Washington State Health Care Authority

Transition to the American Society of Addiction Medicine Criteria, 4th Edition

Edition Information and Implementation Guidebook

Volume 1: Adults

Volume 2: Adolescents and Transition Age Youth

Introduction to the American Society of Addiction Medicine (ASAM) Criteria, 4th Edition 3
Disclaimer: 3
Questions? 3
ASAM Criteria, 4th Edition Implementation Roadmap 4
Transition to ASAM Criteria, 4th edition 4
Objectives 4
Readiness phases 5
Yearly themes 5
Statewide infrastructure changes 6
Partner Expectations and Responsibilities 7
Responsibilities and expectations 7
ASAM Criteria, 4th Edition General Updates 8
ASAM Criteria, 4th edition key updates 8
Broadscale updates 8
Level of Care Changes: 9
The ASAM Criteria, 4th Edition 12
ASAM Criteria, 4th Edition Pre-Implementation Readiness 18
ASAM Criteria, 4th edition readiness 18
Referral network and staffing needs 18
Medications 18
Curriculum 18
Family engagement 18
Assessment 19
Level of care changes: adult volume eliminated criteria 19
ASAM Criteria, 4th Edition Staffing Requirements: Adult Volume 20
ASAM Criteria, 4th Edition Staffing Requirements: ATAY Volume 23
COC and COE Levels of Care 27
COC versus COE services: adult and ATAY volumes 27
Referral services 30

Introduction to the American Society of Addiction Medicine (ASAM) Criteria, 4th Edition

This guidebook was created to assist Tribes, payers, providers, behavioral health agencies, and other entities that are impacted by the statewide transition to the ASAM Criteria, 4th edition. There are three main documents within this guidebook: The Implementation Roadmap, The Transition to the 4th Edition, and the Pre-Implementation Readiness Guide. The Implementation Roadmap is a high-level overview of the processes that will happen over the next two years to prepare the state to go live with ASAM 4 on January 1, 2028. The Transition and Pre-Implementation documents are designed to assist clinical providers with adopting the 4th edition in Washington state.

Disclaimer:

This guidebook is intended to supplement and does not replace the physical or digital copy of the ASAM Criteria. The ASAM Criteria, 4th edition, Volume 1: Adults and Volume 2: Adolescents and Transition-Aged Youth (ATAY), and subsequent volumes, which should remain your primary reference and can be purchased at **asam.org**.

Questions?

On ASAM transition and other related questions: Contact HCA at **SUDdbhrproviderhelp@hca.wa.gov**.

For ATAY questions, please include "ATAY" in the subject line.

For all Washington state ASAM updates, please visit the **HCA website** and sign up for ASAM updates.

ASAM Criteria, 4th Edition Implementation Roadmap

HCA has created an implementation timeline to provide regular communications, technical support, and implementation guidelines to Tribes, providers, and payers.

Transition to ASAM Criteria, 4th edition

The ASAM Criteria is the most widely used and comprehensive set of guidelines for placement, continued stay, and transfer/discharge criteria for individuals with substance use disorder and co-occurring conditions. The ASAM Criteria defines the treatment criteria and levels of care for the treatment of substance-related and co-occurring conditions. Its structure is the underlying framework for service codes (billing guides), fiscal assumptions (rates), etc. Licensed behavioral health agency (BHA) providers are required to use the ASAM Criteria. Additionally, managed care organizations (MCOs) and behavioral health administrative service organizations (BH-ASOs), HCA (fee-for-service), and private insurance plans use the ASAM Criteria as a utilization management tool.

Washington state supports the principal intention of the ASAM Criteria:

> "…to drive improvements in treatment outcomes for patients with substance use disorders and co-occurring conditions and reduce both under- and overutilization of care."
>
> ASAM criteria, 4th edition, page 15.

The 4th edition criteria:

- revises standards of care to reflect the latest advancements in science and clinical practice; and
- enhances a chronic care model that endows seamless transition through a comprehensive continuum of care.
- includes population-specific volumes: Adult (released 2023), Adolescents and Transition-Aged Youth (ATAY) (released 2026), Behavioral Addictions (2028 release date), and Justice-Involved patients (2027 release date).

SB 5361 passed in the 2025 legislative session delayed the adoption date of the ASAM Criteria, 4th edition until January 2028, for both the Adult and ATAY volumes.

Objectives

Through a collaborative effort, HCA, Tribes, providers, and payers will be able to expect the following:

Tribes, providers, and payers will be aware of the upcoming statewide changes /change management timelines (overall understanding)

- HCA teams meet to create discussion and decision-making tools to outline upcoming changes
- Meet with Tribes, providers, and payers for feedback
- Refine tools and publish guidelines on websites

Tribes, providers, and payers will need to understand what the changes are, and have adequate training

- Adult training was held July 2024 to July 2025. Providers and payers are responsible for addressing any further training needs and be aware of what Washington is and is not adopting.
- ATAY volume training is anticipated to start in the fall of 2026
- Published guides and links on HCA pages

HCA will provide spaces to meet with Tribes, providers, and payers regarding what implementation will look like, and then revise after receiving feedback

- Feedback forums and Tribal listening sessions
- Townhalls
- Email for technical assistance: **SUDdbhrproviderhelp@hca.wa.gov**

Readiness phases

Phase 1: Readiness preparedness (June to December 2026)

- Knowing the changes (Knowledge Year 2026)
- Check lists for agency/provider/payer readiness (Organizational, Staffing, Level of Care)
- Timelines for implementation (June to December 2026)
- Preparation for ASAM 4th edition impacts on fee-for-service and SERI guides
- High level understanding of any WAC changes
- Technical assistance, Town Halls, and listening sessions to begin mid 2026

Phase 2: Implementation prep (January 2027 to December 2027)

