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114TH LEGISLATURE
FIRST REGULAR SESSION

STUDY OF THE NECESSITY AND FEASIBILITY OF ESTABLISHING A HEALTH INFORMATION RECORDING SYSTEM

DECEMBER 1988

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THE NECESSITY AND FEASIBILITY OF ESTABLISHING A HEALTH INFORMATION RECORDING SYSTEM

I. SUMMARY OF RECOMMENDATIONS

Having completed a Study of the Necessity and Feasibility of Establishing a Health Information Recording System, the Committee finds that currently, the State of Maine collects a broad array of health care information relating to the cost of and provision of inpatient services. In recent years, however, many procedures and diagnoses that were commonly conducted only on an inpatient basis are now routinely being performed in settings other than the hospital, e.g. doctor's offices, rural health clinics, and ambulatory care centers. In order to track the cost of and utilization of these procedures and diagnoses, it is necessary to begin collecting information from the outpatient setting. Based on these findings, the Committee recommends the following:

Recommendation 1: The state agency charged with hospital data collection should establish an outpatient data base containing information relating to the provision of outpatient type services in both the hospital and non-hospital setting.

Recommendation 2: This information should be collected by procedure, regardless of where the procedure is performed, i.e. in the hospital, in a physician's office, or in a free standing clinic.

Recommendation 3: At least annually, the state agency charged with hospital data collection should compile a list of procedures which must be reported when performed.

Recommendation 4: The outpatient data base established by the state agency charged with hospital data collection should be of such a nature that patient confidentiality is not disclosed.

Recommendation 5: The data collection recommended by this Committee should be collected in such a manner as to minimize the number of documents that must be processed by providers. If necessary, the state agency charged with hospital data collection should have the rule-making authority to develop a uniform data format for the submission of data.

Recommendation 6: The state agency charged with hospital data collection should be able to sub-contract for data collection, storage, and retrieval.

Recommendation 7: The state agency charged with hospital data collection should be permitted to design and implement pilot information reporting systems and to develop proposals for the modification, refinement, or expansion of existing information reporting systems.

Recommendation 8: Additional staff, either full or part time, required to carry out the recommendations of this Committee should be funded by the state agency charged with hospital data collection. Additional expenses should be funded by the General Fund.

Recommendation 9: The state agency charged with hospital data collection should work in collaboration with the Mandated Benefits Advisory Commission in the evaluation of the costs and benefits of both existing and future health care benefits mandated by the Legislature.

II. INTRODUCTION

A. PREFACE

All states collect health care information of one sort or another. However, not all states have established a systematic, centralized health information recording system providing for formalized utilization of the data. This report is concerned with determining the necessity and feasibility of establishing a health information recording system in Maine.

B. BACKGROUND

Rapidly escalating health care costs have been a major concern of legislators for more than a decade. There has been much debate over how to help contain those health care costs. One direct indicator of the rapid increase in those costs has been the swiftness with which health insurance rates have risen in recent years. During the Second Regular Session of the 113th Legislature, LD 2358, AN ACT to Insure Adequate Rate Filing Information from Health Insurers, was introduced to require the submission of additional health information by an insurer whenever a rate increase for health insurance was filed by or on behalf of that insurer. The purpose of LD 2358 was to provide additional information to help the state assess the appropriate level of rate increases in health insurance.

During the public hearing held by the Joint Standing Committee on Banking and Insurance it became apparent that understanding the reasons for the increases in health insurance costs would require more than collecting and analyzing additional information provided by insurers. A wide variety of information would be necessary to provide policy-makers with the necessary tools to understand and address the rapid increase in health care costs. The committee amended LD 2358 by replacing it entirely with a study to determine the necessity and feasibility of establishing a Health Information Recording System.

The bill was further amended in the Senate to strike out the substance of the committee amendment and replace it with an appropriation. The substantive language of the bill, establishing the details of the study committee, was adopted, with some modifications, as a Legislative Council study. The Committee thus focused on assessing the need for a data gathering system and, if that need exists, proposing a mechanism to establish such a system. A copy of the original legislation (LD 2358), the Committee Amendment (H-716), and the final enacted bill (P & S Law, Chapter 138, AN ACT to Study the Necessity and Feasibility of Establishing a Health Information Recording System) is contained in Appendices A, B, and C, respectively.

