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Introduction

As the opioid epidemic continues, Medicaid programs across the country are taking on increasing responsibility to provide beneficiaries with substance use disorder (SUD) treatment including inpatient treatment, residential or community-based 24-hour care, outpatient treatment, and medications used to treat opioid addiction. Medicaid beneficiaries account for 40 percent of all individuals with opioid use disorder (OUD), and adult Medicaid beneficiaries are twice as likely as people insured through commercial insurance to receive treatment for their OUD.¹ As Medicaid programs have grappled with how to best respond to beneficiaries' addiction and substance use needs, many states have received an SUD 1115 Demonstration waiver (SUD waiver) from the Centers for Medicare & Medicaid Services (CMS) to expand Medicaid-funded treatment options.

SUD waivers allow states to use Medicaid funding for SUD treatment services at institutions for mental disease,² and/or to increase access to behavioral health services to treat addiction, such as supportive housing and peer recovery services.³ As of July 2019, 28 states plus the District of Columbia have sought SUD waivers. Five states received approval under CMS guidance issued in 2015, 19 states received approval under subsequent guidance issued in 2017, and several additional states have pending SUD waiver applications or amendments seeking similar demonstration authority.^{4,5}

Some states have used their SUD waivers to formally implement the American Society for Addiction Medicine (ASAM) Criteria to promote consistency in client placement for SUD treatment. The ASAM Criteria is a clinically driven multidimensional client assessment model that emphasizes treatment outcomes, client-specific lengths of service, and a team-based approach to care. The model provides a comprehensive set of guidelines for placement with emphasis on the biopsychosocial aspects that influence substance use and recovery. Controlled research on the ASAM Criteria, which uses a standard, computer-guided structured interview and decision engine, has repeatedly found evidence for better patient outcomes with matching, the process of structuring a client's SUD treatment according to their needs.⁶ The ASAM Criteria also includes a continuum of SUD treatment standards for providers.⁷ CMS encouraged the use of the ASAM Criteria in its 2015 and 2017 guidance, while providing the option for states to use a different nationally recognized model.^{8,9}

To inform this issue brief, we sought to understand the ASAM Criteria's development, its rollout in states that were among the first to implement their SUD waivers, how the Criteria is used within the context of managed care and utilization review, and the challenges and best practices associated with its use. To do so, we interviewed Dr. David Mee-Lee and Dr. David R. Gastfriend, nationally known ASAM experts, as well as Medicaid officials from California, Maryland, Virginia, Massachusetts, and Los Angeles County. We also conducted background interviews with provider associations and managed care plans to understand how providers and health plans are utilizing the ASAM Criteria.

CMS Requirements in SUD Waivers

In its 2015 guidance, CMS cites the ASAM Criteria as a nationally accepted set of treatment criteria for SUD care and recommends that states use the ASAM Criteria as they develop a residential or inpatient SUD service continuum. CMS also encouraged states to adopt the ASAM Criteria for other treatment modalities and levels of care in order to achieve the goals of the 1115 waiver demonstrations, which include: improving access to high quality care; promoting efficiencies; supporting coordinated strategies; increasing beneficiary engagement; enhancing alignment between Medicaid policies and commercial health insurance; and advancing innovative delivery system and payment models.¹⁰

In the 2015 and 2017 guidance, CMS set the following standards for SUD waivers:

- Use established standards of care in states' SUD benefit package design, and incorporate benchmarks for defining medical necessity criteria, covered services, and provider qualifications.
- Implement a process to assess and demonstrate that residential providers meet the ASAM Criteria prior to participating in the Medicaid program under waiver authority.
- Use a multi-dimensional assessment of clients to determine appropriate SUD services, level of care, and length of stay/services recommendations.
- Ensure that networks are sufficiently developed to provide appropriate clinician capacity for each level of care.

This brief provides a high-level overview of approaches taken by specific states and identifies next steps for states seeking to advance the measurement of social risk factor screening.

Overview of the ASAM Criteria¹¹

ASAM is a leading national addiction medicine organization representing physicians, clinicians, and other professionals. *The ASAM Criteria: Treatment Criteria for Addictive Substance-Related, and Co-Occurring Conditions* (the ASAM Criteria) contains the most recent set of evidence-based guidelines on the treatment of SUDs. The ASAM Criteria is a multidimensional client assessment model that specifies clinical decision rules for matching a patient with a given severity and level of functioning to a recommended level of care. The level of care review can also be used to support client placement and medical necessity decisions.

