SIM
End-of-Project Summary

Maine Health Management Coalition

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Paul R. LePage, Governor Mary C. Mayhew, Commissioner

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Overview

- As stated in *Maine State Innovation Model: The Operations Plan for Sustainable Health Care Reform*, many aspects of Maine's SIM model were designed "to test the power of collaboration and a consensus-building process to realize the goals of the Triple Aim."
- Maine's SIM grant also was designed to build upon a strong foundation of existing efforts already underway in the state to advance the Triple Aim, including several MHMC-sponsored initiatives.
- Leveraging its long-standing role as a multi-stakeholder convener, MHMC has engaged purchasers, providers, payers and consumers to collaborate on several key topics, including:
  - Consensus and alignment around a core measure set
  - Development of strategies to constrain healthcare costs
  - Strengthened transparency and public reporting of healthcare performance measures
  - Agreement on key components of a value-based insurance design
- MHMC also has developed a comprehensive data infrastructure and provides analyses to support Coalition and other SIM activities.
- As envisioned in the grant, these collaborative efforts and data analyses have resulted in a range of tools and strategies that stakeholders can use to advance the Triple Aim.

Cross Payer Claims Database and Accountable Communities

OVERVIEW

This objective includes infrastructure, data quality, and warehousing work to provide claims-based analytics, including data and analyses for MaineCare Accountable Communities.

HYPOTHESIS CONCLUSION

Hypothesis. *That a robust data and analytics function helps stimulate better informed decisions regarding quality improvement, patient experience of care and payment reform, as well as strategies to address cost of care.*

The cross payer claims data base—and resulting analyses—provided a range of data to stakeholders, including cost, utilization, and quality data that practices can use to identify improvement opportunities; publicly reported total cost of care information; and behavioral health data that informed discussions among behavioral health providers seeking to better understand patient cost and utilization patterns.

BENEFITS

- The cross payer claims database is an essential precursor to a range of data-related activities undertaken under SIM. Practice reports, state-wide measurement of TCI, and stakeholder discussions within the Behavioral Health Cost Workgroup are examples of activities which relied on warehouse-based analyses.
- Reporting for the MaineCare ACs has allowed those contracted entities to receive robust, actionable data, which has supported continued expansion of the AC program.
- Providers have indicated they are very satisfied with the data and analytic work for the MaineCare ACs, and the Coalition will continue to provide these services to support the Accountable Communities moving forward.

Cross Payer Claims Database and Accountable Communities (cont.)

FUTURE RECOMMENDED CHANGES/LESSONS LEARNED

- Data accessibility is critical and must be effectively managed. Upstream impacts on the availability of data, or lengthy legal processes needed to obtain access to the data, affect the ability to conduct downstream work.
- Maintaining a robust, validated database is a resource-intensive activity, which requires specialized resources to do well.

SUSTAINABILITY RECOMMENDATIONS

Continuing to provide broad access to data and analytics across all payers remains a central tenet of the Coalition's work, but to some extent, such work will be driven by specific projects which bring with them the funds necessary to sustain the work. For example, MaineCare Accountable Community reporting will be continued post-SIM, which will require maintenance of the MaineCare data warehouse.

OTHER?

N/A

NEXT STEPS

N/A

Executive Summits and Healthcare Databook

OVERVIEW

This effort focused on sharing data and strategies with decision makers at both executive summits and via the *Healthcare Databook,* which compiles key demographics, health status, health coverage and utilization, health quality, and health cost information in one easily accessible document, including state and county-level data and comparisons to national figures.

HYPOTHESIS CONCLUSION

Hypothesis. *By providing information and data regarding the health care environment to a broad audience, including those who make purchasing decisions for groups of employees, they are better prepared to make informed coverage decisions.*

- Executive summits engaged many purchasers—including many small and mid-sized employers—in learning more about how they can utilize data and other strategies to better manage their health costs.
- Feedback on the *Healthcare Databook* was uniformly positive, including numerous requests for copies (including, for example, from a labor/management health commission).

