Model Medicaid Addiction Costs Reduction Act (MACRA)

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Model Medicaid Addiction Costs Reduction Act

Policy Statement

Alcohol and other drug abuse and addiction treatment have been demonstrated to reduce health care spending on addiction related illnesses and accidents. In addition, such treatment can remove a major barrier to re-employment and self-sufficiency and work to reduce alcohol and drug related crime.[1] Despite the obvious appeal of cutting down on crime, health care and welfare rolls, the full continuum of alcohol and other drug treatment services is rarely available for Medicaid eligible individuals and families.

State Medicaid coverage of alcohol and other drug abuse and addiction treatment services varies widely around the country and tends to be limited to those services where federal matching monies are available. Federal Medicaid does provide matching funds for limited hospital detoxification and for limited outpatient services.

Missing components of the treatment continuum in many places are: intensive outpatient and residential rehabilitation and family treatment including residential rehabilitation.

Lack of availability of particularly the residential treatment component limits service to pregnant addicted women, addicted parents with dependent children and severely limits the ability of the criminal justice system to access treatment for addicted people. Given the costs to society of fetal alcohol and other drug syndrome and alcohol and other drug related crime, additional effort to address the unmet treatment needs of these populations will yield immediate cost benefits. Such treatment represents a sure investment in our nation's future as well.[2]

There is ongoing discussion with the federal Health Care Financing Administration (HCFA) about re-interpretating federal Medicaid language to include these services. Such a re-interpretation would put the HCFA in the position of leading the national effort to expand treatment capacity to address the needs of these populations.

As part of this and other health care reform discussions, there have been some attempts to pit prevention and treatment, outpatient services, and inpatient and the hospital and non-hospital treatment sectors against one another. Since the treatment needs of addicted people and their families vary greatly, this is a destructive exercise. Advancing one form of treatment at the expense of another will result once more in an incomplete continuum of treatment service available to addicted people and their families.

The proposed Model Medicaid Costs Reduction Act provides for a full continuum of alcohol and other drug abuse and addiction treatment services for addicted individuals and families and calls for aggressive pursuit of federal matching funds by state alcohol and other drug authorities.[3]

ENDNOTES

1. See Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT (Center of Alcohol Studies, Rutgers University, 1993). See, in particular, chapters 4-6 on addiction treatment, insurance, and the workforce.

2. *Id.* at Chapters 6-7, on addiction treatment, crime and pregnancy.

3. For a quick read on opportunities to maximize the use of federal monies in this area, see Gates, D. and Beck, D., *Prevention and Treatment: The Positive Approach to Alcoholism and Drug Dependency*, CLEARINGHOUSE REVIEW, Special Issue 478-486 (1990); Gates, D., MEDICAID FINANCING OF ALCOHOL AND OTHER DRUG DEPENDENCY TREATMENT (U.S. Department of Health and Human Services, TA Pub. Series, July 1991).

Highlights of the Model Medicaid Addiction Costs Reduction Act

- Requires state Medicaid to provide a full continuum of alcohol and other drug abuse and addiction treatment services including:
    1. Detoxification
    2. Short-Term Inpatient Rehabilitation
    3. Long-Term Inpatient Rehabilitation
    4. Outpatient
    5. Intensive Outpatient
    6. Family Treatment
- Establishes minimum levels of coverage within each modality of treatment.
- Limits provision of treatment services to facilities and programs licensed by the [single state authority on alcohol and other drugs].
- Disallows deprivation of coverage in the event of identification and referral from the legal or criminal justice system.
- Encourages aggressive pursuit of federal funding and matching dollars.
- Includes a non-supplantation clause.

Model Medicaid Addiction Costs Reduction Act

Section 1. Short Title.

The provisions of this [Act] shall be known and may be cited as the "Model Medicaid Addiction Costs Reduction Act."

Section 2. Legislative Findings.