The ASAM Criteria includes five broad levels of care (Levels 0.5–4) with specific services and provider requirements to meet client needs at each level. The levels of care comprise the SUD care continuum and are displayed in Figure 1.¹² They are based on the degree of direct medical management structure, safety and security, and the intensity of treatment services provided. Service provision within a specific level of care is designed to promote the best client outcomes in the most effective and least intensive setting.¹³

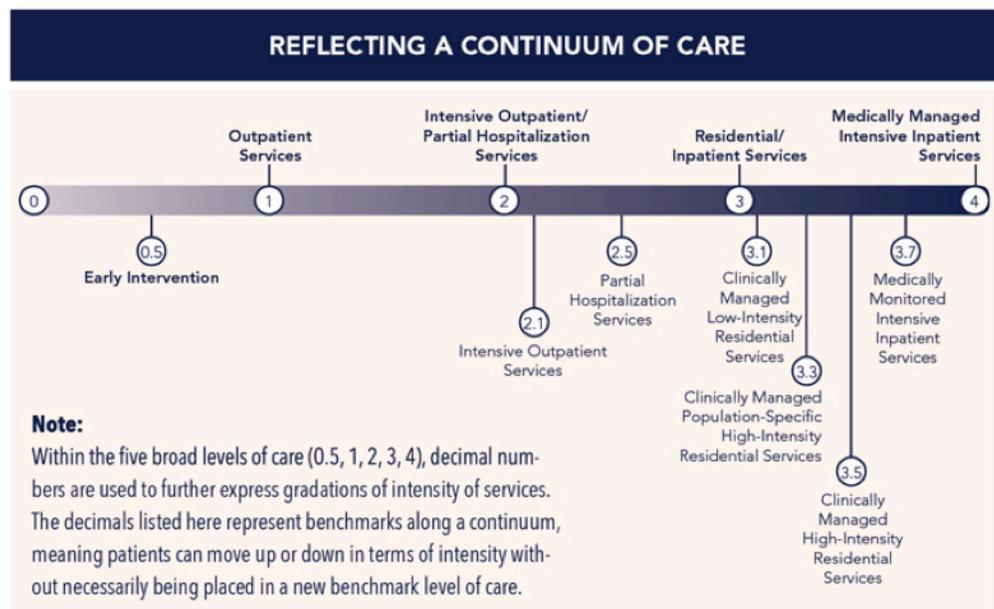


Figure 1: *The ASAM Continuum of Care*, Retrieved from *What are the ASAM Levels of Care?*, 2013, <https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/>

Applying the ASAM Criteria for Client Placement, Assessment, and Treatment

The ASAM Criteria guides clinicians as they assess dimensions of addiction, mental health, and other relevant factors to determine the severity of a client's illness and their functional abilities. This assessment is further stratified by a "risk rating," which helps illustrate the services and modalities that the client should be treated with. Results of the assessment are used to create comprehensive and individualized treatment plans for adults and adolescents. The ASAM Criteria does not consider the availability of services as a component when determining the appropriate level of care for a client.¹⁴

How States and Medicaid Managed Care Organizations (MCOs) Apply ASAM Determination to Utilization Review

Utilization review (UR), also known as utilization management, is the process by which state Medicaid programs and health plans ensure that beneficiaries receive medically appropriate services as a way to promote both quality of care and efficient use of resources by eliminating unnecessary utilization.¹⁵ UR decisions can encompass services, procedures, and settings or facilities. In most cases, review of SUD treatment is done through prospective review or prior authorization.¹⁶

The ASAM Criteria's Use in Managed Care

As state Medicaid programs may only pay for services that are medically necessary, states and their MCOs are required to conduct UR to ensure that limited state and federal resources only pay for the most appropriate and cost-effective treatment. Use of a common model for client assessment and placement can increase the likelihood that clients receive comparable and clinically indicated treatment across providers. If the model, e.g., the ASAM Criteria, is used by both providers and the state or MCO UR staff, the tool can enhance discussions regarding the appropriate level of care for a client. If a standardized, evidence-based tool is used to match patients to care, studies indicate that providers, states, and MCOs will obtain better patient clinical outcomes.¹⁷

Key Themes: ASAM Criteria Implementation in California, Maryland, Massachusetts, and Virginia

As Medicaid officials from California,¹⁸ Maryland,¹⁹ Virginia,²⁰ Massachusetts,²¹ and staff from Los Angeles County elaborated on ASAM Criteria implementation in their state or county, key themes and best practices emerged. These key themes and best practices related to training and engagement, utilizing a standardized assessment tool, evaluation, and system changes that occurred as a result of using the ASAM Criteria. In some of these states, the ASAM Criteria is not fully employed for assessment, placement and standardization of levels of care, but is applied to address clinically appropriate service utilization.

