State Medicaid Advisory Committee (SMAC)

Wednesday, November 16, 2016
AHCCCS
Gold Room - 3rd Floor
701 E. Jefferson Street
1 p.m. – 3 p.m.

**Agenda**

| I. Welcome | Director Thomas Betlach |
| II. Introductions of Members | ALL |
| III. Approval of August 17, 2016 meeting summary | ALL |

**Agency Updates**

| IV. AHCCCS Update | Director Thomas Betlach |
| V. Pediatric Prepared Emergency Care | Tomi St. Mars MSN, RN Peggy Stemmler, MD, MBA |
| VI. Opioid Update | Shana Malone |

**Discussion**

| VI. Call to the Public | Director Thomas Betlach |
| VII. Adjourn at 3:00 p.m. | ALL |

---

*2016 SMAC Meetings*

Per SMAC Bylaws, meetings are to be held the 2nd Wednesday of January, April, July and October. All meetings will be held from 1 p.m.- 3 p.m. unless otherwise announced at the AHCCCS Administration 701 E. Jefferson, Phoenix, AZ 85034, 3rd Floor in the Gold Room:

**January 13, 2016** – Rescheduled to February 3, 2016
**April 13, 2016**

**July 13, 2016** – Rescheduled to August 17, 2016

**October 12, 2016** – Rescheduled to November 16, 2016

For more information or assistance, please contact Yisel Sanchez at (602) 364-4577 or yisel.sanchez@azahcccs.gov
AHCCCS Update
AHCCCS Update
Overview

• Mission
  o Reaching across Arizona to provide comprehensive, quality health care to those in need

• Vision
  o Shaping tomorrow’s managed care from today’s experience, quality, and innovation

• Values
  o Passion, Community, Quality, Respect, Accountability, Innovation, Teamwork, Leadership
Select AHCCCS Initiatives

1. Active Thoughtful Purchaser
2. Integration efforts
3. Value Based Purchasing
4. Justice System transitions
5. Autism related services
6. Opioid Crisis
7. Program Integrity
8. Health Information Technology
9. American Indian care coordination and support

Reaching across Arizona to provide comprehensive quality health care for those in need
## Potential Impact ACA Changes

<table>
<thead>
<tr>
<th></th>
<th>GF Costs</th>
<th>Total $ Removed from Economy</th>
<th>Members Losing Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Eliminate non-categorical adults 0-138%</td>
<td>$328 m</td>
<td>$3,239 m</td>
<td>(425,338)</td>
</tr>
<tr>
<td>2. Waiver at regular FMAP 0-100%, Eliminate 100-138%</td>
<td>$1,021 m</td>
<td>$599 m</td>
<td>(115,823)</td>
</tr>
<tr>
<td>3. Waiver at regular FMAP 0-100%, Freeze enroll. 100-138%</td>
<td>$1,032 m</td>
<td>$175 m</td>
<td>-</td>
</tr>
</tbody>
</table>
Funding Sources impacting GF

1. Hospital Assessment tied to provisions of ACA with automatic repeal
2. Prescription drug rebate for MCO pharmacy spend
3. Enhanced CHIP match for children’s expansion
All that, said Ducey, makes outright repeal without something else to take its place unacceptable.

“I’m not talking about repeal,” he said.

“I’m talking about repeal and replace,” Ducey continued. “I want to see all of our citizens have access to health care that’s affordable.”

With outright repeal unacceptable, the governor said it remains to be seen what Trump and Congress can come up with as an alternative.

“The devil is going to be in the details of a health care plan that allows accessibility to all of our citizens,” he said.

“That’s the discussion that we’re going to have,” the governor continued. “What we have currently isn’t working.”
Amid the discussion of the likely repeal-and-replace of Obamacare that will follow Trump’s inauguration, Brewer said she hopes the expansion of AHCCCS, which she shepherded through the Legislature in 2013, stays intact.