- No later than January 2027, clarify changes to Department of Health and HCA WACs
- Increase provider communications (June to December 2027)
- Website and resource guide updates, implementation component checklists
- Implement and be ready to implement any Department of Health regulatory changes (2027)

Phase 3: Renegotiating contracts (April 2027 to December 2027)

- Foundational understanding of rate changes
- Amending contracts with MCOs and BH-ASOs
- Considerations for Sovereign Nation Agreement
- Receive draft fee-for-service and SERI guide changes (April 2027)
- Receive draft supplemental data changes (April 2027)
- Reconfigure systems for January 1, 2028, go live date (No later than December 2027)

Phase 4: Implementation (January to June 2028)

- Monthly (or more) technical support (January 2028 to July 2028)
- Frequent provider comms
- Website and resource guide updates

Yearly themes

Each year of the implementation plan can be characterized by the following themes:

- **2025 The Year of Preparation**
    - The HCA developed guidelines, implementation timelines and communications to help tribes, providers, and payers know and understand the upcoming changes.
- **2026 The Year of Knowledge**
    - In 2026, Tribes, providers, and payers will have a clear roadmap for implementation.
    - Tribes, providers, payers and HCA will collaborate and deepen our collective knowledge for the transition.

- **2027 The Year of Doing**
    - 2027 is the year that Tribes, providers, and payers will negotiate contracts, put organizational changes into effect, and be ready for the transition.
    - HCA will provide technical assistance, regular communications, and updates.
- **2028 The Year of Being**
    - HCA will offer ongoing implementation support and technical assistance.
    - Technical support workshops will be offered from January through July 2028.

Statewide infrastructure changes

Several statewide infrastructure changes will be amended over the next two years to create the foundation for a smooth and successful shift to the ASAM Criteria, 4th edition. The following changes will go into effect on January 1, 2028.

- State decisions on what will be adopted for both Adult and Adolescent and Transition Aged Youth (ATAY) populations.
- SERI and SUD Billing Guide updates will need to reflect new levels of care and what codes or modifiers will be added.
- Medicaid rates will need to be adjusted to reflect the new levels of care and requirements. HCA will begin work on that this Summer 2026.
- Payors, MCOs, BH-ASOs, and fully funded insurance plans will not switch their utilization management practices to the ASAM Criteria, 4th edition until January 2028. Until then, they will be using UM forms aligned with ASAM Criteria, 3rd edition.
- If providers need to adopt new levels of care or their current levels of care are being eliminated (example, residential 3.3 and withdrawal management 3.2 goes away), then providers will likely need to renegotiate their contracts with MCOs and BH-ASOs accordingly.
- Assessment changes – The 4th edition allows for shorter pathways for the assessment. We think this is great, but the SERI and billing guides won't denote this until January 2028 go live.
- Supplemental data requirements for BHA providers will likely need revision to align with the ASAM Criteria, 4th edition changes.
- Possible DOH WAC changes could also occur due to the ASAM Criteria, 4th edition changes.

Partner Expectations and Responsibilities

HCA is dedicated to a collaboartive partnership with Tribes, providers, payers, stakeholders, and the wider community in working towards a smooth implementation of the Adult and ATAY volumes transition. Below is a summary of the HCA's commitment, responsibilities, and expectations.

Responsibilities and expectations

This table outlines what Tribes, providers, and payers may expect from the HCA regarding guidance on the ASAM transition plan.

HCA Responsibilities	Provider Responsibilities	Payer Responsibilities
1. Present proposed ASAM Plan for the State (2026)	Provide feedback to HCA	Provide feedback to HCA
2. Developing communications, publications and guides	Receive/understand/read communications	Publish updates as applicable
3. Providing technical assistance	Attend/email questions/reach out	Attend/email questions/reach out
4. Launch plan implementation (2027)	Provide feedback to HCA	Deliver support to Tribes, providers, and payers
5. Provide post implementation assistance (2028)	Attend feedback forums/email questions	Communicate with HCA about any concerns, pain points with implementation

ASAM Criteria, 4th Edition General Updates

The ASAM Criteria, 4th edition, represents a philosophical shift in the addiction treatment field. This edition focuses on person-centered collaboration and the integration of medical, mental health, and community supports. The 4th edition changes represent a progressive evolution in the screening, diagnosis, assessment, and treatment of substance use disorder (SUD). The 4th edition recognizes that many of the changes are aspirational and long-term goals to strive towards. For the first time, ASAM has created population-specific volumes, including the ATAY volume, that designates unique levels of care and service standards, distinct from adult populations. Themes of the 4th edition include the integration of medical, behavioral, and substance use treatment (building referral and provider networks), patient collaboration in treatment decisions, focus on building recovery capital and treatment milieu, and recognition of the social determinants of health (SDOH).

ASAM Criteria, 4th edition key updates

ATAY services

One of the most significant changes in the 4th edition is the inclusion of population-specific volumes. ASAM has developed a separate volume specifically for ATAY. This volume was released in March 2026. Washington state plans to adopt both the Adult and the ATAY Volumes on January 1, 2028.

Special populations

Recognizing the systems and population specific needs in SUD treatment, ASAM will be releasing additional population-specific volumes for justice-involved patients (anticipated release in 2027) and behavioral addictions (anticipated release 2028).

Continuum of care revisions

The updated edition features renamed and consolidated levels of care, designed to encourage better integration of physical and behavioral health services, with a focus on community and housing supports. Medically managed levels of care (.7) and co-occurring enhanced (COE) designations have been added to each treatment category.

Assessment and treatment planning updates

A core element of the ASAM Criteria is its use of multidimensional, biopsychosocial clinical assessment. This approach helps clinicians determine diagnoses, select the most appropriate level of care, and design individualized treatment plans. In the 4th edition, there is a clear separation between the initial intake assessment and the treatment planning process. Both assessments consider the patient's biological, psychological, social, and cultural factors.

