

# Spotlight on Medical Necessity Criteria for Substance Use Disorders

*An Analysis of Requirements for Health Plans to  
Use Specific Criteria and Assessment Tools to  
Determine Medical Necessity*



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# Executive Summary

A health plan's selection and application of medical necessity criteria determine whether a patient receives recommended medical care. Medical necessity criteria should reflect generally accepted standards of care for the patient's condition. Yet, for substance use disorders (SUDs), some health plans have used medical necessity criteria to restrict care and control costs. Historically, health plans have had significant discretion in selecting and applying medical necessity criteria. They have also resisted disclosing both their standards and explanations of how the criteria apply to a member's specific condition, despite legal disclosure requirements. These practices have made it difficult for patients to obtain affordable, life-saving SUD care and to challenge health plan denials based on lack of medical necessity.

This *Spotlight on Medical Necessity Criteria for Substance Use Disorders* examines state requirements for public and private health plans to use specific medical necessity criteria and, in some cases, level of care assessment tools when applying the medical necessity criteria.

## Key Findings

- As of October 1, 2020, 15 states require state-regulated commercial health plans to use specific criteria or level of care assessment tools to determine medical necessity for SUD treatment: California; Colorado; Connecticut; Delaware; Illinois; Maryland; New Hampshire; New Jersey; New York; North Carolina; Rhode Island; Tennessee; Texas; Washington; and West Virginia.
- As of October 1, 2020, 24 states require Medicaid plans to use specific medical necessity criteria or level of care assessment tools to determine medical necessity for SUD treatment: Alaska; California; Delaware; Idaho; Indiana; Kansas; Kentucky; Louisiana; Maryland; Michigan; Minnesota; New Hampshire; New Jersey; New Mexico; New York; North Carolina; Ohio; Pennsylvania; Utah; Vermont; Virginia; Washington; West Virginia; and Wisconsin.

This *Spotlight* recommends that states select specific medical necessity criteria that reflect generally accepted standards of care for SUD and require public and private health plans to use the state-designated criteria for medical necessity determinations. In addition, states should designate an evidence-based level of care assessment tool and require public and private health plans to use the state-designated tool in medical necessity determinations to promote standardization and fidelity in the application of the medical necessity criteria. This *Spotlight* identifies trends in the adoption of specific criteria and tools but does not evaluate the validity of any particular criteria, guideline or tool.

# Introduction

Health plans pay for services and benefits that are “medically necessary” for a patient. This means that the service is necessary to prevent, diagnose, or treat the patient’s medical condition, based on generally accepted standards of care and clinical appropriateness, and is not rendered primarily for the provider or patient’s economic benefit or convenience.<sup>1</sup>

Health plans evaluate medical necessity through a utilization review process, whereby the health plan assesses, prior to the delivery of the service and over the course of a patient’s care, whether the practitioner’s recommended service meets its medical necessity criteria based on documentation of the patient’s condition. The health plan’s medical necessity criteria should reflect “generally accepted standards of care,” which are standards that are based on “credible scientific evidence published in peer-reviewed medical literature, generally recognized by the relevant medical community, or otherwise consistent with standards set forth in policy issues involving clinical judgment.”<sup>2</sup>

For substance use disorders (SUDs), health plans often develop their own criteria for determining medical necessity for SUD treatment or use criteria developed by non-profit clinical specialty associations or industry entities. The Mental Health Parity and Addiction Equity Act of 2008 (the Parity Act) requires health plans to adopt and implement medical necessity criteria for mental health (MH) and SUD benefits in a manner that is comparable to the way the health plan adopts and implements medical necessity criteria for medical/surgical benefits. Nonetheless, health plans have significant discretion in selecting and applying medical necessity criteria, which has allowed for tremendous variation in how plans make medical necessity determinations for SUD benefits.

Some health plans have also been reluctant to disclose their medical necessity criteria and reasons for denial of services, even though federal regulatory standards establish disclosure requirements. These practices make it difficult for patients and providers to challenge denials for service authorizations or claims based on medical necessity.

The lack of regulation of medical necessity criteria and flexibility afforded to insurers to develop their own criteria and guidelines for SUDs have allowed health plans to adopt restrictive medical necessity criteria, or to apply criteria so as to limit or deny care and control costs.<sup>3</sup> As a result, patients are denied access to affordable, life-saving care.

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<sup>1</sup> Centers for Medicare & Medicaid Services. (2006). *Glossary*. Retrieved from <https://www.cms.gov/apps/glossary/default.asp?Letter=M&Language=English>.

California Legislature. (2020). SB-855, Health coverage: mental health or substance use disorders. Retrieved from [https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill\\_id=201920200SB855](https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB855).

<sup>2</sup> Institute of Medicine 2012. *Essential Health Benefits: Balancing Coverage and Cost*. Washington, D.C.: The National Academies Press. App. G at 226-27.

<sup>3</sup> *Wit, et al. v. United Behavioral Health*, No. 14-cv-02346-JCS, 2019 WL 1033730, at \*53 (N.D. Cal. March 5, 2019); 2020 WL 6479273, at \* 51 (N.D. Cal. Nov. 3, 2020) (remedies order).

In response, state policymakers have begun to limit health plan discretion to select medical necessity criteria for SUD services by requiring health plans to use specific guidelines or criteria. State policymakers have also imposed requirements for health plans to use a specific patient level of care assessment tool when determining medical necessity to promote fidelity and standardization in the application of medical necessity criteria.

This *Spotlight* explores the use of state requirements to mandate health plans to use specific criteria and/or tools in medical necessity determinations. It does not evaluate the validity of any particular criteria, guidelines or tool. Rather, it explores efforts by states to regulate how health plans make medical necessity determinations for SUD treatment. As of October 1, 2020, 15 states require state-regulated commercial health plans to use specific criteria or level of care assessment tools to determine medical necessity for SUD treatment, and 24 states require Medicaid plans to use specific criteria or tools for medical necessity determinations. See [Exhibit A](#) for additional information.

## Parity Act Requirements

The Mental Health Parity and Addiction Equity Act of 2008 (Parity Act) requires non-discriminatory coverage of and access to substance use disorder (SUD) and mental health (MH) benefits in private and public health insurance. The Parity Act bars issuers from offering health plans that do not comply with the federal non-discrimination standards.<sup>4</sup> Specifically, the Parity Act prohibits the use of separate or more restrictive standards for MH or SUD benefits than for medical/surgical benefits. Such standards (or, plan design features) include the selection and application of medical necessity criteria.

### Nonquantitative Treatment Limitation (NQTL) Requirements

Under the Parity Act, medical necessity criteria are considered a nonquantitative treatment limitation (NQTL) because the criteria, both as written and applied, can limit a patient's access to or duration of SUD treatment.<sup>5</sup> The Parity Act's non-discrimination mandate means that a plan must adopt and implement medical necessity criteria for SUD and MH benefits in a manner that is comparable to and no more restrictive than the way in which it adopts and implements criteria for medical/surgical conditions. That assessment requires the plan to compare the processes, strategies and evidentiary factors it uses to develop and implement medical necessity criteria for MH/SUD services and medical/surgical conditions to ensure that the criteria for SUD and MH benefits are comparable to and applied no more stringently than the criteria for medical benefits. Some states

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California Legislature. (2020). SB-855, Health coverage: mental health or substance use disorders, Section 1. Retrieved from [https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill\\_id=201920200SB855](https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB855).

<sup>4</sup> P.L. 110-343, 122 Stat. 3881 (Oct. 3, 2008); 45 C.F.R. § 146.136(h) (2013).