“They can implement AHCCCS in all 50 states. They probably will tweak it or revise it some, but it’s on the table, as far as I’m concerned, to be discussed. And I’m rooting for Arizona’s AHCCCS program,”
ACA provisions outside coverage

- Essential benefits package
- MAGI income calculations and new eligibility systems
- Former foster youth who were in foster system for 6 months can stay on Medicaid until 25
- CHIP FMAP
- Hospital presumptive eligibility
- Family planning extension
- Drug rebates for managed care
- Authority for dual demonstrations (no direct impact on AZ)
- Program integrity requirements
**Block Grant/PMPM discussion**

- What is in the base for federal grant? (e.g., A Better Way builds off 2016 and phases down enhanced ACA FMAP to regular FMAP.)
  - Note less efficient states may have room to make program changes to save funding and avoid cutting populations; Arizona has little room on benefits or provider rates or utilization rates (things like leveraging home and community services).

- What is the state match or maintenance of effort requirement?

- How is the expansion incorporated?
Block Grant/PMPM discussion

• What is in funding formula for growth and how is that calculated? What inflation factors are used?
• How is population growth accounted for? Is the formula a per member?
• What is the funding formula for recessions?
• What is in statutory framework for requirements?
  o Populations covered
  o Services covered? (mandatory vs optional?)
  o Payment levels? Access to care & network?
• What happens with existing regulatory structure including but not limited to State plans and 1115 waivers?
LAN Payment Reform Framework

Figure 1. APM Framework (At-A-Glance)

Category 1
Fee for Service – No Link to Quality & Value

Category 2
Fee for Service – Link to Quality & Value

Category 3
APMs Built on Fee-for-Service Architecture

Category 4
Population-Based Payment

A
Foundational Payments for Infrastructure & Operations

B
Pay for Reporting

C
Rewards for Performance

D
Rewards and Penalties for Performance

A
APMs with Upside Gainsharing

B
APMs with Upside Gainsharing/Downside Risk

A
Condition-Specific Population-Based Payment

B
Comprehensive Population-Based Payment
## Potential Future VBP Levels

<table>
<thead>
<tr>
<th>CYE</th>
<th>Acute</th>
<th>ALTCS EPD</th>
<th>CRS</th>
<th>RBHA</th>
<th>DDD</th>
<th>LTSS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SMI-Integrated</td>
<td>Non-Integrated</td>
<td></td>
</tr>
<tr>
<td>CYE 14</td>
<td>5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CYE 15</td>
<td>10%</td>
<td>5%/1.5%</td>
<td>5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CYE 16</td>
<td>20%</td>
<td>15%/15%</td>
<td>20%</td>
<td>5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CYE 17</td>
<td>35%</td>
<td>25%/25%</td>
<td>35%</td>
<td>15%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CYE 18</td>
<td>50%</td>
<td>35%/35%</td>
<td>50%</td>
<td>25%</td>
<td>10%</td>
<td>20%</td>
</tr>
<tr>
<td>Anticipated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CYE 19</td>
<td>60%</td>
<td>50%/50%</td>
<td>60%</td>
<td>35%</td>
<td>20%</td>
<td>35%</td>
</tr>
<tr>
<td>Anticipated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CYE 20</td>
<td>70%</td>
<td>60%/60%</td>
<td>70%</td>
<td>50%</td>
<td>35%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Reaching across Arizona to provide comprehensive quality health care for those in need
## APM Proposed Targets

<table>
<thead>
<tr>
<th>DSRIP Year</th>
<th>Percent Spend LAN 2-4</th>
<th>Percent Spend LAN 3 &amp; 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>CYE 2017</td>
<td>30%</td>
<td>NA</td>
</tr>
<tr>
<td>CYE 2018</td>
<td>40%</td>
<td>5%</td>
</tr>
<tr>
<td>CYE 2019</td>
<td>50%</td>
<td>10%</td>
</tr>
<tr>
<td>CYE 2020</td>
<td>60%</td>
<td>20%</td>
</tr>
</tbody>
</table>
Reaching across Arizona to provide comprehensive quality health care for those in need
AMS Transformation in State Government

- Large Cabinet agencies actively pursuing
- MVD reduced wait times and increased throughput in very busy office
- DOC reduced CO hiring from 120 days to 30
- DES UI Call center 100 min to 10 sec
- ADOA building renew visual mgmt. board
- DOR Call center – 45 min drop – calls less than 1 min

Reaching across Arizona to provide comprehensive quality health care for those in need
National Rx Opioid Trends (NIDA)

