Advancing Medicaid Policies that Support People-Centered Care
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Section I: Building a People-Centered Health System – Role of Medicaid
People-Centered Care Begins With People Covered

Trinity Health is committed to working with state Medicaid programs. Our work is guided by the following principles:

1. **Ensure Access to Comprehensive, Affordable Coverage**
   - Maintain/expand Medicaid coverage

2. **Drive Value-Based Care**
   - Accountable care organizations, bundled payments, primary care medical homes

3. **Promote Population Health**
   - Behavioral Health Access

4. **Address Social Determinants of Health**
   - Housing, employment supports, transpiration

5. **Engage Beneficiaries**
   - Health risk assessments
   - Healthy behaviors (e.g. preventative care)
   - Nominal cost sharing
Trinity Health’s Experience Across States Can Inform Policies that Improve Care, Lower Costs

- **$18.3B** in Revenue
- **94 Hospitals** in 22 states

- **1.5M** Attributed Lives
- **$1.1B** Community Benefit Ministry
- **133K** Colleagues

- **66K** Total Births
- **7.8K** Employed Physicians & Clinicians
- **27.5K** Affiliated Physicians

- **34** Participating Hospitals
- **13** PACE Center Locations
- **23** Clinically Integrated Networks
- **109** Continuing Care Locations

*Owned, managed or in JOAs or JVs.*

PACE: Programs of All-Inclusive Care for the Elderly
Medicaid Program Challenges Create Need for High-Value Care and Providers

• Medicaid covers 1 in 5 Americans

• As of Nov. 2018, approx. 72.6 million people were enrolled in Medicaid and CHIP
  - This includes a diverse population (e.g. children, disabled, elderly, parents, adults)

• Medicaid accounts for about 20% of health care spending

• Over 50% of long-term care is financed by Medicaid

• In FY 2014, aged and disabled beneficiaries made up 23% of the Medicaid pop. but contributed to 61% of spending

Over 1 million patients across Trinity Health’s footprint have gained Medicaid coverage since 2014.
States and Providers Are Serving Diverse Populations

ACA Expansion Adults
Low-income Children & Parents
Pregnant Women
Individuals with Disabilities
Elderly

Payment and Care Delivery Approaches
- PCMHs
- ACOs
- Bundled payments
- MLTSS
- HCBS
- PACE
- Medicaid Managed Care
- Post-acute Care

ACA: Affordable Care Act; PCMHs: Patient Centered Medical Homes; ACO: Accountable Care Organizations; MLTSS: Managed Long-Term Services and Supports; HCBS: Home and Community Based Services
Range of Tools Can Support Delivery of High-Value Medicaid Coverage and Care

**Vehicles**
- **State Plan Amendment**
  - (e.g. coverage expansion, VBP for drugs)
- **Section 1115 Waivers**
  - (e.g. VBP, coverage expansion, IMD exclusion)
- **Section 1332 Waivers**
  - (e.g. reinsurance program)

**Approaches**
- **Medicaid Managed Care**
  - (e.g. care coordination, SDoH)
- **Financing Mechanisms**
  - (e.g. provider taxes)
- **Value-Based Payment Models**
  - (e.g. ACOs, Bundled payments)

States have tools to support innovations and public policies that drive better health, better care and lower costs and ensure affordable, high-quality, people-centered care for all.

VPB: Value Based Payment; IMD: Institution for Mental Disease; SDoH: Social Determinants of Health
Key State Trends Inform Identification of Opportunities to Strengthen Medicaid

• **Coverage Changes – Expansions and Work Requirements**
  - 36 states and DC have expanded Medicaid under the ACA, with more considering expansion
  - 10 states have gained CMS approval to implement work requirements; 6 have pending waivers

• **Value-Based Payment – New Models**
  - Most Trinity Health states have implemented models including accountable care organizations, episodes of care and patient centered medical homes

• **Beneficiary Focus - Population Health, Social Determinants of Health, Engagement**
  - Over a third of states provide inpatient treatment for SUD through waivers
  - States, managed care plans and other partners are addressing SDoH
  - A handful of states are testing the impact of healthy behavior or cost-sharing incentives to increase engagement in health and care

State experience and evidence point to promising practices that can inform policy and program development across states.

