Washington State Health Care Authority

Substance Use and Recovery Services Plan Recommendation

Recommendation for a new SUD engagement and measurement process

Because Substance Use Disorder (SUD) is chronic and potentially acutely life-threatening:

- Care for people with SUD needs to be accessible and initiated as quickly as possible.
- Care for people with SUD needs to be accessible in places and care settings that are low barrier/crisis oriented (e.g., Health hubs for people who use drugs (PWUD), Emergency departments, CHC/FQHC) in addition to care settings such as withdrawal management and specialty SUD treatment.
- The initial engagement and measurement process should be focused on what is minimally necessary to document a diagnosis, determine medical necessity and start care the same day and be conducted in less than 15 minutes:
    - This could include brief screening, diagnosis, documentation of a person's care preferences, and if the client wants, initial discussion about the level of care/care setting or lead to a full assessment.
- Initial engagement and SUD measurement must be focused on, and limited to, client's needs and should be limited to only the necessary domains. Trauma and culturally informed approaches must be taken in terms of the total time, content, and process of engagement and measurement.

We ask that:

- The Washington State Health Care Authority (HCA) convene a workgroup who will review current processes and workforce needs related to intake, screening, and assessment for SUD services,
- HCA determine how to build an SUD engagement and measurement process including developing any necessary rules and payment mechanisms,
- HCA work with PWUD, care providers, state regulators, and payors to address this recommendation within 12 months, and,
- In the interim, any work that HCA can undertake to advance these goals should be done.

Initial engagement and measurement goals:

- Be as brief as possible and only what is necessary to initiate care the same day whenever possible, typically less than 15 minutes.
- Be available on demand whether in person or virtually at centralized and accessible community access points.
- Be available in diverse health care, behavioral health, emergency, and SUD settings.
- Be available within four hours of request 8am-8pm and within 12- hours 8pm-8am.
- Be culturally appropriate and trauma informed.[1]
- Consider the patient's self-identified needs and preferences when evaluating direction of treatment and/or referral to services.
- Eliminate financial barriers to accessing immediate and individualized services.
- Be administered by a range of health professionals, guided by the scope of practice of a service provider.
- Assessments should be conducted if only necessary and not more than one per 12-month period.[2]

Bill Requirement(s) – *Low barrier, person-centered care should be informed by people with lived experience.*

[1] https://www.hca.wa.gov/about-hca/trauma-informed-approach-tia
https://www.hca.wa.gov/about-hca/who-we-are/health-equity

[2] Per the HCA Service Encounter Reporting Instructions, "a new assessment evaluation is not required if an assessment was completed in the 12 months prior to the current request and medical necessity was established. The previously completed assessment may be used to authorize care."

Reducing the time required during initial assessments to center on the self-identified need and desire for care that guide the direction of treatment, harm reduction services, recovery supports, and other necessary services based on the needs identified by the client and for the Plan to assist persons with timely access to all services, including treatment.

Defining Terms

Intake: There is no definition for intake established within WAC or RCW. For the purposes of this recommendation, intake would be the process through which an individual gains access to behavioral health services and the associated subprocesses, forms, and declarations associated with that process. This includes the administration of screening tools and assessments done to diagnose and determine medical necessity.

Screening: Per RCW 71.24.630, HCA is directed to maintain an integrated and comprehensive screening and assessment process for substance use and mental health disorders. Under this section, the process shall include an initial screening tool which can be used by intake personnel systemwide and which will identify the most common types of co-occurring disorders, and through screening, identify triggers which would indicate the need to begin an assessment. This could include utilization of screening tools like the GAIN-SS, AUDIT, DAST, ASSIST, etc.

Assessment: Per WAC 246-341-0200 "Assessment" means the process of obtaining all pertinent bio-psychosocial information, as identified by the individual, and family and collateral sources, for determining a diagnosis and to plan individualized services and supports. Per WAC 246-341-0460, the Clinical Record must include “an assessment which is an age-appropriate, strengths-based psychosocial assessment that considers current needs and the individual's relevant behavioral and physical health history according to best practices, completed by a person appropriately credentialed or qualified to provide the type of assessment pertaining to the service(s) being sought, which includes: a diagnostic assessment statement, including sufficient information to determine a diagnosis supported by the current and applicable Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or a placement decision, using ASAM criteria dimensions, when the assessment indicates the individual is in need of substance use disorder services.

HCA’s Service Encounter Reporting Instructions (SERI), which provides Apple Health Managed Care Organizations (MCO) and the Behavioral Health Administrative Services Organizations (BH-ASO) in integrated care regions, and all BH providers in licensed community mental health clinics/licensed behavioral health agencies assistance for reporting behavioral health service encounters, indicates that Assessment services are defined as “The activities conducted to evaluate an individual to determine if the individual has a substance use disorder and determine placement in accordance with the American Society of Addiction Medicine (ASAM) criteria.”