<sup>5</sup> 45 C.F.R. § 146.136(c)(4)(ii)(A) (2013); 29 C.F.R. § 2590.712(c)(4)(ii)(A) (2013).

have codified, in state law, the Parity Act standard in regulating the adoption and implementation of medical necessity criteria.<sup>6</sup>

While not determinative of a parity violation, denial rates are a useful data point for assessing parity compliance.<sup>7</sup> A number of surveys, reports and investigations have identified disparities in denial rates when comparing MH/SUD and medical/surgical benefits. A 2015 survey by the National Alliance on Mental Illness (NAMI) found that a higher percentage of respondents reported being denied MH and SUD care for lack of medical necessity than for medical care in commercial plans.<sup>8</sup> The New York Attorney General (NY AG) identified denial rate disparities in its investigations of health plans for parity violations. For example, the NY AG found that MVP and ValueOptions denied 39% of claims for inpatient psychiatric treatment and 47% of inpatient SUD claims, compared to less than 18% of medical/surgical claims, while EmblemHealth denied 36% of claims for inpatient psychiatric treatment and 41% of claims for inpatient SUD treatment, compared to 29% of inpatient medical/surgical claims.<sup>9</sup>

A 2020 survey of commercial health plans operating in Virginia compared claim denials for MH, SUD and medical/surgical benefits by claims classification.<sup>10</sup> SUD claims were denied at higher rates than medical/surgical claims in all of the claims classifications, and MH claims were denied at higher rates than medical/surgical claims in 4 out of the 5 claims classifications.<sup>11</sup> For example, 15.4% of outpatient claims (other than office visits) were denied for SUD, and 12% of outpatient claims (other than office visits) were denied for MH, as compared to 5.8% of outpatient claims (other than office visits) for medical/surgical claims. For inpatient claims, 14.9% of SUD claims and 12.4% of MH claims were denied, as compared to 9.5% of inpatient claims for medical/surgical benefits. Additionally, there was a higher percentage of denials for lack of medical necessity for SUD benefits (3.4%) as

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<sup>6</sup> See e.g., MD. CODE ANN., INS. § 15-1001(b)(1)(ii) (2013); R.I. GEN. LAWS § 27-38.2-3(b) (2008).

<sup>7</sup> United States Department of Labor. (2020). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*. Retrieved from <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf> (p. 27).

<sup>8</sup> National Alliance on Mental Illness. (2015). *A Long Road Ahead*. Retrieved from <https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead> (pp. 1, 4–5).

<sup>9</sup> New York State Office of the Attorney General. (2014). *In the Matter of MVP Health Care, Inc., Assurance No.: 14-006, Assurance of Discontinuance Under Executive Law Section 63, Subdivision 15*. Retrieved from [https://ag.ny.gov/sites/default/files/pdfs/bureaus/health\\_care/new/2014-03-19%20MVP%20Parity\\_MR.pdf](https://ag.ny.gov/sites/default/files/pdfs/bureaus/health_care/new/2014-03-19%20MVP%20Parity_MR.pdf) (p. 5).

New York State Office of the Attorney General. (2015). *In the Matter of ValueOptions, Inc., Assurance No.: 14-176, Assurance of Discontinuance Under Executive Law Section 63, Subdivision 15*. Retrieved from <https://ag.ny.gov/pdfs/ValueOptionsAOD-FullyExecuted.pdf> (p. 8).

New York State Office of the Attorney General. (2014). *In the Matter of EmblemHealth, Inc., Assurance No.: 14-031, Assurance of Discontinuance Under Executive Law Section 63, Subdivision 15*. Retrieved from [https://ag.ny.gov/pdfs/2014-07-03-EmblemParity\\_MR.pdf](https://ag.ny.gov/pdfs/2014-07-03-EmblemParity_MR.pdf) (pp. 6–7).

<sup>10</sup> The five claims classifications used in the survey are: office visit claims, all other outpatient claims, inpatient claims, emergency care claims and outpatient prescription drugs transactions.

Virginia State Corporation Commission, Bureau of Insurance. (2020). *2020 Report: Claims – Complaints – Appeals, Mental Health & Substance Use Disorder Benefits and Network Adequacy*. Retrieved from <https://www.scc.virginia.gov/getattachment/fd667bd1-9e3f-4f02-b5e9-7093c6ce88e5/2020mhsudrept.pdf> (pp. 2-3).

<sup>11</sup> *Id.*

compared to medical/surgical benefits (1.8%).<sup>12</sup> A 2018 study by the Texas Department of Insurance of private health plans found that inpatient MH/SUD claims were denied 60% more often than inpatient medical/surgical claims.<sup>13</sup> Disparities in denial rates between comparable medical/surgical and MH/SUD benefits may be indicative of parity noncompliance and should necessitate a review of the health plan's medical necessity criteria and utilization review processes.<sup>14</sup>

## Disclosure Requirements

The Parity Act requires health plans to disclose medical necessity criteria for MH and SUD benefits to any member, potential member or contracting provider, upon request.<sup>15</sup> In connection with an adverse benefit determination, individual and non-federal government regulated health plans must provide medical necessity criteria for both medical/surgical and MH/SUD benefits, as well as any other information relevant to the denial.<sup>16</sup> Health plans subject to the Employee Retirement Income Security Act (ERISA) must provide medical necessity criteria for the MH/SUD benefit denied for lack of medical necessity, as well as the medical necessity criteria for the medical/surgical benefits in the same benefit classification, within 30 days of the request.<sup>17</sup> Health plans must also provide, for claims denials based on medical necessity, "an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request."<sup>18</sup>

Despite the Parity Act's disclosure requirements, it is often difficult to obtain a health plan's medical necessity criteria. In a 2017 survey of mental health and addiction treatment providers in Illinois, over 90% of providers reported that both Medicaid and commercial health plans refused to provide their medical necessity criteria upon request.<sup>19</sup> The New York Attorney General also found that health plans failed to identify the medical necessity criteria used to deny a MH/SUD service in their adverse benefit determination letters.<sup>20</sup>

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<sup>12</sup> *Id.* (pp. 2-3, 18).

<sup>13</sup> Texas Department of Insurance. (2018). *Study of Mental Health Parity to Better Understand Consumer Experiences with Accessing Care*. Retrieved from <https://www.tdi.texas.gov/reports/documents/Final-draft-HB-10-report-8.31.18.pdf>. (p. 12).

<sup>14</sup> United States Department of Labor. (2020). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*. Retrieved from <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf> (p. 27).

<sup>15</sup> 29 C.F.R. § 2590.712(d)(1) (2013); 45 C.F.R. § 146.136 (d)(1) (2013).

<sup>16</sup> 45 C.F.R. § 146.136 (d)(3) (2013).

<sup>17</sup> 29 C.F.R. §§ 2520.104b-1 (2020); 2590.712(d)(1) (2013).

<sup>18</sup> 29 C.F.R. § 2560.503-1(g)(1)(v)(B) (2013).

<sup>19</sup> The Kennedy Forum Illinois. (2017). *Illinois Providers Report Barriers to Mental Health and Addiction Coverage for Their Patients*. Retrieved from <http://thekennedyforumillinois.org/wp-content/uploads/2017/09/IL-MHSUD-Coverage-Provider-Survey-Report-Final-1.pdf>. (p. 9).

<sup>20</sup> New York State Office of the Attorney General. (2014). *In the Matter of MVP Health Care, Inc., Assurance No.: 14-006, Assurance of Discontinuance Under Executive Law Section 63, Subdivision 15*. Retrieved from [https://ag.ny.gov/sites/default/files/pdfs/bureaus/health\\_care/new/2014-03-19%20MVP%20Parity\\_MR.pdf](https://ag.ny.gov/sites/default/files/pdfs/bureaus/health_care/new/2014-03-19%20MVP%20Parity_MR.pdf). (p. 5).

New York State Office of the Attorney General. (2014). *In the Matter of EmblemHealth, Inc., Assurance No.: 14-031, Assurance of Discontinuance Under Executive Law Section 63, Subdivision 15*. Retrieved from [https://ag.ny.gov/pdfs/2014-07-03-EmblemParity\\_MR.pdf](https://ag.ny.gov/pdfs/2014-07-03-EmblemParity_MR.pdf). (p. 10).

# Criteria and Tools

Several sets of evidence-based guidelines and criteria have been developed to determine medical necessity for mental health and substance use disorder treatment. In addition, a number of tools have been developed to guide providers in conducting assessments and determining the most appropriate level of care to meet a patient's needs. Many states require providers to use patient placement tools for SUD assessments and/or to determine the appropriate level of care.<sup>21</sup>

Increasingly, states also require health plans to utilize these tools to determine medical necessity for treatment services. These tools help to create standardization and fidelity in applying the criteria used to determine medical necessity. Requiring *both* the provider and the health plan to adopt the same criteria and utilize the same patient placement tool creates consistency in treatment recommendations.<sup>22</sup>

As of October 1, 2020, 30 states require commercial health plans and/or Medicaid to utilize specific criteria and/or a specific tool when applying those criteria for medical necessity determinations: Alaska; California; Colorado; Connecticut; Delaware; Idaho; Illinois; Indiana; Kansas; Kentucky; Louisiana; Maryland; Michigan; Minnesota; New Hampshire; New Jersey; New Mexico; New York; North Carolina; Ohio; Pennsylvania; Rhode Island; Tennessee; Texas; Utah; Vermont; Virginia; Washington; West Virginia; and Wisconsin. See [Exhibit A](#) for additional information.