CMS: Center for Medicare and Medicaid Services; SUD: Substance Use Disorder
Section II: Ensuring Access to Comprehensive, Affordable Coverage
36 States and DC Expanded Medicaid, Interest Growing in Additional States
Coverage and Service Expansions via Waivers
Support Care for More Beneficiaries

• New Jersey Expands Coverage and Access to Opioid Use / Substance Use Disorder Benefits
  - Under Section 1115 waiver, state is expanding access to treatment services—including withdrawal management services in an Institution for Mental Disease (IMD)—to address prescription drug abuse, opioid use disorders

• Indiana Alternative Medicaid Expansion
  - State implemented ACA Medicaid expansion via Section 1115 waiver
  - Includes enhanced benefits to enrollees who contribute monthly to health savings account; lower income individuals (under 100% FPL) who do not make payments are enrolled in more basic plan
  - Over 400,000 individuals have gained Medicaid coverage since expansion
  - Recent renewal includes work requirements and expands access to covered services for individuals in an Institution for Mental Diseases for SUD short-term, residential stays

FPL: Federal Poverty Line
Early Research Shows Positive Impacts of Medicaid Coverage on Health Status, Financial Security, States

• Medicaid coverage increases access to care, associated with better health status
  - Study of OH’s expansion found that since enrolling: 64.3% of newly enrolled reported improved access to care; 47.7% indicated improvement in health; and approx. 33.9% reported fewer ED visits
  - Medicaid expansion in OR associated with decrease in the rate of screening for depression (9.2%) and an increase in utilization of preventive care and screening services

• Medicaid coverage associated with reduced financial burden on individuals
  - Study comparing impacts of Medicaid expansion in KY and AR versus non-expansion in TX found expansion was associated with decline in difficulty paying bills; uninsured people gaining coverage saw $337 reduction in annual medical out-of-pocket spending
  - Catastrophic expenditures decreased by almost 4.5% among Medicaid enrollees after OR’s expansion

• Medicaid expansion states realized economic growth, savings, and reduction in uncompensated care costs
  - CO created 31,074 additional jobs as a result of Medicaid expansion as of 2015-2016
  - In OH, over 50% of employed expansion enrollees reported that Medicaid coverage made it easier to continue working
  - Hospitals in expansion states saw an average annual decline of $2 million in uncompensated care costs between FY2013 and FY 2014
  - Expansion in MT led to a decrease in state spending on separate, health-related programs (e.g. SUD programs) and other savings, which resulted in a surplus of $700,000 the year after expansion
Growing Number of States Targeting Work Requirements

* On March 27, D.C. a District Court Judge ordered AR and KY’s Section 1115 waivers be vacated and remanded back to HHS. Next steps for court case are unclear, but CMS is likely to continue to approve waivers with work requirements.
In Addition to Work Requirements, States Considering Other Policies that Could Lead to Coverage Restrictions

<table>
<thead>
<tr>
<th>Policy</th>
<th>States</th>
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<tbody>
<tr>
<td></td>
<td>Approved</td>
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<tr>
<td>Work Requirement</td>
<td>AR*, AZ, IN, KY*, MI, NH, OH, UT, WI</td>
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<tr>
<td>Enrollment Lock-Out</td>
<td>IN, KY*, MI, MT, NM, WI</td>
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<tr>
<td>Waive Retroactive Eligibility*</td>
<td>AR*, AZ, FL, IA, IN, KY*, NH, NM, UT</td>
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<tr>
<td>Coverage Time Limits***</td>
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**Approved** – Waiver approved by CMS  
**Pending** – Waiver pending CMS approval  
**In Development** – Policy in development at state level  
* On March 27, D.C. a District Court Judge ordered AR and KY’s Section 1115 waivers be vacated and remanded back to HHS.  
** 6 additional states had retroactive coverage waivers that pre-date the ACA. Some states waive retroactive coverage for the expansion populations, others for expansion and traditional Medicaid adults.  
*** Arizona and Kansas’ proposals to impose lifetime limits for some Medicaid enrollees were not approved by CMS.
Data Shows Work Reqs Leading to Coverage Losses, Analysis Projects Increased Uncompensated Care Costs