Training and Engagement

Implementing the ASAM Criteria and requiring that services meet medical necessity requirements are big shifts for the addiction treatment field. Addiction treatment has historically been funded through state human service agencies and had minimal standardization within client assessment or program requirements. Since many SUD providers have limited previous involvement in, and experience with, Medicaid requirements, early engagement and training of providers and other key stakeholders is essential to gain buy-in, to teach stakeholders how to use the ASAM Criteria, and to work together through issues that may arise. Within the ASAM Criteria's implementation process, the state's role is to provide guidance to plans and providers, and to create opportunities for training and engagement by directly sponsoring training or other events supportive of ASAM. States may also consider adoption of the standardized, evidence-based ASAM CONTINUUM toolkit²² for effective implementation.

Maryland implemented the ASAM Criteria as part of their transition of certain SUD services from fee-for-service to Medicaid managed care. Within this process, Maryland phased in their ASAM implementation according to the ASAM levels of care. Originally, many of their stakeholders did not buy-in to the use of the ASAM Criteria. To increase buy-in, state officials offered different types of training. State officials implemented a Quality Improvement Technical Assistance Workgroup that included stakeholders and residential treatment providers operating at ASAM Level 3.1. State officials developed an ASAM best practices “cheat sheet” for their 3.1 providers, which covers topics including: using evidence-based practices to guide treatment planning and placement of individuals utilizing ASAM Level of Care, Medicaid regulations, how to use peer recovery specialists in 3.1 treatment settings, Medication Assisted Treatment, and navigating the administrative service organization (ASO) approval process.

The focus of training should be to create a shared understanding of how to use the ASAM Criteria for client assessment and how to communicate the results of that assessment to UR staff. Trainings can occur through multiple methods including in-person trainings, webinars, or the release of frequently asked questions (FAQs). Before implementation, many states hosted full-day trainings for clinical and non-clinical staff. Trainings and supervision should continue after implementation, to maintain knowledge of the ASAM Criteria and to mitigate the impact of staff turnover. During ASAM Criteria implementation, for example, some states hosted train-the-trainer programs, creating the internal capability to train new staff. Some states, including Virginia, made these trainings available for both medical and behavioral health professionals who work with clients or providers.

States reported that their stakeholders, including providers, build on their ASAM Criteria expertise by using the ASAM Criteria in practice. In **Los Angeles County**, UR staff report that their providers’ knowledge of the ASAM Criteria is reinforced each time they do a client assessment and communicate the result of that assessment to UR. **Massachusetts** staff reported that when providers communicate with UR staff, *“doing this back and forth helped providers to think in the ASAM way.”* A representative from a national behavioral health managed care company made similar observations about the value of two-way communication between providers and MCO UR staff as a reinforcement of training.

Use of a Standardized Tool

When implementing the ASAM Criteria, states must determine if they will require providers to utilize a standardized client assessment approach driven by the ASAM client assessment and program standards. States also must decide whether MCOs will be required to use the ASAM Criteria in their UR process, which can help ensure that UR decisions are consistent with provider’s treatment recommendations.

States have taken a variety of approaches when deciding if they will standardize their assessment tool. **Virginia** and **Maryland** require providers to use a standardized ASAM multidimensional assessment. **Los Angeles County** specifically utilizes the CONTINUUM tool. Massachusetts is grappling with how to include an SUD-focused assessment within their increasingly integrated health care systems. As state officials consider the design of their assessment tool, they are *“conscious about putting forward a specialized tool that’s only used in an addiction-specific environment when we want a more integrated landscape, a more integrated look at our members, and to also think about co-occurring disorders.”*

Use of a standardized ASAM tool results in consistent client assessment between providers and supports fidelity to the ASAM Criteria. In addition, use of a standardized assessment tool helps providers present the client's treatment needs and context to the MCO's UR staff. Using a standardized tool successfully may require providers to have a mindset shift, as the tool may recommend placement of a client at a different level of care than the provider offers or believes to be correct. If the ASAM assessment recommends, and the assessing clinician agrees, that the client be treated at a level of care that the assessing provider does not offer, the client should be referred to a different provider for treatment at the appropriate level of care.

