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Transition of federal government: The path forward for SAMHSA

Bottom Line...
With a new administration coming in 2021, we looked at the path forward for SAMHSA, with input from experts.

Last week, as President-elect Biden worked with his transition team, we asked experts around the country to comment on the path forward for the Substance Abuse and Mental Health Services Administration (SAMHSA). President Trump, who so far has not conceded defeat and is mounting legal challenges to the results, and his administration remain in control until Jan. 20, 2021, inauguration day. Elinore McCance-Katz, M.D., Ph.D., is still assistant secretary for mental health and substance abuse of the Department of Health and Human Services and head of SAMHSA.

The Biden team has two major health challenges to face — not only the pandemic, but also an undiminished high rate of opioid overdose deaths. Both were also challenges for the Trump administration.

President-elect Biden proposed an opioids plan in which $125 billion would be spent, which would build on the Affordable Care Act. The main details are:

- hold accountable big pharmaceutical companies, executives and others responsible for their role in triggering the opioid crisis;
- make effective prevention, treatment and recovery services available to all, including

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Reach of remedies order in UBH case could capture other payers' notice

Bottom Line...
The remedies order issued this month in the Wit v. United Behavioral Health *case mandates reprocessing of thousands of denied claims and oversight from an outside monitor for 10 years.*

The latest order in a legal case that found managed behavioral health care company United Behavioral Health (UBH) used flawed internal guidelines to deny coverage for substance use treatment could reverberate across the insurance industry, as the order gives broad authority to an outside party to oversee corrective action on UBH's part.

While there has been some evidence that other insurers are considering use of more objective criteria for level-of-care determinations, an attorney representing plaintiffs in *Wit v. United Behavioral Health* says there has been little concrete action so far. But that soon may change, attorney Meiram Bendat told *ADAW*, now that federal Magistrate Judge Joseph C. Spero has called for a special master to oversee UBH staff training and the reprocessing of 67,000 behavioral health claims that had been denied during the period at issue in the case.

"I would be surprised if we don't see a more aggressive response

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through a $125 billion federal investment;

- stop overprescribing while improving access to effective and needed pain management;
- reform the criminal justice system so that no one is incarcerated for drug use alone; and
- stem the flow of illicit drugs, like fentanyl and heroin, into the United States — especially from China and Mexico.

For the plan, go to https://joebiden.com/opioidcrisis/.

"We still have COVID-19, and in all fairness, Dr. McCance-Katz in her blogs has recognized that," said H. Westley Clark, M.D., J.D., dean's executive professor at Santa Clara University and former director of SAMHSA's Center for Substance Abuse Treatment (CSAT). "But there is a list of important things SAMHSA needs to deal with."

Among issues SAMHSA should consider in moving forward, according to Clark:

- ***Changing the landscape of marijuana and other recreational drug use.*** "Adult use marijuana" — this is Clark's term for the extended decriminalization and use of some drugs, and the move toward recreational marijuana use. This is a move espoused by both red and blue states, he pointed out.
- ***The importance of SAMHSA itself.*** SAMHSA is needed to serve the administration for substance use disorder prevention, treatment and recovery, according to Clark. This includes the importance of the SAMHSA leader being assistant secretary of HHS — something that only happened with the CURES Act in December 2016 (under President Obama, by a lame-duck Congress). "I like the notion of the assistant secretary position, because it provides HHS and Office of National Drug Control Policy (ONDCP) and Congress and the White House a senior-level position," said Clark. "People are still concerned about the health and welfare of their family members" so that level of importance counts. "You need an agency that can service the administration — whichever it is," he added.
- ***Returning Drug-Free Communities (DFC) to SAMHSA***. Clark said the Centers for Disease Control and Prevention, which houses the DFC program now, has "too many layers."
- ***Deciding on a new SAMHSA chief of staff.*** The new agency head will have to decide who he or she wants as chief of staff, but whoever it is, the role should be defined more clearly, said Clark. "Define the chief of staff role as more narrow, and not so broadly as to make administrative bottlenecks within the administration," he said.
- ***Reinvigorating the centers (CSAT and the Center for Substance Abuse Prevention, in particular).*** "The centers should be the place where the data is collected to inform the administration of relevant issues," Clark said. They should be permitted to interact with state and tribal authorities, and to respond to multiple jurisdictions in the United States, he said.
- ***PEPFAR.*** The President's Emergency Plan For AIDS Relief (PEPFAR) should be brought back in full to SAMHSA, because model treatments can come from other countries, said Clark. "Substance use issues are global," he said. "The issue is not whether you like the Portugal approach or not."
- ***Legalization.*** The country is "moving away from a war on drugs, and now permitting adult use in some places," said Clark, noting Oregon's recent ballot initiative (see p. 8). This is closely related to recovery, "because the demand for drugs

