Center for Health Care Strategies
Better care where it's needed most

Innovations in Substance Use Care Delivery for Medicaid Members: A No Wrong Door Approach

Wednesday, May 6

2:00 – 3:30 pm ET

Center for Health Care Strategies

Dedicated to strengthening the U.S. health care system to ensure better, more equitable outcomes, particularly for people served by Medicaid.

Together with our partners, our work advances:

Effective models for prevention and care delivery that harness the field's best thinking and practices to meet critical needs.

Efficient solutions for policies and programs that extend the finite resources available to improve the delivery of vital services and ensure that payment is tied to value.

Equitable outcomes for people that improve the overall well-being of populations facing the greatest needs and health disparities.

Center for Health Care Strategies

Housekeeping

- Today's session will be recorded and slides will be available soon.
- Closed captions are available at the bottom of the Zoom screen.
- During presentations and Q&A, please share questions and input via Chat and Q&A.
  - → To access the Q&A box, click 'More', then the 'Q&A' button

Center for Health Care Strategies

Agenda

- Welcome and Introductions
- Overview of SUD Care and No Wrong Door Approach
- Review of Strategies
  - → Courtney Pladsen (*MaineCare*)
  - → Justin Alves (*BMC/Grayken Center for Addiction Training and Treatment*)
  - → Rachel Haroz (*Cooper Center for Healing, and Southern New Jersey Medication for Addiction Treatment Center of Excellence*)
- Panel and Moderated Q&A

Substance Use and Medicaid

- Substance use disorder (SUD) **affects about 17% of people in the U.S.**, likely an undercount of true prevalence. (SAMHSA, 2025)
- **Medicaid members** are disproportionately impacted, **with roughly 1 in 5 affected.** (KFF, 2023)
- **Today, effective evidence-based treatments for SUD** exist across care settings, including medications for addiction treatment, counseling/ behavioral therapies, peer supports, and inpatient and outpatient recovery programs.
- But **access remains limited** — only **about 20% of people with SUD receive care** in a given year. (SAMHSA, 2025)
- As the **nation's largest behavioral health payer**, Medicaid is a critical lever for expanding access and improving SUD outcomes.

Barriers to Effective Care

- **Limited service capacity** in underserved and rural areas
- **Fragmented systems** across health care, criminal justice, and social services
- **Stigma** and **knowledge gaps** within the health care system
- **Gaps during important transitions**, e.g., discharge from emergency departments, reentering from incarceration
- **Barriers to Medicaid coverage**, e.g., new federal work requirements, increased administrative burden for members and state agencies

A No Wrong Door Approach

- The “No Wrong Door” approach is a **harm reduction** strategy intended to **meet members where they are**.
- No Wrong Door **reduces missed opportunities** for connection, **supports care continuity**, and is important for **Medicaid members**, who often interact with multiple systems.
- Key entry points in:
  - Emergency response settings
  - Correctional and reentry settings
  - Primary care
  - Community-based organizations and social service settings

Meet Today's Presenters

Meryl Schulman, Senior Program Officer, CHCS

Rachel Haroz, MD, FAACT, Medical Director, Cooper Center for Healing, and Principal Investigator, Southern New Jersey Medication for Addiction Treatment Center of Excellence

Courtney Pladsen, DNP, FNP, FAANP, Chief Medical Officer, MaineCare (Maine Medicaid)

Justin Alves, MSN, FNP-BC, ACRN, CARN, CNE, Addiction Educator, Grayken Center for Addiction Training and Treatment at Boston Medical Center

Center for Health Care Strategies

Office of MaineCare 1115 Waiver

Courtney Pladsen, DNP, FNP-BC, FAANP

MaineCare Medical Director

MaineCare

What are 1115 Demonstration Waivers?

Allow states to request that the Centers for Medicare & Medicaid Services (CMS) “waive” certain Medicaid requirements in order to demonstrate and evaluate policy approaches not otherwise allowed.

Examples of Medicaid Demonstrations:

- **Expand Eligibility/Enrollment**
- **Provide New Benefits** to specific populations
- **Receive federal matching funds for costs not** otherwise Medicaid matchable

Waivers must:

- ✓ Be approved by the Secretary
- ✓ Promote the objectives of Medicaid
- ✓ Be budget neutral
- ✓ Receive stakeholder input during development process

Maine's Planned Whole Person Care Waiver through the 1115 Demonstration Renewal:

Existing Waiver

- Substance use disorder (SUD) – IMD exclusion
  - New: seek authority for Contingency Management services

New Waiver Authorities

- Serious Mental Illness – IMD exclusion
- Pre-release services for justice-involved individuals
- Traditional Healing Services
- Health-related social needs initiatives

The Department is taking a broad-based approach to this waiver renewal and application. Proposed Initiatives are non-binding and subject to availability of needed appropriations. DHHS will consider feedback from partners and the public, as well as available data, to evaluate and adjust its current proposed initiatives going forward, as appropriate.

1115 Re-entry Waiver

- **Provide a set of targeted pre-release Medicaid services in the 90-day period prior to release** for all Medicaid eligible adults and youth. Minimum services will include:
  - ✓ Care management
  - ✓ Medication-assisted treatment (MAT)
  - ✓ Minimum of a 30-day supply of medications in hand upon release
  - ✓ Physical and behavioral health clinical consultation services for youth
- **The following additional services will be phased in** based on readiness to implement and funding appropriations:
  - ✓ Physical and behavioral health clinical consultations for adults
  - ✓ Targeted laboratory services for diagnosis and treatment of priority health conditions like HIV and Hep C
  - ✓ Family planning services
  - ✓ Community health worker and Peer Support services
- **Phase in coverage of pre-release services in all state prisons, county jails, and youth correctional facilities** as readiness allows.
- **Request capacity-building funding** to support the implementation of pre-release services across all correctional facilities

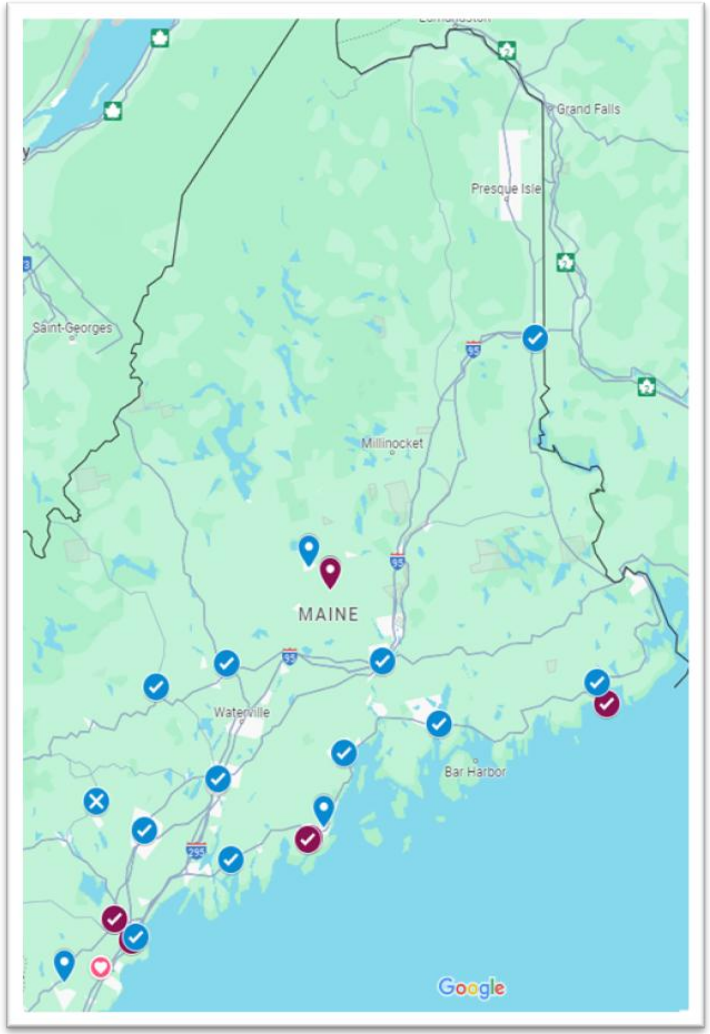
Visits to Maine Jails and Prisons to Date

County Jails

- ✓ Somerset County Jail
- ✓ Franklin County Jail
- ✓ Kennebec County
- ✓ Hancock County Jail
- ✓ Penobscot County Jail
- ✓ Aroostook County Jail
- ✓ Cumberland County Jail
- ✓ Waldo County Jail
- ✓ Washington County Jail
- ✓ Lincoln County
- ✓ Sagadahoc County
- ✓ Androscoggin County Jail
- ✓ Knox
- ✓ Oxford
- ✓ Piscataquis
- ✓ York

Maine State Prisons

- ✓ Maine Correctional Women's Center
- ✓ Maine Correctional Center
- ✓ Women's Reentry Center
- ✓ Maine State Prison
- ✓ Bolduc Correctional Facility
- ✓ Long Creek Youth Development Center
- ✓ Down-East Correctional Facility
- ✓ Mountain View / Charleston Facility



Community Engagement

Jails & Prisons

Maine County Jails
- Androscoggin
- Aroostook
- Cumberland
- Franklin
- Hancock
- Kennebec
- Knox
- Lincoln
- Oxford
- Penobscot
- Piscataquis
- Sagadahoc
- Somerset
- Waldo
- Washington
- York

DOC Maine State Prisons
- Buldoc Correction Center
- Down East Correctional Facility
- Long Creek
- Maine Correctional Center
- Women's Center
- Maine State Prison
- Mountain View
- Women's Reentry Center

Correctional Facility Providers

Alternative Correctional Healthcare
- Aroostook County Jail
- Franklin County Jail
- Somerset County Jail
- Lincoln County Jail
- Oxford County Jail
- Penobscot County Jail
- Sagadahoc County

Correctional Psychiatric Services
- Androscoggin County Jail
- Kennebec County

WellPath
- All Maine State Prisons / DOC

Armor Health
- Cumberland County Jail
- York County Jail

Single Independent Provider
- Washington County Jail
- Hancock County Jail
- Waldo County Jail
- Knox County Jail
- Piscataquis County Jail

DHHS Involvement

Primary Care Providers
- PCPlus

Substance Use (SUD)
- OHH
- IMD SUD Waiver

Mental Health
- Certified Community Behavioral Health Clinics

Case Management
- Intensive Case Management

Psychiatric Hospitals
- Riverview Hospital
- Dorothea Dix Hospital

Residential Providers
- Private Non-Medical Institutions

Enrollment, Eligibility, & Systems
- OFI policy
- MIHMS
- Provider Enrollment

Community Service Providers

Primacy Care Providers
- Federal Qualified Health Centers
- Maine Primary Care Association

Substance Use (SUD) Providers
- Medication Assistance Treatment
- Outpatient
- Intensive Outpatient
- Peer Led Support
- Recovery Residences

Mental Health & Behavioral Health Providers
- Outpatient
- Intensive Outpatient
- Psychiatry
- Community Mental Health Centers
- Hospitals

