

SPEAKING THE SAME LANGUAGE:

A Toolkit for Strengthening Patient-Centered Addiction Care in the United States



ABOUT THE AMERICAN SOCIETY OF ADDICTION MEDICINE

The American Society of Addiction Medicine (ASAM), founded in 1954, is a professional medical society representing over 6,600 physicians, clinicians and associated professionals in the field of addiction medicine. ASAM is dedicated to increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction. For more information, visit www.ASAM.org.

ABOUT WELL BEING TRUST

Well Being Trust is a national foundation dedicated to advancing a vision of a nation where everyone is well in mental, social and spiritual health. Launched by Providence St. Joseph Health in 2016 as an independent 501(c)(3) public charity with an initial seed endowment of \$100 million plus an additional \$30 million to be invested in California from 2017 to 2019, Well Being Trust is now investing in approaches that have the potential to model the way forward. Well Being Trust was created to advance clinical, community and cultural change...*to transform the health of the nation and improve well-being for everyone.*

AUTHORSHIP

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EXECUTIVE SUMMARY





EXECUTIVE SUMMARY

In the face of the ongoing substance use disorder (SUD) crisis and rising overdose deaths, policymakers and other stakeholders continue seeking ways for improving SUD prevention and treatment services. While highly effective treatments for SUD are available, outcomes achieved in community settings rarely approach those that can be achieved in the best designed treatment systems. Historically, there has been significant heterogeneity across states and communities in the organization and oversight of addiction treatment systems. This has contributed to high variability in the quality of care and resulting patient outcomes.

One key strategy that states can deploy is ensuring that SUD treatment services are rooted in a well-defined, consistent approach for identifying the appropriate level of care for people with SUD. Such systems long have been in place for other chronic conditions, but the stigmatization of people with SUD historically resulted in them receiving little or no treatment or ad hoc treatment. Currently, with SUD prevention and treatment now far more likely to be covered, as well as an influx of federal dollars in response to the COVID-19 pandemic, it is more important than ever to establish a strong, consistent framework for evidence-based addiction care. *The ASAM Criteria*[®] provides a framework for organizing addiction treatment systems and a foundation for improving the quality of care and addressing the gap between the efficacy of treatment in clinical trials and effectiveness in real world settings. This toolkit details strategies for the improvement and standardization of the delivery of individualized SUD services using *The ASAM Criteria*.

The ASAM Criteria is the most widely used set of evidence-based guidelines for patient placement, continued stay, and transfer of patients with addictive, substance-related and co-occurring conditions. By rooting SUD services in a common framework such as *The ASAM Criteria*, states can ensure that everyone is “speaking the same language” when it comes to SUD prevention and treatment. The toolkit offers high-level strategies for integrating *The ASAM Criteria* into a state’s approach to SUD services, as well as potential pathways that states can pursue, implementation vehicles, state examples, and model legislative, regulatory, and contractual language from which states can draw. This toolkit was developed for educational and discussion purposes only.

Table 1: Strategies for Integrating Use of *The ASAM Criteria* into SUD Services

| STRATEGY | POTENTIAL PATHWAY |
|--|--|
|  <p>Expand provider use of <i>The ASAM Criteria</i> throughout patient placement and care delivery</p> | <p>Require SUD treatment program utilization of <i>The ASAM Criteria</i> throughout treatment, including for initial assessment for level of care determinations and reassessments for guiding continued stay and transfer determinations</p> <p>Require (or incentivize) SUD treatment program utilization of a state-specified comprehensive assessment tool that is fully consistent with <i>The ASAM Criteria</i> throughout treatment, including for initial assessment for level of care determinations and reassessments for guiding continued stay and transfer determinations</p> <p>Encourage other providers assessing patients with SUD to use a state-specified triage (i.e., provisional referral) or comprehensive assessment tool that is fully consistent with <i>The ASAM Criteria</i></p> <p>Support provider access to <i>The ASAM Criteria</i> and state-specified triage (i.e., provisional referral) and comprehensive assessment tools that are fully consistent with <i>The ASAM Criteria</i></p> |
|  <p>Leverage <i>The ASAM Criteria</i> with payers and SUD providers for ensuring affordable access to the full continuum of care for people with SUD</p> | <p>For purposes of commercial insurance, require payer coverage for all levels of care along the continuum defined in <i>The ASAM Criteria</i></p> <p>For purposes of Medicaid, provide coverage for all levels of care along the continuum defined in <i>The ASAM Criteria</i></p> <p>Require (or incentivize) SUD treatment program obtainment of ASAM Level of Care Certification through the Commission on Accreditation of Rehabilitation Facilities (CARF)</p> <p>Make licensure requirements for SUD treatment programs fully consistent with ASAM levels of care</p> <p>Make information on the level(s) of care offered by SUD treatment programs publicly available</p> <p>Ensure sufficiency of SUD provider networks across state-regulated insurer and Medicaid networks</p> |
|  <p>Ensure accountability for payer use of <i>The ASAM Criteria</i> in coverage decisions</p> | <p>Require payer utilization of policies and procedures that are fully consistent with <i>The ASAM Criteria</i> for medical necessity determinations, utilization management, and appeals decisions</p> <p>Monitor payers' usage of <i>The ASAM Criteria</i> for coverage decisions and troubleshoot issues</p> <p>Promote collaboration across Medicaid officials and insurance regulators</p> |
|  <p>Support understanding of <i>The ASAM Criteria</i> among those who provide, cover, or use SUD services</p> | <p>Provide high-quality education for clinicians, payers, state staff, and the public on <i>The ASAM Criteria</i></p> <p>Establish one or more Center(s) of Excellence for promoting the appropriate use of <i>The ASAM Criteria</i></p> <p>Require payers ensuring that their own staff and network providers are trained properly on <i>The ASAM Criteria</i></p> <p>Convene regular meetings of providers, payers, individuals receiving treatment for SUD, and state staff to share experiences implementing <i>The ASAM Criteria</i></p> |

INTRODUCTION AND BACKGROUND





INTRODUCTION

The United States is grappling with a persistently high rate of SUD and a rise in overdose deaths. In 2020, there were more than 92,000 drug overdose deaths in America, a staggering, nearly 30 percent increase over the prior year, with the fastest increases in Black and Latino populations.^{1,2} While funding and resources remain inadequate to address this crisis, the federal government, states, and localities have increased their efforts to expand access to SUD prevention and treatment in recent years. These trends make it more important than ever to improve the quality and delivery of patient-centered, evidence-based addiction care, beginning with helping providers, payers, and patients “speak the same language” when it comes to addiction care.

Historically, the regulation, delivery, and coverage of addiction care received relatively little attention in the United States, reflecting sparse coverage of SUD treatment and stigmatization of individuals with SUD. Individuals with SUD often had (and sometimes still have) little or no access to medical treatment for SUD unless they could pay out-of-pocket or secure help from a grant-funded SUD treatment program. If they could afford care, then the treatment they sometimes received was just as likely to be determined by where they (or a family member) sought help as what their individual circumstances and condition required. For example, if they called a 28-day residential treatment program, they were likely to be offered 28 days of residential care even if they might have been better served by a different treatment approach. Further, many insurers offered little in the way of coverage for SUD treatment, and those that did, could impose stricter coverage limits on SUD treatment than on treatment for other medical conditions.

Decades ago, experts in addiction care recognized the imperative to bring standardization and consistency in the coverage and delivery of SUD treatment, consistent with other chronic medical conditions. Building on early efforts to develop such standardization and consistency, the American Society of Addiction Medicine (ASAM), the nation's largest nonprofit addiction medicine specialty society, established an evidence-based set of guidelines **for patient placement, continued stay, and transfer of patients with addictive, substance-related and co-occurring conditions**. Now referred to as *The ASAM Criteria*, these standards have evolved over the years to keep pace with research and patient experience. Last updated in 2013, ***The ASAM Criteria provides a consistent way to assess a person's biopsychosocial circumstances, identify an appropriate level of care based on individual needs, and define the services that should be provided at each level of care.*** Use of *The ASAM Criteria for patient assessment and placement* can increase patient engagement, improve outcomes, and reduce both underutilization and overutilization of care.^{3,4}

In combination with the worsening of the drug overdose epidemic in the United States, recent policy developments have contributed to a growing movement for

Trauma Centers Levels of Care

Similar to the levels of care for SUD treatment, trauma center levels are designated by standards of trauma care for adults and children that define resources available in the hospital for assessing and treating injured patients, and the number of patients admitted yearly.

Levels of trauma centers range from most comprehensive capability which provide complete care for every type of injury at **Level I to Level V** where patients are evaluated, stabilized, and prepared for transport to higher levels of care.

The American College of Surgeons (ACS) conducts a voluntary **verification process** for trauma centers that confirms the presence of resources expected at the trauma center's level of care. Verification lasts for a three-year period.

Source: American Trauma Center. Trauma Center Levels Explained. Available [here](#)



National Audit Survey of Residential Addiction Treatment Programs findings:

1/3

of individuals seeking treatment offered admission *before* clinical evaluation

Most programs

required up-front payments

For-profit programs used recruitment techniques more frequently

than non-profit programs

“These findings raise concerns that residential programs...may be admitting a clinically and financially vulnerable population for costly treatment without assessing appropriateness for other care settings.”

Source: Tamara Beetham, Brendan Saloner, Marema Gaye, et al. Admission Practices And Cost Of Care For Opioid Use Disorder At Residential Addiction Treatment Programs In the US. *Health Affairs*, Vol 40. No.2. February 2021. Available [here](#)

further standardization and strengthening of coverage and delivery of SUD treatment. These efforts recognize the foundational need for increased, systematic use of evidence-based criteria such as *The ASAM Criteria* to guide SUD assessments, treatment, and coverage decisions. In 2015, the federal Center for Medicaid and CHIP Services (CMCS) started offering states access to Medicaid funding for residential treatment of SUD in specialized behavioral health treatment facilities with 16 or more beds, but only if those Medicaid programs offered a full continuum of addiction care, deployed evidence-based assessments for connecting people to the appropriate level of care, and used nationally recognized SUD-specific program standards for residential treatment facilities.⁵

