

ALCOHOLISM DRUG ABUSE WEEKLY

News for policy and program decision-makers

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IN THIS ISSUE...

Our lead stories this week look at how new recovery housing guidelines from SAMHSA redefine residences to focus on housing, not treatment.

... See stories, this page

NEXT WEEK

Our deep dive into buprenorphine protocols: formulations and dosages.

SAMHSA issues new recovery housing guideline: “Peers” in charge

Last month the Substance Abuse and Mental Health Services Administration (SAMHSA) released a “best practices” outline for recovery housing that is both an update of a previous guideline (see <https://onlinelibrary.wiley.com/doi/10.1002/adaw.32517>) and a response to a White House order for the new guideline to exclude substance use disorder (SUD) treatment services.

The White House order came within the appropriations law signed last December by President Joe Biden and includes a provision called “Developing Guidelines for States to Promote the Availability of High-Quality Recovery Housing.”

The guideline is intended to apply to states, governing bodies,

Bottom Line...

SAMHSA new guideline on recovery housing emphasizes housing, de-emphasizes treatment, calls having a home recovery.

providers, recovery house operators, and others to reduce the incidence of overdose and promote long-term recovery from SUDs.

Housing or having a home — described as “a stable and safe place to live” — is included in SAMHSA’s working definition of recovery.

‘Setting is the service’

The “setting is the service” when it comes to recovery housing,

See [HOUSING](#) page 2

Advocates see positives in ruling in *Wit* case, but questions remain

The latest ruling in the years-long legal battle surrounding United Behavioral Health’s (UBH) guidelines for determining substance use and mental health coverage represents a turnaround in plan members’ favor, with some advocates thinking that it could set the stage for a remedy in the federal courts

when insurers don’t follow generally accepted standards of care.

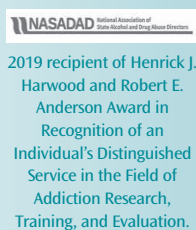
However, last month’s ruling also leaves several matters unanswered or unclear. The appellate panel’s decision that a lower court improperly defined a plaintiff class based on a denial of benefits claim creates uncertainty over whether plaintiffs in the case will ultimately be able to have denied claims reprocessed.

A three-judge panel of the Ninth Circuit Court of Appeals on Aug. 23 issued a ruling vacating a January 2023 opinion that UBH did not breach its fiduciary duty under the Employee Retirement Income Security Act (ERISA) in its use of internally developed coverage guidelines. The

See [Wit](#) page 7

Bottom Line...

*Addiction treatment advocates consider last month’s ruling to vacate an appellate court decision against plan members in *Wit* v. United Behavioral Health to be an affirmation of insurers’ responsibility to base coverage decisions on generally accepted standards of care.*



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Housing from page 1

according to the guideline. Recovery homes cultivate a “milieu” that is supportive of recovery. Those recovery homes that focus on high-need populations do need to add peer recovery support services to “actively link residents to recovery or clinical services in the community.”

Even though the guidelines explicitly are supposed to diverge from actual treatment, recovery housing is repeatedly cited as being helpful for individuals recently released from a residential inpatient treatment program or criminal justice custody.

One sticking point may be the requirement for abstinence, although the SAMHSA guideline states that prescribed medications are allowed. There was a time when methadone and buprenorphine — and any controlled substance — was not allowed by recovery home residents (see <https://onlinelibrary.wiley.com/doi/10.1002/adaw.30486>). That may still be the case, but SAMHSA does not recommend that as a policy.

The history

In 2020, there were about 18,000 recovery homes across the nation. Beginning in the mid-1800s, recovery housing evolved and adapted, SAMHSA’s guideline noted. It continues to adapt, and now is called to meet the needs of the overdose epidemic. Funding from SAMHSA’s State Opioid Response grant

program are being used to support persons living in recovery housing who are taking medications for opioid use disorders (MOUD).

The guideline features the National Alliance for Recovery Residences’ (NARR) four levels of housing, ranging from those that are run by peers to those that are clinical (see box on page 6).

Levels I, II, and III are all led and governed by residents.