BENEFITS

- Two summits provided over 80 executives with data and strategies to better manage health costs, including presentations from Maine and national HR executives.
- Two volumes of the *Healthcare Databook* compiled a range of state and county data on demographics, coverage, quality, and cost. The *Databook* is available on the SIM, MHMC, and Maine Shared Health Needs Assessment and Planning Process (SHNAPP) websites.

Executive Summits and Healthcare Databook (cont.)

FUTURE RECOMMENDED CHANGES/LESSONS LEARNED

After holding statewide and regional summits, MHMC determined that regional summits offered greater opportunities for small and mid-sized employers to learn about trends and strategies in their areas, and possibly to partner with larger regional employers. At the time of the SORT decision, modifications were underway to enhance the value of regional summits to employers, including (1) sharing regional cost, utilization, and condition-prevalence data, as well as identification of variation compared to other areas of the state; (2) sharing cost-management strategies employed by larger regional employers; and (3) encouraging employers to act together to create community-wide strategies to address regional trends.

MHMC concurred with the SORT review that publishing the *Healthcare Databook* once a year—rather than biennially—will keep information current and allow for more meaningful comparisons over time.

SUSTAINABILITY RECOMMENDATIONS

With its robust data resources and analytics, and role as a multi-stakeholder convener, the Coalition is uniquely positioned to engage interested parties—including at the regional level—in a dialogue on collaborative models designed to successfully address issues related to population health, access to services, and containing cost growth.

MHMC plans to continue publishing the *Databook* on a regular basis, and has received grant funding to support that effort moving forward. We will be investigating collaborating with others who understand the value of efforts such as the *Databook,* and are considering undertaking similar work themselves.

OTHER

N/A

NEXT STEPS

N/A

Healthcare Cost Workgroup

OVERVIEW

The Healthcare Cost Workgroup brought together purchasers, providers, health plans, consumers, and other stakeholders to develop actionable strategies to reduce costs while preserving quality.

HYPOTHESIS CONCLUSION

Hypothesis. *Through the use of a consensus-based process involving informed stakeholders, sound guidance regarding strategies to address health care costs may be developed to guide purchasing and policy decisions and that guidance will be adopted by decision makers.*

The multi-stakeholder workgroup developed recommendations on (1) a voluntary growth cap; (2) principles/criteria for evaluating health infrastructure realignment proposals; (3) a scope of work inventory of Maine healthcare resources; and (4) strategies on which purchasers, providers, and health plans can collaborate to reduce costs. Several of those recommendations have been adopted by decision makers:

- Voluntary growth cap was implemented by one health system, and is currently being explored by several large purchasers.
- MHMC Board endorsed the principles/criteria for evaluating infrastructure proposals and offers that review to providers considering realignment proposals. The workgroup recommended MHMC as the multi-stakeholder organization to review and publicly support proposed realignment plans that meet the recommended principles and criteria.
- Maine grant organization agreed to incorporate major components of health resources scope of work into one of its funded studies.

BENEFITS

- Workgroup developed several recommendations that stakeholders can use to reduce costs or inform efforts to reduce costs and more effectively align resources.
- Bringing together some of the state's most instrumental and knowledgeable purchasers, providers, and health plan representatives resulted in innovative, workable, and consensus-based strategies that stakeholders have implemented or are considering in order to better manage healthcare costs.
- Behavioral health providers participated in a subgroup that analyzed cost and utilization patterns among MaineCare participants, creating an important foundation for formulating more cost-effective strategies for this population.

Healthcare Cost Workgroup (cont.)

FUTURE RECOMMENDED CHANGES/LESSONS LEARNED

Many stakeholders participated in multiple SIM workgroups, which required a significant time commitment that was hard to maintain over the long term. Moving forward, the Coalition is working to streamline and integrate its convening activities to reduce duplication and maximize stakeholder utility. Robust participation is essential to multi-stakeholder forums, and that resource must be cultivated and carefully managed.

