The Story Behind Oregon's SBIRT Incentive Measure and its Impact on Implementation

Jim Winkle, MPH
Research Associate
Dept. of Family Medicine
Oregon Health & Science University

The facts:

- Widespread implementation of SBIRT remains elusive in U.S.
- 3 years ago, Oregon saw a big increase in billing for SBI
- This increase correlated with a Medicaid SBIRT performance metric

Questions:

- Can/should this performance metric be replicated elsewhere?
- What lessons can be learned from Oregon's experience?

SBIRT

Screening

Brief Intervention

Referral to Treatment

"A public health approach to the delivery of early intervention and treatment services for people with substance use disorders and those at risk of developing these disorders."

SAMHSA

Oregon Health Authority

Alcohol and Drug Misuse (SBIRT)

Measure Basic Information

Name and date of specifications used: OHA developed these specifications in collaboration with OHSU and CCOs, based on coding recommendations developed by CMS and SAMHSA, while using HEDIS specifications for identifying ambulatory outpatient care services to identify unique outpatient recipients by plan.

URL of Specifications: N/A

Measure Type:

HEDIS☐ PQI☐ Survey☐ Other■ Specify: OHA-developed

Measure Utility:

CCO Incentive■ Core Performance■ CMS Adult Set☐ CHIPRA Set☐ State Performance■
Other☐ Specify:

Data Source: MMIS/DSSURS

Measurement Period: January 1, 2016 - December 31, 2016.

2013 Benchmark: 13%; from Metrics & Scoring Committee consensus.
2014 Benchmark: 13%; from Metrics & Scoring Committee consensus

SBIRT timeline in Oregon

2008:

5-year SAMHSA award

- Resident SBIRT training
- 5 residencies
- Implemented SBIRT into 7 primary care clinics

SBIRT clinic workflow

Waiting room

Adult brief screen

Exam room

AUDIT / DAST

Exam room

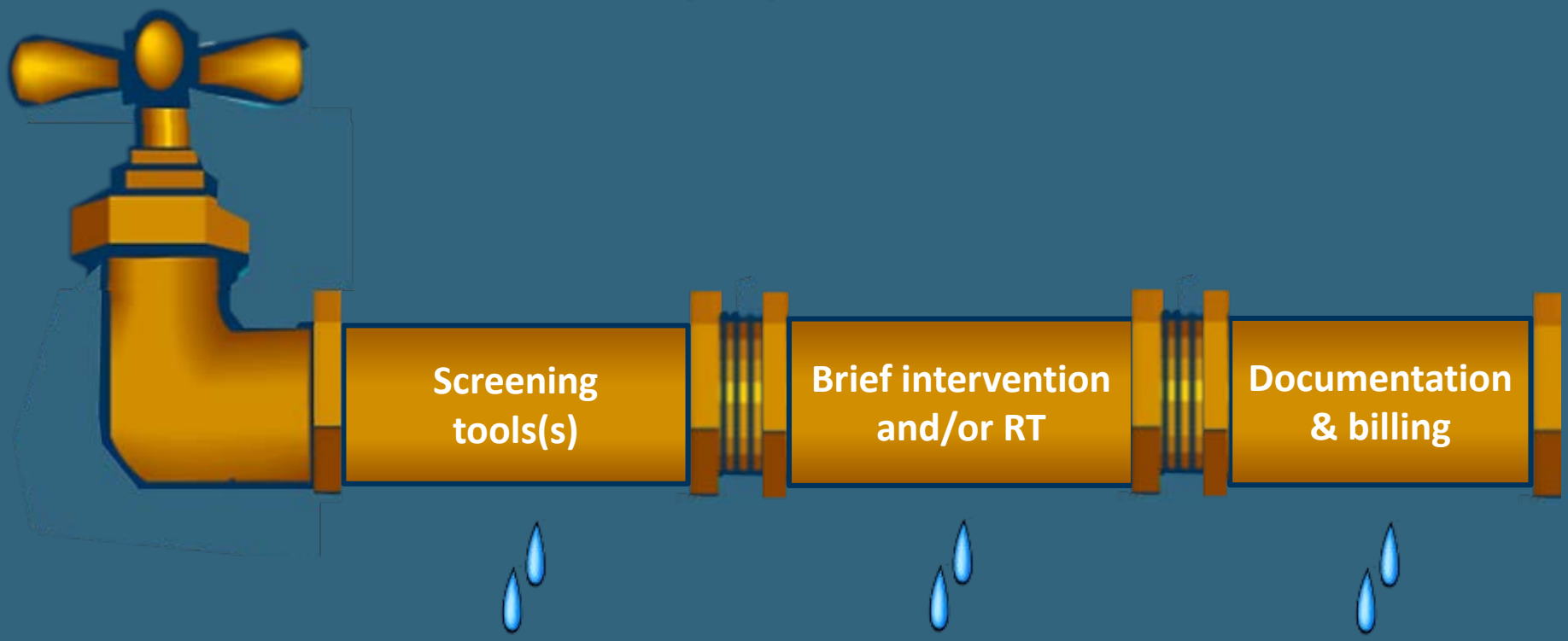
Brief intervention
or
Referral to treatment

Reception

Medical assistant

Clinician

SBIRT workflow resembles pipeline



Step(s) not always performed,

or not always captured in the EHR.

SBIRT timeline in Oregon

2009:

- SBIRT reimbursement codes "turned on" by Oregon Medicaid
- State legislature creates Oregon Health Authority:
  - Now under one roof: Public Health, Addictions & Mental Health, Medicaid, Public Employees Benefits Board etc.

Ron Stock, OHA

SBIRT timeline in Oregon:

2010:

- Governor Kitzhaber elected
- ACA passed nationally

2011:

- Oregon faces $1.9B shortfall in Medicaid budget

Oregon Medicaid shortfall

Traditional budget balancing:

1. Cut people from care
2. Cut provider rates
3. Cut services

4th way: Change how care is delivered.

- Reduce waste, improve health, create local accountability, align financial incentives, pay for performance and outcomes, create fiscal sustainability

Ron Stock, OHA

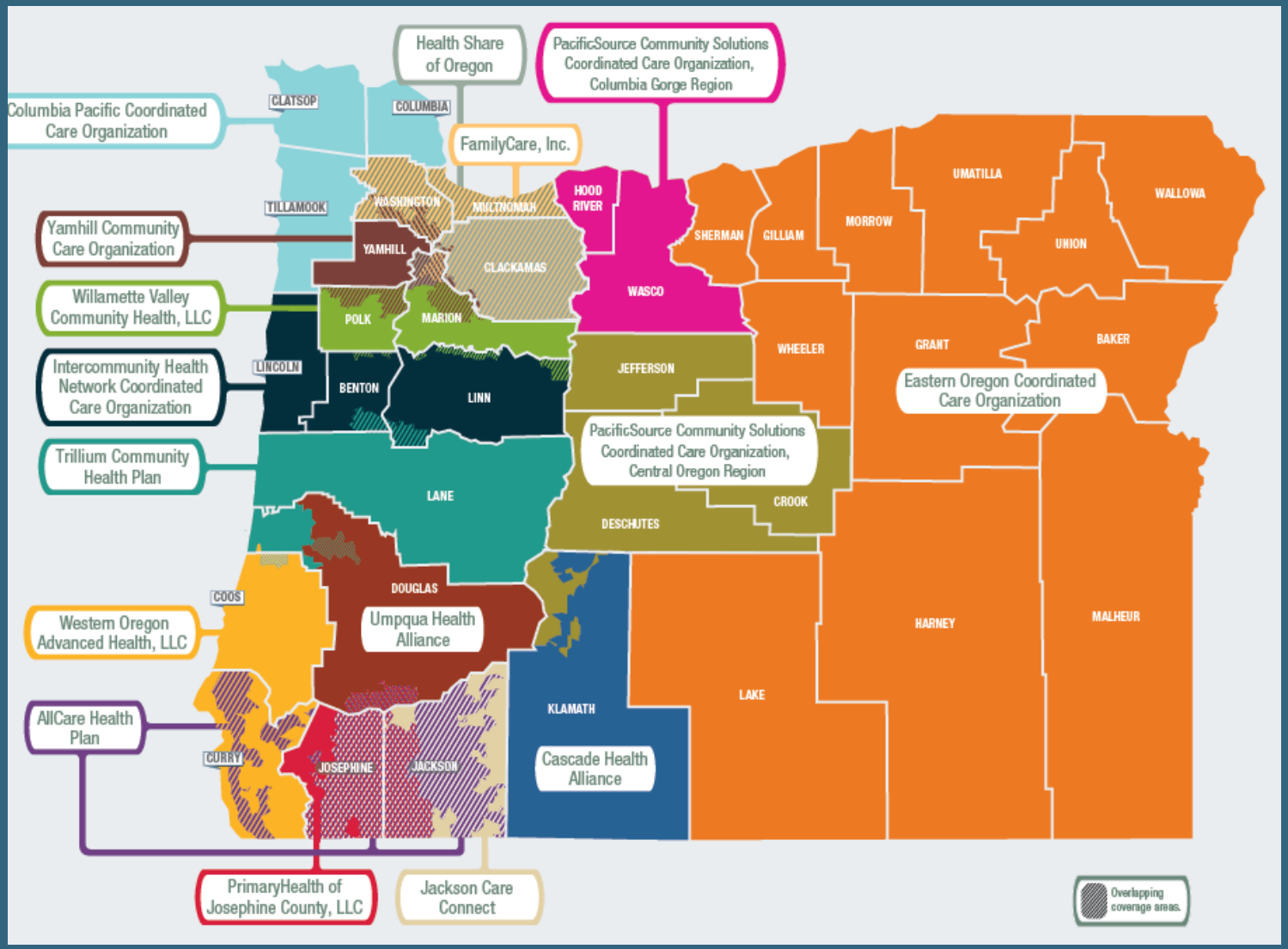
SBIRT timeline in Oregon

2012:

