Washington State Health Care Authority

Report to the Legislature

Recommendations to improve substance use disorder intake, screening, and assessments (SUDISA) in Washington State

SUDISA work group recommendations

Second Engrossed Second Substitute Senate Bill 5536; Section 36(2); Chapter 1; Laws of 2023; codified as RCW 71.24.912

December 1, 2024

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Executive summary

In 2022, the Substance Use Recovery Services Advisory Committee (SURSAC) treatment subcommittee developed a recommendation to create a work group to review current processes and policies around intake, screening, and assessments across Washington State as part of the Substance Use Recovery Services Plan. In 2023, the state Legislature passed 2E2SSB 5536, which directed the Health Care Authority (HCA) to establish this work group. Section 36 of the bill was codified as RCW 71.24.912 and provided the following legislative authority:

> "(1) The authority [HCA] shall convene a work group to recommend changes to systems, policies, and processes related to intake, screening, and assessment for substance use disorder services, with the goal to broaden the workforce capable of administering substance use disorder assessments and to make the assessment process as brief as possible, including only what is necessary to manage utilization and initiate care. The assessment shall be low barrier, person-centered, and amenable to administration in diverse health care settings and by a range of health care professionals. The assessment shall consider the person's selfidentified needs and preferences when evaluating direction of treatment and may include different components based on the setting, context, and past experience with the client.
>
> (2) The work group must include care providers, payors, people who use drugs, individuals in recovery from substance use disorder, and other individuals recommended by the authority. The work group shall present its recommendations to the governor and appropriate committees of the legislature by December 1, 2024."

The Substance Use Disorder Intake, Screening, and Assessments (SUDISA) work group, convened by HCA in December 2023, held twice-monthly meetings to deliver specific, evidence-based recommendations to the Washington State Legislature. These recommendations aim to enhance substance use disorder (SUD) intake, screening, and assessment processes by striving to make them as brief, low-barrier, and person-centered as possible. The goal being to broaden the workforce for SUD assessments, initiate care efficiently, support utilization management processes, and achieve identified goals.

The work group carefully considered the diverse uses of screenings and assessments in medical and behavioral health settings, encompassing the entire continuum of care from inpatient to outpatient services.

We extend our gratitude to all the work group members and associations who contributed their participation, knowledge, and perspective to this essential legislative task.

Refer to the appendix to view the work group roster and a list of consulting associations.

Supportive initiatives

The work group identified several recent and existing solutions to improve SUD intake, screening, and assessment processes. As outlined below, some of these solutions have already been addressed but have not been fully implemented through other work streams and efforts. The following policies were

summarized for the work group by subject matter experts at HCA to help guide and direct the conversation:

- A Medicaid State Plan Amendment (SPA) took effect on January 1, 2024 (**SPA WA-23-0010**), broadening the scope of practice for allowable providers to conduct SUD assessments, including licensed social workers, licensed mental health counselor (LMHC), licensed mental health counselor associate (LHMCA), advanced registered nurse practitioner (ARNP), physicians assistant (PA), psychologist, licensed marriage and family therapist (LMFT). Additionally, the SPA increases access to services within the Crisis Service framework by adding the Peer Support service code to be provided as a part of a crisis intervention; this allows an individual to receive peer support services before an intake evaluation.
- The **American Society of Addiction Medicine** (ASAM) has recently updated its six dimensions in the newly released fourth edition. Dimension six, now known as Person-Centered Considerations, has been expanded to address barriers to care, such as social determinants of health, patient preferences, and the need for motivational enhancement. This update reflects a more comprehensive approach to addressing the diverse needs of individuals seeking addiction treatment.
- The fourth edition ASAM assessment criteria offers a structure that promotes gathering the essential information to access appropriate services. The assessment and treatment planning standards are being updated to differentiate between the intake and treatment planning assessments. There will be a bifurcated assessment process under the fourth edition, where "Level of Care Assessments" emphasize focus on specific ASAM subdimensions, while "Treatment Planning Assessments" will address all ASAM subdimensions.
- **Engrossed Substitute House Bill 2642** (2020) removed the need for prior authorization from insurance providers for residential inpatient treatment as well as withdrawal management for substance use disorder with the intent of reducing barriers to accessing more immediate care.
- For inpatient and residential level of care, **Senate Bill 6228 (2023)** requires that once the appropriate level of care has been determined, insurance providers authorize no less than 14 days of treatment before another utilization review can take place. Any subsequent reauthorization that the health plan approves after the first 14 days must continue for no less than seven days before requiring further reauthorization.

