ADAPTATION HEALTH

AHCCCS
Arizona Health Care Cost Containment System

Arizona Medicaid Innovation Challenge

9am - 4pm PT, March 29, 2019 | AHCCCS Gold Room & *Live Streaming*

Welcome Packet

Partners & Funders:

CHCS
Center for Health Care Strategies, Inc.

Vitalyst HEALTH FOUNDATION
A CATALYST FOR COMMUNITY HEALTH

California Health Care Foundation

THE KRESGE FOUNDATION

Welcome Packet Table of Contents

Welcome Letter

Douglas A. Ducey, Governor
Jami Snyder, Director

March 29, 2019

Good morning!

It is my pleasure to welcome you to the Arizona Medicaid Innovation Challenge. This unique event is the result of several months of collaboration between the Arizona Health Care Cost Containment System, Adaptation Health, and other key partners and funders, including the Center for Health Care Strategies, Vitalyst Health Foundation, the California Health Care Foundation and the Kresge Foundation.

The presentations you will see today represent efforts by our Medicaid managed care organizations and staff to identify market ready, pioneering vendors who can partner with them to address challenges in the areas of Social Determinants of Health and Member Engagement. The Innovation Challenge has provided health plan leaders with robust ideas about the latest market ready approaches for improving digital member engagement, risk identification and referral processes in the Medicaid environment.

As states and managed care organizations are increasingly called upon to offer enhanced care coordination for members with complex health and social needs, partnerships and events like the Innovation Challenge highlight pioneering tools and innovative approaches that bridge the knowledge gap between the Medicaid ecosystem and vendors. The Medicaid Innovation Challenge has been a unique partnership between public and private entities serving as a possible model for healthcare entrepreneurs and state Medicaid agencies in the future.

On behalf of AHCCCS, I want to thank you for joining us today.

Sincerely,

Jami Snyder
Director

About Adaptation Health & The Medicaid Innovation Challenge

The Medicaid Innovation Challenge is a unique partnership with the state Medicaid Agency to bridge the gap between market need and market ready solutions. The project represents a new approach towards building strong collaboration and capacity within the Medicaid ecosystem.

The Arizona Medicaid Innovation Challenge, is the culmination of months work in identifying market-ready, pioneering healthcare entrepreneurs to present their business models for innovation to the seven MCO's in Arizona, and present the value their solution can bring to Arizona Medicaid in addressing either risk identification and referrals in the **social determinants of health** or improved solutions for **digital member engagement.**

From a pool of many dozens of applicants, the Selection Committee, comprised of representatives from each of Arizona's Managed Care Organizations and leadership from AHCCCS, selected eight finalists who will present in Arizona.

Adaptation Health is a buyer-side incubator program developing and building thought leadership and value on behalf of State Medicaid programs and Managed Care Organizations. Based in New Orleans, LA, the organization matches market need and Medicaid priorities against market and product fit.

Contact Us

@AH_Innovation

david@adaptationhealth.org

adaptationhealth.org

Schedule

9am - 4pm PT, March 29, 2019 | AHCCCS Gold Room & *Live Streaming*

Run of Show*

All times are in Pacific Time

9:00 AM	9:10 AM	Welcome and Introductions	Jami Snyder, *AHCCCS* & David Kulick, *Adaptation Health*
9:10 AM	9:30 AM	**Section 1:** Overview on challenge areas, why they are important and why now	**National perspective:** Andrey Ostrovsky, *Solera*
9:30 AM	10:00 AM	**Section 2:** Member Engagement Company Presentations	Care Angel
10:00 AM	10:30 AM		ConsejoSano
10:30 AM	10:45 AM	*Networking Break*	
10:45 AM	11:15 AM		myStrength
11:15 AM	11:45 AM		Pyx Health
11:45 AM	12:30 PM	*Lunch provided by Adaptation Health*	
12:30 PM	1:00 PM	**Section 3:** SDOH Company Presentations	Aunt Bertha
1:00 PM	1:30 PM		Equality Health in partnership with TAVHealth
1:30 PM	1:45 PM	*Networking Break*	
1:45 PM	2:15 PM		Finity
2:15 PM	2:45 PM		Healthify
2:45 PM	3:00 PM	*Networking Break*	
3:00 PM	3:50 PM	**Section 4:** Overview of state and plan-level strategies for leveraging Medicaid to address SDOH and patient engagement, and panel discussion on considerations, challenges and lessons learned for successful digital health partnerships.	**Moderators:** Rachel Davis, & Allison Hamblin, *CHCS* **Panelists:** Sandeep Wadhwa, *Solera* Lorry Bottrill, *Mercy Care* Jami Snyder, *AHCCCS*
3:50 PM	4:00 PM	Closing	

Digital Member Engagement Finalists

Problem Statement:

There are an increasing number of Medicaid beneficiaries who are, for a variety of reasons, not optimally engaged in their own care. These reasons can include previous negative experiences with the health care system, low health literacy, competing priorities for time and urgency, and histories of trauma, to name only a few. Ultimately, this lack of engagement may contribute to poor health outcomes and increased costs to health care systems.

Thus, there is a need for engagement technologies to assist individuals in better managing their care, accessing appropriate services, and empowering them to adopt healthier behaviors, as necessary, to improve outcomes. These are for both high risk and rising risk individuals.

Solutions must provide mechanisms to effectively engage beneficiaries across various populations and geographies from high risk to rising risk, and must demonstrate applicability to low-income populations, including considerations regarding access to technology.