- Oregon agrees to transform Medicaid in exchange for $1.9B waiver from Feds
- State legislature creates Coordinated Care Organizations

Ron Stock, OHA

16 CCOs


Health Share of Oregon
PacificSource Community Solutions Coordinated Care Organization, Columbia Gorge Region
Columbia Pacific Coordinated Care Organization
FamilyCare, Inc.
Yamhill Community Care Organization
Willamette Valley Community Health, LLC
Intercommunity Health Network Coordinated Care Organization
Trillium Community Health Plan
Western Oregon Advanced Health, LLC
AllCare Health Plan
PrimaryHealth of Josephine County, LLC
Jackson Care Connect
Umpqua Health Alliance
Cascade Health Alliance
Eastern Oregon Coordinated Care Organization
PacificSource Community Solutions Coordinated Care Organization, Central Oregon Region
CLATSOP
COLUMBIA
TILLAMOOK
WASHINGTON
MULTNOMAH
HOOD RIVER
YAMHILL
CLACKAMAS
WASCO
POLK
MARION
LINCOLN
BENTON
LINN
JEFFERSON
LANE
DESCHUTES
CROOK
COOS
DOUGLAS
CURRY
JOSEPHINE
JACKSON
KLAMATH
LAKE
SHERMAN
GILLIAM
MORROW
UMATILLA
WALLOWA
UNION
WHEELER
GRANT
BAKER
HARNEY
MALHEUR
Overlapping coverage areas.

How Oregon CCOs differ from ACOs

- Responsible for the full integration of physical, behavioral and oral health, held to one budget
- Must include members and agencies that address social determinants of health
- Community Advisory Board: 51% consumers, representatives from community service providers
- Must perform Community Needs Assessment and create Community Health Improvement Plan
- Regional effort to create "community solutions" with multiple clinical and non clinical stakeholders
- Responsible for health outcomes and receive incentives for quality

Ron Stock, OHA

17 incentive measures

- Access to care
- Adolescent well-care visits
- **SBIRT**
- ED utilization
- Colorectal cancer screening
- Controlling hypertension
- Depression screening and follow-up
- Developmental screenings in the first 36 months of life
- Diabetes HbA1c poor control
- Early elective delivery
- EHR adoption
- Follow-up after hospitalization for mental illness
- Follow-up for children prescribed ADHD medication
- Mental and physical health assessments for children in DHS custody
- PCPCH enrollment
- Prenatal and postpartum care
- Satisfaction with care

SBIRT timeline in Oregon

2012:

- OHA begins formulating metrics for Incentive measures for 2013 start
- SBIRT measure will include drug and alcohol use

Thumbnail summary of evidence behind SBIRT

	BI for risky or harmful alcohol use	RT for severe alcohol use	BI for risky or harmful drug use	RT for severe drug use
Adults	✓	?	X	?
Adolescents	?	?	?	?
Pregnancy	✓	?	?	?

✓ Good evidence for reducing patient self-reported use

X Good evidence for null effect on patient self-reported use

? Insufficient evidence to determine effect

Creating the SBIRT metric

Numerator:

- Screening
- Brief intervention
- Referral to Treatment

Denominator:

Medicaid visits of pts age 18+ in calendar year

≥ ?

Benchmark

Common eval methods:

- Claims data (billing codes)
- EHR reports
- Randomly selected chart reviews
- Surveys of staff and patients
- Standardized patients
- Triangulation

Creating the ratio

- S codes
- BI codes
- RT codes

Visit codes of pts age 18+ in calendar year

≥ ?

Screening codes

Service	Payer	Code	Description
Screening only	Medicaid & Commercial	**CPT 99420**	• Administration and interpretation of a health risk assessment instrument.
	Medicare	G0442	• Screening for alcohol misuse in adults once per year.

- CPT 99420 should be appended to E/M service with modifier 25.

Where CPT 99420 applies

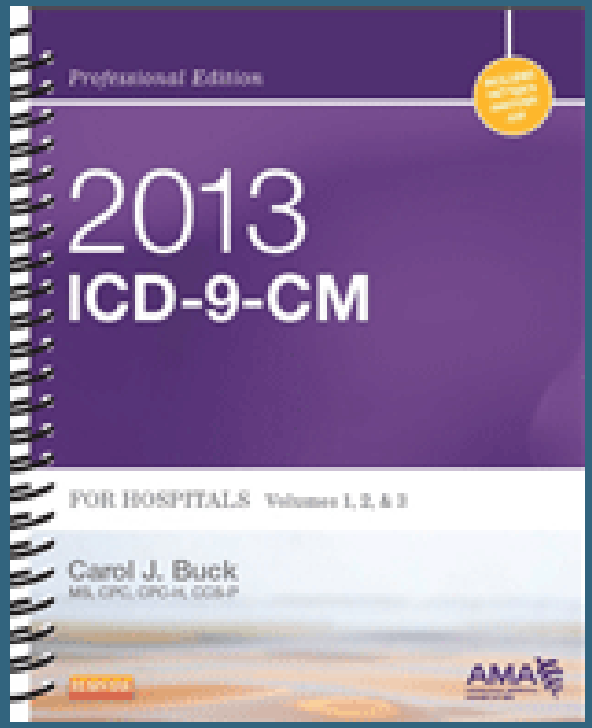
Screening codes available for alcohol or drug use

Service	Payer	Code	Description
Full screen only	Medicaid & Commercial	**CPT 99420**	• Administration and interpretation of a health risk assessment instrument.
	Medicare	G0442	• Screening for alcohol misuse in adults once per year.

OHA-approved diagnosis codes

ICD-9:

- V79.1
  (Screening for Alcoholism)
- V82.9
  (Screening for Unspecified Condition)



Incentive measure screening codes

Service	Payer	Code	Description
Full screen only	Medicaid & Commercial	**CPT 99420** plus V79.1 or V82.9	• Administration and interpretation of a health risk assessment instrument.
	Medicare	G0442	• Screening for alcohol misuse in adults once per year.

Creating the ratio

- CPT 99420 (plus V79.1 or V82.9)
- BI codes
- RT codes

Medicaid visits
of pts age 18+
in calendar year

≥ ?

Brief intervention codes

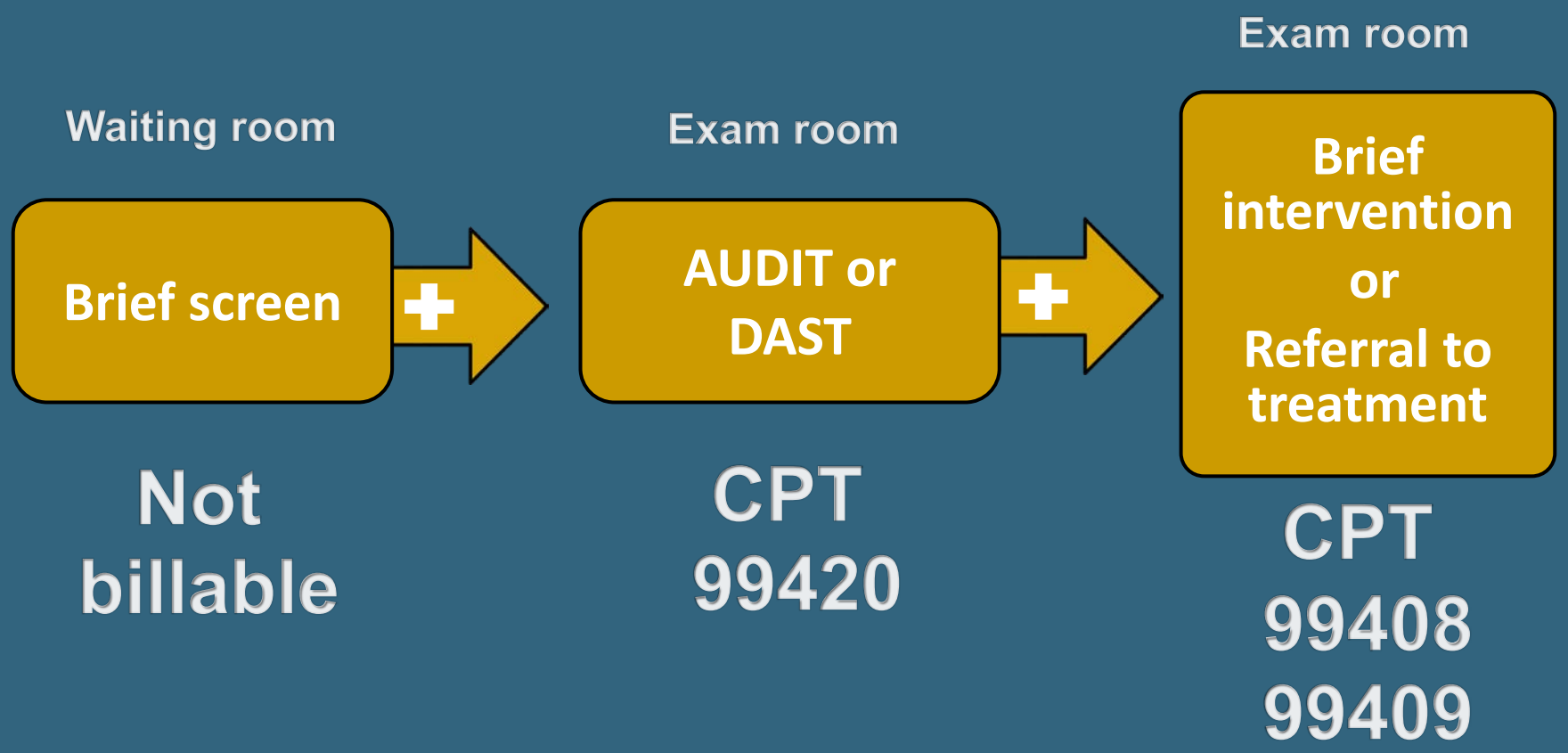
Service	Payer	Code	Description
Full screen + brief intervention	Medicaid & Commercial	CPT 99408	≥15 minutes of aggregate clinic time spent administrating and interpreting a validated alcohol or drug screening tool, plus performing a face-to-face brief intervention.
	Medicare	G0396	
	Medicaid & Commercial	CPT 99409	• Same as above, only ≥ 30 minutes.
	Medicare	G0397	