Revised dimensions

The 4th edition restructures the order of the dimensions and introduces specific key subdimensions to enhance clinical decision-making for timely level of care decisions and treatment planning. It also incorporates the patient's readiness for change throughout all dimensions and adds a new sixth dimension, **person-centered considerations**, to better align care with the patient's unique context and needs.

Broadscale updates

- **Addiction medications:** Several revisions have been made to enhance the availability of addiction medications across all levels of care.
- **Integration of medical, behavioral health, and substance use treatment:** The 4th Edition stresses the importance of integrated and holistic treatment at all levels to include general, and addictions-focused medical care, co-occurring capability, and different modalities of SUD treatment.

- **Medical requirements:** It is expected that within each level of care, patients have received a physical exam within the last year and should be referred to a medical professional if needed. Where applicable, persons capable of pregnancy are expected to receive pregnancy tests to best inform medical care.
- **Withdrawal management:** The 4th edition now incorporates withdrawal management into the medically supervised levels of care (Adult LOC 1.7, 2.7, and 3.7, ATAY LOC 1.7Y, 2.7Y, 3.5Y, 3.7Y).
- **Biomedical services:** Standards for biomedical care have been integrated into the medically managed levels, reflecting the existing presence of medical supervision and nursing support.
- **Co-occurring disorders:** The updated standards emphasize integrated treatment for individuals with co-occurring mental health conditions, requiring all programs to either provide services directly (co-occurring capable [COC]) or refer to care for those with mild to moderate mental health needs. COE levels of care meet the needs of patients with moderate to more acute mental health needs. For both adult and ATAY COE levels of care, it is emphasized that there is a higher staff-patient ratio to best serve the needs of individualized supports.
- **Eliminated levels of care:** Level 0.5, Level 3.2, and Level 3.3 have been eliminated from the ASAM Criteria, 4th edition. Programs will need to adjust programming to the 4th edition levels of care.
- **Home and community-based services:** It is encouraged that ATAY services be expanded to community-based settings, which include schools, third spaces, and the young person's home environment whenever possible.
- **Recovery support services (RSS):** A stronger emphasis is placed on recovery-focused systems, with each level of care expected to provide or coordinate access to appropriate RSS, including recovery residences, alternative recovery supportive home for young people and the integration of Allied Health staff. It is noted in the ATAY volume that RSS services should also be provided to families and caretakers.
- **Harm reduction:** Clinicians are encouraged to assess and address harm-reduction needs as part of individualized patient care planning.
- **Universal service characteristics:** All levels of care now contain universal standards of care pertaining to setting, staffing, support systems, assessment and treatment planning, services, and documentation.
- **Recovery residences:** The 4th edition notes a partnership with the National Association of Recovery Residences (NARR). Recovery Residences have been added to the continuum of care, with one overlapping level-ASAM Level 3.1 Clinically Managed Low-Intensity Residential is RR Type C, Clinical. Recovery residences also occur along a continuum from higher intensity services to lower intensity services.

Level of Care Changes:

Early intervention changes

Level 0.5 has been removed and replaced with the term "Early Intervention and Secondary Prevention." This shift repositions early intervention as a broad-based public health approach to addressing substance use, rather than part of formal addiction treatment. This may include primary care and emergency services provider conversations. These services will still fall under the authorization of a Level 1 licensed provider.

Adult volume: level 1 – Outpatient services

- **Level 1.0 – Long-term remission monitoring:** A new level of care addition, this level supports continued monitoring for individuals in sustained remission, including medication management, recovery wellness checkups, rapid re-engagement, and is not linked to a specific treatment setting.
- **Level 1.5 – Outpatient therapy:** Aligned with what was previously called Level 1.0 in the 3rd edition, this level focuses on individual and group counseling and psychotherapy in outpatient settings.
- **Level 1.5 COE:** Creates co-occurring designations for specialized care. .
- **Level 1.7 – Medically managed outpatient care:** A new designation that includes opioid treatment programs, low-intensity withdrawal management in outpatient settings, and biomedical services addressing co-occurring medical conditions.

- **Level 1.7 COE:** Creates co-occurring care designations for moderate to acute mental health comorbidities in a medically managed environment

ATAY volume: level 1Y – Youth outpatient services

- **Level 1.0Y – Youth long-term remission monitoring:** A new level of care addition, this level supports continued monitoring for individuals in sustained remission, including medication management, and is not linked to a specific treatment setting.
- **Level 1.5Y – Youth and family outpatient therapy:** Aligned with what was previously called Level 1.0 in the 3rd edition, this level focuses on individual and group counseling and psychotherapy in outpatient settings. It is also suggested that this LOC is applicable for those who do not currently meet criteria for SUD but would benefit from prevention services.
- **Level 1.5Y COE:** Creates co-occurring expectations and a higher staff-patient ratio.
- **Level 1.7Y – Youth medically focused outpatient therapy:** A new designation that includes opioid treatment programs, low- withdrawal management in outpatient settings, and biomedical services addressing co-occurring medical conditions.
- **Level 1.7Y Psych - psychiatric:** Creates a specific level of care to support higher intensity of biomedical and psychiatric services

Adult volume: level 2 – Intensive outpatient and partial hospitalization

- **Level 2.1 - Intensive outpatient:** This level remains largely unchanged; often referred to as IOP
- **Level 2.5 - High intensity outpatient:** Previously called Partial Hospitalization, now HIOP. 2.5Y will be available for 18-25.
- **Level 2.5 COE:** HIOP with a Co-occurring enhanced designation; 2.5Y COE will be available for 18 to 25.
- **Level 2.7 – Medically managed intensive outpatient treatment:** This new category includes withdrawal management and care for patients with complex medical needs, provided in an outpatient setting.
- **Level 2.7 COE:** Creates a co-occurring designation

