would a provider do it?"

This respondent would like the state to provide funding separate from Medicaid that reimburses at higher rates than Medicaid, and that also supports paraprofessionals to perform the service.

SBIRT reimbursement rates are an ongoing discussion in several states, especially with regard to federally qualified health centers (FQHCs). The respondent in State III observed that the FQHCs in that state are revenue code-driven. They are cost-based providers that cannot bill separately for specialty services like SBIRT. Hospitals also operate in this manner and are in a similar situation when it comes to billing. One physician in this state established a protocol for SBIRT, but is not getting reimbursed for implementing it via an SBI code.

Respondents made several observations about the low billing rates. The respondent in State VI noted that several of the public health clinics (through which many state residents get their health care) are not billing Medicaid. They are either utilizing other funds or they are simply not billing for the service. Their figures are therefore not reflected in Medicaid's data. This state recently added nurse practitioners to the list of approved providers to perform SBIRT. The respondent expressed hope that this would result in an upsurge in activity.

Low reimbursement rates are also a concern for the Substance Abuse Authority in State II where Medicaid reimburses FQHCs per patient encounter, not per service. Since the per patient encounter reimbursement is substantially higher than reimbursements associated with the specific SBI codes, physicians at FQHCs are not incentivized to bill using the SBI codes. It is not known whether or to what extent the actual screening for risky substance abuse is actually occurring. The Substance Abuse Authority is in conversation with the Medicaid Authority about this issue. There is also interest in this state in using health professionals other than physicians to perform the service.

<u>Providers, training, and other concerns</u>

In addition to reimbursement, the implementation of SBIRT as a covered benefit generated concerns in the provider community. In State VI, the Medicaid Authority chose to roll out SBI with the adults, the population aged 18 years and older. Pediatricians questioned this decision. Medicaid explained that its decision was made to preserve the confidentiality of youth seeking services. Since the explanation of benefits (EOBs) go to parents, Medicaid was concerned that youth would not seek alcohol and drug related services if they knew their parents would be informed of their participation in screening and intervention. The Medicaid Authority would like to see school-based screenings that preserve youth confidentiality.

Another area of concern involved turf. Community mental health providers in State VI were concerned that provision of SBIRT in primary care settings usurped their role. The Medicaid Authority addressed concerns by describing the purpose of SBIRT in primary care and reinforced the fact that physicians were still making referrals to the substance abuse and mental health systems.

Cost containment was also a concern of one of the rural health clinics in this state, and not just for the Medicaid Authority. This rural health clinic tracked expenditures related to high service utilizers before and after implementing SBIRT. This clinic found its medical costs reduced by one-third. The respondent noted that this serves as compelling evidence to other clinics wondering about the cost-benefit of SBIRT.

An ongoing challenge that all states mentioned is the issue of billing procedures and educating physicians about the use of SBI codes. Some states have the infrastructure (supportive legislature, funders' collaboration, etc.) to deploy training of physicians, strengthen and disseminate curricula on SBIRT, and train on motivational interviewing, but most states do not have the resources to provide other than administrative technical assistance.

Early on in its effort to integrate behavioral health in primary care, State I leveraged physician interest in depression screenings to introduce SBIRT. By first providing guidance on mental health screenings – the topic about which physicians requested the most guidance -- the state found it easier to introduce the SBIRT at a later date.

Discussion

Both MHBH and BSAS, the Single State Authorities for Medicaid and SAMHSA respectively, support SBI as a MassHealth paid benefit. CHPR's work in collaboration with the Single State Authorities has been productive toward developing a policy framework for a sustainable SBIRT program with MassHealth. MASBIRT, the SAMHSA funded pilot program, will complete its federal funding cycle in 2011. There is great interest in continuing the SBI services as implemented via MASBIRT, however, a restrictive fiscal environment sanctions adoption of any "new" service.

Screening for risky substance use and referral to substance abuse treatment is not new to MassHealth members, however. MassHealth requires primary care providers in its Managed Care Organization (MCO) plan and its Primary Care Clinician (PCC) plan to employ a health risk assessment tool. MassHealth has yet to require use of a particular instrument with adult enrollees. It only requires screening for adolescents aged 17 and younger as part of the Children's Behavioral Health Initiative (CBHI), and providers can choose from a menu of screening tools. The policy question for MassHealth, therefore, is not "Do we implement SBI or not?" but rather is "How can we best monitor screening assessment and intervention activities?" The concern for policymakers lies more in standardization of current practice. It is only through greater use of common standards for screening questions and for implementation protocols that a state can realize the promised cost savings for each dollar invested across a health plan. Ongoing training and technical assistance are needed to support adoption of service standards.

A state Medicaid authority's challenge for implementing SBIRT, beyond opening the SBI codes, has more to do with collaboration: with how state agencies, funders, providers, and other stakeholders align themselves to support the depth and breadth of the service, and to train providers -- both the practitioners and their billing agents. Fortunately, there are states (some of which are represented in our census) that are well positioned to do this, are already making inroads in their states, and are willing to share lessons learned with Massachusetts. Restrictive fiscal times can assist planning efforts while they can impede implementation. CHPR has identified nine bodies of work, including work related to training and billing, that will occupy the SBIRT team. Few state agencies individually have the dollars to provide technical assistance on the use of billing codes as part of a comprehensive push to train providers, and to strengthen and disseminate curricula. MassHealth and CHPR are investigating ways to leverage technical assistance resources from SAMHSA working in collaboration with BSAS.