- Time requirements results in rare use of these codes
- Two providers required to bill 99408/9 (until recently)

FYI:
Tobacco cessation code

Service	Payer	Code	Description
Brief intervention	Medicaid & Commercial	CPT 99406	• Smoking and tobacco cessation counseling visit; greater than 3 minutes up to 10 minutes

Where CPT codes apply



Who can independently bill for SBI

Oregon Medicaid:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Licensed Clinical Psychologists
- LCSWs
- Licensed Professional Counselors
- Licensed Marriage and Family Therapists

Medicare:

- Physicians (MD, DO only)
- Physician Assistants
- Nurse Practitioners
- Licensed Clinical Psychologists
- LCSWs
- Certified Nurse Midwives
- Clinical Nurse Specialists

OHA, 2014

Possible alternative: Incident-to billing

- Any clinic employee under supervision can bill for SBI
- Examples:
  - CADCs, Health Educators, Registered Nurses, Clinical Nurse Specialist, Students or Graduates entering medical profession, Community Health Workers
- Some limitations apply

OHA, 2014

Required documentation to use CPT 99408 (SBI)

The pt was given a AUDIT screening form today. The total score indicates use that increases the risk of related health problems.

In discussing this issue, my medical advice was that the patient cut back to no more than 14 drinks per week or 4 per day. The pt's readiness to change was 6 on a scale of 0 - 10. We explored why it was not a lower number and discussed the patient's own motivation for change. The patient agreed to cut back and to make a follow up appointment in 8 weeks.

Total clinic time administering and interpreting the screening form, plus performing a face-to-face brief intervention with the patient was greater than 15 minutes.

Reaching out to CMS

Issues raised in letter:

- 15 minute minimum
- Limited personnel who can bill independently
- Confusion around incident-to rules

Marilyn Tavenner
Administrator
Chief Operating Officer
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Ms. Tavenner,

We are writing to ask CMS to clarify and modify Medicare reimbursement policies that are hindering the delivery and spread of a proven cost-saving and health-promoting preventative service.

Implementation of SBIRT (Screening, Brief Intervention, Referral to Treatment), an evidence-based method that addresses substance abuse in medical settings, is seen as a priority at both the federal and state levels. The Department of Health and Human Services continues to award millions in grant funding to promulgate SBIRT implementation, and the White House office of Drug Control recently recognized SBIRT as a key tool in reducing substance abuse in the United States. In Oregon, the Oregon Health Authority has adopted SBIRT as a key performance measure that clinics must sustainably implement in order to receive bonus payments.

Despite widespread support at the policy level, SBIRT continues to be vastly underemployed with Medicare patients. While 27% of men 65 years and older and 10% of older women report binge-drinking within the last 30 days, only 0.01% of Medicare enrollees received a screening and brief intervention (SBI) procedure code on a medical claim in 2010.

Among the major barriers to SBIRT implementation cited by primary care clinics are correctable problems with Medicare's policies in the use of billing codes. Billing codes not only allow for reimbursement but also provide state and federal agencies tools to track SBIRT performance. Medicare has created codes specific to SBI processes (G0442, G0443, G0396, and G0397), but the requirements associated with these codes present significant hurdles to health care providers and clinics.

There are three main barriers:

1) **15-minute minimum.** Despite evidence that brief interventions as short as 3 minutes can decrease a patient's alcohol consumption, Medicare requires that SBI last at least 15 minutes. The 15-minute minimum is an arbitrary time requirement not grounded in evidence. It also contradicts the realities of a busy practice, where clinicians address multiple medical complaints in a short amount of time and quickly decide SBI is unrealistic to implement as part of routine care.

   Remedy: Remove or reduce the time minimum to reflect the evidence base supporting SBI.

2) **Limited types of providers.** Medicare limits the types of medical professionals allowed to bill SBI codes independently, prohibiting clinics from utilizing individuals who may have more specialized training and time to spend with patients than clinicians. For example, Medicare

Centers for Medicare & Medicaid Services
Center for Medicare Management
7500 Security Boulevard
Baltimore, Maryland 21244-1850

FEB 26 2014

Mark Richardson, MD
Dean, School of Medicine
Oregon Health & Science University
3181 SW Sam Jackson Park Road
Portland, Oregon 97239-3096

Dear Dr. Richardson,

Thank you for your letter on behalf of the Oregon Health and Science University and, other colleagues concerning the Medicare program's administration of alcohol and/or substance abuse (other than tobacco), structured assessment and, intervention (SBIRT) services. Under this letter that you co-wrote with Mr. Evan Saulino, MD, PhD, and Ms. Pam Martin, PhD, you stated that you believe there are three barriers under the Medicare program to improved utilization of SBIRT services when furnishing care to patients who are at risk of alcohol and substance misuse. The barriers that you have identified are as follows:

1. You believe that the 15-minute minimum time requirement for time-based SBIRT HCPCS codes (G0396 and G0397) is arbitrary and too onerous for busy practices. Accordingly, you believe that the minimum time requirement should be reduced.
2. You believe that the list of individuals under Medicare who are authorized to bill and be paid for SBIRT services is too restrictive and therefore, prohibits specially trained individuals other than the listed clinicians for Medicare payment for SBIRT services.

In response to
15 minute minimum for CPT 99408/9:

While we are not able to make any changes to the SBIRT provision under Medicare at this time, we will take your recommendations into consideration as we look for ways to improve overall services furnished under the Medicare program.

In response to limited number of individuals who can bill for SBIRT independently:

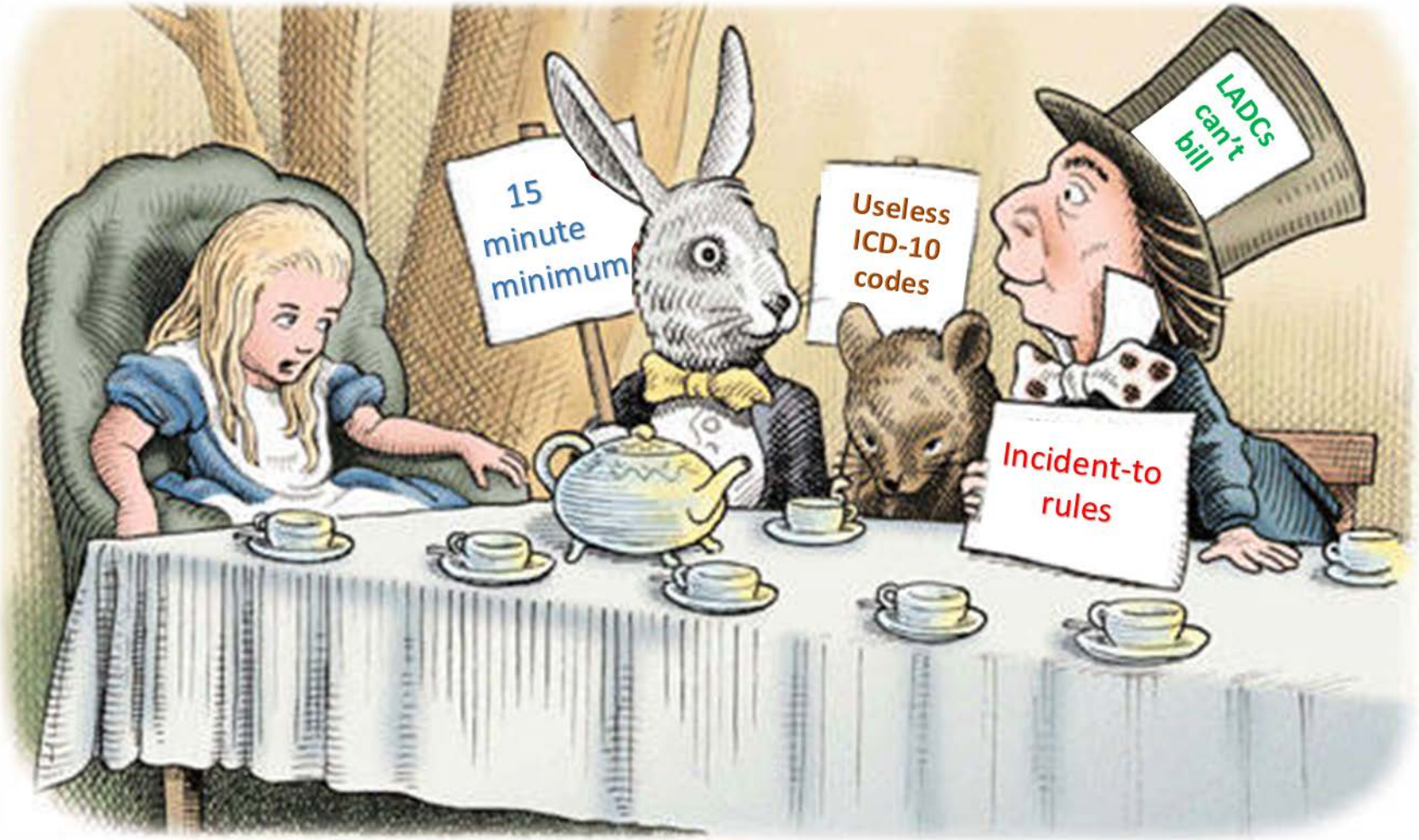
All of these clinicians have separately enumerated benefits under the Medicare program that authorize them to receive payment for "physician services" and/or mental health services which include SBIRT services. Any other health care worker who does not have authorization to furnish these services under a specific benefit enumerated under Medicare law is not entitled to Medicare payment for any type services.