The levels

Level I: An example of level I is the Oxford Houses. According to a two-year follow-up, individuals discharged from residential treatment to an Oxford House compared with those discharged to “standard continuing care” showed lower substance use rates (31.3% vs. 64.8%), significantly higher monthly income (\$989.40 vs. \$440.00), and significantly lower incarceration rates (3% vs. 9%).

Level II: An example of level II is California Sober Living. An 18-month follow-up showed that residents had improvements in abstinence and general mental health, as well as a decrease in criminal justice involvement. These benefits were regardless of referral sources. This level is an example of an “underutilized modality” according to the guideline, which somewhat unfortunately uses the word “clean” to describe recovery (people who use drugs are not “dirty”). This level of a sober living home is helpful

to “individuals completing residential treatment, engaging in outpatient programs, leaving incarceration, or seeking alternatives to formal treatment,” according to the guideline.

Level III: At level III, recovery homes offer “nonclinical support services” that are “often delivered by certified peer specialists or recovery coaches” in the houses themselves, according to the guideline. Peer support specialists, peer coaches, or peer workers (SAMHSA lumps these all together although exactly what they are is still unclear) provide the elements to support recovery. Despite vagueness in definition, these peers “are fully endorsed by SAMHSA as integral components of recovery housing.” By definition, all of the residents are peers, as they all are there for former SUDs.

Level IV: Only level IV — delineated as Therapeutic Communities (TCs) in the guideline — include clinical services, which are combined with “social model recovery.” Sadly, TCs fell out of favor in the past 20 years, as *ADAW* has reported. However, now that housing needs and long-term treatment for the severe types of SUDs patients present with are coming to the forefront, the need for TCs is being recognized.

“Historically, there have been concerns among policymakers and funders about the variability in quality among residences and about their operations,” the guideline states.

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“However, there are best practices to assist state and federal policymakers in understanding and defining what comprises safe, effective, and legal recovery housing.”

“Recovery takes many pathways. Recovery Housing is a huge support to the recovery movement,” Patricia Clay of Therapeutic Communities of America told *ADAW* last week. “Best outcomes include health, housing and substance use disorder treatment. Thanks to SAMHSA for highlighting the important role that TCs play in the recovery movement.”

Best practices

The SAMHSA guideline describes 11 “best practices” that can help improve recovery housing.

“SAMHSA recommends that recovery house operators, stakeholders, and states and jurisdictions use these best practices as a guide when enacting policies and designing programs to provide the greatest support for recovery, safety, and quality of life for individuals living in recovery housing.”

Best Practice 1: Be recovery-centered.

For recovery housing to be recovery-centered, the housing should embrace all aspects of SAMHSA’s definition of recovery. That’s a lot more than just abstinence from drugs and alcohol. SAMHSA has defined recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. This includes addressing an individual’s medical health; mental health; occupational, family, legal, and social needs; including safe and stable housing. SAMHSA recommends that recovery housing promotes the four major dimensions that support a life in recovery (see box).

Best Practice 2: Promote person-centered, individualized and strengths-based approaches.

Recovery housing should ensure that an individual’s strengths, needs, preferences and goals are at the center of decision-making. Individuals

who want to move into a recovery home apply and go through an interview process where both parties can determine whether moving in is the right choice or fit. Individuals should have the choice to live in a recovery house or room that aligns with their gender identity. SAMHSA recommends that all decisions be predicated upon the individual’s need and level of support for housing while balancing individual choice and person-centered recovery goals as the driving factor. Recovery housing should adopt formal person-centered planning approaches to accurately gauge each prospective resident according to their unique needs, strengths, preferences, challenges, and current internal and external resources to sustain recovery. Resident placement should be predicated upon individual needs, goals and choices. Individuals are often referred to a recovery home. Whether the referent is a licensed clinician, concerned family member,

criminal justice professional or other community partner, it is important to know and consider the potential resident’s unique situation before making impactful decisions regarding the recovery housing program (see box about questions to ask).

Best Practice 3: Incorporate the principles of the social model approach.

Recovery housing should incorporate the principles of the social Model Approach. The social model of recovery advances a culture of recovery that:

- Emphasizes social and interpersonal aspects of recovery by the teaching and practice of accountability, grace, and responsibility.
- Values experiential knowledge.
- Promotes peer-to-peer connections and mutual aid.
- Creates an atmosphere in which residents are

[Continues on page 4](#)

SAMHSA’s four dimensions supporting a life in recovery

Health—recovery housing is where people learn to create a life in recovery, overcoming or managing their substance use — for example, abstaining from the use of alcohol, illicit drugs, and non-prescribed medications and making informed, healthy choices that support their physical and emotional well-being.