- Fifteen states require state-regulated commercial health plans to use specific criteria and/or patient placement tools to determine medical necessity for SUD benefits: California; Colorado; Connecticut; Delaware; Illinois; Maryland; New Hampshire; New Jersey; New York; North Carolina;<sup>23</sup> Rhode Island; Tennessee; Texas; Washington; and West Virginia.
- Twenty-four states require Medicaid plans to use specific medical necessity criteria and/or patient placement tools to determine medical necessity for SUD benefits: Alaska; California; Delaware; Idaho; Indiana; Kansas; Kentucky; Louisiana; Maryland; Michigan; Minnesota; New Hampshire; New Jersey; New Mexico; New York; North Carolina; Ohio; Pennsylvania; Utah; Vermont; Virginia; Washington; West Virginia; and Wisconsin.

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New York State Office of the Attorney General. (2015). *In the Matter of ValueOptions, Inc., Assurance No.: 14-176, Assurance of Discontinuance Under Executive Law Section 63, Subdivision 15*. Retrieved from <https://ag.ny.gov/pdfs/ValueOptionsAOD-FullyExecuted.pdf>. (p. 13).

<sup>21</sup> Kolsky, G.D. (2006). Current State AOD Agency Practices Regarding the Use of Patient Placement Criteria (PPC) – An Update. *The National Association of State Alcohol and Drug Abuse Directors*. Retrieved from the American Society of Addiction Medicine's website:

[https://www.asam.org/docs/publications/survey\\_of\\_state\\_use\\_of\\_ppc\\_nasadad-2006.pdf?Status=Master&sfvrsn=2](https://www.asam.org/docs/publications/survey_of_state_use_of_ppc_nasadad-2006.pdf?Status=Master&sfvrsn=2).

<sup>22</sup> State Health & Value Strategies. (2019). *Implementing ASAM Criteria for SUD Treatment through Medicaid Managed Care*. Retrieved from <https://www.shvs.org/wp-content/uploads/2019/11/ASAM-Brief-Updated-Design-11.14.pdf>. (p. 4-5).

<sup>23</sup> Note North Carolina's law allows the health plan to use either the ASAM Criteria or clinical review criteria adopted by the insurer.



Some of the commonly used criteria and level of care assessment tools are described below.

## The ASAM Criteria

Developed by the American Society of Addiction Medicine (ASAM), the ASAM Criteria is widely used to help providers make clinical decisions and support level of care and medical necessity determinations.<sup>24</sup> The Centers for Medicare and Medicaid Services (CMS) has identified the ASAM criteria as evidence-based treatment guidelines,<sup>25</sup> and courts have identified the ASAM Criteria as a source that reflects generally accepted standards of care for SUD treatment.<sup>26</sup> The ASAM CONTINUUM is a computer-guided tool that helps ensure fidelity to the ASAM Criteria.<sup>27</sup>

Many states require treatment providers and facilities to use the ASAM Criteria for assessments, level of care determinations, continued stay requests and discharge planning.<sup>28</sup> Several states also define the levels of care for SUD treatment services using the ASAM Criteria and require providers and facilities to provide SUD services in accordance with the ASAM Criteria. As discussed in greater detail below, CMS requires states with 1115 waivers for SUD services to require that providers participating in the state’s Medicaid program use a nationally recognized multi-dimensional assessment tool for treatment assessments.<sup>29</sup> While CMS encourages states to use the ASAM Criteria, it provides an option for states to use a “different nationally recognized model.”<sup>30</sup>

Increasingly, states are requiring health plans to use the ASAM Criteria for medical necessity determinations.

- Eleven states require commercial health plans to use the ASAM Criteria to define or determine medical necessity for SUD benefits: Colorado; Connecticut; Delaware; Illinois;

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<sup>24</sup> American Society of Addiction Medicine. *About the ASAM Criteria*. Retrieved from <https://www.asam.org/asam-criteria/about>.

<sup>25</sup> Centers for Medicare & Medicaid Services. (November 1, 2017). *SMD #17-003 Re: Strategies to Address the Opioid Crisis* [letter to State Medicaid Directors]. Retrieved from <https://www.medicare.gov/federal-policy-guidance/downloads/smd17003.pdf>. (p. 3).

<sup>26</sup> *Wit*, 2019 WL 1033730, at \*15; 2020 WL 6479273, at \* 55.

<sup>27</sup> American Society of Addiction Medicine. *What is ASAM CONTINUUM?* Retrieved from <https://www.asamcontinuum.org/about/>.

<sup>28</sup> Kolsky, G.D. (2006). Current State AOD Agency Practices Regarding the Use of Patient Placement Criteria (PPC) – An Update. *The National Association of State Alcohol and Drug Abuse Directors*. Retrieved from the American Society of Addiction Medicine’s website:

[https://www.asam.org/docs/publications/survey\\_of\\_state\\_use\\_of\\_ppc\\_nasada-2006.pdf?Status=Master&sfvrsn=2](https://www.asam.org/docs/publications/survey_of_state_use_of_ppc_nasada-2006.pdf?Status=Master&sfvrsn=2).

*Wit*, 2019 WL 1033730 at \*15.

<sup>29</sup> Section 1115(a) demonstrations (“1115 waivers”) allow states to seek a waiver of “certain federal Medicaid requirements so that states can test new or existing ways to deliver and pay for health services,” including receiving federal reimbursement for SUD services that would not otherwise be permitted by law.

Centers for Medicare & Medicaid Services. (November 1, 2017). *SMD #17-003 Re: Strategies to Address the Opioid Crisis* [letter to State Medicaid Directors]. Retrieved from <https://www.medicare.gov/federal-policy-guidance/downloads/smd17003.pdf>. (p. 2, 8).

<sup>30</sup> State Health & Value Strategies. (2019). *Implementing ASAM Criteria for SUD Treatment through Medicaid Managed Care*. Retrieved from <https://www.shvs.org/wp-content/uploads/2019/11/ASAM-Brief-Updated-Design-11.14.pdf>. (p. 1).

Maryland; New Hampshire; New Jersey; North Carolina;<sup>31</sup> Rhode Island;<sup>32</sup> Tennessee;<sup>33</sup> and Washington. See [Exhibit A](#).

- Twenty-two states require Medicaid plans to use the ASAM Criteria to define or determine medical necessity for SUD benefits: Alaska;<sup>34</sup> California; Delaware; Idaho; Indiana; Kansas;<sup>35</sup> Kentucky; Louisiana; Maryland; Michigan; Minnesota; New Hampshire; New Jersey; New Mexico; North Carolina; Ohio; Pennsylvania; Utah; Virginia; Washington; West Virginia;<sup>36</sup> and Wisconsin. See [Exhibit A](#).

## LOCADTR

The Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) was developed by the New York State Office of Addiction Services and Supports (OASAS) and Partnership to End Addiction. LOCADTR is a web-based tool that guides level of care determinations.<sup>37</sup> New York requires both providers and state-regulated commercial and Medicaid plans to use LOCADTR for medical necessity determinations.<sup>38</sup>

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<sup>31</sup> Note plans can choose between the ASAM Criteria and their own clinical review criteria.

N.C. GEN. STAT. § 58-50-61(d) (1999).

<sup>32</sup> Rhode Island requires health plans' medical necessity guidelines to be consistent with the ASAM Criteria.

R.I. GEN. LAWS § 27-38.2-1(g) (2015).

<sup>33</sup> Health plans must use the ASAM Criteria or "other evidence-based clinical guidelines...".

TENN. CODE ANN. § 56-7-2360(b) (2018).

<sup>34</sup> The Administrative Services Organization's "clinical system for evidence-based guidelines" must incorporate the medical necessity criteria required for each ASAM level of care.