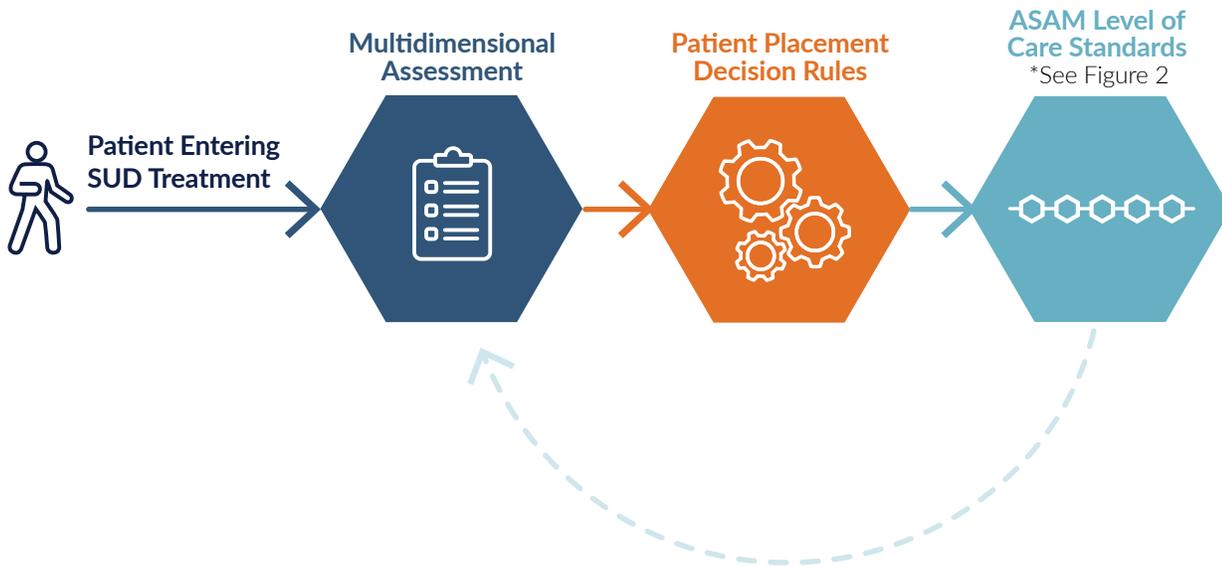
Beyond Medicaid coverage, a federal court ruled in 2019 that United Behavioral Health (UBH), one of the nation’s largest claims administrators for fully insured and self-funded group health plans regulated by the Employee Retirement Income Security Act of 1974 (ERISA), had failed to use “generally accepted standards of care” for coverage determinations, including *The ASAM Criteria*.⁶ The court concluded that UBH, influenced by its Finance Department’s focus on profitability, had used more restrictive standards in deciding when people would be authorized for receiving mental health and SUD treatment. The decision sparked the interest of federal and state policymakers and influenced states, such as California and Illinois, toward adopting legislation requiring state-regulated health plans to deploy specific criteria such as *The ASAM Criteria* when making authorization decisions for SUD treatment.

For a growing number of SUD treatment programs and payers, using evidence-based criteria for assessing patient needs and making (or authorizing) placement in appropriate care is standard practice, but others may still need significant support on reframing how they deliver and authorize SUD treatment (see callout to the left).

This toolkit describes a set of strategies for strengthening the use of *The ASAM Criteria* to improve addiction care, specialty addiction treatment systems, and their coverage. This toolkit focuses specifically on *The ASAM Criteria*, because it is the most widely used set of evidence-based criteria for patient placement and assessment and already serves a key role in the ongoing effort to improve SUD coverage and treatment in the United States. The toolkit is designed to help stakeholders establish a common framework and language across all payers, providers, and patients on describing addiction care and ensuring that care remains focused on the individualized needs of those living with SUD.

Throughout this toolkit, the strategies use the phrase “fully consistent” with *The ASAM Criteria*, reflecting the importance of not merely “aligning” a strategy with *The ASAM Criteria* or making it “consistent” with *The ASAM Criteria*. In the past, the use of weaker language has resulted in some payers and providers taking only selected parts of *The ASAM Criteria* or adding their own modifications that have undermined its effectiveness. As with other evidence-based standards and models for care, *The ASAM Criteria* should be implemented with fidelity, including the multidimensional assessment and program standards.

Components of *The ASAM Criteria*



Beyond *The ASAM Criteria*: Other Strategies for Expanding Access to Evidence-Based SUD Services

While this toolkit is focused on greater standardization of evidence-based addiction care delivery and coverage, more changes and strategies are required for responding to the SUD and overdose crisis. For example, stakeholders can pursue additional strategies for expanding access to:

- Pharmacotherapy for addiction treatment (e.g., methadone, buprenorphine, naltrexone, acamprosate and disulfiram) and opioid overdose (e.g., naloxone), including by explicitly prohibiting providers from refusing the treatment of people who have been prescribed medications for their SUD;
- Underutilized, evidence-based treatment modalities, such as contingency management, which is particularly important for individuals with stimulant use disorder;
- Evidence-based harm reduction initiatives, including syringe services programs and community-based naloxone programs; and
- Evidence-based recovery support services that include a robust role for supportive peers with lived experience.

More generally, along with expanding use of *The ASAM Criteria* and adopting strategies such as those outlined above, people with SUD and their families must be able to identify and receive high-quality SUD treatment.



BACKGROUND ON THE ASAM CRITERIA

The ASAM Criteria offers an evidence-based, standardized, and organized way for connecting people with SUD services based on their individual needs and circumstances. Several guiding principles that serve as the foundation of *The ASAM Criteria* include:

- **Consider the whole person.** *The ASAM Criteria* helps facilitate connections with individualized care through a holistic view of the individual. It recognizes that the causes and facilitators of addiction are multidimensional and considers an individual's risks, strengths, and resources when determining the best course of care.
- **Design treatment for the specific person.** *The ASAM Criteria* recognizes that prevention and treatment cannot be a "one size fits all" approach. Every individual's treatment plan is based on their unique needs and may vary in the type or intensity of services.
- **Individualized treatment timeline.** Some programs, states, and payers prescribe or design a benefit based on a predetermined length of time for treatment (for example, a "28-day program"). *The ASAM Criteria* considers treatment length in the context of an individual's progress and evolving needs.
- **Addiction is a chronic condition that should be treated with a chronic care model.** Individuals can and should move across different levels of care in a continuum based on their current needs. As they progress in treatment, an individual should move toward less intensive services; if they do not progress or even worsen, they may need more intensive services.



THE ASAM CRITERIA IN PRACTICE

Currently, *The ASAM Criteria* includes standards for a **multidimensional assessment** for determining an individual's specific needs and informing service planning and treatment across a **continuum of care**. The assessment reviews six major dimensions of an individual's circumstances and history (Figure 1), generating information that can be used for the determination of the appropriate level of care within the ASAM continuum of care. This continuum of care includes five broad levels ranging from early intervention to medically managed intensive inpatient services (Figure 2). Each level of care is characterized by the level of direct medical management that can be provided; the structure, safety and security required by the individuals receiving care; and the intensity of services that are delivered. *The ASAM Criteria* recognizes that many people with SUD have co-occurring mental health conditions, and identifies specific needs of specialized populations such as people with intellectual or developmental disabilities and adolescents. *The ASAM Criteria* also recognizes that nonmedical contributors such as social and economic factors influence the risk for developing SUD, treatment needs, and health outcomes of people with SUD.

The implementation of *The ASAM Criteria* in a manner that promotes high-quality, patient-centered care requires treating it as a comprehensive framework for organizing treatment and implementing all its elements together. For example, if a state requires SUD treatment programs to use the multidimensional assessment and placement criteria, but the state's Medicaid program or state-regulated plans do not cover the full ASAM continuum of care, it will remain challenging to ensure that individuals in that state receive the right level of care and services.

Figure 1. Six Dimensions of the ASAM Assessment

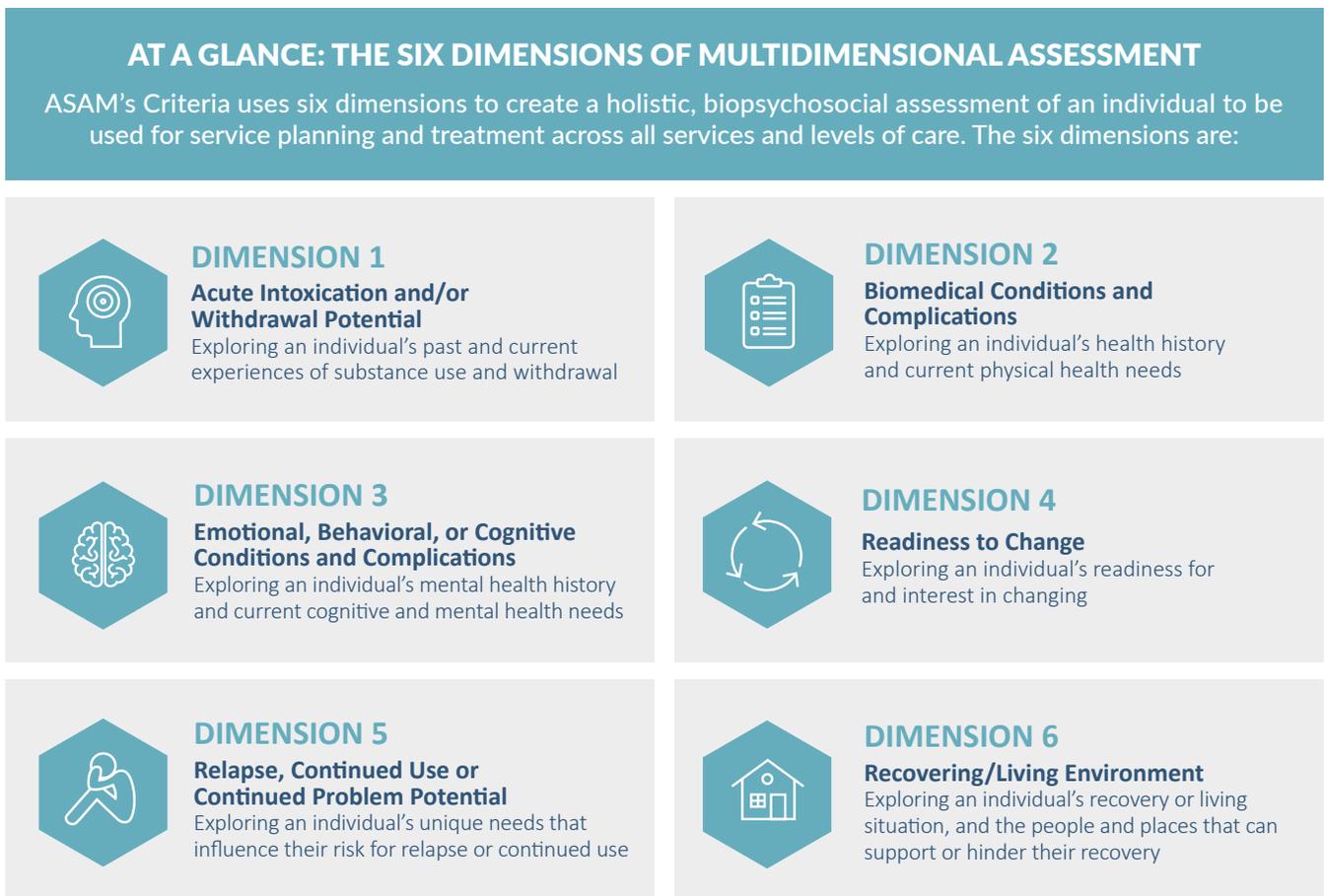


Figure 2. ASAM Continuum of Care

ASAM CONTINUUM OF CARE

▶ ADULT



- .5 Early Intervention
- 1 Outpatient Services
- 2.1 Intensive Outpatient Services
- 2.5 Partial Hospitalization Services
- 3.1 Clinically Managed Low-Intensity Residential Services

- 3.3 Clinically Managed Population-Specific High-Intensity Residential Services
- 3.5 Clinically Managed High-Intensity Residential Services
- 3.7 Medically Monitored Intensive Inpatient Services
- 4 Medically Managed Intensive Inpatient Services