Home—recovery housing provides residents a stable and safe place to live. Persons with substance use issues often return from treatment and institutions to living environments that enable addictive lifestyles. Secure housing is an important component of recovery and has proven to promote successful recovery outcomes.

Purpose—recovery homes promote meaningful daily activities, typically requiring residents to work, go to school, and/or volunteer. Longitudinal research reveals that persons who live in recovery housing have higher monthly income and employment. Moreover, recovery housing creates a functionally equivalent family within the household where residents share mutual aid, reciprocal responsibilities, chores and leadership and/or governance roles.

Community—Using the social model of recovery principles, recovery housing cultivates family like relationships and social networks that provide support, friendship and hope. The support of the community is a critical aspect in achieving and sustaining recovery. A support network of friends and family, peers with lived experience, trained recovery housing staff and access to community resources are essential to helping people achieve sustained recovery. Community, camaraderie, empathy and guidance are necessary ingredients in helping someone remain on track as they navigate a healthy lifestyle.

Continued from page 3

encouraged to participate in their chosen pathway to recovery.

- Provides a sober, supportive environment.
- Has recovery as the common bond.
- Promotes peer-to-peer rather than practitioner-client relationships and replaces the concept of a treatment plan with recovery plans.

Best Practice 4: Promote equity and ensure cultural competence.

Recovery housing should promote equity and ensure operators have competence in serving individuals from all relevant underserved populations. Substance use disorder does not discriminate along racial, cultural, sexual orientation, gender (including gender identity), disability, age or socioeconomic lines. Recovery housing operators support diverse populations and should be responsive and respectful of health beliefs and practices, and of the cultural and linguistic needs of each resident. Recovery houses are predicated on peer-to-peer relationships that support the restoration of healthy relationships. Recovery housing is grounded on the social model of recovery that emphasizes a strong sense of community, which requires recovery housing staff and operators to ensure a culturally competent living environment.

Best Practice 5: Ensure quality, integrity, resident safety and reject patient brokering.

Recovery housing should ensure quality, integrity, and resident safety and not engage in any patient brokering. SAMHSA recommends that all recovery residences adhere to ethical principles that place resident safety as the chief priority. Unethical recovery housing practices place both the residents and communities at risk and prioritize financial gain over resident safety and recovery. Patient brokering is one of the more significant,

life-threatening forms of health care/treatment fraud occurring across both recovery housing and clinical treatment programs. It is an illegal practice used by some programs to pay a third party to procure patients and/or residents for them (see <https://onlinelibrary.wiley.com/doi/10.1002/adaw.30693>). A broker often refers a person with an SUD to an unethical treatment center or recovery house for a financial fee or some other valuable kickback. For example, the patient/resident, who is already in recovery after completing treatment or in a recovery housing program, is enticed through financial inducements and/or free drugs to resume use by the brokering agent, who then refers this person back to treatment and then the recovery housing facility for a kickback. Patient brokering has several consequences that are detrimental to both the resident and community. These include:

- Decreased quality of care;
- Higher overdose rates;
- Incentives to keep residents in active use;
- Hesitance by family to send loved ones to treatment;
- “Not in My Backyard” (NIMBY) attitudes;
- Monetary consequences for ethical providers (e.g., ‘losing’ residents to unethical providers due to inducements); and
- Increased rates for many insurance plans, and others pulling out of certain state marketplaces.

In 2022, the United States Department of Justice successfully prosecuted a doctor for a \$110 million addiction treatment fraud scheme (see <https://onlinelibrary.wiley.com/doi/10.1002/adaw.32858>).

SAMHSA recommends that recovery housing operators: (1) be aware of the existence of these types of practices; (2) report these practices to law enforcement or other governing and accrediting entities; and (3) avoid working or partnering with programs that do not keep resident safety and wellness as their priority.

Best Practice 6: Integrate co-occurring and trauma-informed approaches.

