Community Clinic and Health Center
Case Study Highlights:

Funding Substance Abuse Treatment in Primary Care

"Ideally, treatment needs to be provided on demand. When someone who has a substance abuse issue becomes willing to enter treatment, this is when we must find a way to fiscally provide the means. The willingness for the suffering addict to ask for help is ever so fleeting. So often when they are denied access, that's all the reason they need to justify that no one cares, and they continue using."

William Johnson, NCAC1, RAS
Substance Use Disorder Programs Manager, WellSpace Health

Case study health centers…

…have a patchwork of funding sources and programs that they piece together to try to provide consistency in their staffing and services.

… may receive funds from county departments such as probation, CalWORKS, or child welfare services to offer court-mandated or post-incarceration services.

…are in the early stages of implementing Screening, Brief Intervention, and Referral to Treatment (SBIRT) services for their adult Medi-Cal patients who abuse alcohol. Clinics are reimbursed for in-depth screening, and three 15-minute interventions.

…find that Drug Medi-Cal is one of the more reliable sources of funding, but restrictions on outpatient services and reimbursement create barriers to care.

…may receive Mental Health Services Act (MHSA) dollars from their county to provide mental health and substance abuse services for individuals who are dually diagnosed.

…have faced challenges in continuing services after drastic reductions in Prop 36 dollars for non-violent drug offenders and decreases in county block grant dollars.

Case Study Health Centers

CommuniCare Health Centers • Korean Community Services • San Diego American Indian Health Center

Sonoma County Indian Health Project • WellSpace Health

Affordable Care Act and Government Funding

"There is no illness that will be more favorably affected by the [Affordable Care Act] than substance abuse. This is the beginning of substance abuse disorders being part of mainstream healthcare."[1]

Thomas McLellan, former U.S. Deputy Drug Czar, and Current CEO of the Treatment Research Institute in Philadelphia

Substance Use Disorder Programs

The **Affordable Care Act (ACA)** requires health plans to offer mental health and substance abuse services in addition to a full range of medical inpatient and outpatient services. In the past, substance abuse treatment has been separated from physical health care, in part because these services were "carved out" from mainstream medical care. The ACA provides an opportunity to better integrate those services from a programmatic and fiscal point of view. In addition, the **Mental Health Parity and Addiction Equity Act of 2008** says substance abuse and mental health treatment cannot be more restrictive than other medical coverage, i.e. in terms of co-pays or visit limits.[2] Now that more people have coverage under ACA, more patients will have a funding source for substance abuse services. CommuniCare Health Centers reported that with the passage of the ACA, Medi-Cal is their biggest revenue source, and they are projecting between 10 and 20% more patients with Medi-Cal coverage.

Medi-Cal has two programs that treat substance use disorders (SUDs): **Drug-Medi-Cal (DMC)**, which provides outpatient, residential and detoxification services provided by DMC-certified agencies, and the **Medi-Cal fee-for-service** program that includes physician administered services and inpatient detox for alcohol and opioid use. The 2013-14 California State Budget Act financed a Medi-Cal expansion, and companion legislation (SB X1-1) expanded Medi-Cal SUD benefits, which were at one time only available for certain populations, to all Medi-Cal beneficiaries. The newly eligible include childless adults, of which some are homeless or have been involved in the criminal justice system**. In 2014, 1.9 million individuals became newly enrolled in Medi-Cal, of which approximately 147,000-195,000 are in need of SUD treatment.** However most health centers have not yet felt the impact of the benefit expansion due in part to county backlogs in processing Medi-Cal applications. As of May 2014 there was a backlog of 600,000 Medi-Cal applications. The state is putting systems into place to speed up processing, but due to the numbers it will still take months to catch up.[3] **Once beneficiaries understand the full scope of their benefits and engage in primary care services, mental health and SUD systems will likely see an increased service demand and may face challenges meeting health plan service requirements**. Ultimately the Medi-Cal expansion combined with the ACA creates even greater opportunity for them to get the services they need.[4]

The Substance Abuse Prevention and Treatment Block Grant (SABG) is the federal government's primary source of funding to states for drug and alcohol treatment. The states then allocate the dollars to counties. Counties use some of the funding to cover their own operational, personnel and administrative costs, and make the rest available through contracts and grants. **Counties have flexibility in how they use these funds and may contract with health centers as they seek to improve and expand their networks.** Unfortunately this funding has decreased substantially over the years. For example, at one time the SABG covered 18 months of outpatient treatment, but today it only covers 90 days. Services continue to be cut back as funding is stretched thin. The future of SUD block grants is uncertain as the ACA and Medicaid expansion roll out.