Alaska Department of Health and Social Services. (2019). *Alaska 1115 Substance Use Disorder Waiver Implementation Plan – Final*. Retrieved from

[http://dhss.alaska.gov/dbh/Documents/1115/AK\\_1115waiver\\_ImplementationPlan.pdf](http://dhss.alaska.gov/dbh/Documents/1115/AK_1115waiver_ImplementationPlan.pdf). (p. 25)

<sup>35</sup> KanCare Criteria, which are a "fidelity-based adaptation" of the ASAM criteria. Centers for Medicare & Medicaid Services. (2019). Section 1115 Substance Use Disorder (SUD) Demonstration: Implementation Plan titled KanCare (Project No. 11-W-00283/7). Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/KanCare/ks-kancare-cms-appvl-sud-implementation-plan-20190807.pdf> (p. 3).

<sup>36</sup> MCOs use ASAM Criteria, "or another comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines assessment criteria" for residential treatment medical necessity determinations.

Center for Medicare & Medicaid Services. (2019). *West Virginia Creating Continuum of Care for Medicaid Enrollees with Substance Use Disorders* [letter of approval for West Virginia's section 1115 demonstration project, No. 11-W-0028516]. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wv/wv-creating-continuum-care-medicaid-enrollees-substance-ca.pdf>. (PDF p. 20-21).

<sup>37</sup> New York State Office of Addiction Services and Supports. *Level of Care Determination (LOCADTR)*. Retrieved from <https://oasas.ny.gov/locadtr>.

<sup>38</sup> N.Y. INS. LAW §§ 3216(i)(30)(D) (2016), (31)(E) (2018); N.Y. INS. LAW § 3221(l)(6)(D) (2016), (7)(E) (2018); N.Y. INS. LAW § 4303(k)(4) (2016), (l)(5) (2018).

New York State Office of Addiction Services and Supports. (2019). *Guidance for the Implementation of Coverage and Utilization Review Changes Pursuant to Chapter 57 of the Laws of 2019*. Retrieved from

<https://oasas.ny.gov/system/files/documents/2020/01/insurance-law-guidance.pdf>. (pp. 1–2).

New York State Department of Health. (2015). *Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract*. Retrieved from

[https://www.health.ny.gov/health\\_care/managed\\_care/docs/medicaid\\_managed\\_care\\_fhp\\_hiv-snp\\_model\\_contract.pdf](https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf). (PDF pp. 82-83).

## InterQual Behavioral Health Criteria

McKesson's InterQual's Behavioral Health Criteria are used by health plans to make initial and continued stay level of care determinations for patients with SUDs and psychiatric conditions. The criteria consider a patient's "behavior, symptoms, functions, social risks and social supports" to determine the appropriate level of care.<sup>39</sup> Vermont Medicaid uses InterQual for utilization management determinations.<sup>40</sup>

## MCG Behavioral Health Care Guidelines

The MCG Behavioral Health Care Guidelines are also used by health plans in utilization management determinations. The guidelines are used to assess placement for five levels of care – inpatient, residential, partial hospitalization, intensive outpatient and outpatient care.<sup>41</sup>

# State Standards

As of October 1, 2020, 19 states have passed laws or adopted regulations to require health plans to use specific criteria or tools for determining medical necessity for SUD treatment in state-regulated commercial and/or Medicaid health plans:

- Fifteen states have laws or regulations requiring commercial health plans to use a specific criteria or tool for determining medical necessity for SUD benefits: California; Colorado; Connecticut; Delaware; Illinois; Maryland; New Hampshire; New Jersey; New York; North Carolina; Rhode Island; Tennessee; Texas; Washington; and West Virginia.
- Nine states have laws or regulations requiring Medicaid plans to use a specific criteria or tool for determining medical necessity for SUD benefits: Delaware; Idaho; Maryland; New Hampshire; New Jersey; New Mexico; New York;<sup>42</sup> Ohio; and Virginia.

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<sup>39</sup> McKesson, Care Providers and Payers: InterQual Evidence-Based Clinical Content. Retrieved from <https://www.mckesson.com/documents/health-plans/interqual-criteria/>

<sup>40</sup> State of Vermont Agency of Human Services, Office of the Secretary. (2018). Global Commitment to Health Section 1115 Demonstration, 11-W-00194/1. Retrieved from the Center for Medicare & Medicaid's website <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/Global-Commitment-to-Health/vt-global-commitment-to-health-cms-appvl-demo-amend-06062018.pdf>. (PDF pp. 192-93).

<sup>41</sup> MCG. *MCG Behavioral Health Care Guidelines*. Retrieved from <https://www.mcg.com/care-guidelines/behavioral-healthcare/>.

<sup>42</sup> New York's requirement in Medicaid is established through regulatory guidance. New York State Office of Addiction Services and Supports. (2019). *Guidance for the Implementation of Coverage and Utilization Review Changes Pursuant to Chapter 57 of the Laws of 2019*. Retrieved from <https://oasas.ny.gov/system/files/documents/2020/01/insurance-law-guidance.pdf>. (pp. 1–2).

- Louisiana,<sup>43</sup> Massachusetts,<sup>44</sup> and West Virginia<sup>45</sup> rest authority in the provider to determine medical necessity.

## Medicaid Standards

Section 1115(a) demonstrations (“1115 waivers”) allow states to seek a waiver of “certain federal Medicaid requirements so that states can test new or existing ways to deliver and pay for health services,” including receiving federal reimbursement for SUD services that would not otherwise be permitted by law.<sup>46</sup> Currently, 27 states and the District of Columbia have 1115 waivers for SUD treatment.<sup>47</sup>

The Centers for Medicare and Medicaid Services (CMS) requires states with 1115 waivers to meet certain milestones, including, “implementation of a utilization management approach such that a) beneficiaries have access to SUD services at the appropriate level of care, [and] b) interventions are appropriate for the diagnosis and level of care ...” within two years of approval of the demonstration.<sup>48</sup> Under CMS’s guidelines, states must also require Medicaid providers to conduct treatment assessments using “multi-dimensional tools” such as the ASAM Criteria “or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines.”<sup>49</sup>

As noted above, 24 states have also required Medicaid plans to use specific medical necessity criteria or patient placement/level of care/assessment tools to determine medical necessity for SUD treatment.

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<sup>43</sup> Medical necessity for opioid use disorder (OUD)/SUD residential treatment and withdrawal management provided under the 1115 waiver are determined by a licensed mental health provider or physician. LA. ADMIN. CODE tit. 50, Pt. XXII, § 6501(B) (2019).

<sup>44</sup> MASS. GEN. LAWS ch. 32A, § 17N (2018); MASS. GEN. LAWS ch. 175 § 47GG (2018); MASS. GEN. LAWS ch. 176A, § 8I (2018); MASS. GEN. LAWS ch. 176B, § 4I (2018); MASS. GEN. LAWS ch. 176G, § 4AA (2018).

<sup>45</sup> W. VA. CODE §§ 33-15-4r(d), (k); 33-16-3cc(d), (k); 33-24-7r(d), (k); 33-25-8o(d), (k); 33-25A-8r(d), (k) (2018).

<sup>46</sup> Centers for Medicare & Medicaid Services. November 1, 2017). *SMD #17-003 Re: Strategies to Address the Opioid Crisis* [letter to State Medicaid Directors]. Retrieved from <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>. (p. 2).

<sup>47</sup> Kaiser Family Foundation. (2020). *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State – Waivers with Behavioral Health Provisions: Approved and Pending as of September 1, 2020*. Retrieved from <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table5>. Alaska; California; Delaware; District of Columbia; Idaho; Illinois; Indiana; Kansas; Kentucky; Louisiana; Maryland; Massachusetts; Michigan; Minnesota; Nebraska; New Hampshire; New Jersey; New Mexico; North Carolina; Ohio; Pennsylvania; Rhode Island; Utah; Vermont; Virginia; Washington; West Virginia; and Wisconsin.

<sup>48</sup> *Id.* at 8.

<sup>49</sup> *Id.*

- Twenty-two states require Medicaid plans to use the ASAM Criteria to define or determine medical necessity for SUD benefits: Alaska;<sup>50</sup> California; Delaware; Idaho; Indiana;<sup>51</sup> Kansas;<sup>52</sup> Kentucky; Louisiana; Maryland; Michigan; Minnesota; New Hampshire; New Jersey; New Mexico; North Carolina; Ohio; Pennsylvania; Utah; Virginia; Washington; West Virginia;<sup>53</sup> and Wisconsin.
- New York requires Medicaid plans to use LOCADTR for SUD medical necessity determinations<sup>54</sup> and Vermont uses InterQual tools.<sup>55</sup>

## Wit v. United Behavioral Health

In 2019, the federal district court in California issued a landmark nationwide class action decision regarding the medical necessity criteria utilized by health plans for SUD treatment. The court found that United Behavioral Health (UBH) breached its fiduciary duty by applying medical necessity criteria for SUD that were more restrictive than generally accepted standards of care and adopted its standards to prioritize the health plan’s financial interests to control costs.<sup>56</sup> The court reaffirmed its findings in a subsequent order, issued in November 2020, that sets out the remedial measures

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<sup>50</sup> The Administrative Services Organization’s “clinical system for evidence-based guidelines” must incorporate the medical necessity criteria required for each ASAM level of care.