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"It will be important for the Biden administration to take an approach that has yet to be taken by a White House: one that sees a vast continuum of prevention, treatment and recovery support services, and embraces the continuum as a whole."

Andrew Kessler

comes from the people who use drugs," he added.

Recovery

All our sources agreed that SAMHSA should be playing a larger role in fostering recovery, as opposed to only acute treatment. Fewer than 10% of people who need treatment are getting it.

Citing a regular Faces and Voices of Recovery request, Clark, who is on the board, urged the "new SAMHSA" to set aside 20% of the Substance Abuse Prevention and Treatment (SAPT) block grant for recovery-oriented support services.

"It's important to prioritize recovery," said Clark. And this means money needs to be in the federal budget for it. "We cannot look to sustained support from the private sector," he added. That said, there is still inadequate modeling on what recovery should look like.

It's important to see recovery as part of a continuum, added Andrew Kessler, principal with Slingshot Solutions, a behavioral health lobbying firm based in Washington, D.C. "It will be important for the Biden administration to take an approach that has yet to be taken by a White House: one that sees a vast continuum of prevention, treatment and recovery support services, and embraces the continuum as a whole," Kessler told *ADAW*. "Our piecemeal approach to this point has not yielded results nearly fast enough. I am hopeful the Biden administration will embrace innovation, and invest in long-neglected initiatives, such as addressing trauma, building a robust workforce that is respected and compensated, and commitment to building a vast network of recovery support services."

SAMHSA staff

Over the past four years, SAMHSA, like many federal agencies, has lost staff. SAMHSA should be allowed to staff up to at least 80% of its FTE capacity, said Clark.

In fact, when HHS uses contractors instead of employees, it can cost more money. For example when work is often last-minute, the agency is charged a premium. Having federal employees in place and managing the workflow can save money. But someone is going to have to make the argument that hiring FTEs will "make the most of the money they have" at SAMHSA, our high level HHS source said.

Career vs. political employees

Geoffrey Laredo, former senior advisor to the director of the National Institute on Drug Abuse and a career veteran of administration transitions, said that "people do their job to get the job done." In the past, transitions have been a relatively straightforward process — certainly that was true at the National Institutes of Health (NIH) — and he concedes he has been "lucky enough to be a part of this — you are prepared to provide as much information to the incoming administration as possible about what your agency has been doing, what your agency has been planning to do and so on," he said.

There are many career employees in this administration who have been through transitions before, Laredo added. "They know that as career civil servants their job is to 'do your damn job regardless of what might be swirling around you,'" he said.

Laredo takes issue with the idea that addiction is bipartisan, however. "Addiction and related issues have always been hyperpolitical," he told *ADAW*. However, people who work at the NIH have not been targets during this administration, with the glaring exception of Dr. Anthony Fauci at the NIH, who has been "unjustly attacked," said Laredo.

That said, Francis Collins of the NIH is one of the only HHS political appointees who has crossed from one administration (Obama) to another (Trump). The other significant one is David Kessler of the Food and Drug Administration, who went from Bush 1 to Clinton. Brett Giroir, a political appointee, will be out in a Biden administration, as will McCance-Katz.

But people who feel slighted by the past four years should not expect a reckoning. "The people who are moving on will not be held accountable," a top-level career HHS official told us last week.

As for SAMHSA, it and HHS "face extraordinary challenges" regardless of administration, said Laredo. Particularly during a time of COVID-19, but also rising overdose deaths and the addiction crisis, SAMHSA "has to do what it can to fund and provide mental health and SUD services in a variety of ways across the country," he said.

