

How Arizona Medicaid Accelerated the Integration of Physical and Behavioral Health Services

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ABSTRACT

ISSUE: In most states, one agency has responsibility for Medicaid enrollees' physical health services and at least one other agency has responsibility for their behavioral health services. Apportioning responsibility for the physical and behavioral health of Medicaid beneficiaries into different agencies inevitably leads to different—and sometimes misaligned—policy goals, program priorities, and purchasing strategies, thereby impeding the delivery of integrated care.

GOAL: To describe the rationale, process, and impact of Arizona's 2015 consolidation of its physical and behavioral health services agencies into its Medicaid agency.

METHOD: The study is based on published research, Arizona Medicaid agency materials, and interviews with 34 individuals, including representatives from the current Medicaid agency and previous behavioral health services agency, health plans, primary care and behavioral health providers, consumers, the justice system, and the health information exchange.

FINDINGS AND CONCLUSIONS: Consolidation has led to increased attention to behavioral health services and behavioral and physical health integration, enabled more strategic purchasing and streamlined regulatory processes, and enhanced communication, collaboration, and mutual trust across sectors. Arizona's experience offers lessons to policymakers as they consider how best to integrate physical and behavioral health services and ensure that Medicaid is an efficient and effective purchaser of health care services.

KEY TAKEAWAYS

- ▶ Many states have separate agencies responsible for Medicaid enrollees' physical and behavioral health services, which can lead to misaligned policy priorities and purchasing strategies
- ▶ Arizona's consolidation of its physical and behavioral health services agencies into its Medicaid agency offers lessons to other states in how to achieve agency integration as a means to accelerating delivery system integration in Medicaid



BACKGROUND

Medicaid is the nation's largest health insurer, covering more than one of five Americans. It is also the largest insurer of behavioral health services, including mental health and substance use disorder services. The program's significant role in the delivery of behavioral health services has focused attention on state agency structures for administering these benefits. In most states, one agency has responsibility for Medicaid enrollees' physical health services and at least one other agency has responsibility for their behavioral health services.

Apportioning responsibility for the physical and behavioral health of Medicaid beneficiaries into different agencies inevitably leads to different—and sometimes misaligned—policy goals, program priorities, and purchasing strategies. This can impede the delivery of integrated care to enrollees and the implementation of value-based purchasing. Cultural differences between agencies, as well as the opposition of consumers, providers, and local governments, have perpetuated the historical divides between the agencies.¹

Because behavioral health care has long been marginalized from other medical care, some in the behavioral health community question whether the consolidation of physical and behavioral health agencies will improve services for those with behavioral health needs or merely further marginalize behavioral health care. This issue is made even more complicated in some states by the additional role counties and cities play in administering behavioral health services.²

This brief focuses on Arizona's consolidation of responsibility for physical and behavioral health services into the Medicaid agency. We highlight Arizona for several reasons:

- It expanded its Medicaid program,³ providing comprehensive coverage to low-income childless adults, who are disproportionately affected by behavioral health conditions;
- It is implementing new strategies to integrate physical and behavioral health services at the health plan and provider levels; and
- In 2015, it merged its Medicaid agency, called the Arizona Health Care Cost Containment System (AHCCCS), and its Department of Health Services' Division of Behavioral Health Services (DBHS), giving the state's Medicaid director responsibility for both physical and behavioral health services.

In focusing on Arizona's effort to merge behavioral health services into its Medicaid agency, we are seeking to explore whether agency integration facilitates care integration and, if so, is it worth the effort.

To answer these questions, we reviewed published research and state agency materials and conducted telephone and in-person interviews with 34 individuals, including representatives from AHCCCS (both long-time staff and those who had transferred from DBHS), health plans, primary care and behavioral health providers,

SMART PURCHASING THROUGH EXPANDED COVERAGE

With 87 percent of Arizona's health care providers serving Medicaid patients, the state's Medicaid expansion had a profound impact on provider payments. And with more than 650,000 beneficiaries added to Medicaid from 2013 to 2016—a 52 percent increase—Medicaid has become a significant insurer in the state, enabling smarter purchasing of services.

