STATE OF ARIZONA: SIM INITIATIVE PROJECT NARRATIVE

Introduction: The Arizona State Innovation Model (SIM) initiative is designed around three overarching strategies: 1) Facilitating Integration and Decreasing System Fragmentation; 2) Improving Care Coordination; 3) Driving Payment Reform. These efforts will accelerate the delivery system's evolution towards a value-based integrated model that focuses on whole person health in all settings and regardless of coverage source. Each of the components of the Arizona strategy will 1) Improve population health; 2) Transform the health care delivery system; and/or 3) Decrease per capita health care spending. Due to the success of Governor Brewer's efforts to restore and expand Medicaid, Arizona is well positioned to focus on driving continued innovation in the health care delivery system through targeted efforts to reduce fragmentation, integrate the delivery system and align incentives to improve quality and lower costs. These efforts are critical to ensuring sustainability of health care delivery within Arizona and improved health outcomes for Arizona citizens.

A.i.(1) Plan for Improving Population Health. Arizona will develop and implement a plan to improve the health and wellbeing of the state's population. The plan will assess the overall health of the state and identify measureable goals, objectives and evidence-based interventions that will 1) improve the health of the entire state population; 2) improve the quality of health care across Arizona; and 3) reduce health care costs. The Arizona Department of Health Services (ADHS) undertook a State Health Assessment in partnership with each of the county health departments. This process included engaging approximately 10,000 people statewide in identifying local community health priorities, collecting and analyzing data and information from a variety of sources, and assessing and prioritizing health issues and needs within communities (including system capacity) to determine the best allocation of resources to improve the health and wellness of Arizonans.

The assessment identified 15 leading health issues for Arizona including access to behavioral health services, substance abuse issues, chronic disease management and suicide, to name a few.[1] Additionally, numerous other identified issues are significantly impacted by behavioral health needs, such as obesity, tobacco use, diabetes and unintentional injury. It is clear that significant progress on these identified issues will depend on appropriate access to integrated and well-coordinated care that includes addressing behavioral health needs. In fact, three overarching priorities emerged from the assessment: 1) Improving access and coordination of care; 2) Advocating an environmental shift for individuals and families to live healthier lifestyles (including addressing underlying social determinants); and 3) Achieving healthier communities that are empowered to impact systems and policy-level change. Arizona is now using the results of the Assessment to develop the State Health Improvement Plan (SHIP), a state-wide plan to improve population health, which provides a 5-year strategy for partners to work together toward a healthier Arizona. ADHS is assembling a Steering Committee and workgroups, including representatives from the legislature, the Arizona Health Care Cost Containment System (AHCCCS), business community, academia, healthcare, small business, public health, human services, non-profit and faith-based organizations to formulate the draft plan by December 31, 2014.[2] The State Health Assessment (see footnote 1) documents the numerous opportunities for CDC collaboration on these efforts.

Over the next several months, the Steering Committee will identify the leading health issues to address in the plan, as well as incorporate and align with the SIM initiatives where possible. Priorities will be identified through stakeholder engagement and review, which will consider the status of each leading health issue, the ability to impact the issue based on community support, the availability of evidence-based and best practices, and the State's capacity.

---

[1] http://azdhs.gov/diro/excellence/documents/az-state-health-assessment.pdf

[2] See timeline on p. 22: http://azdhs.gov/diro/excellence/documents/state-health-assessment/launching-the-arizona-state-health-improvement-plan.pdf

For each priority issue, the partners and stakeholders will define specific, measurable, realistic and achievable annual and long-term (5 year) performance objectives that correlate with major initiatives in order to demonstrate progress toward achieving the targeted results. The plan will then be implemented and will include descriptions of ongoing specific activities with a designated lead responsible party, monitoring of progress and a detailed communication process to promote the implementation of the plan. The goal is to ensure ongoing and sustainable communication regarding the status of priority issues and progress made on implementation actions.

A.i.(2) Health Care Delivery System Transformation Plan. Arizona will use existing stakeholder feedback and research to develop a planned, strategic approach to undertake transformation of the health care delivery system using three overarching strategies: 1) Facilitating Integration and Decreasing System Fragmentation; 2) Improving Care Coordination; 3) Driving payment reform.

<u>Facilitating Integration and Decreasing System Fragmentation</u>

Arizona's publicly funded health care system has historically been siloed, primarily due to a fragmented system of care prior to the state's participation in Medicaid, which began in 1982. For most Medicaid populations, services are administered by different entities: acute care plans for physical health, regional behavioral health authorities (RBHAs) for behavioral health. Historically, for children with chronic conditions, a third program known as Children's Rehabilitative Services (CRS) provided services for those conditions separate from other acute and behavioral health services. Over the past year, Arizona has taken significant steps towards integrating care for its Medicaid populations, making one contractor responsible for all services for specialized populations including, separately, CRS children and individuals with Serious Mental Illness (SMI). These transitions offered a new approach to integrated care, enhancing care- and case-management services. For other populations, Arizona has also required data sharing among its acute plans and RBHAs to eliminate blind spots in data that each plan faced and allow the plans to see data regarding utilization across the entire continuum of care. Finally, Arizona has been a national

leader in aligning care for dual eligibles. AHCCCS requires its health plans to serve as Medicare D-SNPs and promotes enrollment of dual eligible members into the same health plan for both Medicare and Medicaid; over 50,000 dual eligibles (almost 40% of all duals) are aligned in the same health plan for their Medicare and Medicaid benefits.[3] However, each of these efforts exposed gaps in the system and identified additional opportunities for facilitating integration.

Additionally, AHCCCS has conducted significant stakeholder outreach to both its health plans (many of whom have commercial products and offer qualified health plans (QHPs) on the Federally Facilitated Marketplace (FFM)), as well as every Accountable Care Organization (ACO) or ACO look-alike in the state.[4] This outreach identified many significant reform efforts occurring across Arizona, including the development of ACOs, patient-centered medical homes, efforts to address super-utilizers, and payment modernization toward value-based payments (including exploring bundled payments). However, it is clear from stakeholder discussions that there are significant gaps in these efforts regarding individuals with behavioral health needs and the fragmentation of the delivery system is a clear barrier to integrating care and realizing the full potential of delivery system reform. It is estimated that a significant percentage of the AHCCCS super-utilizer population (defined as the overlap between the top 20% of members by each of the following: ERG risk score, count of ED visits, and non-maternity inpatient days) has behavioral health needs,[5] so efforts that only focus on reducing emergency department use or readmissions without addressing behavioral health will have limited success. Integration is more than simply facilitating alignment across the continuum of physical health care services (hospitals, outpatient, physicians, and other providers). Behavioral health must be part of the conversation to truly make a difference in improving population health and decreasing per capita spending.

[3] An analysis by Avalere Health of an AHCCCS contractor revealed that, as compared to Medicare FFS members, duals enrolled in the D-SNP exhibited 43% fewer days in the hospital, 19% lower average length of stay, 21% lower readmission rate, 9% fewer ED visits and higher preventive benefits accessed.

[4] Additional detail on the scope of this outreach is available upon request.

[5] An AHCCCS health plan super-utilizer analysis of slightly different scope showed 80% of super-utilizers had behavioral health needs.

Improving Care Coordination

Integration efforts will allow for an increased emphasis on care coordination for the populations that need it most. Arizona intends to improve member outcomes and lower costs by enabling data exchange through the use of health information technology, ensuring access to member data at both the administrative and provider level, facilitating a team-based approach to care, and holding providers accountable for quality and efficiency. The Arizona strategy will identify critical populations to target for care coordination activities. These include individuals with SMI, individuals who are not identified as having SMI but who have substantial medical and behavioral health needs (super-utilizers), dual eligibles, individuals transitioning from the justice system, members moving between QHPs and Medicaid health plans, and the Medicaid American Indian population.

Driving Payment Reform

Payment Modernization is a cornerstone of Arizona's efforts to bend the upward trajectory of health care costs.[6] This health care delivery and payment system transformation will be achieved through collaboration with stakeholders. There are numerous payment reform efforts underway in Arizona. Commercial carriers and health plans are shifting away from traditional FFS models and towards value-based purchasing, and numerous ACOs have emerged in the state, in varying degrees of maturity. These integrated delivery systems are moving to take on risk in exchange for sharing savings achieved through the delivery of high-quality coordinated care. However, as discussed above, through extensive stakeholder outreach, Arizona has determined that there are gaps in many organizations' ability to address and properly coordinate behavioral health, access data and take on risk and new payment methodologies. A baseline survey of Medicaid health plans indicated that only 8% of payments were in a non-FFS arrangement.

[6] http://www.azahcccs.gov/reporting/Downloads/PaymentModernizationPlan_SFY2014.pdf

To implement these three strategies, Arizona will continue its stakeholder-driven work with insurers, Medicare, providers (including integrated delivery systems such as ACOs), provider organizations, consumer groups, tribal representatives, and local governments (including justice system partners). Arizona will engage organizations in collaborative efforts towards delivery system reform and payment modernization. By leveraging the existing reform efforts underway in Arizona, the state will accelerate transformation for the preponderance of care in the state, and work together with stakeholders toward the eleven Transformation Goals identified by CMS in the FOA. Each of the payment and/or service delivery models identified below demonstrates our work towards the Transformation Goals.

A.i.(3) Payment and/or Service Delivery Model. To facilitate the health care delivery system transformation plan outlined above, Arizona will adopt and enhance the following service delivery/payment models.[7] All the models will impact the State's Medicaid program; as of July 1, 2014, 1,552,186 individuals were enrolled in Arizona's Medicaid program, representing an estimated 23.3% of the state's population.[8] In addition, many initiatives also impact Medicare beneficiaries and the commercially insured.

Facilitating Integration and Decreasing System Fragmentation

Integration Efforts (delivery system goals a, c, d, e, f, i, j, k) – Arizona will expand its integration efforts for individuals with SMI statewide. In addition, the State will integrate care for dual eligibles through the AHCCCS acute plans, which will be responsible for both physical health and behavioral health care for duals. AHCCCS requires its health plans to be D-SNPs, so the plans will also have the opportunity to be responsible for Medicare benefits for dual eligible members. Due to Arizona's success in aligning dual eligible members, this will also have a positive impact on the Medicare population. The SIM initiative will target funding for HIT/HIE grants for behavioral health providers who are not eligible for Medicare/Medicaid incentive payments to share information with other providers in the delivery system to the extent allowed by

[7] The models may fit under more than one of the three overarching strategies.
[8] Based on official state 2014 population forecast: http://www.workforce.az.gov/population-projections.aspx

federal law. The ability to share, access and analyze data at the provider level is critical. Existing programs in place to facilitate such sharing do not address infrastructure needs of behavioral health providers. Additionally, the lack of capacity to share data with behavioral health providers has contributed to most ACOs in Arizona having limited engagement with behavioral health providers. Support for major providers to partner with behavioral health providers will improve health outcomes for individuals with behavioral health needs, increase provider accountability for costs and outcomes, enhance ability of ACOs and similar providers to manage population health, and expand value-based purchasing.