Alaska Department of Health and Social Services. (2019). *Alaska 1115 Substance Use Disorder Waiver Implementation Plan – Final*. Retrieved from

[http://dhss.alaska.gov/dbh/Documents/1115/AK\\_1115waiver\\_ImplementationPlan.pdf](http://dhss.alaska.gov/dbh/Documents/1115/AK_1115waiver_ImplementationPlan.pdf). (p. 25).

<sup>51</sup> The ASAM Criteria must be incorporated into the managed care entity’s guidelines for SUD assessments, level of care determinations and length of stay requests for inpatient and residential treatment. Retrieved from

<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-sud-implementation-prtcl-appvl-02012018.pdf> (p. 19).

<sup>52</sup> KanCare Criteria, which are a “fidelity-based adaptation” of the ASAM criteria. Centers for Medicare & Medicaid Services. (2019). Section 1115 Substance Use Disorder (SUD) Demonstration: Implementation Plan titled KanCare (Project No. 11-W-00283/7). Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/KanCare/ks-kancare-cms-appvl-sud-implementation-plan-20190807.pdf> (p. 3).

<sup>53</sup> MCOs use ASAM Criteria, “or another comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines assessment criteria” for residential treatment medical necessity determinations.

Center for Medicare & Medicaid Services. (2019). *West Virginia Continuum of Care for Medicaid Enrollees with Substance Use Disorders* [letter of approval for West Virginia’s section 1115 demonstration project, No. 11-W-0028516]. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wv/wv-creating-continuum-care-medicaid-enrollees-substance-ca.pdf>. (PDF pp. 20-21).

<sup>54</sup> New York State Department of Health. (2015). *Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract*. Retrieved from

[https://www.health.ny.gov/health\\_care/managed\\_care/docs/medicaid\\_managed\\_care\\_fhp\\_hiv-snp\\_model\\_contract.pdf](https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf). (PDF pp. 82,99).

<sup>55</sup> State of Vermont Agency of Human Services, Office of the Secretary. (2018). Global Commitment to Health Section 1115 Demonstration, 11-W-00194/1. Retrieved from the Center for Medicare & Medicaid’s website

<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/Global-Commitment-to-Health/vt-global-commitment-to-health-cms-appvl-demo-amend-06062018.pdf>. (PDF pp. 192-93)

<sup>56</sup> *Wit*, 2019 WL 1033730, at \*49; 2020 WL 6479273, at \* 48-49, \* 51.

required to address UBH’s violation.<sup>57</sup> The court identified a number of specific sources that reflect generally accepted standards of care, including: the ASAM Criteria; Level of Care Utilization System (LOCUS); Child and Adolescent Level of Care Utilization System (CALOCUS); Child and Adolescent Service Intensity Instrument (CASII); CMS Medicare benefit policy manual; American Psychiatric Association (APA) Practice Guidelines for SUD and Major Depressive Disorders; and the American Academy of Child and Adolescent Psychiatry’s Principles of Care for Treatment of Children and Adolescents with Mental Illnesses.<sup>58</sup> The court then identified eight “principles of accepted standards”<sup>59</sup> and found that the medical necessity guidelines developed by UBH were more restrictive than these generally accepted standards of care because they over-emphasize moving patients to less intensive settings and treating acute symptoms rather than providing long-term disease management. UBH was also found to not have specific criteria for children and adolescents or residential SUD treatment. Finally, the court determined that UBH violated specific state laws requiring health plans to use specific level of care guidelines (see below).<sup>60</sup>

## Enforcement

Adopting standardized criteria or tools to determine medical necessity allows for better regulatory oversight and enforcement. In *Wit*, the court found that, in addition to breaching its fiduciary duty, UBH also violated state laws in Illinois, Connecticut, Rhode Island and Texas by utilizing its own internal medical necessity criteria, rather than the criteria required by state law.<sup>61</sup> The Wit Court’s remedy order requires UBH to reprocess approximately 67,000 claims, using state-required criteria or the ASAM Criteria and other designated criteria that the Court has identified as being consistent with generally accepted standards of care.<sup>62</sup> To prevent future violations, the Court also requires UBH to use these same criteria for future claims over the next 10 years.<sup>63</sup>

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<sup>57</sup> *Wit*, 2020 WL 6479273 (N.D. Cal. Nov. 3, 2020).

<sup>58</sup> *Wit*, 2019 WL 1033730, at \*14; 2020 WL 6479273, at \* 48-49.

<sup>59</sup> The eight generally accepted standards of care include: (1) “effective treatment requires treatment of the individual’s underlying condition and is not limited to alleviation of the individual’s current symptoms;” (2) “effective treatment requires treatment of co-occurring behavioral health disorders and/or medical conditions in a coordinated manner that considers the interactions of the disorders and conditions and their implications for determining the appropriate level of care;” (3) “patients should receive treatment for mental health and substance use disorders at the least intensive and restrictive level of care that is safe and effective;” (4) “when there is ambiguity as to the appropriate level of care, the practitioner should err on the side of caution by placing the patient in a higher level of care;” (5) “effective treatment of mental health and substance use disorders includes services needed to maintain functioning or prevent deterioration;” (6) “the appropriate duration of treatment for behavioral health disorders is based on the individual needs of the patient; there is no specific limit on the duration of such treatment;” (7) “the unique needs of children and adolescents must be taken into account when making level of care decisions involving their treatment for mental health or substance use disorders;” and (8) “the determination of the appropriate level of care for patients with mental health and/or substance use disorders should be made on the basis of a multidimensional assessment that takes into account a wide variety of information about the patient.” *Wit*, 2019 WL 1033730, at \*17 – 21; 2020 WL 6479273, at \* 48-49.

<sup>60</sup> *Wit*, 2019 WL 1033730, at \*55; 2020 WL 6479273, at \* 50-51.

<sup>61</sup> *Id.*

<sup>62</sup> *Wit*, 2020 WL 6479273, at \* 54-55.

<sup>63</sup> *Id.*

Market conduct exams in Illinois and New Hampshire have found that health plans failed to use the medical necessity guidelines required by state law, and regulators have levied large penalties against carriers.<sup>64</sup> The New York Attorney General found that health plans did not comply with the State's requirement to use a specific level of care tool (LOCADTR).<sup>65</sup> Oversight and enforcement of insurance requirements is critical for ensuring health plan compliance.

## Recommendations

State lawmakers and insurance regulators should take the following steps to ensure health plans use medical necessity criteria that reflect generally accepted standards of care for SUD treatment; standardize the use of specific medical necessity criteria; and ensure fidelity in application of the criteria by requiring the use of a standardized tool.

1. States should require, via statute or regulation, all private health plans and Medicaid plans to use a uniform set of state-designated medical necessity criteria for SUD services. The medical necessity criteria should be evidence-based and consistent with the generally accepted standards of care.<sup>66</sup> A uniform set of criteria will also aid patients and providers seeking to challenge medical necessity determinations because they will no longer need to rely on a health plan to disclose its criteria.

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<sup>64</sup> CIGNA Healthcare paid \$582,000 for failing to use the ASAM Criteria and other violations; UnitedHealthcare paid \$550,000 for failing to use the ASAM criteria and other violations; and CIGNA Health and Life paid \$418,000 for violating the ASAM guidelines and other violations.

Illinois Department of Insurance. (2020, July 15). *Pritzker Administration Announces Over \$2 million in Fines for Major Health Insurance Companies Violating Illinois Mental Health Parity Laws*. Retrieved from [https://www2.illinois.gov/IISNews/21819-IDOI\\_Press\\_Release.pdf](https://www2.illinois.gov/IISNews/21819-IDOI_Press_Release.pdf).