ATAY volume: level 2Y – Youth intensive outpatient and partial hospitalization

- **Level 2.1Y IOP - Youth intensive home and community-based outpatient treatment:** Aligned with what was previously called Level 2.1 in the 3rd edition, this level focuses on individual and group counseling and psychotherapy in outpatient settings. It is also suggested that this LOC is applicable for those that do notcurrently meet criteria for SUD, but would benefit from prevention services.
- **Level 2.1Y COE:** Creates co-occurring expectations and a higher staff-patient ratio.
- **Level 2.5Y HIOP - Youth high intensity home and community-based treatment:** represents a new level of care in Washington state, previously referred to as partial hospitalization.
- **Level 2.5Y COE:** Creates co-occurring expectations and a higher staff-patient ratio.
- **Level 2.7Y – Youth medically-focused intensive outpatient treatment:** This new category includes withdrawal management and care for patients with complex medical needs, provided in an outpatient setting.

Adult volume: level 3 – Residential/inpatient services

- **Level 3.1 – Low-intensity residential:** Enhancements include increased clinical hours and structured services available every day of the week. Structured, community environment staffed 24/7. Washington state does not require a Master's level clinical staff to be onsite 24/7. Overnight staff may be Allied Health. Clinical staff may be available on call.
- **Removed levels:** Level 3.2-WM has been consolidated into Level 3.5, and Level 3.3 has been discontinued entirely. Providers will need to decide to shift up to Level 3.5, or down to Level 3.1.

- **Level 3.5 – High-intensity residential:** This level remains unchanged and is generally referred to as Intensive Inpatient. *Note that inpatient refers to Level 4 hospitalization in the ASAM Criteria, 4th edition. Please use Intensive Residential Treatment in reference to level 3.5.
- **Level 3.5 COE:** Creates co-occurring designations.
- **Level 3.7 – Medically managed residential:** The 4th edition merges previous Level 3.7 and 3.7-WM standards, emphasizing that this is a residential treatment level with medical oversight.
- **Level 3.7 BIO:** is considered medically enhanced and can accommodate intravenous (IV) treatments, IV fluids, and wound VAC.

ATAY volume: level 3Y – Youth residential/inpatient services

- **Removed Levels:** Levels 3.1 and 3.3 have been discontinued entirely in the ATAY volume. Level 3.2-WM has been consolidated into Level 3.5Y.
- **Level 3.5Y – Youth medically-integrated, clinically-focused residential:** This level remains unchanged and is generally referred to as intensive inpatient. Includes emphasis on acute withdrawal management services. *Note that inpatient refers to Level 4 hospitalization in the ASAM Criteria, 4th edition. Please use Intensive Residential Treatment in reference to level 3.5.
- **Level 3.7Y – Youth medically-focused residential treatment:** The 4th edition merges previous Level 3.7 and 3.7-WM standards, emphasizing that this is a residential treatment level with medical oversight.
- **Level 3.7Y BIO:** is considered medically enhanced and can accommodate IV treatments, IV fluids, and wound VAC.

The ASAM Criteria, 4th Edition

Level of care transition chart: adult volume

The following chart provides a summary of the most significant changes between the ASAM Criteria 3rd edition and ASAM Criteria 4th edition.

3rd Edition	4th Edition	Overiew of Changes
-	Level 1.0 Long-term remission monitoring	New level- allows for longer term services
Level 1 Outpatient	Level 1.5 Outpatient Level 1.5 COE	No major changes
-	Level 1.7 Medically Monitored Outpatient Level 1.7 COE	Includes speciality office based opioid treatment, OTP, and ambulatory WM services
Level 2 Outpatient	Level 2.1 Intensive Outpatient (IOP)	No major changes
Level 2.5 Partial Hospitalization Services	Level 2.5 High Intensity Intensive Outpatient	Creates new level. Formally equivalent to PHP Partial Hospitalization in 3rd edition.
-	Level 2.7 Medically Managed Intensive Outpatient	Includes speciality office based opioid treatment, OTP, and ambulatory WM services
Level 3.1 Clinically Managed Low-Intensity Residential Services	Level 3.1 Clinically Managed Low Intensity Residential Services *See notes on adoptions	Updated to include more clinical service hours and structured services 7 days a week.
Level 3.2 WM Clinically Managed Residential Withdrawal Management	-	Standards for 3.2 WM have been integrated into the 4th edition Level 3.5 programs, with the expectation of clinically monitored WM.
Level 3.3 Clinically Managed Population-Specific High Intensity Residential Services	-	This level goes away in the 4th edition. Providers must choose to shift up to 3.5 or down to 3.1.

Level 3.5 Clinically Managed High-Intensity Residential Services	Level 3.5 Clinically Managed High-Intensity Residential Services (Intensive Inpatient) Level 3.5 COE	No major changes. Clinical service hours have been aligned with that of 2.5
Level 3.7 Medically Monitored Intensive Inpatient Services	Level 3.7 Medically Managed Intensive Inpatient Services Level 3.7 COE	4th edition Level 3.7 programs provide residential withdrawal management and biomedical care. This updated level combines the Third Edition Levels 3.7 and 3.7-WM. Reanmed from “monitored” to “managed”.
-	Level 3.7 BIO	In addition to the medical and nursing capabilities of Level 3.7 programs, Level 3.7 BIO programs provide residential WM, and biomedical and psychiatric conditions that require IV medications, IV fluids and wound VAC.
Level 4 Medically Managed Intensive Inpatient Services	Level 4 Medically Managed Inpatient Level 4 Psych	Name change from the 3rd edition. Standards for Level 4 General Hospital and Level 4 Addiction Speciality Unit specified in 4th edition. 4th edition clarifies that Level 4 is not a speciality level of care, but refers to a general hospital.