Reaching across Arizona to provide comprehensive quality health care for those in need
Reaching across Arizona to provide comprehensive quality health care for those in need
Reaching across Arizona to provide comprehensive quality health care for those in need
Reaching across Arizona to provide comprehensive quality health care for those in need
AHCCCS Generations in workplace (2013)

- Traditionalists: 1.6% (Born: 1927-1945)
- Baby Boomers: 50.7% (Born: 1946-1964)
- Gen X: 30.0% (Born: 1965-1976)
- Gen Y: 17.6% (Millennium Born: 1977-1995)

Total # of employees: 936

Reaching across Arizona to provide comprehensive quality health care for those in need
AHCCCS Generations in workplace 2016

- 0.5% Traditionalists
- 40.3% Boomers
- 31.2% Gen X
- 27.7% Gen Y
- 0.3% Gen Z

Total # of employees: 1,038

Reaching across Arizona to provide comprehensive quality health care for those in need
Arizona’s 1115 Waiver Status

• Arizona’s application for a 5-year waiver included:
  
  o Part I: Governor Ducey’s vision to modernize Medicaid: The AHCCCS CARE program
  o Part II: The Legislative Partnership
  o Part III: DSRIP: Arizona’s Approach
  o Part IV: HCBS Final Rule
  o Part V: American Indian Medical Home
  o Part VI: Building Upon Past Successes
  o Part VII: Safety Net Care Pool
Questions?

Reaching across Arizona to provide comprehensive quality health care for those in need
Pediatric Prepared Emergency Care
Tomi St. Mars MSN, RN
Peggy Stemmler MD, MBA
October 12, 2016
Partnership

- ADHS
- AzAAP - institutional home
- Steering Committee
- Members
2013-14 National Pediatric Readiness Project Assessment Results

The following results represent a national initiative sponsored by the federal Emergency Medical Services for Children Program (EMSC) to ensure that emergency departments (EDs) are ready to care for children. EDs were asked to take an assessment regarding available resources for the care of children and received a score based on a **100 point scale**.

Rev. 3/21/2014

### Average Pediatric Readiness Scores

<table>
<thead>
<tr>
<th>Low Volume (&lt;1800 patients)</th>
<th>Medium Volume (1800-4999 patients)</th>
<th>Medium to High Volume (5000-9999)</th>
<th>High Volume (&gt;=10000)</th>
<th>All Participating Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>62</td>
<td>70</td>
<td>74</td>
<td>84</td>
<td>69</td>
</tr>
<tr>
<td>n = 1629</td>
<td>n = 1248</td>
<td>n = 708</td>
<td>n = 561</td>
<td>n = 4146</td>
</tr>
</tbody>
</table>
State Name: Arizona
Report Date: 3/5/2014 11:35:46 AM
Number of Hospital Respondents: 77
Number of Hospitals Assessed: 77
Response Rate: 100.0%

STATE SCORE AND COMPARATIVE SCORES:

- **72**
  - State Average Hospital Score out of 100
- **73**
  - State Median Hospital Score out of 100
- **69**
  - National Median of Participating Hospitals

**DISTRIBUTION OF STATE SCORES FOR EACH VOLUME TYPE:**

- Low (<1800 patients)
- Medium (1800-4999 patients)
- Medium High (5000-9999 patients)
- High (>=10000 patients)
Voluntary Membership & Certification

• Based on national guidelines
  – American Academy of Pediatrics (AAP)
  – American College of Emergency Physicians (ACEP)
  – Emergency Nurses Association (ENA)

• Refined by Arizona stakeholders
  – Hospital CEOs, emergency department leadership

• Modeled on Arizona Perinatal Trust practices
3 Levels

• Advanced Care
  – Must have PICU and Pediatric Coordinator
  – Highest level of credentials, continuing education required

• Prepared Plus Care
  – Higher level of credentials, education requirements

• Prepared Care
  – Most community EDs inclusive of critical access/tribal hospitals
All Levels

- Pediatric-specific equipment
- Pediatric-specific quality review process
- Review of policies
- Review of facilities
Education