▶ ADOLESCENT



- .5 Early Intervention
- 1 Outpatient Services
- 2.1 Intensive Outpatient Services
- 2.5 Partial Hospitalization Services

- 3.1 Clinically Managed Low-Intensity Residential Services
- 3.5 Clinically Managed Medium-Intensity Residential Services
- 3.7 Medically Monitored High-Intensity Inpatient Services
- 4 Medically Managed Intensive Inpatient Services

▶ CO-OCCURRING CAPABLE (COC) / CO-OCCURRING ENHANCED (COE)

▶ OPIOID TREATMENT SERVICES (OTS) / OPIOID TREATMENT PROGRAM (OTPs)

▶ BIOMEDICAL ENHANCED (BIO)

| LEVEL 1 - WM | LEVEL 2 - WM | LEVEL 3.2 - WM | LEVEL 3.7 - WM | LEVEL 4 - WM |
|--|--|--|---|---|
| Ambulatory Withdrawal Management without Extended On-Site Monitoring | Ambulatory Withdrawal Management without Extended On-Site Monitoring | Clinically Managed Residential Withdrawal Management | Medically Monitored Inpatient Withdrawal Management | Medically Managed Intensive Inpatient Withdrawal Management |

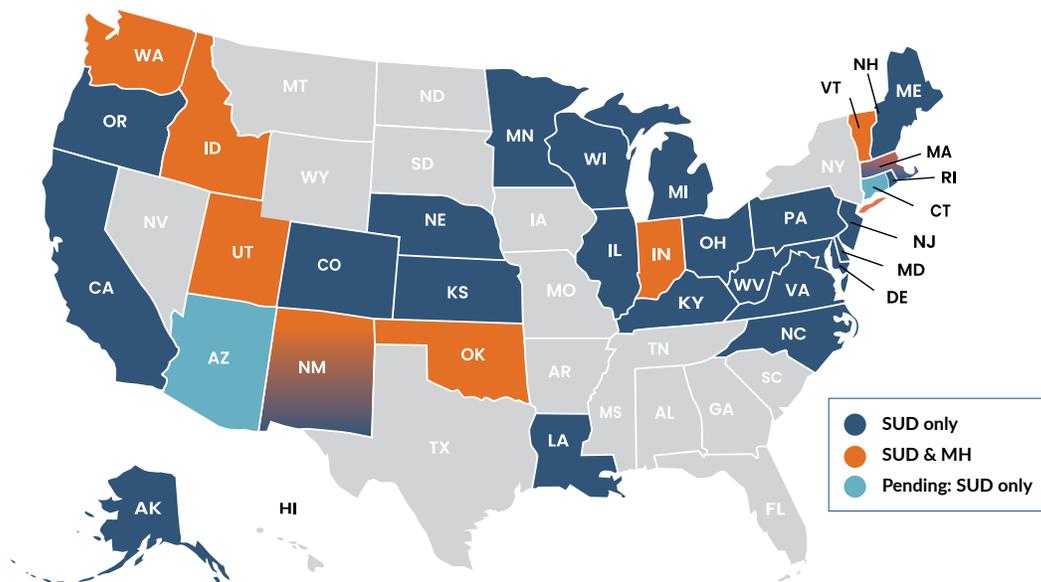


FACTORS DRIVING INCREASED FOCUS ON *THE ASAM CRITERIA*

While the scope and severity of the overdose epidemic are driving interest in expanding accurate, effective, and comprehensive use of evidence-based criteria, including *The ASAM Criteria*, recent policy and legal developments also have contributed toward this trend.

- **Affordable Care Act and expansion of SUD treatment.** Beginning in 2014, the Affordable Care Act (ACA) explicitly required individual and small group insurance plans, sold on and off the Marketplace, to cover SUD treatment.⁷ A significant number of low-income Americans, including those with SUD, also gained health insurance coverage through the ACA's Medicaid expansion. States were required to provide SUD services for individuals covered under Medicaid expansion as part of essential health benefits. In combination with rising overdose deaths, this expansion led many states toward revisiting and strengthening their coverage of SUD services across the continuum of care.
- **Medicaid 1115 waivers to expand coverage of residential SUD treatment.** In 2015, CMCS began approving waivers under Section 1115 of the Social Security Act to allow states to disregard the long-standing prohibition in Medicaid on covering residential and inpatient SUD treatment in "institutions for mental diseases" (IMDs).^{8,i} The waivers offer federal Medicaid matching funds for IMD services, but only if a state commits to ensuring that Medicaid beneficiaries have access to the full continuum of addiction care. States also are required to deploy an evidence-based, SUD-specific assessment, such as ASAM's multidimensional assessment, to determine the level of care that Medicaid beneficiaries require. As of June 2021, 32 states have waivers of the IMD exclusion for SUD services as part of Medicaid Section 1115 demonstrations (Figure 3).

Figure 3. States with Waivers of the IMD Exclusion
States with Approved or Pending Waivers of the IMD Exclusion, as of September 8, 2021



*FL, HI, MO, NY and SC have approved waivers for SUD features that do not include a waiver of the IMD exclusion; VT is requesting an additional exception to the federal IMD payment exclusion to cover mental health and SUD treatment provided in a family-focused residential treatment program.
 *MA and NM have approved SUD IMD waivers and pending MH IMD waivers.

Source: KFF. Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State. September 20, 2021. Available [here](#)

¹ Federal statute defines an IMD as a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Source: Legal Information Institute (July 12, 2006). 42 CFR 435.1009 - Institutionalized individuals. Cornell University Law School. Retrieved May 18, 2016, from <https://www.law.cornell.edu/cfr/text/42/435.1009>.

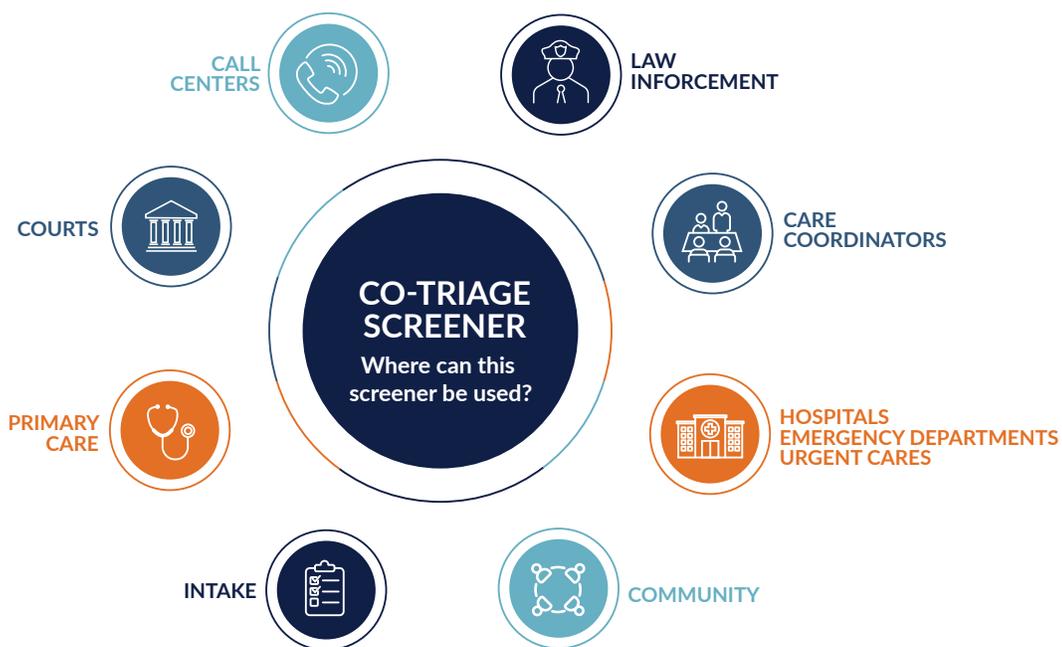
- 
- **Growth in federal funding for addiction care.** In recent years, the Substance Abuse and Mental Health Services Administration (SAMHSA) has disbursed billions of dollars in grants to states to expand access to SUD services. Through its largest opioid-focused grants, alone, the State Targeted Response to the Opioid Crisis (STR), State Opioid Response (SOR) and Tribal Opioid Response (TOR) grants, SAMHSA has released billions of additional dollars to states and tribes in the past four years.⁹ While these resources are not considered adequate to address fully the gaps in the country's response to addiction, they represent an influx of funds that have prompted and allowed a deeper review of addiction care delivery in many states.
 - **Continued growth in focus on parity.** The Mental Health Parity and Addiction Equity Act (MHPAEA) generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.¹⁰ In recent years, states have started increasing their oversight and enforcement of parity requirements, by enacting laws and using other tools, such as attestation requirements or market conduct exams.¹¹ Most recently, the Consolidated Appropriations Act, 2021 amended MHPAEA and now requires group health plans and issuers of individual qualified health plans (QHPs) subject to parity that impose nonquantitative treatment limitations to conduct a comparative analysis of each such limitation. The law also requires issuers and health plans to submit their comparative analysis upon request to their respective state or federal regulator.¹² In some instances, regulators' reviews rely on *The ASAM Criteria* as part of assessing whether SUD services were provided in accordance with parity requirements.¹³
 - **Legal developments in the Wit case.** In 2019, a federal court in California ruled in *Wit v. United Behavioral Health (UBH)*.ⁱⁱ UBH, one of the nation's largest claims administrators for fully insured and self-insured group health plans subject to ERISA, was required to make coverage determinations consistent with "generally accepted standards of care"—essentially standards that are evidence-based and informed by medical experts. The decision faulted UBH for, among other things, failing to make medical necessity determinations using clinical guidelines that are consistent with generally accepted medical standards, such as *The ASAM Criteria* for SUD treatment.¹⁴

ⁱⁱ UBH is appealing the 2019 decision to the U.S. Court of Appeals for the 9th Circuit.

Several practical tools are available, or will be available soon, to make it easier to use *The ASAM Criteria*.

- **Paper-Based ASAM Multidimensional Intake Assessment:** ASAM is partnering with UCLA to develop a free, multidimensional intake assessment offering a publicly available, standardized paper questionnaire with guidance on determining severity ratings in each dimension and the appropriate level of care. This tool is expected to be released in late 2021.
- **ASAM CONTINUUM™:** A computer-guided, structured interview tool allowing clinicians to conduct a comprehensive multidimensional assessment. The ASAM CONTINUUM takes approximately 60 minutes for completion on average and generates a brief report that organizes treatment priorities and recommends the least intensive but safe, efficient, and effective level of care for the assessed individual. This tool can work freestanding or can be integrated into a provider’s electronic health record.
- **ASAM CO-Triage®:** An abbreviated set of questions that takes about six minutes for completion and provides a provisional recommendation on level of care. It also identifies any issues that require immediate attention, including withdrawal. Once individuals arrive at the setting for which they were provisionally referred (Figure 4), they should receive a comprehensive multidimensional assessment. Like the ASAM CONTINUUM, CO-Triage can work as a freestanding tool or can be integrated into an electronic health record.
- **ASAM Level of Care™:** Through a partnership with CARF, the ASAM Level of Care Certification identifies a SUD treatment program’s capacity to deliver a specific level of care in accordance with ASAM standards for a three-year period. As of 2020, the level of care certification is available for adult residential treatment programs that provide levels of care 3.1, 3.5 and/or 3.7, and will expand over time to cover other levels of care and adolescent programs.