Health Center Funding for Substance Abuse Services

"There is a lot of money in the forensic sector right now with re-entry (AB 109). You're working with more of a mandated population, but the money is there and it is targeted to treatment."

Jodi Nerell, LCSW
Interim Director, Behavioral Health Services
CommuniCare Health Centers, Salud Clinic

General Funding Sources

Health centers providing substance abuse services typically juggle a number of funding sources in order to try to maintain consistent alcohol and other drug (AOD) staffing and services to their clients. The health center then matches each client with the most appropriate funding source. Examples of funding sources are provided below, with a more extensive list provided on **Page 9.**

- **Medi-Cal:** Medi-Cal reimburses health centers for behavioral health services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, and licensed clinical social workers; but not for AOD providers (regardless of type of certification), or marriage and family therapists.
- **Federal Section 330 grant**: Federally qualified health centers (FQHCs) receiving a federal Section 330 grant at one time could either provide substance abuse services themselves or make referral arrangements with a community agency. Today the Health Resources and Services Administration (HRSA) expects new grantees to provide the services themselves.
- **Other Federal Grants**: Federal agencies such as HRSA and the Substance Abuse and Mental Health Services Administration (SAMHSA) occasionally offer grant funding opportunities related to substance abuse treatment, such as the supplemental behavioral health grant opportunity HRSA made available this year (see **text box).**
- **Forensic and Court-Mandated Program Funding:** Several case study clinics receive most of their substance abuse treatment funding from contracts with **county departments** such as probation, CalWORKS, or child welfare services. WellSpace Health, for example, receives most of their adult substance abuse treatment funding for post-incarceration treatment. Their primary referral sources are from the California Department of Corrections and Rehabilitation for prisoners released early into the community under **AB 109** (see **text box**).[5] Both of these resources provide treatment dollars for outpatient, residential and detoxification services. CommuniCare Health Centers and Korean Community Services (see **text box** on next page) have also obtained most of their

Health Resources and Services Administration
ACA Mental Health Service Expansion
Behavioral Health Integration Supplemental Funding

The purpose of this competitive grant opportunity due August 13, 2014, is to improve and expand the delivery of mental health and substance abuse services through the establishment/ enhancement of an integrated primary care/behavioral health model at existing health centers. HRSA anticipates awarding $50 million to support 200 grant awards of $250,000 each to current Health Center Program grantees in Fiscal Year 2014. This grant opportunity is supported by the Affordable Care Act, however it is highly competitive as many more health centers apply than are awarded.

AB 109 Safety Realignment

In 2011, Governor Edmund G. Brown Jr. signed AB 109 and AB 117 to reduce the number of inmates in the state's prisons. Under "safety realignment," newly convicted low level offenders without current or prior serious or violent offenses stay in county jail to serve their sentence. AB 109 provides a permanent revenue stream to the counties for local public safety programs, including substance abuse treatment.

substance abuse treatment funding from court-mandated or forensic services.

- **County Mental Health Services Act (MHSA) Funding:** In the last few years, some California health centers have gained access to MHSA dollars through county contracts. Though this funding is focused primarily on mental health services, some funds have been dedicated to programs serving individuals with a dual diagnosis of mental illness and substance abuse.

INDIAN HEALTH CENTER FUNDING

Indian health centers receive most of their overall funding, as well as substance abuse treatment funding, from **Indian Health Services** (an agency within the *U.S. Department of Health and Human Services*) primarily in the form of grants and contracts. These health centers also apply for and receive grants from other funders, such as counties or private foundations, and may partner with others such as the California Rural Indian Health Board (CRIHB) on grant applications.

As an example, **San Diego American Indian Health Center** gets funding for alcohol counseling in their core I.H.S. grant, and they have another competitive grant from I.H.S. for a methamphetamine treatment program. They also receive substance abuse treatment funding in their urban Indian grant. For youth services, all of their prevention/early intervention funding is from MHSA. There was an increase in MHSA dollars last year which allowed them to increase a staff member from part-time to full-time for co-occurring disorders treatment.