Case Management Providers
- Targeted Case Management
- Case Management – HH/ACT

Justice Impacted Community Members

Maine Prisoner Advocacy Coalition

Maine Reentry Network

Wabanaki Nations & Wabanaki Health Alliance

Veterans

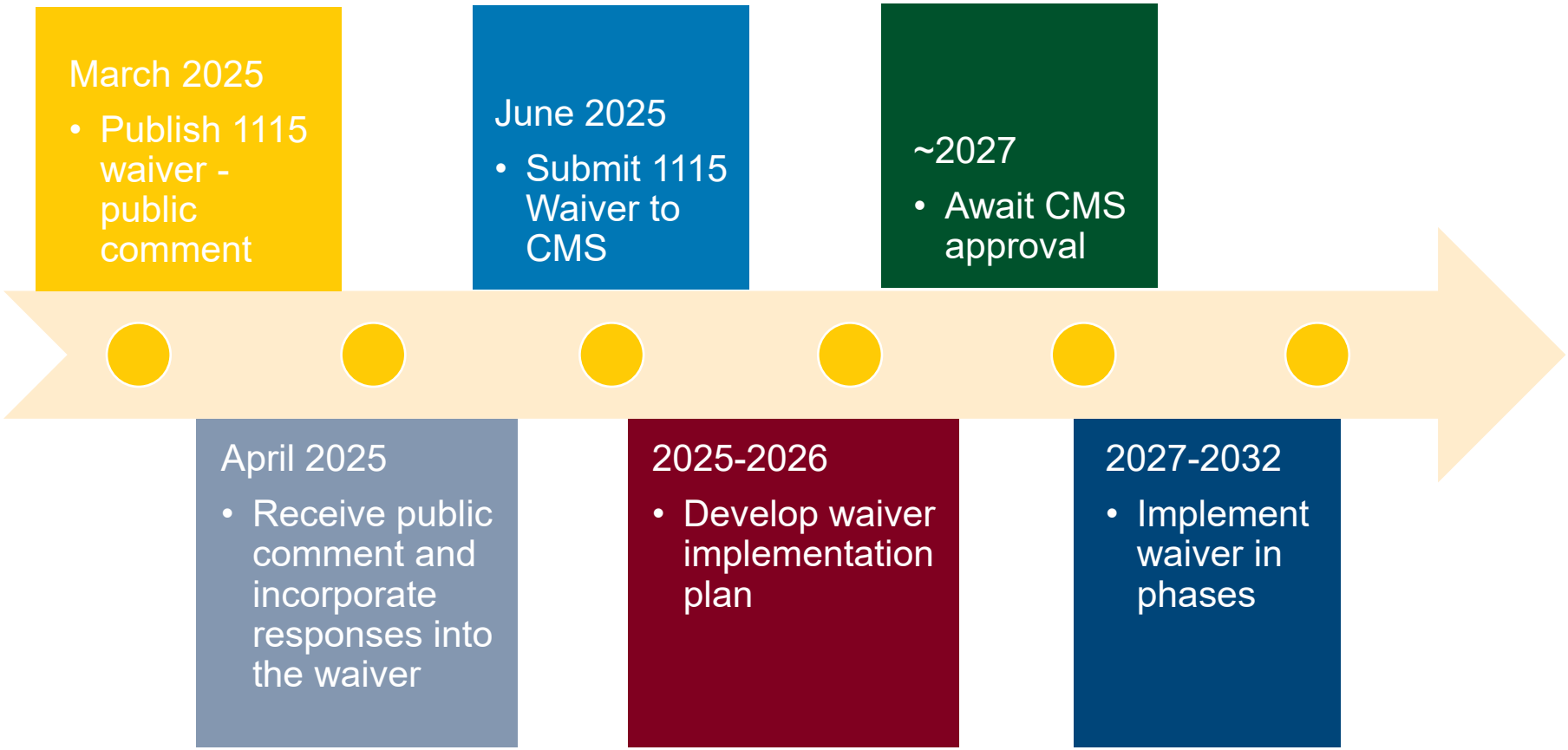
LGBTQIA2S+ Organizations

Board of Visitors (County Jail Specific)

Community Partnerships & Engagement

- Maine Prisoner Advocacy Coalition
  - Four Listening Sessions: MCC Women's Center, Maine State Prison, Franklin County Jail, York County Jail
- Maine Re-entry Network
  - Community Advisory Board
- Health & Reentry Conference
  - Planning for 2026

Timeline


March 2025
• Publish 1115 waiver - public comment
April 2025
• Receive public comment and incorporate responses into the waiver
June 2025
• Submit 1115 Waiver to CMS
2025-2026
• Develop waiver implementation plan
~2027
• Await CMS approval
2027-2032
• Implement waiver in phases

Additional Information

- DHHS Blog Post explaining the waiver: The Department of Health and Human Services Introduces Maine's Whole Person Care Waiver | Department of Health and Human Services
- Public notice: MaineCare Notice of Agency 1115 Waiver Renewal Application, "Maine Substance Use Disorder (SUD) Care Initiative" | Department of Health and Human Services
- Link to the waiver draft: Maine 1115 Waiver Draft.pdf

Contact Information: courtney.pladsen@maine.gov

START

Stimulant Treatment and Recovery Team

Justin Alves

2026

Grayken Center for Addiction
Boston Medical Center

Massachusetts Department of Public Health
DPH

START: STIMULANT TREATMENT AND RECOVERY

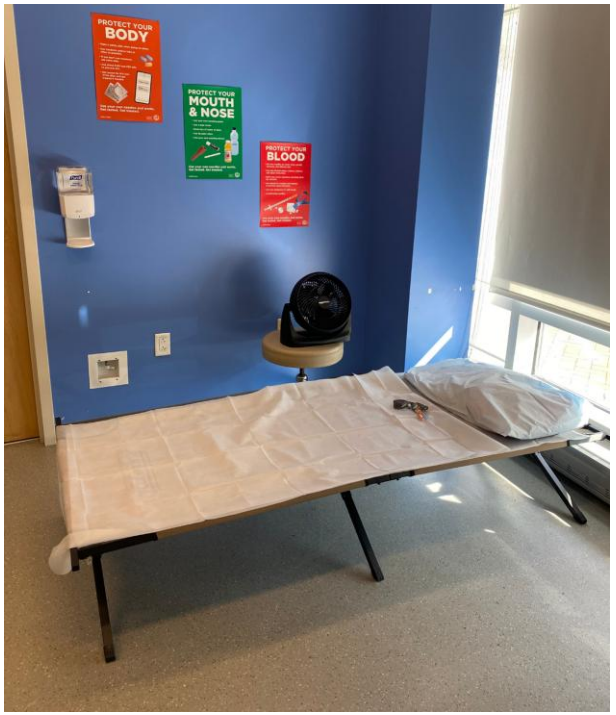
- Provides care through adapted version of the Nurse Care Manager Model
  - Primary care
  - Group therapy
  - Patient navigation services

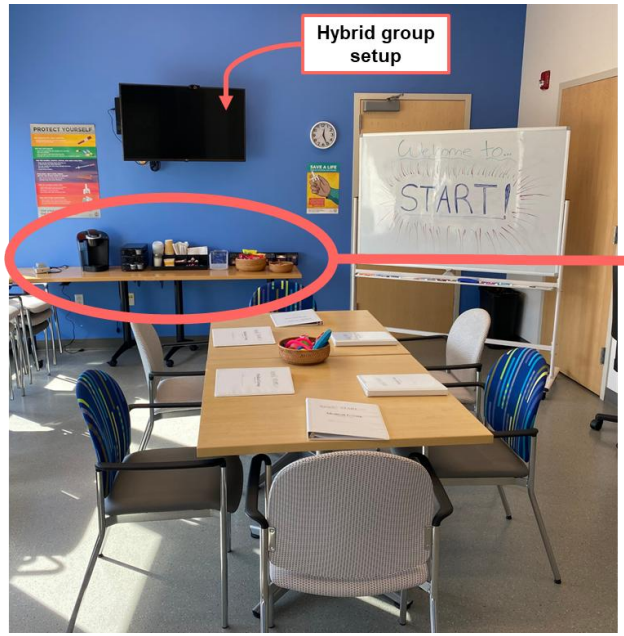
- Utilizes contingency management through Recovery Rewards Program
  - Engagement, Exercise, Expected toxicology


11 Melnea Cass Blvd
Melnea Cass Blvd
Boston, Massachusetts
Google Street View
Aug 2024
See more dates
BOSTON STRONG


GO
SLOW
MFers
gettyimages
Credit: Boston Globe

- Patients with symptoms of **overamping** are promptly brought to START clinic's **"cool-down" space.**
- **Non-pharmacological interventions to reduce symptoms:**
  - Sunglasses and ear plugs to reduce external stimuli
  - Electrolyte water and chewing gum to reduce dehydration
  - A cot with blankets and pillows to address symptoms of sleep deprivation




Hybrid group setup
START!