"Success starts with expanded coverage," one Medicaid health plan representative noted. "We need a strong agency to ensure dollars are being spent wisely and contractors are doing what they are paid to do. Without expanded coverage, the agency's ability to run like a good insurer is diminished."

consumers, members of Native American tribes, the justice system, and the health information exchange (see [Appendix A](#)). Several themes emerged from these interviews:

1. The merger of the Medicaid and behavioral health services agencies was triggered and enabled by ongoing state initiatives to integrate care delivery as well as the state's decision to expand Medicaid.
2. The merger has bolstered physical and behavioral health integration at the health plan and provider levels.
3. Integration of funding and purchasing for both physical and behavioral health services in one agency has accelerated development of policy related to social determinants of health.
4. Leadership has been the single most important factor in the merger's success.

Context and Background for Consolidation

Merging DBHS into AHCCCS occurred as one of a series of state actions to integrate physical and behavioral health services, particularly for high-cost, high-need Medicaid enrollees.⁴ As the state embarked on integrated care models, it became clear that lack of integration across the agencies charged with designing and implementing them was inefficient and detrimental to the state's goals. In response, Governor Doug Ducey proposed in his fiscal year 2016 budget to merge many DBHS responsibilities into AHCCCS, and the Arizona legislature endorsed the consolidation unanimously.⁵ This support was facilitated by the years of collaboration among leaders at the AHCCCS, DBHS, and elsewhere to integrate physical and behavioral health services at the health plan and provider levels. Responsibility for the merger fell to the state's Medicaid director, Tom Betlach, and leaders at both agencies.

Vesting a Medicaid agency with responsibility for the range of services required by enrollees—particularly those with comorbid physical and behavioral health conditions—is garnering attention now, in Arizona and nationally, as a result of the maturation of the Medicaid program, which has evolved from a welfare program to a major health insurer, and the growing recognition of its potential to drive systemwide reform.⁶ With Medicaid squarely in the health insurance space, creating a rational organizational structure that reflects and supports the program's broad responsibilities is imperative.

While not the focus of this brief, it is important to underscore the significance of Arizona's Medicaid expansion to its integration efforts. Several interviewees linked the agencies' merger and resulting improvements back to expansion, which increased the stakes and made the merger more impactful. And the cross-sector work to implement the Medicaid expansion brought together many leaders who were critical to the effort to consolidate AHCCCS and DBHS responsibilities.

OVERSIGHT OF PHYSICAL AND BEHAVIORAL HEALTH SERVICES IN ARIZONA, PRE-CONSOLIDATION

AHCCCS had responsibility for payment and delivery of physical health services for the majority of Medicaid enrollees through Medicaid managed care plans. For most enrollees, behavioral health was "carved out" and managed by DBHS. (While DBHS generally had responsibility for behavioral health services for Medicaid enrollees, for some—including elderly, physically disabled enrollees, those dually eligible for Medicaid and Medicare, and children in the Children's Rehabilitative Services Program—AHCCCS oversaw the delivery of such services.)

DBHS had responsibility for Medicaid mental health and substance use disorder services for the majority of enrollees through oversight of behavioral health plans, called Regional Behavioral Health Authorities, under a contract with AHCCCS. These regional authorities managed behavioral health services for most adults and children. In 2014, Regional Behavioral Health Authorities began managing both physical and behavioral health services for enrollees with serious mental illnesses.