SAMHSA recommends that all recovery housing programs have policies, procedures, and leadership or staffing plans that reflect the prevalence of co-occurring mental health conditions and trauma amongst persons with substance use issues. Further, SAMHSA recommends that recovery residences incorporate trauma-informed approaches and practices that avoid re-traumatizing those seeking help.

Best Practice 7: Establish a clear operational definition.

Recovery houses are safe, healthy, family like substance-free living environments that support individuals in recovery from addiction. While recovery residences vary widely in structure, all are centered on a peer support connection to services that promote long-term recovery. All recovery housing approaches are characterized by alcohol- and drug-free living environments that are grounded in the social model of recovery, but they can differ in their governance or staffing models, as well as whether they offer additional supports and services. As such, recovery housing can range along a continuum of four levels described by the NARR: peer-run houses (level I), homes (level II), supervised housing (level III), and residential treatment housing (level IV).

Best Practice 8: Establish and share written policies, procedures and resident expectations.

Recovery residences should have clearly written and easy to read policies, procedures and resident expectations. To avoid ambiguity, SAMHSA recommends that standards or guidelines are clearly explained and provided in writing to each new resident by a house staff member or designated senior peer at the time of orientation. It is also advisable for recovery homes to establish a resident handbook to help

ease transition and ensure understanding of the recovery house rules and for residents to be informed of their rights. Resident rights should include the following:

- Freedom from abuse and neglect;
- Freedom from forced or coerced labor;
- Privacy of physical health and behavioral health records; Freedom to manage their own finances;
- Freedom to have family supports;
- Freedom from unethical patient brokers; and
- A process to submit and resolve grievances.

Each resident should sign the documents to verify understanding. The recovery housing operators should ensure proper and safe storage of these signed documents, and residents should be given a copy for future reference. An orientation process should accompany the communication of these procedures.

Best Practice 9: Importance of certification.

SAMHSA recommends recovery housing entities be certified. Certification is one noted remedy to address unethical and illegal practices in recovery housing. NARR has developed the most widely referenced national standards to ensure well-operated, ethical, and supportive recovery housing. There are 30 state affiliate organizations that have adopted the NARR standards, and as of 2023, nine states are in development. NARR and these organizations collectively support over 25,000 people in addiction recovery who are living in over 2,500 certified recovery residences throughout the United States. Oxford House has its own certification/chartering process that has been in effect for over 48 years.

Certification of recovery houses ensures that the home meets organizational, fiscal, operational, property and recovery support standards.

[Continues on page 6](#)

Questions to ask and other aspects of the admissions process

Providers and state governing agencies, including law enforcement, are often important referral sources to recovery housing programs. It is necessary for these entities to be well versed about each prospective program prior to referring an individual. Relevant information to be considered along with the individual in determining the most appropriate settings includes:

Certified to national standards — Does the recovery home operate in accordance with national standards as evidenced by a current certification or charter?

House culture — To what degree does the house promote healthy behaviors, requirement of a recovery maintenance program, and a living environment that supports recovery?

Level of support — For residents with higher needs, does the residence offer ancillary recovery support (e.g., peer-specialist services), life skills development, and/or referral to clinical services?

Geographic area — Is the neighborhood or external surrounding environment of the recovery house safe and is there public transportation easily accessible?

Living environment — What are the physical characteristics of the recovery housing program, such as health and safety, number of occupants, accessibility to people with disabilities, etc.?

Current residents — Are they welcoming? Committed to recovery? Employment status? Is there a clear overall community structure including delegation of responsibilities?

Medication(s) — Does the operator and house leadership or staff support the use of medications for mental health conditions or SUD? Are adequate diversion risk management policies and procedures in place? Is medication-assisted recovery embraced and elevated in the recovery house's culture and leadership? Does mutual aid support in the household, alumni, or surrounding community embrace the use of medication(s)?

Staff training and professionalism — For higher levels of support, what is the level of training and professionalism of direct support staff (e.g., co-occurring disorders, trauma-informed crisis interventions, etc.)? NOTE: Level I recovery housing programs, including Oxford Houses, are entirely peer-run and many level II recovery housing programs are monitored by a senior resident. Level I recovery housing programs do not have professionally trained staff on site by design.

Ethics — Has the business been cited for unethical business practices, including fraud and/or abuse of residents?