In **Maryland**, when an ASO clinical team denies an authorization for SUD services that does not meet the ASAM Criteria for the level of care that a provider is requesting authorization for, the authorization is sent to the ASO's Medical Director for further review. Upon review by the ASO Medical Director, if it is determined that the provider does not have sufficient clinical information to meet medical necessity criteria, the ASO clinical team will consult with the provider to assist in determining the appropriate level of care that best reflects the individual's clinical needs. If the ASO finds providers consistently submit authorizations that provide insufficient information to support appropriate placement determination as based on the ASAM Criteria, the ASO will reach out to the provider to offer additional technical assistance.

To encourage the provision of the appropriate level of care based on clients' needs, states should explore how to pay providers for completing assessments separately from payment for treatment to help ensure that clients receive the level of care they need and not the level of care that the assessing provider provides.

Los Angeles County commissioned the creation of the ASAM CO-Triage tool,²³ which is used by intake centers and providers for client screening and provisional referral to an appropriate site for comprehensive assessment. Comprehensive assessment and definitive placement are then conducted with the ASAM CONTINUUM. Providers are reimbursed for the time they spent on client assessments. By establishing the ASAM CO-Triage and CONTINUUM tools and payment to providers for assessments, assuming that medical necessity is established, Los Angeles County has standardized assessment and incentivized treatment based on the level of care that would be most beneficial to the client. Los Angeles County started with a paper assessment that was based off their clinical experience and then transferred to the ASAM CONTINUUM six months into their waiver.

Even when MCOs and providers are trained on the use of the ASAM Criteria, their conclusions do not always match that of ASAM experts. Standardization of the tool used for client placement and assessment helps to set clear expectations and allows for a shared understanding of a patient's needs and what treatment should be provided. If standardization occurs in conjunction with comprehensive training on the ASAM Criteria, standardization should result in client assessments and placements consistently aligning with the recommendations of ASAM experts. Standardization can be accomplished through requiring that providers and MCOs are trained on and use the same tool, such as the ASAM CONTINUUM. This will help to set clear expectations and allow for a shared understanding of a patient's needs and what treatment should be provided.

Clinicians in **Virginia** complete a formal service authorization form²⁴ that is based on the ASAM Criteria multidimensional assessment. This form is then submitted to the MCOs, which have been trained on the ASAM Criteria and are required in their contract to utilize it as they determine medical necessity. Virginia's standardization aids the UR process, as the MCOs and the providers have both undergone training on the ASAM Criteria and use the same information to judge the medical necessity of SUD treatment and services.

Standardization should also be considered within the designation of provider types and levels of care. To ensure that the treatment is standardized across providers and states, ASAM is implementing a Level of Care Certification program in collaboration with CARF International.²⁵ Providers who wish to advertise their services at ASAM levels 3.1, 3.5, and 3.7 are required to obtain the certification.²⁶

In **California**, provider ASAM designation is based on multiple factors including staffing qualification, levels of care and the number of hours of treatment that a clinician provides, their ability to provide clinical services, and program support resources. Providers complete an ASAM questionnaire and provide supplemental documents to support the clinical level(s) of care that they are able to provide within their program. California issues designations for levels 3.1, 3.3, and 3.5.

In **Virginia**, providers attest to the level of care they provide. This attestation is then submitted to the MCOs to ensure that providers are being credentialed consistent with the ASAM level of care available.

States should also consider what provider types they will require to meet ASAM Levels of Care. ASAM would recommend that designations are applied across the continuum of care, as shown in Figure 1, but some states have chosen a different approach. For example, some states either do not offer all services within the continuum or are not asking providers to meet the ASAM Criteria for specific levels of care. According to Dr. David Gastfriend, chief architect of ASAM CONTINUUM, interim solutions, such as matching ASAM levels of care to state level of care maps, have been created in Los Angeles, Massachusetts, New Hampshire, and Florida to identify what levels of care are provided. Based on clinical expert consensus and a number of controlled studies, ASAM recommends that states utilize the full continuum of services and service specifications, as optimal patient outcomes are most likely to be achieved when clients are matched to clinically indicated and individualized (i.e., unbundled) SUD treatments.²⁷

Maryland's 1115 Waiver implemented the ASAM Criteria specifically for providers of residential SUD treatment: levels of care 3.1, 3.3, 3.5, and 3.7.