OVERVIEW OF AGENCY CONSOLIDATION

Rationale for Consolidation

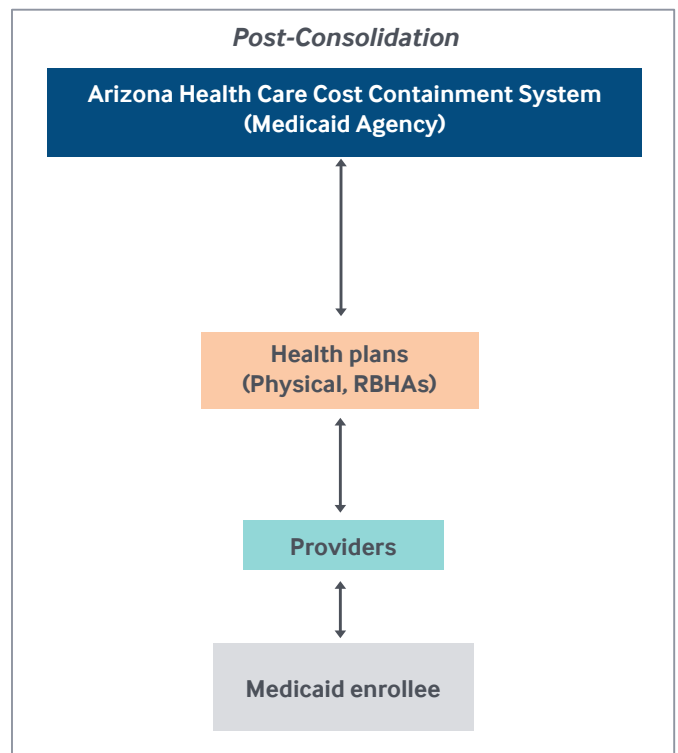
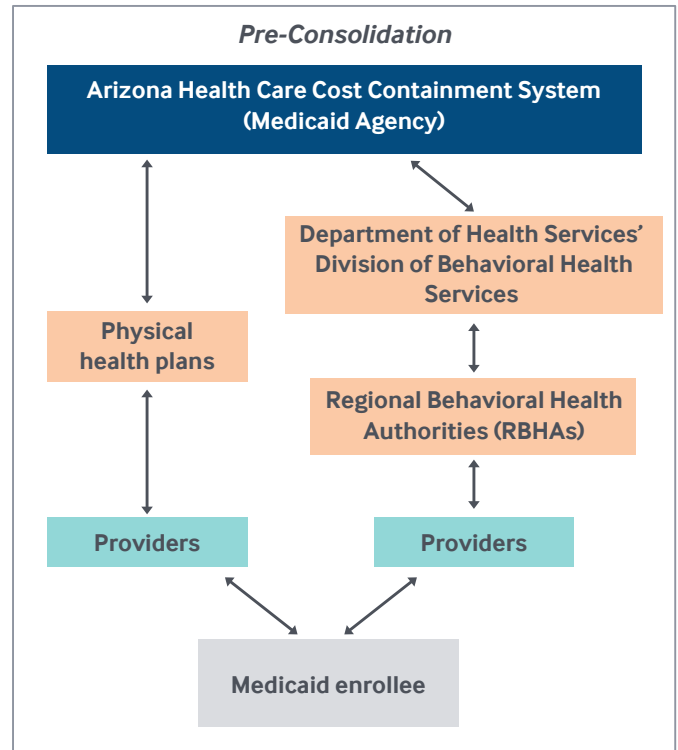
Prior to the 2015 consolidation, responsibility for the physical and behavioral health needs of Arizona Medicaid enrollees was split between AHCCCS and DBHS (Exhibit 1). At the health plan level, specialized health plans, called Regional Behavioral Health Authorities, had responsibility for both the physical and behavioral health needs for enrollees with serious mental illness. However, at the state level, AHCCCS and DBHS had separate and duplicative oversight functions for everything from processing encounters to quality assurance. As the challenges of managing an integrated care system through a bifurcated agency structure became clear to state leaders, the rationale for merging became equally clear: without a single state agency structure under accountable leadership, it would be difficult to realize the state's integration goals.

Process for Consolidation

Through consolidation, functions related to the purchasing and oversight of Medicaid and non-Medicaid behavioral health services (e.g., federal block grant and state-funded programs) moved from DBHS to AHCCCS. DBHS staff with responsibility for housing, employment, crisis, and enrollee, family, and peer services moved to AHCCCS, merging into one agency the full range of services and expertise required to address the physical and behavioral needs of Medicaid enrollees. In all, 114 DBHS staff positions were integrated into six existing divisions and one new AHCCCS division (see [Appendix B](#)).⁷

While a handful of DBHS staff left the agency shortly after announcement of the merger, most staff remained, and a team including staff members from AHCCCS and DBHS was tasked with ensuring these individuals were fully integrated into AHCCCS. The transition team also created 10 workgroups to address various operational issues associated with consolidation, which had the added benefit of increasing staff investment in the merger. Director Betlach convened multiple town halls and listening sessions, both inside and outside the agency, to explain the consolidation and its goal of delivering high-quality, cost-effective, integrated care to all Medicaid enrollees

Exhibit 1. Arizona's Administrative Simplification



and to elicit feedback. Leadership provided by Betlach and others, as well as organizational transparency and clear communication, were critical to successful consolidation.