(a) Alcohol and other drug addicted individuals use medical benefits at rates as high as ten times greater than the remaining population.[1] The babies whose future lives are compromised by being born exposed to alcohol and other drugs in utero will also use many times more medical benefits in their lifetimes than their unimpaired counterparts. Failure to provide sufficient insurance coverage for the complete continuum of alcohol and other drug addiction treatment leads to increased medical assistance costs for the public.

(b) The cost of addiction treatment in reduced benefit utilization alone can be recovered within one to three years, based on studies of health care utilization pre- and post-addiction treatment.[2] Those cost benefits are further enhanced by increased employment, increased productivity, reduced accidents, reduced violent crime, reduced prostitution, reduced drug trafficking, reduced child abuse and healthier parenting.

(c) One in ten Americans who use alcohol and other drugs will become an alcohol or drug abuser or will become addicted.[3] One out of four families in America are impacted by alcohol and other drug abuse.[4]

(d) Alcohol and other drug treatment is a cost effective means of achieving significant social and fiscal goals including: cost containment of Medicaid costs, restoration of health, restoration and healing of families, prevention of child abuse and fetal alcohol\drug syndrome, reduction in deaths on the highways, increased transfer of addicts in recovery from welfare assistance to the workplace, reduction in illegal drug trafficking, theft, prostitution and other crimes, with their attendant criminal justice system and prison system costs, and removal of a major obstacle to successful re-employment and tax-paying self-sufficiency.

(e) Medical assistance that fails to cover a sufficient level of alcohol and other drug treatment to provide a reasonable prospect of recovery is medically and fiscally unsound and inconsistent with general medical assistance practices of providing sufficient resources to secure recovery where possible.

COMMENT

The high cost of untreated alcohol and other drug abuse and addiction to the nation is reflected disproportionately in the health care system as people repeatedly seek medical treatment for a wide array of addiction related accidents and illnesses. This spending can be markedly reduced by providing a full continuum of alcohol and other drug treatment services. Expenditures made on treating the disease directly are generally recouped in savings in health care alone within a one to three year period. Costs of addiction treatment are offset still more rapidly if the calculus is broadened to include not only reductions in Medicaid spending but also factors such

[1] Blue Cross of Greater Philadelphia, 1986 COMMUNITY DATA REPORT (July 1986); Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *Addictions Treatment in General Clinical Populations, Chapter 4,* in SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT (Center of Alcohol Studies, Rutgers University, 1993). For additional information on the use of health care benefits by people with untreated alcohol and other drug problems, see also the Policy Statement on the Health Care Professionals Training Act.

[2] Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 1.

[3] U.S. Department of Health and Human Services, ALCOHOL AND HEALTH, Seventh Special Report to the U.S. Congress 7 (January 1990).

[4] Fitzgerald, K.W., ALCOHOLISM, THE GENETIC INHERITANCE 104, 213 (1988); NCADD, FACT SHEET: ALCOHOLISM AND ALCOHOL-RELATED PROBLEMS (12 West 21 Street, New York, NY).

as: reductions in use of welfare cash grants, food stamps, prevention of fetal alcohol and other drug syndrome and reductions in crime.

In addition, with proper treatment, many recovering individuals disappear entirely from the welfare rolls. They go back to school, to work and to become self-sufficient, taxpaying members of our society.

The relationship between alcohol and other drug abuse and addiction and crime has been well described in the literature. Prison research finds that at least half of those incarcerated have an alcohol and other drug abuse problem.[5] Studies also show that without alcohol and other drug treatment, criminal recidivism and re-arrest can be expected.

Like other chronic progressive illnesses, there are no shortcuts here. Failure to intervene early or failure to provide sufficient treatment early in the disease progression results in high costs to society and in the need for longer term, more intensive treatment.

Until such treatment is provided, the alcohol and other drug problem will firmly block the path to re-employment and self-sufficiency.[6]

Section 3. Purpose.

The purpose of this [Act] is to ensure that medical assistance recipients are provided a level of alcohol and other drug treatment benefits sufficient to meet the minimum requirements of care necessary to provide effective alcohol and other drug treatment. This will increase the recovery rate for successful treatment and reduce the disproportionately high utilization of medical assistance benefits by non-recovering alcoholics and other drug addicts.

