

Virtual Meeting Track 1: Options for Medicaid Managed Care States

Maternity Multi-Stakeholder Action Collaborative

September 25, 2017

2:00-4:00pm ET

Highlights and Key Takeaways

MAC members participated in a two-part virtual meeting which included a discussion on options for Medicaid Managed Care States during the first hour, and a MAC wrap-up during the second hour. Below are highlights and key takeaways from the interactive meeting, which also included a live interview with Douglas Fish, MD, Medical Director at the New York State Department of Health.

Value-Based Payment Approaches in Medicaid Managed Care States

This meeting focused on issues that Medicaid Managed Care states need to consider when working on maternity episode models, and included a review of four optional approaches, with examples pulled from states that have implemented value-based payment using one of these four approaches. Please note that these are four distinct strategies or approaches that are in use now by states; however, they are applicable to all commercial/private sector purchasers and payers. Also note that these four options also relate to value-based payment arrangements in general, and not specifically maternity care arrangements. Finally, the options are not mutually exclusive, and should be viewed as a continuum of least directive to most directive approaches a state can pursue when working with managed care plans.

- **Option 1: Encourage VBP Adoption**

This option is a light touch, non-directive approach used by some states. A few state Medicaid agencies have indicated a strong interest for their health plans to adopt value-based payment arrangements, however they have not contractually obligated their plans to do so. States may indicate their interest by beginning to collect information from MCOs to understand the extent to which they are utilizing any value-based payment strategy.

State Examples:

- **Texas:** MCOs are required to annually report to the Health and Human Services Commission on their use of value-based payment strategies. During this meeting, a MAC participant informed the groups that Texas is requiring 25% of payments to be in a value-based payment model, with 10% at-risk beginning in September 2017. With this information, Texas appears to be moving toward a more prescriptive approach where a certain percentage of payment must be in a model, and they've specified how much must be at-risk. Texas plans will also begin facing penalties in CY 2018 of \$0.10 per member per month if they do not achieve their value-based payment target, which will move them more in line with Option 3 when this is in effect.
- **Illinois:** MCOs are required to meet performance goals. This may include the implementation of value-based payment to serve as one qualifying activity to meet the required performance goals.

- **Option 2: Require MCO-Defined VBP**

Options 2 through 4 are more directive and prescriptive options used by some states. Based on the information received from MAC participants during this session, this option is where Texas currently is by requiring the implementation of value-based payment models. Under this option, the state requires that the MCO implement a value-based payment model, but does not specify exactly which value-based payment model needs to be implemented. This approach offers MCOs more flexibility, but can create challenges for providers in the state. For example, if the health plans decide to pursue different models, or decide to pursue the same model and

define aspects of the model differently such as the performance measures or risk terms, that can be chaotic for providers who are contracting with all of health plans.

State Examples:

- **Texas, South Carolina, Iowa, and Washington:** Targets are set that have to do with a percentage of plan payment, or a percentage of covered lives. States are increasingly setting quantitative targets for adoption and implementation of VBP methodology, and often there is not a lot of definition around the terms of those arrangements. Texas did stipulate that 10% must be at-risk, but in other cases, the state might not go that far, and may just require the use of value-based payment.
- **Hawaii and Michigan:** These two states do not set targets, but they do require their MCOs to increase their use of value-based payment over time.
- **Nebraska:** MCOs are required to implement VBP pilots.
- **Oregon:** CCO's are required to annually increase the number of covered lives under a population-based contract with shared savings, and with risk sharing. This approach is more definitive by stipulating shared savings with risk sharing, and they're using covered lives instead of payments.

- **Option 3: Offer Incentives and Penalties**

This approach uses a “carrot” and/or “stick” approach to influence MCOs to adopt value-based payments with its providers.