SIM strategies: 1) Work with public health partners to develop and integrate the SHIP into SIM process to accelerate transformation, including facilitating partnerships between public health agencies and the delivery system to implement SHIP strategies. *TARGET: Statewide population health strategies; targets TBD based on SHIP strategies*; 2) Accelerate use of HIT/HIE in the delivery system, specifically through grant funding for behavioral health providers not eligible for Medicare/Medicaid HIT incentives. *TARGET: 20-30 provider organizations representing thousands of providers/20,000+ patients*;[9] 3) Grants to major providers such as ACOs and other large systems that partner with community-based behavioral health providers to improve the capability to integrate care. *TARGET: 5 rural hospitals, 4-6 urban hospital systems (~24-40 hospitals), ~16-24 community behavioral health provider organizations/200,000 Medicaid enrollees, tens of thousands of Medicare and commercial members*.

Workforce (delivery system goals a, c, e, h, i, j, k) – Arizona State University has programs specifically focused on integration and applied behavioral health. For example, the College of Nursing and Health Innovation has cohorts of students being trained at the Mayo Clinic and Veterans' Administration. There are also Doctorate of Nursing Practice students training in a variety of health care venues. The Center for Applied Behavioral Health Policy uses evidence-based research to support organizational effectiveness in human services programs including: a) research and development of evidence-based treatment

[9] For all SIM strategies involving competitive grants, actual targets will be dependent upon bids from potential partners

interventions; b) external monitoring and evaluation of programs; c) workforce enhancement and training; and d) organizational change process. The College of Health Solutions (CHS) has an applied doctorate program in integrated behavioral health which focuses on graduating licensed clinicians trained to provide evidence-based integrated care. The School for the Science of Health Care Delivery within CHS is focused on the development of patient-centered cost effective care systems. CHS could be leveraged to develop an integrated behavioral health workforce and training for a variety of providers, including community-based behavioral health providers. These programs are well-positioned to support the proposed SIM workforce efforts to analyze and assess the effectiveness of various models and expand provider training and education opportunities. Community Colleges that train significant numbers of clinicians and extender positions can also support these efforts.

SIM strategies: 4) Conduct research and evaluation of provider-level practices and payer activities to determine best practices for integrated care that can be replicated statewide. 5) Develop additional programs to train clinicians and health systems on effective interventions in integrated, whole person care. 6) Develop training programs for peers and other behavioral health providers to include population health opportunities like obesity, diabetes care and smoking cessation. *TARGETS: Hundreds of providers/Thousands of patients.*

Improving Care Coordination

Super-utilizers (delivery system goals b, c, d, e, f, k) – The super-utilizer initiative will improve care coordination around members whose health outcomes are particularly impacted by a fragmented delivery system. Better care coordination for super-utilizers will improve health outcomes, reduce utilization, and lower costs. AHCCCS and ADHS require Medicaid acute plans and RBHAs to use the comprehensive data they have on their common members (as described above) to identify and coordinate care for super-utilizers. The short-term goals of this initiative are to reduce ED visits by 10% and develop a care

management protocol. The long-term goals are to improve provider and member engagement and develop a prevention model. These efforts also include the American Indian Health Program (AIHP), which has over 100,000 members. The City of Mesa has also piloted an innovative model using physician extenders and EMS services to provide on-site treatment and referral to avoid ED utilization, as well as care coordination activities such as post-discharge follow-up. SIM funding will be used to explore expanding EMS partnerships and accelerate care coordination for individuals with behavioral health needs and other critical populations, including children. In addition to the strategies listed below, these efforts will also benefit from integration efforts, HIT efforts and QHP care coordination.

SIM Strategies: 7) Explore partnerships with plans and EMS providers for low-acuity services and care coordination activities. *TARGET: 2 EMS Providers; Thousands of patients;* 8) Fund projects with goal of developing appropriate infrastructure and capacity to accelerate care coordination for high need adults without serious mental illness (the "general mental health/substance abuse" population) and other populations. *TARGET: Health plans and RBHAs (benefiting thousands of contracted providers)/65,000 Medicaid super-utilizers; tens of thousands patients from other payers.*

Qualified Health Plan Coordination (delivery system goals d, f, k) – Between 3 and 5 percent of AHCCCS members churn on and off the program each month. Prior to the FFM, those members often did not have access to affordable alternatives for coverage; however, today many members who lose Medicaid eligibility will access coverage through QHPs. Arizona previously engaged commercial insurers who planned to offer products on the marketplace and had developed a consensus approach on care coordination to address churn between Medicaid and QHPs. When Arizona did not pursue a state-based exchange, these efforts were put on hold. Arizona will resume these efforts with commercial QHPs to provide data sharing and establish care coordination protocols for members moving between Medicaid and the FFM. Sharing data on historical utilization and medical conditions will result in both improved health outcomes (by reducing

gaps in care due to the transition) and lower costs. This effort will also connect QHPs to state-only resources (e.g., housing and employment support) available for members with serious mental illness and substance use disorders that are critical for recovery and prevent the use of more expensive health care services, but would not otherwise be provided by the QHP.

SIM strategies: 9) Develop formal electronic exchange of information (including IT infrastructure) necessary to improve care coordination for individuals that transition to/from QHPs and Medicaid. 10) Develop formal care coordination infrastructure between QHPs and RBHAs for members with behavioral health needs, including connecting QHP members with serious mental illness to state-only resources. *TARGETS: Medicaid plans and QHPs (benefiting thousands of contracted providers)/Tens of thousands of individuals moving between Medicaid and QHPs.*

American Indian Care Coordination Efforts (delivery system goals c, d, e, f, g, I, j, k) – The delivery system for American Indians is among the most fragmented. Members are eligible for services through IHS and 638 facilities. In addition, more than 40% of Arizona's 350,000 American Indian (AI) population is enrolled in Medicaid, which provides payment for services delivered both inside and outside the IHS/638 system. AI Medicaid members have the choice of receiving care through the AHCCCS acute plans (managed care organizations) or through the AIHP, a FFS program administered by AHCCCS. AIHP recently began providing care coordination and data sharing functions to help improve care for members. The focus of the initiative has been to build relationships necessary to facilitate a person-centered robust care coordination mode and share data among the many providers that serve the AI population. Tribal members' health disparities are exacerbated by a fragmented delivery system that is difficult to navigate and provides little in the way of care coordination. Providers often have limited to no access to data on other settings in which the members they are seeing also seek care, making coordinated care extremely challenging. AHCCCS can share its data on this population to close this gap through support from SIM funding. Funding will also

be used to develop regional care coordination models to assist providers with infrastructure and resources necessary to coordinate care for AIHP members. This will benefit non-Medicaid American Indians served by the same providers as well. Finally, AHCCCS will develop materials to help AI members navigate this uniquely fragmented system.

SIM strategies: 11) Enhance and expand AHCCCS AIHP care coordination infrastructure and data sharing capacity. *Target: 15-25 IHS/638 and non-tribal facilities representing thousands of providers/150,000 American Indian Medicaid members.* 12) Enhance and develop 4 regionally-based care coordination models for the AIHP, including collaboration with IHS, 638 facilities and non-tribal providers, with focus on creating provider infrastructure and reducing fragmentation in delivery system. *Target: 15-25 IHS/638 and non-tribal facilities representing thousands of providers/150,000 American Indian Medicaid members.* 13) Create member health literacy material for American Indians to explain the role of Medicaid, the delivery system, and what members can do to access care appropriately, to be used in conjunction with care coordination models. *Target: 150,000 American Indian Medicaid members.*

Justice System Transitions (delivery system goals c, d, e, f, k) – The restoration and expansion of Medicaid coverage provided significant opportunity to address ongoing challenges of individuals transitioning out of the justice system (e.g., county jails, Arizona Department of Corrections (ADOC)). Mental illness in jails and prisons is, nationally, a well-documented challenge. In State Fiscal Year 2013, ADOC treated a total of: 10,008 inmates for ongoing mental health and substance abuse services, 2,498 for substance abuse treatment, 210 with HIV, and 6,094 with Hepatitis C. ADOC reported that in FY13, of the estimated $140 to $150 million spent on health expenses each year, 60%-70% was for mental health and substance abuse treatment. Counties collectively spend an estimated $90 million on health services in jails annually, between 60% and 70% of this spending is for mental health and substance abuse services. These members also use significant services after their release. In 2011, AHCCCS spent over $187 million on

members who were incarcerated during that year at some point before or after Medicaid enrollment, and the highest costs included spending for conditions related to mental health and substance abuse.[10] Many individuals exit the justice system with acute medical and behavioral health needs. Without a direct connection to health care providers, these individuals experience disruptions in care, which lead to poorer health outcomes, higher costs, and the potential for increased recidivism. AHCCCS already has data feeds in place with six of Arizona's largest counties and ADOC that identify members who are incarcerated and is working to include other counties. In addition, AHCCCS will develop special expedited processes with ADOC, Maricopa County, Pima County and Yavapai County to facilitate Medicaid enrollment upon release for super-utilizers and those with high-risk physical and behavioral health conditions. Arizona will build upon these efforts to establish care coordination requirements for acute plans and RBHAs to connect with the justice system to share information and link members to services upon discharge. These efforts are critically dependent on the ability to share data among entities, so the SIM initiative will target funding toward IT infrastructure and interfaces to allow for data exchange critical to care coordination.