SUSTAINABILITY RECOMMENDATIONS

MHMC will continue to convene stakeholders to improve the value of healthcare in Maine. Key stakeholders continue to see value in the Coalition's convening activities, and remain committed to participating in these efforts. Priority topics will be identified by MHMC members, and may include cost of care, value-based insurance design, measure alignment, and payment reform. These activities will combine stakeholders—and their substantial expertise—with actionable data analyses to identify opportunities for purchasers, providers, and health plans to improve the value of care in Maine.

OTHER

N/A

NEXT STEPS

N/A

Value-based Insurance Design

OVERVIEW

Multi-stakeholder workgroup developing key components of a value-based insurance design tool that stakeholders can use to better align patient costs with the value of health services.

HYPOTHESIS CONCLUSION

Hypothesis. *Development of a baseline value based benefit design that appropriately balances cost of care and value of services will speed adoption and use of such coverage in Maine. When adopted, this type of coverage will lead to improved patient outcomes and experience of care, as well as more appropriate costs of care.*

The VBID effort aimed to create an off-the-shelf insurance plan that commercial carriers could offer as a standardized product. The workgroup made significant progress towards identifying key components of an VBID model, including establishing cost protocols for over 100 preventive services. However, the original scope proved too ambitious for SIM's timeframe and resources. The effort's focus shifted to creation of a template of key components that carriers and purchasers can use to develop their own VBID plans. While SIM funding was discontinued under SORT, MHMC continues to convene stakeholders to work on the template and believes that—once completed—it will support and speed adoption of VBID plans in Maine.

BENEFITS

- The effort catalyzed collaboration among key stakeholders and increased understanding of value-based insurance design, its benefits, and the steps necessary to advance adoption. This sort of foundational work by those who will develop, purchase, and implement VBID plans is essential to advancing the initiative in Maine.
- The workgroup reached consensus on cost-sharing protocols for 100 preventive services.
- The workgroup aligned ACA benefit coverage across commercial payers; workgroup identified several areas where coverage was inconsistent across payers and obtained consensus to align benefits.
- In a move to improve administrative efficiency, several payers agreed to develop and accept a uniform online provider enrollment application that will allow one-stop access for providers to join payer networks. The Coalition is currently working with stakeholders on implementation of the online application.

Value-based Insurance Design (cont.)

FUTURE RECOMMENDED CHANGES/LESSONS LEARNED

The goal of creating an off-the-shelf insurance product that addresses patient-nuanced benefits and other patient engagement strategies proved too comprehensive given the timeline and resources under SIM. Building upon the work already completed by the VBID workgroup, the scope of work was redefined to develop a template of key elements that can be used by purchasers to develop their own VBID policies with health plans. It is anticipated that the template will be completed in September 2016. While the focus of the work has changed, the effort continues to catalyze collaboration and promote understanding among key stakeholders about value-based insurance design.

SUSTAINABILITY RECOMMENDATIONS

The Coalition will continue to convene stakeholders to improve the value of healthcare in Maine. Key stakeholders continue to see value in the Coalition's convening activities, and remain committed to participating in these efforts. Priority topics will be identified by MHMC members, and may include value-based insurance design, cost of care, measure alignment, and payment reform. These activities will combine stakeholders—and their substantial expertise—with actionable data analyses to identify opportunities for purchasers, providers, and health plans to improve the value of care in Maine.

OTHER

N/A

NEXT STEPS

N/A

Measure Alignment

OVERVIEW

The multi-stakeholder workgroup was charged with identifying a common set of core measures with the objectives of producing a measure set capable of gauging ACO performance, aligning commercial and public payer performance measures, and reducing provider reporting burden.