A special Joint Select Committee was established to study the issue. During the course of its deliberations, the Committee evaluated other states' centralized health data collection systems, and received and analyzed information from insurers, health care providers, a private health information collection agency, and the various state agencies. The following organizations contributed to the Committee's efforts:

Blue Cross/Blue Shield of Maine
Bureau of Insurance
Bureau of Medical Services
Health Insurance Association of America
Maine Chamber of Commerce and Industry
Maine Health Care Finance Commission
Maine Health Information Center
Maine Hospital Association
Maine Medical Assessment Foundation
MediMaine Health Associates
Office of Data, Research, and Vital Statistics
Plastic and Hand Surgical Associates
UNUM

This report contains the results of the Committee's study.

C. WHAT IS A HEALTH INFORMATION RECORDING SYSTEM?

Although there are many variations, a typical health information recording system is a system which is designed to collect, analyze, and distribute health information. This information may be used for a variety of reasons including health care regulation and consumer and provider education programs. The system may also include a planning or advisory body to establish policy. Six developmental stages have been identified as being involved in establishing an operational health information recording system. These stages are:

1. Assessment of the need for a health information recording system. This includes a determination of the purposes (or goals) of such a system and what information is necessary to accomplish those goals.

2. If the need for a health information recording system exists, and the benefits to be gained exceed the expected cost in terms of time, effort, and money, the structure for collecting, analyzing, and distributing this information must be developed.

3. Establishment of the health information recording system structure, including enactment of enabling legislation and determination of specific data to be collected by the organization designated as the data collection agency and the the policy making board.

4. Collection of the health data.

5. Evaluation and analysis of the data collected.

6. Preparation of the data in a format which can be readily distributed to accomplish the established goals of the system and the ultimate distribution of that data.

These six steps reflect the entire process of establishing a health information recording system from beginning (determining the need for a data gathering system) to the end (utilization of that data to resolve health care issues.) The purpose of this study is **solely** to assess the need for a data gathering system and, if that need exists, to propose a mechanism to establish such a system. (See steps 1 and 2, above.)

III. PURPOSE/GOALS OF HEALTH INFORMATION RECORDING SYSTEMS

A. INTRODUCTION

State governments have a variety of reasons for establishing health information recording systems; but they can generally be grouped around two major goals: To provide a data base to make health-related policy decisions and to provide health information to consumers and providers. Both of these goals are designed to help provide accessible quality health care at a cost affordable to the citizens of the state.

Health care data is also used to provide adequate information for research purposes and to supply data to providers in order for them to better assess utilization and cost patterns.

It is essential to be clear about the purposes for which the data are to be used. Articulating these purposes is a prerequisite to determining which data to collect.

B. POLICY-MAKING INFORMATION

Health information is essential to provide data upon which to base informed policy decisions, e.g. to choose the most appropriate cost-containment measures, to make health planning decisions (such as new construction), to monitor effects of health policy changes (such as mandated benefits), to evaluate effects of health cost increases on health insurance, to determine why health costs are rising so rapidly in order to take appropriate action, etc.

C. CONSUMER INFORMATION

The collection of health data can be of value to consumers of health care, e.g. price comparisons, quality of service information, etc.

1. State governments as major purchasers of health services may be able to save money by "comparison shopping" and by assuring the appropriateness of services they purchase.

2. State governments serve as major information sources and may be able to save residents money by offering information that increases their ability to make informed, cost-efficient choices among health care providers.

D. PROVIDER INFORMATION

Health care information can be collected to provide information for health care providers, e.g. utilization assessment.

1. Based on hospitalization rates for dental extractions in 1980-81, if the practice style in the Augusta area were the standard for the state, the costs statewide for in-hospital tooth extractions would be $375,000, compared with almost $3.7 million in the practice style for Brunswick were the standard (Wennberg, *Dealing with Medical Practice Variations: A Proposal for Action*, 1984).

2. In 1984, utilization data in Vermont indicated an abnormal number of hospitalizations for tooth extractions in the Burlington area. Local oral surgeons, when enlightened with this information, reduced the rate by performing most oral surgery on an outpatient basis.