Evaluation and Use of Data

Data are helpful at several different stages in the implementation and evaluation process. Initially, baseline data, which may include information on patients' SUD needs, providers' treatment capacity, or the results of UR decisions, can be used to determine if a state could benefit from implementation of the ASAM Criteria or another comparable model for SUD assessment and placement. Baseline data are also helpful in order to evaluate any changes that occurred as a result of implementation of the ASAM Criteria. Ongoing evaluation is recommended and should indicate whether providers are appropriately using the ASAM Criteria to assess client needs, review service utilization patterns, and identify how clients are being served throughout the care continuum over time. Both qualitative and quantitative evaluation methods should be employed.

When **California** was deciding if the ASAM Criteria was appropriate, Medi-Cal officials looked to data from Santa Clara County,²⁸ which had implemented the ASAM Criteria prior to California's adoption of ASAM. The successful use of the ASAM Criteria in Santa Clara County helped convince the state that it could be implemented statewide. The state also engaged in an extensive stakeholder engagement process as part of its SUD Waiver development, during which stakeholders unanimously agreed that ASAM Criteria should be utilized. The 2017-2018 evaluation of CA's Drug MediCal – Organized Delivery System found that in a preliminary analysis, about 90 percent of clients were placed into the level of care that was indicated on their ASAM assessment in live waiver counties.²⁹ **Virginia's** Addiction Recovery and Treatment Services (ARTS) Delivery Transformation program evaluation tracked the number of members utilizing each ASAM level of care to analyze service utilization patterns and determine where to expand service capacity.

How Use of The ASAM Criteria Promotes Individualized Care

Use of the ASAM Criteria promotes individualized care. This is reflected in ASAM's philosophy, as its guiding principles include moving from program driven to clinical and outcomes-driven treatment. ASAM also promotes moving from a fixed length of service to variable lengths of service based on individual need. However, some states that have implemented the use of ASAM Criteria also have mandated benefits for SUD services.³⁰ With mandated benefits, client assessment or utilization review may not occur until the end of a fixed day stay, resulting in the possibility that a client stays longer in a program than is medically necessary. This is problematic, given that research on the ASAM Criteria has shown that mismatching patients to excessive intensity of treatment can yield adverse clinical outcomes.³¹

Massachusetts mandates that MCOs provide up to 14 days of acute treatment and clinical stabilization services (ASAM Levels 4, 3.7, and 3.5) without prior authorization.³² While not a statutory mandated benefit, Massachusetts also provides up to 90 days of residential recovery treatment (ASAM Level 3.1) without prior authorization.³³ **Virginia**, which does not have a mandated benefit, saw a reduced length of staying following a standardized implementation of the ASAM Criteria. This standardized implementation resulted in individuals being correctly placed in levels of care that meet medical necessity requirements.

Key Considerations for State Approaches to SUD Assessment and Provider Level of Care When Expanding SUD Treatment

The ASAM Criteria provides states with a standard, evidence-based approach to assess a beneficiary's need for SUD treatment and identify the appropriate level of care. CMS encouraged state adoption of the ASAM Criteria as a method to standardize client assessment and provider levels of care. However, fully adopting the ASAM Criteria requires a significant investment of time and resources by state Medicaid staff, their MCOs, and SUD providers. When the ASAM Criteria is consistently used to conduct assessments and determine authorization for services, state experience has also shown that it can help improve outcomes for individuals struggling with SUD.³⁴

As states introduce additional SUD benefits and other related reforms, it is important for them to consider how much and what type of UR they will apply to SUD services. In some cases, state laws or regulations dictate lengths of stay. While the ASAM Criteria promotes tailoring services to meet individual needs, it is important for states with laws or regulations that dictate fixed lengths of stay to consider how those laws and regulations interact with the ASAM Criteria.

If states choose to implement the ASAM Criteria, they should consider the feasibility of implementing the full spectrum of the ASAM Criteria for both client assessment and provider levels of care definitions. Some questions for states to consider include:

- › What type of assessment will states adopt? Options include standardizing the tool or allowing provider choice. This assessment can be the ASAM multidimensional assessment, the ASAM CONTINUUM tool, an assessment modified from ASAM to fit a state specific context, or a non-ASAM framework.
- › How will state staff, providers, MCO UR staff, and other stakeholders be trained on the assessment requirements?
- › Will they require Medicaid providers to meet the definitions of services in the ASAM Criteria? If so, how will they certify that providers meet these definitions and standards?
- › How will stakeholders be engaged during the implementation process?
- › Will states pay clinicians for completing client assessments, particularly if the client is found to need a different level of care than the clinician provides?
- › How will states ensure network adequacy and accessibility to all SUD levels of care?
- › How will states monitor implementation and track client outcomes to measure the impact of the ASAM Criteria?