Level of care transition chart: ATAY volume

The following chart provides a summary of the most significant changes between the ASAM Criteria 3rd edition and ASAM Criteria 4th edition.

3rd Edition	4th Edition	Overiew of Changes
.5 Early Intervention	Removed	Prevention and early intervention to be provided throughout the continuum of care
Level 1 Outpatient	Level 1.0Y Youth Long-Term Remission Monitoring	New level- allows for longer term services for monitoring, support
	Level 1.5Y Youth and Family Outpatient Therapy Level 1.5Y COE	New level - less than 6 hours of individual and family outpatient psychotherapy for youth with mild to moderate SUD, in early recovery or youth who don't yet meet criteria, but are using substances.
-	Level 1.7Y Youth Medically Focused Outpatient Treatment Level 1.7 Psych	New level - Includes speciality office based opioid treatment, OTP, and ambulatory WM services
Level 2 Outpatient	Level 2.1Y Youth Intensive Home and Community-Based Outpatient Treatment (IOP)	No major changes. 6-19 hourse of services, which can be delivered in a variety of locations, including home and community settings.
Level 2.5 Partial Hospitalization Services	Level 2.5Y Youth High Intensity Home and Community-Based Treatment (HIOP) Level 2.5Y COE	Creates new level. Formally equivalent to PHP Partial Hospitalization in 3rd edition. 20+ hours of services and to include school coordination and family engagement.
-	Level 2.7Y Youth Medically Focused Intensive Outpatient Treatment 2.1Y COE	New level - Includes speciality office based opioid treatment, OTP, and ambulatory WM services
Level 3.1 Clinically Managed Low-Intensity Residential Services	Removed	

Level 3.2 WM Clinically Managed Residential Withdrawal Management	Removed	
Level 3.3 Clinically Managed Population-Specific High Intensity Residential Services	Removed	This level goes away in the 4th edition. Providers must choose to shift up to 3.5 or down to 3.1.
Level 3.5 Clinically Managed Medium-Intensity Residential Services	Level 3.5Y Youth Medically Integrated – Clinically Focused Residential	All level 3.5Y programs are expected to be able to provide COE care as needed. Youth served in this level of care have the highest severity and complexity of SUD and co-occurring conditions,
Level 3.7 Medically Monitored Intensive Inpatient Services	Level 3.7Y Youth Medically Focused Residential Treatment	4th edition Level 3.7 programs provide residential withdrawal management and biomedical care. This updated level combines the Third Edition Levels 3.7 and 3.7-WM. Reanmed from “monitored” to “medically focused” for this population. .
-	Level 3.7Y BIO	In addition to the medical and nursing capabilities of Level 3.7 programs, Level 3.7 BIO programs provide residential WM, and biomedical and psychiatric conditions that require IV medications, IV fluids and wound VAC.
Level 4 Medically Managed Intensive Inpatient Services	Level 4 Youth Inpatient Treatment Level 4 Youth Psych	Name change from the 3rd edition. Standards for Level 4 General Hospital and Level 4 Addiction Speciality Unit specified in 4th edition. Services may be provided in any appropriate acute care treatment setting with 24/7 nursing staff and physician oversight, typically a general hospital setting.

Dimension changes: Adult and ATAY volumes

*Please note that trainings for the ATAY volume are anticipated to begin in the Fall of 2026.

The 4th edition describes subdimensions, reflecting core actionable factors, that should be assessed within each dimension. During the level of care assessment, the **subdimensions in bold inform level of care recommendations and initial treatment for immediate needs.** All subdimensions are considered for treatment planning purposes. Dimensions 1 through 5 are used to develop a level of care recommendation. When assessing Dimension 6, the assessor works with the patient to determine which level of care the patient is willing and able to engage in.

3rd Edition Dimensions	4th Edition Dimensions	Overiew of Changes
Dimension 1: Acute Intoxication and/or withdrawal potential	Dimension 1: Intoxication, Withdrawal and Addiction Medications: • **Intoxication and Associated Risks** • **Withdrawal and Associated Risks** • **Addiction and Medication Needs**	minimal impacts, appears to be more comprehensive
Dimension 2: Biomedical Conditions and Complications	Dimension 2: Biomedical Conditions: • **Physical Health Concerns** • **Pregnancy-Related Concerns** • Sleep Problems	minimal impacts, appears to be more comprehensive
Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications	Dimension 3: Psychiatric and Cognitive Conditions: • **Active Psychiatric Symptoms** • **Persistent Disability** • Cognitive Functioning • Trauma-Related Needs • Psychiatric and Cognitive History • *ATAY: Intellectual and Developmental Concerns • *ATAY: Trauma Exposure and Related Needs	minimal impacts, appears to be more comprehensive

Dimension 4: Readiness to Change	Dimension 4: Substance Use-Related Risks (renamed and purpose redefined from 3rd edition Dimension 5) • **Likelihood of engaging in risky substance use:** refers to any use with significant risk for adverse medical, emotional, social, financial, and/or legal consequences. • **Likelihood of engaging in risky SUD-related behaviors:** related behaviors refer to any behaviors linked to substance use or SUD that cause or are anticipated to cause significant adverse medical, psychological, emotional, social, financial, and/or legal consequences.	Renamed and Purpose Redefined from 3rd edition Dimension 5
Dimension 5: Relapse, Continued Use, or Continued Problem Potential	Dimension 5: Recovery environment interactions (In 3rd edition related to Dimension 6): • **Ability to Function Effectively in Current Environment** • **Safety in Current Environment** • **Support in Current Environment** • Cultural Perceptions of Substance Use and Addiction • *ATAY: Education Needs	Repurposed and renamed into 4th edition Dimension 4.
Dimension 6: Recovery/Living Environment	NEW Dimension 6 person-centered considerations: • Barriers to Care • Patient Preferences • Need for Motivational Enhancement • *ATAY: Family and Caretaker Preferences	This dimension is not utilized in the level of care determination, but is utilized for shared decision making.