SIM strategies: 14) Develop HIT infrastructure and health plan interfaces to coordinate coverage and care with the ADOC, jails and probation systems. *TARGET: Correctional health (including jails) and Medicaid health plans, benefiting 400+ correctional providers, thousands of jail and community providers/Portion of 106,000 individuals transitioning from incarceration to Medicaid.*

Driving Payment Reform

*Enhancing capacity for payment reform among integrated and behavioral health providers (*delivery system goals a, b, c, f, k) – Arizona's historical success as a Medicaid program has relied extensively on private sector innovation with appropriate oversight by AHCCCS. As such, Arizona typically does not dictate specific models but rather creates outcome expectations that payers and providers must meet. In 2013, AHCCCS required its acute contractors to have 5% of payments in a shared savings arrangement, and

[10] 2011 data is the most comparable to what the state might experience with the Medicaid restoration and expansion.

used 1% of expected capitation payments as an incentive for contractor relative performance on selected quality measures. These requirements will be extended to other lines of business, including RBHAs, and the acute requirements will increase to 10% of payments in a shared savings arrangement tied to quality, with a continuation of the quality incentive payments. Arizona will also explore extending these requirements to D-SNPs to extend the benefits of these arrangements to Medicare enrollees. However, as discussed above, through stakeholder engagement, Arizona found that there are particular challenges regarding value-based contracting with behavioral health providers. In part due to the historical contracting structure for behavioral health providers, and in part due to service delivery fragmentation, behavioral health providers have had very limited participation in many of the value-based purchasing arrangements occurring throughout Arizona. The Arizona strategy facilitates enhanced access to data and provides funding to accelerate organizations' ability to enter into modernized payment structures, which will extend to non-Medicaid/Medicare lines of business as experience grows.

SIM Strategies include: 15) AHCCCS, Commercial and Medicare value-based payment modernization efforts: Funding for providers that partner with plans and RBHAs on value-based contracting tied to care coordination, reduced ED utilization and increased used of PCPs. *Target: 10-15 hospital systems, representing thousands of providers/Hundreds of thousands of patients served by multiple payers*

A.i.(4) Leveraging Regulatory Authority. Arizona is using multiple regulatory authorities to facilitate delivery system reform. Overall, Arizona has few regulatory restrictions impeding reform efforts. It has a very competitive commercial insurance market as well as limited certificate of need (CON) requirements, extending CONs only to ambulance services to ensure service delivery in rural areas. Further, it has relatively broad scope of practice laws for practitioners (e.g., nurse practitioners practice independently). As Arizona evaluated opportunities for integration and delivery system reform, a major barrier identified by stakeholders was the State's health care institution licensure regulations. Laws 2011, Ch. 96 required

ADHS to adopt rules regarding health care institutions that reduce monetary or regulatory costs on persons or individuals and facilitate licensing of "integrated health programs that provide both behavioral and physical health services." To implement these requirements, ADHS engaged in an extensive stakeholder process designed to create an outcome-based system to improve public and population health. This 4-year long process overhauled the State's regulations for hospitals, behavioral health inpatient facilities, nursing care institutions, recovery care centers, hospices, behavioral health residential facilities, assisted living facilities, outpatient surgical centers, outpatient treatment centers, adult day health care facilities, home health agencies, behavioral health specialized transitional facilities, substance abuse transitional facilities, behavioral health respite homes, adult behavioral health therapeutic homes, child care facilities and the regulatory standards for licensed professional midwives. The new model allows providers to offer integrated health services under one license, eliminating regulatory barriers for the integrated whole person care that is a cornerstone of Arizona's SIM strategies. The rules set prescriptive minimum standards and require facility operators to develop an additional set of policies and procedures to ensure patient and resident health and safety. Facilities are also required to measure patient and resident outcomes. Over the next 18 months, ADHS is conducting provider training to ensure a solid understanding regarding the requirements for outcomes, policies and procedures.

In addition to these regulatory reforms, ADHS also regularly analyzes the most common and significant deficiencies identified in their facility inspections. ADHS staff uses this data to identify topics for evidence-based provider training and technical assistance. This collaborative has been identified by the U.S. Department of Health and Human Services (HHS) as a Best Practice Pilot at the Roadmap to Eliminate HAI: 2013 Action Plan Conference.

AHCCCS also uses its regulatory authority over its health plans to influence the structure and performance of the delivery system. Through its contracts with health plans, AHCCCS has required that plans: become D-SNPs to align care for dual eligibles; participate in the Health Information Network of

Arizona ("the Network," the state HIE); develop and implement shared savings reimbursement strategies; and meet quality performance measures to obtain competitive incentive payments that reward high performance. AHCCCS and ADHS have also used their contracts to drive integration through the structure of their procurements, as well as instituted care coordination requirements (particularly for super-utilizers, the American Indian population, and individuals transitioning from the justice system). Where additional barriers are identified, Arizona will continue to use its regulatory authority to drive the goals of the initiative.

A.i.(5) Health Information Technology. Arizona is committed to leveraging HIT solutions for delivery system reform. Arizona has developed numerous successful HIT and HIE initiatives including a sustainable statewide HIE, a behavioral health HIE and a successful Medicaid Electronic Health Record (EHR) Incentive Program that has paid out $170 million to providers. The Arizona Health-e Connection (AzHeC), a statewide non-profit organization, spearheads many of the State's HIT activities. The AzHeC Board includes major healthcare stakeholders such as BCBS, UnitedHealthcare, Healthnet, Medicaid MCOs, hospital systems, ASU, Arizona's Telemedicine program, Health Services Advisory Group (the Arizona QIO), Sonora Quest Laboratories, several provider associations, two behavioral health providers, and three state agencies: AHCCCS, ADHS and the Arizona Strategic Enterprise Technology (ASET) office.

As of April 2014, over $400 million in Medicare and Medicaid EHR Incentive Program payments have been paid to eligible hospitals (EH) and eligible professionals (EP). Over 3,000 Medicaid Incentive Payments were paid to EPs: 2,506 for Adopt, Implement, and Upgrade (AIU) and 519 for Meaningful Use (MU). Over 100 EHs received payments: 67 for AIU and 44 for MU. Between Medicare and Medicaid, approximately 24% of providers are meeting MU requirements in the incentive programs.[11] The EHR adoption rates and participation in HIE and the EHR Incentive Program are a testament to Arizona's success. From 2007-2009 to 2013, physician adoption increased from 45% to 85%, and Community Health Centers (which represent ~25% of Medicaid PCP assignments) increased from 40% to 92%.

[11] Combining unique providers receiving Medicare and Medicaid AIU and MU payments/total eligible in both categories.

According to ONC, Arizona hospitals had a 72% adoption rate in 2013. Providers are also using HIT to exchange data. In 2013: 99.8 % of pharmacies enabled and participated in e-prescribing and 60% of all eligible prescriptions were electronically routed; 65% of labs are sending structured results to providers; and 48% of hospitals are sharing electronic care summaries with unaffiliated providers and hospitals. The Network is seeing increased participation as well. Thirty-seven organizations have signed the Network's participation agreement, including 12 hospital systems, the state's two main reference labs, community health centers and correctional facilities.[12] The Network processes roughly 4.3 million HL7v2 transactions monthly and includes patient data on over 3.5 million Arizonans. Currently 85 users have access to clinical patient information, including ADTs, lab results, radiology results, medication history and transcribed reports. Arizona will leverage these successes and continue to build the functionality and features required by the proposed SIM activities.

SIM Funding for HIT Initiatives: Arizona will use a competitive process to allocate HIT/HIE funds to the strongest proposals. Arizona will be specifically looking for providers who will leverage HIT and HIE to drive improved quality. Funding for HIT and HIE initiatives will be available for the following strategies: 2) HIT/HIE for Behavioral Health, 3) Partnerships for Integrated Care, 8) Super-Utilizers, 9&10) QHP Coordination, 11&12) American Indian Care Coordination, and 14) Justice System Transitions.[13] These initiatives and the role of HIT are described below:

2&3) There are two components to this strategy: a) provide $10 million for adoption and implementation of EHRs for behavioral health providers to adopt and implement EHRs to participate in the electronic exchange of patient data. b) provide $20 million to support some combination of ACOs, large provider systems, FQHCs and behavioral health providers to partner and form Integrated Delivery Systems focused

[12] Funds from the Medicaid EHR Incentive Program are currently being used to support statewide HIE participation, by subsidizing the one-time implementation costs of eligible hospitals, community health centers and rural health clinics.
[13] Numbers tie to the strategy numbers identified in section A.i.(3).

on patient-centered whole-health care coordination strategies. These organizations will require the exchange of timely actionable data to be successful.

8) Arizona will provide $6 million for projects to develop necessary IT and other infrastructure to accelerate care coordination for super-utilizers. These efforts will complement existing efforts regarding data sharing and care coordination by filling in gaps where robust data exchange is not occurring but is critical to managing this high-need/high-cost population.

9&10) Arizona is proposing to use $2 million to build necessary interfaces for data exchange between Qualified Health Plans and Medicaid plans and RBHAs to ensure coordinated care for members transitioning between the two systems.

11&12) To accelerate care coordination for the American Indian population, Arizona is proposing to leverage HIT in two ways: 11) allocate $3 million to develop a care coordination platform that will leverage the extensive claims data that resides within Medicaid to better coordinate care for American Indian members using a care management system that will provide nurses and care coordinators with extensive data analytics to evaluate and provide better care to high cost members; and 12) allocate $10 million for regional care coordination initiatives, which will need to leverage HIT to create actionable data as part of developing care coordination protocols and strategies.

14) Arizona is proposing to use $5 million to award grants to criminal justice entities to partner with Medicaid and greatly expand the capability to provide appropriate care coordination by leveraging actionable health care information for care coordination for individuals transitioning between systems to prevent disruptions in care. Current care coordination efforts are largely manual processes and focused on a very limited number of individuals, but Arizona can expand these efforts through HIT.

HIT Domains: *Governance:* Arizona will leverage the experienced resources within AzHeC, ASET, AHCCCS and ADHS to achieve multiple components of the proposal. These organizations have been heavily involved in HIT and HIE efforts to date and have an excellent understanding of strengths and

challenges in Arizona. Arizona has taken advantage of multiple opportunities including Federal grants, the EHR incentive program, and community resources to build its existing HIT/HIE programs and infrastructure. Arizona used ONC HIE Cooperative Agreement funds to support the Network, which is now moving toward a sustainable business model. Hospitals, insurers and community providers pay fees to support interface implementation, as well as ongoing operational and infrastructure costs. Arizona will also leverage the ONC HIE grant that ASET received for HIE technical and strategic planning support for mental health providers, Critical Access Hospitals, rural hospitals, long term care provider, correctional health providers, and American Indians. These funds were also used for large organizations (behavioral health, ACOs, hospitals) that were initiating, improving, or maturing their HIE enterprise.