Safe sex supplies
Phone charging station
Coffee + tea
Narcan pouches
Snacks

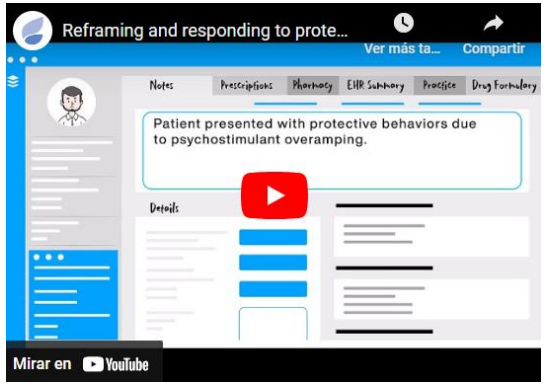

Movable wall to create two rooms


Fidget toys

STIMULANT TREATMENT AND RECOVERY TEAM

CLINICAL GUIDELINES

A COLLABORATIVE CARE APPROACH



BOSTON MEDICAL CENTER START Stimulant Treatment and Recovery Team

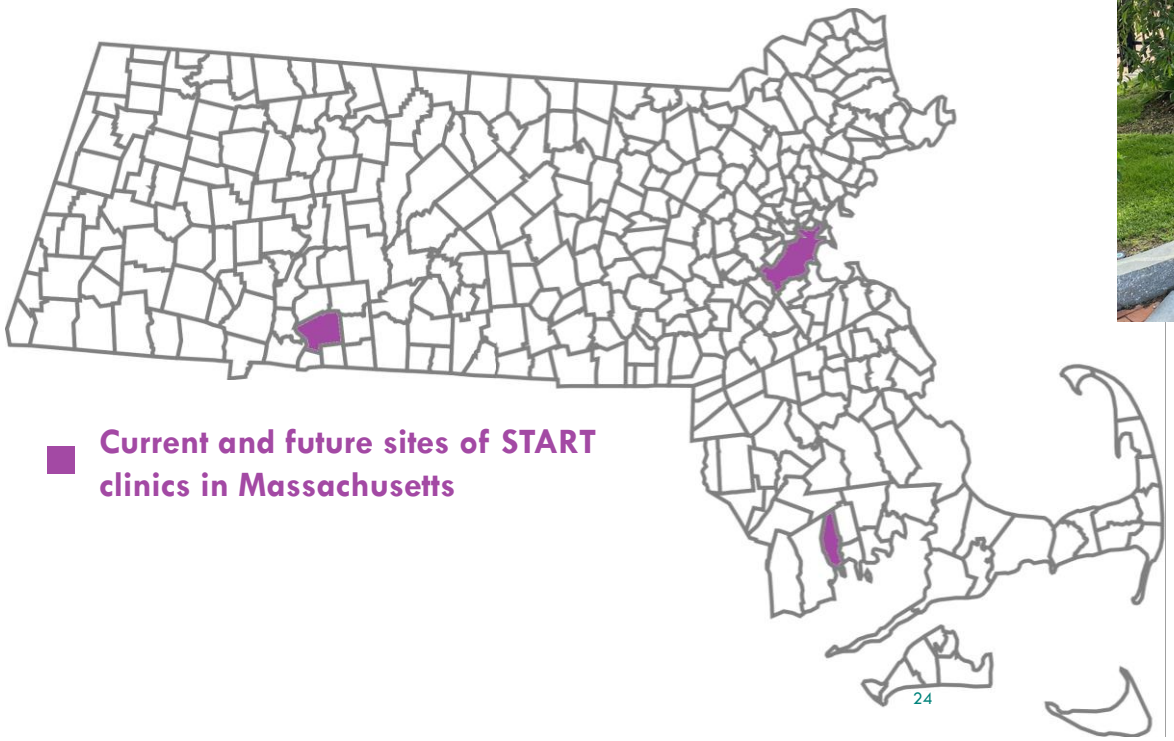
Medical Group Plan

BOSTON MEDICAL CENTER START Stimulant Treatment and Recovery Team

Behavioral Health Group Plan

START

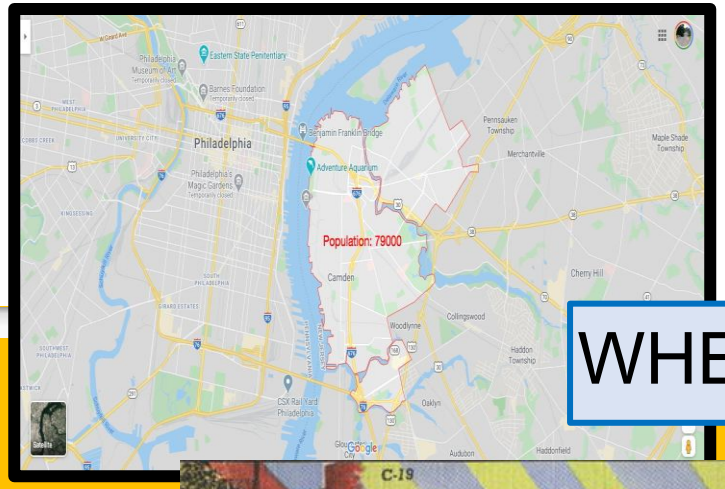
Stimulant Treatment and Recovery Team



- **Current and future sites of START clinics in Massachusetts**

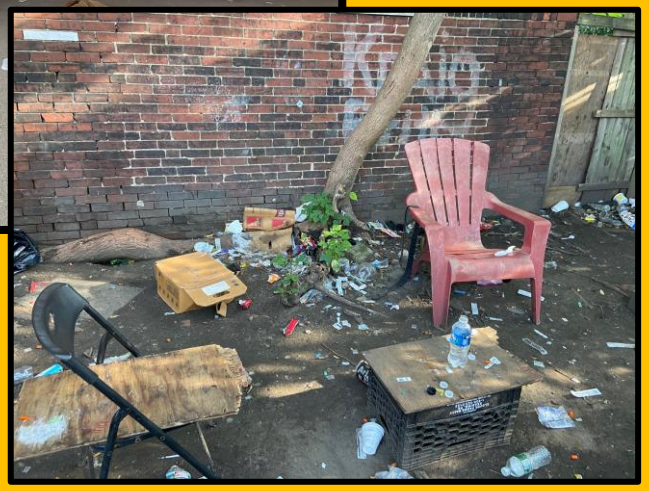
Reimagining Solutions
BupeFirst EMS

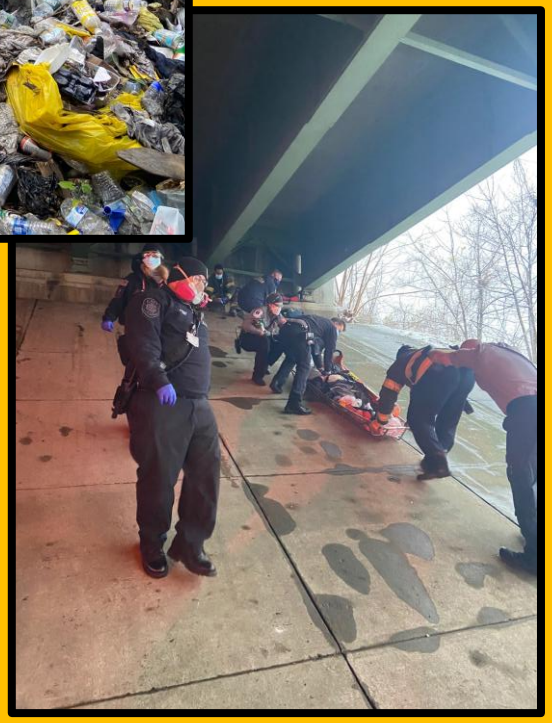
Rachel Haroz MD
Cooper University Health Care