GUIDING PRINCIPLES FOR CONSOLIDATION

AHCCCS and DBHS developed a set of principles to guide agency consolidation, including:

A seamless transition for enrollees. The consolidation should not affect what services are offered or how services are delivered and should be seamless for enrollees and their families.

Continued focus on enrollee services. All functionality that was in place to serve members prior to the merger should continue as part of the new organization.

A transparent process. AHCCCS and DBHS should err on the side of “overcommunicating” the status of consolidation efforts to staff, Medicaid enrollees, families, advocates, health plans, providers, and policymakers.

Open-door policy. The process should ensure that all parties have ample opportunity to provide feedback about the transition process.

IMPACT OF AGENCY CONSOLIDATION

Agency consolidation began in mid-2015 and has already facilitated a number of improvements related to the delivery and payment of integrated physical and behavioral health services.

Increased Attention to Behavioral Health and Integration with Physical Health

The integration of DBHS and AHCCCS sent a clear message to stakeholders that physical and behavioral health integration is a top priority for Arizona. As one state official put it, “we see it as leading by example.”⁸ Medicaid assumed a new level of leadership in integration. And with 114 staff members focused on behavioral health, the agency gained significant behavioral health expertise, leading it to incorporate patients’ families and peer counselors into their integration strategy and extend integration beyond the population with serious mental illness. One state official noted that consolidation has accelerated

the shift from an emphasis on patient diagnosis to an emphasis on population health management and the social determinants of health for *all* populations—not just those with a behavioral health diagnosis.⁹ The agency is now looking to tackle fragmented delivery models affecting enrollees with Autism Spectrum Disorder, chronic pain, and substance use disorder as well as children in foster care. One stakeholder described consolidation as “piercing a bubble,” observing that “years of isolation led to agencies functioning in a partnership-free world.”

Strategic Purchasing of Physical and Behavioral Health Services

Prior to the merger, there were two distinct purchasers of health care services for Medicaid enrollees, each of which deployed different payment methodologies and incentives. For example, under DBHS, providers were often paid an aggregate amount based on past expenditures, referred to as “block purchasing.” AHCCCS and its contracted health plans paid providers for services rendered to specific patients, consistent with a traditional insurance model. These disparate payment methodologies made alignment of physical and behavioral health services nearly impossible.¹⁰ Today, AHCCCS is moving to eliminate block purchasing and align incentives for health plans and providers, encourage greater collaboration among providers, and enable value-based purchasing. One plan representative noted: “Agency integration laid the foundation for aligning incentives across plans and providers. Without agency integration, you cannot truly get to value-based purchasing.”¹¹

Consolidation also has enabled AHCCCS to pay for more comprehensive care models by interweaving Medicaid and non-Medicaid funding streams. For example, as part of its efforts to address the opioid epidemic, AHCCCS covers anti-overdose medication and is using federal block-grant funding to expand community-based outreach and education to prevent overdoses. Additionally, AHCCCS can now use non-Medicaid funds to provide permanent supportive housing to enrollees with complex needs who might otherwise be homeless. Access to non-Medicaid funds has enabled AHCCCS to tackle social determinants of health and purchase the array of services needed to improve enrollee health and well-being.

STRONGER HEALTH INFORMATION EXCHANGE

AHCCCS' attention to behavioral health services and their integration with physical health services has enabled Arizona's statewide health information exchange (HIE) to flourish. The HIE supports improvements in care coordination by linking health care organizations through a single platform. In the 18 months following the start of the merger, the HIE went from having no behavioral health provider participants to 70, and it expects to more than double that number in the coming year.