Figure 4. CO-Triage Assessment



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- **ASAM Provider and Payer Trainings:** ASAM offers live and online trainings on *The ASAM Criteria* that are tailored for different stakeholders using *The ASAM Criteria* (e.g., clinicians and payers). For example, ASAM conducts workshops for providers on conducting multidimensional patient assessments and determining appropriate levels of care. ASAM also offers a utilization management course for payers, helping them conduct objective clinical case reviews, evaluate treatment plans, and determine the appropriate level of care in accordance with *The ASAM Criteria*.¹⁵
 - **The ASAM Criteria Powered by InterQual®:** ASAM and Change Healthcare are partnering to incorporate *The ASAM Criteria* into the InterQual Medical Review Service technology, a utilization management product created by Change Healthcare. This tool is expected to be available soon and endorsed by ASAM as fully consistent with *The ASAM Criteria*.¹⁶ *The ASAM Criteria* will be a part of utilization management workflows for payers and providers. Change Healthcare and ASAM are also collaborating on the development of interrater reliability testing for ensuring that decisions related to *The ASAM Criteria* are consistent across users of the tool.

STRATEGIES AND PATHWAYS



STRATEGIES AND PATHWAYS

In this section, a series of potential actions (or “pathways”) are outlined for standardizing and strengthening a state’s specialty addiction treatment system using *The ASAM Criteria*. They generally are organized around the following strategies:

-  **Expand provider use of *The ASAM Criteria* throughout patient placement and care delivery**, including for reassessments and transfer decisions.
-  **Leverage *The ASAM Criteria* with payers and SUD providers for ensuring affordable access to the full continuum of care for people with SUD** and co-occurring conditions to ensure they can receive services at the appropriate level of care.
-  **Ensure accountability for payer use of *The ASAM Criteria* in coverage decisions** to ensure that payers integrate *The ASAM Criteria* into key medical necessity and utilization management decisions and that payers deploy it with fidelity.
-  **Support understanding of *The ASAM Criteria* among those who provide, cover, or use SUD services**, including clinicians and payers, so that they feel confident using *The ASAM Criteria* and view it as an important tool in their work, as well as people with SUD and their families so that they understand why it matters whether care matches individual circumstances.

For each strategy, the toolkit provides:

- An overview of the strategy;
- Key issues the strategy addresses;
- Potential pathways for implementing the strategy, including use of implementation tools;
- Implementation vehicles and state examples; and
- Model language (Appendix).

Although this toolkit offers pathways for how a state might want to implement each strategy, in practice, there are a range of ways that a state could do so, including:

- **State legislation and regulatory changes**, including with respect to Medicaid; other federal, state, or local public programs for SUD services, and commercial insurance products that are subject to state regulation (i.e., “state-regulated plans”).
- **Oversight and enforcement of state and federal laws and regulations**, including with respect to MHPAEA. States have enforcement responsibility for MHPAEA for individual plans and small and large group plans sold to employers, as well as any state-specific laws and regulations that govern the medical necessity standards for state-regulated plans.
- **SUD treatment program licensure and certification standards**, which offer a comprehensive way for reinforcing or changing the way that SUD treatment programs operate. For example, states such as Virginia have integrated *The ASAM Criteria* into the licensing regulations for SUD treatment programs.ⁱⁱⁱ
- **Medicaid and other federal and state SUD treatment program rules, contracts and funding standards**. States can use their Medicaid regulations, clinical guidelines, and managed care contracts (if applicable) for integrating *The ASAM Criteria* into the way that care is delivered to Medicaid beneficiaries. They also can attach incentives and requirements to dollars they distribute to SUD treatment programs through other means, such as grant-funded programs, for encouraging use of *The ASAM Criteria*.

ⁱⁱⁱIn accordance with state legislation, Virginia utilized emergency authority to develop licensing regulations that align with *The ASAM Criteria*. The emergency licensing regulations went into effect on July 1, 2021, for a period of at least 18 months while the state develops permanent regulations. Source: DBHDS. Aligning the Licensing Regulations with the ASAM Criteria. April 19, 2021. Available [here](#).

EXPAND PROVIDER USE OF *THE ASAM CRITERIA* THROUGHOUT PATIENT PLACEMENT AND CARE DELIVERY

OVERVIEW

A key goal of this toolkit is ensuring that SUD treatment begins (or resumes) with a thorough assessment of what an individual needs; regularly reviews the individual's treatment needs; and systematically connects individuals with the appropriate level of care. While this may be standard operating practice with respect to other chronic medical conditions, people with SUD often find themselves enrolled in treatment programs through a haphazard process. Their treatment may depend on whom they first reached out to for help, rather than what the evidence suggests will be most effective. In light of this, the first set of strategies addresses ways for ensuring that *The ASAM Criteria* is used throughout patient placement and care.

KEY ISSUES TO ADDRESS

- **Use of *The ASAM Criteria* only for initial assessment**, rather than throughout SUD treatment as an individual's needs evolve.
- **Use of an assessment tool** that is not truly individualized or that fails to reflect the full array of biological, social, and psychological factors that affect treatment needs.
- **Need to accommodate variation in how individuals enter the SUD system of care**, such as via the emergency department (ED) where it may not be realistic to conduct a comprehensive multidimensional assessment for all patients.

POTENTIAL PATHWAYS

- **Require SUD treatment program utilization of *The ASAM Criteria*, throughout treatment, including for initial assessment, for level of care determinations and reassessments for guiding continued stay and transfer determinations.** It is considered a best practice to use the full ASAM multi-dimensional assessment when an individual first presents in need of services, and also to re-assess the person periodically to determine whether they require continued or modified care. To reduce the time required for re-assessment, clinicians may be able to “carry forward” static information gathered in the initial assessment, such as family history.
- **Require (or incentivize) SUD program utilization of a state-specified comprehensive assessment tool that is fully consistent with *The ASAM Criteria* throughout treatment, including for initial assessment for level of care determinations and reassessments for guiding continued stay and transfer determinations.** SUD treatment programs can be required (or incentivized) to use specific comprehensive assessment tools to determine level of care. Especially in states with Medicaid 1115 IMD waivers, it is standard practice to require Medicaid managed care plans and SUD treatment programs to use an evidence-based, SUD-specific assessment, as 24 states of the states with IMD waivers now have done.¹⁷ Without a requirement that SUD treatment programs use a specified tool that is fully consistent with *The ASAM Criteria*, however, there is a significant risk of “homegrown” assessments that miss critical questions and considerations.



Arizona's Support for an Evidence-Based Assessment Tool that is Fully Consistent with *The ASAM Criteria*

Arizona is phasing in a requirement that Medicaid plans and SUD treatment programs use *The ASAM Criteria* for assessment, service planning and level of care planning. Since it is a well-established tool and endorsed by ASAM, Arizona is paying an enhanced reimbursement rate for assessments conducted using ASAM CONTINUUM.

Using grant funding, Arizona's Medicaid agency has established an online platform that all SUD treatment programs in the state can use to access ASAM CONTINUUM. They can do so from their own electronic health record, removing a key barrier to provider use of the tool. The state's behavioral health administrating entities also identified "champion providers" to pilot ASAM CONTINUUM.

Source: AHCCS. Contract/RFP YH19-0001. October 1, 2019. Available [here](#). AHCCS. American Society of Addiction Medicine. (ASAM) CONTINUUM® Tool, July 23, 2019. Available [here](#).

- **Encourage other providers assessing patients with SUD to use a state-specified triage (i.e., provisional referral) or comprehensive assessment tool that is fully consistent with *The ASAM Criteria*.** In recent years, the federal government and states have been encouraging primary care providers and other nonspecialists to play a greater role in identifying and providing initial treatment to people with SUD, reflecting the high need for more treatment capacity in the United States. For those nonspecialist providers with appropriate training on *The ASAM Criteria*, offering them support and requirements (or incentives) for using a multidimensional assessment that is fully consistent with *The ASAM Criteria* is important. For those nonspecialist providers who do not yet have the time, training, or expertise for routinely conducting comprehensive assessments, a provisional referral tool may be a more realistic option. New York, for example, requires SUD treatment programs, Medicaid managed care plans, and other referral sources to use Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) 3.0, a web-based tool, to identify and refer individuals to a level of care.¹⁸ The LOCADTR tool is not intended to replace a comprehensive, multidimensional assessment, which is critical for treatment planning.
- **Support provider access to *The ASAM Criteria* and state-specified triage and comprehensive assessment tools that are fully consistent with *The ASAM Criteria*.** While tools such as the paper-based ASAM multi-dimensional intake assessment will be available to providers without charge, providers must pay a fee and then secure an ongoing license to use more sophisticated and comprehensive clinical decision support tools. These payments support ASAM software maintenance and customer support, but also can be a barrier to use. States and localities can cover the cost of using effective tools for a period of time or even on an ongoing basis. Along with supporting access to the tools themselves, states (and localities) may want to consider offering high quality training and support on how to use the tools, including ways to integrate them into workflow and electronic health records. While these types of decision support tools come with more upfront costs, they may offer advantages to states in that they allow clinicians with less experience and training to complete the comprehensive assessment with improved inter-rater reliability, and they support more standardized data collection.