State Examples:

- **New York:** This state created a “carrot” in the form of a premium enhancement for its health plans for the adoption of state-defined alternative payment models. This example can actually be viewed as an amalgam of Option 3 and Option 4 because it's an incentive to use a state-defined model. Although New York does not forbid the use of MCO-defined models, the state does discourage this by not providing the rate enhancement and requiring that MCO-defined arrangements be approved by the state.
- **Arizona:** Similar to South Carolina, Iowa, and Texas, this state sets targets. If the health plans meet the state defined target, or threshold, they're eligible to recoup a 1% withhold. Although Arizona does not specify certain models that plans must implement, they are requiring a certain percent of overall spend, which is increasing, and they are aligning their models with the LAN framework, moving toward Categories 3 and 4. Arizona's approach also selects specific performance measures that each plan must achieve, and the plans compete for that 1% withhold. This approach has helped align the delivery system around key measures.
- **Pennsylvania:** A certain percentage of revenue is required to be paid under value-based payment models and the state will hold back 2% of the annual capitation rate if the target isn't met.

- **Option 4: Specify Models and Obligate Adoption**

This is the most prescriptive option of the four discussed. This option contractually obligates MCOs to adopt specific value-based payment models, and state-defined models tend to provide consistency within a marketplace. However, this may be much more challenging for national health plans who would have to standardize their business practices across the country as opposed to domestic health plans that exist only within the state. Generally, alignment in this area is well received by providers because they like having the same rules across all participating health plans.

State Examples:

- **Tennessee and Ohio:** The MAC has previously heard from these two states during the course of our virtual session. They both require their MCOs to participate in episode-based payment models for

maternity care as well as various other conditions. Both states expended significant resources during this process.

- **Minnesota:** Not specific to episodes, Minnesota requires its MCOs to participate in an ACO program, but the ACO program, specifically the financial terms, were defined by the state’s Department of Human Services.
- **Rhode Island:** Similar to Minnesota, Rhode Island does not have a program specific to episodes. In this state, MCOs are required to participate in coordinated care pilots with accountable entities, but the financial arrangements and the performance measurements are all state-defined.

Considerations

The four options outlined above are not available options for states that are in between contract cycles. If you are state that is in the process of writing a new RFP right now, you can decide which of these options you may want to include. Some states may have some flexibility written in between contract years to be able to modify terms, but usually there are limitations to what can be done to change a contract in between contract years. If you are coming across limitations, you can begin to do staging work so you will be ready for implementation of maternity episode-based payment models when the time is appropriate. One way to do begin staging is to convene stakeholders who will design and voluntarily adopt a maternity episode program, perhaps on a pilot basis. The MAC has heard examples of implementation of maternity episodes on a small scale or pilot basis over the course of our virtual sessions. For example, Community Health Choice of Texas started with two provider groups, and Horizon Blue Cross Blue Shield of New Jersey started with just a few providers and has since expanded. This is something that can be done on a voluntary basis to begin, completely separate from any contractual requirements.

A second consideration is that in some states, there might be regulatory leverage to help advance payment reform and adoption of episodes. One example is with Rhode Island, where the Office of the Health Insurance Commissioner has in statute the authority to ensure the affordability of health insurance premiums. This has allowed the health insurance commissioner to require commercial health insurers to adopt value-based models, including the consideration of episode-based models. This has also allowed the insurance commissioner to strategically coordinate with the Medicaid program around common areas of interest in order to forge alignment and consistency among commercial health plans and Medicaid MCOs.

Next, consider the configuration of the health plan market within the state. There is often variation in terms of what health plan markets look like. One big distinction is whether the state is dominated by national insurers or domestic insurers who are specific to the state or who might only exist in a couple of states. States with domestic plans might have more success because the national plans might be using a national model that they are reluctant to tailor to a state. However, national plans may already have developed a maternity episode that they’ve applied in another state and that might serve as a platform for beginning a maternity episode initiative in your state, so there would not be the need to start from scratch. This type of alignment worked well in Arkansas when Blue Cross Blue Shield worked in tandem with the Arkansas Medicaid program.

Another consideration that is important to decide at the outset is whether your state should start on a small scale, or whether it would be more beneficial to “go big” and do something state-wide as seen by Arkansas, Ohio, and Tennessee. It is important to note that even these states who implemented network-wide only started with a limited number of episodes.