There are efforts under way to add county correctional facilities and social services agencies to the HIE to enable more comprehensive information-sharing. AHCCCS leaders recognized the importance of information-sharing to integration efforts and invited HIE staff to participate in policy discussions throughout the agency consolidation process.

Streamlined Regulation and Consistent Policy

Consolidation also means that health plans, providers, and enrollees and their representatives that formerly navigated two different bureaucracies now must navigate just one. One justice system representative noted: "I now have one place to go when something comes up; I had a lot of trouble navigating where to go before [the merger]."¹² Further, prior efforts to integrate the delivery of services were often stymied by two distinct regulators with different cultures, program goals, and rules. Plans, providers, and enrollees report that the consolidated administration has resulted in faster resolution of problems and other streamlined processes.

For example, having a direct line of communication to AHCCCS gave behavioral health providers seeking to deliver integrated care an opportunity to raise concerns about rates not reflecting the time and resources needed for true integrated care delivery. In response, AHCCCS determined to increase rates by 10 percent for certain physical health services provided by integrated clinics. This change went into effect in October 2016.

Enhanced Communication and Cross-Sector Collaboration

AHCCCS' efforts to communicate to all parties affected by the merger and enlist their feedback have now expanded

into a permanent part of program operations. Behavioral health experts and enrollee, family, and peer support community representatives now sit on AHCCCS' Medicaid policy committee, resulting in a more holistic approach to policymaking. AHCCCS now includes a Division of Health Care Advocacy and Advancement responsible for interfacing with enrollees, families, peers, and other stakeholders. Importantly, this enhanced communication is sparking on-the-ground change.

Notably, agency consolidation, along with Medicaid expansion, has given Arizona additional tools to address the prevalence of serious mental illness and substance use disorder among former inmates, improving their health, reducing unnecessary use of emergency departments and hospital beds, and cutting recidivism rates. Representatives of state and local corrections and their colleagues in the private sector are among the biggest supporters of the merger. One justice system representative highlighted the powerful effect of increased collaboration: "We've come to realize how little we communicated before. Now, everyone is at the table and everything is on the table. The mindset has changed to 'what else can we do?' The silos that existed have gone away and we are now focused on a person's interaction with the *entire* system."¹⁵

ALLEVIATING STAKEHOLDER CONCERNS

One of the greatest concerns among members of the behavioral health community before the merger was the potential loss of DBHS' focus on and commitment to recovery services, including the central role of family and peer supports. Yet they say this has not come to pass:

“We now know we have a seat at the table.”

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“AHCCCS is now working in partnership with us.”

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“The days of shouting and pointing fingers are over.”

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“Integration just makes sense.”

.....

“Consolidation was absolutely the right thing to do.”

.....

“The focus has shifted from compliance with contract requirements to the delivery of more integrated, collaborative care.”

.....

“We’ll be a much better system because of [the merger] down the road.”

CONCLUSION

As Medicaid has transitioned from a welfare program to a major insurer and, through expansion, taken on a larger role, many states are developing purchasing strategies to ensure that enrollees have access to quality, cost-effective, and integrated care. Arizona has gone a step further by reforming its agency infrastructure to advance integration. While still in its infancy, the merger has thus far been a success. The state's experience offers lessons to policymakers as they consider how best to integrate physical and behavioral health services and ensure that Medicaid is an efficient and effective purchaser of health care services.

There is no “one-size-fits-all” approach in Medicaid. But Arizona's consolidation suggests that vesting the Medicaid director with responsibility and accountability for the full range of health care services can facilitate progress in achieving integrated, holistic, and responsive care that addresses social determinants of health. The Arizona experience also indicates that repeal of the Medicaid expansion, or a reduction in federal Medicaid funds, could place at risk the progress that has been made in improving health care access, quality, and efficiency for the highest-need individuals.