IMPLEMENTATION VEHICLES AND STATE EXAMPLES

|  Pathway |  Implementation Vehicle(s) |  Select State Examples |
|--|---|---|
| <p>Require SUD treatment program utilization of <i>The ASAM Criteria</i> throughout treatment, including for initial assessment for level of care determinations and reassessments for guiding continued stay and transfer determinations</p> | <ul style="list-style-type: none"> • SUD program certification and licensure regulations • Medicaid policy documents (e.g., managed care contracts, provider manuals) | <p>Illinois requires all licensed SUD treatment programs to conduct an assessment on each patient prior to providing care (except with respect to preventive care). Assessments must include an evaluation of the patient under the six dimensions identified by ASAM, among other requirements.¹⁹</p> |
| <p>Require (or incentivize) SUD treatment program utilization of a state-specified comprehensive assessment tool that is fully consistent with <i>The ASAM Criteria</i> throughout treatment, including for initial assessment for level of care determinations and reassessments for guiding continued stay and transfer determinations</p> | <ul style="list-style-type: none"> • Medicaid policy documents (e.g., managed care contracts, provider manuals) • SUD treatment program certification and licensure regulations | <p><i>See page 22 for callout on Arizona.</i></p> |
| <p>Encourage other providers assessing patients with SUD to use a state-specified triage (i.e., provisional referral) or comprehensive assessment tool that is fully consistent with <i>The ASAM Criteria</i></p> | <p>Medicaid policy documents (e.g., managed care contracts, provider manuals)</p> | <p>Los Angeles recently required all of its SUD contracted treatment network provider sites that serve Medicaid beneficiaries and do not offer the full continuum of care to use CO-Triage or the Youth Engagement Screener to establish a provisional level of care recommendation.²⁰</p> |
| <p>Support provider access to <i>The ASAM Criteria</i> and state-specified triage (i.e., provisional referral) and comprehensive assessment tools that are fully consistent with <i>The ASAM Criteria</i></p> | <ul style="list-style-type: none"> • Funding • Webinars • Guidance • FAQs | <p>In 2017, Los Angeles signed a ten-year contract to cover the use of CO-Triage and ASAM CONTINUUM for 1,500 SUD providers who treat Medicaid beneficiaries.²¹ Beneficiaries first receive a brief triage assessment using CO-Triage to establish a provisional level of care recommendation. SUD treatment providers are encouraged to use ASAM CONTINUUM to confirm placement decisions, continued stay and transfer decisions.²² Los Angeles held webinars and developed materials to support providers during implementation.²³</p> |



LEVERAGE THE ASAM CRITERIA WITH PAYERS AND SUD PROVIDERS FOR ENSURING AFFORDABLE ACCESS TO THE FULL CONTINUUM OF CARE FOR PEOPLE WITH SUD

OVERVIEW

For *The ASAM Criteria* to work as intended, people with SUD should have access to the full continuum of care as defined in *The ASAM Criteria*. Because addiction is a chronic condition, individuals with SUD may move into and out of treatment and recovery in a nonlinear fashion. They may need a less intensive level of care as they progress in treatment, or their progress may stall and require more intensive services. When individuals cannot enter or transition to the appropriate level of care consistent with their evolving needs, they face higher risk of relapse and worse behavioral and physical health outcomes.^{23,24}

KEY ISSUES TO ADDRESS

- **Limited coverage of the full continuum of care** due to the lack of enforcement of MHPAEA and a comprehensive mandate across payers to cover the full continuum of SUD treatment. MHPAEA requires large group and small group, individual market, and self-insured plans that cover at least one mental health and SUD benefit to cover a comprehensive array of mental health and SUD benefits (though there is no explicit requirement to cover all levels of care along *The ASAM Criteria*). State insurance regulators are required to enforce MHPAEA as covered in the next section of the toolkit in more detail. Most individual and small group plans are obligated to cover some MH/SUD services under the ACA, but states have broad discretion to determine the extent of any such coverage and many have not adopted strict standards.²⁶ In Medicaid, coverage of SUD treatment is more common and expanding relatively rapidly even though coverage of most SUD treatment services remains optional for many key groups in Medicaid.
- **Gaps in capacity at certain levels along the continuum of care defined in *The ASAM Criteria***, such as withdrawal management services, residential treatment for individuals with intellectual and developmental disabilities or other cognitive impairments, and services for other specialized populations such as individuals with co-morbid mental illness and adolescents. In many parts of the country, such services routinely are difficult to secure due to a lack of available providers even if they are covered by insurance. In other instances, providers may be available but not included in a plan's network or unwilling to serve patients with relatively complex conditions or low-paying insurance.
- **A lack of readily available and/or accurate information on the level of care offered by SUD providers**, making it challenging to identify a SUD provider that offers the level of care that an individual requires. SUD treatment providers may indicate that they offer treatment consistent with ASAM level of care standards but may not fully understand or implement the standards.

POTENTIAL PATHWAYS

- **Require commercial payer coverage for all levels of care along the continuum of care defined in *The ASAM Criteria***, including withdrawal management levels and enhanced services (i.e., co-occurring enhanced and biomedical enhanced services) across early intervention, outpatient, residential and inpatient settings for adults and adolescents, as well as special populations. A number of states, such as California, Delaware, Illinois and Maryland, have adopted sweeping legislation requiring state-regulated plans to provide access to SUD services along the full continuum of care, often as part of broader legislation for individuals with mental health conditions, SUD and co-occurring conditions.
- **Provide coverage for all levels of care along the continuum of care defined in *The ASAM Criteria* in the Medicaid program**, including withdrawal management levels and enhanced services (i.e., co-occurring enhanced and biomedical enhanced services). States with Medicaid 1115 IMD waivers are required to cover the full continuum of care in Medicaid as a condition of securing their waivers, and many states without such waivers have opted to expand SUD treatment as well. Along with offering care to individual beneficiaries, such policies may encourage Medicaid managed care plans to assist in addressing capacity gaps, especially if they otherwise must provide access to more intensive (and more costly) levels of care. In New Hampshire, for example, the state's Medicaid managed care contract requires plans to pay for a more intensive level of care for pregnant women if the plans cannot find them care at the recommended level within 48 hours.²⁷



California Legislation Strengthening Access to Care Across the Full Continuum

California enacted legislation in 2020 that, among other things, requires health care service plans to cover intermediate services for SUD and mental health services. These include but are not limited to residential treatment, partial hospitalization and intensive outpatient services.

Source: S.B. 855.151. 2018-2020 Reg. Sess. (Cal. 2020). Available [here](#)



Connecting Implementation of *The ASAM Criteria* to Quality & Value

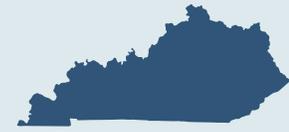
The quality of SUD treatment that is provided is as important as ensuring that people receive the appropriate type of care. States can also link their implementation of *The ASAM Criteria* with their quality and value-based payment efforts. Quality and outcome measures for SUD treatment are evolving, though there is emerging consensus among individuals in treatment and recovery for SUD that critical outcome measures include staying alive, improving quality of life, and mental health. As a first step, states can monitor and reward adherence to evidence-based practices including SUD provider fidelity to *The ASAM Criteria*, specifically regarding the use of assessments, which has been shown to improve retention in treatment. States can also emphasize and reward medication for addiction treatment which is part of the recommended standard for addiction treatment. More broadly, efforts such as ATLAS (see Box on next page) are designed to help people with SUD identify both those providers that offer the right level of care for their circumstances and the quality of care that they offer.

Source: Community Catalyst. Peers Speak Out: Improving SUD Treatment Outcomes During COVID-19. December 3, 2020. Available [here](#)

- **Require (or incentivize) SUD treatment program obtainment of ASAM Level of Care Certification through CARF.** States can require or incentivize SUD treatment programs to obtain a Level of Care Certification from CARF. (As of July 2021, CARF certification is available only for adult residential treatment, but certification for additional levels of care is expected to be available in the future.) States also may be able to streamline selected aspects of licensure and inspection processes for programs with ASAM Level of Care Certification. For example, California will deem facilities that receive such certification as automatically in compliance with key state requirements for licensed SUD facilities, creating a powerful

incentive to pursue it.²⁸ Note, however, any such deeming initiative will prove controversial and potentially ineffective if deeming is used to eliminate important requirements that are not fully captured by the certification, such as the right of consumers to challenge a certification or licensure finding.

- **Make licensure requirements for SUD treatment programs fully consistent with the ASAM levels of care.** States can align their licensure requirements for SUD treatment programs with ASAM level of care standards. While doing so can help ensure that SUD treatment programs are using *The ASAM Criteria*, it also requires a state's licensing agency to learn about and train staff on how to assess compliance with ASAM standards, including potentially through a field survey and inspections. For example, Virginia has just updated its licensure requirements for SUD services to align with ASAM's level of care standards, and is training its licensure and state staff on how to assess a SUD treatment program for compliance with those licensure standards effective July 1, 2021.²⁹



Kentucky's Phase-in of ASAM Level of Care Certification

Kentucky required its adult residential SUD treatment providers to obtain ASAM Level of Care Certification from CARF by July 1, 2021, as a condition of Medicaid reimbursement. To ease implementation, Kentucky offered qualified providers an enhanced reimbursement rate for provisional certification during a transitional period.

Source: 907 Ky. Admin. Regs. 15:022. Available [here](#). Kentucky Department for Medicaid Services. SUD 1115 Demonstration Update. Available [here](#)

- **Make information on the level(s) of care offered by SUD treatment programs publicly available.** A state can maintain and share a list of SUD treatment programs throughout the state by level of care so that clinicians, health plans, patients and families understand the type of care that a provider offers. Los Angeles, for example, created and maintains the Service and Bed Availability Tool, which allows individuals seeking treatment or their loved ones or providers to see available SUD services by level of care; data is updated at least daily.³⁰ A system for determining and tracking the level of care offered by SUD treatment programs also makes it easier for states to assess, monitor and address gaps in their continuum of care.^{iv}
- **Ensure sufficiency of SUD provider networks in state-regulated insurer and Medicaid networks,** at all levels of care and for populations with specialized needs, including adolescents, individuals with co-occurring mental health and SUD needs, and individuals with cognitive disorders. If the issue is that providers are available but are not included in a plan's network, states can establish network adequacy standards to address the gap. States can establish quantitative standards for SUD services for state-regulated plans, including geographic distance, appointment wait time and provider-enrollee ratios. For example, states such as West Virginia opted to require Medicaid managed care plans to contract with all residential SUD treatment facilities in the state when it appeared that Medicaid beneficiaries were not able to secure the necessary care.³¹ In addition, states can require state-regulated payers to allow members to see SUD providers who are out of network at no additional cost compared with in-network coverage if there is an insufficient number of in-network providers at that level of care.



Providing People with SUD Information on How to Find Appropriate, High Quality Care: Shatterproof's ATLAS Project

In 2020, Shatterproof launched the Addiction Treatment Locator, Assessment, and Standards Platform (ATLAS). ATLAS is a web-based tool designed to help individuals and families find high-quality addiction treatment. ASAM partnered with Shatterproof and OpenBeds on the development of a self-administered assessment that can help guide an ATLAS search based on an individual's needs and SUD severity. ATLAS tracks facilities' use of best practices measured against enumerated standards established by national and other clinical experts. Shatterproof intends to incorporate information about the ASAM Level of Care Certification program into ATLAS, allowing individuals to search for programs that have been certified to deliver specific ASAM level(s) of care.

ATLAS is currently available in Delaware, Louisiana, Massachusetts, New York, North Carolina and West Virginia. ATLAS is expanding to Florida, New Jersey, Oklahoma and Pennsylvania by spring 2022, as well as California by winter 2022.

Source: Shatterproof. Shatterproof Expands to The State of California with Free Tool to Help Individuals and Families Find Trusted and High-Quality Addiction Treatment. July 21, 2021. Available [here](#)

^{iv} Permission from ASAM may be required (at no cost to public entities) if ASAM trademarked name(s) are referenced, as well as a disclaimer clarifying lack of endorsement by, or affiliation with, ASAM.