In response to confusion surrounding incident-to billing rules

There is no authority under Medicare law to pay for SBIRT services when furnished in an "incident to" capacity. Accordingly, SBIRT services cannot be billed "incident to" under Medicare.

Reaching out, cont.

- Letter to CMS
- White House Office of Drug Control Policy
- AMA
- U.S. Sen. Wyden's staff
- SAMHSA



"It's the stupidest SBIRT billing party I ever was at in all my life!" said Alice.

Back to creating the ratio

- CPT 99420 (plus V79.1 or V82.9)
- CPT 99408, 99409
- RT codes

Visit codes of pts age 18+ in calendar year

≥ ?

Creating the ratio

$$\frac{\text{CPT 99420, 99408, 99409}}{\text{Visit codes of pts age 18+ in calendar year}} \geq ?$$

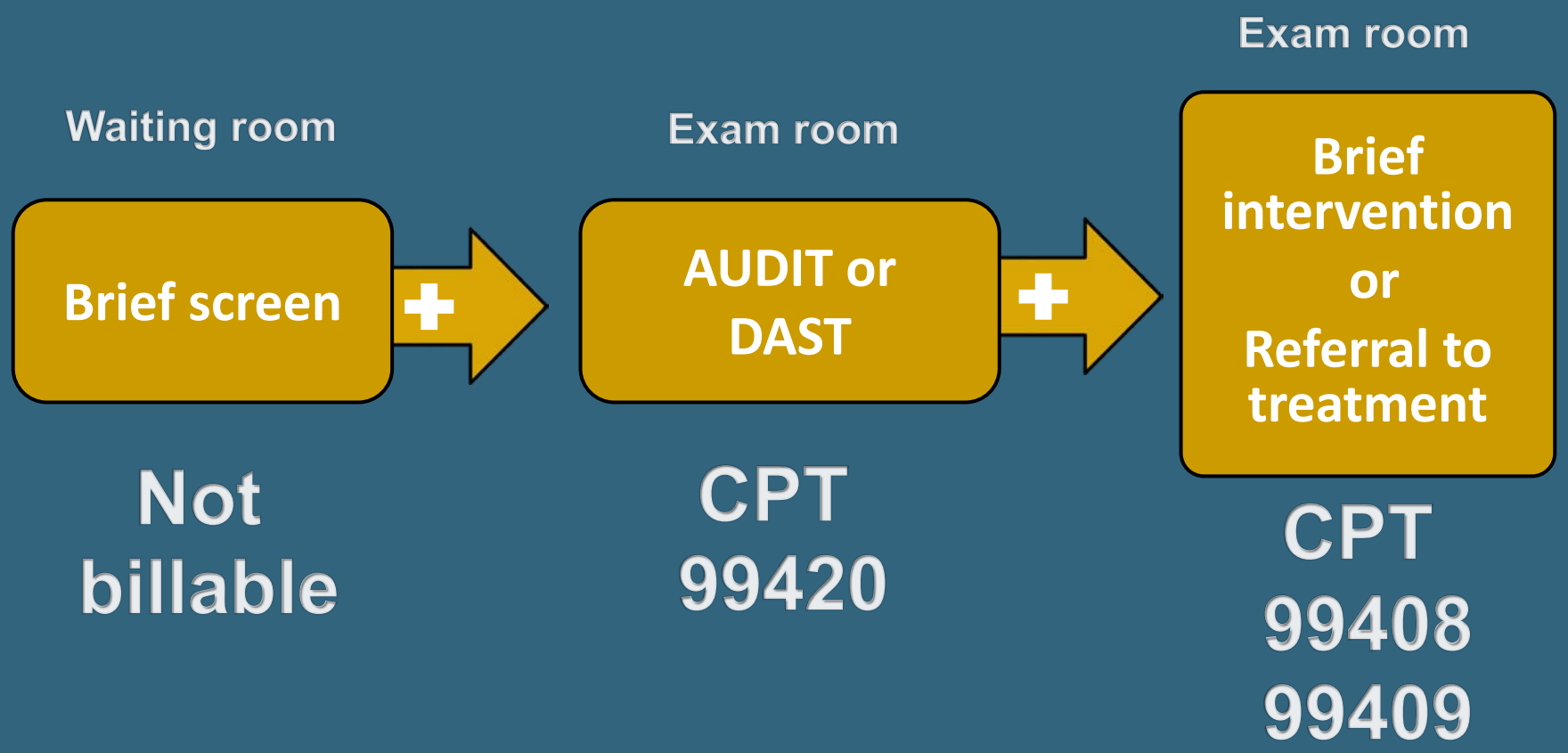
Benchmark rate

Setting a benchmark rate

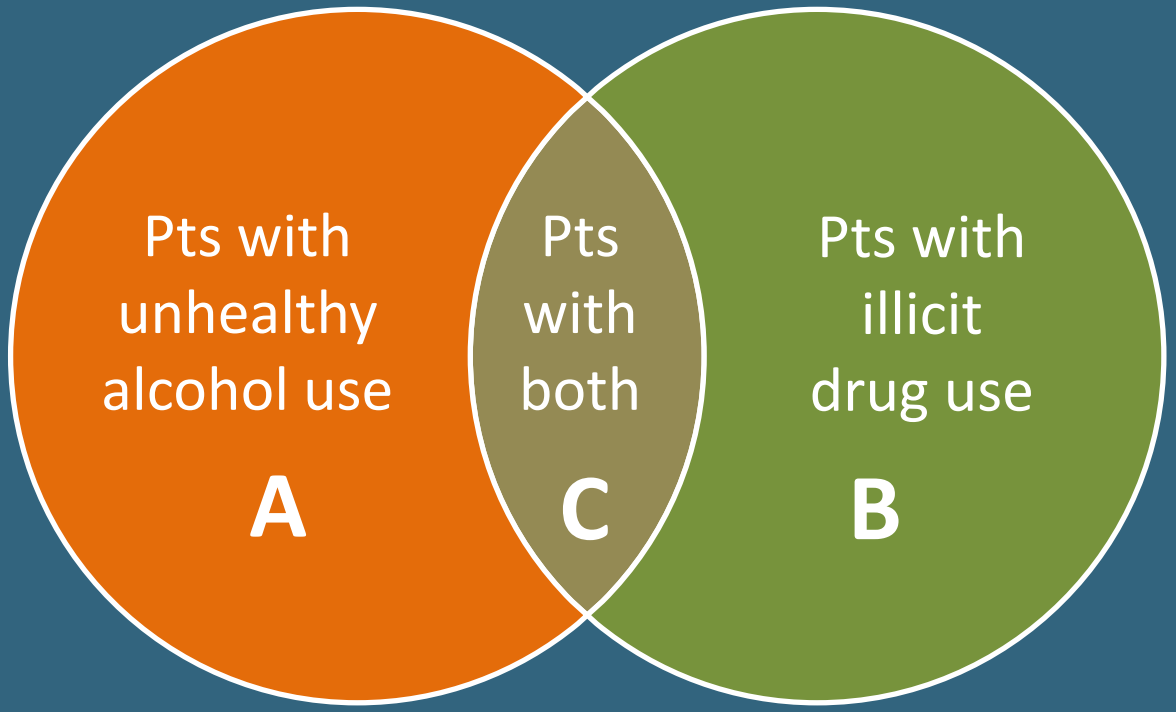
1. First, identify the rate if perfect implementation occurs
2. Then create benchmark rate that is reasonably lower, or even better: evidence-based

$\geq$?