E. ADVANTAGES AND DISADVANTAGES

As with most issues, data collection systems as a means of helping to control health care costs have their supporters and their critics. The debate generally evolves around the following issues:

1. **Fostering competition:** Traditional economic theory suggests that a better informed consumer will make purchasing choices which will stimulate competition among providers to provide a better quality product at the lowest possible cost. Providing information to the consumer of health care has been suggested as one way to encourage healthy competition among health care providers to attract patients and to minimize increases in health care costs.

   Critics, however, cite several reasons to believe that the health care market is unique and does not respond in a traditional manner to market pressures. In many cases the individual consumer does not have a realistic choice of health care providers. This would be more true in a largely rural state like Maine where health care providers may be spread thin in some parts of the state. No amount of price comparisons will be helpful if there is only one place to purchase your health services. Some consumers rely totally on their doctor to choose a hospital for treatment. Some would even suggest that if there is a meaningful choice among providers, price comparisons may cause patients to choose higher-priced providers because of a tendency to equate price with quality.

2. **Price comparisons:** The health care consumer needs price information to make economically sound purchasing decisions.

   Opponents argue that an emphasis on price comparisons may cause consumers and policy-makers to ignore other factors of equal or greater importance to consumers such as quality of care, physician advice, and location of services to the ultimate detriment to the consumer. Price differences may reflect differences in the nature of the care provided.

   Opponents also argue that publication of so-called "comparable price" data can be misleading There are many inherent difficulties in comparable data. Some hospitals treat patients with less severe illnesses and appear to be less expensive than others. It is difficult to standardize charges for various services among providers so that meaningful comparisons can be made. In addition, data may often be outdated by the time it is published and available for the consumer or the policy-maker.

3. **Cost effectiveness:** Utilization of data to reduce a state's health care expenditures may generate savings far in excess of the cost of a data collection system. Cost comparison data and utilization rate data may help reduce unnecessary health care expenditures in state government programs. California was projected to save Medi-Cal (the state's Medicaid program) $235 million in 1984-85 by selectively contracting for inpatient care.

   Critics argue that data collection programs are expensive to operate correctly. They also contend that there is insufficient empirical evidence to show that these programs reduce health care costs or change patient utilization patterns.

4. **Providing an objective, uniform, broad-based source of information:** No one is currently collecting and analyzing the entire range of comparative and statistical data which a health information recording system would address. Current information gathering is for other purposes and the lack of uniformity in format, terms, and price categories makes that information virtually useless for purposes other than that for which it is currently collected. State involvement in data collection and distribution ensures an objective and uniform source of information. Broad-based data collected on a statewide basis is more reliable for policy decisions since smaller units of data collection (e.g. individual providers or even large businesses) do not have a sufficient pool of information to provide statistically meaningful information.

5. **Policy-making decisions:** Informed state policy-making is difficult without comparative data. Data is needed for health planning activities (such as assessing future needs, devising cost containment measures, and evaluating health policies) and for monitoring program effectiveness.

6. **Measuring and improving the quality of care:** Comparative data may be useful in measuring and improving the quality of care for patients.

   Critics contend that quality of care is difficult, if not impossible to measure based on a statewide data system.

IV. ORGANIZATIONAL STRUCTURES TO COLLECT, ANALYZE, AND DISTRIBUTE DATA

A. INTRODUCTION

In the report "What Legislators Need to Know About Health Data/Cost Information Programs", (NCSL, 1986) it is noted that existing health information recording systems can be loosely grouped into four categories based on organizational structures: Independent agencies dedicated solely to collecting and distributing health information, data collection agencies that also include a regulatory or health planning role, health data collection programs with a narrow purpose, and voluntary reporting programs.

B. INDEPENDENT AGENCIES

Health data collection systems may be independent agencies dedicated solely to collecting and distributing health information. Colorado, Illinois, Iowa, New Hampshire, North Carolina, Pennsylvania, and Vermont are states which have established separate health data commissions or have created new program units within existing offices to perform health data functions.