CareAngel™

ConsejoSano

myStrength

Pyx Health

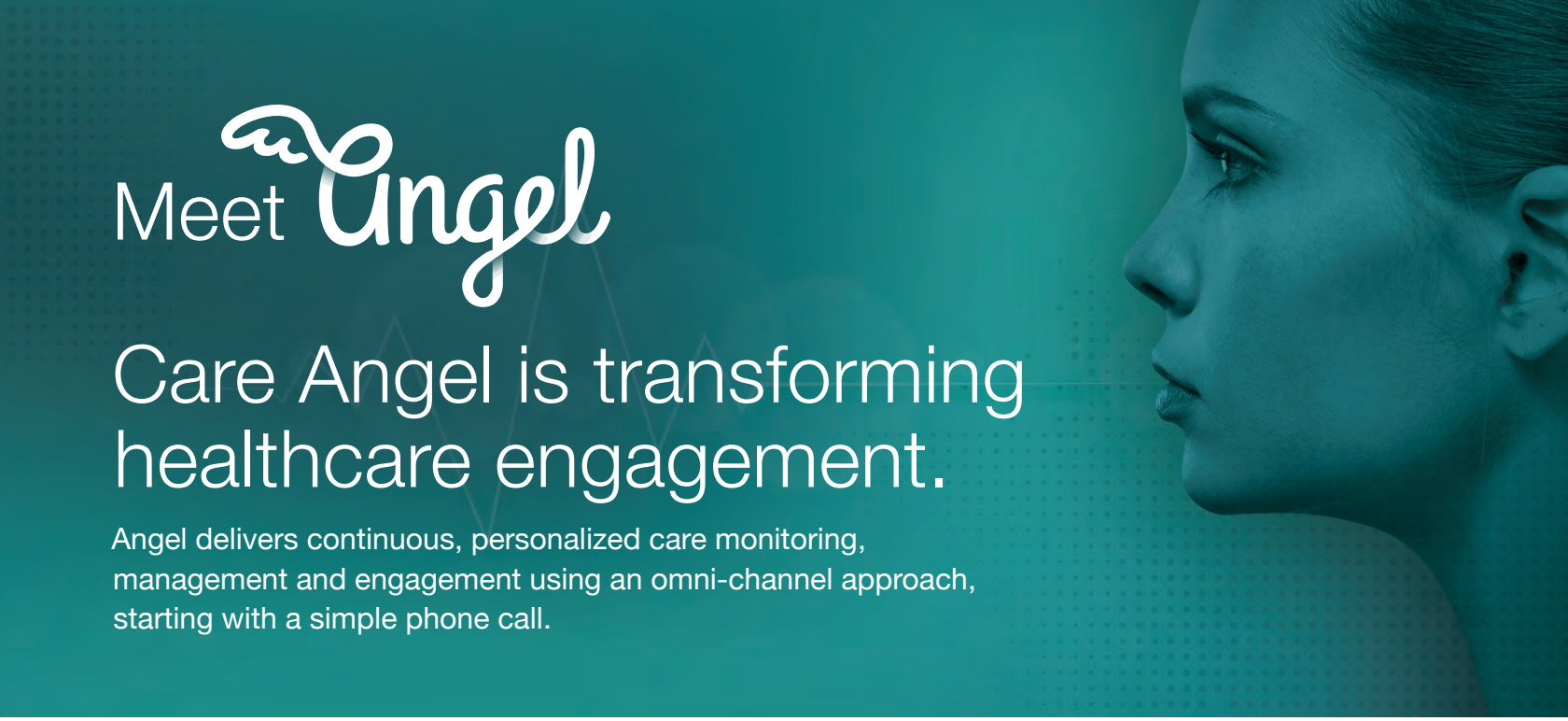
Care Angel

Care Angel offers the world's first voice AI, Virtual Nurse Assistant, Angel. Angel empowers the most effective, efficient and scalable way to engage monitor and manage large populations at scale, starting with a simple phone call. Care Angel's multi-modal engagement platform helps providers and payers to close gaps in care by automating conversational, outbound check-ins, capturing regular updates on vitals, well-being, SDOH and informs real-time interventions. Our solution is proven to reduce administrative and operational costs, reduce avoidable ED, (re)admissions, improve medical and financial outcomes and optimize patient satisfaction and STARs performance.

We help large MCO, state Medicaid offices, MSO, ACO, health systems, payers, and channel partners to improve engagement and quality, reduce costs and optimize coordination of care. Plus, improve and automate workflows. Quick time to market. Typically, under 30 days!

Presenters:

- Wolf Shlagman, Founder / CEO
- Darren Hay, CRO



Meet Angel

Care Angel is transforming healthcare engagement.

Angel delivers continuous, personalized care monitoring, management and engagement using an omni-channel approach, starting with a simple phone call.

On a Global Mission to Empower Millions of People to Take Better Care

Care Angel addresses the objectives that matter most to state Medicaid and MCOs – high quality care, patient satisfaction, improved outcomes and lower costs.

END-TO-END MEMBER ENGAGEMENT

Seamlessly manage health of whole populations, high risk and rising risk. Expedite interventions.

IMPROVE PERFORMANCE MEASURES

Boost HEDIS/STAR ratings. Improve care coordination, PCMH. Better health outcomes, lower healthcare costs.

ENHANCE CARE EFFICIENCIES

Scale engagement across demographically diverse populations. Exponentially expand capacity with a human touch.

GROW REIMBURSEMENTS AND REVENUES

Close gaps in care. Align with VBP initiatives. Improve quantitative and qualitative results.

To learn more, visit us at CareAngel.com

CareAngel™

Let's start a conversation

www.careangel.com
hello@careangel.com

ConsejoSano

At ConsejoSano, we are on a mission to change health outcomes for the millions of people who are disenfranchised by the healthcare as it works today. We recognize the enormous disparity in healthcare and we are addressing it through a suite of world-class technologies designed for today's society. We provide multi-channel messaging, care management, patient engagement, healthcare data analytics, consciously tailored content to drive action and other tools that help our clients increase member engagement, improve healthcare quality measures and enhance revenue. We understand people, culture and determinants of health and use our knowledge to help people live healthier lives.

Presenters:

- Abner Mason, CEO and Founder
- Kevin McCarthy, Vice President of Sales
- Kim Howell, Director of Client Relations

ConsejoSano

HEALTH PLAN

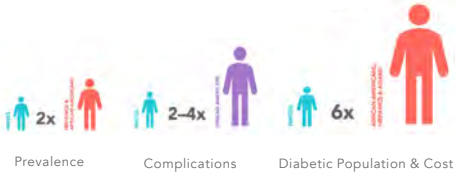
America is multicultural, but healthcare isn't.