Policy: AzHeC will be significantly involved in developing the SIM activities and award of funds to ensure existing infrastructure is leveraged. Arizona's Health IT Roadmap 2.0, published jointly by AzHeC and the ASET office as part of the HIE Cooperative Agreement Program, outlined 19 initiatives identified by the Arizona health care community that should be completed within the next 24 to 36 months.[14] Items in Roadmap 2.0 that the SIM funds may address include interoperability and content standards and adherence, addressing challenges with patient identification, identifying incentives to support continued expansion of HIT/HIE adoption and use, collaboration and support for broadband access and support, creating a common patient consent approach, developing and implementing a statewide strategy and supporting accelerated statewide HIE adoption and use.

Infrastructure: Arizona will leverage the existing HIT/HIE infrastructure and coordinate the efforts of its public and private partners. As part of the coordinated care initiatives, Arizona will implement analytical tools and use data-driven evidence-based approach to coordinate and improve care across the state and drive quality improvement at the point of care. To promote public health, ADHS is currently evaluating the Network for transmission of public health MU measures as well as identifying coordinating registry data

[14] http://www.azhec.org/?page=HealthIT_Roadmap

across several registries to improve public health coordination. In rural Arizona, robust telehealth networks exist and both the Integration and AI Care Coordination strategies will expand these efforts.

Technical Assistance: The State envisions engaging providers and experts early and often with regards to developing the competitive opportunities that will exist to access the SIM funds. The range of providers that potentially can access new resources is extensive, ranging from large hospital systems, IHS/638 providers, FQHCs, behavioral health providers, criminal justice systems and insurers. Many of these have not been previously eligible for Medicaid incentive payments. The State will also leverage AzHEC, which brings these organizations to the table as part of its membership. AzHEC will also be able to support the efforts of the funded entities as a continuation of its Regional Extension Center program, which can be leveraged to support ongoing HIT and HIE implementation and technical assistance.

A.i.(6) Stakeholder Engagement. Health care reform cannot be achieved without comprehensive engagement from various stakeholders. Arizona engages in robust stakeholder involvement on major initiatives, and the SIM strategies will be no exception. As evidenced by letters of support from 56 organizations from across the state, the community has great confidence in Arizona's ability and willingness to partner and collaborate on the SIM strategies.

Stakeholder Commitment

ADHS has been a leader in engaging the public through its State Health Assessment, the basis for development of the SHIP designed to target leading public health issues. Through this assessment process, ADHS worked with 15 county health departments and their local partners, who together reached approximately 10,000 people statewide to identify local community health priorities. That commitment is carried forward through development of the SHIP.

In addition, AHCCCS has built a culture of learning regarding payment reform and health system transformation through robust stakeholder engagement including input from hospitals, ACOs, health plans, county governments, tribal stakeholders, and providers. Some of these organizations include: ADOC;

Arizona Counseling and Treatment Services; Community Partnership of Southern Arizona; Northern AZ Regional Behavioral Health Authority; Corizon Health; AZ Peer and Family Coalition; Southwest Behavioral Services; Arizona Department of Economic Security/Children's Medical and Dental Program; Pima County Health Department; Maricopa County Correctional Health Services; Yavapai County Sheriff's Office; Arizona Connected Care (ACO); Commonwealth ACO; Cenpatico; Arizona Care Network ACO; Tenet Healthcare; Phoenix Children's Hospital; University of Arizona Health Network; Care 1st; Bridgeway; Arizona Health e Connection; Banner Health Network; People of Color Network; Dignity Health; Mercy Care Plan; Mercy Maricopa Integrated Care; United Healthcare; Health Choice; HealthNet; John C. Lincoln Health Network; Scottsdale Healthcare; Kayenta Health Center; Chinle Comprehensive Health Care Facility; Tuba City Regional Health Care Corporation; Tucson IHS Area Office; San Xavier Health Center; Winslow Health Care Center; Tse'Hootsooi' Medical Center-Ft Defiance Indian Hospital; Phoenix IHS Area office; Phoenix Indian Medical Center; Gila River Health Care Corporation; and Flagstaff Medical Center.

These stakeholders described various initiatives being implemented across the State designed to achieve transformation within the health care delivery and payment systems. Stakeholders clearly articulated their passion and commitment to achieve the goal of health system transformation. Stakeholders were equally clear that collaborating with the State's largest insurer – AHCCCS – was fundamental in achieving success. This collaboration was particularly helpful in connecting all of these existing efforts and identifying the missing link – behavioral health.

On Wednesday, June 18, 2014, the Governor's Office convened an opening meeting to introduce the State's interest in pursuing the SIM opportunity and to explain the State's focus. The response was overwhelming. In addition to groups already mentioned, additional associations expressed their support for the State's initiative and articulated their commitment to the proposal's aims. These organizations include: Arizona Council of Human Service Providers; St. Luke's Health Initiatives; National Alliance on Mental Illness (NAMI); Stand Together And Recover (STAR); Arizona Health Care Association; Valle del Sol;

Arizona State University Center for Applied Behavioral Health Policy; Maricopa Integrated Health Services; Arizona Medical Association; Arizona Hospital and Healthcare Association; Arizona Osteopathic Medical Association; Arizona Association of Health Plans; Blue Cross Blue Shield of Arizona; Arizona Alliance of Community Health Centers; Native American Connections; and the County Supervisors Association.

Maintaining Stakeholder Engagement

This proposal reaches across various types of stakeholders, each of whom will play slightly different roles in implementation. Step one is to identify stakeholder roles; step two is to develop workgroups specific to identified roles. Upon receiving the SIM award, Arizona will develop a stakeholder strategy to make sure each SIM Strategy proposed includes the relevant stakeholders to contribute to achieving the milestones during the implementation of the test model.

St. Luke's Health Initiatives (SLHI), a Phoenix-based public foundation focused on Arizona health policy and strength-based community development, will assist as a convener. SLHI brings a wealth of expertise in stakeholder engagement and is at the center of many of the initiatives that will be brought together through this proposal, both as a funder and participant.

AHCCCS has already established a tribal consultation process through its Office of Intergovernmental Affairs. The State has discussed care coordination for the American Indian population in tribal consultation on numerous occasions and connected its effort to IHS' national Improving Patient Care initiative.

The State also has a network of peers and family members that are committed stakeholders through the Office of Individual and Family Affairs (OIFA) at ADHS. OIFA works with the Arizona Peer and Family Coalition, the Arizona chapter of the National Alliance on Mental Illness (NAMI) and many others to ensure participation and outreach to AHCCCS members and families.

In addition to already established partnerships and processes, the State will use its website to allow for multiple forms of communication and public input. AHCCCS and ADHS have robust websites and

a savvy consumer base. One of the best examples was the significant public outreach and participation through the AHCCCS website during Arizona's debate of Medicaid restoration and expansion.

A.i.(7) Quality Measure Alignment. AHCCCS is aligning its measures with other payers through the adoption of CMS measure sets that are also being utilized for other programs such as Medicare and QHPs. Many of these measures are also included in the NCQA HEDIS Measures. Meaningful Use measures required of providers to receive full Medicare or Medicaid EHR Incentive Program payments also help with alignment since CMS has included measures for children and adults, and meaningful use measures are also included in some of the proposed measures for SNP and long term care.

AHCCCS incorporates HEDIS measures which are a major focus across all insurance types including Medicaid, Medicare, and all major commercial companies in Arizona (e.g., Cigna, Humana, HealthNet, United, Aetna, and BCBS). In addition, many HEDIS measure are nationally highlighted as part of Meaningful Use, Quality Reporting Document Architecture submissions, Physicians Quality Reporting System submissions, and PCMH or ACO monitoring. AHCCCS also recently conducted comprehensive Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys across multiple lines of business. Consumer surveys are also included in most measure sets across multiple programs at the federal level including Medicare and QHPs, as well as commercial plans as part of NCQA.

Arizona has also had tremendous success in collaborative efforts that have targeted specific initiatives and quality measures. For example, the Medicare QIO and a number of stakeholders convened to address hospital readmissions through the *No Place Like Home* effort. This effort combining providers, payers, government and other experts resulted in the largest measurable decrease nationally in re-admissions. Other collaborative efforts over the past couple of years include dialysis infections, hospital-acquired infections, improved birth outcomes and the Arizona Prescription Drug Misuse and Abuse Initiative

AHCCCS will continue this alignment by working with SLHI to convene and collaborate with commercial and government payers across the state to identify and select quality and outcomes measures that will provide meaningful and actionable information that is an accurate indicator of the status of the health care delivery system. Arizona will target key organizations that will cover multiple payer sources. For example, companies like United Healthcare bring together multiple lines of Medicaid business, Medicare Advantage, commercial populations, State employees and, in 2015, QHPs. Other payer organizations like Aetna, Blue Cross Blue Shield, Health Net and others also bring multiple lines of business that span a full spectrum of insurance products. Through these efforts, it is envisioned that 80 percent of the insured Arizona population would be represented through aligned reporting on select measures, with alignment targeted by the conclusion of the 12 month pre-implementation period.

SLHI can convene regular representative workgroups focused on establishing a comprehensive measure set that will provide for an appropriate baseline and track progress over time as the SIM initiatives progress. Given the existing number of measure sets used in the various insurance segments, there is enough overlap to create data sets that will be meaningful while not creating new administrative burdens for providers, members or insurers. These measures will also align well with tracking the impacts of expanded coverage and the SHIP.

The plan would also keep the measure set manageable and meaningful by limiting the overall number of measures. Quality measurement efforts can easily become overly complex and burdensome. Arizona has had some of the best success by focusing on a limited number of measures.

The focus of the multi-payer work group will be to leverage quality and outcomes measures that are consistent with measures required by CMS to reduce the administrative burden on providers. At a minimum, measure sets used by ACOs, value-based purchasing initiatives, Medicare, Medicaid, QHPs, Patient Centered Medical Homes, as well as Meaningful Use and measure sets that focus on the integration of physical and behavioral will be reviewed and considered. In addition, the measure selection

process will consider opportunities for inclusion of e-measures and measures that will encourage the expanded use of EHRs, HIEs, care coordination and integration processes across systems of care as well as administrative measures that include data from these sources. In addition, the SIM HIT strategies will help expand opportunities for the use of electronic measures as additional providers will have the capacity to participate and report data on these measures. Even the efforts limited to Medicaid will change provider prescribing patterns, which will benefit other lines of businesses and other payers.