Rights protection — Are the residents informed of their rights? Is there a clear policy for addressing complaints and grievances including local or state ombudsman services?

Cost — Are resident costs and fees reasonable?

Recurrence of use policy — Are there adequate and clear policies surrounding instances when residents experience a recurrence of use?

FDA-approved overdose reversal medication — Is there the availability of opioid-overdose reversal drugs such as naloxone?

Continued from page 5

Best Practice 10: Promote the use of evidence-based practices.

There are several evidence-based practices that complement the effectiveness of recovery housing, including outpatient treatment, medications prescribed to treat mental health and SUDs and urinalysis. Recovery housing that meets nationally recognized standards (e.g., Oxford House Inc. and NARR) are evidence-based practices as summarized earlier. Many residents stay in recovery housing during and/or after outpatient treatment, with self-determined residency lasting for several months to years. SAMHSA recommends that recovery housing providers offer resources to help residents access and remain in outpatient treatment. SAMHSA recommends that recovery housing operators not have any barriers or restrictions for residents to use prescribed medications for behavioral or physical health conditions. Medications for substance use and mental health disorders can be lifesaving. This includes the use of the federal Food and Drug Administration (FDA)-approved medications for alcohol use and/or opioid use disorders — including buprenorphine, methadone and naltrexone. Medication therapy in conjunction with counseling, behavioral therapies, and community recovery

support services provide a whole-individual approach to the treatment of SUDs. Since most recovery homes do not have direct support staff, diversion risk management can look different across different recovery homes and levels of support. The following strategies are recommended when appropriate:

- Utilizing medication lock boxes;
- Ensuring that residents and staff are properly trained on the medication policy and procedures;
- Conducting medication counts with residents and staff present;
- Using 42 CFR Part 2 and HIPAA-approved communication between recovery house staff and clinical teams;
- Providing proper documentation regarding medication;
- Facilitating open discussion of medication use (e.g., groups, triggers, etc.); and
- Knowing daily dosing at licensed facilities when applicable.

SAMHSA recommends drug testing. To maintain alcohol- and illicit-drug-free environments, SAMHSA recommends urinalysis testing if someone in the home may be suspected of using alcohol and/or drugs and the environment becomes

unsafe to other residents. This may also be necessary for individuals involved in the criminal justice system or other institutions. However, nonclinical recovery housing programs are not able to bill third-party payers for these services.

Best Practice 11: Evaluate program effectiveness.

SAMHSA recommends that recovery housing operators properly assess how each program performs in the delivery of quality recovery housing.

SAMHSA recognizes that program evaluation may occur at varying levels depending on the size and scope of the recovery housing program and recommends collecting data on measures such as sustained recovery, employment, criminal justice involvement, transition to permanent housing and social connectedness. This data would greatly assist the recovery home in gauging the effectiveness of services provided and would also enable these entities to utilize data to support requests for state and federal funding. In addition, SAMHSA recommends resident satisfaction surveys, which can be a valuable indicator as to the overall performance of the recovery housing facility and thus lead to program modification as necessary. •

Summary of National Alliance for Recovery Residences' Levels of Support				
NAAR Level	Typical Residency	On-site Staffing	Governance	On-site Supports
Level 1 (e.g., Oxford Houses)	Self-identifies as in recovery, some long-term, with peer-community accountability	No on-site paid staff, peer to peer support	Democratically run	On-site peer support and off-site mutual support groups and, as needed, outside clinical services
Level 2 (e.g. sober living homes)	Stable recovery but wish to have a more structured, peeraccountable and supportive living environment	Resident house manager(s) often compensated by free or reduced fees	Residents participate in governance in concert with staff/recovery residence operator	Community/ house meetings, peer recovery supports including "buddy systems," outside mutual support groups and clinical services are available and encouraged
Level 3	Those who wish to have a moderately structured daily schedule and life skills supports	Paid house manager, administrative support, certified peer recovery support service provider	Resident participation varies; senior residents participate in residence management decisions; depending on the state, may be licensed; peer recovery support staff are supervised	Community/ house meetings, peer recovery supports including "buddy systems." Linked with mutual support groups and clinical services in the community, peer or professional life skills training on-site, peer recovery support services
Level 4 (e.g., therapeutic community)	Require clinical oversight or monitoring, stays in these settings are typically briefer than in other levels	Paid, licensed/ credentialed staff and administrative support	Resident participation varies, organization authority hierarchy, clinical supervision	On-site clinical services, on-site mutual support group meetings, life skills training, peer recovery support services

Source: SAMHSA

Wrr from page 1

ruling last January had reversed a U.S. District Court judgment in plan members' favor in 2019, following a bench trial in 2017.