Finally, it is essential to seek input from MCOs and providers in advance of proceeding with a maternity episode initiative. The MAC has heard this recommendation from multiple states, including Tennessee and Arkansas. Extensive work has to be done in terms of outreach and education with providers in advance of implementing a maternity episode. This work can’t just be done in partnership with a states MCOs. The change in business models for all providers who are moving from fee-for-service to episode-based payment is profound, so there needs to be a lot of education and outreach for them as well as for consumers/consumer representatives, and legislatures.

Interview: Using Managed Care Contracts to Advance Implementation of Maternity Payment (New York State Department of Health)

MAC Participants engaged in discussion with Dr. Douglas Fish to learn more about how New York is using its Medicaid MCO contracts to advance adoption of value-based payment in general, and maternity episode payment in particular, and what New York's experience has been to date. New York is implementing a broad set of value-based payment reforms, including a maternity episode, as part of its Delivery System Reform Incentive Payment (DSRIP) initiative, and the state has a goal of reaching 80-90% of managed care payments to providers under value-based payment by 2020. New York is one of the "carrot" and "stick" models referenced earlier in Option 3. The "carrot" is rate enhancement, and the "stick", although not currently present, the state intends to consider penalties on plans that fail to adopt or make progress toward value-based payment adoption.

While this interview is specific to Medicaid MCOs, the content of the discussion applies to state employee purchaser programs and private employers as well.

- **Question 1: Can you provide us with some broader context as to what is included in New York's program?**
 - The New York Medicaid program includes 18 Medicaid MCOs that cover about 5.3 million lives. We work with various provider organizations, including accountable care organizations, independent physician associations, and other large health care systems to develop value-based payment contracts. Our current timeline is to have 80-90% of all dollars in some type of value-based payment arrangement by 2020, starting with gradually increasing requirements set at 10% participation by April 1, 2018, and 50% by 2019, and finally, 80-90% by 2020. There are additional stipulations that 15% must be in risk-bearing contracts by 2019, and 35% by 2020.
 - This program is being implemented in various levels:
 - Level 1: Retrospective reconciliation against a target budget set based on 3-years of claims data as well as growth- and risk-trend adjustments; shared savings **with no** downside risk to the provider.
 - Level 2: Retrospective reconciliation against a target budget set based on 3-years of claims data as well as growth- and risk-trend adjustments; shared savings **and** shared risk (only if there are losses).
 - Level 3: Prospective capitated per member per month payment arrangement.
 - In order to reach the goals laid out in that timeline, New York has outlined a variety of arrangement types including the Total Care for the General Population group, which is an all-in total cost type of arrangement that providers may incorporate a maternity care episode-based arrangement and/or an Integrated Primary Care arrangement into. There is also a Health and Recovery Plans arrangement for those with serious mental illness and substance use, an HIV/AIDs population, and a Managed Long-Term Care population.
- **Question 2: Earlier in this session I reviewed four optional approaches states can use to implement a value-based payment program with their MCOs. What was the thought process behind New York's decision to align with Option 3 (offering incentives and penalties)?**
 - New York developed a State Value-Based Payment Roadmap, a CMS-approved document, which includes requirements, standards, and some guidelines. Within those requirement, and built into our DSRIP program, is the metric of achieving 80-90% movement toward value-based payment. We must meet this to earn all of the eligible dollars as a state from CMS and the federal government. Although this is an aggressive goal, our Medicaid Director, at the time of negotiation of our DSRIP waiver between the governor and CMS, incorporated this goal as part of our special terms and conditions for the DSRIP program and also baked it into the State Value-Based Payment Roadmap. Since the roadmap is what

guides our work, over time, elements of the roadmap are being incorporated into the contracting process, however, following the roadmap is not a contractual requirement out the gate.