• Over 18,000 Arkansans lost Medicaid coverage between June and December 2018 due to non-compliance with work and reporting requirements
  - Number of beneficiaries losing coverage could grow in 2019 as requirement is expanded to individuals age 19-29; previously requirement only applied to those age 30-49
  - As of March 2019, 116,229 individuals were subject to work requirements—13,373 of which did not meet the requirement

• Early analysis of Arkansas’ program found beneficiaries were confused by the program or unaware of requirements
  - Initial reporting found that the state, health plans, providers, and advocates had difficulty contacting beneficiaries and setting up online accounts for reporting compliance was a complex and challenging program for beneficiaries
  - In Dec. 2019, state announced it would expand outreach and allow reporting via phone
  - Despite increased outreach (e.g. phone calls, advertising, text messages), almost 6,500 AR enrollees have not met reporting requirements for 2 months in 2019

AHA analysis projects work requirements could increase hospitals’ uncompensated care costs by 13% to 158%, depending on the state, with larger impact on rural hospitals.
Work Requirements Likely to Increase States’ Financial & Administrative Burden, Complexity for Beneficiaries

- **Upfront State Investment in Updating Systems and Building Capacity.** States likely need to modify eligibility systems, establish processes to document compliance, and invest in beneficiary communications and staff training.
  - Projections indicate states will experience increased cost and administrative burden in implementing these new requirements.

- **New Complexities for Beneficiaries.** Understanding work requirements and documenting compliance/exemptions will likely increase complexity for - and burden on - beneficiaries.
  - Arkansas – of those likely to be subject to work requirements, 54% of those working and 78% of those not working face at least one of the following barriers in complying:
    - No internet access, no access to a vehicle, less than a high school education, a serious health limitation, or a household member with a serious health limitation.

Most analyses indicate that net savings from work requirements—and other policies such as lock-outs, premiums, etc.—will result from lower Medicaid enrollment. Testing of these policies should promote beneficiary engagement, while not undermining access to coverage and care or creating additional burden for states.

Montana’s Voluntary Employment Support Programs Show Promising Outcomes Without Impacting Coverage

• **Montana offers voluntary enrollment in employment support programs**
  - State’s Health and Economic Livelihood Partnership Link (HELP-LINK) program connects Medicaid expansion beneficiaries* with training and job services to support stable, higher-paying employment
  - MT also connects Medicaid beneficiaries with federally funded workforce training programs

• **Since 2016, 25,000 Medicaid beneficiaries have received career and training support services; 3,000 have enrolled specifically in HELP-LINK**

• **Early outcomes of HELP-LINK show positive impacts for participants**
  - HELP-LINK increased participation in the labor force for low-income residents by 6 - 9%
  - 71% of HELP-LINK participants had increased wages after completing the program; 81% were employed in 2017

States can improve employment and wage outcomes without requiring work or job training to maintain Medicaid coverage.

*Program primarily targets Medicaid beneficiaries paying premiums.*
States Have Tools Available to Support Employment Without Mandating Work or Community Engagement

- **Case Management Services to Support Employment**: State-provided case management services can link individuals to employment resources.
- **Coordination Across State Agencies to Link Individuals to Employment**: States can improve coordination across service agencies to connect individuals to employment resources.
- **MCO Care Coordination Services Can Support Employment**: Medicaid plans have flexibility to offer non-medical services; could be leveraged to connect individuals to employment.
- **State Plans and Waivers Support Employment Relates Services**: States can already use SPAs or waivers to offer employment-related services to disabled individuals eligible for Medicaid HCBS.

