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Testimony for Hearing on Draft Amendment to L.D. 541

“An Act To Improve Health Care Data Analysis”

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and

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Good afternoon Senator Sanborn, Representative Tepler and other distinguished representatives of this Committee. My name is Kimberley Fox and I am submitting this testimony on behalf of research staff and faculty within the Cutler Research Institute of Health and Social Policy and Masters of Public Health (MPH) graduate program in the Muskie School of Public Service at the University of Southern Maine. The Muskie School and Cutler Institute research staff and faculty have decades of experience analyzing and using Maine’s large administrative health care datasets for the purposes of conducting health services research, policy analyses, program evaluation, and public health surveillance to improve service delivery and population health outcomes for Maine residents.

Given our extensive experience using and analyzing Maine’s All-Payer Claims Data (APCD) and hospital discharge data for quality measurement and research purposes, we appreciate the opportunity to testify on the importance of LD 541 for expanding Maine’s ability to conduct cutting-edge, applied health services and public health research that can inform improvements in health care quality, outcomes and efficiency in the state and nation.

Maine is a nationally recognized leader in its efforts to transform health care, making it an ideal laboratory for learning what works and what doesn't. Access to APCD and hospital discharge data through the Maine Health Data Organization (MHDO) has already enabled researchers to secure external funding and design strong evaluations of many of Maine's unique initiatives. This research ranges from evaluating the impact of Maine's Patient-Centered Medical Home Pilot on cost and quality, to examining trends in telehealth use in rural and urban settings, to assessing primary care spending, to assessing Medication for Addiction Treatment (MAT) and postpartum health care utilization among pregnant women with Opioid Use Disorder (OUD). All of these studies contribute to understanding the impact of programs and improving health outcomes for Mainers. In addition, USM has a Memorandum of Understanding with MHDO to support greater interdisciplinary graduate workforce development and training in health data management, analytics and research to expand use of these critical datasets for research purposes. Without the MHDO, and the access it provides to data for research purposes, workforce training and research studies of this kind that support state-level research would not be possible.

However, based on our research and data analytic experience, we are aware of the limitations of the existing data to support certain types of research and analyses that could be extremely beneficial to the state and state policymakers. We believe the proposed amendments in LD 541 could help address these limitations.

Specifically, we support the provisions in LD 541 to establish MHDO as the state's public health authority for reporting on public health activities and allowing MHDO to adopt rules to require reporting of cancer registry data and vital statistics to enable greater linkages of health and public health datasets. This would allow key connections to be made among different datasets that could expand the types of analyses and scope of research that could be undertaken and make Maine researchers more competitive for research funding. In our use of MHDO data for research on birth-related outcomes (e.g. neonatal abstinence syndrome or substance use disorders), we have found using claims or hospital discharge data alone is difficult due to limited ability to match mother with children in claims and the bundling of maternity care services. Linkage of medical

claims with birth records could greatly improve maternal and child health research, validation of birth record information, assessment of access to pre-/post-natal treatment associated with mother/child outcomes, and lead to improved health outcomes for women and children in Maine.

In terms of funding, federal health organizations such as the National Institutes of Health and the Agency for Healthcare Research & Quality are increasingly interested in funding studies that emphasize comparative effectiveness and patient-centered outcomes as well as measuring the impact of social determinants of health (SDOH). For example, USM researchers have recently proposed to study whether pregnant women with opioid use disorder receive medication-assisted treatments during pregnancy and how different treatment type impacts postpartum health of the mother and baby. While we can identify certain types of outcomes, like hospital re-admissions and emergency department use, from claims, other critically important outcomes—including whether these rural residents are at greater risk of death—can't be measured without linking to other data sources like vital statistics. The possibility of linking different sources of health data, with full respect for individual privacy, would enhance Maine's position as a leader in health care data and increase opportunities for new federal and private foundation funding for research.

In addition to linkages to the cancer registry and vital statistics data, we would go further to support connecting other public health (e.g. immunization registry) and social service datasets (e.g. housing and criminal justice) to promote greater cross-sector research and to facilitate the assessment of how social determinants of health (SDOH) affect outcomes of interventions that target specific at-risk populations (e.g. unhoused or recently incarcerated individuals).

We also support LD 541 provisions related to establishing a provider database and service locator tool, given limitations in provider information currently submitted in claims. New alternate payment models join providers, practices, and hospital systems together to assume responsibility for the cost and quality of services at a population-level, and practice-based patient-centered medical homes have prompted increased

interest in monitoring provider, practice and system level outcomes. These models of care, such as Accountable Care Organizations, are driving an interest in using the APCD for provider site, practice, and system-level analyses to assess and compare healthcare costs, quality and performance within and across practice sites, medical groups, health care systems and ACOs to better target improvements and study the impact of these care models on population health.

Within the limits of current legislation, MHDO has made every effort to improve provider identification by service location in claims reporting, but the tasks of assigning patients to providers and providers to practices, systems, or ACOs for such analyses has been challenging. They require either fieldwork and additional data collection or algorithms that use claims data to assign patients and providers to locations and may not result in accurate assignments. For example, for the Patient-Centered Medical Home evaluation, to confirm whether specific providers were practicing at multiple service clinics or hospitals, we had to contact each practice individually to confirm whether providers were part of their practice. Further, the information that providers and insurers collect and report can limit researchers' ability to assess patterns of care at practice or system levels or by rural and urban areas of the state.

While some of the analyses referenced above could currently be conducted for individuals with public insurance, as the federal Centers for Medicare and Medicaid Services have procedures to release identifiable health data for research purposes, these groups only represent a segment of Maine's population. They exclude individuals covered through commercial insurance and thus don't give us a complete picture of the impact of health care delivery innovations in the state. In addition, lags in availability and the cost of data can make these studies prohibitive.

Finally we also support establishing a Health Information Advisory Committee to identify priorities for public reporting of health care trends, and recommend that the membership include a representative from the university or research community with expertise in health care cost and quality research to advise on how Maine's reporting might be informed by existing research.

Focusing on opportunities to increase data quality and availability in Maine is a critical component of health care transformation and research development in the state. For these reasons, on behalf of researchers at the University of Southern Maine, we are in full support of LD 541.

Thank you for your time.