Recommendations

In alignment with RCW 71.24.912, the work group was tasked with providing specific, actionable, state-level, and evidence-based recommendations to the Washington State Legislature that improve systems, policies, and processes for conducting SUD intake, screening, and assessment that are designed to broaden the workforce capable of administering SUD assessments, make processes as brief, low-barrier, and person-centered as possible, including only what is necessary to initiate care, support utilization management, and achieve any additional goals as identified by the work group members.

Given the short timeframe with which to establish, recruit, and convene an interdisciplinary work group, the group was unable to fully develop all proposed recommendations. The following recommendations were determined to be the highest priority and are intended to be the first elements needed to achieve these goals:

1. Reimbursement rates
2. Education campaign for behavioral health workforce
3. Expansion of peer counselor services
4. Telemedicine expansion

Recommendation 1: reimbursement rates

Background

The workforce shortage among behavioral health professionals has been identified by the SUDISA work group as a barrier to accessing care. In 2017, the **Washington State Behavioral Health Work Force Assessment**, funded by Governor Inslee's Workforce Innovation and Opportunity Act (WIOA) discretionary funds, recommended that the state "adjust reimbursement rates to support better competitive recruitment and retention of a skilled behavioral health workforce." The assessment found that:

> "stakeholders consistently identified low reimbursement rates for behavioral health services as the root cause for challenges to paying competitive salaries, and for recruiting, educating, training, and retaining a skilled behavioral healthcare workforce, especially in settings with large numbers of Medicaid-insured patients, such as Community Behavioral Health Centers."

In the **Washington Behavioral Health Performance Measure Study Report,** conducted for HCA by Comagine Health and published in June 2021, results confirmed the workforce shortage problem. Comagine surveyed behavioral health providers for the report. When asked whether their organization had adequate staff to see clients without long wait times (for appointments or urgent/emergent care) over the past year, a majority of respondents (55 percent) disagreed or strongly disagreed.

Work group recommendation

The work group recommends that the state increase reimbursement rates — including Medicaid managed care rates as well as the fee schedule for fee-for-service — to support higher wages for SUD treatment providers to help broaden the workforce capable of providing SUD services. The work group additionally recommends that, to increase the salary of the behavioral health workforce, the state reimburse room and board at a higher rate. By increasing reimbursement rate both for Medicaid-covered services and cost of

operation, the work group believes that behavioral health provider organizations can reinvest in the workforce to support improved recruitment and retention.

Additional considerations and recommendations that the work group discussed to support and sustain interventions intended to increase substance use treatment provider salary include:

- Utilizing the comparison rate study (**Behavioral Health Comparison Rate Development: Phase two**) and in phase 3 of this work, making targeted increases in alignment with these findings, as well as implementing a minimum fee schedule for both residential and outpatient treatment.
- Increasing state tuition reimbursement options for behavioral health professionals pursuing SUD professional and trainee (SUDP/SUDPT) credentialing and/or clinicians building on their SUD knowledge to support further access to education to improve the quality and integration of care.
    - Providing financial support and initiatives to support with the SUDPT application, continuing education, renewal costs, etc.
    - Creating stipends for continuing education as many SUD agencies cannot afford to pay for staff time and costs associated with obtaining continued education credits. This could include subsidizing continuing education costs to maintain licensure and offering more asynchronous courses so that providers need not spend as much of their time and money on continuing education training/travel.