- One of New York’s goals is to allow maximum flexibility between the health plans and the value-based payment contractor – the provider organization type. We believe it is very important, and we work hard to incorporate stakeholder feedback, not only from the health plans, but from trade associations, providers, provider groups, and our membership.
- **Question 3: Did you receive any feedback as to whether the roadmap was too prescriptive or not prescriptive enough?**
 - There was an overall favorable response from providers. We work hard to provide transparency, education, and enough lead time for providers, and they appreciate our attempts to be flexible to their needs. The “carrots” and “sticks” of New York’s program are being discussed at regular meetings, so there is plenty of opportunity for interactive engagement with providers.
- **Question 4: From your experience, do you believe this program is working as New York has intended?**
 - I think it has generally worked as we would intend. One marker of that is we have an annual survey that we get back from the health plans in the summer. We have the most recent evaluation, and state-wide we currently have 9% contracting at Level 1 (upside shared savings only), 27% at Level 2 (shared savings and shared risk), and 2% at Level 3. Although we all have a lot of work to reach that ultimate goal of 80-90% by 2020, I feel we are on the right path. The trajectory is appropriate and I believe we are on target and are where we should be at this time. As always it would be nice if we were further along, but we are encouraged by these results.
- **Question 5: How did you use the levers available to you as a purchaser to advance the adoption of your model (e.g., regulation or sub-regulatory guidance documents)?**
 - The State Value-Based Payment Roadmap is a source of truth, so whenever a question is raised, our Medicaid Director always refers back to that document. This document is easily available for everyone to reference on the New York State Value-Based Payment Resource Library online.
 - The Roadmap has not been made a part of the contract per se, but as elements are discussed, operationalized, and implemented, they are being added to the Roadmap. For example, our Category 1 measures, the measures that will be used to determine whether providers are eligible for the shared savings, were added. These are measures that have been approved by the state, recommended by our clinical advisory groups and our stakeholders, and have gone for review to the state’s steering committee for value-based payment, what New York calls our Value-Based Payment Workgroup. It’s one thing for a state to have the efficiency to find in this contractual year they had savings, but it’s another thing to be able to determine if those savings were earned by the provider group by meeting the performance metrics.
 - Our guidance also dictates that we hold regular webinars and meetings. We have a monthly meeting with the plans, and this is always an agenda item on those meetings.
- **Question 6: Have you applied any of the “carrots”, the enhanced rates, or the “sticks”, financial penalties, to date with your MCOs?**
 - Yes, and these have been disseminated and discussed with the health plans. Our “Carrot” includes an upward stimulus adjustment, this is in the rates for 2016/2017. In part, some of that is guaranteed and some of that is tied to the percentage of risk-based contracting and their compliance with the timeline for that. To qualify for the stimulus adjustment in 2018/2019, and 2019/2020, contracts also have to achieve greater than the 40th percentile in their quality metrics.

- We also have a penalty adjustment, or “stick”, that starts out at ½ percent, and goes up to 1 percent by 2021. These are levied based on the value of the margin between the threshold where we want the health plans to be in terms of those 10%, 50%, and 80-90% targets, where a given plan is, and how far away they are from meeting those contracting requirements.
 - Another “carrot” being phased in over the next few years is a performance-based adjustment, which takes into account performance, efficiency, and quality. That is a variation starting at 1 percent either above or below any given year, and ultimately we hope to move that up to 2 percent, and then 3 percent over the subsequent years.
- **Question 7: Why did New York decide to create its own maternity episode definition and use the “carrot” and “stick” approach?**
 - Technically, New York is not using a self-created model, but is using the Altarum Institute’s Prometheus episode definitions for maternity care. We do have our own specific measures that were recommended by our Clinical Advisory Group, but our model is something that was developed before us, that we are adopting. It is also used in our Integrated Primary Care episode-based arrangement type.
 - Although we do have some pilot programs beginning this year that will receive support from the state and incentive dollars, we did not have any uptake in our maternity episode.
- **Question 8: Explain the pilot approach and what challenges or barriers you think might have impeded participation by providers in the maternity episode.**
 - There are a few barriers/challenges that come to mind for the maternity episode pilot:
 - The contracting period was very short
 - There was a lack of experience with episode-based arrangements
 - Delays in gathering the data that enabled us to establish target budgets
 - Provider attribution questions (e.g., delivering obstetrician vs the provider delivering the majority of services)
 - Requirements to move to risk-based contracting too soon
 - Another consideration is with the timing and frequency of convenings around arrangement types. Our last Clinical Advisory Group around maternity care had met in 2015. They were the first group to convene, and at that time, there was no plan to include Level 4 NICU costs in the arrangement. Ultimately, that is how the grouper works in the New York State model with Altarum – it includes Level 4 NICU costs with a stop loss provision. Across other maternity models, that has increasingly become the recommendation, but that topic has created some confusion. So because our Clinical Advisory Group around maternity care was the first group to meet and the first one done, about a year had lapsed where the group wasn’t convening while we were still convening around the other arrangement types.
 - Overall, education is very important at the provider level, and it should be an ongoing activity. A fair amount of confusions still exists as to what value-based payment is and a general reluctance on the provider’s part to adopt these programs.
- **Question 9: Does New York have any plans to extend the maternity pilot?**
 - In our regular pilot program that is supported by incentive dollars, there is not a specific plan to extend the maternity pilot. However, we are hopeful that we will have maternity provider groups willing to take on this type of arrangement and that the state will provide the technical support and other needed support.