HYPOTHESIS CONCLUSION

Hypothesis. *The identification and adoption of a set of core metrics for ACOs will allow for benchmarking performance across plans and more informed purchasing decisions on the part of purchasers, as well as decreasing pressure on providers (in terms of reporting burdens).*

The adoption of the core measure set produced general alignment among private sector and public payers. The measure set was not intended to be an exclusive set, but to provide the foundation of performance measures for ACO contracts. As a result, the core set has been identified as having broad application in the commercial sector and with MaineCare. A pilot is in development to produce system-level performance benchmarking to facilitate comparative analysis.

BENEFITS

- The workgroup produced a core measure set of 27 measures identified for payment purposes and 17 measures identified for monitoring performance.
- The measure set was endorsed by workgroup stakeholders (payers, providers, and purchasers), and has achieved broad adoption, with systems and health plans reporting that between 66–72% of the 2015 ACO performance measures were from the core set.
- The MHMC and PCHC are meeting regularly to advance the first phase of a pilot to compare system-level measure set performance with statewide results.

Measure Alignment (cont.)

FUTURE RECOMMENDED CHANGES/LESSONS LEARNED

The vast majority of core measures are claims-based. These were selected based on ease of data collection. A major challenge remains around determining an efficient method for reporting selected clinical measures without creating additional administrative burden on providers.

SUSTAINABILITY RECOMMENDATIONS

The workgroup recommended that it continue to convene post-SIM to facilitate the ongoing multi-stakeholder collaboration on a core measure set. Both the workgroup and ACI Steering Committee believe that the Coalition is the appropriate place to undertake this collaborative measurement work moving forward, and the Coalition is committed to continuing the effort post-SIM.

Specifically, the workgroup recommends convening periodically to consider adjustments to the core set. Revisions may result from emerging national measure sets, changes to clinical guidelines, or payment reform developments that may warrant new measure requirements. The workgroup also will survey health plans to gauge any growth in the use of the core set for ACO performance.

OTHER

N/A

NEXT STEPS

N/A

Payment Reform

OVERVIEW

This effort promotes multi-stakeholder collaboration to advance the transition from volume-based (fee-for-service) payment to value-based payment in order to support delivery system transformation.

HYPOTHESIS CONCLUSION

Hypothesis. *Investment in a stakeholder-based process to support development of alternative payment arrangements—including ACOs—will lead to an increased uptake/spread of these arrangements in the Maine marketplace, furthering our objective of moving further away from paying on the basis of volume to a greater emphasis on value.*

While it is not possible to quantify the extent, the multi-stakeholder dialogue played a role in advancing alternative payment models. Communication with health systems and health plans enabled the plan sponsors to gain insight into the design, implementation, and evaluation of alternative payment arrangements. More informed plan sponsors encouraged the dialogue with willing health system and health plan partners. The multi-stakeholder collaboration facilitated an understanding of the relative risks and potential benefits of emerging alternative payment models.

BENEFITS

- Considerable multi-stakeholder dialogue to identify the alternative payment models (APMs) and scope of implementation in Maine market, with the intent of developing common expectations, accountability, and principles for primary care APMs.
- The Coalition engaged Discern Health to produce a report on innovative payment models for advanced primary care. The report and subsequent dialogue served as a critical resource to inform multi-stakeholder consensus on key elements of a second tier of multi-payer primary care payment strategies. These strategies provided for continued infrastructure support, payment incentives for improved clinical outcomes and lower costs, and more defined accountability.
- With the impending end of the MAPCP demo, stakeholders examined various APMs in other markets to sustain payment for advanced primary care.

Payment Reform (cont.)

FUTURE RECOMMENDED CHANGES/LESSONS LEARNED

There are challenges in advancing primary care payment reform in a market with considerable ACO investment and development. Both the health systems and health plans have focused attention on payment reform initiatives at the system level to accelerate value-based payments.