C. AGENCIES WITH A REGULATORY OR HEALTH PLANNING ROLE

Arizona, Florida, and Maryland have created agencies which include health data/cost information functions in their hospital review or rate-setting programs. California, Nevada, Oregon, Tennessee, and Wyoming incorporate their data programs within health planning functions.

D. PROGRAMS WITH A NARROW PURPOSE

Nebraska and South Carolina have developed programs with a narrowly defined purpose or limited cost disclosure function. Specifically, South Carolina focuses on uncompensated care data, but also maintains a data collection and dissemination program that encompasses health cost information from all payor sources. Nebraska requires hospitals to make available to consumers a list of average charges and lengths of stay for their 20 most common diagnosis-related groups.

E. VOLUNTARY REPORTING PROGRAMS

Minnesota and Wisconsin are the only states with voluntary reporting programs. Minnesota's price disclosure statute requires the commissioner of health to encourage various health care providers to publish prices for procedures and services.

Wisconsin presently uses a survey methodology to collect health care data. However, in 1989 Wisconsin plans to establish a discharge data base which will result in mandatory reporting requirements.

F. SUMMARY

As noted above, health date collection systems can be operated within a variety of organizational structures. It appears, however, that the goals of the system play an integral part in determining the most appropriate organizational structure for collecting, analyzing and distributing health care data.

V. OTHER STATES' PROGRAMS

A. INTRODUCTION

The National Association of Health Data Organizations (NAHDO) compiles and publishes information on various health data initiatives being undertaken nationwide. In its 1988 Resource Manual, NAHDO lists 31 member states as operating some form of a health information recording system. The Committee surveyed 14 of these states to obtain descriptions of existing health information recording systems The survey, conducted by telephone, included questions relating to the following:

1. the presence of a centralized health information recording system;
2. the goals of a health information recording system;
3. uses of the information collected;
4. the date a system was established and the date data collection was begun;
5. the organizations submitting data;
6. the collection of data on a voluntary basis as opposed to a mandatory basis;
7. compensation to organizations submitting data;
8. intervals at which data are updated;
9. the completion of a legislative or executive level evaluation of the system; and
10. the regulatory environment of the health care industry.

(A complete list of survey questions is contained in Appendix D.)

The states included in the survey are states that have or are reputed to have developed a unique aspect to their health information recording system, have a regulated health care industry, or have been operating a health information system for an extended period of time. These states and the criteria upon which their selection was based are listed in Table 1.

Table 1

State	Selection Criteria
Arizona	Health data system has been in place for more than 15 years.
California	Information is collected from a wide range of health care providers.
Connecticut	Hospital rates are regulated.
Florida	Hospital rates are regulated.
Illinois	Data providers are compensated for their activities.
Iowa	Health information is collected from 3rd party payors.
Massachusetts	Hospital rates are regulated.
Maryland	Hospital rates are regulated.
Nevada	System is evaluated by a Permanent Legislative Oversight Committee.
New York	Hospital rates are regulated.
North Carolina	Data providers are compensated for their activities.
Pennsylvania	Outpatient data collection (Scheduled to begin in March of 1989).
Washington	Hospital rates are regulated.
Wisconsin	Data is collected via a survey methodology.

B. SURVEY RESULTS

1. Introduction

The results of the survey indicate that several states have expanded or are considering expanding the responsibilities of their health data collection organizations. In addition to collecting hospital discharge data, California, Iowa, Maryland, Nevada, New York, Pennsylvania, and Washington are presently considering or have begun collecting outpatient information. Table 2 lists the states surveyed and a brief description of the survey results.