IMPLEMENTATION VEHICLES AND STATE EXAMPLES

States can use a variety of vehicles to implement the pathways in this strategy, ranging from legislation to SUD treatment program certification and licensure regulations, Medicaid policies, and grant funding.

|  Pathway |  Implementation Vehicle(s) |  Select State Examples |
|--|--|--|
| Require commercial payer coverage for all levels of care along the continuum of care defined in <i>The ASAM Criteria</i> | Legislation | <i>See California callout box on page 25.</i> |
| Provide coverage for all levels of care along the continuum of care defined in <i>The ASAM Criteria</i> in the Medicaid program | <ul style="list-style-type: none"> • Medicaid state plan • Medicaid waiver | <ul style="list-style-type: none"> • West Virginia's 1115 waiver expanded Medicaid's SUD offerings to cover all levels of care on the ASAM continuum.³² • Kentucky covers all levels of withdrawal management services in its 1115 SUD Demonstration.³³ |
| Require (or incentivize) SUD treatment program obtainment of ASAM Level of Care Certification through CARF | <ul style="list-style-type: none"> • SUD treatment program certification and licensure regulations • Medicaid provider bulletins • Medicaid State Plan Amendments • Federal Grants • State funding, including from possible opioid litigation settlement proceeds | <i>See Kentucky callout box on page 26.</i> |
| Make licensure requirements for SUD treatment programs fully consistent with the ASAM levels of care | <ul style="list-style-type: none"> • SUD treatment program certification and licensure regulations • Medicaid provider bulletins and provider manuals | Virginia aligned its licensure standards for SUD treatment providers with ASAM level of care standards, including admission and transfer criteria, effective July 1, 2021. The state created an expedited review process to transition treatment providers who need to be relicensed based on ASAM level of care. ³⁴ |
| Make information on the level(s) of care offered by SUD treatment programs publicly available | <ul style="list-style-type: none"> • Web portals | Los Angeles, for example, created and maintains the Service and Bed Availability Tool, which allows individuals seeking treatment or their loved ones or providers to see available SUD services by ASAM level of care; data is updated at least daily. ³⁵ |
| Ensure sufficiency of SUD provider networks across state-regulated insurer and Medicaid networks | <ul style="list-style-type: none"> • Medicaid managed care contracts • Network adequacy requirements for state-regulated insurers | <ul style="list-style-type: none"> • Sixteen states have adopted specific standards for SUD providers for their commercial insurance products.³⁶ • Ohio requires its Medicaid managed care plans to contract with a specific number of providers who can prescribe medications for addiction treatment by county, as well as any willing opioid treatment program.³⁷ |



ENSURE ACCOUNTABILITY FOR PAYER USE OF *THE ASAM CRITERIA* IN COVERAGE DECISIONS

OVERVIEW

Once an individual has been assessed and referred to the appropriate level of care, their payer—whether Medicaid or commercial—plays a critical role in ensuring that they obtain the care they need. If they elect or are otherwise required to cover MH/SUD treatment services, most payers are required by MHPAEA to cover them to the same extent they cover medical and surgical benefits and to demonstrate their compliance by conducting detailed comparative analyses. However, payers historically have been able to make coverage and appeals decisions using their own definitions of medical necessity. This is changing with state laws and court decisions such as the Wit case increasingly requiring payers to rely on generally accepted standards of care, including *The ASAM Criteria* standards, to make medical necessity determinations.

These developments are critical because, absent law, regulation or court decisions, payers may develop and apply their own guidelines for determining medical necessity that do not fully reflect *national evidence-based standards for treatment*. As the Wit case illustrates, there is significant concern that payers have incorporated financial considerations into their development of clinical guidelines for people with SUD and/or MH conditions in an inappropriate way that may lead to coverage determinations that are not fully aligned with evidence-based care. In these situations, patients seeking SUD treatment may be denied services altogether, or approved at a level of care that does not meet their individual needs, increasing the chances of relapse and poor outcomes.

Another important development is the increasing overlap between parent insurers that serve both Medicaid (through managed care and other contracts) and commercial populations (through QHPs and other products), which opens the door to regulator collaboration to set consistent standards across Medicaid and commercial coverage.[†]

KEY ISSUES TO ADDRESS

- **Use of medical necessity, utilization management strategies, and appeals processes concerning service intensity, level of care determination, continued stay or transfer** that are inconsistent with *The ASAM Criteria*.
- **Inconsistent coverage determinations and authorization requirements across and within payers**, which can make it more difficult for SUD providers and individuals requiring SUD services to obtain approval for necessary services, as well as increase paperwork and time diverted from treatment to utilization review.
- **Need for consistent oversight of payers** to help ensure that there is a commonly accepted practical understanding of parity requirements, that plans are complying with parity requirements, including comparative analyses, and any state-specific legislation on medical necessity standards and bans or limitations on certain utilization management techniques.

[†] Insurers such as Centene and Molina, which primarily serve Medicaid populations, are expanding into commercial coverage, and the national commercial insurers are moving into the Medicaid managed care space.

POTENTIAL PATHWAYS

- **Require payer utilization of policies and procedures that are fully consistent with *The ASAM Criteria* for medical necessity determinations, utilization management, and appeals decisions concerning service type, service intensity, level of care determination, continued stay and transfer for SUD.** States can establish requirements for regulated health insurers, including Medicaid and commercial plans, to apply *The ASAM Criteria* when making medical necessity determinations, operating their utilization management systems and reviewing appeals for SUD treatment services. States with Medicaid managed care can require Medicaid managed care plans and commercial plans to meet the same standards, especially in states where the two types of entities are part of the same parent insurer. As part of such requirements, a state could, for example, establish a requirement for payers to:
 - **Submit medical necessity, utilization management policies, appeals policies and policies for compliance MHPAEA** for SUD services with the relevant state agency for review as written and in operation.^{vi} Even when payers are required to use *The ASAM Criteria* to make coverage and appeals decisions, payers may vary in how they apply *The ASAM Criteria* to make level of care authorization decisions.
 - **Engage and train appropriate utilization management staff** to ensure that plan reviewers and consultants tasked with reviewing requests for authorization for SUD treatment have the licensure, expertise and training necessary to determine whether the patient meets *The ASAM Criteria* for the level of care requested by the provider.
 - **Participate in interrater reliability testing of the application of medical necessity criteria** to ensure that level of care authorization decisions are consistent with federal and state law, as well as with a payer's stated medical necessity standard. For example, a state could provide each payer with a comprehensive set of scenarios of individuals requesting authorization for services based on actual case decisions, including those where a higher level of care was denied with approval for a lower level of care, and require each payer to make a determination. The state could also require each plan to conduct interrater reliability testing among internal staff involved in utilization management decisions using independently developed testing approved by the state. This process would help the state identify inconsistent application of *The ASAM Criteria* and gaps in understanding across payers. For payers that do not meet expectations, the state could require corrective action plans, including changes to medical necessity standards and utilization management strategies, offer further training and, if problems persist, impose fiscal penalties.



Maryland's Use of *The ASAM Criteria* for Coverage Decisions

Maryland amended its insurance law to require the use of the most recent edition of *The ASAM Criteria* for all medical necessity and utilization management determinations for SUD treatment benefits provided by insurers, nonprofit health service plans or health maintenance organizations operating in the state. Maryland also requires Medicaid and SAMHSA-funded programs to use *The ASAM Criteria* for coverage decisions.

Source: House Bill 599, Chapter 358, Acts of 2019—Utilization Review Criteria of SUD Benefits. Available [here](#). Maryland SAMHSA Block Grant Application. 2018-2019. Available [here](#)

^{vi} MHPAEA requires payers to share medical necessity criteria for behavioral health benefits with any member, potential member or contracting provider, upon request. Source: Legal Action Center. Spotlight on Medical Necessity Criteria for Substance Use Disorders, December 2020. Available [here](#).

- **Monitor payers' usage of *The ASAM Criteria* for coverage decisions and troubleshoot issues.** For states that institute use of *The ASAM Criteria*, state oversight is critical for ensuring that *The ASAM Criteria* is used as intended. States can require payers to self-assess and report on their use of *The ASAM Criteria* in order to encourage them to proactively find and correct violations. The new federal requirement for comparative analysis by payers, including self-insured plans, bolsters the value of self-assessment, since plans are required to conduct such an analysis for medical necessity criteria—to compare standards for SUD services to other medical services—since medical necessity criteria is a nonquantitative treatment limitation.^{vii} For their commercial plans, states can also examine whether a payer uses *The ASAM Criteria* when making medical necessity and utilization management decisions in market conduct exams. Finally, states can require corrective action plans for any violations they find when reviewing a plan's filings or completing a market conduct exam, with increasing penalties for repeat violations.
- **Promote collaboration across state Medicaid officials and insurance regulators** to ensure, wherever possible, that best practices in the Medicaid market are extended to other payer markets and vice versa, especially in cases where the parent insurer is operating in multiple market segments.



New Hampshire's Attestation Requirements

New Hampshire requires health plans to file an annual attestation that they comply with the state's requirement to use *The ASAM Criteria* for determining medical necessity and establishing utilization management standards for SUD treatment services.

Source: N.H. REV. STAT. ANN. § 420-J:16 (2016)

^{vii}As part of these reports or separately, states can require payers to report on a number of metrics, including service approval rate, discrepancy in level of care determination between plan and provider, percentage of placement at each level of care, denial rate, and appeal rate. See Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA), available [here](#), and FAQs About Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45, available [here](#), for additional information.

IMPLEMENTATION VEHICLES AND STATE EXAMPLES

States can adopt legislation to require all regulated payers to use *The ASAM Criteria* when making medical necessity determinations and deploying utilization management strategies, and reinforce the directive by regulating and monitoring insurer practices.

|  Pathway |  Implementation Vehicle(s) |  Select State Examples |
|---|---|---|
| Require payer utilization of policies and procedures that are fully consistent with <i>The ASAM Criteria</i> for medical necessity determinations, utilization management, and appeals decisions | | |
| Require payer utilization of policies and procedures that are fully consistent with <i>The ASAM Criteria</i> for medical necessity determinations, utilization management, and appeals decisions concerning service type, service intensity, level of care determination, continued stay and transfer for SUD. | Legislation | <i>See Maryland callout box on page 30.</i> |
| <ul style="list-style-type: none"> - Require payer submittal of medical necessity, utilization management policies, appeals policies and policies for compliance MHPAEA to the state for review | <ul style="list-style-type: none"> • Legislation • State insurance regulations • State-regulated insurer contracts | North Carolina requires Medicaid managed care plans to submit their utilization management policies for all services, including SUD, to the state. ³⁸ |
| <ul style="list-style-type: none"> - Require payer engagement and training of appropriate utilization management staff | | Virginia requires Medicaid managed care plans to utilize a licensed practitioner with clinical experience in treatment of SUD to perform independent assessments of requests for intensive outpatient, partial hospitalization, residential treatment services and inpatient services. ³⁹ |
| <ul style="list-style-type: none"> - Require plan participation in interrater reliability testing of the application of medical necessity criteria using independently developed testing approved by the state | | California requires health care service plans to conduct interrater reliability testing to ensure consistency in utilization review decision-making, run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process, and meet certain thresholds. ⁴⁰ |
| Monitor payers' usage of <i>The ASAM Criteria</i> for coverage decisions and troubleshoot issues | | |
| Require payer self-assessment and reporting on their compliance for using <i>The ASAM Criteria</i> for coverage decisions | Insurance regulations | New York requires that insurers self-assess and report on their compliance with mental health parity prospectively, which was bolstered by the new federal requirements. ⁴¹ |



SUPPORT UNDERSTANDING OF *THE ASAM CRITERIA* AMONG THOSE WHO PROVIDE, COVER OR USE SUD SERVICES

OVERVIEW

All the strategies outlined above will work more effectively if they're part of a comprehensive effort to support, educate and engage payers, SUD providers and other clinicians, as well as patients and their families, on the importance of rooting SUD prevention and treatment in evidence-based practices and individualized care. With patients (and their families or friends) often desperate for help, they otherwise may enroll in the first treatment option that they encounter without an assessment of what care setting is likely to be most effective for them.⁴² For many SUD providers, the use of a multidimensional assessment and development of individualized treatment plans is now a standard part of the care delivery process. Others will need significant support to begin conducting multidimensional assessments, using them to identify the most appropriate level of care for the individual patient, developing and modifying individualized treatment plans throughout treatment. Training and other tools for supporting implementation and leveraging the value of the assessment are important for effective implementation of *The ASAM Criteria*.