SUSTAINABILITY RECOMMENDATIONS

The Coalition will continue to convene stakeholders to improve the value of healthcare in Maine. Key stakeholders continue to see value in the Coalition's convening activities, and remain committed to participating in these efforts. Priority topics will be identified by MHMC members, and will allow for continued multi-stakeholder dialogue on specific issues related to payment and system reform. The MHMC also will continue to survey health plans to measure the growth of APMs.

OTHER

N/A

NEXT STEPS

N/A

PTE-Behavioral Health

OVERVIEW

The Pathways to Excellence (PTE) Behavioral Health (BH) Steering Committee brings together behavioral health providers, purchasers, consumers, and health plans to identify metrics to measure and publicly report on quality in outpatient behavioral healthcare settings.

HYPOTHESIS CONCLUSION

Hypothesis: *The development and public reporting of quality measures for behavioral health will serve to introduce more public accountability in behavioral health care and will provide consumers with information that will assist them in assessing where they might seek care.*

The Steering Committee–including representatives from many of the state's large behavioral healthcare agencies—introduced and vetted quality measures for public reporting. Currently 459 providers are reporting on four different measures on *GetBetterMaine,* with additional measures scheduled for public reporting in 2017. Consumers using the website are able to see the differences in performance across measured agencies/providers and use that information to inform their choices.

BENEFITS

- This effort marks the first time that quality in behavioral health has been defined and publicly reported in Maine.
- The PTE-BH Steering Committee is the first nationally to publicly report behavioral health quality measures specifically for Behavioral Health providers, according to our internal research.
- 3 categories of BH metrics were published on *GetBetterMaine.org* in 2015. A 4th (diagnosis specific—Depression and ADHD) was added in 2016.
- Additional metrics, including case management services, are expected to be added in 2017. Work is underway to expand reporting to psychiatric services as well.
- Behavioral Health/Primary Care integration designation was added to *GetBetterMaine* in 2016.
- To date, 459 providers (representing 135 sites) are reporting on *GetBetterMaine.*
- The identified metrics have motivated some providers to undertake quality improvement efforts in the areas being publicly reported.

PTE-Behavioral Health (cont.)

FUTURE RECOMMENDED CHANGES/LESSONS LEARNED

- Following the same strategy undertaken by the PTE Clinicians and Systems Steering Committees, the PTE-BH Steering Committee's initial focus has been on process measures. As borne out in the Clinician and Systems Steering Committees, this approach helps to spotlight areas for improvement, build buy-in, and develop infrastructure to support outcomes-based measures.
- The types of providers and levels of care for behavioral health is complex, making development of claims-based and other measures complicated.
- With multiple organizations/provider types often responsible for a client's care, making determinations of accountability for measures can be challenging.

SUSTAINABILITY RECOMMENDATIONS

MHMC is planning to continue convening the PTE-BH Steering Committee. Moving forward, the work will add rigor to current measures, widen the scope of BH provider types participating with *GetBetterMaine*, and move towards outcomes measurement (including patient-reported outcomes).

OTHER

N/A

NEXT STEPS

N/A

PTE

OVERVIEW

The Pathways to Excellence (PTE) Program (Clinicians and Systems Steering Committees) brings together providers, purchasers, consumers, and health plans to identify metrics to measure quality in outpatient and inpatient healthcare settings. The metrics identified are vetted for use in public reporting.

HYPOTHESIS CONCLUSION

Hypothesis. *The development and public reporting of health care quality, patient experience, and cost measurement through a multi-stakeholder process (the Pathways to Excellence-PTE-Program) will serve to create transparency and drive improvement in the state of Maine's health care delivery system network. This work will not only drive improvement in terms of public accountability, but will provide consumers and the public with information about the quality of care delivered at various levels of the health care delivery system (inpatient/hospital care, outpatient care-primary and specialty).*

The PTE Steering Committees have made significant advances in the publication of patient experience data, total cost of care data, and other quality measurements. Post-public reporting, CG-CAHPS data have shown improvement in performance year over year. This is further evidence that transparency and public accountability act as contributors to overall quality improvement. Specialty workgroups for reporting on specialty services quality also were convened, and specialty reporting began in April 2016.