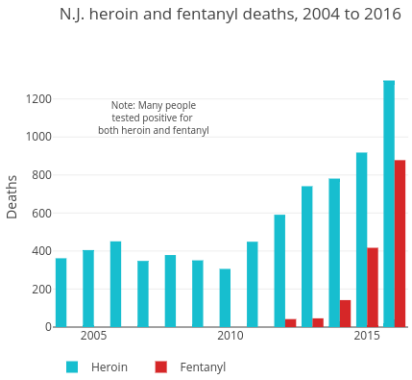
WHERE IT STARTED

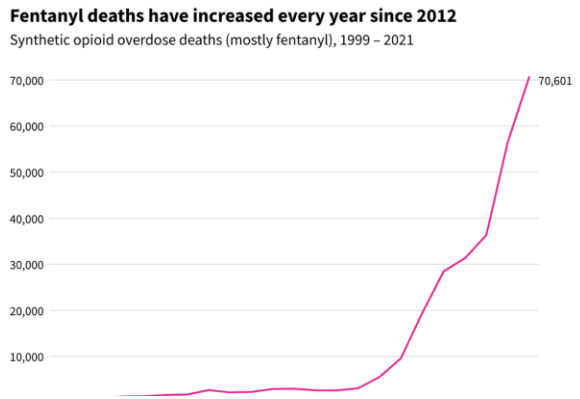
THE DAY TO DAY

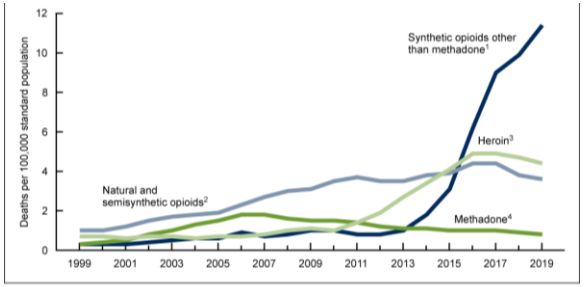




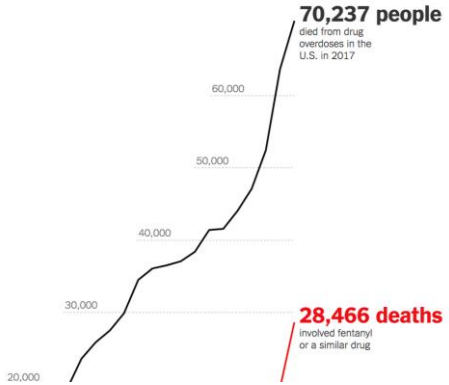
THE PROBLEM

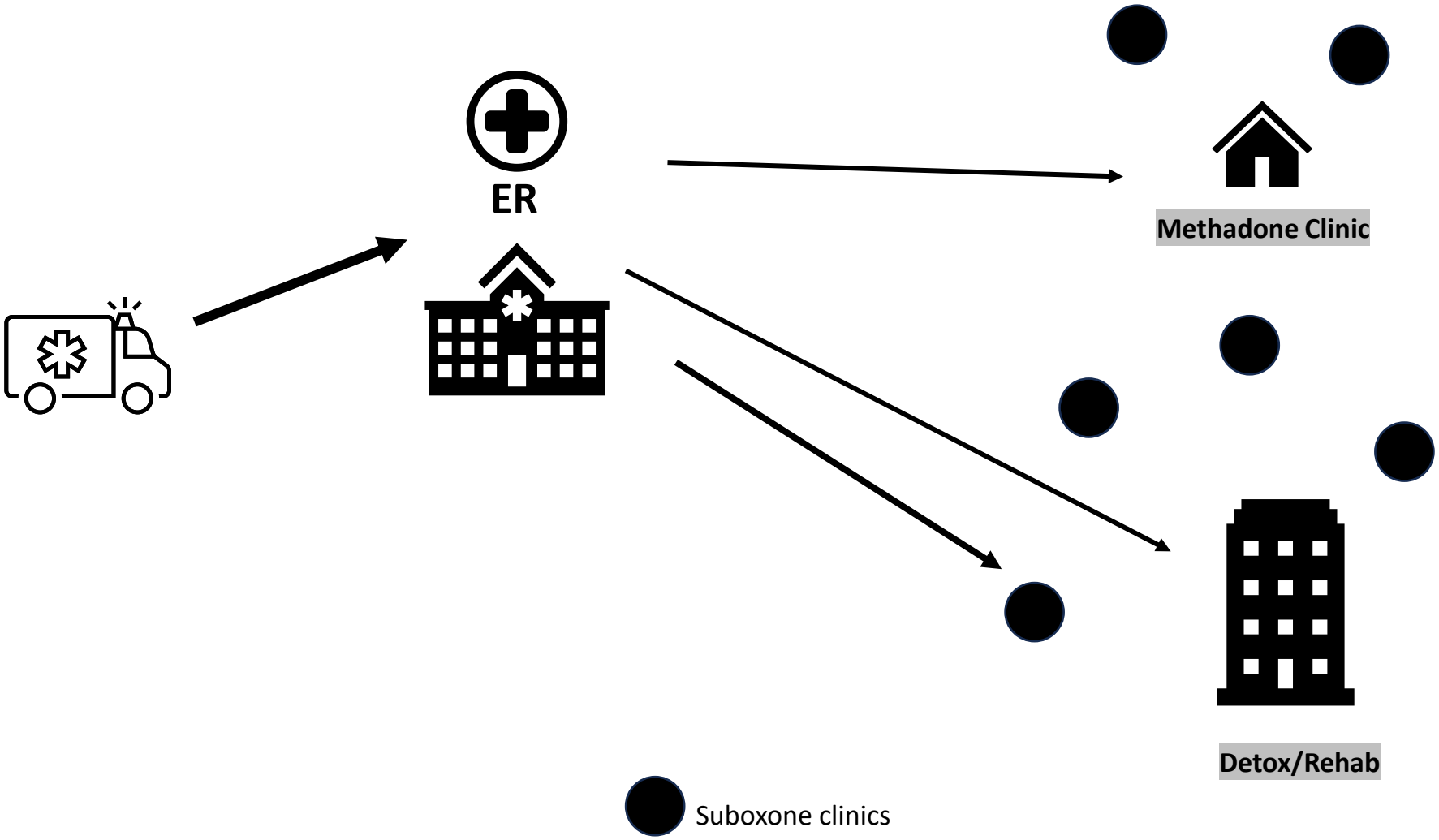


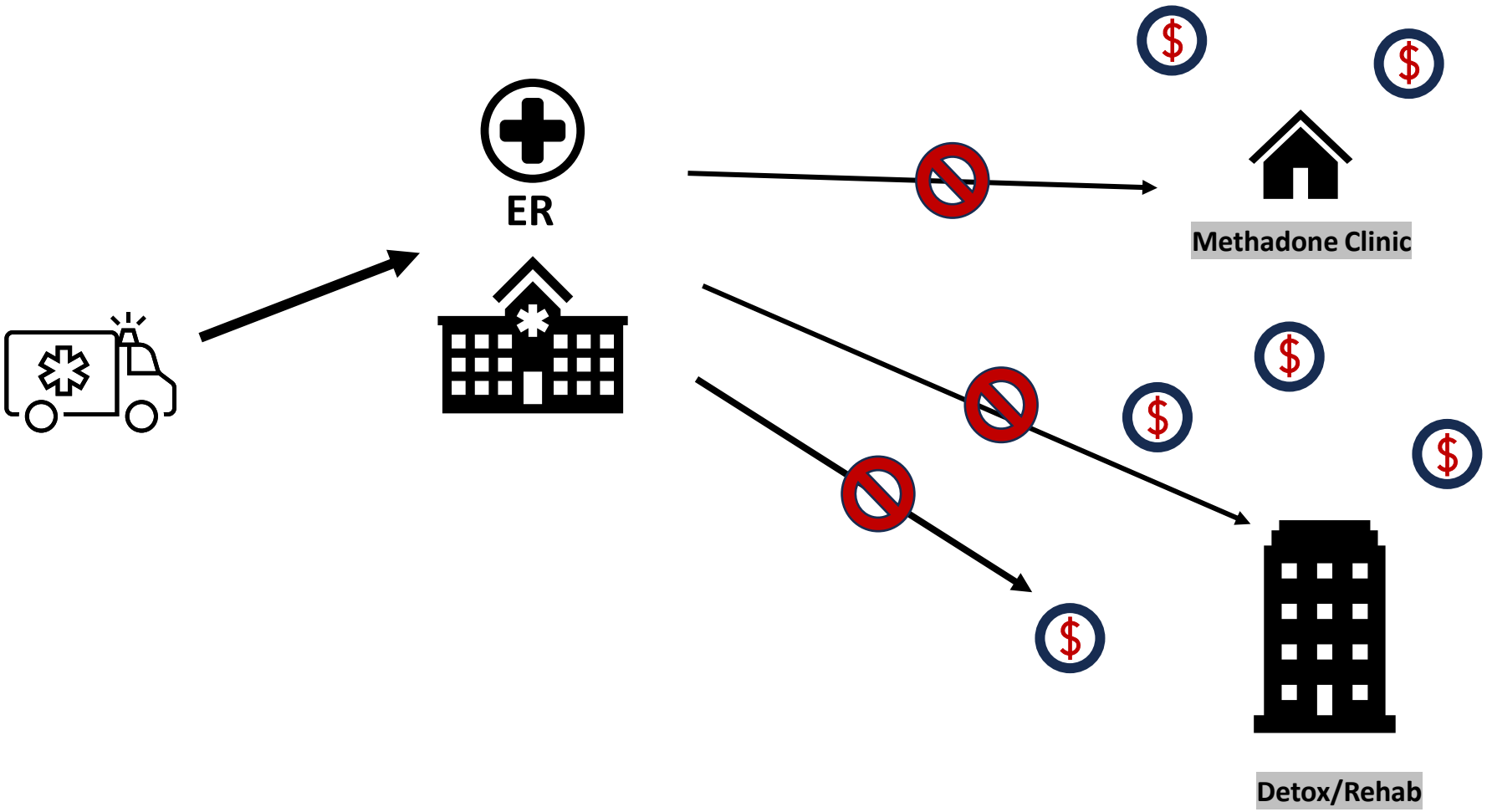




[1]Significant increasing trend from 1999 through 2006 and 2013 through 2019, with different rates of change over time, $p < 0.05$.
[2]Significant increasing trend from 1999 through 2017, with different rates of change over time, $p < 0.05$.
[3]Significant increasing trend from 2005 to 2016, with different rates of change over time, then significant decreasing trend from 2016 through 2019, $p < 0.05$.
[4]Significant increasing trend from 1999 to 2006, with different rates of change over time, then significant decreasing trend from 2006 through 2019, $p < 0.05$.
NOTES: Drug overdose deaths are identified using the *International Classification of Diseases, 10th Revision* (ICD–10) underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Drug overdose deaths involving selected drug categories are identified by specific multiple-cause-of-death codes: heroin, T40.1; natural and semisynthetic opioids, T40.2; methadone, T40.3; and synthetic opioids other than methadone, T40.4. Deaths involving more than one opioid category (e.g., a death involving both methadone and a natural or semisynthetic opioid) are counted in both categories. Natural and semisynthetic opioids include drugs such as morphine, oxycodone, and hydrocodone; and synthetic opioids other than methadone include drugs such as fentanyl, fentanyl analogs, and tramadol. The percentage of drug overdose deaths that identified the specific drugs involved varied by year, ranging from 75%–79% from 1999 through 2013 and increasing from 81% in 2014 to 94% in 2019. Access data table for Figure 3 at: https://www.cdc.gov/nchs/data/databriefs/db394-tables-508.pdf#3.