Funding

It's true that SAMHSA has gotten $2 billion a year extra for the opioid use disorder (OUD) crisis, and Laredo

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doesn't want to discount this. "None of us should be crass enough to talk about this as if it's nothing — $1 billion here, $1 billion there," he said. "But this is a $100 billion problem."

If the country continues to spend $1 billion a year on naloxone, and nothing else, that doesn't even approach a credible solution, said Laredo. "It's not that we shouldn't do that, but we need to do much more," he said.

Looking back, however, the purchases by the federal government of naloxone would have been unthinkable in a Bush administration. Encourage drug use by rescuing people from overdoses? But the Trump administration embraced it. Maybe it was "handed out like candy," as one source said, but the important point is that administrations evolve in their thinking.

Rob Morrison, executive director of National Association of State Alcohol and Drug Abuse Directors, urged that work is still needed to understand how helpful State Targeted Response and State Opioid Response grants have been to patients. These grants, which began under Obama and continued under Trump, have been vital, he said, but should be folded into the SAPT block grant to give states more flexibility.

"We've always promoted a strong SAMHSA and a strong ONDCP," added Morrison.

Given Biden's long history on the judiciary committee, and his position as vice president with Obama, in which he worked on the topic of criminal justice reform, there is hope in the field that there will be a strong pillar for treatment and reentry.

Treatment focus

According to Robert Lubran, who retired from SAMHSA as Division of Pharmacologic Therapies director in 2016, the focus of the new administration should be on patient concerns.

"I'd like to see new leadership at SAMHSA bring together diverse groups of people from around the country to create a new vision and a sense of urgency for the agency with a focus on the key issues we face in behavioral health," he told *ADAW* last week. Here are some of the issues Lubran sees as critical.

- ***Criminal justice reform.*** Many communities are struggling with the need for improvements in how law enforcement deals with people in mental health crises. "I am saddened every time I read about a person having a mental health crisis that ends up being assaulted, or worse, by a law enforcement official who is not trained in Mental Health First Aid or other techniques to deescalate situations," Lubran said.
- ***Restoring faith in the privacy of SUD records.*** This is a critical issue for many in the addictions field. There is a feeling among patient advocacy organizations that SAMHSA has acceded to the interests of the business community and ignored the concerns and fears of patients that the regulatory changes put forth will harm rather than protect their records from unnecessary and unreasonable access.
- ***Moving away from harsh penalties for illicit drug use.*** Lubran points to the Oregon ballot initiative and cannabis becoming more widely available. Are there new models that should be adopted and studied? What can be learned from the National Institute on Drug Abuse–funded HEALS grants? SAMHSA has a wonderful resource in the mental health, prevention and treatment Technology Transfer Center models, he said. Can SAMHSA strengthen relationships with the states that are implementing the SOR funding to help share successes and failures around the country?
- ***Improving employee morale.*** "I know many current SAMHSA employees who have told me that their perceptions of SAMHSA's effectiveness as an agency declined under the Trump administration," Lubran said. "I am aware of other long-standing career employees of the agency who took other positions within HHS and reported they were glad to be gone. This makes recruitment difficult."
- ***Addressing America's racial injustice.*** SAMHSA should play an important part, Lubran said.
- ***Reforming the methadone/opioid treatment program (OTP) regulatory system and starting to bring OTPs into the 21st century.*** "They should not be an island sitting outside of our health care system," Lubran said. "They represent a critical element of OUD treatment and could do an even better job if not hindered by outdated rules." (Lubran was in charge of regulating the methadone/OTP system when he was at SAMHSA.)

Historical perspective

Mark Weber, deputy assistant secretary for public affairs at HHS, told *ADAW* last week that the key thought for any administration coming in is "the importance of working with the bureaucracy, because once you get something entrenched in the bureaucracy, there's a livelihood depending on it." Weber, who is on his fifth transition, added that "once something gets established within the bureaucracy, that's an accomplishment for an administration."

Back when Nelba Chavez, Ph.D. was SAMHSA administrator in 1994, the agency's main emphasis was just proving that substance use prevention and treatment worked, and even that mental health services worked. "We'd go to hearings [on Capitol Hill] and they'd say, 'How can you prove prevention works?'" recalled Weber.