Note: Bolded sub-dimensions lead to LOC determinations in the placement algorithm.

ASAM Criteria, 4th Edition Pre-Implementation Readiness

SB 5361 passed in the 2025 legislative session delayed the adoption date of the ASAM Criteria, 4th edition until January 2028, for both the adult and ATAY volumes. Throughout this process, HCA is here to provide implementation support, guidance, and timely responses for questions.

We are receiving questions about how providers may be able to start adapting 4th edition changes prior to the January 1, 2028, implementation rollout. There are several ways in which agencies can begin to adopt some of the changes prior to implementation.

ASAM Criteria, 4th edition readiness

HCA encourages providers to examine their relationships with other providers, community, and sober supports in preparation for the upcoming changes. Providers may engage in ongoing quality improvements that align with the ASAM 4th edition principles.

Referral network and staffing needs

Prior to full implementation, SUD providers can begin to evaluate how they interact with SUD, mental health, and medical providers. HCA is encouraging providers to strengthen their referral and provider networks to include the following, either to be provided in-house or on a referral basis:

- Primary care physicians
- Pregnancy and postpartum healthcare (including pregnancy testing)
- Community healthcare (for physicals)
- Addictions medication prescribers (MOUD, MAUD, MTUD)
- Psychotherapists and psychiatrists
- Emergency departments and medical detox
- Recovery residences
- Recovery cafes and sober social support
- Recovery support meetings
- Assess telehealth medicine options

Staffing

Leading up to the implementation, agencies can begin to evaluate their current and future staffing needs, based on the 4th edition requirements, as designated by level of care. Agencies can conduct a staffing assessment to evaluate co-occurring provider adequacy, through a multi-disciplinary lens.

Medications

Agencies can begin to assess for the need for addictions medications (Dimension 1) and make appropriate referrals.

Curriculum

Providers may begin to evaluate and make changes to their curriculum, ensuring the use of Trauma Sensitive Programming (TSP), language shifts, and the incorporation of co-occurring material, such as groups built around the management of SUD and mental health as chronic disorders.

Family engagement

Collaborating and supporting family members during the treatment process is highlighted in the 4th edition. Family can be defined as the individual's primary support system. It is not limited to biological family and may include other caregivers or individuals who have emotional attachments. While not a separate dimension, family

and the recovery/living environment are considered in the comprehensive assessment to determine the most effective level of care, to enhance treatment engagement and outcomes.

Agencies are encouraged to look at their approaches to family engagement and the programming they provide, especially for the ATAY population. Examples could include family-based therapies, family psychoeducation, and family/caregiver skills training.

Assessment

Several significant changes are occurring in assessment within the ASAM Criteria, 4th edition. Agencies can begin evaluating their assessment process. ASAM has several assessment examples for use on their website.

Level of care changes: adult volume eliminated criteria

Due to the elimination of Level 3.3, providers who are currently offering this level of care will need to determine if they will be shifting up to Level 3.5 high intensity residential or shifting down to Level 3.1 low intensity residential. Enhancements to level 3.1 include increased clinical hours and structured services every day of the week.

Level 3.2 withdrawal management shifts to services that may be received in Level 3.5 (high intensity residential) and 3.5Y (youth medically integrated-clinically focused residential treatment).

Leading up to January 2028, providers can begin to lay down the infrastructure for the shift, including evaluating staffing needs.

ASAM Criteria, 4th Edition Staffing Requirements: Adult Volume

*Please note that trainings for the ATAY volume are anticipated to begin in the Fall of 2026.

	Supervision of patients	Medical Director	Nursing	Program Director	Allied Health Staff	Nursing Assessment	Clinical Services	Clinical Service Hours	Recovery Support Services
Level 1.0 Longterm Remission Monitoring				*Variable	*Variable		Recovery and remission management services	Quarterly	Recovery management checkups
1.5 Outpatient				Yes. Master's degree in field related to clinical behavioral health	Variable		Direct psychosocial services	<9h/wk per week	Yes
1.7 Medically Managed Outpatient		Yes *Directly, or through formal affiliation	Variable	*Not typical	Variable	At initial assessment	Direct WM management services Management of common psychiatric disorders Psychosocial services*	<9h/wk	
2.1 IOP				Yes. Master's degree in field related to clinical behavioral health	Yes		Direct psychosocial Therapeutic milieu	9-19 h/wk	Yes

2.5 HIOP		Yes	Variable	Yes. Master's degree in field related to clinical behavioral health	Yes		Direct psychosocial Therapeutic milieu	>20h/wk	Yes
2.7 MM IOP		Yes	Yes	Yes. Master's degree in field related to clinical behavioral health	Yes	At admission	Direct WM management services Management of common psychiatric disorders Psychosocial services*	>20 h/wk	Yes
3.1	Patients may leave independently during the day with appropriate accountability checks			Yes. Master's degree in field related to clinical behavioral health	On-site and alert 24h/d		Direct psychosocial Therapeutic milieu	9-19h/wk available 7d/wk	Yes
3.5	24/7	Yes	Yes	Yes. Master's degree in field related to clinical behavioral health	On-site and alert 24h/d		Direct psychosocial Therapeutic milieu	>20 h/wk, available 7d/wk	Yes

3.7	24/7	Yes	Available 24/7	Yes. Master's degree in field related to clinical behavioral health	Yes	At admission	Direct WM management services Management of common psychiatric disorders Psychosocial services*		

*COE levels of care require psychiatric management or oversight, a higher staff to patient ratio, and established relationships with mental health treatment programs

Washington State Health Care Authority

ASAM Criteria, 4th Edition Staffing Requirements: ATAY Volume

*Please note that trainings for the ATAY volume are anticipated to begin in the Fall of 2026.