We're on a mission to change that.

MULTICULTURAL AMERICA AND THE IMPACT ON YOUR ORGANIZATION

Today, 2 out of 5 Americans are minorities. In just 30 years, there will be no racial or ethnic majority group.

Minorities have poorer health outcomes: An AHRQ study found that for 20 access to care measures, Hispanics and Blacks experienced worse care compared to Whites, for 75% and 50% of measures respectively.



Chronic conditions, such as diabetes, impact ethnic groups disproportionately by frequency and severity. The result is that minorities represent the majority of your diabetes population and costs.

What We Do

We deliver a member engagement and care navigation solution to help health plans activate their multicultural member populations to better engage with the healthcare system.

FOR HEALTH PLANS, CULTURAL COMPETENCE AND EFFECTIVE MULTICULTURAL ENGAGEMENT ARE PREREQUISITES FOR SUCCESS.

DISCONNECT: CONSUMERS DON'T RATE THEIR PLANS HIGHLY, DON'T ENGAGE

1 in 4 consumers have a low/poor rating of their health plan. It's not surprising that some health plans have difficulty engaging their members.

OUR THESIS & APPROACH

We have demonstrated success in engaging multicultural members to close gaps in care and improve outcomes. Contact us to explore how we can partner together for the betterment of your population and organization.

5200 LANKERSHIM BLVD, STE 310 | NORTH HOLLYWOOD, CA 91601 | 855.735.6726 | CONSEJOSANO.COM

myStrength

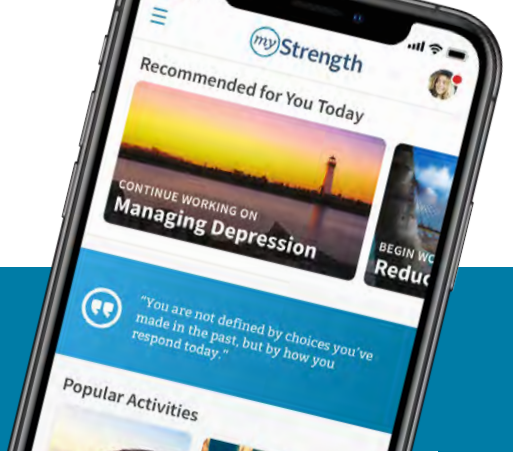
myStrength is a recognized leader in digital behavioral health and wholly owned subsidiary of Livongo Health, the leading Applied Health Signals company empowering people with chronic conditions to live better and healthier lives. myStrength's evidence-based resources uniquely empower consumers with interactive applications to address depression, anxiety, stress, substance use disorders, chronic pain/opioid management and insomnia. myStrength's highly secure and scalable web and mobile applications are proven to extend care, improve outcomes, and reduce cost of care delivery. Founded in 2010, myStrength currently partners with more than 140 of the largest health plans and health systems in the country including Medicaid-funded community healthcare organizations across 32 states.

Presenter:

- Scott Cousino, CEO

Livongo® | myStrength

Digital Behavioral Health Platform Empowering Individuals with Engaging, Clinically-Proven Resources



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Hope, Health and Happiness

myStrength is secure and personalized, integrating multiple programs to uniquely help manage comorbid challenges. myStrength addresses:

- Depression
- Stress
- Anxiety
- Drug, Alcohol and Opioid Recovery
- Chronic Pain
- Mindfulness and Meditation
- Insomnia
- Balancing Emotions
- Weight Management
- Smoking Cessation
- Lifestyle Topics (Parenting, Relationships and More)

Payer and Provider Benefits

Empowers Consumers to partner with their care teams to cultivate overall health and well-being.

Improves Outcomes through evidence-based tools that facilitate peer-reviewed, demonstrated results.

Reduces Costs with scalable, consumer-directed resources that extend and enhance care models.

Boosts Engagement via a tailored, consumer-centric interface and engaging outreach.

Increases Access for non-treatment-seeking members, waitlist management, rural consumers, etc.

Engaging, Effective, Economical

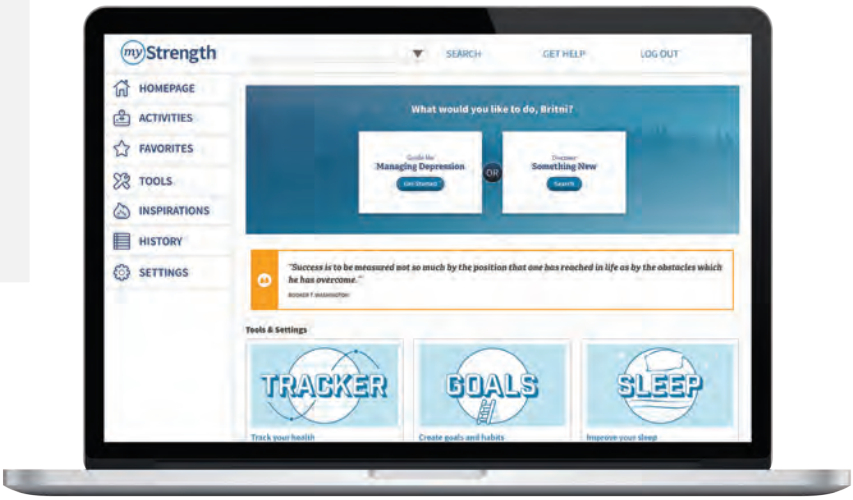
myStrength demonstrates exceptional user engagement and rapid symptom reduction while facilitating substantial cost savings to healthcare payers and providers.

