A White Paper from the Wisconsin Initiative to Promote Healthy Lifestyles

Recommendations to the Federal Government for Promoting the National Dissemination of Evidence-Based, Cost-Saving Behavioral Screening and Intervention (BSI)

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Assumptions

1. **All adult patients should be screened for tobacco use, alcohol use and depression annually, and those with positive screens should receive evidence-based brief assessment, intervention and referral services as appropriate.**

   Rationale: These services carry Grade A or B recommendations from the US Preventive Services Task Force (USPSTF). These are the only preventive services known to generate net savings in healthcare costs. All patients must receive BSI so that BSI can exert maximal public health impact.

2. **All adult patients should also be screened and receive evidence-based assessment, intervention and referral for illicit drug use and non-medical use of potentially addictive prescription medications.**

   Rationale: Although a USPSTF recommendation on drug screening, intervention and referral is lacking, research is growing on the effectiveness of these services. Furthermore, drug use exacts a heavy toll on many individuals, families and communities, and drug screening and intervention is easy to integrate into alcohol screening and intervention. Expanding delivery of drug screening and intervention services is a key element of the Office of National Drug Control Policy strategy for addressing our nation's drug problems.

3. **All adult patients should also be screened and receive intervention and referrals for poor diet, physical inactivity, and obesity.**

   Rationale: The USPSTF recommends that "clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults." A recent review conducted for the USPSTF concluded: "Counseling to improve diet or increase physical activity changed health behaviors and was associated with small improvements in adiposity, blood pressure, and lipid levels."

   Although these services typically result in small gains, such gains when multiplied across a large population with a high prevalence of risks can substantially improve public health. Attention to

all 7 behavioral risks is important, as together those risks lead to 40% of deaths, most chronic disease and most disability in the United States.

4. Current healthcare staff – even if well trained – do not have time to provide evidence-based assessment, intervention and referral to patients who screen positive for one or more of the seven behavioral risks.

Rationale: The combined adult prevalence of these behavioral issues is quite high – approximately 25% for tobacco use, 25% for risky drinking, 8% for drug use, 7% for depression, and 34% for obesity. In addition, 77% of adults have inadequate fruit and vegetable intake, and 24% get virtually no regular physical activity. Most adults have two or more behavioral risks. In many clinical settings, especially those that serve economically disadvantaged patients, the prevalence of these behavioral risks is even higher.

The time demands for delivering optimal BSI services are substantial. According to the most recent federal tobacco cessation guideline, optimal quit rates are obtained with more than 8 one-on-one visits and up to 5 hours of total visit time. The recommended additional care for depression requires many face-to-face and phone contacts with patients. While alcohol or drug interventions can sometimes be delivered in several minutes, CPT codes require at least 15 minutes of contact for reimbursement. Taking more time to deliver such interventions allows a more collaborative and patient-centered approach rather than a paternalistic approach emphasizing information and advice.

Thus, primary care settings, as currently configured, cannot possibly deliver evidence-based BSI systematically to their patients. They already address an average of 3 clinical concerns in rather brief visits. It would take over 7 hours of every workday for such providers to deliver all recommended preventive care to an average-size patient panel, suggesting that primary care practices as currently configured cannot possibly deliver systematic BSI. Moreover, our primary care provider shortage is expected to worsen, especially as more Americans gain health insurance under healthcare reform. And most clinical settings are either at or under recommended staffing levels for nurses and medical assistants. Current staff cannot simply squeeze BSI into their busy routines.

For all these reasons, there is widespread agreement that a team approach is needed to deliver systematic BSI.

5. Well-trained and well-supported paraprofessionals are the best individuals to respond to positive screens, deliver evidence-based interventions for patients with risks or disorders of moderate severity, and refer patients for serious concerns (suicidality, major depression, alcoholism and addiction).