Sonoma County Indian Health Project also receives funding from different sources to cover staff salaries and various substance abuse services. They have received SAMHSA funding as a subcontractor to CRIHB for training, patient education, and housing assistance, among other things. SCIHP also receives operating funds from local tribes, and some salaries are covered through third-party billing.

> *"In addition to myself we have one full-time substance use counselor who works with Native Americans who are incarcerated, and an LCSW who mainly focuses on patients with substance use and other behavior issues. We do our best to make it work with the funding limitations."*
>
> **Kenny Dumbrill, Substance Use Counselor**
> **Sonoma County Indian Health Project**

Korean Community Services

Korean Community Services received their first court-mandated services funding in 1981 when they received a small DUI court-mandated counseling program that was very cost effective. In 1997 they responded to a Request for Proposals for Penal Code 1000 drug counseling, and were successful in obtaining funding. A few years later they received funding for court-mandated counseling and treatment for batterers. They then received funding for child abusers' counseling and anger management, followed by Substance Abuse and Crime Prevention Act (Prop 36) funding. Soon they had a whole portfolio of court-mandated counseling programs, and today these programs form the core of their substance abuse services.

Kenny Dumbrill, Substance Use Counselor, said the health center encourages eligible Native American patients to apply for Medi-Cal coverage to get access to Drug Medi-Cal detox and inpatient services, as well as other services not covered by I.H.S. *(Courtesy photo)*

SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT

As of January 1, 2014, California is covering Screening, Brief Intervention and Referral to Treatment (SBIRT) services for adult Medi-Cal beneficiaries who have or are at risk of developing alcohol use disorders. SBIRT integrates screening into health centers and other systems of care such as college health clinics, hospitals and trauma centers in order to identify patients with drinking problems early and to intervene in a timely manner. **The model decreases the risk of long-lasting physical and emotional damage related to harmful drinking,** and the benefit aligns with the U.S. Preventive Services Task Force Recommendations to screen patients for alcohol abuse and refer to treatment as appropriate.[6]

In February 2014, the California Department of Health Care Services (DHCS) sent a letter to all Medi-Cal managed care health plans to explain their new SBIRT obligation, and during the same month, the department issued a Medi-Cal update in Bulletin 473 describing it as well. **As of January 2014, DHCS set minimum reimbursement for an expanded alcohol screen using a Medi-Cal-approved alcohol screening tool at $24 (limited to one per year). Minimum reimbursement for brief intervention services is at $48 per session for each 15-minute period of service up to 45 minutes, even if the visits take place on the same day as another visit type.** Some Medi-Cal managed care plans may reimburse for SBIRT services at a higher rate to create additional incentives for primary care providers to conduct the screening and interventions. For example, *Partnership HealthPlan of California* in a presentation to providers (January 2014) said extended screening would be reimbursed at $29.27 and each 15-minute brief intervention at $58.54. Neither the administration of the pre-screen question during the primary care visit nor treatment services are reimbursable.[7]

Because intervention services can be provided by an AOD professional or other staff who have met the SBIRT training requirements, this creates an opportunity for these individuals to be reimbursed for Medi-Cal services under supervision of a licensed health provider, whereas they are normally not eligible for reimbursement. At the time this report was written, very few health centers had implemented SBIRT, in part because of several considerations related to implementation and reimbursement (see **text box**).

Health Center Considerations Regarding SBIRT

- Health centers will need to modify their workflow for patients needing the longer alcohol screening to assure a warm handoff between departments.
- Health centers will need to update their electronic health record to reflect the new SBIRT visit type.
- More work is needed to link health centers with alcohol treatment centers and to develop interagency relationships and referral mechanisms.
- The Medi-Cal Update states that providers must attest that they have obtained the necessary training on SBIRT, but goes on to say that DHCS may require documentation when they conduct an audit. What kind of training documentation would meet the audit requirements?

Challenges and Limitations of Alcohol and Drug Treatment Funding

ELIMINATION OF PROPOSITION 36 FUNDING

The decrease in California **Proposition 36** dollars and eventual elimination was devastating for health centers who serve this population. This entitlement act gives first and second time non-violent, simple drug possession offenders the opportunity to receive community substance abuse treatment instead of incarceration. **Despite the documented success of this program in reducing the number of drug offenders in prison, California reduced treatment funding from a high of $145 million in 2007-08 to nothing in 2010-11.** Because Prop. 36 has become an unfunded mandate, health centers obtain funding from other sources to cover the cost of these services, such as from county block grant dollars or other county funds. This depletes funding that was previously available for other people needing treatment.