New Hampshire Insurance Department. (2020). *New Hampshire Insurance Department Market Conduct Targeted Examination of Harvard Pilgrim Health Care of New England, Inc., NAIC # 96717, 93 Worcester Street, Wellesley, Massachusetts 02481, For the Period of January 1, 2016 through July 31, 2017, Regarding Mental Health Parity and Substance Use Disorder Benefit Treatments, Docket No. Ins 17-047-MC* at p. 17. Retrieved from <https://www.nh.gov/insurance/consumers/documents/harvard-pilgrim-parity-exam-final-report.pdf>.

<sup>65</sup> New York State Office of the Attorney General. (2014). *In the Matter of MVP Health Care, Inc., Assurance No.: 14-006, Assurance of Discontinuance Under Executive Law Section 63, Subdivision 15*. Retrieved from [https://ag.ny.gov/sites/default/files/pdfs/bureaus/health\\_care/new/2014-03-19%20MVP%20Parity\\_MR.pdf](https://ag.ny.gov/sites/default/files/pdfs/bureaus/health_care/new/2014-03-19%20MVP%20Parity_MR.pdf). (p. 6).

New York State Office of the Attorney General. (2015). *In the Matter of Excellus Health Plan, Inc., Assurance No.: 14-201, Assurance of Discontinuance Under Executive Law Section 63, Subdivision 15*. Retrieved from Legal Action Center's website: <https://www.lac.org/assets/files/Excellus-Parity-AOD-Executed.pdf>. (p. 8).

New York State Office of the Attorney General. (2014). *In the Matter of EmblemHealth, Inc., Assurance No.: 14-031, Assurance of Discontinuance Under Executive Law Section 63, Subdivision 15*. Retrieved from [https://ag.ny.gov/pdfs/2014-07-03-EmblemParity\\_MR.pdf](https://ag.ny.gov/pdfs/2014-07-03-EmblemParity_MR.pdf). (p. 11).

New York State Office of the Attorney General. (2015). *In the Matter of ValueOptions, Inc., Assurance No.: 14-176, Assurance of Discontinuance Under Executive Law Section 63, Subdivision 15*. Retrieved from <https://ag.ny.gov/pdfs/ValueOptionsAOD-FullyExecuted.pdf>. (pp. 14-15).

<sup>66</sup> See e.g., *Wit*, 2019 WL 1033730 at \*17 -21; and California Legislature. (2020). SB-855, Health coverage: mental health or substance use disorders. Retrieved from [https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill\\_id=201920200SB855](https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB855).

2. States should designate a patient level of care assessment tool and require it to be used by both health plans and treatment providers. The tool should be evidence-based and clinically reviewed. Many states are already requiring providers to use patient placement tools for assessments, level of care determinations, continued stay requests and discharge planning, and health plans should be required to use the same tools for medical necessity determinations. Utilization of the same tool by all parties will help ensure fidelity to the medical necessity criteria and create consistency in treatment determinations.
3. Health plans should be barred from denying service authorizations or claims for lack of medical necessity unless the care requested or provided was contrary to the state-designated patient placement tool.<sup>67</sup> The prescribing practitioner should have the responsibility to make the medical necessity determination, which should be overturned by the plan only if the care is not supported based on application of the state-designated tool. This helps to ensure that patients are held harmless for costs related to care that is determined to be not medically necessary during a retrospective review.
4. Insurance regulators and/or state attorneys general should enforce state law requirements related to the implementation of specific medical necessity criteria and/or level of care assessment tools through market conduct exams, investigations of consumer complaints, and system-wide investigations based on disparate levels of service and claim denials. Medical necessity requirements are meaningless if not well enforced.
5. In states that have not adopted requirements for insurers to use specific medical necessity criteria, state insurance regulators should review health plans' medical necessity criteria to ensure consistency with the specific sources that reflect generally accepted standards of care.

## Conclusion

A health plan's selection and application of medical necessity criteria will determine whether a patient will receive SUD care, the level of care prescribed by a practitioner and the duration of treatment. Historically, health plans have developed their own criteria for SUD treatment approval and level of care determinations, and have resisted disclosing both their standards and explanations of how the criteria apply to a member's specific condition. The Parity Act's non-discrimination standards and the *Wit* case confirm what many mental health and substance use disorder patients, providers and advocates have known: health

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<sup>67</sup> See e.g., DEL. CODE ANN. tit. 18, §§ 3343(d)(1)(d), 3578(d)(1)(d) (2017); N.Y. INS. LAW §§ 3216(i)(30)(D), (31)(E) (2019); N.Y. INS. LAW § 3221(l)(6)(D), (7)(E) (2019); N.Y. INS. LAW § 4303(k)(4), (l)(5) (2019).



plans use medical necessity criteria to restrict care and control costs. Federal law and federal court decisions affirm that health plans have a fiduciary duty to utilize medical necessity criteria for SUD and MH care that meet objective standards for patient care, are applied in a non-discriminatory way and are comparable to criteria for other medical services.

A growing number of states are regulating medical necessity standards for SUD treatment by requiring health plans to use specific medical necessity criteria and, in some cases, level of care assessment tools to ensure a more standardized application of medical necessity criteria. Ensuring that medical necessity criteria are evidence-based and consistent with generally accepted standards of care ensures patients with SUD will be able to access affordable, life-saving care.

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# EXHIBIT A

## State Requirements for Commercial and Medicaid Health Plans to Use Specific Criteria for SUD Medical Necessity Determinations

State	State-Regulated Commercial	Medicaid
Alabama	N/A	N/A
Alaska	N/A	Alaska Medicaid utilizes an Administrative Services Organization (ASO) to review the provider’s use of ASAM Criteria in the clinical assessment. The ASO’s “clinical system for evidence-based guidelines” must incorporate the medical necessity criteria required for each ASAM level of care and be approved by Alaska Medicaid. ( <a href="#">Alaska 1115 Substance Use Disorder Waiver Implementation Plan – Final (2019)</a> , p. 25).
Arizona	N/A	N/A
Arkansas	N/A	N/A
California	Health plans are required to base any medical necessity determinations on generally accepted standards of care for MH/SUD. When conducting utilization review, health plans must use the “criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.” ( <a href="#">SB 855</a> §§ 5, 8, signed by Governor September 25, 2020; to be codified at CAL. HEALTH & SAFETY CODE § 1374.21, CAL. INS. CODE § 10144.5).	The ASAM Criteria is used to define medical necessity. ( <a href="#">Drug Medi-Cal Organized Delivery System (2015)</a> , PDF p. 131).
Colorado	Health plans must utilize the ASAM Criteria for placement, medical necessity, and utilization management determinations for SUD treatment. If the ASAM Criteria are no longer available, relevant, or do not follow best practices for SUD, the insurance commissioner will designate an alternate nationally recognized and evidence-based SUD-specific criteria for placement, medical necessity, or utilization management. ( <a href="#">SB 20-007</a> , signed July 13, 2020; to be codified at COLO. REV. STAT. § 10-16-104(5.5)(a)(I)(B)).	N/A

Connecticut	<p>Health plans must use the ASAM Criteria or clinical review criteria that the carrier demonstrates is consistent with the ASAM Criteria for SUD treatment utilization review determinations. Carriers can develop or purchase/license clinical review criteria to address technological or treatment advancements that are not covered in the ASAM Criteria. Any clinical review criteria developed/purchased/licensed by the carrier “must be based on sound clinical evidence” and periodically evaluated by the carrier (CONN. GEN. STAT. § 38a-591c(3) (2017)).</p> <p>The Department of Mental Health and Addiction Services relies on the ASAM Criteria or another state-authorized level of care tool to define “medical necessity” for substance use disorders. (CONN. AGENCIES REGS. § 17a-453a-2 (31) (2009)).</p>	N/A
Delaware	<p>SUD treatment facilities and carriers must use the ASAM Criteria to determine medical necessity. (DEL. CODE ANN. tit. 18, §§ 3343(d)(1)(c), 3578(d)(1)(c) (2017)).</p> <p>Health plans must cover unlimited, medically necessary residential, intensive outpatient, and inpatient withdrawal management treatment for SUD as determined by the use of the full set of ASAM Criteria. (DEL. CODE ANN. tit. 18, §§ 3343(b)(1)(a)(2), 3578(b)(1)(a)(2) (2017)).</p> <p>Any portion of the initial 14 days of inpatient SUD treatment can only be denied on the basis of lack of medical necessity if treatment was contrary to the ASAM Criteria. (DEL. CODE ANN. tit. 18, §§ 3343(d)(1)(d), 3578(d)(1)(d) (2017)).</p>	<p>SUD treatment facilities and carriers must use the ASAM Criteria to determine medical necessity. (DEL. CODE ANN. tit. 31, § 525(d)(1)(c) (2017)).</p> <p>Medicaid plans must cover unlimited, medically necessary residential, intensive outpatient and inpatient withdrawal management for SUD as determined by the use of the full set of ASAM Criteria. (DEL. CODE ANN. tit. 31, § 525(b)(a)(2) (2017)).</p> <p>Any portion of the initial 14 days of inpatient SUD treatment can only be denied on the basis of lack of medical necessity if treatment was contrary to the ASAM Criteria. (DEL. CODE ANN. tit. 31, § 525(d)(1)(d) (2017)).</p> <p>Delaware utilizes a state specific ASAM tool for eligibility and treatment determinations. <a href="#">(Delaware Diamond State Health Plan 1115(a) Demonstration (2019), p. 86).</a></p>
District of Columbia	N/A	N/A
Florida	N/A	N/A
Georgia	N/A	N/A
Hawaii	N/A	N/A
Idaho	N/A	ASAM Criteria used to make medical management decisions. <a href="#">(Idaho Behavioral</a>