COMMENT

Coverage of alcohol and other drug addiction treatment through state Medicaid varies greatly from state to state. State Medicaid reimbursed treatment is scarce in some states. Coverage for intensive outpatient, for family and for long term residential treatment is rare. At this time, federal matching funds are limited to outpatient, hospital detoxification and hospital rehabilitation. As a result, many states provide only the alcohol and other drug treatment services that can draw these matching monies into the state.

The purpose of this statute is to delineate and provide for a full continuum of treatment service for alcohol and other drug abuse and addicted individuals through state Medicaid and to maximize the use of federal funds and federal matching monies to achieve this goal. The continuum of treatment services delineated seeks to reflect the complex treatment needs of individuals and families deteriorated with an addiction to the point of eligibility for welfare and Medicaid.

Providing the full continuum will maximize recovery of addicted individuals while simultaneously reducing other health care spending for addiction related accidents and illnesses. In addition, such care will reduce crime and work as a crime prevention tool.[7]

Section 4. Definitions. As used in this [Act]:

(a) "Alcohol and other drug abuse" means any use of alcohol and/or other drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

(b) "Drugs" means addictive substances and substances of abuse scheduled in the [state controlled substances act].

(c) "Detoxification" means the process whereby an alcohol-intoxicated or drug-intoxicated or alcohol-dependent or drug-dependent person is assisted, in a facility licensed by the [single state authority on alcohol and other drugs] through the period of time to eliminate, by metabolic or other means, the intoxicating alcohol and other drugs, alcohol and other drug dependency factors or alcohol in combination with drugs as determined by a licensed physician, while keeping the physiological risk to the patient at a minimum.

(d) "Hospital" means a facility licensed as a hospital by

[5] Bureau of Justice Statistics, DRUGS AND CRIME FACTS, 1992 6,8.

[6] For material on the costs of untreated alcohol and other drug problems in terms of health care, crime and the workplace, see Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT (Center of Alcohol Studies, Rutgers University, 1993).

[7] Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 1, at *Addictions Treatment in CJS Populations and Narcotics Users, Chapter 6.*

the [state health department], the [state welfare department], or operated by the state and conducting an alcoholism and other drug addiction treatment program licensed by the [single state authority on alcohol and other drugs].

(e) "Inpatient care" means the provision of medical, nursing, counseling or therapeutic services 24 hours a day in a hospital or non-hospital facility, according to individualized treatment plans.

(f) "Non-hospital facility" means a facility, licensed by the [single state authority on alcohol and other drugs] for the care or treatment of alcohol and other drug abusing and addicted persons, except for transitional living facilities.

(g) "Non-hospital residential care" means the provision of medical, nursing, counseling or therapeutic services to patients suffering from alcohol and other drug abuse or dependency in a short-term or long-term residential environment, according to individualized treatment plans.

(h) "Outpatient care" means the provision of medical, nursing, counseling or therapeutic services in a hospital or non-hospital facility on a regular and predetermined schedule, according to individualized treatment plans.

(i) "Partial hospitalization or intensive outpatient care" means the provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a hospital or non-hospital facility or intensive outpatient program licensed as an alcoholism and other drug addiction treatment program by the [single state authority on alcohol and other drugs], designed for a patient or client who would benefit from more intensive care than is offered in outpatient treatment but who does not require inpatient care.

COMMENT

To ensure quality, accountability and proper use of health care dollars, any treatment service provided under the terms of this statute must be licensed by the [single state authority on alcohol and other drugs].

Section 5. Medical Assistance Coverage.

(a) Medical assistance shall in addition to other provisions required by this [Act] include benefits for alcohol and other drug abuse and dependency as provided in Sections 6, 7, 8, 9, 10 and 11.

(b) No medical assistance recipient shall be deprived of alcohol and other drug treatment or benefits due to identification of an alcohol and other drug problem that occurs as a result of contact with the criminal justice or legal system.