MEDI-CAL BARRIERS

Medi-Cal will not reimburse a health center for a **same-day visit** for a medical and behavioral health appointment. Nor will Medi-Cal reimburse for **marriage and family therapists (MFT)** or **AOD providers**, regardless of certification. These Medi-Cal reimbursement barriers to services are a disservice to health center patients, but clinics will often provide the service anyway and absorb the cost because it is often difficult for patients to return for another visit.

> *"When you are talking about a low income clinic with people who are dealing with substance abuse issues and mental health issues and other barriers to care, like transportation, or safety, asking them to come back is not easy. So we do a lot of same-day visits in the interest of best patient care because it is what is best for them. When they're here, let's take advantage of it because they got through those barriers and got to our clinic."*
>
> **Laura Bein, Ph.D.**
> **Behavioral Health Clinical Services Coordinator**
> **WellSpace Health**

DRUG MEDI-CAL CHALLENGES

Drug Medi-Cal is one of the more reliable sources of funding for substance abuse treatment. It covers outpatient substance abuse services for Medi-Cal patients, as well as inpatient detox, residential treatment, methadone maintenance, day care services and perinatal treatment in facilities that are certified for these types of treatment. Drug Medi-Cal is a carved-out benefit, and like mental health, is run separately from regular Medi-Cal. Some health centers have applied and have been certified as outpatient substance abuse providers under Drug Medi-Cal. FQHCs that provide DMC services run them as a separate line of business – not through the prospective payment system. Interviewees reported some limitations of the Drug Medi-Cal program, however. For example:

- **The State has a backlog for certifying or re-certifying clinics for Drug Medi-Cal.** Interviewees reported that the application requirements were unclear. They were told it could be a year or more before they would be re-certified.
- **Drug treatment centers with more than 16 beds cannot bill Medicaid for adult residential services.** This is due to a decades-old restriction to prevent federal funds from going to "Institutions for Mental Diseases" (IMDs), which are private mental institutions with more than 16 beds. The purpose of the restriction was to avoid "warehousing" patients with mental illness. **In California, only about 10% of available inpatient drug treatment beds are in facilities that meet the size restrictions**.[8] In July 2014, the *Breaking Addiction Act of 2014* was introduced which would establish demonstration projects in 8-10 states that would remove the IMD exclusion.

- **Drug Medi-Cal imposes strict restrictions on services and reimbursement.** For example, until recently it required support groups to have a minimum of four clients and a maximum of 10 on any given day. So if there were five Drug Medi-Cal clients and six block grant dollar clients in a group, a clinic could not bill for the five Drug Medi-Cal clients because the group exceeded 10 participants. As of July 2014, these numbers were changed to a minimum of two and a maximum of 12.[9] These stipulations can make it challenging for health centers to provide and get reimbursed for the care.

- **The Drug Medi-Cal rate is considered to be low** - $35 per person per group - due to the numerous administrative contract requirements, such as additional forms and reporting obligations outside of the group setting. Other contracts often want to use the same reimbursement rate, even though it is not adequate.

- **Drug Medi-Cal limits the types of outpatient services that are reimbursable**. For example, all individual sessions must be tied to treatment planning, crisis intervention, or discharge planning. A session that does not meet that criteria is not reimbursable. All Drug Medi-Cal services have to be justified based on the criteria that is allowed, and must meet medical necessity (Diagnostic and Statistical Manual of Mental Disorders' diagnostic criteria for SUDs) or the health center may not bill.

Amendment to the 1115 Waiver: DHCS is seeking a Drug Medi-Cal Organized Delivery System Amendment to the current Section 1115 Bridge to Reform Waiver to demonstrate how organized SUD care increases the success of DMC beneficiaries.[10] At the time this report was produced, DHCS had just released for review and input the draft amendment, also known as the Special Terms and Conditions, after receiving prior input from various stakeholders. **After submitting the Terms and Conditions there will be a continuing process of revisions between DHCS and the Centers for Medicare and Medicaid Services (CMS) until they are approved**.[11]