Medical Necessity: According to WAC 182-500-7010, “medically necessary” or “medical necessity,” with regard to substance use disorder, is defined by the most recent version of the *ASAM Criteria, Treatment Criteria for Addictive, Substance Related, and Co-Occurring Conditions* as published by the American Society of Addiction Medicine (ASAM). Based on WAC 182-500-0070, “medically necessary” is a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purposes of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all.

Background & Supporting Data

Access to timely SUD assessments varies widely across WA State. In urban areas, people seeking or needing an assessment may go to drop-in hours multiple times over several weeks before they obtain an assessment. In rural areas there may be a single provider currently allowed to do assessments and

they may have a multi-week wait list. Alternatively, in some care settings all that is needed to initiate care is an SUD diagnosis, e.g., a medical clinic with a licensed prescribing provider onsite. The variable access to care by geography, provider types, and care settings is an example of state and federal rules and regulations negatively impacting equitable access to care.

The ASAM Criteria is the most widely used and comprehensive set of guidelines for placement, continued stay, transfer, or discharge of patients with addiction. Other tools, some used in the mental health system or by Managed Care include the LOCUS, CALOCUS, Interqual, and Milliman. Although ASAM as a biopsychosocial assessment is not specifically required in a State Plan Amendment for Medicaid, it is mentioned in Washington State's 1115 Medicaid Waiver. ASAM is also a requirement in HCA policy (the SUD Fee-for-Service Billing Guide) and WAC 246-341-0640, "Clinical record content." This policy is in place to ensure sufficient information to guide placement decisions when the assessment indicates the individual is in need of substance use disorder services.

The shorter engagement and measurement processes proposed in this recommendation can therefore be used to demonstrate medical necessity for any level of behavioral health care / SUD treatment placement, as long as they include questions that align with the ASAM criteria needed for the health plan's utilization review team to apply ASAM to assess medical necessity in order for the service provider to receive reimbursement for services provided.

However, while the DSM-5 criteria for substance use disorder is composed of 11 yes/no questions , the ASAM Criteria Assessment Interview Guide is 31 pages long, takes the average clinician about 90 minutes to complete, and covers six dimensions of assessment (Acute Intoxication and/or Withdrawal Potential, Biomedical Conditions and Complications, Emotional, Behavioral or Cognitive Conditions and Complications, Readiness to Change, Relapse, Continued Use or Continued Problem Potential, and Recovery and Living Environment) intended to identify optimal treatment placement for an individual. It is typical for individuals who come into contact with providers to have well documented needs, numerous system encounters and history of assessments and admissions, and ample documentation of necessity and diagnosis.

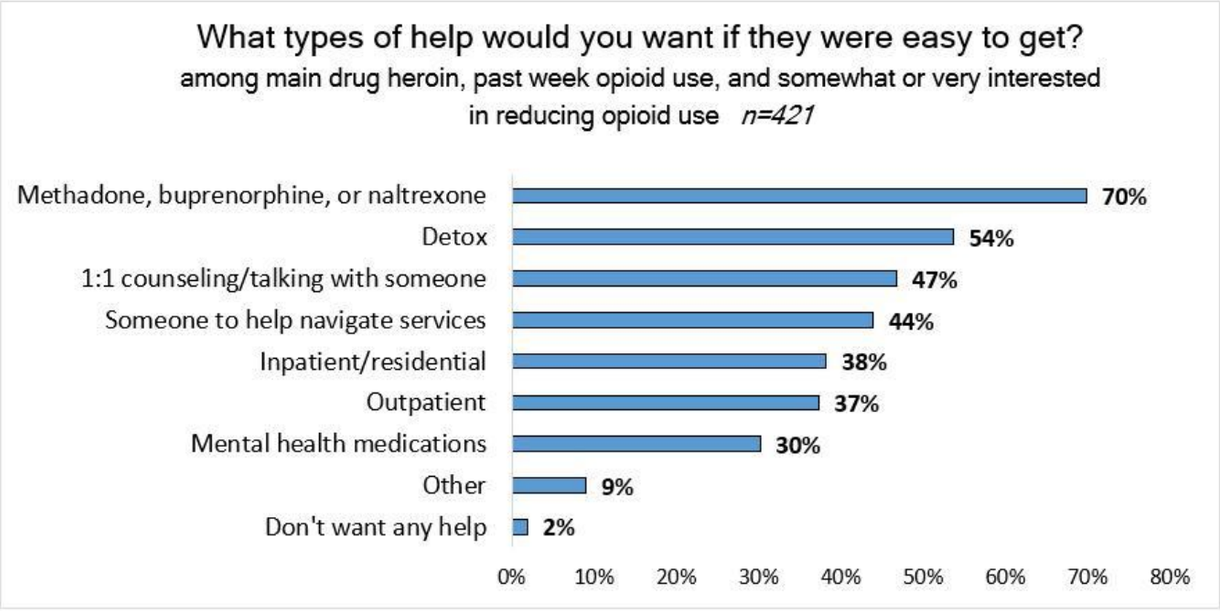
The volume of questions, the speed at which they are administered, and the potential personal trauma from highly sensitive questions (many unrelated to immediate care needs) are all potential reasons for people to avoid participating in these lengthy assessments, which then becomes a barrier to accessing treatment services.