		<a href="#">Health Transformation (2020), PDF pp. 88-89).</a>
Illinois	<p>Insurers must use the ASAM Criteria to make medical necessity determinations for SUD treatment and are prohibited from using any additional criteria for SUD medical necessity determinations. (215 ILL. COMP. STAT. 5/370c(b)(3) (2017)).</p> <p>Insurers must use the ASAM Criteria to determine medical necessity for acute treatment services, clinical stabilization services, and medication-assisted treatment. (215 ILL. COMP. STAT. 5/370c(b)(5.5) (2017)).</p>	N/A
Indiana	N/A	<p>Managed care plans are required to use a “nationally recognized set of guidelines for its medical management criteria,” such as InterQual, Milliman Care Guidelines, “or any other accepted set of evidence-based guidelines.” The ASAM Criteria must be incorporated into the managed care entity’s guidelines for SUD assessments, level of care determinations and length of stay requests for inpatient and residential treatment. (<a href="#">State of Indiana 1115 SUD Waiver Implementation Plan (2018), p. 19</a>).</p>
Iowa	N/A	N/A
Kansas	N/A	<p>“The KanCare criteria for treatment is a fidelity-based adaptation of the ASAM Patient Placement Criteria.” (<a href="#">KanCare (2019), p. 3</a>).</p>
Kentucky	N/A	<p>MCOs are required to use ASAM Criteria for authorization of SUD treatment and recovery services. (<a href="#">Commonwealth of Kentucky Section 1115 Substance Use Disorder (SUD) Demonstration Implementation Plan (2018), p. 9</a>).</p>
Louisiana	N/A	<p>Medical necessity for OUD/SUD residential treatment and withdrawal management provided under the 1115 waiver are determined by a licensed mental health provider or physician. (LA. ADMIN. CODE tit. 50, Pt. XXII, § 6501(B) (2019)).</p> <p>MCO SUD service authorization criteria must meet ASAM Criteria standards. (<a href="#">Healthy Louisiana Opioid Use Disorder/Substance Use Disorder 1115 Demonstration (2018), PDF p. 101</a>).</p>
Maine	N/A	N/A

Maryland	Health plans must use the ASAM Criteria for all medical necessity criteria and utilization management determinations for SUD benefits. (MD. CODE ANN., INS. § 15-802(d)(5) (2019)).	In Medicaid, Administrative Service Organizations (ASOs) must use the ASAM Criteria to determine medical necessity for residential SUD services. (MD. CODE REGS. 10.09.06.08(B)(1) (2017); <a href="#">(HealthChoice Medicaid Section 1115 Demonstration (2016), PDF p. 29)</a> ).
Massachusetts	“Medical necessity for acute treatment services and clinical stabilization services shall be determined by the treating clinician in consultation with the patient...” (Mass. Gen. Laws ch. 32A, § 17N (2018); Mass. Gen. Laws ch. 175 § 47GG (2018); Mass. Gen. Laws ch. 176A, § 8II (2018); Mass. Gen. Laws ch. 176B, § 4II (2018); Mass. Gen. Laws ch. 176G, § 4AA (2018)).	N/A
Michigan	N/A	Health plans must use the ASAM Criteria for all treatment authorization decisions. <a href="#">(Michigan 1115 Behavioral Health Demonstration (2019), pp. 56, 58, 114, 127–128)</a> .
Minnesota	N/A	Minnesota uses evidence-based placement criteria based on the ASAM six dimensions of multidimensional assessment, and it will assess where its policies need to be more closely aligned with the ASAM placement criteria. MCOs are required to conduct an assessment that incorporates the six dimensions of the ASAM placement criteria to assess the SUD treatment needs of beneficiaries. The state is updating its patient placement criteria to align with the ASAM levels of care by June 2021. <a href="#">(Minnesota Substance Use Disorder System Reform (/2020), PDF p. 60-62)</a> .
Mississippi	N/A	N/A
Missouri	N/A	N/A
Montana	N/A	N/A
Nebraska	N/A	N/A
Nevada	N/A	N/A
New Hampshire	Health plans must rely on ASAM Criteria when determining medical necessity and developing utilization review standards for SUD benefits. Health plans must file an annual attestation of compliance with the insurance commissioner. (N.H. REV. STAT. ANN. § 420-J:16 (2016)).	SUD services must be delivered in accordance with the ASAM Criteria and provided in accordance with the ASAM Levels of Care descriptions. (N.H. CODE ADMIN. R. ANN. He-W 513.05(b) (2020)).  Services delivered at a higher level than the level recommended under the ASAM Criteria are not covered by Medicaid. (N.H. CODE ADMIN. R. ANN. He-W 513.06(a) (2020)).

		State law (N.H. REV. STAT. ANN. § 420-J:16) requires all treatment programs and insurance carriers, including MCOs, to use the ASAM Criteria. ( <a href="#">Substance Use Disorder Treatment and Recovery Access (2018)</a> , p. 46).
New Jersey	<p>State-regulated health insurance carriers, the State Health Benefits Program, and the School Employees' Health Benefits Program must use a state-designated evidence-based and peer-reviewed clinical review tool for medical necessity determinations. (N.J. STAT. ANN. §§ 17:48-6nn(h); 17:48A-7kk(h); 17:48E-35.38(h); 17B:26-2.1hh(h); 17B:27-46.1nn(h); 17B:27A-7.21(h); 17B:27A-19.25(h); 26:2J-4.39(h); 52:14-17.29u(h); 52:14-17.46.6f(h) (2017)).</p> <p>The state designated the ASAM Criteria as the evidence-based clinical practice guidelines for medical necessity determinations and the LOCI or “any similar tool with fidelity to the ASAM criteria” for reviewing medical necessity for SUD treatment. (N.J. ADMIN. CODE § 10:163-2.1 (2017)).</p>	<p>Medicaid managed care organizations must use the ASAM Criteria for level of care, prior authorization and continuing care determinations (consistent with N.J. ADMIN. CODE § 10:163). (<a href="#">MCO contract</a>, PDF p. 131 (Article 4 – p. 59)).</p> <p>The state will operationalize the use of the ASAM criteria and the LOCI-3 assessment tool for SUD treatment. (<a href="#">New Jersey FamilyCare Comprehensive Demonstration (2018)</a>, PDF p. 10).</p>
New Mexico	N/A	<p>Medicaid will reimburse for services provided in residential treatment centers when patients meet ASAM Criteria level 3 requirements. (N.M. CODE R. § 8.321.2.10 (2020)).</p> <p>Medicaid will reimburse for intensive outpatient services for patients who meet ASAM Criteria level 2.1 requirements. (N.M. CODE R. § 8.321.2.25(D) (2020)).</p> <p>Patient placement and utilization determinations are based on ASAM Criteria. (<a href="#">Centennial Care 2.0 Medicaid 1115 Demonstration (2019)</a>, p. 13-14).</p>
New York	<p>Medical necessity for inpatient and outpatient SUD treatment is determined by a state-designated evidence-based and peer-reviewed clinical review tool, utilized by both the insurer and provider. (N.Y. INS. LAW §§ 3216(i)(30)(D) (2016), (31)(E) (2018); N.Y. INS. LAW § 3221(l)(6)(D) (2016), (7)(E) (2018); N.Y. INS. LAW § 4303(k)(4) (2016), (l)(5) (2018)).</p>	<p>Medicaid Managed Care plans are required, by contract, to use LOCADTR 3.0. Other clinical review tools can be submitted to and designated by OASAS if they meet requirements set forth in statute. (<a href="#">OASAS Guidance for the Implementation of Coverage and Utilization Review Changes Pursuant to Chapter 57 of the Laws of 2019</a>, p. 3-4).</p>