Opportunities

The ACA requires health plans to offer substance abuse and mental health services, a requirement that will benefit health centers currently offering SUD services, and open the door for other health centers to begin offering services. As ACA implementation continues and performance-based payment gets put into place, health centers have an opportunity to bend the cost curve and improve clinical outcomes by addressing underlying addiction issues in their patients and families. By addressing alcohol abuse in their patients, health centers can reduce the incidence of conditions such as hypertension, gastritis, liver disease and cirrhosis, cognitive impairment, anxiety, depression and other conditions. Ultimately, expanding access to SUD services will not only benefit patients, but may reduce overall costs as previous unmet needs are addressed. *(Please see next page for a summary of opportunities.)*

Disadvantages of Relying on Grant Funding

Health centers rely on grant funding for many programs, including substance abuse outreach and treatment services. Programs that suddenly end at the end of a grant term can be a disservice to patients, especially when the program has had demonstrable results. Case study health centers identified the following disadvantages to grant funded substance abuse programs:

- Reliance on grant funding has resulted in very effective programs abruptly ending when the funding runs out.

- Providers are bothered by pilots being done for a year or fixed amount of time and then ending. It is not good for patient care and it is hard on patients and providers to have a program end arbitrarily.

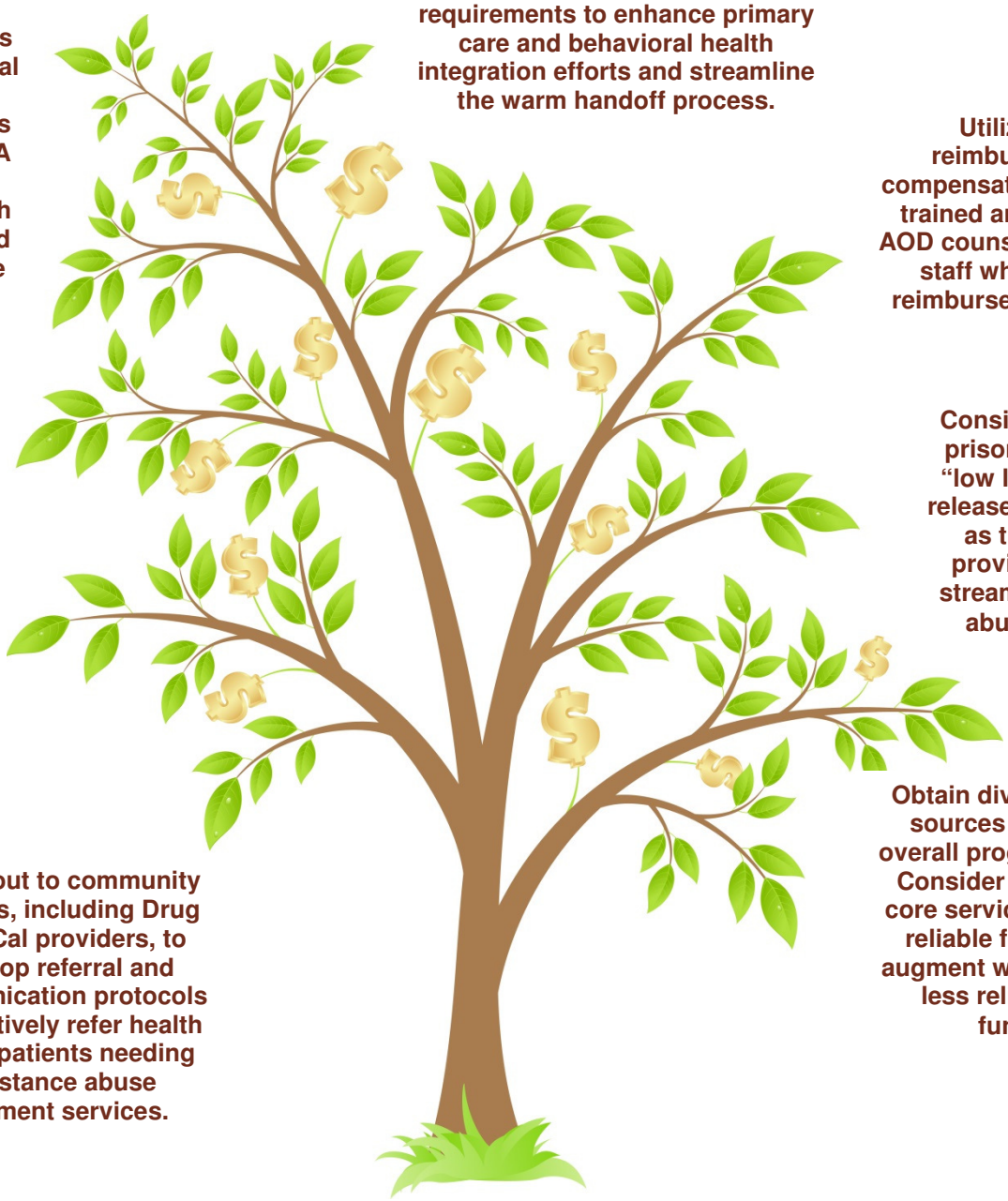
- Some funders require applicants to use evidence-based practices (EBPs) even if an organization believes an "emerging," or "community-supported" practice would be more effective. It is difficult to build an evidence base when counties and/or private foundations will not fund the necessary studies.