Sustainability is a critical consideration when implementing these changes. It is essential to secure funding from the general fund to match the Medicaid money when setting or increasing rates. Careful deliberation is required to determine the funding source, whether it involves reallocating funds from other areas or implementing tax increases. The work group discussed existing revenue resources as an opportunity to fund the incentives. Additionally, if fee schedules are to change to support the workforce, funds would need to be monitored at the provider level to ensure they're going towards the recruitment, retention, and development of SUD treatment staff.

Recommendation 2: education campaign for behavioral health workforce

Background

Previously, only SUDPs or SUDP trainees being supervised by a state-approved SUDP supervisor, were reimbursed by Medicaid for SUD assessments. However, according to the amendment of the Washington Medicaid State Plan (effective January 2024), staff members with specific credentials, such as LMHC, LMFT, and LICSW, can also be reimbursed by Medicaid to conduct comprehensive SUD assessments, after receiving proper training, if it falls within their scope of practice at a behavioral health agency. With this change, expanding the scope of practice for existing and future clinical staff, will subsequently broaden the workforce capable of administering SUD assessments.

The work group recommends the following steps:

- Share this knowledge among educational institutions, which are training the behavioral health workforce.
- Share this update and education with the current workforce.
- Incentive SUD training through some of the avenues explored in recommendation one (e.g., tuition reimbursement and subsidizing continuing education credits).

Additionally, the work group identified that patients with opioid use disorder had limited treatment options in the emergency room due to resource and training constraints. Fortunately, ScalaNW has expanded provider resources, supporting efforts to increase treatment for patients with this disorder. Healthcare providers can access information on treating patients with opioid use disorder quickly via the ScalaNW website, and there is also a 24/7 consultation line available for further assistance. The ScalaNW website could also share critical information about the expansion of clinicians able to provide SUD Assessments. Ultimately, furthering education about this resource to emergency departments is necessary to improve response to opioid overdose or other opioid-related concerns managed in this setting and quickly connect individuals to immediate and ongoing treatment.

Work group recommendation

The work group proposes an educational campaign to clarify the state's requirements for intake and assessments before offering various behavioral health services. There has been confusion among various entities such as managed care organizations (MCOs), Behavioral Health – Administrative Services Organizations (BH-ASOs), the Department of Health (DOH), and SUD providers regarding interpreting the SUD/ASAM Criteria requirements for assessment/intakes into treatment services at all levels of care. In the past, individuals seeking treatment had to deal with the burden of obtaining prior authorization for admission into residential treatment centers or withdrawal management facilities, which also necessitated a full SUD assessment. However, with the passing of HB 2642 (2020), the requirement for prior authorization for inpatient or residential substance use disorder treatment has been eliminated as a requirement for admission.

In addition to what's been stated above, education campaigns should consider the following components:

- Education to providers regarding prescriber education about medications for opioid use disorder (MOUD), including the removal of X-Waiver, which removed the federal requirement for practitioners to submit a waiver to prescribe medications like buprenorphine for the treatment of opioid use disorder.
- Education on ESHB 2642, "no wrong door" initiative.
- Provider education on the ability to provide MOUD/Medication for Alcohol Use Disorder (MAUD) before SUD assessment.
- Dedicated website as part of that educational campaign.
- Education on billable telehealth options for providing behavioral health services

We also received feedback from a statewide association that, given that:

1. The high prevalence of co-existing mental health conditions in those with SUD, and
2. Overwhelming evidence that individuals with SUD benefit more from integrated/whole person treatment compared to segmented, "SUD only" treatment programs,

Washington State can maximize the impact of finite funding by prioritizing increasing rates and quality incentives for providers who are trained in the full scope of behavioral health conditions and offer treatment for SUD and mental health concurrently. This approach is further supported by ASAM Criteria fourth edition, which describes specific co-occurring capabilities expected at each ASAM Criteria level of care.