- Emergency Nurse Pediatric Course (ENPC)
- Emergency Nurse Certification prep (CEN)
- Pediatric Emergency Nurse Certification prep (CPEN)
- Focus on pediatric-specific CME
- Pediatric mock codes
- Arizona Pediatric Symposium
  - Annual pediatric conference
  - EMS and ED staff
Small Changes = Big Results

• Scales locked in kilograms
• Standardize code carts
• ENPC
• Membership resource site
• Raising the bar every 3 years
ALL pediatric meds MUST be double checked with another RN, pharmacist or M.D.
Common Challenges

• Pediatric disaster policies
• Behavioral health inpatient beds
• Child maltreatment protocols
Certification

• **Advanced Care**
  – Arizona Children’s Center at Maricopa Medical Center
  – Banner Thunderbird Medical Center
  – Banner University Medical Center – Tucson
  – Cardon Children’s Medical Center
  – Phoenix Children’s Hospital
  – HonorHealth – Shea Medical Center
  – Tucson Medical Center for Children

• **Prepared Plus Care**
  – Dignity Mercy Gilbert Medical Center
  – HonorHealth Deer Valley Medical Center
  – HonorHealth Osborn Medical Center
  – HonorHealth Thompson Peak Medical Center
  – Summit Healthcare Regional Medical Center
  – Yuma Regional Medical Center
Certification

- Prepared Care
  - Abrazo Central Campus
  - Banner Baywood Medical Center
  - Banner Boswell Medical Center
  - Banner Del E Webb Medical Center
  - Banner Estrella Medical Center
  - Banner Gateway Medical Center
  - Banner Goldfield Medical Center
  - Banner Ironwood Medical Center
  - Banner Page Hospital
  - Chinle Comprehensive Health Care Facility
  - Cobre Valley Regional Medical Center
  - Copper Queen Community Hospital
  - Mount Graham Regional Medical Center
  - Northern Cochise Community Hospital
  - Oro Valley Hospital
  - Tuba City Regional Health Care Corporation
  - White Mountain Regional Medical Center
Members

- In progress for certification
  - Abrazo Maryvale
  - Banner Casa Grande Medical Center
  - Banner University Medical Center – South Campus
  - Benson Hospital
  - Cochise Regional Hospital
  - Gila River HuHuKam Memorial Hospital
  - La Paz Regional Hospital
  - Parker Indian Health Center
  - Phoenix Indian Medical Center
Analysis

• Emergency Department and Death data
• Facilities pre/post and non-verified centers
• Injury is a sensitive indicator
• Improvements
Pediatric Mortality Rates Pre/Post Emergency Department Certification (All Pediatric ED Visits), Arizona 2011-2014

- Pre-certification: 35.2
- Post-certification: 34

Mortality Rate per 100,000 Pediatric ED Visits
Comparing the Certified Emergency Department's Pediatric Mortality Rate to the Overall Pediatric Injury Mortality Rate, Arizona 2011-2014

Rate per 100,000 ED Visits

- All Hospitals: 35.5
- Certified Hospitals: 25.6

ARIZONA DEPARTMENT OF HEALTH SERVICES
Health and Wellness for all Arizonans
Figure 4. Pediatric Trauma Mortality Rates among Certified and Non-Certified Hospitals, 2011-2014

- Non-certified: 11.9 per 1,000
- Certified: 8.6 per 1,000

Mortality Rate per 1,000 Pediatric Trauma Emergency Department Visits
Figure 6. Pediatric Trauma Emergency Department Mortality Rates among Certified and Non-Certified Hospitals by Age Group, 2011-2014

Mortality Rate per 1,000 Pediatric Trauma Emergency Department Visits

- 15-17 Years
- 10-14 Years
- 5-9 Years
- 1-4 Years
- <1 Year

Non-Certified
Certified
Moving Evidence into Practice

• Demonstrating success
• Flexibility to respond to evidence
• Kids win regardless of geographic location
Questions?

www.azaap.org/Pediatric_Prepared_Emergency
Opioid Update
Arizona’s Opioid Epidemic
Understanding the Problem and Finding Solutions
The National Opioid Influx

- A 4 fold increase in the quantity of Rx Opioids sold in the U.S.