KEY ISSUES TO ADDRESS

- **Need for engaging and educating people with SUD and their families on the importance of obtaining high-quality care that meets their specific needs.** People with SUD and their families often make decisions on treatment based on limited information. They may not know what evidence-based SUD treatment entails and which providers are best equipped to meet their needs.
- **Need for educating state insurance, Medicaid, ombudsman and consumer assistance staff on how to regulate program and plan adherence to *The ASAM Criteria*.** State staff, including those tasked with overseeing SUD treatment program licensure and health plans for compliance with *The ASAM Criteria*, may not understand the details and import of *The ASAM Criteria* and what exactly they are tasked with monitoring. This can lead to states and plans mistakenly applying *The ASAM Criteria* to wrongly **deny** coverage of SUD services that should have been covered. This may make it difficult for them to provide technical assistance or support to providers and plans when needed.
- **Need for ongoing engagement, collaboration and education efforts targeted at providers and payers.** Deploying *The ASAM Criteria* accurately, effectively and comprehensively may require significant changes to provider and plan practices.

POTENTIAL PATHWAYS

- **Provide high-quality education on *The ASAM Criteria* for clinicians and state staff.** States can ensure access to high-quality training from experienced and knowledgeable trainers to providers and state staff. States can provide intensive training and supports to providers and their supervisors at the outset of implementation and can scale back their



New Jersey's Center of Excellence for Addiction Treatment

New Jersey collaborated with Rutgers New Jersey Medical School and Cooper University Health Care/Rowan University School of Osteopathic Medicine to establish the Northern New Jersey and Southern New Jersey Medication-Assisted Treatment Centers of Excellence (NNJ-MATrx-COE), which educate and mentor providers in community and health care settings to increase access to medication for addiction treatment and recovery support.

Source: Southern NJ MAT Center of Excellence. About Us. Available [here](#)

efforts depending on the needs of providers. States can establish a dedicated phone line/inbox for providers to request assistance with using *The ASAM Criteria* and communicate concerns related to inappropriate use of *The ASAM Criteria* by health plans and vice versa. For example, Maryland operates the Maryland Addiction Consultation Service (MACS), a warm line answered by a behavioral health consultant on Mondays to Fridays from 9 a.m. to 5 p.m. that provides consultation for providers and their patients. MACS also offers technical assistance services and educates providers on ASAM levels of care. All MACS services are available free of charge, regardless of the patient's insurance status.⁴³

- **Partner with consumer and family-oriented organizations for the development of educational materials and tools** to highlight the importance of using a multidimensional assessment to identify the appropriate level of care and refer the patient to it. States that have behavioral health ombudsman programs can task their ombudsmen with leading these efforts.
- **Establish one or more Center of Excellence for promoting the appropriate use of *The ASAM Criteria*** that will serve as the hub(s) for providing training and ongoing support to the state, providers, and payers on the appropriate use of *The ASAM Criteria*, as well as for helping the state monitor provider/payer fidelity to *The ASAM Criteria*.
- **Require payers ensuring that their own staff and network providers are trained properly on *The ASAM Criteria***. For example, California requires health care service plans to sponsor a formal education program by nonprofit clinical specialty associations to educate staff about clinical review criteria.⁴⁴
- **Convene regular meetings of providers, payers, and state staff for the sharing of experiences implementing *The ASAM Criteria*** and work through issues that may arise, and encourage plans to regularly check in with their providers on their experience utilizing *The ASAM Criteria*. Plans can work with their providers to reconcile differences in assessments and coverage decisions, as well as to provide further support on using the criteria.

IMPLEMENTATION VEHICLES AND STATE EXAMPLES

|  Pathway |  Implementation Vehicle(s) |  Select State Examples |
|--|--|--|
| Provide high-quality education for clinicians, state staff, and the public on <i>The ASAM Criteria</i> | Federal grants and state funding; states may also be able to secure Medicaid administrative matching funds for a portion of costs attributable to Medicaid beneficiaries | Indiana and Maryland offer provider trainings in coordination with ASAM as part of broader efforts to embed <i>The ASAM Criteria</i> into addiction care delivery. |
| Establish one or more Center of Excellence for promoting the appropriate use of <i>The ASAM Criteria</i> | | <i>See callout box on New Jersey on page 33.</i> |
| Require payers ensuring that their own staff and network providers are trained properly on <i>The ASAM Criteria</i> | <ul style="list-style-type: none"> • Legislation • Health plan contracts • Federal grants • State funding, including from possible opioid litigation settlement proceeds | <ul style="list-style-type: none"> • <i>See California example above.</i>⁴⁵ • West Virginia requires its Medicaid managed care plans to provide training on the ASAM standards, including the application of <i>The ASAM Criteria</i> in the patient assessment process.⁴⁶ |
| Convene regular meetings of providers, payers, individuals with receiving treatment for SUD, and state staff for the sharing of experiences implementing <i>The ASAM Criteria</i> | | Virginia brings together providers and Medicaid managed care plans to discuss their experience implementing <i>The ASAM Criteria</i> . ⁴⁷ |



CONCLUSION

The strategies and tools presented in this toolkit reflect an array of flexibilities and pathways for states to more accurately, effectively, and comprehensively deploy *The ASAM Criteria* across addiction care delivery and coverage. The influx of federal, state, and local funding to curb persistently high rates of SUD and overdose offers an opportunity to build sustainable and quality addiction care delivery and coverage fully consistent with *The ASAM Criteria*. States can build on existing transformation efforts to ensure that individuals with SUD are connected with high-quality care that meets their individualized needs.

APPENDIX



APPENDIX

MODEL LANGUAGE

The table below includes model language that states can modify to implement select pathways using vehicles such as state legislation, SUD treatment program certification and licensure regulation, health plan contracts, and Medicaid provider and policy manuals. The model language is based on the strategies described in this toolkit, and in some instances draws from current state statutes and regulations, such as those in California and Illinois. This toolkit and its model language were developed for educational and discussion purposes only.

|  Pathways |  Implementation Vehicle |  Model Language |
|--|--|--|
| Expand provider use of <i>The ASAM Criteria</i> throughout patient placement and care delivery ^{viii} | | |
| <ul style="list-style-type: none"> Require SUD treatment programs utilization of <i>The ASAM Criteria</i> throughout treatment, including for initial assessment for level of care determinations and reassessments for guiding continued stay and transfer determinations Require (or incentivize) SUD treatment program utilization of a state-specified comprehensive assessment tool that is fully consistent with <i>The ASAM Criteria</i> throughout treatment, including for initial assessment for level of care determinations and reassessments for guiding continued stay and transfer determinations Encourage other providers assessing patients with SUD to use a state-specified triage (i.e., provisional referral) or comprehensive assessment tool that is fully consistent with <i>The ASAM Criteria</i> | <ul style="list-style-type: none"> Legislation SUD treatment program certification and licensure regulations Medicaid provider and policy manuals | <p>Licensed SUD treatment programs shall perform SUD assessments and make SUD service decisions for initial patient assessment, service type, service intensity, level of care determination, continued stay and transfer for SUD in accordance with the most current edition of evidence-based, SUD-specific criteria developed by a nonprofit medical association generally recognized for its expertise in addiction treatment (e.g., <i>The ASAM Criteria</i> developed by the American Society of Addiction Medicine).</p> <p>Licensed SUD treatment programs shall conduct a comprehensive, multidimensional SUD assessment using a state-specified tool to determine the appropriate level of care for an individual who requires SUD services. Such state-specified tools shall be used to perform SUD assessments and make SUD service decisions for purposes of the initial patient assessment, service type and intensity assessment, level of care determination, ongoing assessment of continued stay, and transfer decisions to transfer an individual with SUD to an alternative care setting or service intensity.</p> <p>The comprehensive, multidimensional SUD assessment shall include:</p> <ul style="list-style-type: none"> An evaluation of the severity of the six dimensions established in <i>The ASAM Criteria</i>; and A recommendation for a level of care determination according to the continuum of care established by <i>The ASAM Criteria</i> that addresses levels of care for treatment and withdrawal management and enhanced service requirements (e.g., co-occurring enhanced/biomedical enhanced). <p>The Department of Behavioral Health or other state-designated agency shall create or designate assessment tools that meet the above requirements and must be used by licensed SUD treatment programs (e.g., the Paper-Based ASAM Multidimensional Intake Assessment or ASAM CONTINUUM) to identify appropriate levels of care. The Department of Behavioral Health or other state-designated agency shall create or designate one or more triage tools that are fully consistent with <i>The ASAM Criteria</i> (e.g., CO-Triage) that other providers assessing patients with SUD (e.g., primary care providers, emergency department providers) should use to identify the appropriate, provisional level of care when a state-specified, comprehensive multidimensional SUD assessment tool is not used.</p> |

^{viii} Model language assumes the use of a requirement rather than an incentive for SUD programs to use a specific tool.



|  Pathways |  Implementation Vehicle |  Model Language |
|---|---|---|
| Leverage <i>The ASAM Criteria</i> with payers and SUD providers to ensure affordable access to the full continuum of care for people with SUD ^{ix} | | |
| Require commercial payer coverage for all levels of care along the continuum of care defined in <i>The ASAM Criteria</i>, including withdrawal management levels, and enhanced services (i.e., co-occurring enhanced and biomedical enhanced services) | <ul style="list-style-type: none"> • Legislation • State insurance regulations • State-regulated insurer contracts | <p>Every health plan policy or contract issued, amended or renewed on or after [DATE] shall cover at least the following benefits ... Food and Drug Administration approved medications for the treatment of a SUD, substance withdrawal, or overdose and the full range of levels of care in accordance with the most current edition of evidence-based, SUD-specific criteria developed by a nonprofit medical association generally recognized for its expertise in addiction treatment (e.g., of <i>The ASAM Criteria</i> developed by the American Society of Addiction Medicine), including but not limited to:</p> <ul style="list-style-type: none"> • Early intervention services; • Outpatient services; • Intensive outpatient services; • Partial hospitalization services; • Residential treatment services; • Ambulatory withdrawal management services; • Residential withdrawal management services; • Inpatient withdrawal management services; and • Inpatient services. |
| Require (or incentivize) SUD treatment program obtainment of ASAM Level of Care Certification through CARF | <ul style="list-style-type: none"> • SUD treatment program certification and licensure regulations • Medicaid provider bulletins and provider manuals | <p>An adult residential treatment program providing SUD treatment shall ... after [DATE] obtain an ASAM Level of Care Certification from CARF in accordance with <i>The ASAM Criteria</i>.</p> |
| Make licensure requirements for SUD treatment programs fully consistent with the ASAM levels of care | <ul style="list-style-type: none"> • Legislation | <p>The [RELEVANT STATE AGENCY] shall incorporate level of care standards for all levels of care set forth in the current edition of evidence-based, SUD-specific criteria developed by a nonprofit medical association generally recognized for its expertise in addiction treatment (e.g., <i>The ASAM Criteria</i> developed by the American Society of Addiction Medicine) into licensure requirements for SUD treatment programs by [DATE]. The revisions to [LICENSING REGULATION] shall establish standards for the types of SUD services to be offered, hours of clinical care and credentials of clinicians providing SUD services, and shall ensure that SUD treatment is in accordance with the aforementioned criteria (e.g., <i>The ASAM Criteria</i>).</p> |