The work group noted that the recommendation for an education campaign has a fiscal impact. Existing funding streams would need to be allocated to cover any components not already covered by Medicaid.

Recommendation 3: expansion of peer counseling services

Background

Results from the 2023 WA State Syringe Services Program Health Survey conducted by Addictions, Drug, and Alcohol Institute demonstrated that about one-third (32 percent) of respondents said there was a time in the last 12 months when they "tried to get help to reduce their drug use but didn't/couldn't get it." These participants were then asked, "What got in the way of that happening?" Their open responses were coded into the categories in Table 1. (Kingston, Alison Newman, Caleb Banta-Green, & Sara Glick, 2024)

Table 1: Barriers to help as reported in the Washington State Syringe Services Program Health Survey

Barrier faced when trying to get help to reduce drug use	Percentage of responses
Availability/access problem (e.g., long waitlists, no treatment beds, no place to get MOUD, no I.D., no help to navigate entry)	23%
Lack of transportation	12%
Personal motivation (e.g., couldn't follow through, go scared)	11%
"Being homeless" (e.g., no phone, no place to store belongings, camp "sweeps" prevented follow through)	7%
Restrictive program issues or rules (e.g., strict appointment/attendance rules)	6%
No insurance/cost too high	6%

Note: n=357 responses given.

Peers are often limited to engagement with clients until after intake and assessment, and they have a robust engagement skill set that would benefit patients and sustain motivation until intake and assessment becomes available. The work group identified that HCA should explore with Centers Medicare and Medicaid Services (CMS) on whether outreach and engagement services could be billable to Medicaid when provided by peers before intake and assessment could help increase funding capacity and engagement with individuals waiting for these essential services.

Work group recommendation

The work group recommends expanding the availability of Medicaid-billable services provided by Certified Peer Counselors before a formal SUD assessment or intake is completed. This includes implementing behavioral health care and community integration services in various settings, such as syringe service programs, emergency departments, supportive housing, and homeless encampments.

Expanding service encounter reporting instructions language regarding peer support to include transitions from community-based settings, homelessness, and emergency departments under the "Community Support and Care Coordination" umbrella would allow non-inpatient staff to conduct a needs assessment and provide support.

This expansion should also cover transitions to inpatient and incarcerated settings where formal assessments have already been completed, as well as encouraging other substance use disorder treatment settings to accept assessments that have been completed elsewhere.

The current behavioral health agency (BHA) WAC (**WAC 246-341-0700**) indicates the following:

> (3) An agency providing any behavioral health support service must:
>
> (a) Conduct a needs assessment or screening process that determines the appropriateness of the support service(s) based on the individual's needs and goals;
>
> (b) Develop a support plan that indicates the goal(s) the individual intends to achieve through receiving the support service(s) and the progress made toward the goal(s);
>
> (c) Maintain an individual's service record

The aim is to enable the initiation of services without requiring a formal clinical assessment, especially for populations that may face barriers to seeking or accessing treatment services. As indicated, research has shown that about one-third of individuals with substance use issues in Washington State have tried to get help but faced barriers. By allowing peers to provide services, or facilitate connection to services, to such high-need populations, we can increase the number of individuals receiving assistance and addressing their needs before formal treatment.

The work group noted that this recommendation may require an amendment to the Washington Medicaid State Plan, carries a fiscal impact, and that existing funding streams could be considered to cover any components not already covered by Medicaid (e.g., Dedicated Cannabis Account, Opioid Abatement Settlement Account).