States and managed care plans have tools to help link beneficiaries to employment resources, which can be pursued as an alternative to mandatory requirements. WellCare in KY has announced plans to help members find jobs to complete community service requirements.

MCO: Managed Care Organizations; SPA: Medicaid State Plan Amendment
Section III: Driving Value-Based Care
Trinity Health Committed to Value-Based Payments and Care to Improve Quality, Control Costs

<table>
<thead>
<tr>
<th>Model*</th>
<th>Trinity Health States</th>
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<tbody>
<tr>
<td>Accountable Care Organizations</td>
<td>CT, IA, ID, MA, NJ, NY, OR, PA</td>
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<tr>
<td>Patient-Centered Medical Homes</td>
<td>AL, CT, DE, FL, ID, IL, IA, MA, MI, NE, NJ, NY, NC, OH, OR, PA</td>
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<td>Episodes of Care</td>
<td>OH</td>
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<tr>
<td>Delivery System Reform Incentive Payment Program</td>
<td>CA, MA, NJ, NY</td>
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<tr>
<td>Program of All-Inclusive Care for the Elderly (PACE)</td>
<td>AL, DE, IN, MA, MI, NJ, NY, NC, PA</td>
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<tr>
<td>Financial Alignment Demonstration</td>
<td>CA, IL, MA, MI, NY, OH</td>
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<tr>
<td>Outcomes-Based Contracting for Select Drugs</td>
<td>MI</td>
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</tbody>
</table>

Trinity Health participates in XX value-based arrangements in Medicaid and supports cross-payer, provider driven models to control costs rather than limiting coverage.

*Table reflects models in place in FY 2017 or planned for implementation in FY 2018, or actively being pursued by state. May include cross-payer or SIM models
Massachusetts and Oregon Testing ACO-Like Models Within the Medicaid Programs

**Oregon: Statewide Accountable Care Organizations**
- **Overview:** Using a state-based initiative and a Section 1115 waiver, in 2012 OR launched CCOs — ACO-like models—that provide integrated physical, behavioral and oral health
  - **Goals:** Provide care integration, improve prevention and chronic disease management, reduce spending growth
  - **Payment and Delivery:** CCOs are an ACO-like model and are required to implement at least one alternative payment model (i.e. pay-for-performance, shared savings/risk, or EOC based payments)
- **Initial Results:** As of 2017, 92% of CCO enrollees in PCMHs; statewide, since 2016, there has been a 1.1% decrease in ED utilization and a 21.3% increase in depression screening and follow-up

**Massachusetts:** Statewide Accountable Care Organizations
- **Overview:** Under Section 1115 waiver, MA implementing ACOs statewide; launched 3/2018
  - **Goals:** Improve care integration (e.g. physical, behavioral, LTSS); support safety net redesign; expand SUD programs
  - **Payment and Delivery:** Three ACO model options with different payment arrangements
- **Scope:** 17 ACOs providing services to approx. 850,000 Medicaid enrollees
Ohio and New York System Transformation Efforts Showing Different Approaches to VBP

- **Ohio: Episode-Based Payments**
  - **Overview:** Via State Innovation Model, OH is launching 50 episode based payments statewide
    - **Goals:** Episodes target high-cost conditions/diagnoses
    - **Payment and Delivery:** Payments incentivize provider accountability (shared saving/risk)
  - **Scope:** As of Aug. 2018, over 1 million patients covered in 43 episodes; over 13,000 Medicaid providers lead on at least 1 episode
  - **Initial Results:** Acute asthma treatment and COPD treatment costs decreased by 21% and 18%, respectively, over 2 years

- **New York: Delivery System Reform Incentive Payment Program**
  - **Overview:** Under a section 1115 waiver, NY is implementing integrated delivery networks to improve regional and statewide population health
    - **Goals:** Safety net transformation, improving care and reducing avoidable inpatient and emergency care utilization, leveraging managed care
    - **Payment and Delivery:** PCMH-like model; moving 80% of MCO provider payments into VBP with upside and downside risk by end of waiver
  - **Initial Results:** Providers reduced potentially preventable readmissions by 14.9%, and reduced potentially preventable ER visits by 11.8% by year 2 of program