Table 2 Survey Highlights

STATE	SURVEY HIGHLIGHTS
ARIZONA Arizona Department of Health Services	Patient discharge data collected only from hospitals with more than 50 beds. (Hospital rates are not regulated.)
CALIFORNIA Office of Statewide Health Planning and Development	Information collected from hospitals, licensed care facilities, licensed surgical centers, and licensed home health organizations. Data collection from ambulatory centers is under consideration. (Hospital rates are not regulated.)
CONNECTICUT Connecticut Commission on Hospitals and Health Care	Discharge data collected from hospitals. (Hospital rates are regulated.)
FLORIDA Florida Hospital Cost Containment Board	Financial and patient information collected from hospitals and nursing homes. Physician charge information collected from third party payers. (Hospital rates are regulated.)
ILLINOIS Illinois Health Care Cost Containment Council	Patient information collected from hospitals. Hospitals are reimbursed $.10 per patient discharge record. (Hospital rates are not regulated.)
IOWA Iowa Health Data Commission	Inpatient and outpatient information collected from 3rd party payers. (Hospital rates are not regulated.)
MASSACHUSETTS Massachusetts Rate Setting Commission	Patient information collected from hospitals, nursing homes, and mental health facilities. (Hospital rates are regulated.)
MARYLAND Maryland Health Services Cost Review Commission	Hospital inpatient and outpatient data collected. Compensation for data provision included in rates. (Hospital rates are regulated.)
NEVADA Nevada Health Resources and Cost Review	Hospital discharge data presently collected. Legislative Oversight Committee has recommended that hospital outpatient and ambulatory surgical center data be collected. (Hospital rates are "quasi-regulated".)
NEW YORK New York State Department of Health Cooperative System	Hospital discharge data and ambulatory surgery data collected. (Hospital rates are regulated.)
NORTH CAROLINA North Carolina Medical Database Commission	Hospital discharge data collected. Hospitals are reimbursed $.40 per discharge record involving 3rd party payment. (Hospital rates are not regulated.)
PENNSYLVANIA Pennsylvania Health Care Cost Containment Council	Hospital discharge data collected. Plan to begin collecting outpatient data in 1989. (Hospital rates are not regulated.)
WASHINGTON Washington State Hospital Commission	Hospital discharge data collected. Will soon begin collecting outpatient data and regulating rates for ambulatory centers. (Hospital rates are regulated.)
WISCONSIN Center for Health Statistics	Data presently collected via a survey methodology. Expect to begin a hospital discharge data base in 1989. (Hospital rates are not regulated.)

2. Health Data Collection Organizations

Every state contacted indicated the existence of a centralized health information recording system. Such a system can be characterized as one that is used to collect both patient and provider information. The extent to which both of these types of information are collected may vary.

The majority of these organizations are independent state agencies, boards, or commissions. Wisconsin's health data collection organization, however, is actually a division within a state agency.

3. The Importance of Health Data System Goals

Thirteen of the 14 states surveyed articulate health data system goals in statute. (It should be noted that the lack of clearly articulated goals makes it difficult to evaluate the system's effectiveness and usefulness.) Arizona was the only state indicating that health data system goals are not statutorily defined.

The states surveyed listed a wide array of health data system goals. States in which hospital rates are regulated (Connecticut, Florida, Massachusetts, Maryland, New York, and Washington) obviously use this information as part of the rate making procedure. States in which hospital rates are not regulated use this information to enable consumers to make informed health care choices. In addition, virtually all states surveyed use this information when establishing health care policy. Other goals of health information recording systems include providing adequate information for research purposes and providing health care providers with information needed to assess utilization and cost patterns.

4. Data Providers, Compensation, and Uses of the Data

The results of the survey indicate that health information is being collected from a variety of different sources including both health care providers and third party payers. In addition, every state but Wisconsin maintains a patient discharge data base. A patient discharge data base is a data base containing records of each patient discharged from an acute care facility. By definition, this data base contains only inpatient information. Wisconsin currently uses a survey methodology to collect information. However, a patient discharge data base is planned for 1989.

Every state but Iowa indicated that information is collected from hospitals. Iowa collects information from third party payers. California collects information from a variety of sources including hospitals, long-term care facilities, licensed surgical clinics and licensed home health organizations. Illinois, Maryland, North Carolina, Washington, and Wisconsin collect information from hospitals only.

The UB-82 billing form, a uniform hospital bill mandated for nationwide use under Medicaire's prospective reimbursement system, is used by all states but California, New York, Pennsylvania, and Wisconsin to collect health information. California, New York, and Pennsylvania rely on unique data collection systems.

None of the states surveyed indicated a lack of cooperation on the part of data providers. However, California did note that their lack of enforcement powers may be of concern and that they may attempt to introduce legislation during the 1989 session that would provide them with enforcement powers.