6 myStrength sessions in the first 45 days[1]

74% experience improvement in depression scores[2]

4.8X myStrength ROI on physical and behavioral health claims[3]

$382 greater cost reduction in annual all-cost claims for myStrength users, relative to the standard of care control group[3]



www.myStrength.com

[1] Average number of sessions over time across myStrength's full book of business user base.
[2] In a case study with 2 large commercial partners, 74% of myStrength users with severe depression improved by at least one severity category in the DASS-21 depression scale within 6 months.
[3] Abhulimen, S. & Hirsch, A. (2018). Quantifying the Economic Impact of a Digital Self-Care Behavioral Health Platform on Missouri Medicaid Expenditures. Journal of Medical Economics, DOI: 10.1080/13696998.2018.1510834.

PYX Health

Pyx Health is an emotionally intelligent mobile solution built for the Medicaid population. Pyx helps connect Medicaid members to their community and encourages them to engage in their healthcare. Engagement is driven by a chatbot personality inside the app who delivers personalized self-management techniques, in-the-moment resources, and a trusted connection to the member's natural supports. Our goal is to emotionally take care of Medicaid members so we can help them improve their health outcomes and provide them with the resources they need during the 90% of time they aren't in a provider's office. The Pyx Health tool screens for social determinants of health, administers evidence based screenings, provides real-time ED and crisis alerts and tracks loneliness, depression and anxiety through daily interactions and self-management activities. Pyx Health is an Arizona based company with over 36 years of healthcare technology experience.

Presenters:

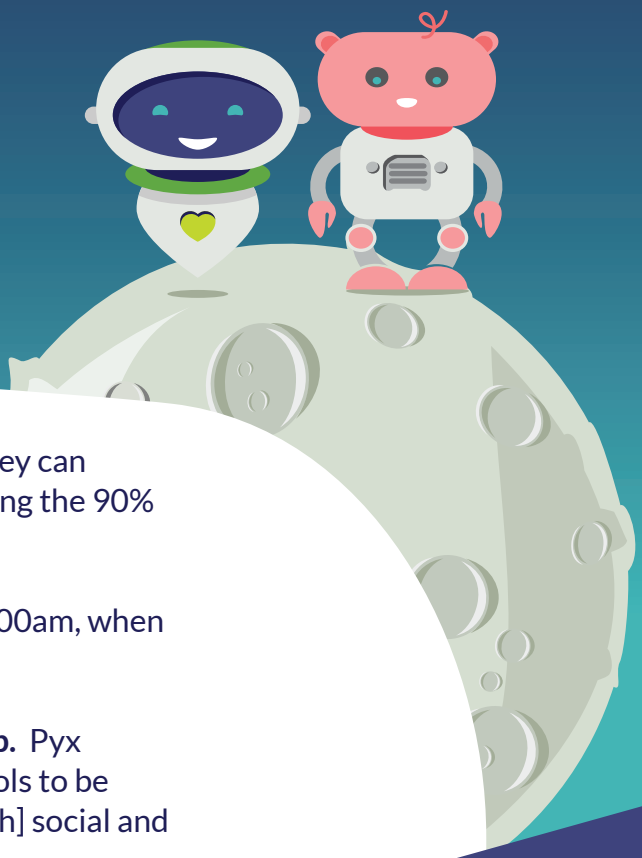
- Cindy Jordan, Chief Executive Officer
- Anne Jordan, Chief Experience Officer
- Christina Myren, Vice President of Operations

What if chatbots could solve your member engagement problems?

Pyx Health provides a Member Mobile Care Solution.

Whole-person care starts with the belief that understanding the members' needs requires:

- member engagement,
- insight into actionable Social Determinants of Health information,
- and meeting the member where they are in their healthcare journey.

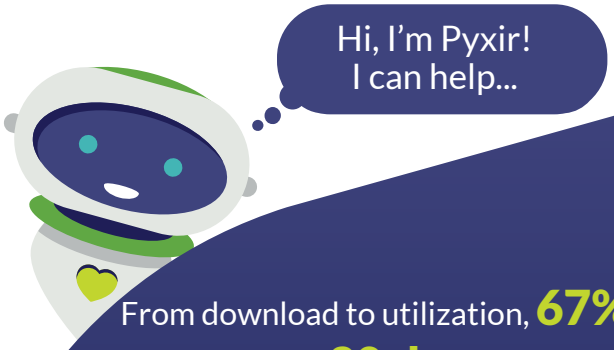


Our goal is to emotionally take care of Medicaid members so they can improve their health outcomes and reduce their cost of care during the 90% of time they aren't in a provider's office.

Empathetic chatbot technology is available 24/7, including at 2:00am, when your member need's it most.

Engaging the people around the member who are willing to help. Pyx Health utilizes member's natural supports and gives them the tools to be effective. A recent study showed that "a robust relationship [with] social and emotional support from others can be protective for health."

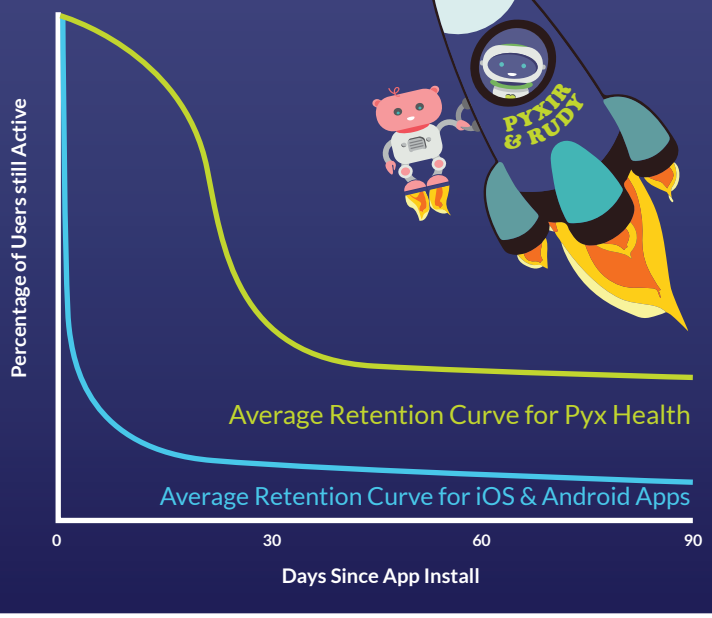
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2729718/



From download to utilization, **67%** of users are on Pyx Health for **30 days**.