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COPD: Chronic Obstructive Pulmonary Disease
Section IV: Promoting Population Health and Addressing Social Determinants of Health
Over 20 States Have Waivers That Expand Access to Behavioral Health Care

<table>
<thead>
<tr>
<th>Waiver Component</th>
<th>States with Approved Waivers</th>
<th>States with Pending Waivers</th>
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<td>Payment for SUD Treatment in IMD</td>
<td>AK, CA, IL, IN, KS, KY, LA, MA, MD, NC, NH, NJ, NM, PA, RI, UT, VA, VT, WA, WI, WV</td>
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<tr>
<td>Eligibility Expansion</td>
<td>AZ, MT, NJ, UT, VA, VT</td>
<td>NJ, NY</td>
</tr>
<tr>
<td>Delivery System Reform</td>
<td>AZ, CA, MA, NH</td>
<td>MI, MN</td>
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Source: Kaiser Family Foundation, "Waivers with Behavioral Health Provisions: Approved and Pending as of January 23, 2019"

Access to behavioral health is an important component of improving population health. Trinity Health supports greater access to SUD/MH services, including waivers to the IMD exclusion.
 Efforts to Address SDoH Connect Providers and Community Based Organizations

- States, managed care plans, and health systems are testing approaches to addressing SDoH via SPAs, waivers or MCO contracts
  - **New York**: Providers and MCOs in VBP agreements with upside and downside risk, must include at least one social determinant of health intervention in their contract
  - **Massachusetts**: MCOs must evaluate new enrollees within 90 days and assess SDoH needs and linkages (e.g. housing search)
  - **Michigan**: MCOs must refer enrollees to resources to reduce socioeconomic challenges (e.g. healthy food)
  - **Oregon**: MCOs are encouraged to provide non-medical social services

Trinity Health believes SDoH programs that help coordinate care and link to social services for Medicaid beneficiaries (e.g. housing, employment) are critical to improving health outcomes.
Ensuring access to and coverage of behavioral health services can improve population health and reduce costs
- Research has shown a positive impact of integrating behavioral health and primary care for adults with anxiety and depression
- According to National Institute on Drug Abuse, treatment for substance use disorder could have a 12 to 1 return on investment

Addressing social determinants of health supports whole-person care, improved health outcomes and reduced spending
- A growing body of research has shown that addressing social determinants of health may play a large role in improving health while reducing costs
- Early results from New York’s Supportive Housing Initiative—which provides rental subsidies/other supports to vulnerable, high-cost Medicaid members—found that participants experienced a 40% reduction in inpatient days, 26% reduction in ED visits, and 15% reduction in overall Medicaid health expenditures
- An evaluation of Oregon’s CCO model found that CCOs viewed investment in SDoH as important for improving health and reducing health care costs
Section IV: Engaging Beneficiaries
Healthy Behavior Incentives Should Be Structured to Promote Engagement, While Maintaining Coverage

• **Michigan’s Healthy Behaviors Incentive Program**
  - Beneficiaries with income up to 100% can reduce their cost sharing requirements by completing healthy behaviors
  - Beneficiaries with income 100-133% FPL, who have been enrolled for 48 months cumulatively, are required to complete an Health Risk Assessment or healthy behavior (e.g. preventive dental services, vaccinations, or screening) to maintain coverage
    • Previously, beneficiaries had the option to *voluntarily* complete an HRA with a primary care provider when enrolling in managed care
    • Under the previous waiver 374,331 HRA were completed —a 95% completion rate—as of March 2018

• 6 additional states (AZ, IA, IN, KY, MI, NM, and WI) have approved section 1115 waivers with healthy behavior incentive programs—some require participation in healthy behavior to maintain coverage
More States Testing Cost-Sharing and Tying to Lock-Out of Coverage