	<p>The insurer may only deny the first 28 days of inpatient or outpatient treatment for lack of medical necessity if the treatment was contrary to the state-designated evidence-based and peer-reviewed clinical review tool. (N.Y. INS. LAW §§ 3216(i)(30)(D), (31)(E) (2019); N.Y. INS. LAW § 3221(l)(6)(D), (7)(E) (2019); N.Y. INS. LAW § 4303(k)(4), (l)(5) (2019)).</p> <p>The evidence-based and peer-reviewed clinical review tool designated by the state is LOCADTR 3.0. Commercial insurers may only use LOCADTR 3.0 or another OASAS-designated tool for care provided within NYS. Other clinical review tools can be submitted to and designated by OASAS if they meet requirements set forth in statute. (<a href="#">OASAS Guidance for the Implementation of Coverage and Utilization Review Changes Pursuant to Chapter 57 of the Laws of 2019 p. 3-4; Insurance Circular No. 13 (2019)</a>)</p>	<p>The Medicaid Managed Care <a href="#">model contract</a> requires use of LOCADTR to make initial and ongoing level of care determinations for SUD services. (PDF p. 82, 99).</p>
North Carolina	<p>Insurers must use either the ASAM Criteria or clinical review criteria adopted by the insurer or its utilization review organization when determining whether a patient needs to be placed in SUD treatment. (N.C. GEN. STAT. § 58-50-61(d) (1999)).</p>	<p>Medicaid MCOs, standard plans and BH I/DD tailored plans must use the ASAM Criteria to determine medical necessity. (<a href="#">North Carolina Medicaid Reform Demonstration (2019), PDF p. 94</a>).</p>
North Dakota	N/A	N/A
Ohio	N/A	<p>SUD treatment must be defined by and provided according to ASAM Criteria for admission, continued stay, discharge, or level of care referral. (OHIO ADMIN. CODE 5160-27-09(A) (2017)).</p> <p>SUD services provided in the managed care and fee-for-service delivery systems must comply with the ASAM Criteria for all prior authorization and utilization review decisions. (<a href="#">Section 1115 Demonstration Waiver Proposal for Substance Use Disorder Treatment (2019), PDF p. 7</a>).</p>
Oklahoma	N/A	NA
Oregon	N/A	N/A
Pennsylvania	N/A	<p>Effective July 2018, ASAM Criteria must be used for level of care determinations, and behavioral health MCOs are required to conduct utilization management in accordance with ASAM. (<a href="#">Pennsylvania</a></p>

		<b>Substance Use Disorder (SUD) 1115 Demonstration (2018), PDF pp. 72).</b>
Rhode Island	Health plans must rely on the ASAM Criteria when developing coverage for SUD levels of care. (R.I. GEN. LAWS § 27-38.2-1(g) (2015)). <sup>68</sup>	N/A
South Carolina	N/A	N/A
South Dakota	N/A	N/A
Tennessee	Health plans must use the ASAM Criteria or “other evidence-based clinical guidelines,” such as those referenced by SAMHSA, as the clinical review criteria for all SUD utilization review or benefit determinations and may not use any additional criteria. (TENN. CODE ANN. § 56-7-2360(b) (2018)).	N/A
Texas	Plans are required to comply with utilization review standards and guidelines established by the Texas Commission on Alcohol and Drug Abuse for SUD treatment admission to appropriate level of care, continued stay, and discharge (for inpatient or residential detoxification, inpatient rehabilitation/treatment (inpatient or residential), partial hospitalization, intensive outpatient, outpatient, and outpatient detoxification services). (28 TEX. ADMIN. CODE § 3.8001 – 3.8030 (1991)).	N/A
Utah	N/A	Utilization review processes are based on ASAM criteria. ( <b>Primary Care Network (2019), PDF pp. 81, 83).</b>
Vermont	N/A	The utilization management team uses McKesson InterQual tools. ( <b>Global Commitment to Health, Section 1115 Demonstration (2018), PDF pp. 192-93).</b>
Virginia	N/A	Medical necessity determinations for Addiction and Recovery Treatment Services in Medicaid are based on the ASAM Criteria. (12 VA. ADMIN. CODE §§ 30-130-5040(C); 30-130-5030 (2020) <b>Virginia’s Addiction and Recovery Treatment Services Delivery System Transformation (2016), p. 33).</b>
Washington	Insurance code defines medical necessity with regard to SUD by the most recent version of the ASAM Criteria. (WASH. ADMIN. CODE § 284-43-7010 (2020)).	MCO utilization review for residential treatment must be based on medical necessity and ASAM placement criteria.

<sup>68</sup> The Court in *Wit v. United Behavioral Health* has interpreted this provision to require payers to use criteria that are consistent with the ASAM Criteria to make coverage determinations. 2019 WL 1033730, at \* 44 (N.D. Cal. March 5, 2019).



	<p>By Jan. 1, 2021, the state will adopt a standard set of criteria to define medical necessity and level of care for substance use disorder treatment. “The criteria selected must be comprehensive, widely understood and accepted in the field, and based on continuously updated research and evidence.” State employee health plans, health plans, and managed care organizations must base medical necessity review on the standard set of criteria. (2020 Wa. ALS 345, 2020 Wa. Ch. 345, 2019 Wa. <b>HB 2642</b>, §§ 2–4, 6) (enacted April 3, 2020; effective June 11, 2020).</p> <p>As of Jan. 1, 2021, health plans must use a (to be determined) standard set of criteria for medical necessity review for SUD treatment. (Rev. Code Wash. (ARCW) § 41.05.____ (added by 2020 Ch. 345 § 2)).</p> <p>Health plans must follow a medical necessity determination process set forth in regulation. (WASH. ADMIN. CODE § 284-43-5440(2) (2015)).</p>	<p><b>(Washington State Medicaid Transformation Project (2018), p. 327).</b></p>
<p>West Virginia</p>	<p>Health plans must use an evidence-based and peer-reviewed clinical review tool, developed by the Insurance Commissioner, to conduct medical necessity reviews. The Insurance Commissioner must develop rules to ensure the tool is based on appropriate evidence-based criteria and has been peer reviewed. (W. VA. CODE §§ 33-15-4r(j); 33-16-3cc(j); 33-24-7r(j); 33-25-8o(j); 33-25A-8r(j) (2018))</p> <p>Medical necessity for inpatient and outpatient SUD treatment and outpatient prescription drugs to treat SUD is determined by the patient’s physician, psychologist or psychiatrist. (W. VA. CODE §§ 33-15-4r(d), (k); 33-16-3cc(d), (k); 33-24-7r(d), (k); 33-25-8o(d), (k); 33-25A-8r(d), (k) (2018)).</p> <p>Medical necessity for intensive inpatient or partial hospitalization treatment is determined by the patient’s physician and cannot be reviewed by the health</p>	<p>MCOs use ASAM Criteria, “or another comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines assessment criteria” for medical necessity determinations. <b>(West Virginia Medicaid Section 1115 Waiver Amendment Approval: Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders (2019), PDF pp. 20-21).</b></p>

	plan for the first five days. (W. VA. CODE §§ 33-15-4r(i); 33-16-3cc(i); 33-24-7r(i); 33-25-8o(i); 33-25A-8r(i) (2018)).	
Wisconsin	N/A	Medical necessity criteria used by MCOs cannot be more restrictive than the definition used by fee-for-service Medicaid. For residential treatment services, “Wisconsin Medicaid will establish coverage and reimbursement policies aligned with American Society of Addiction Medicine (ASAM) criteria and state regulations, including but not limited to: eligible provider criteria, medical necessity criteria, claims submission and reimbursement guidelines, and utilization management. Benefit design and implementation will be completed by February 2020.” ( <a href="#">Wisconsin BadgerCare Reform (2018), PDF pp. 66, 69-70</a> ).
Wyoming	N/A	N/A