NOTES

- ¹ D. Bachrach, S. Anthony, and A. Detty, *State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment* (The Commonwealth Fund, Aug. 2014). In New York, three separate state agencies remain despite a 2006 report highlighting the adverse effects of the state's dispersed administrative structure in areas such as licensure, establishment of payment rates, and program development. See D. Bachrach, K. Lipson, and K. Bhandarkar, *Administration of Medicaid in New York State: Key Players and Their Roles* (United Hospital Fund, Nov. 2006).
- ² In 2012, California transferred responsibility for its Medicaid mental health services from the state's mental health agency to the Medicaid agency. However, these services are still delivered primarily through county systems that operate separately from other publicly funded health care services. See California State Assembly Bill No. 102, signed into law June 2011, and S. Arnquist and P. Harbage, *A Complex Case: Public Mental Health Delivery and Financing in California* (California Health Care Foundation, July 2013).
- ³ Between December 2013 and December 2016, Medicaid enrollment in Arizona increased 52 percent (by 658,529 enrollees). See Arizona Health Care Cost Containment System, *AHCCCS Population Highlights, December 2016* (AHCCCS, Dec. 2016); see also Arizona Health Care Cost Containment System, *AHCCCS Population Highlights, December 2013* (AHCCCS, Dec. 2013).
- ⁴ In 2013, Arizona integrated services for children with special needs covered under the state's Children's Rehabilitative Services program; these children, who previously received services through three separate health plans, now have their care coordinated by one plan. Similarly, in 2014, Regional Behavioral Health Authorities began covering both physical and behavioral health services for adults with serious mental illnesses. The state also integrated physical and behavioral health care services for enrollees eligible for both Medicaid and Medicare, required its Medicaid plans to serve as Medicare Dual Special Needs Plans, and promoted enrollment of dually eligible enrollees into the same plan for both programs.
- ⁵ State of Arizona, *Executive Budget Summary, Fiscal Year 2016* (Jan. 2015), p. 12; and State of Arizona, *Senate Bill 1480, Chapter 19, Section 9* (March 2015).
- ⁶ D. Bachrach, P. Boozang, and A. Traub, *Medicaid at a Crossroads: What's at Stake for the Nation's Largest Health Insurer* (Robert Wood Johnson Foundation State Health Reform Assistance Network, Feb. 2017).
- ⁷ The Arizona Health Care Cost Containment System and the Division of Behavioral Health Services assessed the experience and skill set of each staff member being moved to determine the most appropriate division for each.
- ⁸ Manatt Health interview with Arizona state official, Dec. 14, 2016.
- ⁹ Ibid.
- ¹⁰ Block purchasing effectively caps the number of patients that providers can treat in a given month, while fee-for-service payments incentivize delivery of more services.
- ¹¹ Manatt Health interview with health plan representative, Dec. 15, 2016.
- ¹² Manatt Health interview with justice system representative, Dec. 15, 2016.
- ¹³ Ibid.

ABOUT THE AUTHORS

Deborah Bachrach, J.D., a partner with Manatt, Phelps & Phillips, has more than 25 years of experience in health policy and financing in both the public and private sectors and an extensive background in Medicaid policy and health care reform. She works with states, providers, plans, and foundations in implementing federal health reform and Medicaid payment and delivery system reforms. Most recently, Ms. Bachrach was Medicaid director and deputy commissioner of health for the New York State Department of Health, Office of Health Insurance Programs. She has previously served as vice president for external affairs at St. Luke's-Roosevelt Hospital Center and as chief assistant attorney general and chief of the Civil Rights Bureau in the Office of the New York State Attorney General. Ms. Bachrach received her B.S. from the University of Pennsylvania, Wharton School, and her J.D. from New York University School of Law.

Patricia M. Boozang, M.P.H., senior managing director at Manatt Health, advises clients on the implementation of coverage, delivery system, and payment reforms across government and private health insurance programs. Her clients include federal agencies, states, foundations, providers and health plans. Ms. Boozang guides states and marketplaces on policy matters including eligibility and enrollment, benefit design, delivery system improvements, and technology development, and she has particular expertise in Medicaid Section 1115 waivers. Prior to joining Manatt, Ms. Boozang was a vice president and leadership team member of Physician Weblink, a national health care technology and physician management company. Earlier, she worked at Sterling Health Capital Management, Inc., assisting hospitals and community health centers in business planning and implementation. Ms. Boozang received her B.A. from Boston College and her M.P.H. from the Columbia University Mailman School of Public Health.