- The U.S. makes up 4.6% of the world’s population, but consumes 80% of its Rx opioids

- ~52 deaths every day!
Nearly 2 million Americans abused or were dependent on prescription opioids in 2014.
Availability of Rx Opioids in Arizona

• ~575 million Class II-IV pills are dispensed each year in Arizona

• Opioids account for 60%

• Access & probability

Oxycodone 27.9%
Hydrocodone 20.9%
Benzodiazepine 21.8%
Other Rx Pain Relievers 11.2%
Cialisoprolol 3.9%
All Other Rx Drugs 14.9%
Volume: Access Ratio

- Enough Rx opioids were dispensed last year to medicate every Arizona adult around the clock for more than 2 weeks.
Emerging Heroin Trends

Prescription opioid misuse is a major risk factor for heroin use

3 out of 4 people who used heroin in the past year misused opioids first

7 out of 10 people who used heroin in the past year also misused opioids in the past year

DEA Issues Alert on Fentanyl-Laced Heroin as Overdose Deaths Surge Nationwide

BY JOIN TOGETHER STAFF

March 19th, 2015
What the Opioid Epidemic is Costing Arizona
Arizona Opioid-Related ED Encounters and Hospital Admissions

- EMERGENCY ENCOUNTERS: 114.5% Increase
- HOSPITAL ADMISSIONS: 91.6% Increase

Reaching across Arizona to provide comprehensive quality health care for those in need
AHCCCS represented 51% of Arizona hospital births between 2008 and 2014, but was the payer for 79% of the NAS cases.
Number of Drug Overdose Deaths Involving Opioids, Arizona 2005-2015 (ADHS)

- Opioid pain relievers* (T40.2-T40.4): 44.2% Increase
- Heroin (T40.1): 693.3% Increase

*includes methadone
The Path to Opioid-Mortality

• Dosage too large for opioid-naïve individuals

• Given tolerance:threshold ratio, users begin taking more and more just to get to “baseline”

• Users in recovery who start again, often start with their last dose. If tolerance has lessened, body can’t accommodate

• Cocktailing with alcohol, Rx benzos, and Rx muscle relaxers
Finding a Solution
3 Groups to Target

1. Opioid-Naïve Individuals
2. The Chemically Dependent
3. Diverters
Strategy #1

Promote Responsible Prescribing and Dispensing Policies and Practices
Opioid-Naïve Individuals

- Those who have never taken narcotics and have minimal experience with controlled substances
  - Don’t get them started if you don’t have to
  - Non-opioid Tx first
  - Minimal supply of opioids if necessary
  - No refills
Talking to Uninformed Patients

- Educate patients about the importance of proper adherence and the risks of misuse
  - Taking more than prescribed
  - Mixing with other drugs and/or alcohol
  - Not sharing scripts with others and why
  - Proper storage and disposal – especially if kids are present in the home
The Chemically Dependent

• Individuals who have developed symptoms of tolerance or physiological and/or psychological withdrawal if use of the Rx drug (legitimately or illegally acquired) is reduced or discontinued

• At GREATEST risk for overdose!
  - Use data to identify “high risk” members – coordinate member care
  - Use data to identify problematic prescribing patterns – coordinate provider education

AHCCCS
Arizona Health Care Cost Containment System
High-Risk Groups

- 45-54 year olds
- Youth and young adults (quicker path to heroin)
- Women of child-bearing age
- Criminal Justice population
- American Indians
- Polypharm patients
  - Specifically those combining opioids with benzodiazepines and/or muscle relaxers
- Former users
- Medicaid patients

AHCCCS
Arizona Health Care Cost Containment System
Sign Up and **USE** the CSPMP

- Ensure Patient Safety
- Limit Liability
- Now Easier than Ever with Delegate Option
Facilitate Use of Best Practices

SUMMARY OF ARIZONA OPIOID PRESCRIBING GUIDELINES FOR THE TREATMENT OF CHRONIC NON-TERMINAL PAIN (CNTP)

#1: A comprehensive medical and pain related evaluation that includes assessing for substance use, psychiatric comorbidities, and functional status should be performed before initiating opioid treatment for chronic pain.

#2: A goal directed trial of opioid therapy is considered appropriate when pain is severe enough to interfere with quality of life and function and the patient has failed to adequately respond to indicated non-opioid and non-drug therapeutic interventions. Potential benefits should be determined to outweigh risks. The patient should agree to participate in other aspects of a pain care plan such as physical therapy and cognitive behavioral therapy when these therapies are recommended and available.