Where CPT codes apply



Determining prevalence

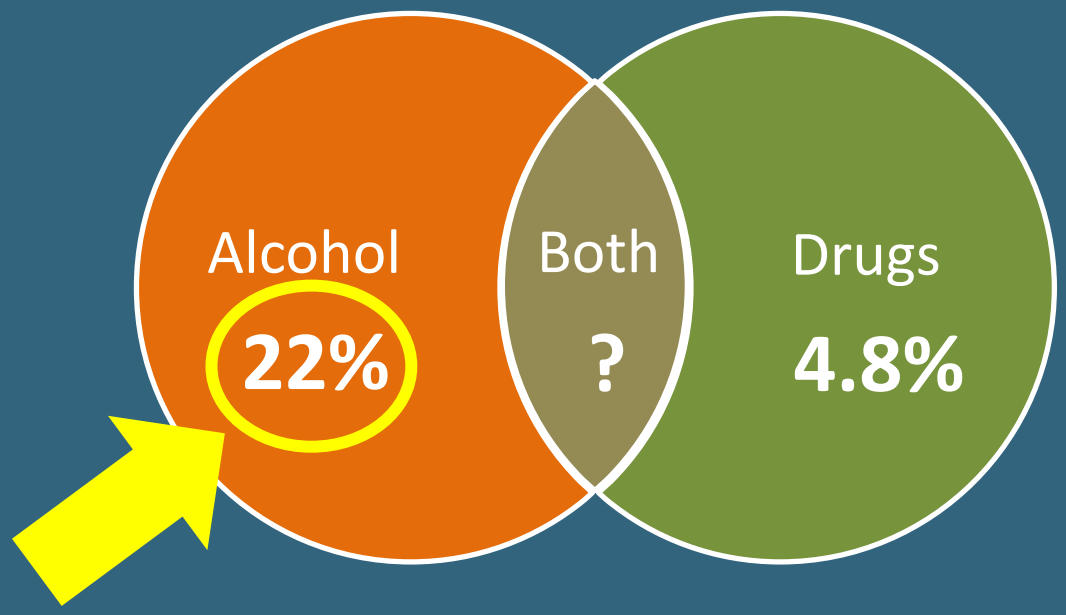


A or B = A + B - C

Determining prevalence

Shortcomings of prevalence studies:

- Age and N varies
- Can be outdated
- SUDs measured rather than use
- Time period varies
- Not always specific to primary care



Manwell et al, 1998. Age 18+, 3 months.

Manwell et al, 1998. Age 18+, 6 months.

Creating the ratio

$$\frac{\text{CPT 99420, 99408, 99409}}{\text{Medicaid visits of pts age 18+ in calendar year}} \geq 22\% \times ?$$

OHSU SBIRT project workflow

Waiting room

Adult brief screen

Exam room

Adult full screen

Exam room

Brief intervention
or
Referral to treatment

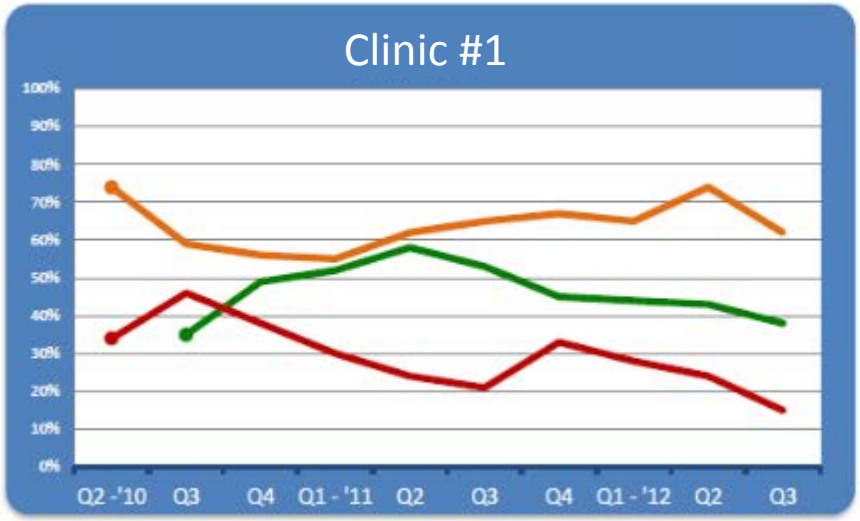
Reception

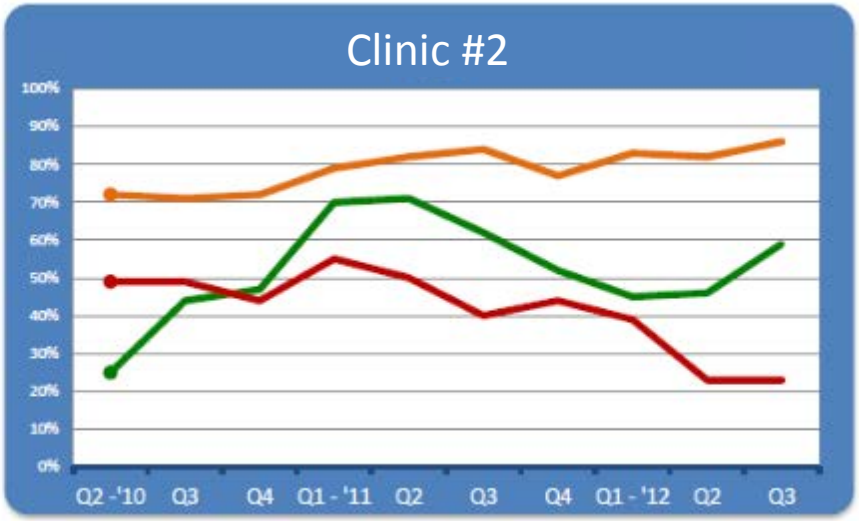
Medical assistant

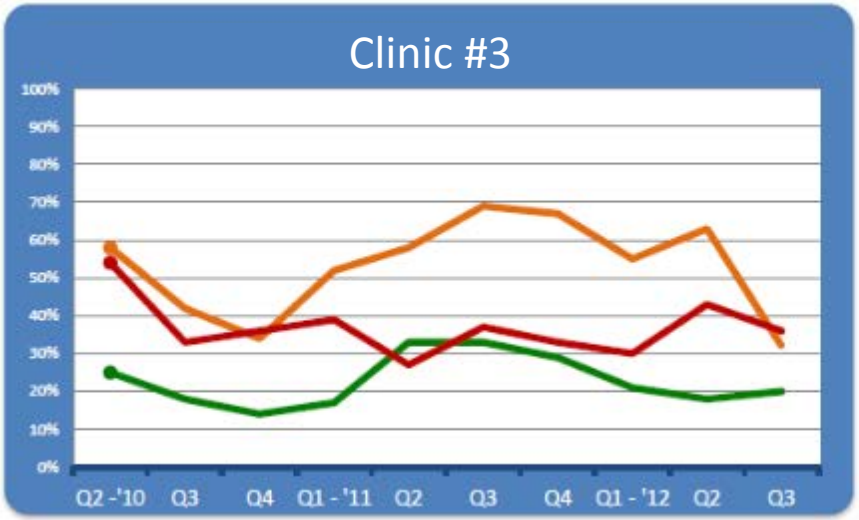
Clinician

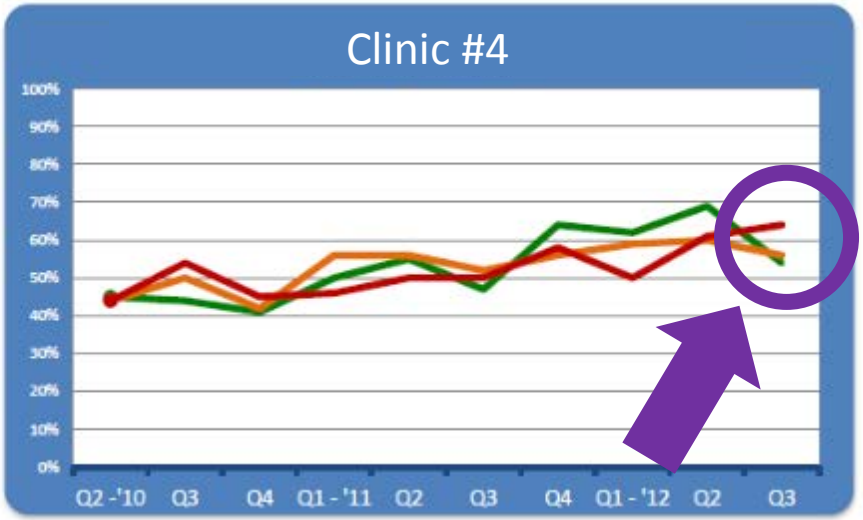
SBIRT tools built in 3 EMRs

	Brief screen	Full screen	Brief intervention and/or referral
OHSU Family Medicine	Annual screen given to patients at front desk during check-in process. Annual "tickler" built into EMR scheduling module to record event.	Medical assistant reviews annual screen while rooming patient . If positive, offers AUDIT and/or DAST to be completed in exam room. Results are later entered into a doc flow sheet.	Clinician quickly scores AUDIT/DAST, performs intervention and/or referral, then marks checkboxes. Results are entered later into EMR by MA.
Providence Health Systems	EMR tickler in "vitals" section alerts medical assistant to verbally administer annual prescreen questions.	Scores placed in EMR prompt medical assistant to hand patient a written AUDIT and/or DAST .	EMR pop-up screen offers brief intervention steps if AUDIT or DAST scores place patient into ZONE II or higher. Clinician clicks radio buttons to record steps of the brief intervention.
Sky Lake Medical Center/OHSU	Date of last annual screen built into vital signs section of EMR. Annual questions listed on screen for MA to give verbally and score answers.	Medical assistants give written full screens to positive patients, who complete full AUDIT/DAST while waiting in exam room.	Brief intervention performed by physician who marks checkboxes on back of full screen. Data entered by MA afterwards.









Brief screen given when indicated

AUDIT or DAST given when indicated

Brief intervention done when indicated

Creating the ratio and benchmark

$$\frac{\text{CPT 99420, 99408, 99409}}{\text{Medicaid visits of pts age 18+ in calendar year}} \geq 22\% \times .6$$

Creating the ratio and benchmark

$$\frac{\text{CPT 99420, 99408, 99409}}{\text{Medicaid visits of pts age 18+ in calendar year}} \geq 13\%$$

Alternative: Improvement target

- CCOs that do not meet the benchmark can still earn quality pool funds by reducing the gap between their previous year's performance and the percent benchmark by improving at least 3 percentage points.