These questions can help guide state Medicaid programs as they weigh if, and how, to implement the ASAM Criteria. Ultimately, this decision may be based on whether state Medicaid programs believe that use of the ASAM Criteria will help them achieve the goals of their SUD waivers. The science of addiction treatment is well ahead of practice, and the science appears to apply regardless of regions and populations. Because of differences in state Medicaid programs and the needs of the populations served, however, practical steps toward progress must be taken on a regional or systems basis; there is no one-size-fits-all approach. Rather, the decision of if, and how, to implement the ASAM Criteria must be made for each state individually.

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ABOUT BAILIT HEALTH

This brief was prepared by Rachel Isaacson, Ellie Shea-Delaney, and Beth Waldman. Bailit Health is a health care consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies and private purchasers. For more information on Bailit Health, see www.bailit-health.com.

Endnotes

1. Orgera, K., & Tolbert, J. (2019, June 25). *The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment*. Retrieved from <https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/>
2. Institutions of Mental Disease (IMD) is defined in federal statute 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 alcohol and substance use disorders. Primarily engaged is often defined as 51 percent of people in the facility having serious mental illness. Facilities can serve either children or adults.
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10. About Section 1115 Demonstrations. (n.d.). Retrieved August 6, 2019, from <https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html>
11. Some insurance companies, such as Beacon Value Options and Aetna, distribute a guide for clients and families that explains how the ASAM Criteria is applied to treatment decisions and utilization management. This document can be accessed here: <https://www.beaconhealthoptions.com/pdf/members/Introduction-to-The-ASM-Criteria-for-Patients-and-Families.pdf> or <http://www.aetna.com/healthcare-professionals/documents-forms/asam-criteria.pdf>.
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16. Prospective review or prior authorization requires that approval for medical care occur before care is provided.
17. Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller MM eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. Carson City, NV: The Change Companies; 2013
18. California's 1115 SUD demonstration, the Drug Medi-Cal Organized Delivery System, includes an evidence-based benefit design, a care integration strategy, quality measure reporting requirements, a benefit management strategy, and requires providers to meet industry standards of care. Counties in California may selectively contract with providers to deliver the full continuum of services consistent with the ASAM continuum of care.
19. Maryland's 1115 SUD demonstration includes an evidence-based treatment design that covers the full continuum of care, implements benchmarks from industry standards of care, and integrates physical and behavioral health.
20. Virginia's 1115 SUD demonstration, the Addiction Recovery and Treatment Services (ARTS) Delivery Transformation, strengthens the state's SUD delivery system, expands the SUD benefits package, integrates SUD services, and introduces provider and managed care requirements consistent with national treatment guidelines.
21. Massachusetts's 1115 SUD demonstration strengthened the state's system of recovery-oriented SUD treatments and covers a more comprehensive array of services. The ASAM Criteria was included to provide a biopsychosocial clinical assessment to MassHealth members in need of addiction treatment services.
22. The ASAM Continuum is a computerized clinical decision support system that enables clinicians to assess clients to assist in determining the appropriate treatment option according to the ASAM Criteria. More information on the ASAM Continuum can be found here: <https://www.asamcontinuum.org/knowledgebase/what-is-continuum-2/>.
23. The ASAM CO-Triage tool is a shortened electronic assessment that determines a provisional level of care. ASAM advertises that client can be assessed using the CO-Triage tool in only 10 minutes, as compared to an hour using the ASAM Criteria. More information on the CO-Triage tool can be found here: https://www.asamcontinuum.org/wp-content/uploads/2019/03/CO-triage_Page1n2_PRINT_FINAL_v7_small.pdf

24. Virginia's ARTS Initial Service Authorization Request Form can be found here: <http://www.dmas.virginia.gov/#/artsregistration>
25. Because of the new certification standards, the cost to implement ASAM is an evolving issue. The certification was piloted in May 2019, with full implementation expected later in 2019, and may be extended to apply to additional Levels of Care in the future. The certification only applies to clinicians who wish to market that they provide services consistent with ASAM standards and is intended to verify that the services provided are consistent with the ASAM Levels of Care. ASAM estimates that their Level of Care Certification will cost about \$500, with potential for the fee to be waived based on financial necessity. More information can be found here: <https://www.asam.org/resources/level-of-care-certification>
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28. More information on Santa Clara's implementation plan can be found here: https://www.dhcs.ca.gov/provgovpart/Documents/Santa_Clara_FINAL.pdf
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