Users average **20** engagements in the first **30 days**.

As compared to the national average of 5% for all apps, not just healthcare apps, **18%** of Pyx Health users stay active for **180 days or more**.



www.pyxhealth.com

Rachael Jacobson
Vice President, Pyx Health

Phone: 413-626-8514
Email: rachael@pyxhealth.com

Association for Community Affiliated Plans
www.communityplans.net

Technology Partner for several winning State Medicaid bids

Social Determinants of Health Finalists

Problem Statement:

Social determinants of health (SDOH) are the conditions in which people are born, grow, live, work and age. These dramatically impact an individual's health outcomes and quality of life. There is growing recognition that the impact of SDOH greatly affects health outcomes and cost of care.

Thus there is a need to ensure that Medicaid enrollees have effective access to SDOH services and supports available in their communities. The Arizona Medicaid system is in need of a solution to improve SDOH risk identification and facilitate beneficiaries' connections to SDOH services.

At a minimum, this solution must include the ability to either identify individual risk factors among Medicaid beneficiaries, create referrals for SDOH services, and/or provide feedback on referral outcomes.

Solutions must meet one or more of the following criteria:

1. An ability to collect SDOH patient risk, share data with health information systems and/or health information exchanges, and provide actionable intelligence on individual and population data.
2. Aggregate SDOH service referral options and digital referrals for services.
3. Referral feedback on the completion of the service to the platform.

Aunt BERTHA

EQUALITY HEALTH

TAVHealth

finity

Healthify

Aunt Bertha

Our mission is to connect all people in need and the programs that serve them (with dignity and ease). When we started out in 2010, we defined a new way for people to access social services that empowered them to own their search. However, navigation was just the beginning! We believe in giving people who reach out for help the dignity of a response through thoughtful consideration of their journey, from beginning to end. When you refer people to social supports on Aunt Bertha, you'll know that they got the help you recommended.

Presenters:

- Erine Gray, President & CEO
- Chris Bryan, Account Executive

Aunt BERTHA

The Social Care Network

An Existing Network

People in need who are searching for social services benefit from an abundant choice of high-quality, relevant supports. A network of Community Based Organizations (CBOs) that's ***already in place*** is in their best interest. Building this network is difficult and takes a long time, though (we've been at it for nearly a decade)! Join Aunt Bertha, the largest social care network in America.

1.7M+ users

Curated by Humans

Investing in high-quality program data is the only way to ensure that people get the help they need, simply and quickly. Data curation is our biggest investment at Aunt Bertha, with a Data Operations Team of 25 people based in Austin, Texas.

42K ZIP Codes

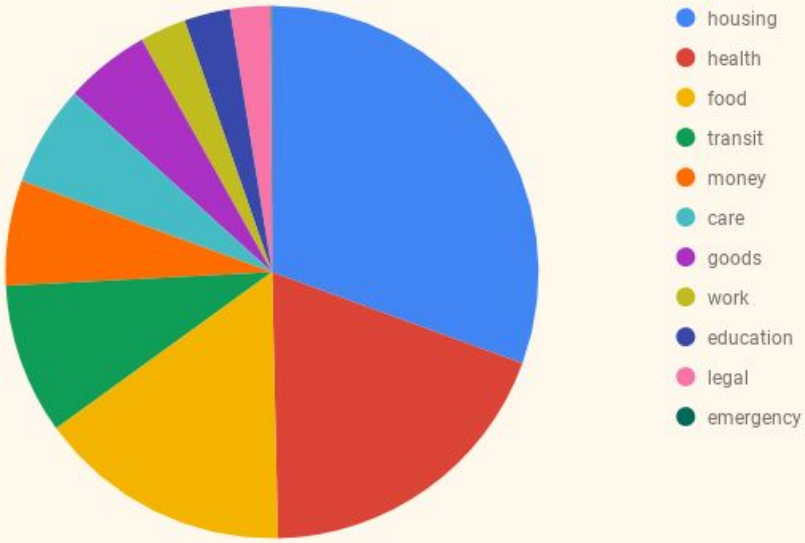
The Dignity of a Response

Connecting folks to free & reduced cost resources is just the beginning! Giving someone the dignity of a response when they reach out for help from our platform is at the heart of what we do.

160+ customers

65+ teammates

Searches by Category on Aunt Bertha in Arizona (2018)



https://company.auntbertha.com/

Equality Health in partnership with TAVHealth

Equality Health's Cultural Care Model focuses on improving healthcare delivery for diverse populations via culturally sensitive programs, provider networks, tech-enabled MSO, and CareEmpower® care coordination technology. TAVHealth is addressing social determinants of health by bringing together accountable and curated networks of community and health partners that use the TAVConnect platform to safely coordinate services and generate longitudinal social records. Together, they are turning neighborhoods across the country into collaborative safe-sharing networks which solve for the social determinants of health at scale. These industry-leading innovators teamed up to launch a first-of-its-kind multi-payer platform in which providers, care coordination teams, and community-based organizations (CBOs) reciprocally make, confirm and track outcomes of referrals. The technology builds community capacity, generates outcome measures, and allows all participants to collaboratively identify and solve the clinical and social issues that put outcomes at risk — the result: healthier members, improved outcomes and lower costs.

Presenters:

- Anabell Castro Thompson, MSN, RN, ANP-C, FAAN, Senior Vice President of Equity, Diversity and Inclusion at Equality Health
- Jamo Rubin, MD, CEO and Founder of TAVHealth
- Claire Zimmerman Nichols, Vice President, Product Innovation and Management, at Equality Health

UNIQUE VALUE PROPOSITION

Equality Health has integrated its care navigation platform, CareEmpower®, with TAVHealth's community-based SDoH platform, TAVConnect. This unique partnership provides an outcome-proven SDoH solution that enables collaborative networks of payers, providers, care coordinators, and community-based organizations (CBOs) to solve the social and clinical issues that put outcomes at risk.