Ron Stock, OHA

Back to the SBIRT timeline in Oregon

2013:

- SBIRT measure goes into effect

2014:

- First performance report published

2015:

- Denominator changed to include pts age 12+
- Benchmark lowered to 12%
- ICD 10 codes in use (Oct)

Old ICD-9 codes

Service	Payer	Code	Description
Full screen only	Medicaid & Commercial	**CPT 99420** plus V79.1 or V82.9	• Administration and interpretation of a health risk assessment instrument.
	Medicare	G0442	• Screening for alcohol misuse in adults once per year.

Oct. 2015: ICD-10 codes

- 13 codes: Alcohol abuse …
- 20 codes: Alcohol dependence …
- 14 codes: Alcohol use unspecified …
- 14 codes: Alcoholic …
- 2 codes: Alcoholic induced …
- 24 codes: Toxic effect of ….
- 9 codes: Blood alcohol level …

CMS.gov

Approved diagnosis codes

New ICD-10 codes OHA chose to accompany CPT 99420:

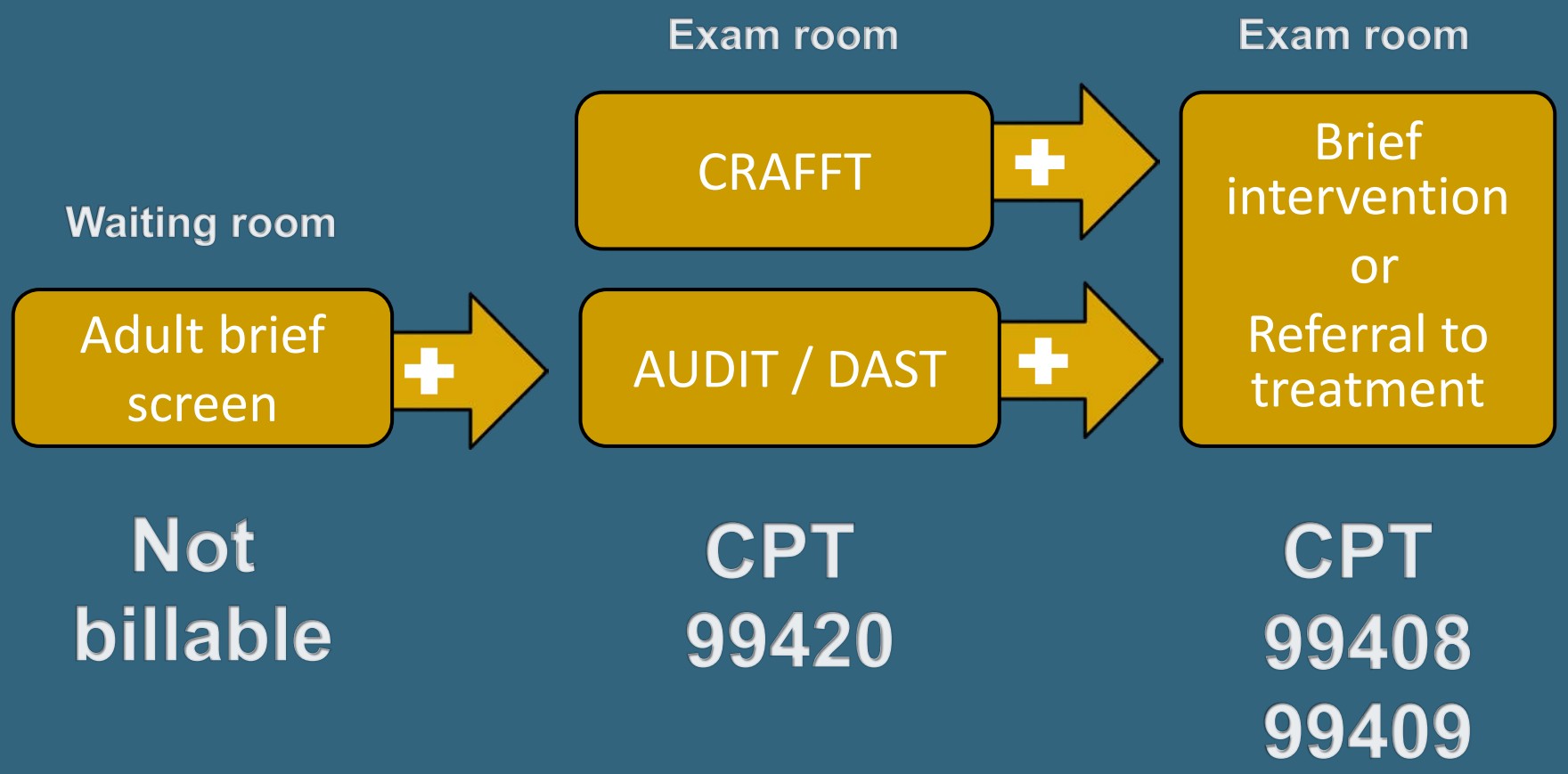
- Z13.89: “Encounter for screening for other disorder”
- Z13.9: “Encounter for screening for other diseases and disorders”

Problem: no codes exists that simply indicate “unhealthy alcohol use” or “drug use”

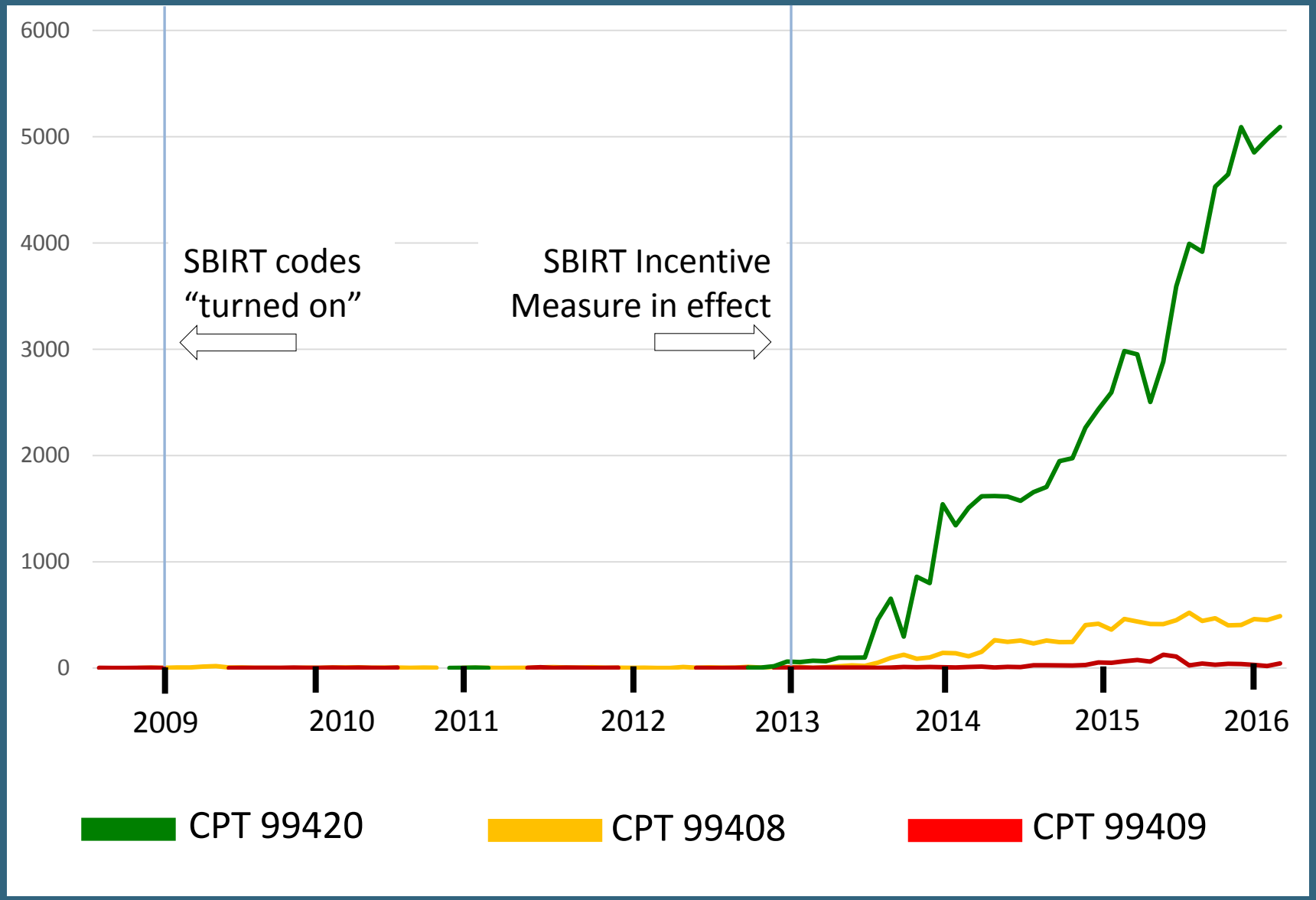
Incentive measure screening codes

Service	Payer	Code	Description
Full screen only	Medicaid & Commercial	**CPT 99420** plus Z13.89 or Z13.9	• Administration and interpretation of a full screen.
	Medicare	G0442	• Screening for alcohol misuse in adults once per year.