BENEFITS

- PTE provides a forum for multiple stakeholders to discuss the importance of delivering quality healthcare. Through SIM, PTE was able to expand measure development and public reporting on critical topics such as specialty practices and cost of care.
- Public reporting of cost (Total Cost of Care Index-TCI measure) for adult primary care practices and practice groups began in October 2015.

PTE (cont.)

BENEFITS (cont.)

- New specialty workgroups for Women's Health, Oncology, and Orthopedics reached consensus on quality measures for clinical quality, safety, and patient experience. Specialty measures began to be publicly reported on *GetBetterMaine* in April 2016. Cardiology measure development is continuing.
- Public reporting on patient experience (via CG-CAHPS) began in 2014. Practice improvements in this area have been substantial, requiring updates to the methodology to reflect improved performance.

FUTURE RECOMMENDED CHANGES/LESSONS LEARNED

- With the addition of behavioral health and specialty workgroups under SIM, there are now multiple committee governance processes in the various committees, creating opportunities to streamline committee structure, specifically when there is overlap in content and participation.
- Due to the exponential increase in required provider reporting, PTE is moving to align with measures that financially support providers and also provide valuable data for public reporting.

SUSTAINABILITY RECOMMENDATIONS

MHMC is planning to continue convening the PTE Steering Committees post SIM. The work will continue to enhance capacity and convenience to report current measures, expand specialty providers participating with *GetBetterMaine*, and move towards outcomes measurement (including patient-reported outcomes).

OTHER

N/A

NEXT STEPS

N/A

Provider Portals

OVERVIEW

The provider portals objective envisioned allowing providers access to the claims data which the Coalition was already processing for analytics and reporting purposes.

HYPOTHESIS CONCLUSION

Hypothesis. *By facilitating access to claims data for their patient panels, providers will have access to a potentially powerful tool to help them understand how their patients are accessing services.*

A primary example where patient portal value has been proven is in the various portals provided by MaineCare. While de-identified, claims-lagged data remains valuable for retrospective analyses, portals are most effective when populated with timely claims for identified patient panels.

BENEFITS

The work under this hypothesis supported analytics essential to the MaineCare Accountable Community portals, as well as analytics portals for internal MHMC use in answering provider questions. The portal work was intended to be foundational, in that it would provide a mechanism for identifying opportunities for improvement. For example, the MaineCare AC portal provides a mechanism to support that initiative.

Provider Portals (cont.)

FUTURE RECOMMENDED CHANGES/LESSONS LEARNED

- Provision of a data portal is not an activity which can occur in isolation. Simply making the portal available will not necessarily create usage—there needs to be a use case which spurs adoption, such as a provider being at risk for a population.
- Providers are looking for integrated solutions. Many of the larger systems have robust analytic tools themselves, and prefer to have data integrated into those systems, rather than having another destination to visit.
- Providers are looking at portals as population management tools, and as such, patient-identified, timely data is a necessity in order to allow them to develop specific care plans. De-identified, claims-lagged data remains valuable for retrospective analyses.
- Access to claims without analytics is a good first step, and is most valuable in those instances where it is filling a void, as in the case of the Behavioral Health Homes where there was a lack of detailed data until the BHH portal became available.

SUSTAINABILITY RECOMMENDATIONS

Continued access to portals for Health Homes, Behavioral Health Home, and Accountable Communities is being provided by the State. Claims portals will not be an ongoing focus of MHMC. The Coalition will continue to provide access to provider data through a portal for its members in certain cases, and will continue to use the analytic portals as an internal tool where appropriate.

OTHER

N/A

NEXT STEPS

N/A

Practice Reports

OVERVIEW

The practice report effort allows for the generation and delivery of practice-specific cost, utilization, and quality measures across an attributed panel of patients. Separate reports are generated for commercial, MaineCare, and Medicare data.

