Memo

To: Peer Assistance Services
From: Health Management Associates
Date: April 10, 2019
Re: Update on Maryland SBIRT Model

Introduction

HMA Community Strategies engaged in research to understand the outcomes of the specific billing and reimbursement policies for Screening Brief Intervention and Referral to Treatment (SBIRT) in Maryland. The following is an update on the Maryland model and an inquiry into the extent that has expanded provider utilization of SBIRT.

Summary of the Maryland Model

In June 2016, Maryland established a set of local procedural codes created by Department of Health and Mental Hygiene (DHMH, Maryland Medicaid agency) to support greater provider flexibility when billing SBIRT services.[1] In creating these procedural codes, Maryland made the Federal SBIRT procedural codes (99408 and 99409) inactive. The local codes permitted SBIRT to be reimbursed for a maximum of one screening (self or provider administered) and four interventions annually per recipients ages 12 and up. Screening and intervention provided on the same day can be included on the same claim. There are three brief intervention (BI) codes, one for 3-10 minutes, 11-20 minutes and 21+ minutes. Up to 4 BI's may be billed annually.

For Federally Qualified Health Centers (FQHCs), 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. The new codes permit one screening and one brief intervention to be invoiced in conjunction with an "encounter visit"; and subsequent brief interventions can be billed with or without an "encounter visit."

Maryland SBIRT conducted an evaluation of SBIRT implementation and outcomes, including an assessment of whether greater flexibility and access to shorter timeframes for billing (e.g., 3-10 minutes) changed provider use of the SBIRT billing codes.

Additional information and background about Maryland's model is included in HMA's February 2017 report.

Update

HMA initiated the update by outreaching Maryland SBIRT program coordinator, Bonnie Campbell, who shared Medicaid billing data and Maryland SBIRT program data.

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[1] 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.

SBIRT Utilization in Primary Care and other Medical Providers
Medicaid claims data was shared with HMA. The data showed SBIRT billing activity in January 2018 (for period ending 3rd QTR of 2017), almost two years following the release of the new SBIRT codes in July 2016. The following was reported:

- 43% increase in the number of patients for whom SBIRT claims were submitted, from 617 patients in Quarter 1 2015 to 1,348 patients in Quarter 3 2017.

SBIRT Utilization in FQHCs
Maryland began implementing SBIRT in FQHC's in 2011. Up until 6/30/16, FQHC's were not paid for SBIRT services (separate from the daily patient rate) and most centers did not enter codes for SBIRT services. After 7/1/16, FQHCs had to revise their billing systems to include the Maryland-only SBIRT codes. As of 1/1/18, most centers had not changed their billing systems or started billing for SBIRT.

Maryland SBIRT also shared monthly data from participating providers on # visits, # screens, # positive screening results, # brief interventions and #referral to treatment. At the clinic level, data reveals the percent of visits with screens, results, brief intervention, and referral to treatment. However, this data does not look at trends over time, nor does it look at before and after the implementation of the new SBIRT codes.

Next steps
Maryland SBIRT agreed to ask DHMH if it could provide a break-down of separate billing codes indicating number of minutes for brief intervention. This may provide insight into the amount to which the availability of a code for the 3 to 10 minutes was related to the overall increase in SBIRT.