Hailey E. Davis, M.P.H., senior manager at Manatt Health, provides policy expertise, strategic and regulatory advice, and project oversight to states, health plans, providers, foundations, and other health care stakeholders. Her work focuses primarily on the implications of federal health

reform and the redesign of state Medicaid programs. Prior to joining Manatt, she served as a program analyst in the Office of the Inspector General, Office of Evaluation and Inspections at the U.S. Department of Health and Human Services. In this position she conducted national and statewide evaluations of Medicaid and served as a member of the Healthcare Reform Strategy Work Group. Ms. Davis received her B.A. from the University of Texas and her M.P.H. from the Columbia University Mailman School of Public Health.

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APPENDIX A. List of Interviewees

Markay Adams, Integrated Services Administrator, Division of Fee-for-Service Management, Arizona Health Care Cost Containment System (AHCCCS)

Jeffrey Alvarez, M.D., Director/Medical Director, Correctional Health Services, Maricopa County

Kathy Bashor, Bureau Chief, Office of Individual and Family Affairs, AHCCCS

Tom Betlach, Medicaid Director, AHCCCS

Eddy Broadway, Chief Executive Officer, Mercy Maricopa Integrated Care

Elizabeth Carpio, Director, Division of Fee-for-Service Management, AHCCCS

Steve Chakmakian, M.D., Chief Medical Officer, United Healthcare

Peggy Chase, President and CEO, Terros Health, Inc.

Monica Coury, Vice President, Legislative and Government Affairs, Centene

Shelley Curran, Court Services Administrator, Mercy Maricopa Integrated Care

Jim Dunn, Executive Director, National Alliance on Mental Illness (NAMI) Arizona

Christy Dye, Chief Executive Officer, Partners in Recovery

Mark Fisher, President and Chief Executive Officer, Mercy Care Plan

Blythe FitzHarris, Adult System of Care Administrator, Mercy Maricopa Integrated Care

Paul Galdys, Assistant Director, Health Care Advocacy and Advancement, AHCCCS

Dan Haley, Chief Executive Officer, H.O.P.E., Inc.

Jennifer Hawkins, Health Care Services Integration Administrator, Office of the Deputy County Manager, Maricopa County

Karen Hellman, Division Director, Inmate Programs and Reentry, Arizona Department of Corrections

George Jacobson, Project Management/Payment Modernization, AHCCCS

Emily Jenkins, President and CEO, Arizona Council of Human Service Providers

Shana Malone, Clinical Initiatives Project Manager, AHCCCS

Tara McCollum, Chief External Affairs Officer, Arizona Alliance for Community Health Centers

John McDonald, Chief Executive Officer, Arizona Alliance for Community Health Centers

Mike Mote, Chief Information Officer, Arizona Health-e Connection

Kari Price, Executive Project Manager, AHCCCS

Mary K. Reinhart, Communications and Public Relations Administrator, Mercy Maricopa Integrated Care

Ginny Roberts, Chief Operating Officer, Director of Managed Care, Arizona Alliance for Community Health Centers

Virginia Rountree, Assistant Director of Operations, Division of Health Care Management, AHCCCS

Michal Rudnick, Project Manager, Office of the Director, AHCCCS

Sara Salek, M.D., Chief Medical Officer, AHCCCS

Shelli Silver, Assistant Director of Finance Rate Development and Data, Division of Health Care Management, AHCCCS

Bonnie Talakte, Tribal Relations Liaison, AHCCCS

Therese Wagner, Deputy Chief, Adult Probation, Maricopa County

Charlton Wilson, M.D., Chief Medical Officer, Mercy Care Plan

APPENDIX B. Staff Movement from the Division of Behavioral Health Services (DBHS) to the Arizona Medicaid Agency (AHCCCS)

AHCCCS division	New staff from DBHS
Division of Health Care Management	64
Division of Health Care Advocacy and Advancement*	24
Office of Administrative Legal Services	9
Information Services Division	6
Division of Fee-for-Service Management	5
Division of Business and Finance	5
Office of Inspector General	1
Total	114

* New division, post-consolidation.



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