Our integrated operating model is a leap forward in the science and practice of delivering whole-person care, with a comprehensive multi-payer solution that aligns community care teams, optimizes workflows, and improves member engagement for healthier outcomes and lower costs.

Turning neighborhoods into collaborative care teams

A PROVEN MODEL FOR SDOH RESOLUTION AND OUTCOMES

- **Assessment:** In line with our Cultural Care Model, our social and cultural risk assessment (SCRA) tool identifies insecurities related to SDoH, as well as cultural values which influence health utilization and behavioral health needs. The assessment can be administered by a provider, a partner CBO, the care management team, or through our mobile phone app. Assessment results inform risk stratification, intervention identification, and development of clinical and social care pathways.
- **Community Network Formation:** We have proven methods to identify, credential, onboard, and scale cross-sector care teams of community and health partners.
- **One-of-a-kind Privacy:** Our platform goes beyond HIPAA - incorporating all state and federal information laws with role-based privacy protections. This enables CBOs to become full-fledged members of the care team.
- **Longitudinal Social Records:** Privacy-enabled collaboration allows network partners to create longitudinal social records for each member, providing more informed care.
- **Outcomes:** We have proven social and clinical outcomes, with meaningful data on readmission reduction, ED utilization, quality scores, and financial performance.
- **Integration:** Tightly bonded API integration ensures a streamlined path for the most up-to-date member data. It can also leverage mobile app technology, integrate with EMRs, and connect to the Arizona HIE (Health Current).

EQUALITY HEALTH®

An innovative healthcare delivery system for diverse populations that struggle with the one-size-fits-all U.S. healthcare system. Our Cultural Care Model enhances access, engagement, and member trust. With nearly 3,000 culturally competent providers, we help improve outcomes for vulnerable populations.

- Headquartered in Phoenix, Arizona
- Tech-enabled Management Services Organization focused on risk-based performance
- Partner with 5/7 AHCCCS Managed Care Organizations
- CareEmpower® nationally deployed in 50 states across Medicaid, Medicare and Commercial lines of business
- Enable providers and payers to improve value-based care

equalityhealth.com

TAVHealth

An SDoH management solution that combines its secure, privacy-enabled platform, TAVConnect, with a host of supporting services that improve community collaboration, enable the compliant exchange of information, and generate outcomes.

- Headquartered in San Antonio, Texas
- Collaborative SDoH technology solution
- Nine years experience with three million people served
- Serves payers, providers, and community alliances
- 30% reduction in readmissions; 46% reduction in post-acute care spend

TAVHealth.com

Finity

Finity is a leading Health Intelligence (Hi.) solutions company serving millions of Medicaid and Medicare beneficiaries across the country. Our mission is to empower individuals to make conscious, healthy decisions that improve their health and well-being. Our innovative engagement, wellness, SDOH, and population health management solution is designed to engage beneficiaries at the right time, with the right activities, incentives, tools, and communication mediums. Finity's solution drives increased quality improvement and lower cost of care.

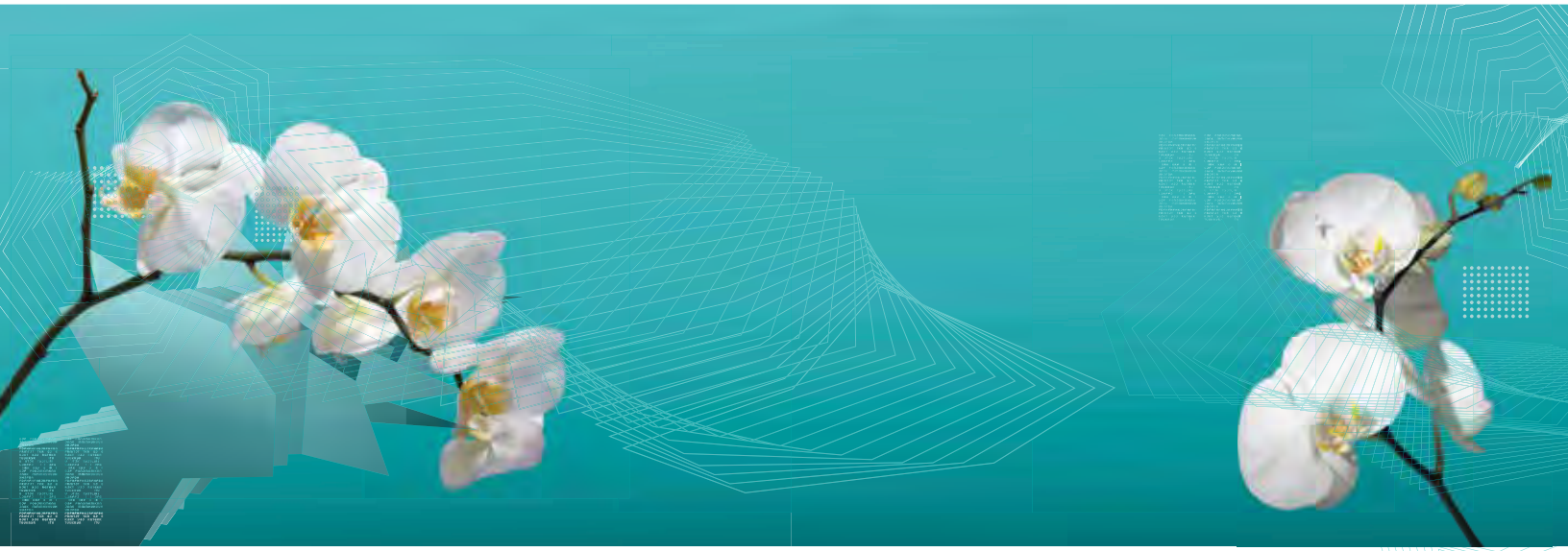
Presenters:

- Deborah Stewart, President/CEO
- Matthew Onstott, SVP Data Analytics
- Michael Nugent, VP Client Services

WELCOME TO FINITY

FINITY IS A LEADING HEALTH INTELLIGENCE (Hi.) SOLUTIONS COMPANY

Our mission is to empower individuals to make conscious, healthy decisions that improve their health and well-being. Finity's innovative engagement, wellness, SDOH, and population health management platform is designed to engage beneficiaries at the right time, with the right activities to close targeted gaps in care and reduce cost of care.
Finity is headquartered in Portland, Oregon and serves millions of Medicaid and Medicare beneficiaries across the country.