Illinois and North Carolina both offer compensation to data providers for their activities. Illinois pays data providers $.10 per discharge record. North Carolina pays data providers $.40 per discharge record involving third party payment. Maryland law contains a provision within the ratemaking scheme for compensation to data providers.

The survey results revealed that the information collected is used in a variety of different means. Nearly all states use the information collected to produce consumer guides to health care services as well as hospital financial reports. Other states, Connecticut for example, use the information collected strictly for regulatory purposes. All states surveyed indicated that the use of the data collected is dependent upon the goals of the system.

5. System Establishment, Data Collection, and Updating the Data

The survey revealed that some of the heath data systems were established as early as 1973 and others as late as 1986. In certain cases the present health data collection system may be only a few years old yet may have evolved from a previous system. Therefore, the date the system was established may be somewhat misleading.

According to the responses to the survey, there appears to be approximately a one year start-up period after the system is established in which no data is actually collected. This lag time is generally attributed to filling staff positions and obtaining and installing a computer system.

Although the precise time periods in which data providers must submit data varied from state to state, certain generalizations can be drawn. Financial information is generally required on an annual basis. Patient information, however, is generally required on a more frequent basis such as monthly or quarterly.

Wisconsin presently conducts surveys once every two years. In 1989, when Wisconsin converts to a patient discharge data base, reporting periods will be similar to those found in other states.

6. System Evaluation

Only 5 of the 13 states surveyed (Connecticut, Maryland, Nevada, Washington, and Wisconsin) indicated that the health data system in their state had undergone an executive or legislative level evaluation. Nevada indicated that their system is under continual evaluation by a Permanent Oversight Committee. In addition, Washington's system is presently being evaluated by the legislature. In every state in which an evaluation had been conducted, the evaluating agency recommended continued operation of the health data system.

The remaining states have yet to be evaluated. This may be explained in part by the relatively short period of time that health data collection systems have been in place in some of these states.

7. The Regulatory Environment

Hospital rates in Connecticut, Florida, Massachusetts, Maryland, New York, and Washington are regulated. Nevada has what might be termed a "quasi-regulatory" health care environment. Rates are not regulated in Nevada on an ongoing basis. However, there are rate reduction mandates in the Nevada statutes which are put into effect if rates increase at more than a specified rate. Wisconsin deregulated their health care industry in 1987.

The remaining states, Arizona, California, Illinois, Iowa, North Carolina, Pennsylvania, and Wisconsin have non-regulated health care environments.

C. OBSERVATIONS

Public policy-makers, regulatory agencies, and consumers all make certain judgments or decisions related to or based on the health care industry. Public policy makers may need information regarding the incidence rate of a specified disease such as AIDS. Regulatory agencies need cost and revenue information in order to establish rates for the entities they regulate. Consumers may need to know some indication of the quality of care they can expect to receive at a specific hospital. The common premise upon which each of these possibilities is based is the availability of adequate health care information. Many states have realized the importance of this premise and are now collecting health care information.

As the various types of health care providers continue to grow, states are taking the initiative to collect a broader array of health care information. Seven of the 14 states contacted are considering collecting or have begun collecting outpatient data in addition to patient discharge data. In general, this information is collected on a mandatory basis with no compensation being awarded to the data provider. The information collected is then used as a mechanism to achieve statutorily defined goals established in conjunction with the health care data collection system.

VI. DATA CURRENTLY AVAILABLE IN MAINE

A. INTRODUCTION

A major step in determining what information is necessary to accomplish the goals of a health information recording system is to determine the availability and extent of existing data, how the current data is used, and if it is in a format appropriate with the proposed use.