The outcome measures that the workgroups will work towards focus on the domains of: 1) access to health care, 2) chronic conditions, 3) health behaviors, 4) maternal and child health, 5) mental/behavioral health, 6) overall health status, and 7) use of emergency room and inpatient stays. Further, the metrics will connect the health care delivery system to public health initiatives such as smoking cessation, obesity, and diabetes care, suicide prevention and substance abuse. Examples of outcomes measures that we may focus on through the collaboration include: 1) readmissions, 2) follow-up after discharge, 3) emergency department utilization (visits/1000), 4) inpatient utilization (days/1000), 5) access to primary care/ambulatory care, and 6) comprehensive diabetes care.

A.i.(8) Monitoring and Evaluation Plan. The State will continually monitor the effects of various SIM initiative components on the costs and health outcomes of the target populations. To that end we have developed a set of Key Performance Indicators (KPIs) for the monitoring and evaluation of the care coordination populations. These KPIs will set the baseline measures from which we will measure progress toward our goals and will track that progress over time as the long-term effects of the initiatives take hold. We have designed these KPIs to be measureable within our existing data analytics systems so that they utilize data with strong quality controls and a reliable data infrastructure. We will also work with commercial insurers and CCIIO to obtain and report on similar measures for commercial members.

The model will include both baseline metrics and annual performance goals which will help in determining whether the care coordination process is achieving the desired impact on costs and health outcomes. Our focus under the three measure domains as designated in the grant announcement is to:

1. **Strengthen population health** by reducing preventable problems and finding coordinated solutions to mental and physical health care needs;

2. **Transform the health care delivery system** by increasing the meaningful use of EHRs and e-prescriptions and breaking down the barriers between physical and behavioral health care; and

3. **Decreasing per capita health care spending** by a) using innovative methods to direct utilizers toward preventative and proactive health care rather than interacting with the health care system through the ED and other more expensive means; b) aligning incentives of payers and providers toward high quality, cost effective health care.

1. **Strengthening population health**:

a. *Obesity* – Since 1993, Arizona has seen a 19% increase in individuals who are overweight or obese which is the largest increase in the nation. Through these efforts Arizona will track and plan on seeing overall reductions in obesity which currently for adults is 25.2% and for juveniles is 14.5%..

b. *Substance Abuse* – From 2006 to 2010, the number of deaths from prescription drugs has increased 141%, from 147 to 355. Through improved integrated efforts it is expected that this measure will be favorably impacted.

c. *Diabetes* – The percentage of adults in Arizona told by a doctor they have diabetes increased from 7.5% in 2005 to 9.1% in 2010. In 2010, American Indians in Arizona were 4 times more likely to die from diabetes than the average Arizonan. Both these measures will be monitored and impacted by the SIM initiatives.

d. *Smoking Cessation* – From 2002 to 2010, adult smoking in Arizona decreased from 23.1% to 15% placing Arizona below the national rate. Through the SIM initiative, Arizona expects this favorable trend will continue.

e. *CAHPS Data* – Arizona will work to aggregate and analyze CAHPS to establish baseline information along with looking at specific populations in how they view the delivery system.

f. *Incarceration Recidivism* – While not a traditional public health, measure one of the major SIM initiatives is around improved transition planning between the justice system and the delivery system. As a result of restored and expanded coverage, Arizona will be looking to create a more efficient system that improves health outcomes. While there are a number of factors that impact recidivism, Arizona will track this measure to see what type of favorable impact improved care coordination may have on this measure.

2. **Transforming the health care delivery system**:

a. *Percent of spend and number of providers participating in shared savings arrangements* – Currently less than 10% of the Medicaid spend by managed care organizations is in a shared savings or quantifiable value based arrangements that truly aligns incentives. This measure will be tracked annually for both Medicaid and the almost $1 billion in aligned D-SNP spending. Arizona will also look to expand these measures where possible to other payers.

b. *Increase use of e-prescribing by providers* – The SIM initiatives include a number of strategies that leverage existing efforts to expand the use of e-prescribing and connectivity. Based on Surescripts data Arizona currently ranks 42nd in e-prescriptions in 2013 and this measure must be improved.

c. *Increase providers connected to the Health Information Network of Arizona and Behavioral Health Information Network of Arizona.* There are a number of SIM strategies that target infrastructure and capacity for improved care coordination through leveraging data sharing. Incredible effort has been expended to date by a number of community organizations to create the Network and the behavioral health HIE and the SIM initiative will expand these efforts.

d. *Increase providers and hospitals achieving Meaningful Use* – The federal government has invested billions of dollars in EHR adoption. Leveraging these tools for improved care coordination will allow more providers to qualify for meaningful use incentive payments.

e. *Increase IHS and 638 facilities NDC reporting* – As part of claiming for the all-inclusive rate, these facilities have historically not had to provide any NDC information as part of the claim record. To improve care coordination, Arizona will work with these facilities to improve the data to make it more meaningful and robust.

f. *Reduce inpatient hospital readmissions per capita* – Integrating behavioral health providers into the hospital discharge process and coordinating follow-up care among providers will reduce preventable readmissions. Similar benefits are expected to accrue to the American Indian population. This measure will track Medicaid, aligned duals in D-SNPs, and Medicare FFS.

g. *Reduce the number of preventable adverse drug reactions per capita.* The use of e-prescribing and EHR tools that automatically alert the provider to potential adverse reactions and improved care coordination will help to prevent these occurrences and the dangerous health consequences for the patient. Initially this will be a Medicaid measure.

h. *Increase the number of members with serious mental illness in permanent supported housing with tenancy rights* – Supported housing is critical to the stability and recovery of members with serious mental illness. Increasing the number of members in permanent housing will support recovery and avoid utilization of other costly services.

3. **Decreasing per capita health care spending**:

a. *Reduce ED visits with a non-emergent diagnosis per capita* – We will utilize both on-site redirection efforts as well as proactive contact with super utilizers to help them meet their needs without showing up in the ED. We plan to monitor this on multiple levels: overall decrease in ED visits; ED utilization for members recently released from incarceration, ED utilization for member with SMI, and ED utilization for the

American Indian population. Initially these will all be Medicaid measures and, where available, Medicare (based on the significant D-SNP alignment). This measure may evolve to other populations and payers where possible.

b. *Reduce overall costs per capita in super-utilizer subpopulation* – Many of the SIM initiatives will target these measures. This measure will be begin with the targeted Medicaid population and, where applicable, Medicare for aligned dual eligible members. This measure also will be further delineated by populations like members with Serious Mental Illness, American Indians, and acute members with high behavioral health needs.

c. *Maintain the Medicaid program PMPM growth at the cost of inflation.* Sustainability is one of the ultimate challenges for Medicaid programs. In order for state and federal governments to be able to address other critical policy areas, Medicaid spending must be manageable. This means overall PMPM growth cannot exceed inflation.

A.i.(9) Alignment with State and Federal Innovation. This SIM proposal is structured specifically to leverage, build and accelerate the innovation occurring within the Arizona health care delivery system which aligns with many CMS initiatives. The proposal builds on the ACO structures that have evolved as a result of the ACA and Medicare efforts, and expands the capacity of the ACO model to address significant behavioral health needs allowing for more integrated holistic treatment. While these efforts are well-aligned with Medicare efforts and can build upon much of the same infrastructure, they are not duplicative due to the populations served and the enhanced focus on behavioral health.

The proposal expands on the Medicaid and Medicare EHR Incentive Program by targeting and incentivizing collaboration with providers not eligible for the incentives, which will expand upon the number and type of providers using actionable electronic data necessary for integrated care, care coordination and payment reform. The effort is focused on behavioral health providers, the justice system and long term

care providers that are willing to collaboratively and contractually partner with larger delivery systems and the Medicaid program.

The SIM proposal also builds on and supports the IHS IPC model. Arizona has modeled its care coordination efforts on the IPC model and the proposal provides resources to support care coordination and regional models that look to build off the IPC model.

The proposal includes development of care coordination opportunities between QHPs and Medicaid. No federal resources have been provided for that purpose.

While considerable resources have been devoted to align dual eligible members, this proposal will leverage the D-SNP platform that Arizona has utilized to achieve significant alignment. Again these efforts are in concert with and supportive of CMS initiatives without duplication.

In addition, CMS has promoted a number of innovations and opportunities for the Medicaid program that are in place in Arizona: reducing non urgent use of the ED by focusing on super-utilizers and addressing needs of members with behavioral health problems, development of integrated care models and emphasizing the creation of new forms of payments that focus on improving quality.

ARIZONA SIM INITIATIVE OPERATIONAL PLAN

Introduction: Arizona's Operational Plan describes the approach, key personnel, milestones and budget to implement the SIM initiative. The following proposed strategies accelerate the delivery system towards a value-based integrated model that focuses on the whole person health in all settings: A) Reduce fragmentation within the delivery system with a focus on the integration of behavioral health services; B) Expand the necessary infrastructure to develop care coordination programs to reduce unnecessary utilization and improve the quality of care; and C) Implement multi-payer, value-based payment reform programs to align incentives toward high quality, cost-efficient health care and improved population health.

A leader in health care innovation, Arizona has the resources and track record to implement its SIM proposal. Governor Brewer has been a leader in healthcare innovation during her tenure and has set the State on a path to health system transformation. She spearheaded the State's efforts to integrate behavioral and physical health for individuals with serious mental illness and children with special health care needs, and ensured the implementing agencies were equipped to do the work. Governor Brewer has been a steadfast champion of behavioral health, both by raising awareness and clearly demonstrating that many public health issues have a basis in behavioral health. Most importantly, Governor Brewer led the effort to secure Medicaid restoration and expansion, which provided coverage for 300,000 Arizonans.

Governor Brewer's leadership also demonstrates her confidence in the implementing agencies, primarily AHCCCS and ADHS, which are well equipped with steady leadership, strong IT systems and institutional knowledge allowing for robust tracking, monitoring and reporting. The AHCCCS and ADHS Directors have over 45 years of combined State service, each having served multiple Governors. Arizona's Medicaid program is nationally known as innovative and well-managed. At the heart of Arizona's success is the public/private partnership involving committed stakeholders across the State.

Key Personnel: Arizona is committed to dedicating the appropriate level of support to this project. Key Executive Staff will be dedicated to the SIM initiative, and will be supported by subject matter experts throughout State government and in the community. Below are the key personnel tasked to the project:

Don Hughes, *Deputy Director for Policy, Office of the Governor Janice K. Brewer*. Before joining the Governor's office, Mr. Hughes was a lobbyist representing the insurance industry and other health care clients. He also served as a policy advisor for Governor Jane Dee Hull on regulatory, insurance and health care issues. Mr. Hughes will provide policy and executive oversight to the Arizona SIM Initiative.