Then there was the study in which 440 publicly funded treatment

programs proved that treatment worked. "It makes sense that if you invest, something changes, and if you don't invest, nothing changes," Weber said.

Then, during Charles Curie's tenure at SAMHSA, from 2001 to 2006, when it was already accepted that treatment and prevention worked, the emphasis became recovery, something about which he had a strong personal belief. "Personnel is policy," Weber commented. "And so as they go through the personnel process, they try to find people who are aligned with them."

Another change is marijuana. When Donna Shalala was HHS secretary and Chavez was at SAMHSA, there was a huge anti-marijuana initiative, which was continued by the Bush administration. Now, if you don't ask, nobody wants to talk about it, and even if you do ask, HHS points to "research."

In the meantime, the country is still waiting for what the government calls "ascertainment" – a concession from Trump, or Trump to be able to take the win away from Biden. •

Neurofeedback did reduce medication for ADHD

Many parents are opposed to the idea of stimulant medication for their child's moderate to severe attention deficit hyperactivity disorder (ADHD), even though it is the first-line recommended treatment. A recent study has found that neurofeedback (NF), even though it had no effect at either the end of treatment or at the 13-month follow-up based on inattention only, did result in the need for less medication.

The study, "Double-Blind Placebo-Controlled Randomized Clinical Trial of Neurofeedback for Attention-Deficit/Hyperactivity Disorder with 13 Month Follow-up," was published online Aug. 25 in the *Journal of the American Academy of Child and Adolescent Psychiatry*. It was a randomized controlled trial (RCT) conducted to see if neurofeedback had a specific effect, beyond a nonspecific benefit, on ADHD.

However, the children who received NF needed less medication at the 13-month follow-up than the controls.

Study details

For the study, 144 children ages 7 to 10 with moderate to severe ADHD were randomized either to deliberate neurofeedback or a sham treatment of equal duration, intensity and appearance. The primary outcomes measured were parent- and teacher-rated inattention.

Results

The blinding was excellent. Both groups had significant improvement in parent- and teacher-rated inattention, from baseline to treatment end, and at the 13-month follow-up. Neurofeedback is expensive, and not superior to the control condition at either time point. Of the children, 61% of the NF group responded, and 54% of the control group responded.

However, the NF group required significantly less medication at follow-up.

The most successful and commonly used treatment for ADHD is medication. However, 32% of children with ADHD do not achieve remission if they also get behavioral treatment, and in the real world, 69% do not achieve remission, the authors wrote. Even for young people with good initial response, a benefit that persists beyond two years is difficult to document. The follow-up of the Multimodal Treatment study of ADHD called for new treatments with long-term benefits.

Neurofeedback using EEGs is one of the more promising non-pharmacological treatments for ADHD. It works by providing real-time audiovisual feedback, including primary reinforcement of targeted neurophysiological activity, reinforcement by psychological factors implicit in treatment protocols, placebo response and synergism with other treatments, including psychotherapy, coaching and sleep hygiene.

This study is the first large randomized double-blind placebo-controlled clinical trial employing a standard NF protocol. The authors emphasized long-term outcomes and follow-up assessments. An additional follow-up assessment will be conducted at 25 months.

One of the original hypotheses for the study is that the NF group would have less need for medication than controls at follow-up — and that is what happened.

Along the way, researchers decided that patients who did not show a 10% improvement in the parent and teacher attention ratings at midpoint would leave treatment — whether neurofeedback or controls — also in a blinded fashion.

Outcomes

Primary outcome:

- Parent- and teacher-rated *Diagnostic and Statistical Manual of Mental Disorders (DSM)* inattentive symptoms on the Conners 3rd Edition: Long Version (C3P and C3T). These rate symptoms/problems from 0 (no problem) to 3 (severe) and yield 12 subscales, including *DSM* inattention. It has norms and T scores.

Secondary outcomes:

- The other 11 subscales of the C3P/C3T.
- The Functional Assessment Checklist rated by parent (FAC) and teacher (FACT).
- Items (45 on FAC, 38 on FACT) were rated from 1 (worst) to 5 (best) and averaged. Impairment thresholds were < 3.0 for FAC and < 2.5 for FACT.