COMMENT

Under this section, alcohol and other drug treatment cannot be withheld because the alcohol and other drug problem was identified as a result of contact with the criminal justice or legal system.

Few people with alcohol and other drug problems reach a decision to seek help on their own without some kind of intervention. Typically, an accumulation of outside pressure drives that decision. For many, the process of recovery begins with an intervention by an employee assistance program, a student assistance program, a family intervention or a drinking and driving arrest and/or pressure by the criminal justice system. The language in subsection (b) will ensure that the type of intervention employed is not used as grounds to deny treatment and that criminal justice interventions are welcomed as an opportunity to assist the individual, to reduce health care costs, to cut crime and to meet other goals consistent with both the needs of managed care and the needs of society.

Section 6. Inpatient Detoxification.

(a) Inpatient detoxification as a covered benefit under this [Act] shall be provided either in a hospital or an inpatient non-hospital facility which has a written referral agreement with a hospital for emergency, medical and psychiatric or psychological support services, and is licensed by the [single state authority on alcohol and other drugs] as an alcoholism and/or drug addiction treatment program.

(b) The following services shall be covered under inpatient detoxification:

(1) Lodging and dietary services;

(2) Physician, psychologist, nurse, certified addictions counselor and trained staff services;

(3) Diagnostic X-ray;

(4) Psychiatric, psychological and medical laboratory testing; and

(5) Drugs, medicines, equipment use and supplies.

(c) Treatment under this section shall be covered for a

minimum of 15 days in any calendar year unless medical complications require additional days.

COMMENT

This section delineates the services that are reimbursable within an inpatient detoxification setting licensed by the [single state authority on alcohol and other drugs].

Particularly for these more deteriorated patients, the process of detoxification can be life threatening and requires medical monitoring. At the point of admission, it is often impossible to discern who will have a problem free withdrawal and who will experience severe medical complications. Often, the individual is unable to remember or provide medical history or information on types and quantities of alcohol and other drugs consumed.

The length of detoxification typically depends on such factors as the following: the types, quantities and combinations of alcohol and other drugs consumed over a specific period of time, length and severity of addiction, age of onset of addiction and general physical health. Uncomplicated detoxification generally ranges from 1-7 days in duration with certain kinds of prescription medications taking 15 days or longer. Addicted people at this level of deterioration tend to have numerous complicating medical problems, use a wide variety of alcohol and other drugs and are susceptible to a more troublesome withdrawal process.

The detoxification process is similar to stabilizing a diabetic in crisis. For both illnesses, failure to provide treatment after initial stabilization will result in an additional medical crisis and expenses as the individual is admitted for additional detoxification or other medical problems.

During the course of detoxification, an assessment of the need for ongoing alcohol and other drug treatment is made and preparation for referral to treatment occurs. Assignment to, or length of stay in outpatient or inpatient care will vary with the needs of the individual and is dependent on the degree of chronicity, deterioration of the individual's health, strength of support systems such as the family, the employer and others and many other factors. Key here is sophisticated patient matching to care. This is accomplished by use of alcohol and other drug diagnostic criteria combined with personnel skilled in making these determinations.

An additional factor affecting patient matching to level of treatment and length of care, is the degree of denial by the patient. In fact, denial of the alcohol and other drug problem by both the patient and the family, is one of the symptoms of alcohol and other drug problems. Like patient and family denial of other serious illnesses, denial must be addressed vigorously as part of the treatment recommendation and process. Dealing with denial is critical to opening the patient and family up to full participation in the recovery process. In general, the more severe the denial, the more intense the level of treatment will need to be and the longer the length of that treatment.

Other factors influencing treatment recommendations are public safety, homelessness or drug infested living quarters, high suicide rates of untreated alcohol and other drug abusers and high utilization of health care if the primary illness is left unaddressed.