Under this latest action, the appellate panel has essentially revived plaintiffs' fiduciary duty claim in the *Wit v. United Behavioral Health* class action lawsuit, and has remanded for District Court review the question of whether that claim is subject to health' plans internal appeals ("administrative exhaustion") requirements, and, if so, whether plan members satisfied those requirements before bringing the lawsuit. But the ruling also reverses the District Court's certification of plaintiffs' denial of benefits claim as a class action.

The final outcome of this case therefore remains unknown. But treatment providers and advocates see this latest ruling as potentially leading to a judicial remedy when administrators of ERISA-governed plans use coverage guidelines designed mainly to deny care.

"This signals the potential for an obligation not previously established in law," Marvin Ventrell, J.D., president and CEO of the National Association of Addiction Treatment Providers (NAATP), told *ADAW*. "If I'm in executive leadership at a payer organization, I'm paying very close attention to this."

Of concern for the actual plaintiffs in *Wit*, however, is that "The relief we want for all these people does not appear to be available," Ellen Weber, senior vice president for health initiatives at the Legal Action Center, told *ADAW*. "The only way to save the remedy is to have the [denial of benefits] claim live on."

States' involvement

In his communication to NAATP member provider organizations concerning this latest ruling, Ventrell thanked the attorneys general of Illinois, Connecticut and Rhode Island for informing the appellate

"This decision affirms that plans have to conform to contract standards."

Ellen Weber, LAC

court through legal briefs that if the reversal of the original District Court ruling were allowed to stand, it would have damaging consequences for efforts to combat the opioid epidemic. These states are among those in which legislators have mandated use of widely accepted standards such as the American Society of Addiction Medicine (ASAM) Criteria in coverage determinations for substance use treatment.

Rob Kent, president of Kent Strategic Advisors, recalled similar actions at the state level in New York when he served as general counsel at the state's Office of Addiction Services and Supports. Kent told *ADAW* that when agency officials had the opportunity to review payers' coverage determination guidelines, they found a laundry list of items with no relationship to true clinical standards.

Payers were using standards such as "fail first in outpatient treatment," or "not motivated to get better," to justify denials of needed care, Kent said. "We didn't feel they were an honest broker," he said of insurers.

This led the state to bar use of prior authorization practices and other restrictive managed care policies, Kent said, but officials remained frustrated because these changes would apply to less than half of the state's health plans (those not covered by ERISA). As a result, advocates have been left to wait for Congress to take similar action protecting members in ERISA-governed plans. But with no sign of

that happening at this time, a strong judicial remedy appears to be plan members' best hope, Kent said.

"The notion that there might be a pathway under ERISA when an insurer is not following any clinical standard of care is really important," he said.

In last month's ruling, the same appellate panel that issued last January's ruling decided that the District Court did not err in certifying plaintiff classes to pursue the fiduciary duty claim. The plaintiffs had alleged that UBH administered their plans in its own financial self-interest and in conflict with plan terms. "Their alleged harm further includes the risk that their claims will be administered under a set of guidelines that impermissibly narrows the scope of their benefits and also includes the present harm of not knowing the scope of the coverage their plans provide," the appellate panel wrote.

"This decision affirms that plans have to conform to contract standards," Weber said.

However, the panel also ruled that the District Court did err in its certification of plaintiffs' denial of benefits claims as class actions, because the classes were not limited to those whose denials were based on challenged provisions of UBH's coverage guidelines. The court pointed to evidence presented by UBH that some of these claims had been denied for reasons independent of its coverage guidelines.

The panel wrote that "UBH's interpretation that the plans do not require coverage for all care consistent with [generally accepted standards of care] does not conflict with the plain language of the plans." It reversed the District Court's judgment that UBH wrongly denied benefits "to the extent the District Court concluded the plans require coverage for all care consistent with [generally accepted standards of care]."