Rationale: With appropriate training, support, guidance from evidence-based protocols, and on-site supervision and back-up from credentialed healthcare professionals, paraprofessionals are capable of administering high-quality BSI. In a large demonstration project in Wisconsin (117,580 patients screened), they attained reductions of 20% in binge drinking, 48% in regular marijuana use, and 55% in depression symptoms. In addition, more highly trained and skilled

individuals, such as masters-level counselors and social workers, are difficult to retain in positions that emphasize screening, intervention and referral for particular behaviors, as most such professionals prefer to administer counseling and psychotherapy, and few are comfortable addressing all seven behavioral risks. In fact, no health profession currently trains its students to respond to positive screens for all of these behavioral risks.

Bachelors-level paraprofessionals can be trained to serve as first-responders for patients with positive screens. They experience more satisfaction in providing BSI and are more cost-efficient than masters-level professionals. Employing paraprofessionals to deliver BSI is consistent with the recommendation that all individuals in the healthcare system function at the top of their capabilities. And paraprofessionals would be highly cost-effective.

6. It is in the federal government's interest to promote BSI service delivery as soon as possible.

Rationale: The United States' poor international rankings in healthcare system effectiveness and its urgent need to reduce health care costs make BSI dissemination a high priority.

Reimbursement – Progress and Remaining Gaps

There has been substantial progress toward making third-party reimbursement available for BSI. National billing codes are in place for tobacco, alcohol and drug screening and intervention services. Under the Patient Protection and Affordable Care Act (PPACA), Medicaid programs will be required by 2013 to reimburse for all services that carry USPSTF Grade A and B recommendations. Commercial plans in exchanges will be required to reimburse by 2014. For Medicaid and commercial plans, out-of-pocket payments for BSI by patients will be prohibited.

Nevertheless, several additional gaps in reimbursement must be addressed before it will be financially feasible for healthcare providers to hire paraprofessionals to provide BSI.

1. Reimbursement codes for several aspects of BSI are needed.

There are no specific billing codes that allow providers to bill for paraprofessional-administered depression services. Such services include "collaborative care," which has been shown more effective than usual in 37 randomized controlled trials, and which generates positive return on investment over 2 years. Elements of collaborative care include administering and giving feedback on validated depression assessment instruments, educating patients and families about depression, facilitating referrals and communication among treatment professionals, and proactively promoting adherence to treatment regimens – either face to face or via telephone.

Another valuable aspect of collaborative care for which reimbursement is unavailable is brief telephone or e-mail consultations between primary care providers and psychiatrists, and regular case reviews by psychiatrists. Such consultations could improve the quality of primary care-based mental health care, reduce the need for more expensive conventional consultations, avoid long waits by patients and providers for expert guidance, ameliorate the

impact of psychiatrist shortages in many locations, and make for a more time- and cost-efficient mental health delivery system. Qualified addiction medicine specialists are scarcer than psychiatrists, and reimbursement for telephone and e-mail consultations would improve the primary care management of addictive disorders, as well.

Reimbursement codes are also needed for intervention and ongoing support around diet, exercise and obesity.

2. **Medicare "incident-to" requirements block most BSI reimbursement.** Medicare has stringent "incident-to" requirements that credentialed providers must meet to bill for paraprofessional-administered services delivered under their supervision. "Incident-to" rules prevent paraprofessional-administered services from being reimbursed in hospitals, including emergency departments – important venues for delivering BSI, which would decrease hospital readmissions and surgical complications.

   In outpatient settings (Place of Service Code 11), a paraprofessional must be the only individual to deliver services at a particular visit for those services to be eligible for Medicare reimbursement. Of course, most patients who receive BSI services do so at visits where they see another provider for other health concerns. Thus, Medicare reimbursement is excluded for most initial BSI services and would only be available when patients only see paraprofessionals at follow-up visits. Medicare "incident-to" rules must be substantially revised to support delivery of BSI.

   The recently proposed changes in Medicare reimbursement for alcohol screening and intervention exclude paraprofessional-administered services from reimbursement. Therefore, such changes will result in little increase in alcohol screening and intervention services. The same is true for Medicare's recently proposed changes for depression screening.