How to financially expand or begin offering substance abuse services…

Utilize the new Medi-Cal SBIRT requirements to enhance primary care and behavioral health integration efforts and streamline the warm handoff process.

Seek partnerships with County Mental Health Plans to explore strategies to leverage MHSA dollars to treat patients with both mental health and substance abuse issues.

Utilize SBIRT reimbursement to compensate appropriately trained and supervised AOD counselors and other staff who lack other reimbursement sources.



Open a dialog with the county to identify possible substance abuse block grant funds that might be available and develop strategies to partner in substance abuse treatment.

Consider treating the prison population of "low level offenders" released under AB 109, as the legislation provides a revenue stream for substance abuse treatment.

Obtain diverse funding sources to increase overall program stability. Consider establishing core services with more reliable funding, and augment with those with less reliable grant funding.

Reach out to community partners, including Drug Medi-Cal providers, to develop referral and communication protocols to effectively refer health center patients needing substance abuse treatment services.

About the Case Studies: The purpose of this project was to better understand the range of substance abuse services offered by experienced community clinics and health centers. Because more patients have health coverage under the Affordable Care Act, and because more substance use disorder treatment is covered, some health centers may be interested in adding or expanding services. At the time of this study, however, not much information was available about model clinic programs. In order to gather the information, the **CalMHSA Integrated Behavioral Health Project** worked in partnership with **AGD Consulting** in a two-part process. First they used statewide data to identify the highest volume substance use disorder treatment health centers, and in February 2014 asked their substance abuse services directors to complete an online survey. Thirteen out of 18 clinics responded to the survey. Secondly, the study team conducted site visits at five of those health centers in order to gather more in-depth information. A series of **"Case Study Highlights"** were developed for key topics: **Funding, Integrated Services**, **Staffing and Stigma**, and **Treatment**. The papers are available at www.ibhp.org. (August 2014)

EXAMPLES OF FUNDING SOURCES:

AB 109: In 2011, Governor Brown signed AB 109 and AB 117 to reduce the number of inmates in the state's prisons. Under "safety realignment," newly convicted low level offenders without current or prior serious or violent offenses stay in county jail to serve their sentence. AB 109 provides a permanent revenue stream to the counties for local public safety programs, including substance abuse treatment.

Drug Medi-Cal Treatment: Residential and non-residential programs with DMC treatment certification can be reimbursed for outpatient substance abuse services for Medi-Cal patients, as well as inpatient detox, residential treatment, methadone maintenance, day care services and perinatal treatment.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT): EPSDT is a Medicaid benefit for full-scope Medi-Cal beneficiaries under age 21 to provide medically necessary procedures or treatment services related to a defect, physical illness or mental illness or condition, even if the service is not included in the State's Medicaid Plan. This includes services to beneficiaries who are dually diagnosed with mental health and substance abuse problems.[12]

FQHC Medi-Cal Reimbursement: Medi-Cal will reimburse FQHCs for behavioral health services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, and licensed clinical social workers, but not for AOD providers (regardless of type of certification), or marriage and family therapists. Medi-Cal also does not reimburse health centers for same day visits for a medical and behavioral health visit.

Indian Health Services funding: The Indian Health Service (I.H.S.), which is an agency within the Department of Health and Human Services, is responsible for providing health care services to American Indians and Alaska Natives who are members of federally recognized tribes. I.H.S. has a behavioral health initiative that focuses on substance use disorders, mental health disorders, violence prevention, and increasing the integration of behavioral health into primary care.