Our conversations with the ten states have not produced an actual description of the cost of implementation, other than the reports of low claims volume. While policymakers express concern about the cost of implementation, a relevant question to ask is "What is the cost of not screening?" Numerous studies have demonstrated the impact that behavioral health issues have on increasing health care claims and costs. As noted earlier, SBI is known as an effective strategy for reducing health risk behaviors.

Limitations

Two limitations of the study should be noted. First, MassHealth tasked CHPR with contacting those states with open billing codes related to SBIRT. Therefore, what we conducted was a census of states with open codes. Our bias therefore is toward states positively inclined toward SBIRT. We did not attempt a representative sample of all states that would have allowed us to contrast these states' experiences with those whose initiatives have not yet let to SBIRT adoption into Medicaid policy as a paid benefit.

A second limitation involved finding the subject matter experts in each state. Only a few respondents could respond to every question posed in the interview. It was more common for respondents to refer the interviewer to colleagues in Medicaid, Substance Abuse Authorities, primary care associations, or consultants. Follow up calls on the part of the interviewer were made as time allowed. However, the majority of findings in this report were garnered from the respondents who were originally contacted and interviewed. It is important to remember that in state government, information is rarely kept by just one person. It is more common for different staff members to be the keepers of partial data. One is reminded that coordination takes time, and if one is inclined to follow all leads, sufficient time and resources would be necessary to do so.

CHPR's success in gaining access to information from states that had implemented SBIRT as a paid benefit was due in great part to its ongoing role as MassHealth's business associate. As we spoke with other states, we did so less as a university and more as colleagues seeking guidance from their experience and to share our own process.

Conclusions

Medicaid Authorities considering the implementation of SBIRT as a covered benefit can be reassured that (1) other states have done it, (2) have done it in ways that made sense given their individual state plans and waivers; (3) have done it as part of larger initiatives such as Medical Home, and (4) done it in a manner reflective of their health care delivery infrastructure. None of the ten we interviewed had to amend their formal Medicaid state plan in any manner to implement use of the SBI codes. Furthermore, opening use of the SBI codes did not result in a flood of claims. Opening the SBI codes, however, is a first step toward better tracking and understanding the extent to which SBIRT is being performed.

Medicaid authorities (and managed care plans under their purview) interviewed see the risky use of alcohol and drugs as they do other risk behaviors such as tobacco use and lack of exercise. These behaviors are related to multiple chronic diseases and conditions and are best modified to promote health and wellness. SBI, and the associated expertise in motivational interviewing gained, is seen as a helpful tool for improving member health, reigning in costs, preventing injury, and saving lives. This universal belief in the importance of screening for risk behaviors means that some kind of screening for risky alcohol use is already established as part of practice standards, but that it is likely reimbursed within a more general billing code.

There is great interest among federal policymakers in having health plans, including state Medicaid authorities, adopt SBIRT as a paid benefit. With this interest comes a desire for a 'roadmap' which can lead an interested state to implement an SBIRT benefit. When using a roadmap it is important to know the starting point. The MA experience, as well as that of other states, indicates the importance of thoroughly examining and understanding the current state's Medicaid operations and an 1115 Waiver demonstration plan. This examination takes time but that time is well spent both in gaining information, building support and developing the infrastructure for training, operations, monitoring and billing. An equally vital component for SBIRT adoption is collaboration between the state's Medicaid and Substance Abuse State Authorities.

APPENDIX

**Medicaid Reimbursement for Screening and Brief Intervention:
Massachusetts' Preparations**

INTERVIEW GUIDE

I. Preliminary Questions

(1) We understand that your state has HCPCS Level 2 or Level 1 CPT codes open. Is this the case?
(2) Which codes are open in your state?
(3) Are providers in your state using these codes to bill Medicaid for Screening and Brief Intervention?
    If yes: 3a. Can you give me a sense of how widely the codes are used?
    3b. Are the codes being used related to screening for addiction or risky use of alcohol and drugs?

II. History of SBIRT In Your State

(4) How did SBIRT get started in your state?
(5) Who was the executive sponsor of the initiative?
(6) What were the difficulties of getting it implemented?
(7) How long did it take to get it implemented, including the planning phases?
(8) What would you say was the secret of your success?
(9) What other state agencies or stakeholders were involved?

III. How SBI is Implemented In Your State

(10) In what settings is SBIRT implemented? (e.g., primary care, emergency rooms, CHCs?)
(11) Do you know who does the screening?
(12) What screening tools are being used?
(13) Is the tool a part of a health risk assessment (HRA)?
(14) Is SBIRT a part of or connected to a larger initiative (like Medical Home)?
(15) Are you getting federal funding participation (FFP)?
    If yes: 15a. How did you secure FFP and how do you report it?

IV. Final Questions

(16) If you could do it all over, what would you do differently?
(17) With whom should I talk to learn more or get additional perspectives?
(18) Is there anything else you would like to share?

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