[Continues on page 8](#)

Continued from page 7

History of case

This is the fourth key opinion issued in a case that many observers see as pivotal to delineating the rights of health plan members with substance use and mental health disorders and the obligations of plan administrators. In the three previous rulings:

- U.S. District Court Chief Magistrate Judge Joseph C. Spero in 2019 issued a strongly worded ruling in which he concluded that UBH had adopted unreasonable coverage guidelines that were not in keeping with generally accepted standards of care, and that the insurer had issued arbitrary denials of benefits based on the flawed guidelines (see “Ruling against UBH in class action resonates within treatment community,” *ADAW*, Aug. 5, 2019; <https://doi.org/10.1002/adaw.32445>). Spero in 2020 directed UBH to implement new guidelines (including use of the ASAM Criteria for substance use treatment) and ordered that 50,000 denied claims be reprocessed under the guidelines. He also appointed a special master to oversee UBH’s compliance for 10 years.
- A three-judge panel of the U.S. Court of Appeals for the Ninth Circuit in March 2022 sided with UBH in its appeal of Spero’s ruling, issuing a decision short on specifics but suggesting that the District Court had misapplied a standard of review of UBH’s authority to interpret the terms of the health plans it manages (see “Advocates fear implications of reversal of *Wit* decision for plans’ coverage,” *ADAW*, April 4, 2022; <https://doi.org/10.1002/adaw.33392>).
- The appellate panel in January 2023 reversed the original District Court ruling that UBH had wrongfully denied benefits to plan members. The

Coming up...

“**Liberating methadone**” will be held **September 21-22** at NYU Langone in New York City; it is sponsored by the Urban Survivors Union and Pew. For more information, go to <https://www.liberatemethadone.org/home>

The **NAADAC annual conference** will be held **October 6-12** in Denver, Colorado. For more information, go to <https://www.naadac.org/annualconference>

AMERSA’s annual conference will be held **November 2-4** in Washington, DC. For more information, go to <https://amersa.org/2023-conference/>

The **American Academy of Addiction Psychiatry annual symposium** will be held **December 7-10** in San Diego. For more information, go to <https://www.aaap.org/training-events/annual-meeting/2023-annual-meeting/>

The **2024 AATOD conference** will be held **May 18-22** in Las Vegas. For more information, go to <https://aatod.eventscribe.net/>

panel appeared to give UBH the authority to develop coverage guidelines without regard to whether they are consistent with generally accepted standards of care (see “Appellate court overturns judgment for health plan members in *Wit* case,” *ADAW*, Feb. 13, 2023; <https://doi.org/10.1002/adaw.33689>).

Last month’s appellate panel ruling vacates the January opinion. Ventrell said he believes the judges might have been persuaded by arguments that mass denials of benefits based on flawed standards can place

many individuals at high risk during an opioid crisis and post-pandemic. “Environmental conditions impact courts’ decisions,” he said.

Kent said managed care companies would be better served, including from a financial standpoint, if they offered necessary treatment when needed and ensured a transition to effective follow-up care. This would end up lowering the costs of emergency care and repeat treatments over the long run. “They spend too much time creating their own tools that are basically set up to deny, deny,” he said of payers. •

In case you haven’t heard...

It may be just a political ploy but reports that the White House wants to de-schedule marijuana quickly came under scrutiny by Kevin Sabet of Smart Approaches to Marijuana (SAM). “While under [the Department of Health and Human Services] HHS’s recommendation marijuana would remain illegal under federal law, the move flies in the face of science, reeks of politics, and would allow the industry to deduct business, promotional, and other expenses, like ads promoting kid-friendly THC-flavored gummies and candies by repealing Section 280E of the tax code. The addiction profiteers who have been exposed for lying about marijuana’s physical, mental and economic impacts, are desperately looking for legitimacy in the wake of mounting evidence [that] their products are harming millions of Americans. It is regrettable that the Department of Health and Human Services’ move now appears to be a nod to those monied interests.” And even Yasmin Hurd, Ph.D., whose work on marijuana research has often placed her in a difficult balancing act, came out strongly to state that marijuana is not good for the developing brain. “I feel frustrated that people are willing to sacrifice kids and young people for their quote-unquote right to get high,” she told *Science Daily* this summer.