Mental Health Services Act: California voters passed Proposition 63, the Mental Health Services Act, in 2004, to increase public mental health services. It is funded by a 1% tax on annual incomes greater than $1 million. Funds are granted to counties who are responsible for planning and carrying out services themselves or through contracts with other community providers. Although the focus is on mental health services, some funds have been dedicated to programs serving individuals with a dual diagnosis of mental illness and substance abuse.

Penal Code 1000: PC 1000 is California's deferred entry of judgment ("DEJ") program that allows eligible defendants to be diverted out of the criminal court system and into a drug rehabilitation program. Following a plea, the individual must complete an outpatient drug and alcohol program, not be arrested for 18 months, and pay a fee to the courts. If he or she successfully completes these steps, the court will enter a judgment of dismissal allowing the person to move forward without a criminal record.

Penal Code 1210: The Substance Abuse and Crime Prevention Act, also known as **Proposition 36**, was passed by 61% of California voters on November 7, 2000. This initiative gives first and second time non-violent, simple drug possession offenders the opportunity to receive community substance abuse treatment instead of incarceration. After treatment, a person is required to complete periodic drug testing. If she or he remains drug free and crime free, the original charges may be dismissed. PC 1210 does not have funding attached so health centers need to find other funding that will sustain services.

Screening, Brief Intervention and Referral to Treatment (SBIRT): As of January 1, 2014, California covers SBIRT services for adult Medi-Cal beneficiaries who have or are at risk of developing alcohol use disorders. Medi-Cal will reimburse providers for an expanded alcohol use screening and up to three 15-minute sessions for the brief intervention.

Substance Abuse Prevention and Treatment Block Grant (SABG): This is a noncompetitive, formula grant mandated by the U.S. Congress. The program provides funds and technical assistance to all 50 states, territories and one tribal entity. Grantees use the funds to plan, implement, and evaluate activities that prevent and treat substance abuse and promote public health. SABG is the federal government's primary source of funding to States for drug and alcohol treatment and for primary prevention programs, but it has decreased over the years.

References

[1] Gorman, A. (2014, April 10). Barriers remain despite health law's push to expand access to substance abuse treatment. Kaiser Health News in collaboration with USA Today. http://www.kaiserhealthnews.org/stories/2014/april/10/substance-abuse-treatment-access-health-law.aspx.

[2] SAMHSA. Understanding health reform: Understanding the federal parity law. Retrieved from http://www.samhsa.gov/healthreform/docs/ConsumerTipSheetParity508.pdf

[3] Insure the Uninsured Project. (2014, July). CaliforniACA, Issue 34.

[4] Connolly J & Pegany V. (2014, February 5). Toward a better Medi-Cal substance use disorder benefit in California: Smart investments for improving lives. Insure the Uninsured Project.

[5] California Department of Corrections and Rehabilitation. (2013, December 19). Fact sheet: 2011 Public safety realignment. www.cdcr.ca.gov

[6] Department of Health Care Services. (2014, March). Fact sheet: Screening, Brief Intervention and Referral to Treatment (SBIRT) to reduce alcohol misuse for adults in primary care settings. http://www.dhcs.ca.gove/services/medi-cal/Pages/SBIRT.aspx

[7] Department of Health Care Services. (2014, January 23). Implementation of a new Medi-Cal benefit for current and expansion populations. SBIRT – Alcohol screening, brief intervention and referral to treatment. Powerpoint presentation available at http://www.dhcs.ca.gov/provgovpart/Documents/DHCS%20SBIRT.pdf

[8] Gorman, A. (2014, April 10). Barriers remain despite health law's push to expand access to substance abuse treatment. Kaiser Health News in collaboration with USA Today.

[9] Senate Bill No. 1045, chaptered in July 2014.

[10] DHCS letter dated July 16, 2014 from Karen Baylor, Deputy Director, Department of Health Care Services, to Stakeholders and Interested Parties.

[11] More information on upcoming meetings related to the waiver and a copy of the Terms and Conditions can be found at http://www.dhcs.ca.gov/provgovpart/Pages/MH-SUD-UpcomingMeetings.aspx

[12] Fact Sheet: EPSDT for Co-Occurring Disorders. http://www.mhsoac.ca.gov/meetings/docs/Meetings/2011/Jan/OAC_Jan2011_Tab7_FactSheetEPSDT.pdf