	Supervision of patients	Medical Director	Nursing	Program Director	Allied Health Staff	Nursing Assessment	Clinical Services	Clinical Service Hours	Recovery & Family Support Services
Level 1.0Y Longterm Remission Monitoring	During hours of operation			Yes. Master's degree in field related to clinical behavioral health	Yes. CPSS, Case Managers, School coordinators, SUDP/T, MHP, Co-Occurring Specialists, Family Support Services	As needed	Recovery and remission management services	Quarterly	Recovery management checkups
1.5Y Youth Outpatient ***1.5Y COE**	During hours of operation			Yes. Master's degree in field related to clinical behavioral health and 1 year experience working with adolescents	Yes. See above	As needed	Direct psychosocial services Prevention Services Family Education	<6h/wk per week	Yes

1.7Y Youth Medically Focused Outpatient ***1.7 Psych COE**		Yes. At least 2 years of experience in adolescent SUD treatment	Available on-site or on-call, or via telemedicine during hours of operation, with prescribing authority	As needed	Yes. See above	Within reasonable timeframe of initial assessment	Direct WM management services Management of common psychiatric disorders Family Education Psychosocial services*	As needed	
2.1Y Youth Intensive Home and Community-Based Outpatient ***2.1Y COE**	During hours of operation			Yes. Master's degree in field related to clinical behavioral health and 2 years experience working with adolescents	Yes. See above. As well as directly or with formal affiliations with adolescent psychiatric specialists	Psych assessment within 7/d of admission through direct or formal affiliations	Direct psychosocial Therapeutic milieu Family Education Prevention Services	6-19 h/wk	Yes
2.5Y Youth High-Intensity Outpatient ***2.5Y COE**	During hours of operation	Yes. At least 2 years of experience in adolescent SUD and Co-Occurring treatment	Available on-site or on-call, or via telemedicine during hours of operation, with prescribing authority	Yes. See 2.1Y	Yes. See 2.1Y	Psych assessment within 24 hours of through direct or formal affiliations *as needed	Direct psychosocial Therapeutic milieu Family Education Prevention Services School Coordination	>20h/wk	Yes

2.7Y Youth Medically Focused Intensive Outpatient ***2.7 Psych COE**	During hours of operation	Yes. At least 5 years of experience in specialty SUD and Co-Occurring treatment	Available on-site or on-call, or via telemedicine during hours of operation, with prescribing authority.	Yes. Master's degree in field related to clinical behavioral health and 5 years of Co-Occurring experience	Yes. See 2.1Y	Within 24-48 hours of admission. Psych assessment within 72 hours of admission through direct or formal affiliations *as needed	Direct WM management services Management of common psychiatric disorders Psychosocial services* Family Education School Coordination	>20 h/wk	Yes
3.5Y Youth Medically Integrated-Clinically Focused Residential	24/7	Yes. At least 2 years of experience in adolescent SUD and Co-Occurring treatment	As needed.	Yes. Master's degree in field related to clinical behavioral health and 2 years experience working with adolescents	Yes. See 2.1Y	As needed. Psych assessment within 72 hours of admission through direct or formal affiliations *as needed	Direct WM management services Direct psychosocial Therapeutic milieu Family Education School Coordination	>20 h/wk, available 7d/wk	Yes
3.7Y Youth Medically Focused Residential ***3.7 BIO**	24/7	Yes. At least 5 years of experience in specialty SUD and Co-	Available 24/7 with prescribing authority	Yes. Master's degree in field related to clinical behavioral health and 5 years of Co-	Yes. See 2.1Y	Within 24 hours of admission Psych assessment within 72	Direct WM management services Management of common psychiatric	>20 h/wk, available 7d/wk	Yes

	Occurring treatment	Occurring experience	hours of admission through direct or formal affiliations *as needed	disorders Direct psychosocial Therapeutic milieu Family Education School Coordination

*COE levels of care require psychiatric management or oversight, a higher staff to patient ratio, and established relationships with mental health treatment programs

Washington State Health Care Authority

COC and COE Levels of Care

The ASAM Criteria, 4th edition requires that all levels of care are COC for all levels of care and populations. Below are the distinctions between COC and COE expectations.

COC: All standard addiction treatment programs across all levels of care are expected to be COC, at minimum; meaning they have the capacity to provide integrated services for mental health symptom management as part of routine operations. Providers must be able to identify and appropriately manage patient's co-occurring needs (ASAM, p. 321).

COE: COE services have enhanced resources to routinely serve patients who have more serious co-occurring mental health or cognitive conditions. These patients may have more acute or serious disabilities, but are able to successfully participate in addiction and mental health treatment services if provided with appropriate symptom management assistance and function supports (ASAM, page 320). Patients treated in COE may present with severe mood disorders, schizophrenia spectrum disorders, severe trauma-related or anxiety disorders, significant dissociative disorders, or severe personality disorders (ASAM, page 326).

COC versus COE services: adult and ATAY volumes

This table outlines what the main designations between COC and COE Services

COC	COE	COC Staffing Needs	COE Staffing Needs
Welcoming patients with co-occurring conditions. **For ATAY, including families and caretakers in the orientation process.**	Welcoming patients with more acute co-occurring conditions. **For ATAY, including families and caretakers in the orientation process.**	Trained mental health staff.	Higher staff-to-patient ratios.
Screening, identifying, and documenting the presence of any co-occurring conditions, regardless of formal diagnosis.	Recognize mental health concerns that would indicate the need for further assessment.	Established relationships with external support systems that can provide integrated care.	Ready access to pyschiatric care.
Collaborating with any existing mental health treatment providers, including obtaining existing mental health assessment and treatment information when available to	Deliver trauma sensitive assessments and care. **For ATAY, engaging families and caretakers in coordination of care to assess for specific needs.**	Utilizing telemedicine in rural areas.	Staff with mental health expertise.