Tom Betlach, *Medicaid (AHCCCS) Director.* Mr. Betlach has 23 years of State Service. He has served as State Budget Director for 5 years, AHCCCS Deputy Director for 7 years and AHCCCS Director for the past 5 years. Mr. Betlach brings a wealth of operational, financial and policy experience. He will serve as the Executive Sponsor and will lead Executive Steering Committee oversight and monitoring of the project.

Beth Lazare, *AHCCCS Deputy Director.* Ms. Lazare has 15 years of health care policy and administration experience. Prior to her work at AHCCCS, she was the Deputy Policy Director and health and humans services policy advisor in the Arizona Governor's Office. Ms. Lazare has also worked as a Medicaid consultant for various states, and has served as a senior fiscal and health policy advisor for the Arizona Legislature. Ms. Lazare will serve as the SIM initiative lead and be responsible for day-to-day oversight of the initiative.

Will Humble, *Director, ADHS.* Mr. Humble has over 25 years in public health service and as the Director of ADHS he oversees Arizona's public and behavioral health systems. Mr. Humble is leading the development of the SHIP and will facilitate the integration of public health strategies into the SIM.

Cory Nelson, *Deputy Director, ADHS.* Mr. Nelson oversees Behavioral Health Services for the State of Arizona, including oversight of the state's public behavioral health system and the Arizona State Hospital. Prior to his work in Arizona he was the CEO of the South Dakota Human Services Center for 10

years; Director of Juvenile Corrections for two years and also worked as a Chief Probation Officer and line level officer. Mr. Nelson will provide leadership on integration and care coordination efforts.

George Jacobson, *Payment Modernization Project Manager*, Mr. Jacobson has worked in health care in Arizona for 26 years, serving as a hospital executive and in various nursing facility executive positions. Mr. Jacobson coordinates the agency's care delivery and payment reform initiatives, and he will be responsible for leading the payment reform strategies.

In addition to these key personnel, Arizona has committed experienced subject matter experts to support implementation of the Arizona SIM strategies. Additional information on these individuals, including their backgrounds and expertise, is provided in Appendix A.

Sustainability: The Arizona SIM initiative allocates more than 90% of the funding out to the delivery system through largely competitive processes to accelerate robust integration, care coordination and payment reform activities. A very limited portion of the funding will be used for internal infrastructure to establish allocation mechanisms and monitor the progress of the system. While the SIM funds are significant, they pale in comparison with the large scale investments being made within the delivery system to create integrated structures that leverage HIT and data analytics. Ultimately, the Arizona SIM strategy is to distribute one-time limited funding that will accelerate ongoing delivery system reform.

Integration: This strategy is predicated on strong models of care and actionable data. The State and the managed care organizations (MCOs) (many of whom are owned by hospitals in Arizona) have invested heavily in developing integrated models of care. Given that these monies will be used as a one-time accelerator to develop more robust integration efforts, it is expected that these new contractual relationships will continue. These fully integrated delivery systems will generate results for members and payers that will enable the infrastructure to be maintained in the future.

Care Coordination: The SIM initiative provides funds to develop and enhance care coordination activities, specifically for the American Indian population, super-utilizers, individuals transitioning from the justice system and individuals transitioning between Medicaid and QHPs. These funds will be used to create infrastructure to leverage data and create regional systems of care to initiate managing the health of the population. Activities include leveraging HIT to move information more effectively and efficiently, with minimal operational costs. These activities are sustainable because the investments are primarily one-time in nature and will yield significant results (e.g., reduced recidivism for individuals transitioning from the justice system) and lower health care costs, and will provide data and systems necessary to justify ongoing investment as needed.

Payment Reform: Under the SIM initiative, Medicaid will continue to incentivize MCOs to create new system of payments and expand these efforts to Medicare for the D-SNP plans. The infrastructure associated with these new models will be ingrained into the fabric of the healthcare delivery system and will be maintained. The SIM funding provides the upfront capital to create and expand shared saving structures and other models that are already evolving. A critical component of the SIM initiative will be engaging payers and providers in ongoing sustainability discussions for these efforts, including working with CMS to determine actuarially sound mechanisms to account for ongoing reforms.

Project Plan: The Project Narrative has described the details of each of the 15 SIM Strategies. In this Operational Plan, the SIM Strategies have retained their numbers from the Project Narrative and are presented in the plan according to their SIM Strategy number. In Table 1, we provide the major milestones and associated budget for each model year of the SIM initiative. Table 2 describes the quarterly milestones and accountability targets for each of the four model years of the SIM project. The targets are presented on an annual basis and tied to the specific milestones when the activity that directly impacts providers/beneficiaries commences, but are applicable throughout the duration of the strategy. In Table 3, we then describe the potential project risks and propose strategies to mitigate those risks.

Table 1: Budget and Summary Activities by Year

Strategy	Year 1	Year 2	Year 3	Year 4
1.	Identify funding allocations based on SHIP strategies	Award funding, Implement and Monitor *Budget: $3,000,000*	Evaluate and implement necessary modifications *Budget: $2,000,000*	Closeout and Evaluate
2.	Award Round 1 Funding *Budget: $2,500,000*	Implement and Evaluate *Budget: $2,500,000*	Award Round 2 Funding *Budget: $2,500,000*	TA, Closeout and Evaluate *Budget: $2,500,000*
3.	Stakeholder Engagement/Determine Round 1 Funding Opportunity (FO) Requirements	Award Funding, Implement and Monitor *Budget: $10,000,000*	Stakeholder Feedback, Determine Round 2 Funding Requirements:	Award Funding, Implement, Closeout and Evaluate *Budget: $10,000,000*
4., 5. &6	Develop and Begin Evaluation/Pilot Training *Budget: $2,000,000*	Evaluation/Pilot Continues; Full Implementation of Training *Budget: $2,500,000*	Implementation Strategy/ Training Programs Ongoing *Budget: $1,500,000*	Implement, Closeout and Evaluate. *Budget: $1,500,000*
7.	Stakeholder Engagement, Announce FO	Award and Implement *Budget: $1,000,000*	Monitor and Refine *Budget: $1,000,000*	Closeout and Evaluate
8.	Award and Implement Greater AZ RBHA; Stakeholder Engagement	Announce FO, Award Funding and Implement *Budget: $3,000,000*	Monitor and Refine as Necessary *Budget: $3,000,000*	Closeout and Evaluate
9. & 10	Determine Infrastructure Requirements; Begin IT Build *Budget: $500,000*	Continue IT Build, Test and Begin Data Sharing *Budget: $1,500,000*	Monitor and Refine as Necessary	Closeout and Evaluate
11.	Stakeholder Engagement/Develop and Release RFP	Award Funding, Roll Out *Budget: $1,500,000*	Continue Rollout, Evaluate, Determine Additional Sites *Budget: $1,000,000*	Closeout and Evaluate *Budget: $500,000*
12.	Stakeholder Engagement/Develop and Release RFP	Award Funding and Implement *Budget: $5,000,000*	Monitor and Refine as Necessary *Budget: $2,500,000*	Closeout and Evaluate *Budget: $2,500,000*
13.	Gather Information for Material Development *Budget: $400,000*	Tribal Engagement on Materials, Release Materials *Budget: $600,000*	Monitor and Refine as Necessary	Closeout and Evaluate
14.	Determine Infrastructure	Continue IT Build, Test and	Evaluate, Determine Additional	Closeout and Evaluate

Strategy	Year 1	Year 2	Year 3	Year 4
	Requirements; Begin IT Build *Budget: $1,500,000*	Roll Out *Budget: $2,500,000*	Sites *Budget: $1,000,000*	
15.	Develop Criteria for FO	Award Funding; Implement *Budget: $2,500,000*	Monitor, Collect Feedback *Budget: $2,500,000*	Develop Sustainability Strategy, Closeout and Evaluate

Table 2: Quarterly Milestones and Targets[1] for the Four-Year Funding Period

Strategy	Year 1 – Q1	Year 1- Q2	Year 1-Q3	Year 1-Q4
1.	Milestone: Work with ADHS and stakeholders to identify funding allocations and accountability targets based on SHIP strategies	Milestone: Work with ADHS and stakeholders to identify funding allocations and accountability targets based on SHIP strategies	Milestone: Work with ADHS and stakeholders to identify funding allocations and accountability targets based on SHIP strategies	Milestone: Finalize funding allocations and accountability targets for potential award
	Target: Statewide population health strategies; targets TBD based on SHIP strategies			
2.	Milestone: Determine FO requirements	Milestone: Release FO requirements for first round of funding	Milestone: Proposals Due	Milestone: Round 1 Funds Awarded
	Target Round 1: 10-15 provider organizations representing thousands of providers/10,000+*			
3.	Milestone: Stakeholder engagement regarding potential funding allocations	Milestone: Stakeholder engagement regarding potential funding allocations	Milestone: Determine FO requirements	Milestone: Release FO requirements for first round of funding
4.	Milestone: Work with ASU on requirements for evaluation	Milestone: Work with ASU on requirements for evaluation	Milestone: Evaluation begins	Milestone: Evaluation continues
5. and 6	Milestone: Work with ASU and Comm Coll to develop parameters for new training	Milestone: ASU & CC to develop new training	Milestone: ASU & CC to develop new training	Milestone: Pilot new training opportunities

[1] Targets are displayed by: # of providers and hospitals impacted/# of beneficiaries impacted.
*For competitive grants, actual targets will be dependent upon bids from potential partners.