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- Clinical Global Impression severity (CGI-S) and improvement (CGI-I), each rated 1–7, from best to worst.
- The Adverse Events Tracking Form recorded all adverse events in pharma-like fashion.
- Medication changes: A Concomitant Treatment Form recorded medication name, dose and starting/stopping dates at screen and each subsequent visit from parent informant in pharma-like fashion. For analysis of changes over time, discontinuation without substitution and dose reduction were grouped as less medication, while dose increase and starting a new medication were grouped as more medication.
- Blinding checks: Consumer Satisfaction and Blinding Questionnaire (parent and child) and Trainer Blinding Questionnaire, administered after the last treatment, offered three choices: active NF, placebo or "can't tell."
- Clinical response and remission: Response was defined as CGI-I rating of 1 or 2. Remission (loss of diagnostic severity) was defined in two ways: as a CGI-S rating of 1 or 2 and an ADHD symptom rating item mean < 1.00.

Treatment lasted for three months.

Adverse events, possibly attributable to treatment with neurofeedback, were, however, similar for both groups: 10.6% of the neurofeedback group had headaches, compared to 8.6% of the control group. Eye pain was occasionally noted about one to three hours after a treatment session, probably due to the strain of focusing on the feedback screen.

Implications

The study, while it did not find a significant difference between the NF group and the control group based on the primary outcome, "advances the field in several ways," the authors concluded. "It is the first double-blind RCT of NF with a large enough sample to detect a medium specific effect using a standard NF protocol," they wrote. "Previous double-blind trials had samples too small to rule out type 2 error [false negative] and employed non-standard protocols. Conversely, most large multicenter RCTs that did employ standard protocols and showed a significant effect were not well-blinded, so it was uncertain whether the result was specific to NF itself (systematic continuous brain-wave-contingent reinforcement) rather than nonspecific effects of the total treatment package (supportive coaching, practice focusing on a screen, reinforcement for sitting still, placebo response). This study for the first time addressed both shortcomings and benefited from the combined expertise of both ADHD clinical-trial specialists (to insure credible scientific rigor) and neurofeedback experts (to insure credible, rigorous neurofeedback). Pharma-like recording of adverse events was another improvement over previous studies. Finally, double-blinding technology allowed masking trainers and other study staff as well as participants."

Only 32% of children, 34% of parents and 39% of trainers were able to correctly guess whether treatment was active or placebo control.

An enduring benefit is needed to pass a cost-benefit analysis, the researchers wrote, noting that neurofeedback is expensive. The neurofeedback effect in this study suggested a slightly improved inattention score in the 10 months following the end of treatment, with an increase in remission rates from 27.4% at the end of treatment to 39.7% at follow-up, by the criterion of ADHD symptoms severity. This occurred while the direction of medication changes showed significantly less medication was needed for the NF group.

Medication

Medication dose was not used as an outcome. If it had been, the NF group would have done "better" in terms of being able to eliminate or reduce medication.

The researchers weren't surprised that the medication contrast only showed up at the 13-month follow-up, and not at the end of treatment. This is because participants had to consent not to start any new medications or change any doses during the randomized treatment (except for reduction for medication side effects), and the families honored that commitment. After the treatment effect was seen, medication was stopped, started or modified in dose as needed. More of the children who had received neurofeedback were able to stop or reduce medication, and fewer needed new or increased medication, than in the control group.

"The significantly reduced need for medication with nonsignificant improvement in primary outcome compared to controls may have resulted from a cumulative effect of a virtuous cycle initiated by the treatment," the researchers wrote.

The study neither proves nor disproves efficacy of the total neurofeedback package, the researchers cautioned. And although there were improvements in the control group too, the 13-month durability of the response suggests more than a placebo response, they wrote.

A combination of several components, either synergistically or additively, could add up to the large effect seen for both groups. For example, both groups had many assessments of sleep, with a focus on sleep hygiene. There was also a focus on nutrition for both groups. And finally, the practice exerting mental effort to focus on a boring activity with supportive coaching and monetary rewards could have further contributed to the improvement in both groups. •

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now," said Bendat, the co-counsel for plaintiffs in the *Wit* class action who works for the insurance advocacy law firm Psych-Appeal Inc. "No one wants to have a monitor appointed."