Recommendation 4: telemedicine expansion

Background

To support access to care, especially for those in rural or underserved communities, telehealth has been an allowable modality for service delivery prior to COVID-19. While telehealth had been gaining traction prior to the PHE, the pandemic had significant impact on the expansion and increase in utilization of telehealth services, particularly in the field of behavioral health, including SUD. Due to policies on social distancing, restrictions on in-person visits, and increased demand for behavioral health services, telehealth became crucial during the pandemic. This prompted the development of policy and guidelines to support safe and effective care as well as providing the structure for service delivery (i.e. in person vs. telehealth HIPPA compliant audio-visual platforms).

Telehealth has allowed individuals to receive services such as counseling and medication monitoring, to include MOUD, remotely, ensuring continuity of care and reducing the risk of relapse and recidivism. Furthermore, implementation of regulatory changes and reimbursement policies have helped facilitate the provision of telehealth services, making it easier for healthcare providers to offer SUD services remotely. Compiling with CMS guidance and legislative updates that encourage utilization of telemedicine including ensuring payment parity between in-person and telemedicine options. As a result, telehealth has and will continue to play a crucial role in behavioral health service delivery.

Work group recommendation

The work group recommends expanding remote access options for SUD assessments and treatment by encouraging utilization of telemedicine for assessment and treatment services. We can enhance virtual treatment possibilities for SUD, by encouraging treatment agencies to update their policies and procedures to align with HCA standards and reimbursement models for telehealth delivery of SUD treatment.

Secondly, to support the timely completion of the use of the ASAM Criteria and appropriate placement in level of care, the work group recommends HCA create and publish a list of SUD agencies and consultation services that perform SUD assessments and treatment services via telehealth, specifically those who can reach out when clients may be in a hospital or emergency room setting.

Additionally, the work group recommends contracting a third party to provide support (e.g. providing guidance, discussing workflow) to agencies who may be hesitant to provide telehealth services. The intent is to expand utilization of telehealth services which is vital to increase entry and lower-barrier access to services.

To support this recommendation HCA could incorporate existing telehealth guidance documents to support agencies in providing virtual services and remain in compliance both at the federal level and statewide. This would include helping agencies develop policies related to allowable and nonallowable use of SUD services provided via telehealth, including audio-visual and telephone (audio only)-based interventions and ensuring safe and effective care.

The work group recommends collaboration between HCA and DOH to add requirements regarding telehealth to licensing and provider agreements and provide technical assistance to agencies not currently offering telehealth services as critical next steps.

Finally, the work group recommends the state address internet access barriers to make telehealth more widely accessible within BHAs, as many of our rural communities may not have internet access.

Conclusion

This report outlines the SUDISA work group's recommended changes to systems, policies, and processes related to intake, screening, and assessment for substance use disorder services. The goal of the recommendations is to broaden the workforce capable of administering SUD assessments and to make the assessment process as brief as possible, including only what is necessary to manage utilization and initiate care.

Additional recommendations

Due to the short time span for creating the work group and submitting recommendations, the work group could only fully define the four recommendations outlined above in this report from the several discussed during the meetings. Additional recommendations are listed below for consideration. Given an extended timeframe for the work group to convene, there is an opportunity to expand upon the recommendations outlined below. Furthermore, HCA will conduct an internal review of these recommendations, and continue to work with SUDISA, to assess their viability within the scope of our current work.

- Shortening the process of getting into desired services due to limited options available to offer people coming to emergency departments, providing more options for when hospital beds are not available to help reduce wait list times.
- Further investments made by the state to increase housing options and subsidize rent, particularly for those exiting inpatient SUD treatment and transitioning into recovery housing
- Mobile intake services should be more accessible and available to individuals who cannot leave their homes.
- Provide technical assistance on how to braid Medicaid billing with other funding (grants, etc.) to enable a provider to employ a Peer to serve the population without being strictly held to Medicaid eligibility and funding.
- Address gaps in Medicare coverage with CMS regarding Medicare's lack of coverage for residential inpatient SUD treatment. At present, CMS requires inpatient SUD treatment take place in a hospital setting to reimburse.