Strategy	Year 1 – Q1	Year 1- Q2	Year 1-Q3	Year 1-Q4
7.	Milestone: Stakeholder work begins on existing programs and opportunities	Milestone: Stakeholder work continues	Milestone: Stakeholder work continues	Milestone: FO announced
8.	Milestone: Greater AZ RBHA Awarded	Milestone: RBHA transition planning	Milestone: Stakeholder engagement on FO	Milestone: Greater AZ RBHA Implementation
9. and 10.	Milestone: Revisit QHP stakeholders to gauge if previously-determined format still appropriate	Milestone: Refine format if necessary	Milestone: Determine infrastructure requirements for plans and QHPs	Milestone: Refine requirements, begin build
11.	Milestone: Tribal Consultation	Milestone: Develop Care Coordination Tool RFP	Milestone: Release RFP	Milestone: Evaluate Proposals
12.	Milestone: Tribal Consultation	Milestone: Additional stakeholder engagement and development of FO requirements	Milestone: Additional stakeholder engagement and development of FO requirements	Milestone: FO announced
13.	Milestone: Evaluate process for developing literacy material	Milestone: Tribal Consultation and other stakeholder engagement	Milestone: Gather information for material development, including existing materials	Milestone: Gather information for material development, including existing materials
14.	Milestone: Bring on additional resources. Engage justice system in stakeholder discussions	Milestone: Continue stakeholder discussions and determine infrastructure requirements	Milestone: Refine infrastructure requirements	Milestone: Begin IT build
15.	Milestone: Continue meeting with providers and payers re: existing efforts, challenges, possible approaches	Milestone: Convene discussions with behavioral health providers	Milestone: Develop criteria for funding announcement	Milestone: Finalize criteria for funding announcement

Strategy Number	Year 2- Q1	Year 2- Q2	Year 2- Q3	Year 2-Q4
1.	Milestone: Award and begin kickoff with funding recipients	Milestone: Implementation and reporting	Milestone: Implementation and reporting	Milestone: Implementation and reporting
2.	Milestone: Implement	Milestone: Additional technical	Milestone: Evaluate results of	Milestone: Determine Round 2

Strategy Number	Year 2- Q1	Year 2- Q2	Year 2- Q3	Year 2-Q4
		assistance as needed	first round of funding	FO requirements
3.	Milestone: Proposals Due	Milestone: Funds Awarded	Milestone: Implement	Milestone: Monitor and technical assistance
	Target Round 1: 2 rural hospitals, 2-3 urban hospital systems (~12-20 hospitals), ~8-12 community behavioral health provider organizations/100,000 Medicaid, tens of thousands of Medicare and commercial members[2]*			
4.	Milestone: Evaluation continues	Milestone: Evaluation continues	Milestone: Evaluation continues	Milestone: Evaluation due
5. and 6.	Milestone: Pilot new training opportunities	Milestone: Evaluate pilot	Milestone: Modify training programs if necessary	Milestone: Full implementation of training programs
	Target: 25 providers/Limited			*Target: Hundreds of providers/Thousands of patients*
7.	Milestone: Proposals due	Milestone: Funding awarded	Milestone: Implement	Milestone: Implement
	Target: 2 EMT providers/Thousands of patients			
8.	Milestone: FO announced	Milestone: Proposals due	Milestone: Funding awarded	Milestone: Implementation
	Target: Health plans and RBHAs (benefiting thousands of contracted providers)/65,000 Medicaid super-utilizers; tens of thousands patients from other payers			
9. and 10	Milestone: Continue IT build	Milestone: Testing	Milestone: Begin data sharing:	Milestone: Monitor
	Target: Medicaid plans and QHPs (benefiting thousands of contracted providers)/Tens of thousands of individuals moving between Medicaid and QHPs			
11.	Milestone: Award; work with vendor on implementation	Milestone: Continue work with vendor	Milestone: Implement	Milestone: Roll out to sites
	*Target: 15-25 IHS/638 and non-tribal facilities representing thousands of providers/150,000 American Indian Medicaid members**			
12.	Milestone: Proposals due and awarded	Milestone: Begin provider implementation	Milestone: Monitor	Milestone: Monitor
	*Target: 15-25 IHS/638 and non-tribal facilities representing thousands of providers/150,000 American Indian Medicaid members**			

[2] Represents Medicaid participants actively receiving behavioral health services; number impacted will depend on systems and providers who receive competitive grants.

Strategy Number	Year 2- Q1	Year 2- Q2	Year 2- Q3	Year 2-Q4
13.	Milestone: Present material to tribes and tribal providers	Milestone: Modify material, additional tribal consultation	Milestone: Release materials for distribution	Milestone: Implement
	Target: 150,000 American Indian Medicaid members			
14.	Milestone: Continue IT build	Milestone: Testing	Milestone: Roll out to initial sites	Milestone: Continue rollout
	Target for full implementation: Correctional health (including jails) and Medicaid health plans, benefiting 400+ correctional providers, thousands of jail and community providers/Portion of estimated 106,000 individuals transitioning from incarceration to Medicaid.			
15.	Milestone: Release FO	Milestone: Q&A	Milestone: Proposals evaluated and awards made	Milestone: Implementation
	Target: 10-15 hospital systems, representing thousands of providers/Hundreds of thousands of patients served by multiple payers			

Strategy	Year 3-Q1	Year 3-Q2	Year 3-Q3	Year 3-Q4
1.	Milestone: Implement and evaluate	Milestone: Use evaluation results to determine whether modification necessary	Milestone: Use evaluation results to determine whether modification necessary	Milestone: Continued implementation with modifications, if necessary
2.	Milestone: Release FO requirements for second round of funding	Milestone: Proposals Due	Milestone: Funds Awarded	Milestone: Implement
	Target Round 2: 10-15 provider organizations representing thousands of providers/10,000+ patients*			
3.	Milestone: Stakeholder engagement regarding first round of funding	Milestone: Evaluate stakeholder feedback	Milestone: Determine Round 2 FO requirements	Milestone: Release FO requirements for second round of funding
4.	Milestone: Review results of evaluation and determine strategy for replication	Milestone :Develop education/implementation strategy	Milestone :Develop education/implementation strategy	Milestone: Implement
	Target: Hundreds of providers/Thousands of patients			
5. and 6	Milestone: Training programs ongoing	Milestone: Training programs ongoing	Milestone: Training programs ongoing	Milestone: Training programs ongoing
7.	Milestone: Implement	Milestone: Implement	Milestone: Monitor and data	Milestone: Monitor and data

Strategy	Year 3-Q1	Year 3-Q2	Year 3-Q3	Year 3-Q4
			evaluation/reporting; refine as necessary	evaluation/reporting; refine as necessary
8.	Milestone: Implement	Milestone: Implement	Milestone: Implement	Milestone: Monitor and data evaluation/reporting; refine as necessary
9. and 10.	Milestone: Monitor	Milestone: Evaluate; Use evaluation results to determine if modification necessary	Milestone: Modify interface if necessary	Milestone: Implement
11.	Milestone: Continue roll out to sites	Milestone: Evaluate	Milestone: Evaluate	Milestone: Determine additional sites for rollout
12.	Milestone: Monitor	Milestone: Evaluate; Determine necessary modifications	Milestone: Monitor	Milestone: Monitor
13.	Milestone: Monitor	Milestone: Evaluate and refine	Milestone: Implement	Milestone: Implement
14.	Milestone: Determine if modifications are necessary	Milestone: Roll out to additional sites	Milestone: Implement	Milestone: Implement
15.	Milestone: Implement	Milestone: Implement	Milestone: Feedback collection	Milestone: Continue feedback collection

Strategy	Year 4-Q1	Year 4-Q2	Year 4-Q3	Year 4-Q4
1.	Milestone: Implement	Milestone: Implement	Milestone: Closeout	Milestone: Final Evaluation
2.	Milestone: Additional technical assistance as needed	Milestone: Additional technical assistance as needed	Milestone: Closeout	Milestone: Final Evaluation
3.	Milestone: Award	Milestone: Implement	Milestone: Implement	Milestone: Final Evaluation
	*Target Round 2: 3 rural hospitals, 2-3 urban hospital systems (~12-20 hospitals), ~8-12 community behavioral health provider organizations/100,000 Medicaid, tens of thousands of Medicare and commercial[3]**			
4.	Milestone: Implement	Milestone: Implement	Milestone: Closeout	Milestone: Final Evaluation

[3] Represents Medicaid participants actively receiving behavioral health services; number impacted will depend on systems and providers who receive competitive grants.

Strategy	Year 4-Q1	Year 4-Q2	Year 4-Q3	Year 4-Q4
5. and 6.	Milestone: Evaluate impact of new programs	Milestone: Evaluate impact of new programs	Milestone: Closeout	Milestone: Final Evaluation
7. - 14.	Milestone: Implement	Milestone: Implement	Milestone: Closeout	Milestone: Final Evaluation
15	Milestone: Work with plans and providers on sustainability strategy	Milestone: Work with plans and providers on sustainability strategy	Milestone: Closeout	Milestone: Final Evaluation

Table 3 Project Risk Identification and Associated Mitigation Strategies

Risks	Impact and Probability	Mitigation Strategies
Integration: Challenges of any community-supported HIE, exacerbated by minimal prior support for BH providers; less organization in BH community surrounding HIT/HIE and data sharing.	Medium/High	Work closely with AzHEC and the Network on resources and potential IT transition. Will utilize project management and track timelines.
Integration: Partnerships between ACOs and other physical health care providers with BH providers not historically well-established; potential resistance from providers on significant challenges.	Medium/High	Continue work with stakeholders on education and communication opportunities. Identify promising models and provide TA to providers. Further align funding through continued payer integration.
Workforce: Universities require longer lead time and are not as nimble as the private sector, so timelines may be aggressive.	Low/Medium	Requirement to partner with providers will create more flexibility. Establish stakeholder team early to expedite communication
AI Care Coordination: Fragmentation in the delivery system between IHS, 638 and non-tribal providers is generally very significant. Data from IHS system is limited and work required to expand the codes reported. Providers need significant assistance with data analysis.	Medium/Medium	Focus on regional approach with at providers who have extensive AI populations; incrementally expand data reporting requirements. Use experienced staff to build and leverage relationships.
Justice System Transitions: Aggressive timeframes, limited resources and limited data infrastructure in justice system. Large numbers of inmates transitioning , so need to focus on highest acuity first.	Low/Medium	Establish formal project management and executive oversight. Leverage existing relationships and infrastructure. Begin with larger jails and ADOC.
QHP Coordination: Engagement of commercial plans can be challenging, require corporate involvement/signoff. Arizona has over 30 commercial plans.	Medium/High	Build on previous stakeholder work; engage Governor's Office leadership to bring commercial carriers. Start with major carriers representing a significant portion of

Risks	Impact and Probability	Mitigation Strategies
		the population, then expand.
Payment Reform: Aggressive contractual requirements on plans. Shared savings and other models are complex and both payers and providers have limited experience. Need addition actuarial work to retain savings in system while still meeting CMS requirements.	Medium/Medium	Leverage vertically integrated systems to mitigate risks. Continue learning collaboratives to share information. Use experience from pilots to inform actuarial work.
Schedule Risks – Aggressive timelines mean need for continual monitoring	High/Medium	Significant resources are dedicated. Plan to establish project managers specific to each project component.
Technical Risks – Ensuring compatibility among various disparate systems.	High/Medium	Will require careful planning of technical specifications. Ensure sufficient IT resources dedicated to the project.

Appendix A – Key Arizona SIM Initiative Resources

In addition to the details provided in the Operational Plan, Arizona provides this summary of key resources committed to the Arizona SIM Initiative.