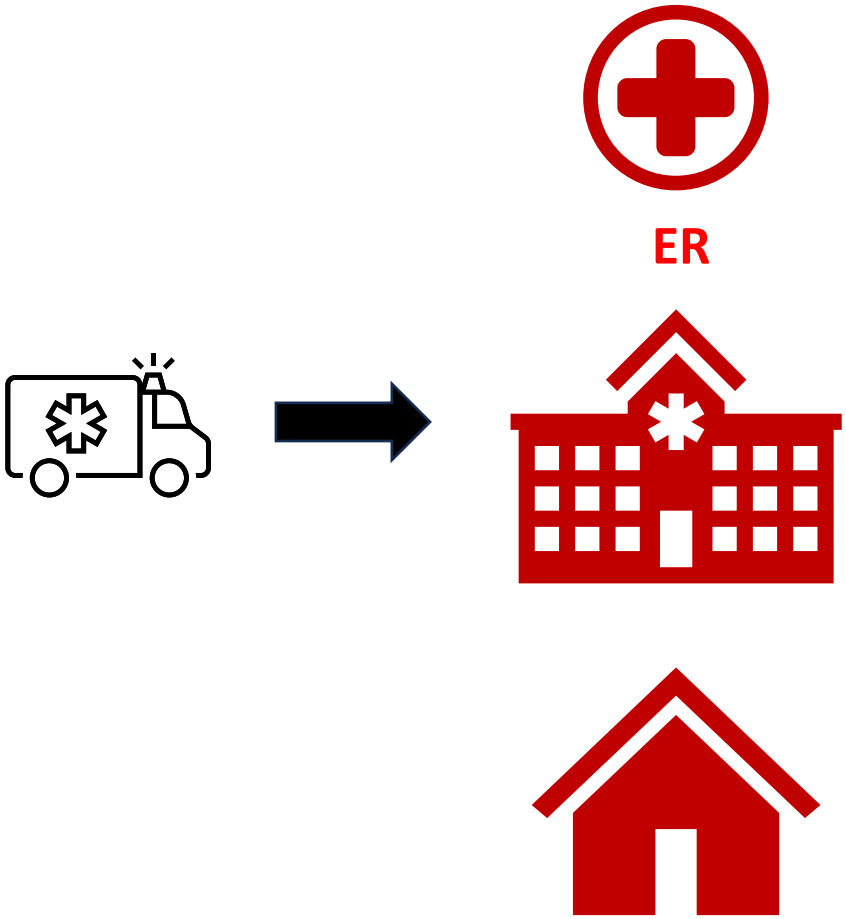


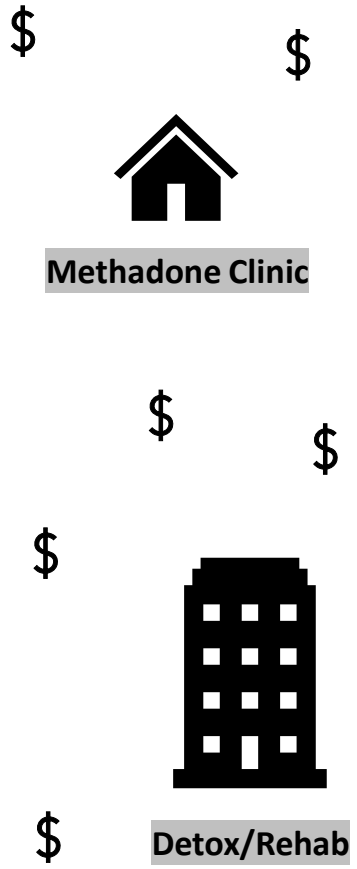

ER
Methadone Clinic
Detox/Rehab
Suboxone clinics



$ Suboxone clinics- mostly cash only

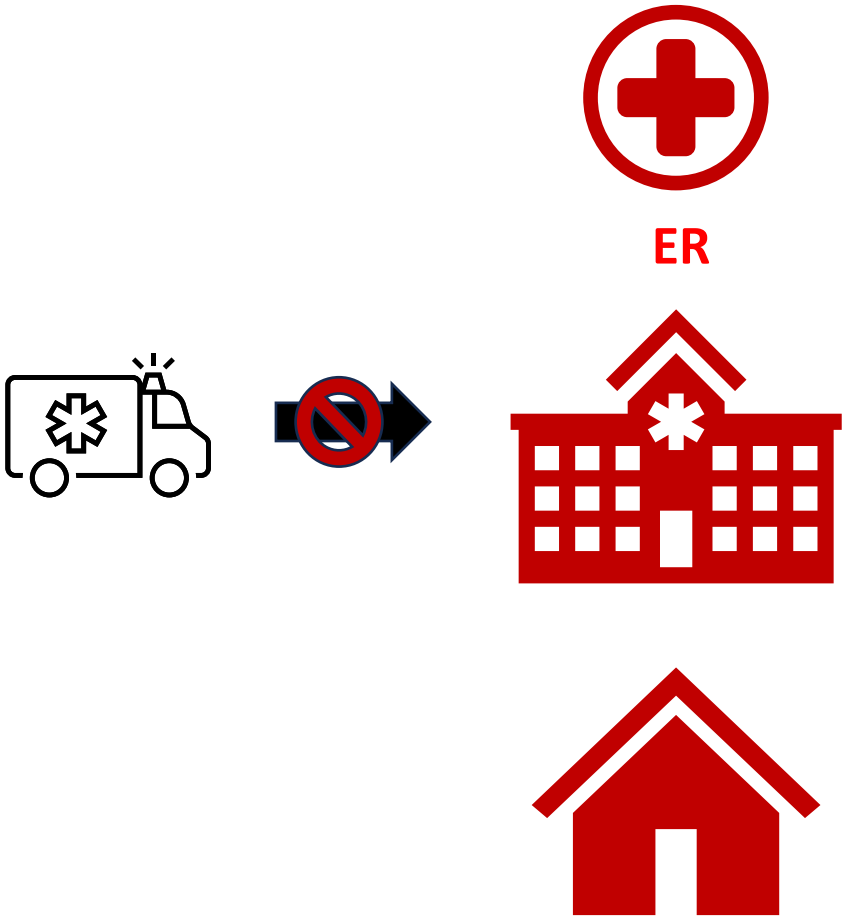
Cooper University Health Care

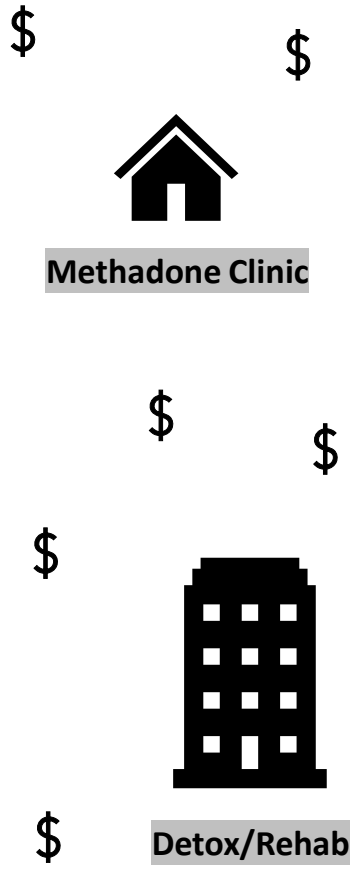




$ Suboxone clinics- mostly cash only

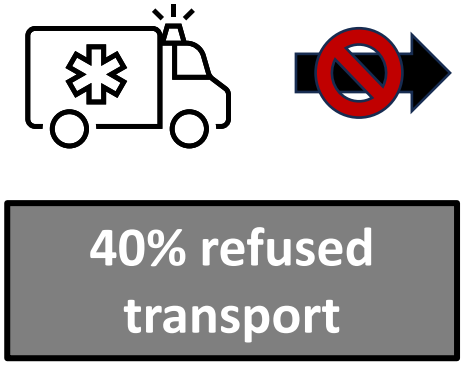
Cooper University Health Care

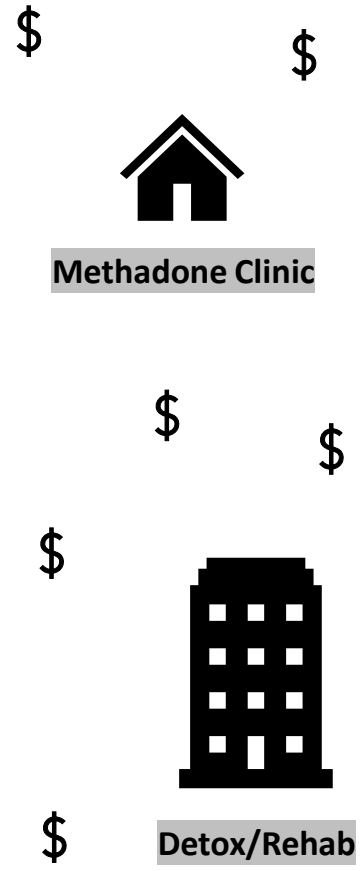




$ Suboxone clinics- mostly cash only

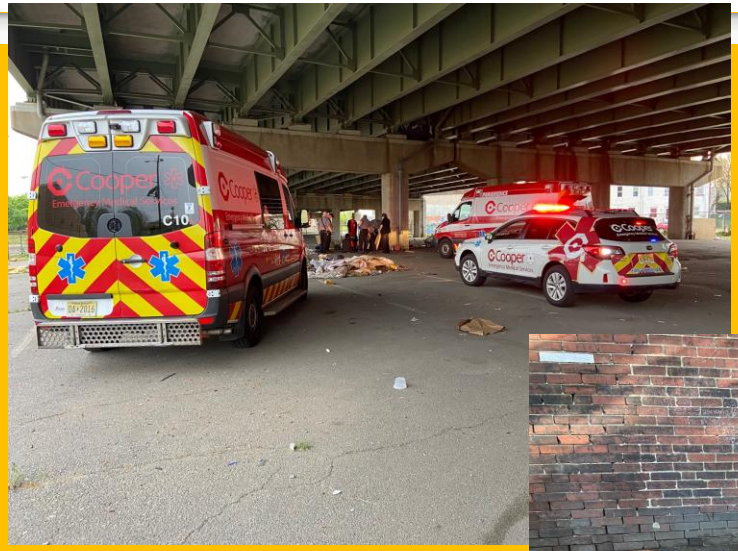
Cooper University Health Care

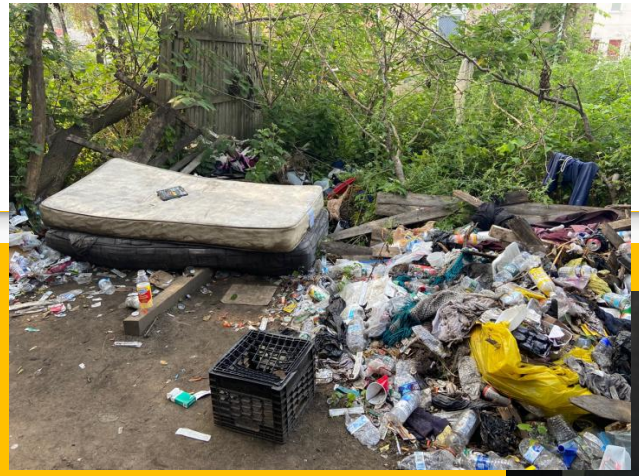




$ Suboxone clinics- mostly cash only

THE DAY TO DAY





One-Year Mortality of Opioid Overdose Victims Who Received Naloxone by Emergency Medical Services

Weiner SG, Baker O, Bernson D, Schuur JD/Brigham and Women's Hospital, Boston, MA; Massachusetts Department of Public Health, Boston, MA

Death records indicated that 6.5% (n⅟4787) died the same day as the documented naloxone administration, 9.3% (n⅟41,132) died within one year and 84.3% (n⅟410,273) were alive at one year. Excluding those who died the same day as naloxone administration, 9.9% (1,132/11,405) died within one year.

30% of OD deaths saw EMS in the preceding year

10%

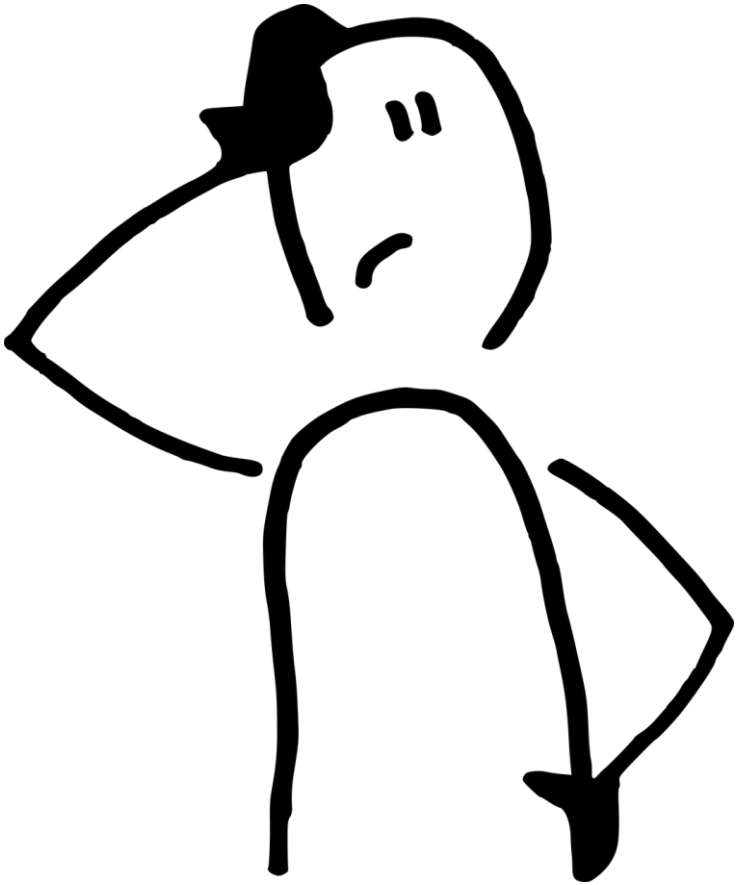
mortality

vs

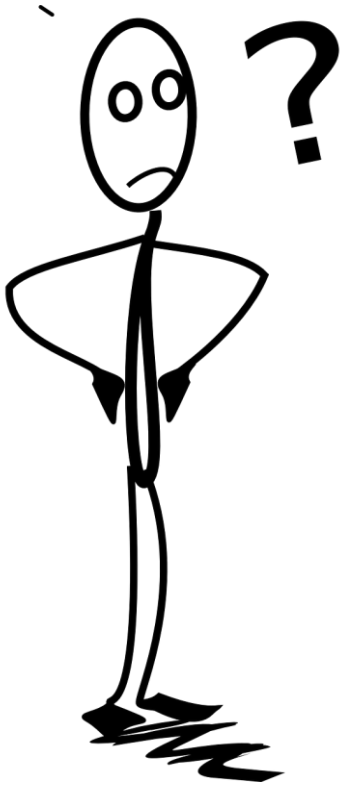
STEMI – 11.5%

Doost Hosseiny A, Moloi S, Chandrasekhar J, *et al. Open Heart* 2016

Cooper University Health Care



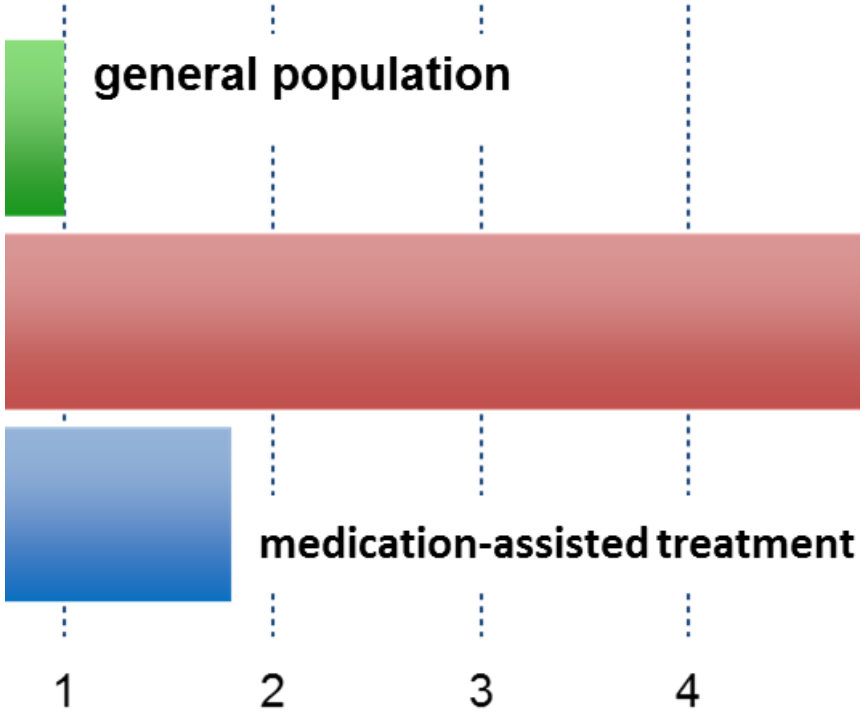
$250,000



Cooper University Health Care

⅔

- **Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association With Mortality A Cohort Study**
- Marc R. Larochelle, MD, MPH, Dana Bernson, MPH, Thomas Land, PhD, Thomas J. Stopka, PhD, MHS, Na Wang, MA, Ziming Xuan, ScD, SM, Sarah M. Bagley, MD, MSc, Jane M. Liebschutz, MD, MPH, and Alexander Y. Walley, MD, MSc