^{ix} This toolkit does not include model regulatory language for providing coverage for all ASAM levels of care in the Medicaid program given the specificity of each state's circumstance.

|  Pathways |  Implementation Vehicle |  Model Language |
|--|---|--|
| | <ul style="list-style-type: none"> • SUD treatment program certification and licensure regulations • Medicaid provider bulletins and provider manuals | <p>SUD treatment programs shall be licensed to provide specific services as defined in this chapter or as determined by the commissioner. [Note: To be defined in accordance with the most current edition of evidence-based, SUD-specific criteria developed by a nonprofit medical association generally recognized for its expertise in addiction treatment (e.g., <i>The ASAM Criteria</i> developed by the American Society of Addiction Medicine).] These services include but are not limited to:</p> <ul style="list-style-type: none"> • Intensive outpatient services; • Partial hospitalization services; • Clinically managed low-intensity residential services; • Clinically managed population-specific high-intensity residential services; • Clinically managed high-intensity residential services; • Medically monitored intensive inpatient services; and • Medically managed intensive inpatient services. <p>Program standards shall include:</p> <ul style="list-style-type: none"> • Staff criteria, including composition of clinical and nonclinical staff and relevant training and expertise; • Assessment and reassessment requirements and time frames; • Patient placement policies and procedures; • Admission criteria; • Individualized treatment planning • Required services; • Documentation standards; • Continued stay criteria; and • Transfer criteria. |
| <p>Ensure sufficiency of providers in state-regulated insurer and Medicaid networks</p> | <ul style="list-style-type: none"> • Legislation • State insurance regulations • State-regulated insurer contracts | <p>[AN INDIVIDUAL/GROUP HEALTH BENEFIT PLAN OR MEDICAID MANAGED CARE PLAN] shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards if medically necessary services, as defined in SUD-specific criteria developed by a nonprofit medical association generally recognized for its expertise in addiction treatment (e.g., <i>The ASAM Criteria</i> developed by the American Society of Addiction Medicine), are not available in network. As used in this subdivision, to “arrange coverage to ensure the delivery of medically necessary out-of-network services” includes but is not limited to providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards. The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider.</p> |



|  Pathways |  Implementation Vehicle |  Model Language |
|--|---|--|
| Ensure accountability for payer use of <i>The ASAM Criteria</i> in coverage decisions | | |
| <p>Require payer utilization of policies and procedures that are fully consistent with <i>The ASAM Criteria</i> for medical necessity determinations, utilization management, and appeals decisions concerning service type, service intensity, level of care, continued stay, and transfer for SUD.</p> | <ul style="list-style-type: none">• Legislation• State insurance regulations• State-regulated insurer contracts | <p>[AN INDIVIDUAL/GROUP HEALTH BENEFIT PLAN OR MEDICAID MANAGED CARE PLAN] shall make all medical necessity, utilization management, and appeals decisions concerning service type, service, intensity, level of care, continued stay, and transfer for SUD in accordance with the most current edition of evidence-based, SUD-specific criteria developed by a nonprofit medical association generally recognized for its expertise in addiction treatment (e.g., <i>The ASAM Criteria</i> developed by the American Society of Addiction Medicine).</p> <p>AN INDIVIDUAL/GROUP HEALTH BENEFIT PLAN OR MEDICAID MANAGED CARE PLAN] shall not apply different, conflicting, or more restrictive utilization review criteria concerning service type, service intensity, level of care, continued stay, or transfer for SUD. [AN INDIVIDUAL/GROUP HEALTH BENEFIT PLAN OR MEDICAID MANAGED CARE PLAN] shall authorize placement at the medically necessary level of care in accordance with the assessment of the insured using the required criteria. If that level of care placement is not available, [AN INDIVIDUAL/GROUP HEALTH BENEFIT PLAN OR MEDICAID MANAGED CARE PLAN] shall authorize the next higher medically necessary level of care. In the event of a disagreement, [AN INDIVIDUAL/GROUP HEALTH BENEFIT PLAN OR MEDICAID MANAGED CARE PLAN] shall provide to the provider of the service and the patient full detail of its assessment using the required criteria.</p> <p>To ensure the proper use of the criteria described above, every health plan shall:</p> <ul style="list-style-type: none">• Provide, at no cost, the clinical review criteria and any training material or resources regarding the SUD-specific criteria to providers and its members, subject to copyright laws;• Provide, at no cost, a formal education program presented by the nonprofit medical association that established the criteria described above to educate the plan's staff, including any third parties contracted with the plan, who review claims, conduct utilization reviews, or make medical necessity determinations in accordance with that criteria;• Regularly monitor how the clinical review criteria are applied to certify care, deny care, and support the appeals process; and• Conduct interrater reliability testing at least annually to ensure consistency in utilization review determination regarding medical necessity of SUD services. |

|  Pathways |  Implementation Vehicle |  Model Language |
|--|---|--|
| <ul style="list-style-type: none"> - Require payer submittal of medical necessity, utilization management, and appeals policies to the state for review | <ul style="list-style-type: none"> • Legislation • State insurance regulations • State-regulated insurer contracts | <p>[AN INDIVIDUAL/GROUP HEALTH BENEFIT PLAN OR MEDICAID MANAGED CARE PLAN] shall document its utilization management and appeals processes for utilizing evidence-based, SUD-specific criteria developed by a nonprofit medical association generally recognized for its expertise in addiction treatment (e.g., <i>The ASAM Criteria</i> developed by the American Society of Addiction Medicine) to make coverage and appeals decisions concerning service type, service intensity, level of care, continued stay, and transfer for SUD in a policy that has been reviewed and adopted by its [INSERT COMMITTEE]. [AN INDIVIDUAL/GROUP HEALTH BENEFIT PLAN OR MEDICAID MANAGED CARE PLAN] shall submit the policy to the [RELEVANT STATE AGENCY] on an annual basis or following a substantive change.</p> |
| <ul style="list-style-type: none"> - Require payer engagement of appropriate utilization management staff | | <p>Any decision by [AN INDIVIDUAL/GROUP HEALTH BENEFIT PLAN OR MEDICAID MANAGED CARE PLAN] to deny a SUD treatment service in an amount, duration or scope that is requested must be made by or in consultation with a licensed practitioner with clinical experience in the treatment of SUD, and, when the request is concerning the service type, service intensity, level of care determination, continued stay or transfer for SUD and is in accordance with the most current edition of evidence-based, SUD-specific criteria developed by a nonprofit medical association generally recognized for its expertise in addiction treatment (e.g., <i>The ASAM Criteria</i> developed by the American Society of Addiction Medicine), by or in consultation with a board-certified addiction specialist physician].</p> |
| <ul style="list-style-type: none"> - Require payer participation in interrater reliability testing of the application of medical necessity criteria using independently developed testing approved by the state | | <p>[AN INDIVIDUAL/GROUP HEALTH BENEFIT PLAN OR MEDICAID MANAGED CARE PLAN] shall:</p> <ul style="list-style-type: none"> • Run standardized scenarios as instructed by [RELEVANT STATE AGENCY] of an individual's requiring SUD treatment services; • Conduct interrater reliability testing at least annually to ensure consistency in utilization review determination regarding medical necessity of SUD services; • Develop interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process; • Achieve interrater reliability pass rates of at least 90 percent for each staff member annually and, if this threshold is not met, immediately provide corrective action to staff who had poor interrater reliability scores; each plan shall perform interrater reliability testing for all new staff before they can conduct utilization review without supervision; and • Report on their coverage decision, including a level of care determination, to [RELEVANT STATE AGENCY] on a [] basis, in the form and manner required by the [RELEVANT STATE AGENCY]. |

|  Pathways |  Implementation Vehicle |  Model Language |
|--|--|---|
| <ul style="list-style-type: none"> - Require payer: <ul style="list-style-type: none"> • Self-assessment and reporting on their compliance for using <i>The ASAM Criteria</i> for coverage decisions • Reporting on coverage-related metrics | | <p>[AN INDIVIDUAL/GROUP HEALTH BENEFIT PLAN OR MEDICAID MANAGED CARE PLAN] shall submit an annual report to [RELEVANT STATE AGENCY] that analyzes how its application of the most current edition of evidence-based, SUD-specific criteria developed by a nonprofit medical association generally recognized for its expertise in addiction treatment (e.g., <i>The ASAM Criteria</i> developed by the American Society of Addiction Medicine) are used to certify care, deny care, and support the appeals process for SUD treatment. The plan shall report on the following metrics:</p> <ul style="list-style-type: none"> • Service approval rate for each level of care; • Discrepancy in level of care determination between plan and provider requesting service authorization; • Percentage of placements at each level of care; • Denial rate; and • Appeal rate. |
| <ul style="list-style-type: none"> - Impose penalties on plans for failing to meet utilization management requirements | | <p>[RELEVANT STATE AGENCY] shall assess administrative fines or civil penalties, as specified, for [AN INDIVIDUAL/GROUP HEALTH BENEFIT PLAN OR MEDICAID MANAGED CARE PLAN]'s failure to use the most current edition of evidence-based, SUD-specific criteria developed by a nonprofit medical association generally recognized for its expertise in addiction treatment (e.g., <i>The ASAM Criteria</i> developed by the American Society of Addiction Medicine) when making utilization review determinations concerning service type or intensity, level of care, continued stay, or transfer for SUD</p> |
| Support understanding of <i>The ASAM Criteria</i> among those who provide, cover, or use SUD services | | |
| <p>Require payers ensuring that their payer staff and network providers are trained properly on <i>The ASAM Criteria</i></p> | <ul style="list-style-type: none"> • Legislation • State insurance regulations • State-regulated insurer contract | <p>[AN INDIVIDUAL/GROUP HEALTH BENEFIT PLAN OR MEDICAID MANAGED CARE PLAN] shall sponsor a formal education program by, or approved by, a nonprofit medical association generally recognized for its expertise in addiction treatment to educate the health care service plan's staff, including any third parties contracted with the health care service plan to review claims, conduct utilization reviews, or make medical necessity determinations, in accordance with the most current edition of evidence-based, SUD-specific criteria developed by that nonprofit medical association (e.g., <i>The ASAM Criteria</i> developed by the American Society of Addiction Medicine). The education program shall be available, at no cost, to the health care service plan's participating providers and members.</p> |

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