Key Executive Personnel

Don Hughes, *Deputy Director for Policy, Office of the Governor Janice K. Brewer*. He is responsible for policy issues regarding health care, behavioral health, public health, Medicaid, insurance, tort reform and health care innovation. Before joining the Governor's office, he was a full time lobbyist representing the insurance industry and other health care clients. He also served as a policy advisor for Governor Jane Dee Hull on regulatory, insurance and health care issues. Mr. Hughes will provide policy and executive oversight to the Arizona SIM Initiative.

Tom Betlach, *Medicaid (AHCCCS) Director* Mr. Betlach has 23 years of State Service. He has served as State Budget Director for 5 years, AHCCCS Deputy Director for 7 years and AHCCCS Director for the past 5 years, where he reports directly to Governor Brewer. In these roles Mr. Betlach has served at the pleasure of four different Governors spanning both political parties. Mr. Betlach brings a wealth of operational, financial and policy experience. He will serve as the Executive Sponsor and as such will lead Executive Steering Committee oversight and monitoring of the project.

Beth Lazare, *AHCCCS Deputy Director.* Ms. Lazare has 15 years of health care policy and administration experience. As the Deputy Director, she oversees the day to day operations of the agency and helps set the strategic vision for the program. Prior to her work at AHCCCS, she was the Deputy Policy Director and health and human services policy advisor in the Arizona Governor's Office. Ms. Lazare has also worked as a Medicaid consultant for various states, and has served as a senior fiscal and health policy advisor for the Arizona Legislature. Ms. Lazare will serve as the SIM initiative lead and be responsible for day-to-day oversight of the initiative.

Will Humble, *Director, ADHS,* Mr. Humble has over 25 years in public health service and as the Director of ADHS, he oversees Arizona's public and behavioral health systems. Mr. Humble led the overhaul of Arizona health facility regulations that facilitated integrated care with a focus on outcomes and evidence-based standards. Mr. Humble is leading the developing of the SHIP and will facilitate the integration of public health strategies into the SIM.

Cory Nelson, *Deputy Director, ADHS.* Mr. Nelson oversees Behavioral Health Services for the State of Arizona, including oversight of the state's public behavioral health system and the Arizona State Hospital, a 300 bed facility that operates three distinct programs for civil, forensic and sex offender populations. Prior to his work in Arizona he was the CEO of the South Dakota Human Services Center for 10 years; Director of Juvenile Corrections for two years and also worked as a Chief Probation Officer and line level officer.

George Jacobson, *Payment Modernization Project Manager*, Mr. Jacobson has worked in health care in Arizona for 26 years. He served as a hospital executive including chief operating officer positions and in various nursing facility administrative positions including as regional vice president. In April 2013, Mr. Jacobson assumed his current position at AHCCCS as the Project Manager Payment Modernization. In this capacity he coordinates the agency's care delivery and payment reform initiatives.

Subject Matter Experts and Other Support Resources

The following individuals are key individuals leading the Arizona initiatives and, as such, will provide support to the SIM initiative in the same capacity. Unless otherwise noted, these individuals work for AHCCCS:

Sara Salek, M.D., *Chief Medical Officer.* Dr. Salek earned her medical degree from The University of Arizona College of Medicine. She completed the Child and Adolescent Psychiatry Residency Training Program at Boston Children's Hospital and Harvard Medical School. Dr. Salek is board certified in both Psychiatry and Child and Adolescent Psychiatry. Dr. Salek previously served as Deputy Chief Medical Officer and Medical Director for Children's Services at ADHS/Division of Behavioral Health Services.

Cara Christ, M.D., *Deputy Director for the Division of Public Health Services, Assistant Director for the Division of Licensing Services and Agency Chief Medical Officer, ADHS*. Before assuming her current roles, she led the Department's Bureau of Epidemiology and Disease Control and served as Chief Medical Officer for the Divisions of Public Health Preparedness and Prevention. In her capacity as Bureau Chief, she oversaw a wide variety of programs ranging from infectious diseases, immunizations, environmental health, HIV epidemiology, and Ryan White Care and Services. She received her Bachelor and Master of Science Degrees in Microbiology, with an emphasis in molecular virology and epidemiology, from Arizona State University in Tempe. She attended medical school at the University of Arizona in Tucson, and trained in Obstetrics and Gynecology at Banner Good Samaritan Medical Center in Phoenix.

Kari Price, *Assistant Director.* Ms. Price has responsibility for Health Plan Operations, Medical Management, Clinical Quality Management including the implementation of incentive payments for Electronic Health Record implementation, Behavioral Health and Medicare. Ms. Price has been with AHCCCS in various capacities for over 19 years. Prior to coming to AHCCCS, she worked at an AHCCCS health plan, a hospital and in public accounting.

Shelli Silver, *Assistant Director.* Ms. Silver's division is responsible for procuring contracts for, and the ongoing performance management of, MCOs serving more than 1.5 million members, with expenditures exceeding $10 billion annually. Ms. Silver's areas of responsibility include capitation and rate development and oversight of MCO financial and encounter data operations. Ms. Silver has over 15 years of service with AHCCCS.

Elizabeth A. Carpio, MGS, *Tribal Care Coordinator*. Ms. Carpio is the Interim Assistant Director for the Division of Fee for Service Management at the Arizona Health Care Cost Containment System (AHCCCS). She has 15 years of experience working in diverse communities, most notably as the Director of the Senior Services Department for the Salt River Pima-Maricopa Indian Community in Scottsdale, AZ. Ms. Carpio brings a wealth of knowledge and expertise in the areas of care coordination, behavioral health and integration.

Craig Srsen, *Business Intelligence Administrator.* Mr. Srsen is the Business Intelligence Administrator for AHCCCS, where he has oversight over the data warehouse and a staff of data analysts for reporting and analytics on AHCCCS' data. Prior to joining AHCCCS, Mr. Srsen was a Medicaid policy and financial consultant for twelve years, during which time he led or assisted in consulting projects for Medicaid agencies in 25 states.

Jim Cockerham, *CFO.* Mr. Cockerham has 23 years of State service, 7 years in private industry and over 6 years in public accounting with a Big 4 accounting firm. His state career includes serving as the AHCCCS Chief Financial Officer and Assistant Director of the Division of Business and Finance for 17 years and with the State Budget Office where he was the Deputy Director. Mr. Cockerham is a Certified Public Accountant and a Certified Management Accountant and has acquired an abundance of state government finance and policy knowledge over the past 23 years.

Michal Rudnick, *Project Manager – Criminal Justice Transitions.* Ms. Rudnick has 15 years of State Service working in multiple capacities for AHCCCS. For the past 7 years, Ms. Rudnick has served as a Project Manager directing and supervising agency projects from beginning to end providing leadership, direction and oversight. She leads teams that include both internal and external stakeholders that often focus on changes related to Federal and State policy initiatives.

Lorie Mayer, *Medicaid HIT Coordinator and State of Arizona HIT Coordinator*. Ms. Mayer has 10 years of State Service as the Medicaid HIT Coordinator filling a concurrent, dual role for the last three years as the State of Arizona HIT Coordinator for the Arizona Strategic Enterprise Technology Office. Ms. Mayer is the Medicaid liaison to the Regional Extension Center and in that capacity has coordinated the dissemination of EHR technology in Arizona under the American Recovery and Reinvestment Act of 2009.

Kim M. Elliott, Ph.D., C.P.H.Q., *Clinical Quality Administrator.* Dr. Elliott oversees the Clinical Quality Management Unit. Kim participates in numerous initiatives at the community, state and national level including care integration/coordination, performance metrics, quality improvement, and meaningful use. She has been with AHCCCS since 2001. Prior to joining AHCCCS, Kim worked in clinical and operational areas of health plans serving Medicaid, Medicare and commercial members.

Bonnie Talakte, *Tribal Liaison.* Ms. Talakte has served as AHCCCS Tribal Relations Liaison since 2012. In this position, she serves as the liaison between AHCCCS, IHS, and P.L.-638 tribal health facilities, and Arizona Tribes. Bonnie also has 20 years of Higher Education experience having served as the Dean of Student Services at Central Arizona College, Director of American Indian Programs at Scottsdale Community College, and Director of Recruitment and Enrollment at UCLA.

Barbara Lang, *Behavioral Health Administrator.* Ms. Lang is an administrator, a Licensed Substance Abuse Counselor, a Licensed Professional Counselor and a Certified Clinical Sex Offender Treatment Specialist with a total of over 20 years of experience working in the behavioral health field.

Jeffery Tegen, *Budget Administrator.* Mr. Tegen has been with the AHCCCS Budget Department for over 18 years, the last 13 years in the role of Budget Administrator. In this role, he directs the submission of the agency's $10 billion annual administrative and programmatic budget to the Governor's Office of Strategic Planning and Budgeting and the Joint Legislative Budget Committee Staff.

Melissa Kotrys, *CEO of Arizona Health-e Connection, and CEO of Health Information Network of Arizona*. She has 15+ years of health care experience and 7 years of HIT and HIE expertise. Mrs. Kotrys is a leading expert on electronic health records, e-prescribing, health information exchange and HIT/HIE policy. She brings a wealth of leadership, policy and operations expertise and developed and executed initiatives that bring major health care stakeholders together for a common goal of utilizing technology to advance the health and wellness of Arizonans.

Monica Coury, *Assistant Director.* Ms. Coury is an attorney that has served as Assistant Director of Intergovernmental Relations with AHCCCS for over 7 years. In this role, she oversees the State's 1115 waiver and State Plan, tribal relations, media relations, state legislative affairs and community outreach and education. She was with a private law firm in Phoenix before coming to AHCCCS and has a background in public policy having worked in Washington DC for 10 years prior to becoming an attorney.

Windy Marks, *Lead Actuary.* Ms. Marks served as the State Medicaid Actuarial Administrator for 10 years. Before that role she served as a consultant actuary and a health plan actuary. Ms. Marks brings a wealth of actuarial experience. She will serve as the Lead Actuary and will have oversight of actuarial work for the project.

Matthew J. Devlin, *Assistant Director, Office of Administrative Legal Services*. As the AHCCCS General Counsel, Mr. Devlin serves as the Privacy Officer and as in-house counsel for the agency. During his 25 plus years of practicing law, Mr. Devlin has also worked for the Arizona Attorney General, the University of Wisconsin-Madison, as an Administrative Law Judge for the State of Wisconsin, and has been in private practice in Dubuque, Iowa. He has been with AHCCCS since 1999.