Appendix

Table 2: SUDISA work group members

	Area of representation/expertise	Member name and affiliation	County
1	Psychotherapist	Ana Hartu, JBLM	Thurston
2	Behavioral health intake/referral	Cathy Assata	Snohomish
3	Behavioral health coding, billing, and medical record (EMH/EHR) professionals	Trina Gallacci, Tribal FQHC	Clallam
4	Substance Use Disorder Professional (SUDP)	Sarah Gillard, Greater Columbia Behavioral Health BHASO	Franklin
5	Recovery Housing Provider	Susan (Sue) Cherry	Pierce
6	Managed Care Organization (MCO)	Katherine (Katie) Ramos, Coordinated Care of Washington	Spokane
7	Behavioral Health Administrative Services Organization (BH-ASO)	Cara Reidy, Spokane regional BHASO	Spokane
8	Lived experience with SUD recovery	Charnay DuCrest	Pierce
9	Designated Crisis Responders	Dominique Fortson-Jordan	Franklin
10	Hospital Social Workers	Adrienne Tillery, HMC, University of Washington	King
11	Tribal Health / Fee-for-Service	Bethany Barnard, Willapa Behavioral Health	Pacific
12	SUD Outpatient Provider (1 of 2)	Amy Ruge, Columbia River Mental Health, Northstar Clinic	Clark
13	SUD Outpatient Provider (2 of 2)	Wayne Swanson, Subacute Recovery Services	Kitsap
14	SUD Residential/Inpatient Provider (1 of 2)	Alicia Egan, Sundown M Ranch	Yakima
15	SUD Residential/Inpatient Provider (2 of 2)	Brandy Branch, Lifeline Connections	Clark
16	MOUD Prescriber	Molly Martin	Clallam
17	SUD Withdrawal Management Provider	Qudsia Khan, Northwest Integrated Health	Pierce
18	SUD/MH Co-Occurring Provider	Jackielyn Jones, Peninsula Community Health Services	Kitsap
19	Family member of individual(s) with SUD	Elizabeth Bridges	Clark
20	Drug Court Graduate	Dallas Delagrange	Cowlitz
21	Harm Reduction Strategies Expert	Elizabeth Myers	Jefferson
22	Emergency Department Crisis Worker/ED Behavioral Healthcare Provider	Angela Tonkovich, LCSW, Harborview Medical Center Emergency Department	King
23	Addiction Medicine Physician (MD)	David Sapienza, MD	King

Table 3: SUDISA work group consultants

Association or agency	Consulting representative
Washington Association of Drug Court Professionals (WADCP)	Bob Cooper Steve Freng
Washington State Hospital Association (WSHP)	Brittany Weiner
Association of Alcoholism and Addiction Professionals (AAP)	Loretta Stover
Washington State Association for Addiction Professionals (WAADAC)	Christopher Weigenstein
Designated Crisis Responders (DCR) Association	Laura Pippin, Co-President Dawn Macready Santos, Co-President Melissa Jackson, Co-Vice President Ann Marie Ridinger, Co-Vice President Steven Hightower, Secretary
SUD college educators	Mirelle Cohen
Association of Washington Health Plans (AWHP)	Peggi Fu Kelly Tower
Washington State Office of the Insurance Commissioner (OIC)	Jane Beyer
Health Care Authority's Office of Tribal Affairs	Lucilla Mendoza Aren Sparck
Washington State Medical Association (WSMA)	Hillary Norris
Washington Association of Addiction Treatment Professionals	Vania Rudolf, MD, WA Society of Addiction Medicine
Washington Association for Community Health	B. Marsalli
Washington Recovery Alliance	David Coffey
Office of Behavioral Health and Advocacy	Michelle Tinkler
Washington Council for Behavioral Health	Joan Miller Julia OConnor
Washington State Association for treatment of Opioid Dependence (WSATOD)	Misty Challinor