SBIRT workflow in primary care



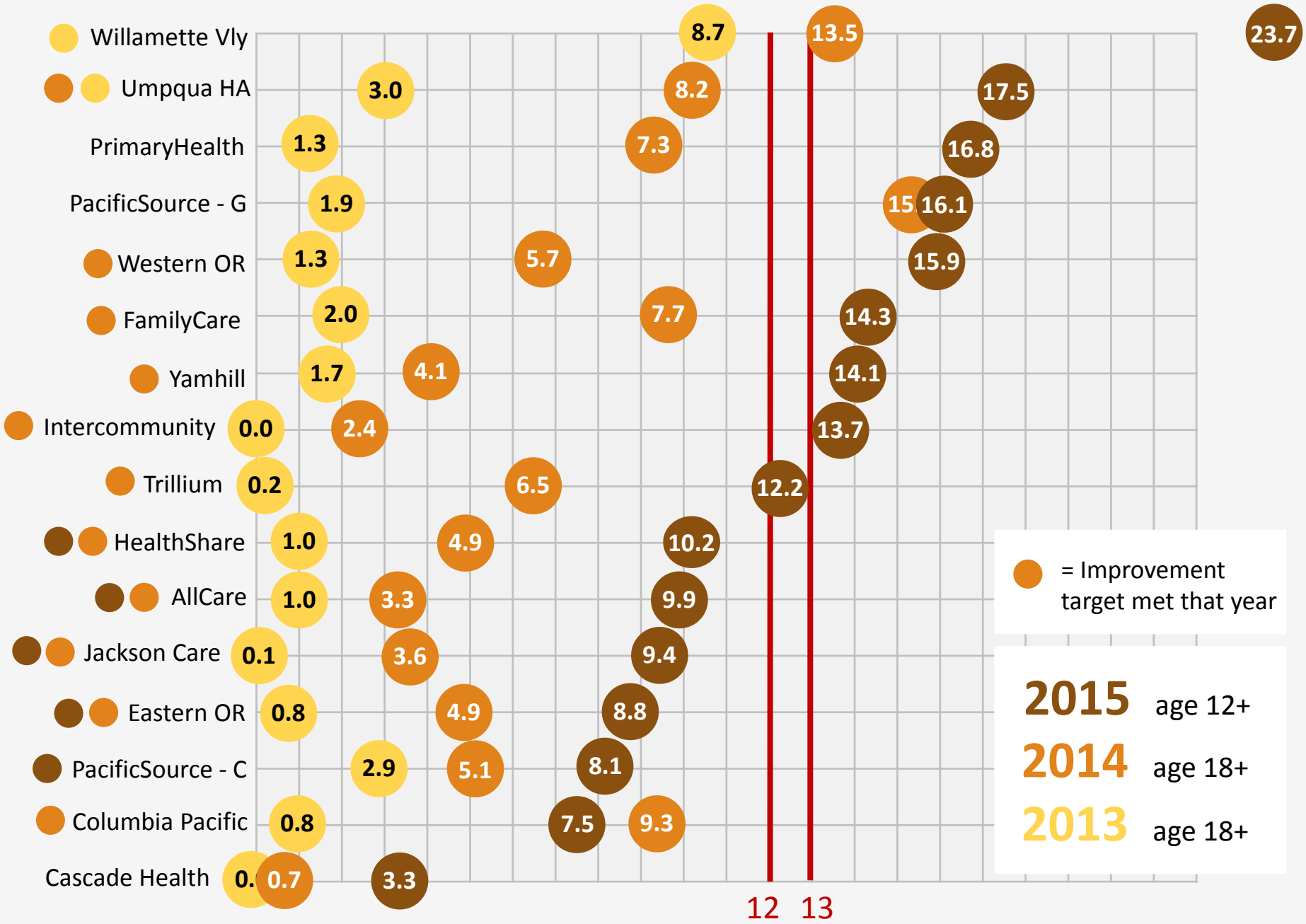
Monthly counts of SBIRT codes submitted to OR Medicaid



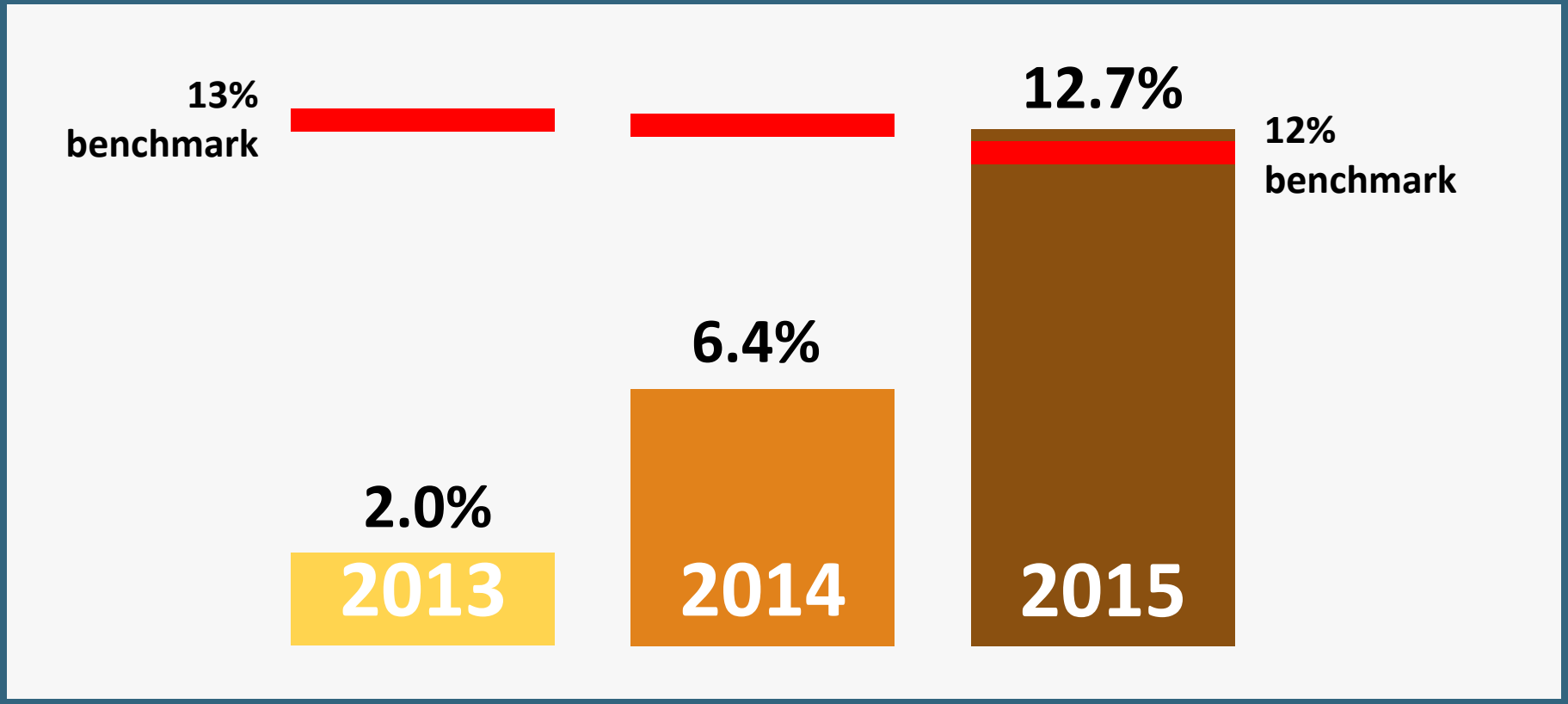
SBIRT codes submitted to and paid by OR Medicaid

Code	2013 paid/submitted %	2014 paid/submitted %	2015 paid/submitted %
CPT 99420 (screening only)	2689/3616 74.4%	15,934/20,343 78.3%	22,162/27,132 81.7%
CPT 99408 (screening + brief intervention ≥15 mins)	469/567 82.7%	2204/2713 81.2%	3212/4379 73.4%
CPT 99409 (screening + brief intervention ≥30 mins)	41/66 62.1%	151/200 75.5%	483/626 77.2%