LINKING DATA ACROSS THE HEALTHCARE CHAIN

Driven by SDOH and health data collected across the healthcare chain, Finity's Health Intelligence Solution motivates beneficiaries to complete targeted quality improvement activities and provides critical real-time support for SDOH concerns. By linking federal, state, health plan, provider, and community resources into a data-driven system, Finity empowers beneficiaries to make behavior changes that break the cycle of poverty.

For more information, contact Michael Nugent at: mnugent@finity.com | (442) 888-2785

Healthify

Healthify is a mission-driven organization seeking to "build a world where no one's health is hindered by their need." To accomplish this mission, Healthify partners with payers, providers, and community partners to deploy the infrastructure necessary to manage the social determinants of health by equipping these organizations with access to:

1. A network of healthcare and social service entities with the required governance, legal, and accountability structures to coordinate care across communities;
2. The software to allow organizations to identify social needs, locate appropriate social services, and coordinate referrals in a network; and
3. The data and reporting to prove the efficacy of the healthcare and community organizations' programs to address social determinants.

Healthify's operational and technical infrastructure aligns healthcare and community-based organizations to improve outcomes, reduce costs, and provide access to an integrated network of sustainable social services focused on addressing individuals' needs.

Presenters:

- Manik Bhat, CEO
- Cesar Herrara, VP of Client Services

Healthify

There's more to health than healthcare

Healthify is fundamentally rethinking how health plans, providers, and community organizations work together to connect vulnerable populations to vital resources. Our founding team of social workers and technologists came from a background of working with at-risk patients in Baltimore hospitals. They saw how social needs - like access to food and housing - dramatically impacted health outcomes in the East Baltimore community and were moved to create Healthify.

Healthify's mission is to build a world where no one's health is hindered by their need. To achieve this, Healthify builds the infrastructure needed to integrate the social determinants of health into the era of value based healthcare.

We deliver solutions that enable our partners to identify social needs, search for social services, and coordinate referrals in an integrated network of community partners to improve outcomes.

SDOH Platform

Healthify provides an interoperable suite of technology solutions that allow the ability to identify social needs, find resources, coordinate referrals, and measure the success of SDOH interventions.

Network Services

In addition to our platform, we provide network management services to support network strategy, network building, and network maintenance. These services ensure that our partners have well-defined and sustainable SDOH interventions with a set of community based organizations.

Questions?

If you'd like to learn more about Healthify and how to leverage these solutions to improve health outcomes in your community please contact us at:

info@healthify.us

Speakers at the Medicaid Innovation Challenge

*In approximate order of appearance**

Jami Snyder

Director at Arizona Health Care Cost Containment System (AHCCCS)

Jami Snyder serves as the Director for the Arizona Health Care Cost Containment System (AHCCCS), providing comprehensive health care coverage to 1.9 million Arizonans at a cost of $14 billion annually. Prior to her current role, Ms. Snyder served as the Deputy Director of AHCCCS and the Medicaid Director for the state of Texas, a program offering coverage to 4.7 million enrollees at an annual cost of $29 billion. She has over 20 years of public and private sector experience in the health and human services industries. Ms. Snyder's areas of expertise include regulatory oversight, policy making and leadership development, stemming from her tenure in Texas as well as her prior service at AHCCCS, the Arizona Department of Health Services and the University of Arizona Health Plans, where she functioned as the managed care organization's Chief Operating Officer.

Ms. Snyder holds a master's degree in political science from Arizona State University and a bachelor's degree in political science from Gustavus Adolphus College.

David Kulick, MPH

Co-founder of Adaptation Health

David is a co-founder of Adaptation Health, a virtual incubator focusing exclusively on driving Medicaid innovation and improving the commercialization of socially impactful ventures. He has worked across 36 states and 15 countries on strategies for margin and mission with diverse health companies including early startups, private equity, nonprofits & NGOS, bilateral aid agencies, state and federal governments, and large multinational corporations. David earned his MPH from Tulane University, Bachelors in Chemistry from the University at Buffalo. Early in his career he worked on the ground with communities and vulnerable populations as an AmeriCorps Volunteer and then with the U.S. Peace Corps in South Africa. He lives in New Orleans, LA with his wife and two children.

Dr. Andrey Ostrovsky

Chief Medical Officer & SVP Behavioral Health at Solera Health

Dr. Andrey Ostrovsky is a senior operating leader and health policy expert with over a decade of experience applying human-centered design, agile development, lean management, quality improvement, and health system strengthening to eliminate disparities and achieve large-scale, sustainable achievement of the Triple Aim.

He is the Chief Medical Officer and SVP of Behavioral Health at Solera Health, a platform that connects health plan members to a curated and actively managed network of digital and in-person community providers addressing chronic disease prevention and management. He previously operated a series of methadone clinics in Baltimore, Maryland. Prior to working on

the front line of the opioid use disorder crisis, he served as the Chief Medical Officer for the Center for Medicaid and CHIP Services, the nation's largest health insurer, where he advocated to protect the program against several legislative efforts to significantly dismantle the program. He also led efforts to streamline Medicaid and make it more customer-centric. Before leading the Medicaid program, he co-founded the software company, Care at Hand, an evidence-based predictive analytics platform that used insights of non-medical staff to prevent aging people from being hospitalized. Care at Hand was acquired in 2016 by Mindoula Health. Before Care at Hand, Dr. Ostrovsky led teams at the World Health Organization, United States Senate, and San Francisco Health Department toward health system strengthening. Dr. Ostrovsky has served on several boards and committees dedicated to behavioral health, interoperability standards, quality measurement, and home and community based services including the National Academies of Medicine, National Quality Forum, Institute for Healthcare Improvement, and the Commonwealth Fund. Through Social Innovation Ventures, he and his wife invest in companies dedicated to eliminating disparities.