Given the cost to society of untreated or inadequately treated alcohol and other drug problems, provision of and access to the full continuum of treatment services is essential and in the interest of the national economy. Failure to intervene or undertreatment at this point is likely to result in the alcohol and other drug addicted person returning to the health care system without a job, becoming dependent on public funding and, for some, increasing criminal activity.

No part of the continuum of treatment services described below can fill the role of the other. Some individuals will need every component of the entire continuum while others may not. However, some generalities can be made. As with other illnesses, where intervention occurs late in the addictive disease process, the individual is more likely to need longer and more intense levels of care. Early interventions result in less intense care over shorter periods of time.

Unfortunately, denial and the lack of understanding of this problem by the individual, the family, the employer, the physician, the caseworker and the criminal justice system is such that intervention, if it occurs at all, tends to be late in the progression of the disease.

The [Model Health Professionals Training Act] and the [Model Criminal Justice Treatment Act] attempt to address just this issue. The [Model Health Professionals Training Act] sets up training in early intervention and treatment for health care professionals and the [Model Criminal Justice Treatment Act] attempts to address some of the training needs of criminal justice personnel. Such intervention should assist in reducing health care utilization and could reduce some of the need for more intensive alcohol and other drug treatment.

The [Model Medicaid Addiction Costs Reduction Act] calls for longer and more intense treatment than provided in the [Model Addiction Costs Reduction Act] for individuals with insurance coverage. This difference reflects the chronicity and severity of the addiction of these more deteriorated individuals.

Even with this more intense treatment, costs of care will be quickly recouped in savings through a decrease in health care costs and a reduction in crime.

Section 7. Short Term Non-Hospital Residential Alcohol and Other Drug Treatment Services.

(a) Minimum additional treatment as a covered benefit under this [Act] shall be provided in a facility which is appropriately licensed by the [single state authority on alcohol and other drugs] as a non-hospital residential alcoholism and other drug addiction treatment program. Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol and other drug abuse or dependency and refer the insured for the appropriate treatment.

(b) The following services shall be covered under this section:

(1) Lodging and dietary services;

(2) Physician, psychologist, nurse, certified addictions counselor and trained staff services;

(3) Rehabilitation therapy and counseling;

(4) Family counseling and intervention;

(5) Psychiatric, psychological and medical laboratory tests; and

(6) Drugs, medicines, equipment use and supplies.

(c) The treatment under this section shall be covered, as required by this [Act], for a minimum of thirty (30) days per calendar year for residential care.

COMMENT

This section delineates the services that are reimbursable within a residential rehabilitation setting. Nothing in this section bars provision of the service in an inpatient hospital setting.

Section 8. Long Term Non-Hospital Residential Alcohol and Other Drug Treatment Services.

(a) Minimum additional treatment as a covered benefit under this [Act] shall be provided in a facility which is appropriately licensed by the [single state authority on alcohol and other drugs] as a non-hospital residential alcoholism and other drug addiction treatment program. Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol and other drug abuse or dependency and refer the insured for the appropriate treatment.

(b) The following services shall be covered under this section:

(1) Lodging and dietary services;

(2) Physician, psychologist, nurse, certified addictions counselor and trained staff services;

(3) Rehabilitation therapy and counseling;

(4) Family counseling and intervention;

(5) Psychiatric, psychological and medical laboratory tests; and

(6) Drugs, medicines, equipment use and supplies.

(c) The treatment under this section shall be covered, as required by this [Act], for a minimum of 18 months in a residential program.

COMMENT

Depending on the needs of the individual entering Medicaid supported addiction treatment, residential rehabilitation can range from 30 days to over 1 year. Most who enter this treatment are deteriorated in the addiction, have few positive support systems, little family contact and some impairments to health.

Many individuals appropriate for extended rehabilitation, have long term chronic addictions, lengthy records of detention, crime and hospitalization. Many got involved with alcohol and other drugs in adolescence, have limited or no work experience and little pre-addiction success to recall or to resume. The alcohol and other drug abuse and addiction settled in early and hard. Many come from troubled, unsettled homes with few role models of successful adulthood. Some are the children of alcoholics and other addicts. Some dropped out of school, have learning deficiencies and are unable

to read. Some have simply given up all hope of recovery.