- To help support the maternity episode, New York is developing a dashboard for our value-based payment programs to make the data and information readily available and transparent. We are also continuing to convene our Clinical Advisory Group, who met twice this summer on maternity care and developed committees around the implementation, calculation, and reporting of the measures at a contracting level, at the plan level, and at the state level. Lastly, we also have state-wide Value-Based Payment Boot Camps which is a broad scope educational effort.
- **Question 10: Based on feedback New York has received on its value-based payment programs, are there plans to revise the episode definition to either change the attribution rule or eliminate the requirement for risk assumption in year 2?**
 - There has been a lot of discussion around the attribution rule. The Roadmap provides recommended guidance on attribution, and that’s the model upon which we will do our analytics. The recommended attribution is only a guideline, though, so a provider group may choose to use the delivering obstetrician, and that would be considered “off-menu”. There is a section in the Roadmap that addresses “off-menu” arrangements and how they are considered. There is no penalty to a plan if it goes “off-menu”, the plan just needs to use a program that is either roadmap-compliant or approved by the state as in the spirit of moving toward our value-based payment reform system.
 - Moving to Level 2 by year 2 is only a requirement of the pilot, so an organization operating in a non-pilot environment does not have that requirement. A provider group not participating in the pilot could adopt the maternity episode and just stay at Level 1. Of course, we hope they would continue to move toward the direction of Level 2 and 3 since we think that is where there is opportunity, but there is not that provision in the episode definition.
- **Question 11: Do you have plans and providers who are speaking with one another or with you about implementing a maternity episode?**
 - In general conversation, yes. We thought we were going to have one upstate and one downstate pilot, but both decided not to participate this year. Conversations are continuing, so we are hopeful that in 2018 we will have providers implement the maternity care episode.
- **Question 12: What type of support are you offering MCOs or providers that have an interest in adopting a maternity episode (e.g. data support, technical support, or financial support)?**
 - First, we have to understand the arrangement type the MCO or provider is pursuing, and then we can help set that up and provide assistance on how the process works for setting a target budget. For example, in a Level 1 retroactive reconciliation against a target budget, we can help providers understand how that would work, and make the 2015 data available to the organization so they can analyze cost and claims data. Then, a dashboard is being built for purposes of value-based payment to look at efficiency and quality scores and provide data transparency across plans and provider groups.
- **Question 13: Based on your experience to date, what advice or recommendations would you provide to purchasers, health plans, and providers?**
 - Have an open mind, incorporate broad stakeholder engagement, and provide enough advanced notice of information or changes to providers.
 - If New York were to do this differently, for the pilots at least, I think we would avoid venturing into the target budget setting process and let the provider groups and health plans determine that on their own. Also, although we did a good job educating the leadership level of health plans, provider groups, and our performing provider systems, that information did not filter down as much into the practice level and we have found we still have a lot of work to do to get providers comfortable with this new payment

model. Especially focusing on the terminology, educating providers so they understand it and feel like they can participate in the conversation.