coordinate care throughout treatment. **For ATAY, engaging families and caretakers in coordination of care.**			
Arranging additional mental health or psychiatric assessments, including diagnostic, as needed.	Conduct preliminary screening to identify if a patient poses an imminent danger to seld or others.	Co-occurring capability may be achieved with strategic hiring and ongoing training for existing staff.	COE programs require higher payment rates.
Engaging patients with integrated treatment teams that are coordinated in their efforts to support progress with both SUD and mental health concerns.	Refer patients to appropriate internal or external mental health services.		Access to a psychiatrist or an advanced practice provider with speciality certification in psychiatry.
Identifying the stage of change that patients are in regarding their mental health conditions and providing stage-matched interventions.	Coordinate care with appropriate internal and experinal mental health care providers.		Ability to provide crisis stabilization for frequent anticipated mental health crises.
Helping patients learn about their mental health concerns and the types of interventions that may help them manage these concerns effectively. **For ATAY, including families and caretaker education and support skills.**	Establish and implement a collaboratively integrated treatment plan that addresses co-occurring needs, including sequenced goals depending on urgent requirements, stages of recovery and level of engagement. **For ATAY, including families and caretaker education and support skills by providing specific groups and individual services.**		*Note: The ASAM 4 clarifies that screening and assessment will help the provider determine if services are to be offered through the SUD or the MH system. If a patient's presenting issue is SUD and the MH needs are less intense, the appropriate setting would be SUD treatment. If the patient presents with more intensive, unstabilized MH needs and less intensive SUD concerns, the patient should be served in the MH system (ASAM, p. 332-333).

Helping patients learn basic skills for managing their mental health symptoms during addiction treatmentm including how to utilize SUD and/or mental health peer support.	Support patient adherence to their integrated treatment plan.		
Helping patients develop skills for working effecitvely with prescribers to initiate or adjust any needed medications and take medications as prescribed. **For ATAY, providing education to families and caretakers on addiction medications.**	Assist patients to overcome systemic barrieris-including stigma-that prevents care from being assessed. **For ATAY, providing education to families and caretakers on addiction medications.**		
Incorporating routine discussion of co-occurring mental health concerns into programming.	Provide individual and group counseling to support patient management of their co-occurring disorders, including: • Developing techniques for managing mental health symptoms and trauma without using substances; • Asking for help with mental health symptoms from peers or professionals as needed; • Working honestly and effectively with mental health treatment providers; and • Taking mental health and addiction medications as prescribed.		
Developing a culture supportive of co-occurring recovery. **For ATAY, providing services outside of the clinical setting, which include home, school or other community-based settings.**	Work with patients to navigate the healthcare system to access appropriate care for mental health symptoms. **For ATAY, providing services outside of the clinical setting, which include home, school, or other community-based settings.**		

Ensuring that transition planning addresses continuing co-occurring mental health needs.	Provide basic education about the availability of evidence-based medications for both SUDS and mental health conditions.		
	Structured to permit highly individualized adjustment of behavioiral expectations, group participation capacity, and titration of emotional intensity.		

Providers may begin to evaluate their referral networks, and make organizational decisions regarding which services to offer in-house, and which services would best be accomodated by a robust referral program.

Referral services

Please note, trainings for the ATAY volume are anticipated to begin in the Fall of 2027.

Level of Care: Adult and ATAY Volumes	**Component** ***All components are included in both volumes, with additional ATAY components in bold.**
All Levels of Care	Referral for psychosocial services through formally affiliated providers, when services are not directly provided.
	Referral for psychotherapeutic services (counseling, therapy) when services are not directly provided.
	Referral for recovery support services through formal affiliations with external providers (e.g., WAQRR) when not directly provided. **Referral for Family Recovery support services through formal affiliations with external providers (e.g., NAMI, Helping Families Help) when not directly provided.**
	Established relationships (MOU or less formal connection) with nearby hospitals, local urgent care providers, and emergency departments. **In addition, ATAY programs should have established relationships with schools, juvenile rehabilitation, housing services providers, and vocational programs.**
Level 1.5 **Level 1.5Y**	Collaborative relationships with psychiatrists and/or advanced practice providers with specialty certification in psychiatry, **with additional training in adolescent and transition-aged youth treatment as needed.**
Level 2.5Y	Established relationships with school districts and/or vocational programs to provide on-site academic or technical training support.

Level 2.7 **Level 2.7Y**	Psychiatrists or advanced practice providers with specialty certification in psychiatry on staff and available onsite or via telemedicine during program hours and accessible on a 24/7 on call model **with additional training in adolescent psychiatry as needed.**
Level 3.1	Continuous access to 24/7 on-call medical support to address urgent or emergent medical issues.
	Qualified and trained clinical staff available onsite or on call 24/7.
Level 3.5 **Level 3.5Y**	Physician or advanced practice provider available on call 24/7 to respond to urgent situations, including evaluating and supporting management of patients who are intoxicated or experiencing withdrawal.
	Psychiatrist or advanced practice provider with specialty certification in psychiatry available onsite, on-call, or via telemedicine for regular medication adjustments with additional training in ATAY treatment as needed.
Level 4 **Level 4Y** ***DOH Oversight**	Level 4 General Hospitals: • Relationships with less intensive levels of addiction treatment to support care coordination and effective transitions in care. • Relationships with any external addiction or mental health care providers involved in the patient's care**.**
	Level 4 Addiction Specialty Unit: • Relationships with any external mental health care or other providers.
	Level 4 Psychiatric: • At least one clinical staff member qualified by training and licensure to assess and treat SUD available onsite or via telemedicine. • Relationships with more and less intensive levels of care. • Relationships with community physicians and/or advanced practice providers who prescribe addiction medications and have controlled substance prescribing authority. • Relationships with external addiction care providers involved in the patient's care.