For the reasons cited above, in addition to immersion in education on alcohol and other drug abuse and addiction and therapy, treatment here must go much further and address the wide array of factors complicating the recovery. The extended rehabilitation programs tend to be highly structured, sometimes confrontational, always emphasizing and teaching personal responsibility and basic life skills.

In addition to treating the addiction, many other health, educational and vocational goals must be addressed as well.

Many treatment programs select and train diverse personnel to match the patient population served. This is done purposefully with an eye to encouraging identification with successful recovering people working professionally in the field. Such identification is often key in the restoration of hope for people who have given up.

The process delineated here is generally called habilitation in contrast to the more commonly known concept of rehabilitation.

These most vulnerable-to-relapse individuals will need ongoing care in intensive outpatient and/or outpatient programs for some time after leaving the inpatient setting. By providing an ongoing support system with positive role models of successful recovery, Alcoholics and Narcotics Anonymous and other self-help groups will continue to play a critical role in the ongoing recovery process as well.

Like other diseases addressed late in the disease progression and where treatment has been delayed, recovery here will be more time consuming and more resource intensive than for people for whom intervention came early. However, an analysis of the cost of illness projections for untreated addictions and similar calculations of costs to the criminal justice system, persuades one of society's financial reward for treating such individuals.[8]

Section 9. Outpatient Alcohol and Other Drug Treatment Services.

(a) Minimum additional treatment as a covered benefit under this [Act] shall be provided in a facility appropriately licensed by the [single state authority on alcohol and other drugs] as an outpatient alcoholism and other drug addiction treatment program. Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol and other drug abuse or dependency, and refer the insured for the appropriate treatment.

(b) The following services shall bc covered under this section:

(1) Physician, psychologist, nurse, certified addictions counselor and trained staff services;

(2) Rehabilitation therapy and counseling;

(3) Family counseling and intervention;

(4) Psychiatric, psychological and medical laboratory tests; and

(5) Drugs, medicines, equipment use and supplies.

(c) Treatment under this section shall be covered as required by this [Act] for a minimum of 72 outpatient, full-session visits per calendar year.

Section 10. Intensive Outpatient or Partial Hospitalization Alcohol and Other Drug Treatment Services.

(a) Minimum additional treatment as a covered benefit under this [Act] shall be provided in a facility appropriately licensed by the [single state authority on alcohol and other drugs] as an intensive outpatient or partial hospitalization alcoholism and other drug addiction treatment program. Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol and other drug abuse or dependency and refer the insured for the appropriate treatment.

(b) The following services shall bc covered under this section:

(1) Physician, psychologist, nurse, certified addictions counselor and trained staff services;

(2) Rehabilitation therapy and counseling;

[8] Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 1, at *Cost-of-Illness Studies of Addictions, Chapter 3,* and *Addictions Treatment in CJS Populations and Narcotics Users, Chapter 6.*

(3) Family counseling and intervention;

(4) Psychiatric, psychological and medical laboratory tests; and

(5) Drugs, medicines, equipment use and supplies.

(c) Treatment under this section shall be covered as required by this [Act] for a minimum of 72 intensive outpatient, full-session visits or days of partial hospitalization per year.

COMMENT

Sections 9 and 10 delineate the services reimbursable under outpatient, intensive outpatient or partial hospitalization alcohol and other drug treatment services.

Many addicted individuals entering outpatient or intensive outpatient programs and group and individual sessions learn about addiction and develop the skills to stay sober. In general, these are individuals for whom intervention and referral occurs relatively early in the disease progression.

Other addicted people require detoxification or detoxification and inpatient care before entering outpatient or intensive outpatient treatment. Upon completion of the inpatient programs, many will progress to an outpatient setting for ongoing treatment.

Outpatient or intensive outpatient or combinations of the two are generally recommended for at least a year. Intensive outpatient is recommended for those in need of a more structured treatment experience than can be provided in a traditional outpatient setting but who are not in need of inpatient treatment.