- **Question 14: [Participant Question]: Can you address the politics of the use of high cost interventions and reliance on high cost settings? What’s really holding up progress on adoption of the birth center model?**
 - What I can speak to is what New York calls regional perinatal centers in our model. Providers are encouraged to refer to these centers if they have mothers who need higher levels of care. These centers are used to providing this higher level of care, they have a history of volume and claims, so in their contracting process the target budget would take into account those costs and claims. These regional centers are being increasingly discussed and recommended across the state to ensure that the patient is at the right level of care for the delivery.
- **Question 15: [Participant Question]: Birth centers are providers of low-risk maternity value-based episodes of care. New York does not require its plans, both commercial and Medicaid MCOs, to reimburse birth centers, which is a requirement of CMS guidelines as of July 1, 2017. What are your thoughts regarding birth centers which are in the DSRP program?**
 - I don’t have a specific comment on that, I’ll have to do some homework on that question.
- **Question 16: [Participant Question]: Can you clarify, did I hear the presenter say the “majority of the care” provider was the preferred methodology vs. the delivering provider, however, an MCO may go off-menu and choose an alternate attribution model?**
 - That is correct, the roadmap guidance is to use the plurality of service provider. However, we did have in our Health and Recovery Plans arrangement type that the health home is the recommended provider and what they’re doing in the Integrate Primary Care arrangement is using the PCP as opposed to the health home. So, we would prefer it to be the “majority of care” provider because that is our recommended way for our data analytics, but if a provider wants to propose a different attribution methodology then that proposal can go through our off-menu process to be considered.

MAC Final Assessment

As a Medicaid director, how much has repeal and replace conversations taken your time and focus?

- **Tom Betlach, Arizona Health Care Cost Containment System:** It has been all consuming really since November 8th. Even after the vote in July, we have still been spending a lot of time. An example of that is today, yet another version of Graham-Cassidy came out that we've been spending our whole morning looking at so it has taken a lot of high-level time and energy. And energy that we were using previously around various strategies like alternative payment methodologies and other things like that, and has really been consumed it as related to the repeal and replace debate.

Share where you are right now compared to where you were last December. Rather than using the 5-point scale, use the Participants Range in Readiness.

- **Karen Love, Community Health Choice of Texas:** I would say, although I don't feel like we have expertise in episode payments, based on the number of people who have been asking for us to talk about our program, I guess I'd put myself in that bubble for the maternity care bundle. That and integrated care are probably the only two bundles that make a whole lot of sense in the Medicaid space. We are coming to the close of our second year, which is where the providers had downside risk, so in your 1 to 5 scale, I would say that we are at a 4.5, evaluating the pilot program data. We are still working with 2 providers, although we've had interest from other providers, we would like to get through the evaluation of the 2nd year data before we expand to other providers.
- **Tom Betlach, Arizona Health Care Cost Containment System:** I think we are in the white space outside of Exploring Episode Models. We have been looking at alternative payment models, not necessarily episode models, for many of the reasons you described in terms of some of the challenges. I thought it was great the discussion you had with Doug in the previous hour, where they were doing a lot of things right, they had a mandate, they were doing a lot of good work, they had a model, and still it was very difficult for them to get takers, and I think that we're going through that space now of spending a lot of time, effort and energy learning between the various managed care organizations and providers, but without the capital, we have not jumped into the episode space but clearly are looking at various alternative payment models and trying to get some alignment around the measures.
- **Casey Grabenstein and Janelle Reiner, CareOregon:** We feel like we fit in the green bubble, I think we were hoping to be further along this year, but I think the reality for us is we've learned a lot and it's really for us the staging, so we have a lot of different alternative payment programs going on and we are increasingly shifting our dollars into that realm in a significantly fast way by participating in the LAN and other ways, so I would say our energy has really gone toward that, and so in terms of on the ground work for maternity models, we've had to kind of put it on a bit of a back burner so that we could get all of these other pieces a little stronger and up and running. Part of that is to do with that we have engaged the network so heavily in that, and they have been great partners and willing to engage with us, and we're a little worried about adding one more thing and request onto them right now while we're still adjusting to some of our other value-based payment models, but we feel like we've really benefited from hearing from other organizations' challenges and successes, and it just gives us a better perspective of what to expect as we try to hone in on that specific conversation, we have a couple of providers in mind that we really do want to engage in that conversation, hopefully in early 2018, and kind of move that forward, and just trying to be thoughtful of the timing of that with all of the other work that is going on.
- **Annette Pounders, Physicians Primary Care of Southwest Florida:** We are still in the exploring episode models. Doesn't seem to be on the forefront of programs for Medicaid MCO in Florida, or at least in my area of the state.
- **Wanda Hembree, Aetna (WV):** We are totally in the exploratory mode at this point.