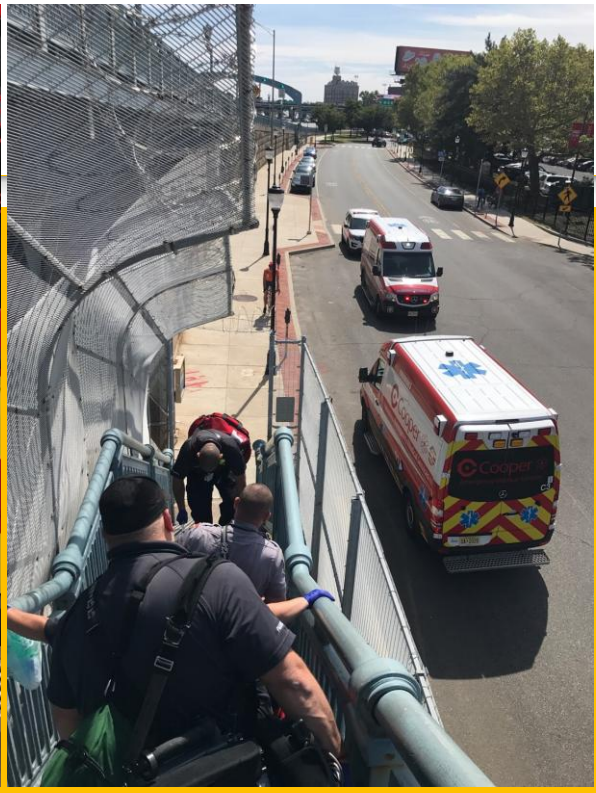
Cooper University Health Care

Buprenorphine

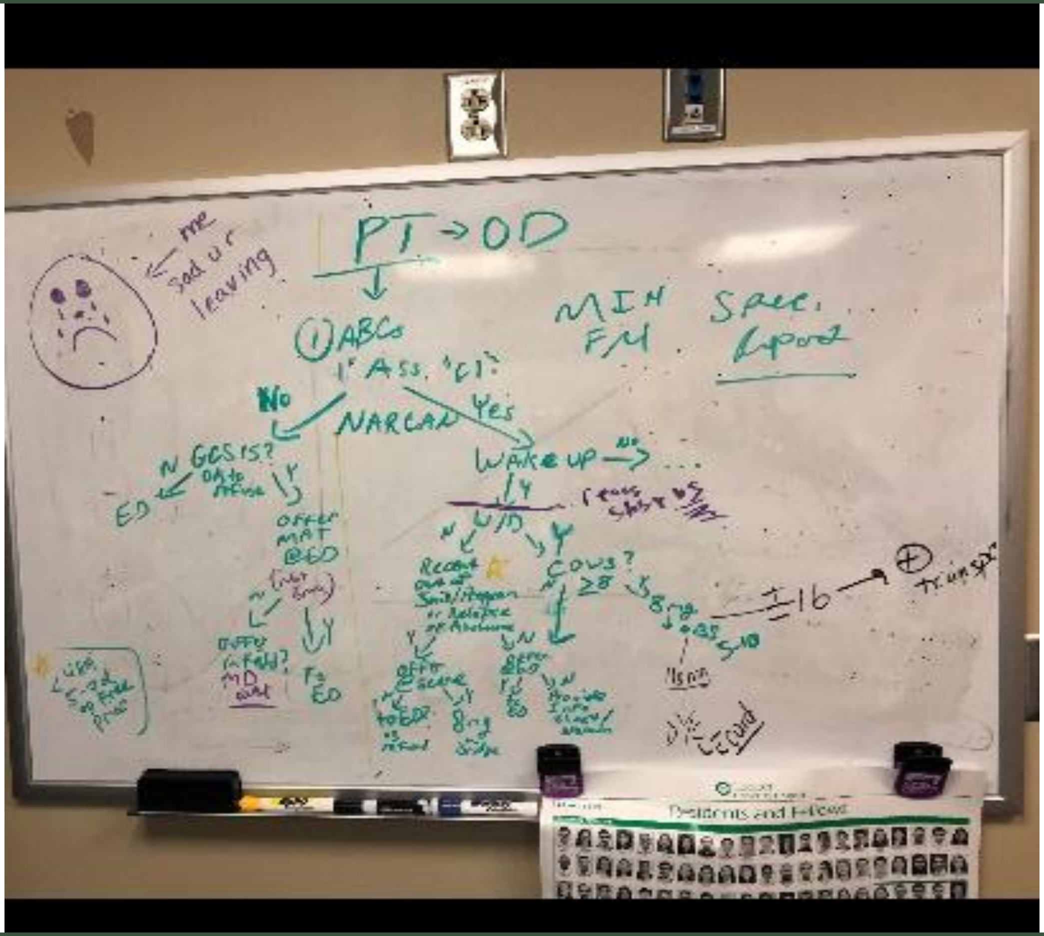
Cooper University Health Care

Cooper University Health Care

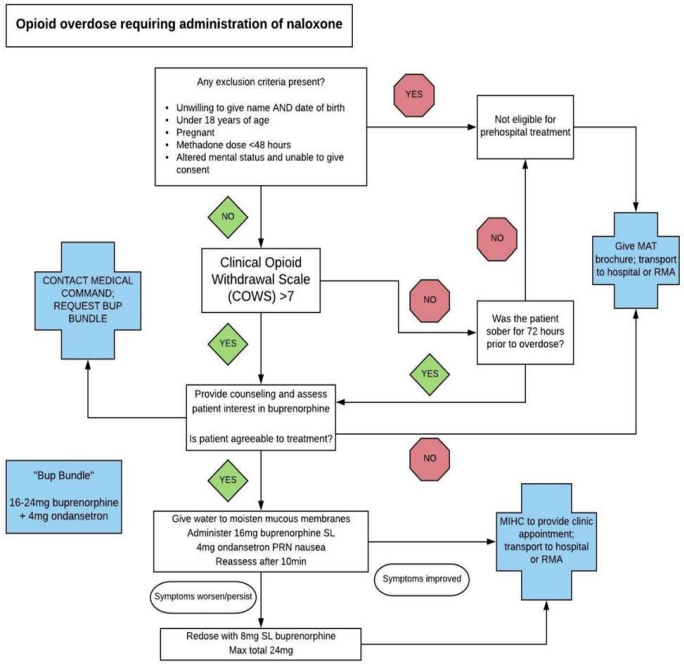
EMS



- Medically Trained Capable Professionals
- Mobile
- Available 24/7
- 5-10 Minutes away
- Immediate access to medical command
- Universally Trusted
- Already effectively geographically deployed across this entire country

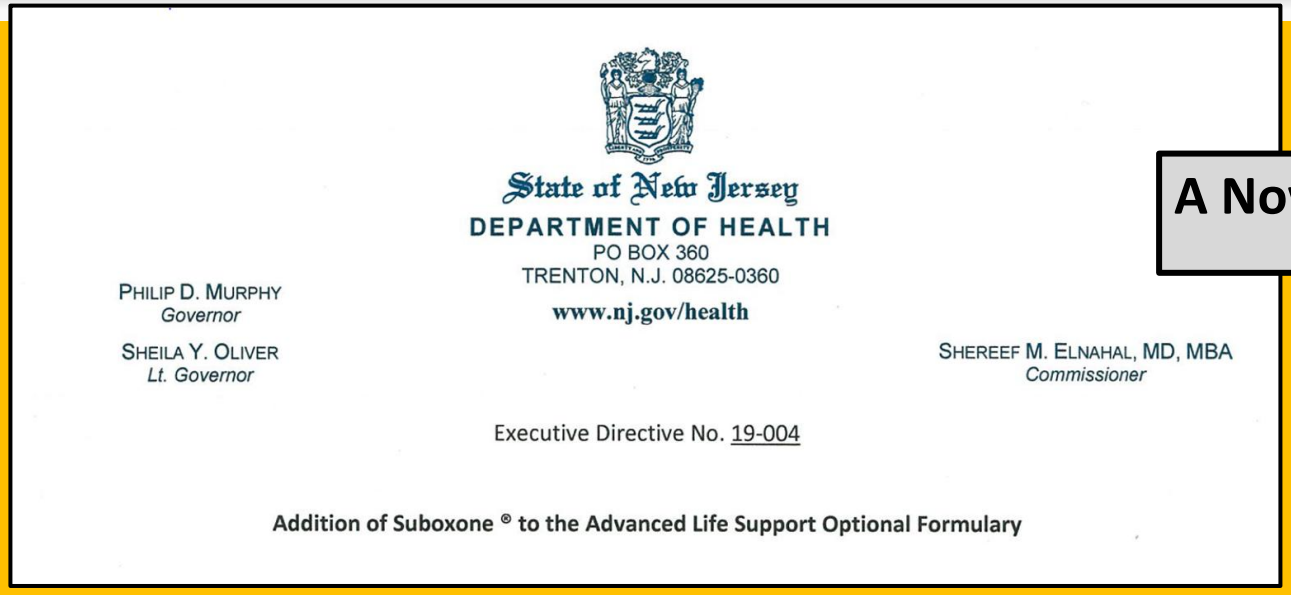

PT → OD
me
sad u r
leaving
① ABCs
No
NARCAN
Yes
GCS 15?
ED
WAKE UP
COWS?
≥8
±16

Cooper EMS/Disaster Medicine



Cooper University Health Care

LEGISLATION



State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 360
TRENTON, N.J. 08625-0360
www.nj.gov/health

PHILIP D. MURPHY
Governor

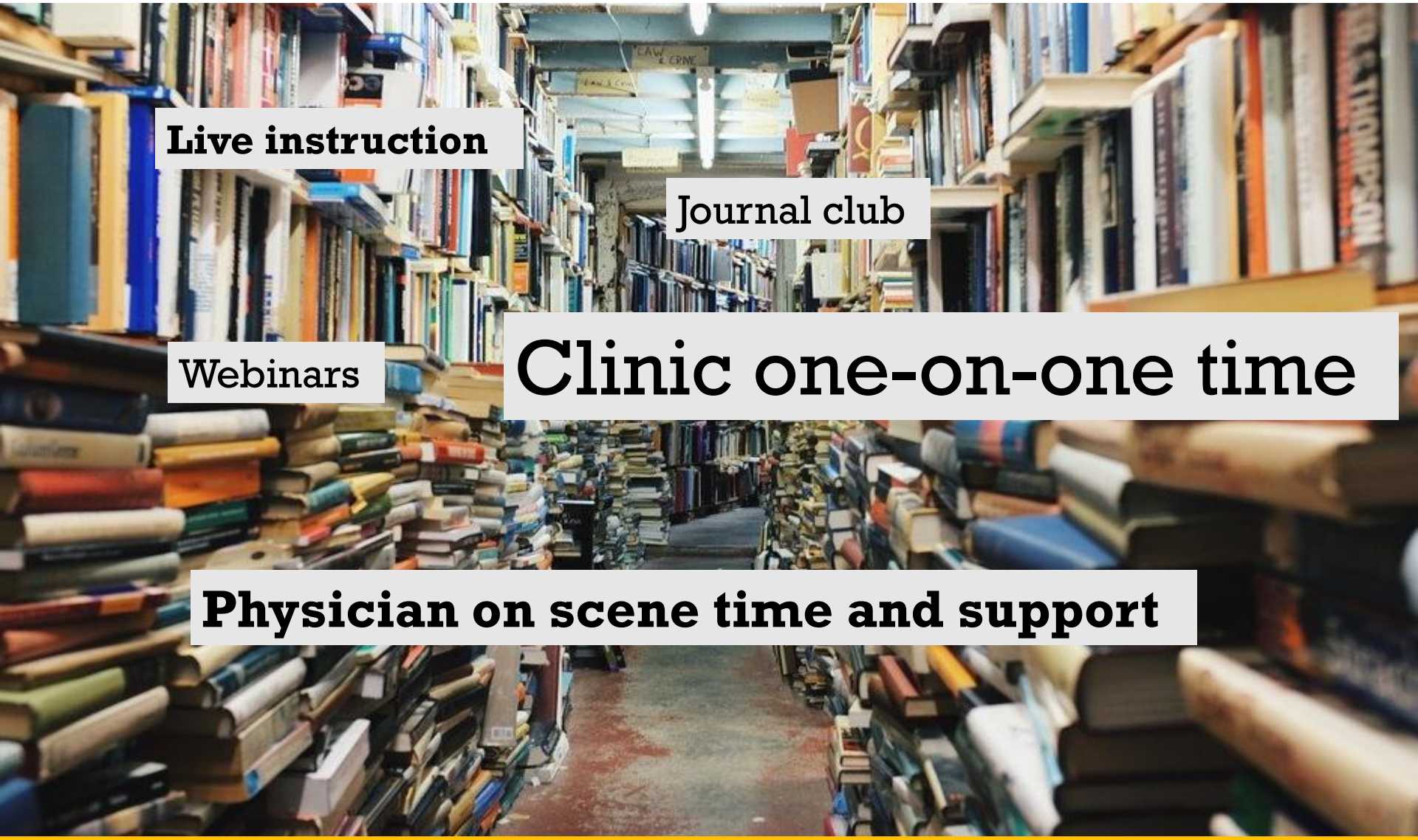
SHEILA Y. OLIVER
Lt. Governor

SHEREEF M. ELNAHAL, MD, MBA
Commissioner

Executive Directive No. 19-004

Addition of Suboxone ® to the Advanced Life Support Optional Formulary

A Novel Directive


Live instruction
Journal club
Webinars
Clinic one-on-one time
Physician on scene time and support

EMS Buprenorphine Literature

Prehospital Emergency Care

ISSN: 1090-3127 (Print) 1545-0066 (Online) Journal homepage: https://www.tandfonline.com/loi/ipec20

Buprenorphine Field Initiation of ReScue Treatment by Emergency Medical Services (Bupe FIRST EMS): A Case Series

Gerard G. Carroll, Deena D. Wasserman, Aman A. Shah, Matthew S. Salzman, Kaitlan E. Baston, Rick A. Rohrbach, Iris L. Jones & Rachel Haroz

Prehospital Emergency Care

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/ipec20

Prehospital Initiation of Buprenorphine Treatment for Opioid Use Disorder by Paramedics

H. Gene Hern, David Goldstein, M Kalmin, S Kidane, S Shoptaw, Ori Tzvieli & Andrew A Herring

Annals *of* Emergency Medicine

Impact of Administering Buprenorphine to Overdose Survivors Using Emergency Medical Services

Gerard Carroll, MD • Keisha T. Solomon, PhD • Jessica Heil, MS • ... Emily Murphy, MD • Kaitlan Baston, MD • Rachel Haroz, MD • Show all authors

Cooper University Health Care

Protocol

- Pt receives naloxone
- Exclusions for Bupe
  - AMS/ lack capacity
  - Refuses name /DOB
  - METHADONE IN LAST 72 hours
  - No Daily opiates
  - < 16
- IF yes to any of the exclusionary criteria, then no Buprenorphine

Precipitated Withdrawal Protocol

- The following procedures are authorized for patients who have overdosed on opioids AND received naloxone by EMS provider or bystander:
  - Assess patient for any exclusion criteria
    - Altered mental status/ no capacity
    - Unwilling to give name and DOB
    - **Taken any methadone within the past 48 hours** - patients who have taken methadone in the last 48 hours are at risk of severe withdrawal if given buprenorphine
    - Patient does not take opiates daily
    - Under 18 year olds

***If any of the above are present, the patient is NOT eligible for buprenorphine, continue with Overdose protocol.

- Calculate a Clinical Opiate Withdrawal Scale (COWS) score (Below)
  - Score of less than 7
    - The patient is NOT eligible for buprenorphine
  - Score of 7 or greater
    - Counsel patient regarding buprenorphine treatment for withdrawal
    - Assess the desire to initiate treatment
    - If the patient DECLINES, the patient is NOT eligible for buprenorphine
- Patient agreeable to buprenorphine treatment
  - 16mg initial SL buprenorphine dose
  - 4mg ondansetron SL/IM/IV PRN nausea
  - 8mg additional PRN dose of buprenorphine
- Give water to moisten mucous membranes
  - Administer 16mg SL buprenorphine
  - Reassess COWS score after 5-10min
    - If improved, proceed to appointment scheduling
    - If COWS worsens or not improve, can give an additional 8mg SL buprenorphine
  - Administer 4mg ondansetron SL/IM PRN nausea
- Contact EPICC to help provide post-overdose referrals
  - Eastern: 314-819-4275
  - Central: 1-800-395-2132
  - Western: 1-888-279-8188

*** This protocol is written by Gerard G. Carroll, MD, FAAEM, EMT-P*

Cooper University Health Care

Protocol - Calculate COWs & Sell the Intervention

- **> 5 or >8 go time**
- **Engagement – pt willing to accept buprenorphine?**

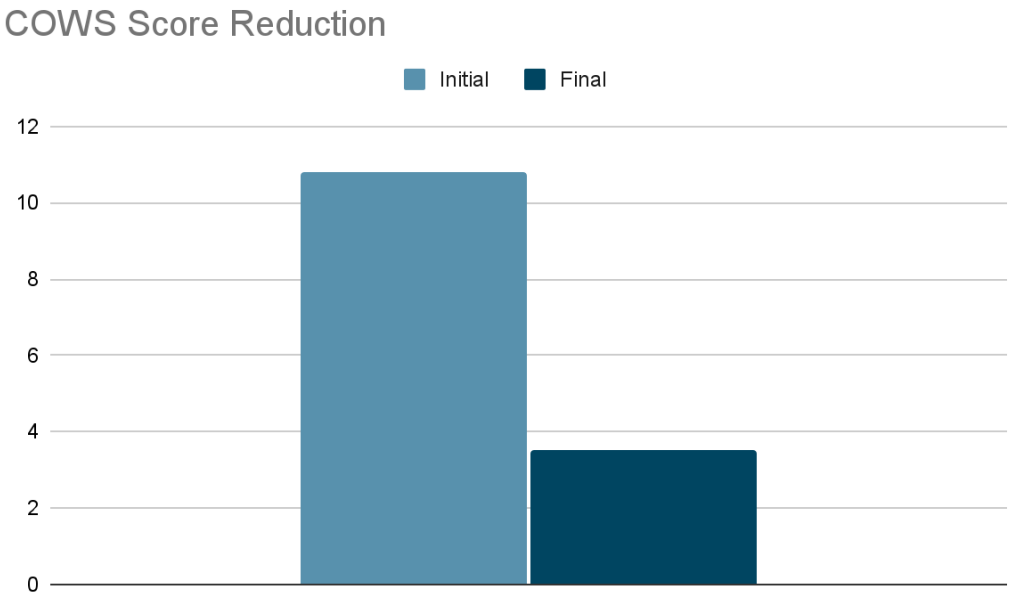
This is the art of medicine.

Buprenorphine 16mg S/L

Ondansetron – 8 mg ODT/IM/IV

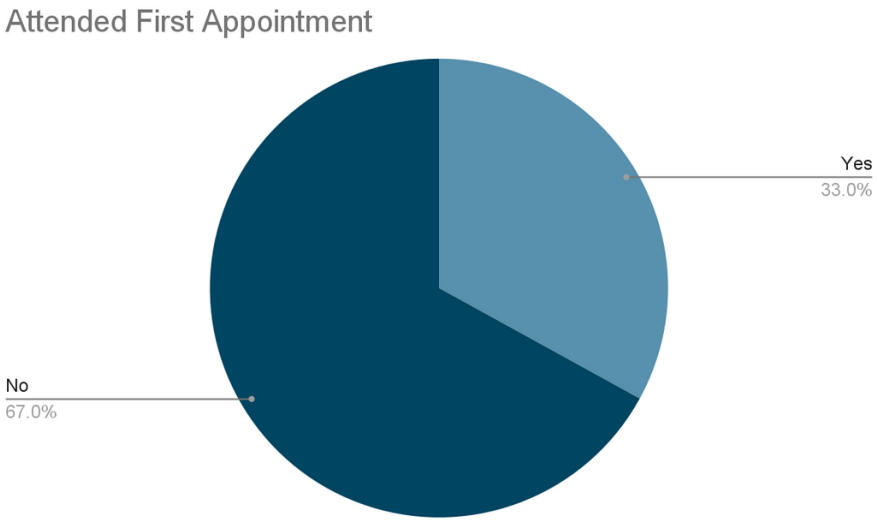
Buprenorphine – 8mg S/L

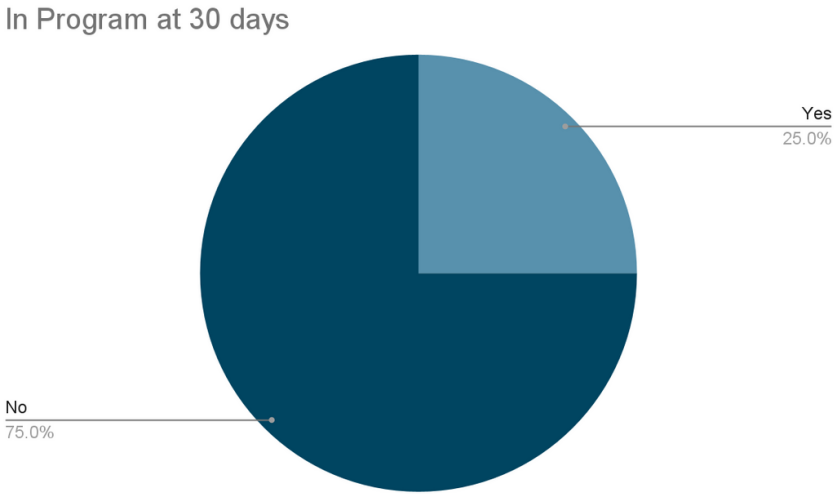
Results



Cooper University Health Care

Results





Cooper University Health Care

An innovative approach to field inducted Medication Assisted Treatment

The EMS Bridge to MAT Program is a new, innovative and critical program in Durham County, North Carolina.

Operations

Pittsburgh (PA) EMS Begins Administering Buprenorphine for Opioid Overdoses

As part of the pilot, Advanced Life Support EMS units will be able to administer buprenorphine to patients experiencing opioid withdrawal

Seattle Fire Department launches pilot program allowing paramedics to administer buprenorphine in the field

by Callie Craighead on March 12, 2024

State of Delaware
Department of Health and Social Services
Division of Public Health
Office of Emergency Medical Services

State of Delaware Buprenorphine Pilot

County of San Diego

JEFF COLLINS
DIRECTOR
San Diego County Fire
(619) 339-0283

PUBLIC SAFETY GROUP
SAN DIEGO COUNTY FIRE
SAN DIEGO COUNTY EMERGENCY MEDICAL SERVICES OFFICE
5560 Overland Avenue, Suite 400, San Diego, CA 92123-1204
www.SanDiegoCountyEMS.com

September 21, 2023

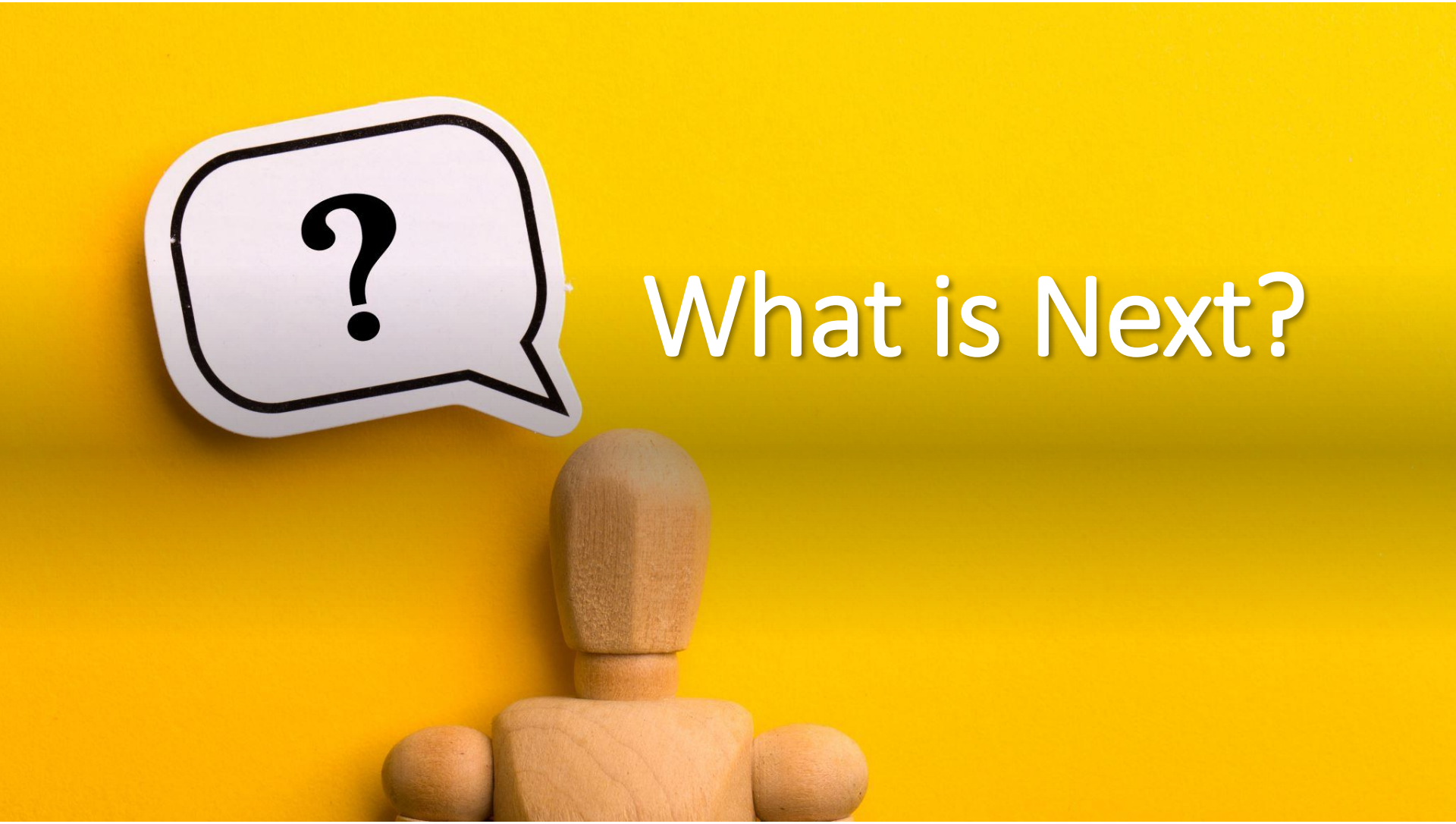
COUNTY OF SAN DIEGO PREHOSPITAL BUPRENORPHINE (SUBOXONE®)

EMS workers across Missouri are receiving training on how to give overdose victims a dose of buprenorphine, which manages cravings and withdrawal symptoms, after reviving them from an overdose with the overdose reversal drug naloxone.

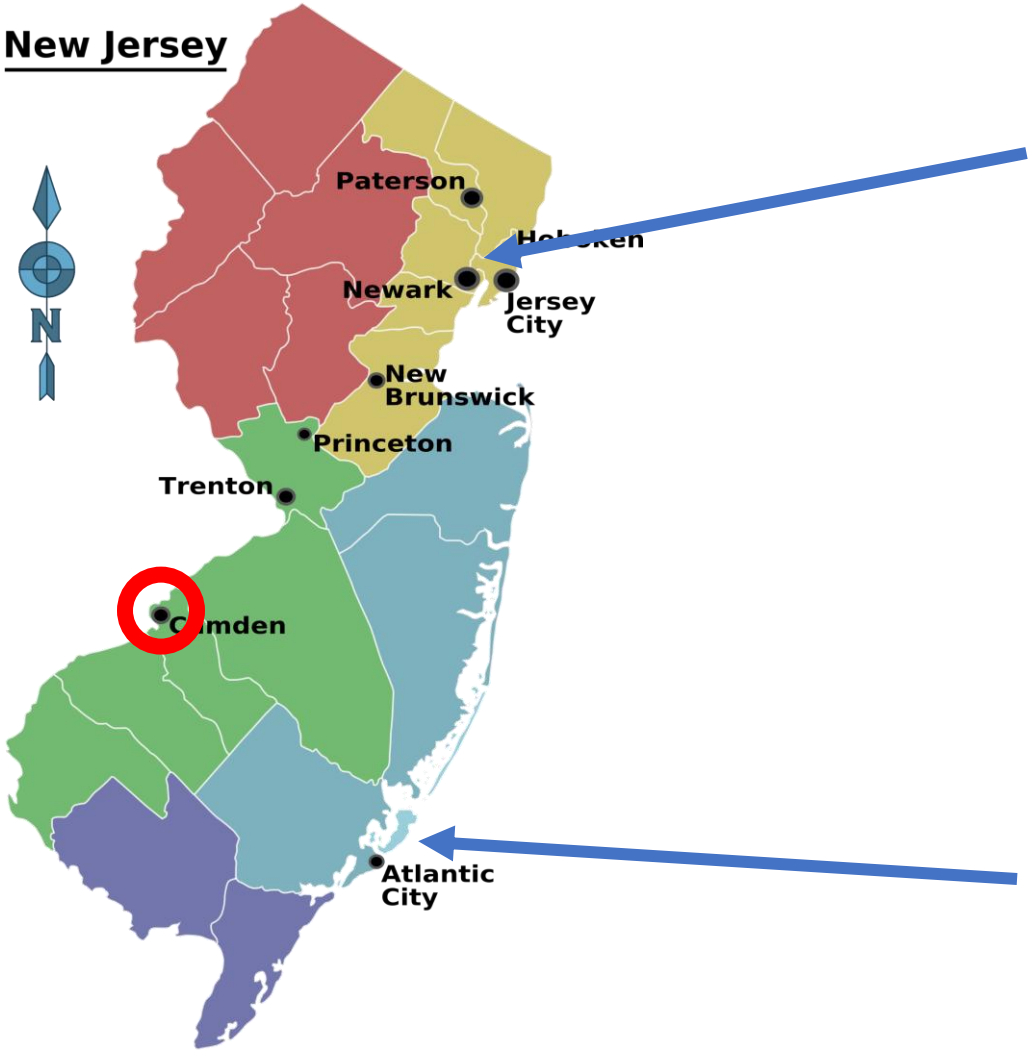
Six emergency medical districts in Missouri will soon distribute an opioid addiction medication as part of a state-funded pilot program.

Cooper University Health Care

Cooper University Health Care


What is Next?

Here in NJ



Cooper University Health Care

CTN Trial – NIH Heal Initiative

EMS initiated Buprenorphine for Opioid Use Disorder

Funded by the NIH HEAL Initiative℠

Emergency Medical Services (EMS) encounters for opioid overdose and withdrawal offer a crucial touchpoint to initiate buprenorphine treatment and to increase treatment participation rates for persons with opioid use disorder (OUD). This project will develop and refine a prehospital EMS clinical field protocol to initiate buprenorphine in persons with OUD presenting with an overdose requiring naloxone rescue or acute opioid withdrawal. Employing a Delphi Consensus process and stakeholder focus groups; followed by a sequence of pragmatic controlled field studies, the study will provide preliminary feasibility, acceptability, and safety data. Finally, a multi-site, systematic, prospective evaluation trial will be conducted to assess the rates of engagement in continuation of medication for OUD post EMS initiation.

CTN Protocol ID: CTN-0154
Status: Development

Principal Investigator(s)

Gail D'Onofrio, M.D., M.S.

Professor of Emergency Medicine
Yale University School of Medicine
Chair, Department of Emergency Medicine
464 Congress Avenue
Suite 260
New Haven, CT 06519
United States
gail.donofrio@yale.edu

Andrew Herring, M.D.

Assistant Clinical Professor, UCSF and Associate Director of Research
Highland Hospital-Alameda Health System
Department of Emergency Medicine
1411 East 31st Street
Oakland, CA 94602
United States
aherring@alamedahealthsystem.org

Gerard Carroll, M.D., FAAEM, EMT-P

EMS Medical Director; Program Director, EMS Fellowship Program; Division Head of EMS/Disaster Med
Professor of Emergency Medicine
Cooper Medical School of Rowan University
One Cooper Plaza
Camden, NJ 08103

Cooper University Health Care

ELSEVIER

The American Journal of Emergency Medicine

Available online 30 April 2026

In Press, Journal Pre-proof ? What's this?

Extended-release buprenorphine administration by emergency medical services paramedics: A case series

Paul Comber [a], Rachel Haroz [a b], Jessica Heil [a], Gerard Carroll [a b]

Cooper University Health Care

Medication for Addiction Treatment and Electronic Referrals (MATTERS) Network

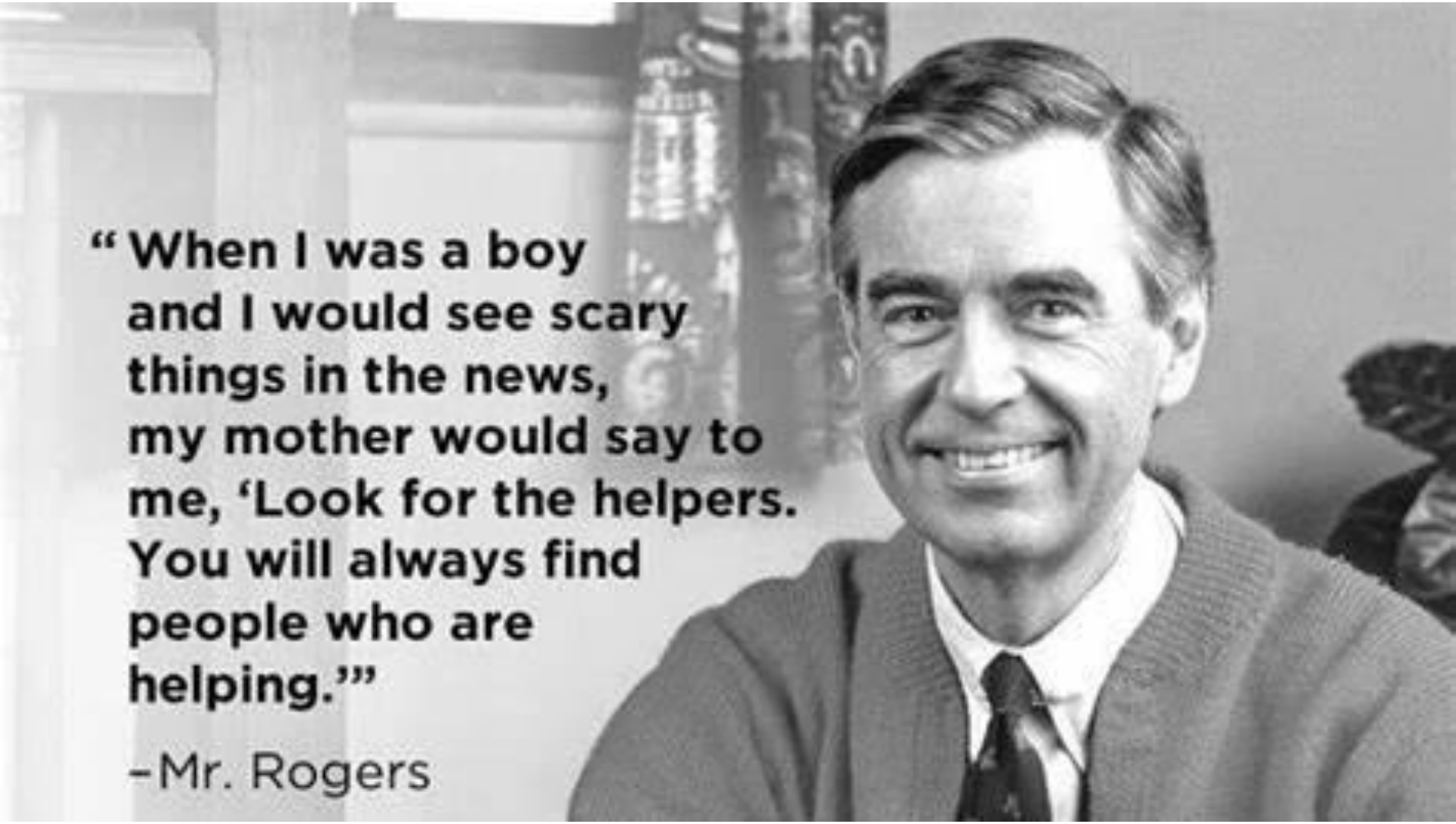
How it works:

1. Encounter an individual(s) with SUD

2. MATTERS facilitates a rapid referral, offering medication vouchers, transportation vouchers, and peer referrals to assist individuals in getting to their first clinic appointment.

3. Individuals are connected to outpatient treatment organization of their choice and seen in as little as 24 hours from their referral

Cooper University Health Care



Cooper University Health Care

Thank You!

Haroz-Rachel@cooperhealth.edu

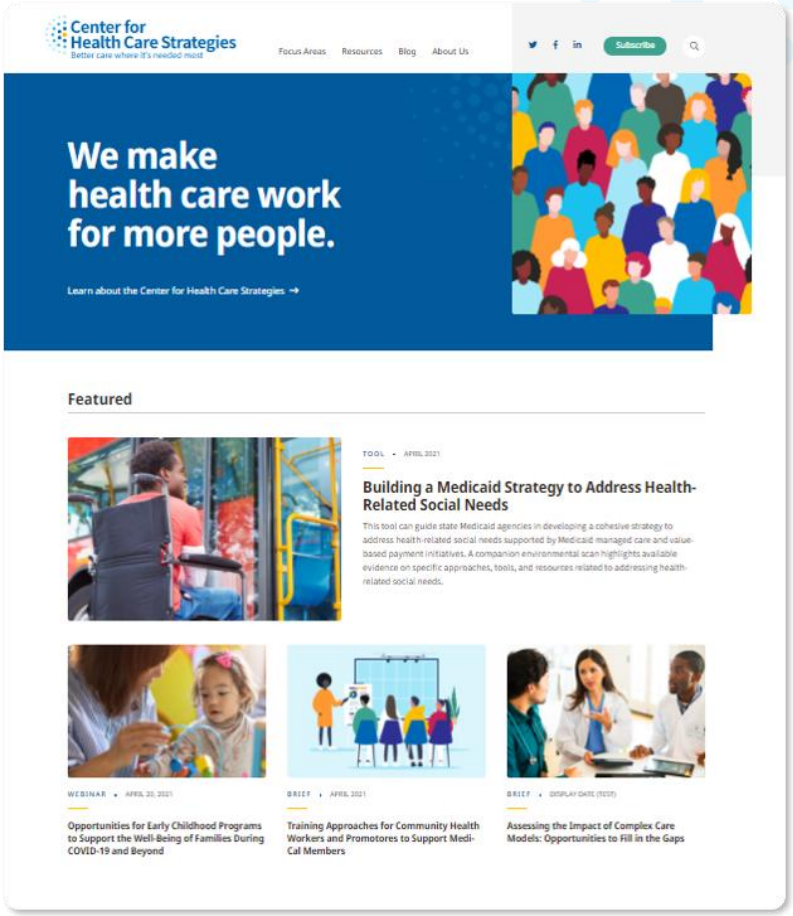
Cooper University Health Care

Panel Discussion and Q&A

Center for Health Care Strategies

Visit CHCS.org to…

- **Download practical resources** to improve health care for people served by Medicaid.
- **Learn about cutting-edge efforts** from peers across the nation to enhance policy, financing, and care delivery.
- **Subscribe to CHCS e-mail updates**, to learn about new resources, webinars, and more.
- **Follow us on LinkedIn or Twitter** @CHCShealth.



Center for Health Care Strategies