3. **Medicare reimbursement guidelines for Yearly Wellness Visits exclude paraprofessional-administered services.** Such visits would be ideally suited for delivering BSI. Paraprofessional-administered BSI should be reimbursable as part of Yearly Wellness Visits.

4. **There is no federal requirement that Medicaid programs or commercial payers reimburse when BSI is delivered by paraprofessionals.** Consequently, current PPACA requirements on BSI reimbursement, alone, will spur little BSI service delivery. A federal regulation is needed to ensure that paraprofessional-administered BSI is reimbursed when appropriately supervised by on-site providers and guided by evidence-based protocols.

5. **BSI service delivery is hindered by Medicare-like rules of Medicaid programs and commercial insurers that prohibit reimbursement for services delivered by multiple individuals at the same visit.** A federal regulation is needed to ensure that paraprofessional-administered BSI is reimbursed when credentialed providers deliver other services at the same visit.

6. **Sliding scale fee requirements at federally qualified health centers (FQHCs) hinder BSI delivery.** At many FQHCs, patients in a certain income range are obligated to pay a sliding scale fee for each service delivered. When such patients are offered BSI for as little as a few dollars, most decline. Many FQHC administrators would be willing to forego sliding scale fees on BSI but cite requirements, including state regulations, that they make earnest attempts to collect sliding scale fees. A federal regulation is needed to bar FQHCs from collecting any out-of-pocket payments from patients for BSI.

7. **Few patients will receive BSI unless a critical mass of payers reimburse for it.** Most clinical settings accept reimbursement from a variety of payers, including Medicare, Medicaid and several commercial plans. Because of ethical and logistical concerns, most clinical settings are averse to delivering BSI to only certain segments of their patient population. More importantly, there must be sufficient incentives across all or most of a setting's payers before that setting can hire paraprofessionals to deliver BSI to all of its patients.

8. **Even in primary practices where BSI is financially feasible, other priorities often hinder implementation.** Many clinical settings and staff feel overwhelmed in meeting other administrative demands – retaining current staff, hiring new staff, implementing electronic health records and moving toward meaningful use, running quality improvement projects on diabetes and other chronic illnesses, providing process and outcome data to various third-party payers, and keeping abreast of ever-changing regulations. Even if the previous recommendations are implemented, current reimbursement rates will be insufficient incentives for most clinical settings to deliver BSI. To accelerate the spread of BSI, further impetus will be necessary and could come in the form of greater financial incentives, mandates, quality measures, or a combination.

Summary of Recommendations

1. Establish national billing codes for paraprofessional-administered collaborative care for depression and for intervention for poor diet, physical inactivity and obesity.
2. Establish billing codes for reimbursing psychiatrists and addiction medicine specialists for telephone or e-mail consultations with primary care providers.
3. Revise Medicare "incident-to" rules so that paraprofessional-administered BSI can be reimbursed in outpatient settings, inpatient settings and emergency departments.
4. Allow Medicare reimbursement for paraprofessional-administered BSI at Wellness Visits.
5. Require Medicaid programs and commercial payers to reimburse for BSI when delivered by paraprofessionals.
6. Require all payers to reimburse for paraprofessional-administered BSI when other professional services are delivered by credentialed providers at the same visit.
7. Prohibit federally qualified health centers from collecting out-of-pocket payments from patients for BSI.

8. Undertake immediate and simultaneous efforts to enhance BSI reimbursement by all payers, as each clinical setting will hire dedicated paraprofessionals to deliver BSI only if a critical mass of its payers reimburse favorably.
9. Establish stronger incentives for clinical settings to deliver BSI, because simply making current levels reimbursement more widely available will be insufficient incentive for most clinical settings to systematically deliver BSI.
10. Support the development and training of a new paraprofessional workforce to deliver BSI.

Systematically administered in healthcare settings across the nation, BSI would improve health outcomes and decrease healthcare costs. Other positive impacts would include safer highways and communities, reduced burden on social and justice services, and a healthier and more productive workforce. Implementing the above recommendations would bring substantial benefit to individuals, families, communities, employers and taxpayers.

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