- **Healthy Indiana Plan (HIP) 2.0**
  - Enrollees who contribute to a health savings account (HSA) can access enhanced benefits (e.g. dental, vision)
  - Enrollees with income up to 100% FPL that do not make payments to an HSA are enrolled in basic plan and pay cost sharing;
    - However enrollees with income above 100% FPL who fail to pay premiums may be disenrolled and locked out of coverage
  - All enrollees eligible to have HSA contribution reduced if they complete preventive services

- **9 states require beneficiaries to pay premiums or monthly contributions under their 1115 waivers**—more linking failure to pay with disenrollment
  - Beneficiaries in 6 of these states—**IN, KY, MI, MT, NM, WI**—may lose and be locked out of coverage for a period of time for failure to pay premiums
  - Beneficiaries in 2 states—**AZ, IA**—may lose coverage for failure to pay premiums but will not be locked out of coverage
Beneficiary Engagement Programs Should Aim to Improve Health Status, Not Impede Access

- Research on impact of healthy behaviors on health is mixed and limited, indicating need for effective beneficiary outreach and education, and more evaluation
  - A review of healthy behavior incentive programs in FL, MI, IN and IA found that in the first two years, these programs had little or no positive impact on targeted healthy behaviors
  - An analysis of the first four years of IA's program found that only about 25% of those subject to premiums had completed healthy behaviors to waive premiums; evaluation cited lack of beneficiary awareness of program as a potential barrier
  - An review of studies of healthy behavior programs found that beneficiary outreach and education were essential to effectiveness

- Cost-sharing in Medicaid must be implemented cautiously
  - Evidence shows that shifting too many costs/imposing cost-sharing on the lowest-income beneficiaries can lead to reduced enrollment, barriers to care, and worse outcomes
  - An analysis or OR's 2003 expansion found that cost-sharing was associated with decreased enrollment—44% of enrollees disenrolled within 6 months of cost-sharing
    - Those who left the program due to cost-sharing reported poorer access to needed care, less use of primary care, and increased use of ERs, compared to those who left program for other reasons

Trinity Health believes SDoH programs that help coordinate care and link to social services for Medicaid beneficiaries (e.g. housing, employment) are critical to improving health outcomes.
Section IV: Next Steps
Trinity Health Can Serve as Resource and Partner to Strengthen Medicaid

1. Medicaid Innovation Resource Center
2. Policy Cards
3. E-Advocacy
4. Social Media
Medicaid Innovation Resource Center

• Trinity Health’s Medicaid Innovation Resource Center includes tools and resources to help policymakers and stakeholders ensure that programs maintain access to coverage and care—especially for the most vulnerable—and incentivize accountability

• The Resource Center supports assessing the potential impacts of Medicaid trends and innovations on states and beneficiaries, and identifies policies that support a people-centered system of care
Education is Empowering
Learn more at: http://advocacy.trinity-health.org/home
Every Voice Matters: Take Action

It’s Time to Advance Solutions that Protect Coverage

Urge the U.S. Senate to advance Affordable Care Act replacement legislation that provides:

- Secure and affordable coverage to Americans.
- Key insurance protections such that insurers can’t charge excessive amounts for pre-existing conditions or for being older Americans.
- Sufficient financial resources in the Medicaid program and individual Marketplace to ensure high-value coverage and care for Americans.

Go to the link below and Take Action today!
bit.ly/TakeActionProtectCoverage

Go to:
Bit.ly/TakeActionProtectCoverage
Now you can access the latest Trinity Health Advocacy information, track important issues and directly Take Action by joining us in Facebook or Twitter.

Stop by and like or follow and be sure your Ministry is also following along: Go to:

Facebook: [https://www.facebook.com/TrinityHealthAdvocacy/](https://www.facebook.com/TrinityHealthAdvocacy/)

Twitter: [https://twitter.com/THAdvocacy](https://twitter.com/THAdvocacy)
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