Moreover, someone undergoing an SUD assessment may be under the influence of substances and are not in an appropriate frame of mind to be answering so many personal questions; people need the opportunity to stabilize / allow their spirit to return to their bodies before engaging in the longer assessments.

There is usually a small window of readiness when a person with a substance use disorder is ready and willing to engage in treatment and recovery services, and a lengthy assessment process not only does not guarantee treatment access, but it can also often lead to frustration, and eventually deter someone from pursuing treatment and recovery. Neither ASAM nor SAMHSA guidelines should be interpreted or used as a standard of care or specifically required by WA State agencies.

The ability to do an assessment should be guided by the scope of practice of a service provider and not be limited to a single and specific credential in certain settings (e.g., SUDP), as it is currently. For example, a hospital setting should not need an SUDP to complete an assessment that is reasonably in the scope of practice of another provider. A solution could include the capturing of necessary information by trained professionals with supervision and oversight by credentialed practitioners, so that a shortage of SUDPs at a given facility does not impede someone seeking SUD services from receiving an urgently needed assessment

Ease of access improves engagement with services: According to the 2019 results of the WA State Syringe Exchange Health Survey[3], among opioid users who had used opioids in the past week (mainly heroin) and were somewhat or very interested in reducing their opioid use, most of them would want methadone, buprenorphine, or naltrexone (70%) and withdrawal management services (54%) if those services were easy to get (see graph from the report below). Low barrier treatment programs, informed by these clients' preferences, utilizing buprenorphine at harm reduction programs found high client uptake and engagement[4].



Concerns & Considerations

- **Role of SUDPs:** Providing ASAM Criteria assessments is a significant aspect of the roles of Substance Use Disorder Professionals (SUDPs). If these assessments are no longer used or needed prior to initiating SUD care, it could reduce the demand for SUDPs and have a detrimental impact on their employment opportunities and SUD agency financial viability. SUDPs are vital contributors in the behavioral health workforce, and we want to ensure their role in providing evidence-based care going forward. Their value extends beyond the ability to do assessments and it is important to support their ability to do more valuable work to support people with SUD including assessment, addiction counseling, case management and care navigation. However, there is no existing requirement for the service provider to conduct an ASAM-specific assessment, if the patient's health plan can use information from the assessing provider to apply ASAM criteria themselves. For higher acuity needs like withdrawal management, full ASAM structure for assessments are not always needed, if the member meets criteria in ASAM dimension 1 (acute intoxication/withdrawal potential) to medically authorize withdrawal management in those cases.

- **Maintaining objectivity:** Shorter assessments that do not use ASAM criteria and the specific decision pathways it provides may increase risk of subjectivity and bias in the assessment process.

- **Demonstrating "Medical necessity" based on level of care needed:** There is a "medical necessity" clause to receive money/be paid for services, depending on the type of care needed.

[3] WA State Syringe Exchange Health Survey, 2019 Results | Addictions, Drug & Alcohol Institute (uw.edu)
[4] Care Navigation at Harm Reduction Programs: Community-Based "Meds First" Buprenorphine Program Preliminary Data. | Addictions, Drug & Alcohol Institute (uw.edu)

- **Regulatory and financial implications:** The Treatment subcommittee recognizes that there are regulatory and financial implications of replacing the ASAM with a shorter version of SUD Assessment, such as determining whether and how the shorter assessments will be billed; such details will need to be sorted out within HCA/DBHR.

- **Multiple diagnoses and medical necessity:** Often, what providers deliver in terms of care and services are supportive interventions to address symptoms and behaviors. These symptoms and behaviors are related to any number of diagnoses a client has, and they do meet medical necessity. Additionally, there are many records and assessments that tell us that. Our current rules and coding guidelines are precise and restrictive in ways that prevents access. The goal here is to expand access and allow for interventions to be delivered by qualified professionals. A consulting SUDP can provide the additional training, consultation, and record oversight.

- **Reimbursement parity needed between SUD and MH:** We have bifurcated BH treatment into MH and SUD modalities but when treating symptoms and behaviors we should consider the value of interventions traditional in the MH system, like CBT, DBT. There is not parity in reimbursement in SUD system and contracting and credentialing make it challenging to access services in one system rather than another. An integrated system would consider the interventions for symptoms and behaviors rather than diagnosis. In other words, know our population, align with the right services, and support access to additional interventions you are not able to provide.

Collaboration with Existing Resources:

- *Community partners: Collaborate with workforce efforts at two and four year higher education schools. Coordinate with other behavioral health workforce efforts including those underway at the UW's Behavioral Health Institute.*

Approximate Financial Support & Staffing Needed:

Dollars	FY23	FY24	FY25
Legislative / State Budget Funding	140,000	140,000	140,000
HCA Grant-Based Funding			
Total Funds			
Staff (FTE)	1	1	1

SURSA Committee Feedback: