



**County Alcohol and Drug Program
Administrators Association of California**

*Dedicated to the reduction of individual and community problems related to the use of alcohol and other drugs
and the chronic disease of addiction*

CADPAAC Policy Statement: Drug Medi-Cal

Background & Issues:

As part of his FY 2011-12 Budget plan, the Governor proposed the transfer of the state administration of the Drug Medi-Cal program from ADP to the Dept. of Health Care Services (DHCS), while realigning the program services to the counties. The Legislature passed, and the Governor signed into law, AB 106 to implement this transfer.

The Drug Medi-Cal realignment proposal shifts to counties the responsibility for a program that is already inadequate relative to all other Medi-Cal systems, with reimbursement rates that are insufficient to cover actual costs for service delivery, and a range of services that is too limited to be clinically sound. Due to low reimbursement rates and the limited range of benefits, many providers will not serve Drug Medi-Cal clients, because the program does not allow them to provide professional and ethical services that reflect established standards of care in the field.

Drug Medi-Cal was never intended as an evidence-based benefit design, but rather a description of outpatient coverage that qualified for Medi-Cal reimbursement. It is restricted, out-of-date and no longer reflects the growing evidence base in SUD disorder treatments. What DHCS/Medi-Cal needs to cover under D/MC should include the entire evidence-based SUD specialty continuum of care developed through careful research, supported by the NIH. This begins with screening and brief intervention, intake and science-based assessment leading to severity of illness and diagnosis, detoxification or emergency/inpatient intervention if medically appropriate and necessary. The continuum then indicates that the next level of services includes evidence-based counseling and care coordination of various modalities indicated for patients and families, medication-assisted treatment if appropriate and necessary, treatment of co-occurring disorders (medical and psychiatric/psychological), residential non-hospital treatment if necessary and appropriate, supportive transitional housing, day care/day reporting center interventions, intensive outpatient treatment, telemedicine if needed and appropriate, and recovery support services including continuing care. (See Attachment A)

CADPAAC Recommendations:

- CADPAAC supports the transfer of the state administration of the Drug Medi-Cal program from ADP to DHCS, the state's Medicaid agency, with continuation of current program and staff requirements.
- As a long-term goal, the Drug Medi-Cal program should undergo significant revisions, including the provision of a full range of SUD benefits that meet established standards of care in the substance abuse treatment field. At minimum, SUD benefits should reflect the scope of benefits and reimbursement rates available under the rehab model.
- At the same time, while counties support expansion of Drug Medi-Cal benefits to provide an adequate continuum of care, counties must also have the ability to manage the fiscal risks associated with providing mandated Drug Medi-Cal services. Therefore, CADPAAC supports a full discussion regarding the pros and cons of moving from a fee-for-service system only into a managed care system for Drug Medi-Cal.
- Some D/MC regulations should be reexamined/changed, i.e. two services on the same day, funding case management, etc.
- There is a need to review state regulations for the Drug Medi-Cal Services. In addition to the federal Medicaid regulations, California has over the years added layers of additional state regulations to govern the operations of D/MC programs. These added state regulations appear unnecessary, can add cost to providing services, are often cumbersome, inefficient, and interfere with the delivery of appropriate treatment and health care delivery. The state's additional regulations governing the Drug Medi-Cal services inhibit the ability to deliver appropriate care based on proper protocols, assessment, and identified treatment needs. The state regulations make the use of medically-recognized best practices impossible. Examples of such restrictions include, but are not limited to:
 - ✓ Restrictions on medications that can be used;
 - ✓ Limitations on the frequency and type of sessions;
 - ✓ Limitations on group size;
 - ✓ Requiring added drug testing which is not based on clinical need;
 - ✓ Certification based on the site rather than the primary provider;
 - ✓ Requiring operating hours in excess of federal regulations, which is costly; and
 - ✓ Allowing only the five limited services.