Spero, chief magistrate of the U.S. District Court for the Northern District of California, ruled last year that the subsidiary of UnitedHealth Group committed a breach of its fiduciary duty by adopting unreasonable coverage guidelines that did not conform to generally accepted standards of care (see "Ruling against UBH in class action resonates within treatment community," *ADAW*, Aug. 5, 2019, https://onlinelibrary.wiley.com/doi/10.1002/adaw.32445). This month, the judge issued the remedies order in the case. Under the order, UBH will be required for the next 10 years to use the widely accepted American Society of Addiction Medicine (ASAM) Criteria to make substance use coverage determinations for plans governed by the Employee Retirement Income Security Act (ERISA).

Also, a court-appointed special master will help design and implement training in the ASAM Criteria and related subjects for all UBH personnel who have input into coverage decisions, including care advocates, peer reviewers and external clinical consultants. The special master will issue a report to the court every 60 days as an update on UBH's progress in meeting the terms of the order.

UBH leaders have said that in the wake of the initial *Wit* ruling, the company already has adopted the ASAM Criteria to guide coverage determinations, but Bendat disputes that. Additional lawsuits have been filed against UBH over its handling of more recent substance use and mental health claims.

"They have not been properly applying the guidelines they say they voluntarily transitioned to," Bendat said of UBH. Now, with a court-ordered remedy that involves training and outside oversight, "It's going to be harder for UBH just to pretend that it's complying," he said.

UBH's parent UnitedHealth Group replied to an inquiry from *ADAW* about the remedies order with this comment: "Over the last several years, we have taken concrete steps to improve access to quality care by enhancing coverage through clinician-developed evidence-based guidelines, expanding our network of providers, and providing new ways for people to quickly access care through telehealth and other digital platforms. We are focused on ensuring our members get the quality, compassionate care they need, and will continue working closely with people across the behavioral health community on this important issue."

A UnitedHealth spokesperson added that the company is reviewing Spero's remedies order and is considering its options.

Prospects for residential care

The remedies order states in the description of the mandate that UBH use the ASAM Criteria: "Faithful application of the ASAM Criteria to requests for coverage of residential treatment requires consideration of the criteria applicable to each of the sub-levels of residential treatment identified in the ASAM Criteria (i.e., Levels 3.1, 3.3, 3.5 and 3.7)."

Bendat commented, "My expectation is UBH will be required to approve coverage at all ASAM sublevels." He said the vast majority of denied claims over a six-year period that the carve-out now will be required to reprocess within the next year are for substance use treatment services. About half of those claims are for residential treatment and the rest for intensive outpatient and outpatient treatment, he said.

The order also specifies the external guidelines that will have to govern UBH's coverage determinations for adults and children with a primary mental health condition, including the American Association of Community Psychiatrists' LOCUS criteria for adult mental health treatment.

Regarding training, UBH will be required to complete training of any personnel involved in reprocessing of claims within 60 days of appointment of the special master. All other personnel will have to receive training within 90 days of the special master's appointment.

Personnel with coverage determination responsibilities, and all senior and executive management at UBH, will be required to receive training on "UBH's duties under ERISA, including what it means to be an ERISA fiduciary and to administer benefit plans solely in the interests of participants and beneficiaries, as well as the need to comply with plan terms," the order states.

Bendat said that in the court briefings that led up to Spero's remedies order, plaintiffs argued to the judge that UBH has maintained an adversarial stance even after the 2019 ruling.

"My sense is they remain defiant," he said. "Left to their own devices, we don't believe they will do what they're supposed to do."

Legislative actions

While the *Wit* case proceeds in the federal court in California, legislative action in that state signals another avenue states could pursue to force insurers to adhere to parity mandates that have not led to the level of consumer protection substance use treatment advocates would like to see.

California state legislators this year responded to the notion that the state's 1999 parity law has not been sufficient by adopting Senate Bill 855, which requires coverage for all behavioral health disorders that are spelled out in the *Diagnostic and Statistical Manual of Mental Disorders*. The measure also requires insurers to use the objective criteria cited in the *Wit* ruling when making level-of-care determinations. That means that in

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California, at least, all insurers and not just UBH will have to use the ASAM Criteria rather than any internally derived guidelines for level-of-care decision-making.