Here too, the more deteriorated alcohol and other drug abusers and addicts will generally need more intense levels of outpatient services over a longer period of time.

Outpatient and intensive outpatient as well as inpatient treatment programs encourage involvement with self-help groups such as Alcoholics Anonymous and Narcotics Anonymous as well.

Section 11. Family Codependency Treatment.

(a) Minimum additional treatment as a covered benefit under this [Act] shall be provided in a facility appropriately licensed by the [single state authority on alcohol and other drugs] as an alcoholism and other drug addiction treatment program. Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a family member suffering from codependency as a result of an alcohol and other drug abuse or dependency within the family, and refer the insured for the appropriate treatment.

(b) The following services shall be covered under this section:

(1) Physician, psychologist, nurse, certified addictions counselor and trained staff services;

(2) Rehabilitation therapy and counseling;

(3) Family counseling and intervention;

(4) Psychiatric, psychological and medical laboratory tests;

(5) Prevention services for children; and

(6) Drugs, medicines, equipment use and supplies.

(c) Treatment under this section shall be covered as required by this [Act] for a minimum of 60 outpatient, full-session visits per year.

COMMENT

This section delineates the services reimbursable under the family codependency treatment section.

Treatment for the families of addicted people has only become available in the past decade. Until recently, newly recovering individuals returned from outpatient and inpatient treatment to families made dysfunctional by the addiction, anger and blame.

In addition, there is emerging research demonstrating that families of addicted individuals use health care at rates higher than found in the general population. After treatment of the addicted individual, health care spending by family members can be expected to be reduced.[9] Direct treatment of the overall family in distress may well have additional positive and measurable benefits for the emotional and physical health of all concerned.

Family treatment increases the likelihood of recovery by the alcohol and other drug abusing individual and addresses the needs of family members and children at risk of developing alcohol and other drug problems.

[9] Langenbucher, J.W., McCrady, B.S., Brick, J., Esterly, R., *supra* note 1, at *Cost-of-Illness Studies of Addictive Disorders, Chapter 3,* and *Addictions Treatment in General Clinical Populations, Chapter 4.*

Section 12. Minimum Level of Medical Assistance Coverage for Alcohol and Other Drug Treatment.

Notwithstanding any other provision in this [Act], alcohol and other drug treatment coverage under state medical assistance shall not be less, in any respect, than coverage required by the state in the policies of health insurance companies or health maintenance organizations.

Section 13. Maximizing Use of Federal Resources.

The [insert executive of state agency administering welfare and Medicaid programs] shall aggressively pursue federal funding and matching funds available through Medicaid, through the Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) program, SSI and all other appropriate federal sources. In addition, the [insert title of executive] shall pursue federal matching funds through Medicaid for non-hospital residential alcohol and other drug treatment services from the federal Health Care Financing Administration.

COMMENT

A number of federal funding streams are available to provide federal match or support to states for the alcohol and other drug treatment of Medicaid recipients. For example, the federal program entitled, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, can provide federal financial support for diagnosis and treatment of young people with alcohol and other drug problems who are under age 21.

Section 14. Non-Supplantation of Addiction Treatment Funding.

No medical assistance funding or increase in such funding for alcohol and other drug treatment shall be used to supplant or replace existing municipal, county, state or federal funding or resources for alcohol and other drug treatment. The provisions of this [Act] shall in no way be construed to limit access to or funding of alcohol and other drug treatment services currently available.

Section 15. Liberal Construction.

The provisions of this [Act] shall be liberally construed to effectuate the remedial purposes, objectives and policies set forth in Sections 2 and 3 of this [Act].

Section 16. Severability.

If any provision of this [Act] or application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or application of the [Act] which can be given effect without the invalid provision or application, and to this end the provisions of this [Act] are severable.

Section 17. Effective Date.

This [Act] shall be effective on [reference to normal state method of determination of the effective date][reference to specific date].

Appendix B

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