Andrey holds a Medical Doctorate and undergraduate degrees in Chemistry and Psychology Magna cum Laude from Boston University and is a member of Phi Beta Kappa. Andrey completed his pediatrics residency training in the Boston Combined Residency Program at Boston Medical Center and Boston Children's Hospital where he was a clinical instructor at Harvard Medical School. He is currently teaching faculty and attending physician at Children's National Medical Center.

Rachel Davis, MPA

Associate Director for Program Innovation at Center for Health Care Strategies, Inc.

Rachel Davis, MPA, is the associate director for program innovation at the Center for Health Care Strategies (CHCS). In this role, she promotes innovative approaches to serving complex populations. Ms. Davis leads CHCS' work on the Complex Care Innovation Lab (CCIL) and the Digital Health Initiative. Through the CCIL, leading innovators in the field of complex populations are collaborating to advance approaches to tackle persistent challenges facing high-need, high-cost

populations. The Digital Health Initiative promotes the development of technologies that could support complex Medicaid populations and link those tools to programs and policymakers to better understand how to improve patient outcomes.

Prior to joining CHCS, Ms. Davis worked for the New York City Health + Hospitals (HHC). She helped to develop and launch HHC's Health Home, and also served as the assistant director of the corporation's Chronic Illness Demonstration Project. Both initiatives focused on providing coordinated, multi-disciplinary care to medically and socially complex low-income patients, with the overall goal of reducing patients' costs and improving their health outcomes. Prior to moving to New York, Ms. Davis worked as a case manager for individuals living with HIV/AIDS in Boulder, Colorado.

She has bachelor's degrees in history and Spanish from Washington University in St. Louis, and received her master's degree in public administration from New York University's Robert F. Wagner Graduate School of Public Service.

Allison Hamblin, MSPH

Senior Vice President at Center for Health Care Strategies, Inc.

Allison Hamblin, MSPH, is senior vice president at Center for Health Care Strategies (CHCS). In this role, she oversees CHCS' program development and organizational planning activities. Ms. Hamblin also leads CHCS programming for Medicaid beneficiaries with complex needs, including efforts focused on children and adults. Major initiatives in this area include: (1) the Innovations in Complex Care program, a national initiative supported by Kaiser Permanente Community Health to develop integrated care models for Medicaid's highest-need beneficiaries; and (2) Advancing Integrated Models of Care, a multi-site demonstration supported by the Robert Wood Johnson Foundation (RWJF) to promote integration of person-centered approaches to care for individuals with complex health and social needs. Ms. Hamblin also directs CHCS' work in advancing the use of Pay for Success financing

approaches for social service investments and supporting the sustainable spread of the Project ECHO model through Medicaid financing.

Ms. Hamblin has previously led CHCS' efforts in developing return on investment tools and assessing the business case for quality initiatives. She has specific expertise in the areas of physical and behavioral health integration and complex chronic care management.

Prior to joining CHCS, Ms. Hamblin worked at Apax Partners, Inc. and Goldman, Sachs & Co., where she provided venture capital and investment banking services to companies in the health care and technology industries. She has a master's degree in public health from the University of North Carolina at Chapel Hill, and a bachelor's degree in biology from Duke University.

Dr. Sandeep Wadhwa

Chief Health Officer and SVP, Market Innovation for Solera Health

Dr. Sandeep Wadhwa is the Chief Health Officer and SVP, Market Innovation for Solera Health. Prior to joining Solera, Sandeep worked as the chief medical officer and vice president for payer solutions at 3M Health Information Systems where he oversaw innovative payment and quality methodologies including bundled payments and potentially preventable readmissions. Sandeep was appointed State Medicaid Director for Colorado and served from 2008 to 2010. While there, he led the effort to implement the accountable care collaborative. Prior to his state service, he led McKesson Health Solution's care management services. Sandeep serves on the board of directors of the Population Health Alliance as well as Reinvestment Fund, a $1 billion non-profit, financial institute devoted to revitalizing low-income neighborhoods. Sandeep continues to see patients at the Seniors Clinic at the University of Colorado School of Medicine. He earned his BA at Wesleyan, MD at Cornell, and MBA from Wharton and is dual board certified in internal medicine and geriatrics.

Lorry Bottrill

Chief Executive Officer at Mercy Care

Lorry has been a leader in Arizona's health care community for more than 25 years. As Mercy Care's Chief Executive Officer, Lorry Bottrill is responsible for results, including more than $3.8 billion in revenue serving more than 450,000 Medicaid and Medicare Dual SNP members. Mercy Care manages five lines of business, including the Regional Behavioral Health Authority for Maricopa County, AHCCCS Complete Care, Arizona Long Term Care System (ALTCS), Developmentally Disabled and Medicare Dual SNP contracts.

Prior to her role as CEO, Lorry served as Mercy Care's chief operating officer. As the COO, she was responsible for health plan operations focused on contracting, claims, enrollment, appeals, Medicare product and sales, and long term care. She also previously served as Mercy Care's chief financial officer, overseeing all finance functions and leading initiatives to improve financial performance.

Before joining Mercy Care, Lorry was regional finance officer for Health Net of Arizona and led the finance team for the national senior products division, including private-fee-for-service and Part D only membership.

Additionally, Lorry held various leadership positions at PacifiCare of Arizona/UnitedHealthcare, including vice president of operations, vice president of network management, director of strategic development, and director of network management. Lorry is a Certified Public Accountant. She earned her bachelor's degree in business administration from the University of Arizona.

In 2017, Lorry was named one of Arizona's Most Influential Women in Business by the Phoenix Business Journal. She also received Aetna's Chairman's Leadership Excellence Award in 2010 and was a PacifiCare of Arizona President's Circle Award recipient in 1997.