Of course, that law doesn't directly affect any other state, though Bendathopes other state legislatures will choose to follow California's lead. Bendat was involved in drafting the legislative language for the California Senate bill that became law with Gov. Gavin Newsom's signature.

In the meantime, a great deal continues to happen in the courts. Bendat cited two class-action cases in their initial stages: an action in Wisconsin against another UnitedHealth subsidiary and a lawsuit against Anthem in New York. Another lawsuit against UBH in California covers a period after the initial class cutoff, since UBH continued to use its internal guidelines through 2018, Bendat said.

Also, much attention is focused on a lawsuit against UBH that seeks class status for providers whose payments were wrongfully denied (see "New lawsuit over UBH's guidelines could yield windfall for providers," *ADAW*, Sept. 23, 2019, https://onlinelibrary.wiley.com/doi/10.1002/adaw.32486; and "Some providers may proceed cautiously on latest legal challenge to insure," *ADAW*, Sept. 30, 2019, https://onlinelibrary.wiley.com/doi/10.1002/adaw.32493).

Bendat said there has been word that Cigna decided to switch to use of the ASAM Criteria since the initial ruling against UBH, but he has not seen documentation of that.

Bendat termed it "rather shocking" that many insurers continue to deny substance use treatment when the result is that patients continue to fare poorly and end up needing more expensive care later. However, "I'm less surprised to see this from carve-outs" such as UBH, he said. "They're not looking at the overall picture. They are saying, 'Hire us and we'll reduce your costs.'" •

Coming up...

The **NIAAA 50th Anniversary Science Symposium**, days 1 and 2, will be held online **November 30 and December 1**. For more information, go to **https://www.niaaa.nih.gov/news-events/meetings-events-exhibits/niaaa-50th-anniversary-science-symposium-day-1** and **https://www.niaaa.nih.gov/news-events/meetings-events-exhibits/niaaa-50th-anniversary-science-symposium-day-2**.

The 31st annual meeting of the **American Academy of Addiction Psychiatry** will be held online **December 10-13**. For more information, go to **https://www.aaap.org/training-events/annual-meeting/about-the-aaap-annual-meeting/**.

Stay tuned, as other changes will probably be forthcoming.

Names in the News

Ramstad, champion of addiction treatment and recovery, dies at 74

James Ramstad, Republican senator from 1981–1991 and congressman from 1991–2009, died last week at the age of 74 from Parkinson's disease. For his work on the Mental Health and Addiction Treatment Parity Act, which he co-authored with the late Democrat Minnesota Senator Paul Wellstone, he was named "Legislator of the Year" by the National Association of Alcoholism and Drug Addictions Council in 1998, the National Mental Health Association in 1999 and the National Association of Police Organizations in 1997 and 2000. After retiring from Congress, Ramstad was an advisor to the Hazelden Foundation, the National Association of Drug Court Professionals and the alliantgroup. He was also on the board of the Partnership to End Addiction. He had been sober for 39 years and was active in Alcoholics Anonymous. The celebration of Ramstad's life will be held for family only at Wayzata Community Church and livestreamed to the public on Sunday, Nov. 29. Details of the service will be available at WayzataCommunityChurch.org. Memorials are preferred to the Ramstad Recovery Fund, which is for veterans seeking recovery (RamstadRecoveryFund.org). •

In case you haven't heard...

Oregon's Measure 110, passed earlier this month, which decriminalized personal use amounts of marijuana, heroin and cocaine, also can improve access to treatment, according to the Drug Policy Alliance (DPA), which wrote the initiative. "It changes what we currently have," a DPA spokesman told *ADAW* last week. "If you get caught with possession of drugs, instead of being arrested, you have two options: paying a civil penalty of $100 or avoiding that penalty by going for a health assessment at one of the new addiction recovery centers that the initiative will be funding." At the recovery centers, there are counselors and triage, he said. "The counselors would discuss the person's drug use, and based on that, recommend a treatment plan if necessary," he said, adding that "there are currently people pushed into programs who don't have a problem, and we definitely want to avoid that." The funding for these recovery centers will be primarily from marijuana tax revenue, said Sutton.