#3: The provider should assess for risk of misuse, addiction, or adverse effects, and perform a risk stratification before initiating opioid treatment.

#4: Initiating opioids in patients with CNTP should ideally be limited to the evidence-based indication of short term therapy with the purpose of facilitating participation in a comprehensive care plan; however, if chronic opioid therapy (COT) is considered, a goal directed trial lasting 30-90 days should be the starting point. Continuing opioid treatment after the treatment trial should be a deliberate decision that weighs the risks and benefits of chronic opioid treatment for that patient.

Arizona Guidelines
For Dispensing Controlled Substances

SUMMARY OF ARIZONA OPIOID PRESCRIBING GUIDELINES FOR THE TREATMENT OF ACUTE PAIN

The goal of these guidelines is to balance the appropriate treatment of pain with approaches to more safely prescribe opioids. Thoughtful opioid prescribing for acute and post-operative pain can improve safety, reduce harm, and prevent the unintended or inappropriate long-term use of opioid medications.

Note: These guidelines are not intended to apply to hospice or palliative care patients (as defined by the World Health Organization), patients at end of life, or cancer-related pain.

#1: Opioid medications should only be used for treatment of acute pain when the severity of the pain warrants that choice, and non-opioid pain medications or therapies will not provide adequate pain relief.

#2: When opioid medications are prescribed for treatment of acute pain, the number dispensed should be no more than the number of doses needed. This should be based on the expected duration of pain severe enough to justify prescribing opioids for that condition.

#3: When opioid medications are prescribed for acute pain, the patient should be counseled on the following:

- Sharing with others is illegal.
Register for FREE CME

www.VLH.com/AZPrescribing

Safe and Effective Opioid Prescribing While Managing Acute and Chronic Pain

An online program offering 2 Free CME Credits to help Arizona DEA prescribers incorporate into practice the 2014 Arizona Opioid Prescribing Guidelines.

CLICK HERE to Get Started and Register Your VLH.com Account

Learning Objectives

There is increasing evidence that opioid medications are over-prescribed and poorly managed because physicians are not aware of appropriate opioid risk management strategies and non-opioid approaches to treating chronic pain. This
Educate Patients

Pain Management
A Guide for Patients

You would do anything for your friends...

but when it comes to medicine,
sharing isn’t caring!
Your meds are just for you.

Click here for Pain Management video

Parent talk kit
Tips for Talking and What to Say to Prevent Drug and Alcohol Abuse
Diverters
Doctor Shoppers, Pill Mills and the Candy Man

- Individuals seeking controlled substances for the purpose of selling them to others or healthcare professionals engaged in fraudulent prescribing practices

- What to do
  - Check the CSPMP
  - Safeguard DEA # and script pads
  - Communicate with other prescribers and pharmacists
  - Look for red flags
  - When to contact Regulatory Boards and Law Enforcement
Strategy #2

Enhance Harm Reduction Strategies to Prevent Opioid Overdoses
Reverse Overdoses Through Naloxone

- HB2355
  - Pharmacists can dispense without a prescription to person at risk, family member or community member
What’s Needed for Naloxone?

1. Develop and disseminate CME training modules on Naloxone
2. Develop and disseminate community-based Naloxone trainings and educational material for members
3. Support community-based distribution project
4. Promote co-prescribing to high risk members
Strategy #3

Enhance Access to Integrated Medically Assisted Treatment
Evidence-Based Treatment

MEDICATION-ASSISTED TREATMENT (MAT)

Thought
Emotion
Behavior

What we think affects how we act and feel.
What we feel affects what we think and do.
What we do affects how we think and feel.

Motivational Interviewing

Reaching across Arizona to provide comprehensive quality health care for those in need
What's Needed for Integrated MAT

- Capacity assessment and gap analysis
- Awareness of CARA ACT and Data2000 changes
- Expanding MAT providers into primary care practices
- Centers of Excellence for Integrated MAT?
- Education and training on MAT (members, community, providers and external partners)
Coming Soon!

NAS and pregnant member strategy
Thank You.

Reaching across Arizona to provide comprehensive quality health care for those in need