HYPOTHESIS CONCLUSION

Hypothesis. *By providing practices with practice-specific reports on patient panels (by payer source), providers and practice owners will gain a better appreciation for the trends in utilization, cost, and quality demonstrated by their own practice as compared to a statewide benchmark, leading to efforts to improve their own performance.*

Feedback from providers on the value of the practice reports has been positive. Numerous practices proactively request the reports to support their ongoing practice management efforts. And several practice groups use the reports to find opportunities for improvements across practices, often leveraging the reports to assist with external requirements, such as ACO arrangements, or other contracted cost and quality initiatives.

BENEFITS

- The practice reports afford practices and practice owners the opportunity to examine their practice patterns relative to cost, utilization, and quality measures, and to compare those practice patterns to state benchmarks.
- Systems report using the reports to look for areas of variation across their practices, understand causes, and identify opportunities for improvement.
- Seeing the data from different payers in the same format allows practices to explore assumptions regarding care for patients covered by different payment arrangements.
- Four sets of commercial and MaineCare practice reports, covering both the pediatric and adult populations, have been delivered to over 300 practices for MaineCare and nearly 400 practices for commercial.

Practice Reports (cont.)

FUTURE RECOMMENDED CHANGES/LESSONS LEARNED

- While the practice reports were primarily intended to provide data to individual practices, the systems that own—or are otherwise responsible for—those practices have also found value in the reports, particularly the ability to easily compare their various practices on a common measure set.
- Individual practices may not have the resources to undertake quality improvement efforts in response to information included in the reports.
- Aligning report metrics with contractual requirements around cost or quality improvements could provide additional incentives to pursue improvement opportunities.
- Many larger provider groups are developing or have developed analytic capabilities which would allow them to look at similar data within their own practices, albeit with the limitation that it only includes those claims which were incurred within their system. Broad-based comparative data remains a valuable by-product of the practice report process, though not one that is limited to just that delivery mechanism.

SUSTAINABILITY RECOMMENDATIONS

The practice reports have led to conversations—particularly with multi-practice health systems—about continuing practice-specific analytics on a case-by-case basis. While MHMC is currently considering continuation of the practice reports post SIM, the reports have set the stage for ongoing discussions about the generation, use, and value of practice-level reporting.

OTHER

N/A

NEXT STEPS

N/A

Consumer Engagement

OVERVIEW

Consumer engagement activities included development and implementation of a media campaign to engage and educate consumers and other stakeholders about the benefits of VBID, and the broader topic of payment reform.

HYPOTHESIS CONCLUSION

Hypothesis. *By engaging the public around issues related to payment reform (with this term being taken broadly), cost, and quality, we will have more informed consumers and decision makers who will be able to make better decisions regarding their own health and care, as well as participate in broader discussions of health policy.*

Outreach to in-state media resulted in:

- Numerous VBID-related stories published in outlets with aggregate average audience of 90,000+
- VBID presentation to HR-focused radio show with average monthly listenership of 6,000–7,000
- 9 webinars hosted, with 248 registrants and 277 downloads

BENEFITS

- A VBID curriculum that is eligible for continuing education credits was developed for brokers and HR specialists and offered at numerous stakeholder forums.
- A VBID video and toolkit were developed and made available to payers and purchasers.
- VBID training was provided to payer and MaineCare staff.

Consumer Engagement

FUTURE RECOMMENDED CHANGES/LESSONS LEARNED

While consumer outreach and education is key to VBID education efforts, it was difficult to generate substantial interest in these efforts prior to final development of a VBID plan.

Post-SORT, other MHMC SIM workgroups recommended broader consumer engagement activities designed to better inform consumers, including around health insurance literacy.

SUSTAINABILITY RECOMMENDATIONS

N/A

OTHER

N/A

NEXT STEPS

N/A