Percent of eligible Medicaid visits billed with SBIRT codes, by CCO

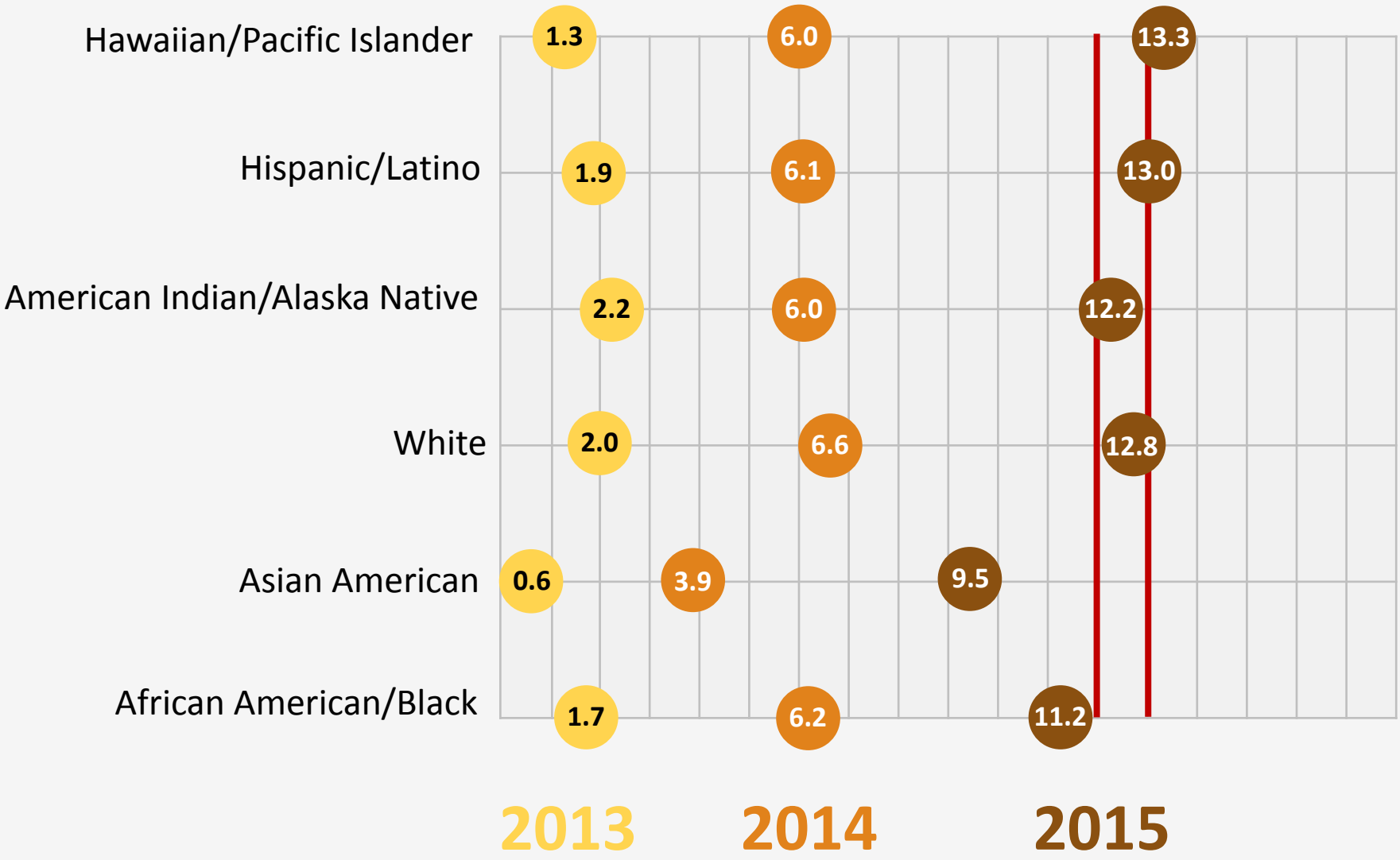


Percent of eligible Medicaid visits billed with SBIRT codes, statewide



OHA, 2016

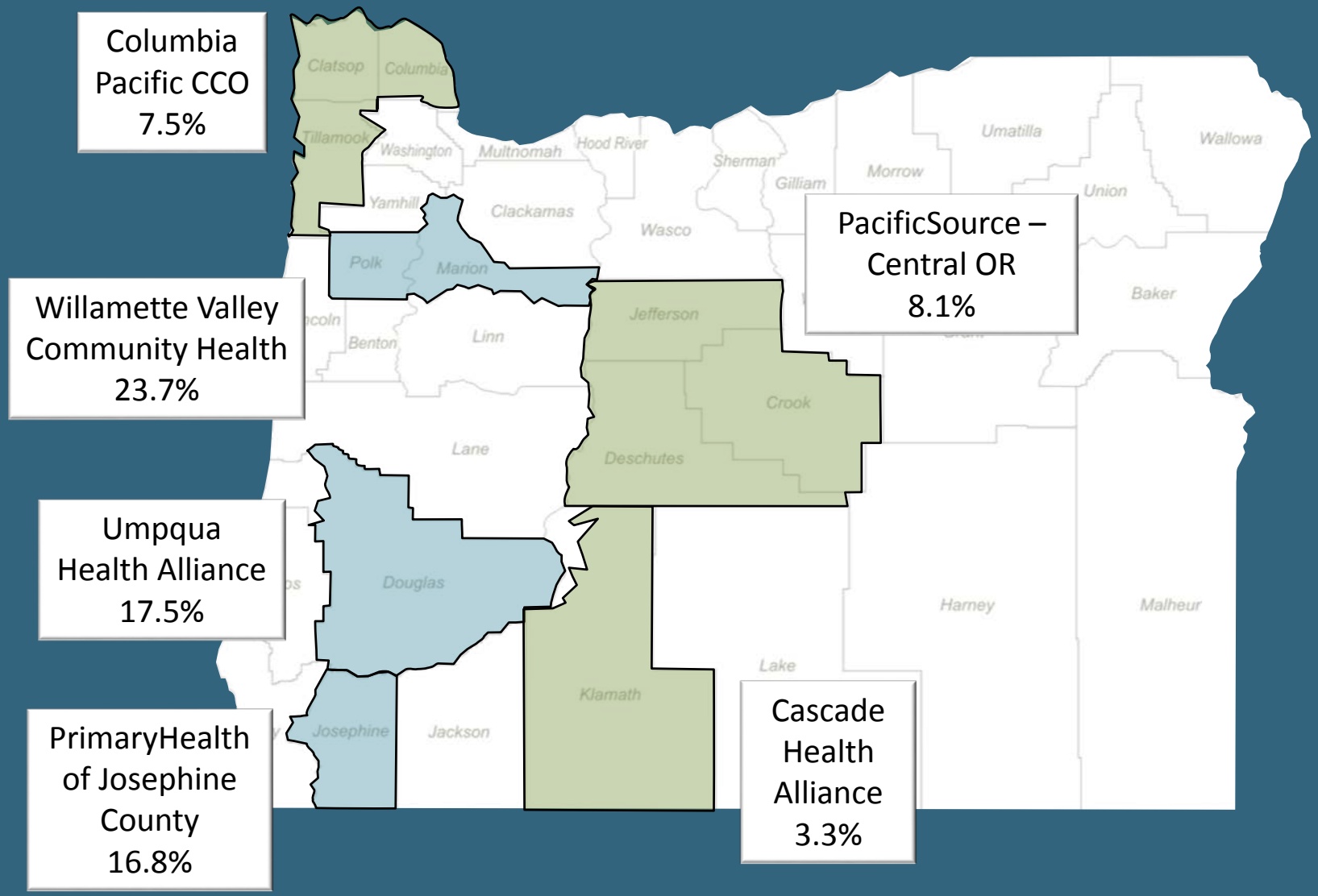
Percent of eligible Medicaid visits billed with SBIRT codes, by race and ethnicity of patients



OHA, 2016

Highest performing CCOs, 2015

Lowest performing CCOs, 2015



Highest and lowest SBIRT performing CCOs in 2015

CCO	2015 SBIRT rate	Total members as of Jan 2016	Sq. miles miles of coverage area	Members per square mile
Willamette Valley Comm. Health	23.7%	103,295	~1922	~54
Umpqua Health Alliance	17.5%	26,430	~4200	~6
PrimaryHealth of Josephine County	16.8	11,910	~2500	~5
Pacific Source Central Oregon	8.1%	52,271	7783	6.7
Columbia Pacific	7.5%	27,100	2906	9.3
Cascade Health Alliance	3.3%	18,063	~5500	~3

Observed clinic traits associated with sustainable SBIRT implementation

- Leadership “bought-in” to implementation
- Clinic identifies workflow
- All staff attend training
- Champions identified
- EMR optimized
- Tools employed

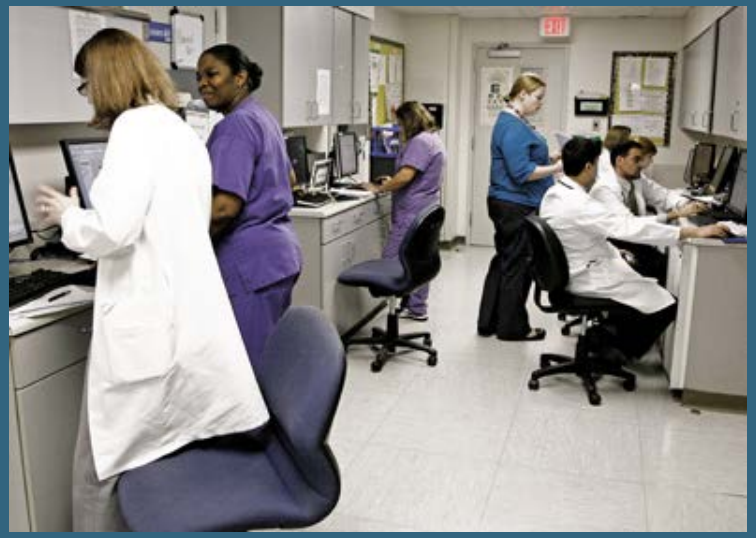
Where are we today?

- Finer points of billing still being clarified – **CPT 99420 being discontinued????**
- Clinics and systems still building new/better EMR tools
- Metric to include EMR reports in future
- Referral tracking methods needed
- Inclusion of MAT would be nice

OHA, 2014

Positive effects so far

- Foundation now laid for improved and continued SBIRT implementation
- Even screening alone may produce benefits for pts
- CCO performance is improving
- Clinics receiving new revenue from use of codes
- Encourages commercial reimbursement



Drawbacks

- Metric fails to measure BI & RT in real world
- Quality of brief intervention unknown, probably poor
- CCOs can be rewarded by skipping brief screen
- Documentation contributes to serious burden for clinicians
- Ironically, metrics can steer clinician focus away from patient care

Lessons learned

- Consider alternatives to using billing codes to track clinic processes
- People who create metrics often unaware of their feasibility and impact
- Changes and clarifications need to be disseminated regularly and clearly

Questions to consider

- Should OHA have used EHR reports to collect data from the beginning?
- Should SBIRT training be required before clinicians can bill?
- Will the SBIRT incentive measure help bend the cost curve?
- Others?

Thanks!

Jim Winkle, MPH

OHSU Family Medicine
winklej@ohsu.edu