What are the most pressing questions that you have related to how to get to the next step in APM adoption, specifically maternity APM adoption, and what do you think you need in order to keep making progress?

- **Tom Betlach, Arizona Health Care Cost Containment System:** From Arizona’s perspective, it’s really resources. It’s time, expertise, and capital infrastructure for us to be able to advance this. So, I see all of those as major limiters, not to make excuses, as leaders it’s our job to prioritize resources so that we can do these types of things but that is a limiter in this point in time.

Whether participating in the MAC helped your organization in getting some organizational interest and commitment to maternity episodes, and in what ways have our meetings fostered learning and action on your part?

- **Janelle Reiner, CareOregon:** I think just listening around the nation to how other plans are progressing and what they’re doing, and giving us ideas looking forward, I think that has been very valuable, and we’ve really enjoyed the process and we’re very committed to doing this, so it’s kind of helped us foster how we want to go. And also, I will reiterate with Arizona, we struggle with our system infrastructure, and the manual workarounds of the work, and kind of moving it forward, the resources and infrastructure is kind of what we’re struggling with on the horizon, so hopeful we can get that caught up with what we want to do.
- **Karen Love, Community Health Choice of Texas:** It has allowed me to hear some thoughts that I’ve kind of stashed away for the next version of this. We are in our pilot program with our two providers, coming to the end of our second year with them with downside risk, so I’ve heard some things definitely from other participants on the call that I want to take into consideration in the next iteration of our maternity bundle.
- **Tom Betlach, Arizona Health Care Cost Containment System:** Michael, I would like to compliment you in terms of all of the material you’ve covered in these discussions. I thought you’ve done a good job in terms of facilitating and really bringing out information for various stakeholders. For me, the takeaways really fall into two buckets: 1) we’ve got a long way to go when you look at the variety of needs that we have a state to stand this up, and 2) it gave our team some hope that there have been a number of organizations out there that have moved forward on this successfully when you look at the three states that have done episodic payment, and when you look at Horizon Blue Cross Blue Shield and Community Health Choice. There are organizations that have successfully stood this up so that provides us a pathway forward and I appreciate the information that’s been made available to give us that hope in terms of how to do this.
- **Annette Ponders, Physicians Primary Care of Southwest Florida:** I have found the meetings to be quite informative and has helped me to be more knowledgeable as these models get introduced in our area (in the future). I especially enjoyed hearing how this has been successful in some states. Personally, the information provided is something that I could see happen in the commercial market.
- **Jill Alliman, American Association of Birth Centers:** We’ve learned a lot about what is going on in some states. Now, where to go from here? Where do freestanding birth centers go to be included in more payer networks with APMs? American Association of Birth Centers is looking for Medicaid MCO’s or states who want to partner with freestanding birth centers in a pilot to include these birth centers in APM model networks.
- **Carol Sakala, National Partnership for Women & Families:** The National Partnership for Women & Families appreciates work of the MAC and commits to continued support for implementing maternity care APMs. We would like others to know that we will be releasing an issue brief this fall that lays out woman- and newborn-centered principles for performance measurement in maternity care APMs and the measures that best meet these criteria. We will welcome the opportunity to share that document with MAC participants, among others.

Appendix: Interactive Poll Result

Poll Question	Participant Response	Total Percent
Rate the Value of this Meeting	Very Valuable	75%
	Valuable	25%
	Somewhat Valuable	0%
	Not Valuable	0%