B. THE HEALTH CARE SERVICES CONTINUUM

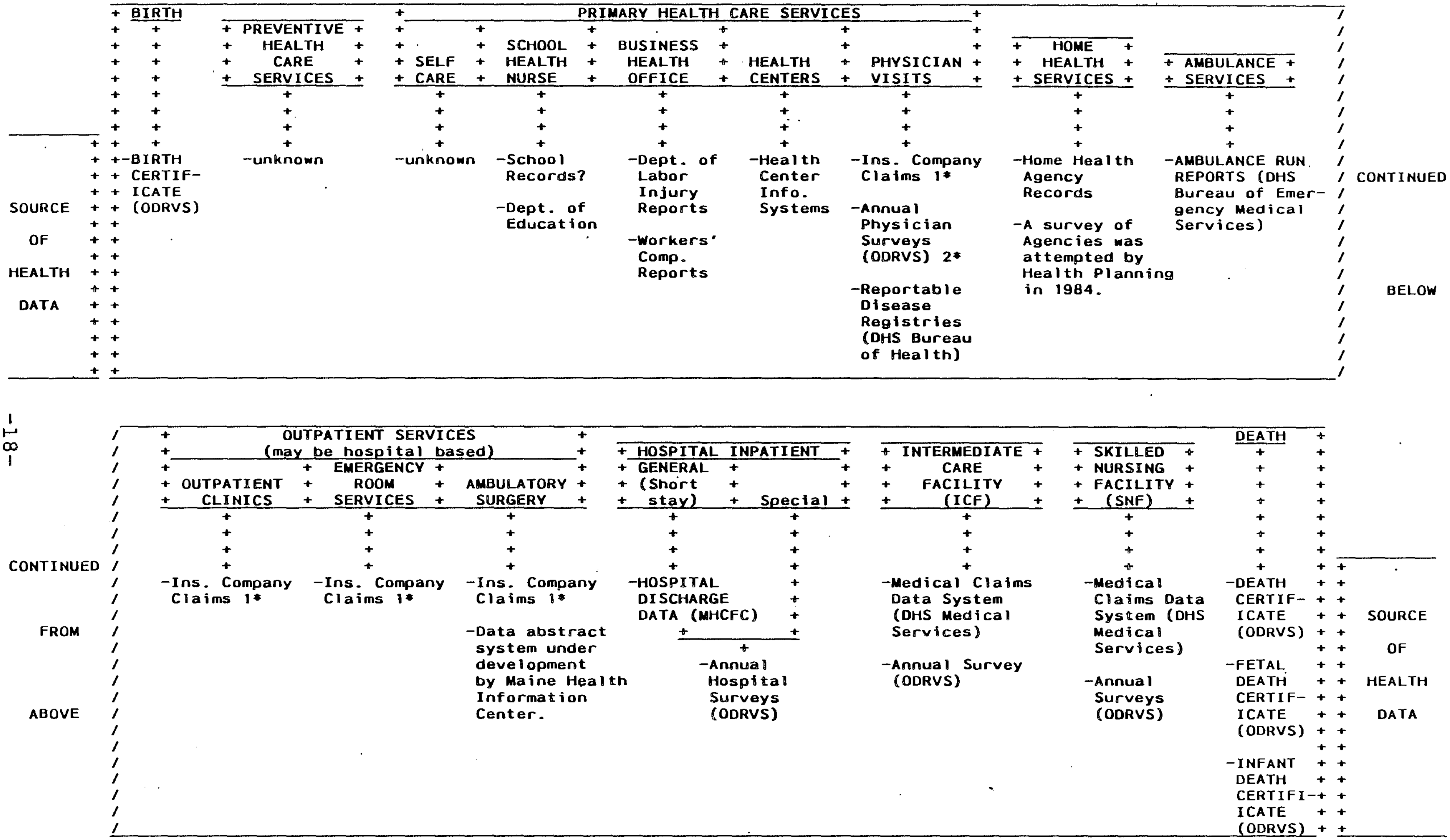
The journey from birth to death can result in many great rewards yet may also seem long and tiresome at times. Unfortunately for the traveler, there are stops along the way, both scheduled and unscheduled, that require the attention of health care professionals. At each of these stops, potentially important health care information is processed by health care professionals and possibly collected by organizations specializing in the compilation of health care statistics.

From a public policy-maker's standpoint, the many types of health care services available and the numerous settings in which they can be provided tend to complicate the identification of potentially useful health care services information. However, a careful evaluation of the health care services available on the journey from birth to death yields a well-organized depiction of the sources of potentially useful health care services information. This depiction, the Health Care Services Continuum, is shown in Figure-1.

The Health Care Services Continuum (the Continuum) represents the health care services available to us from the time of birth to the time of death. The following services are included in the Continuum:

1. Preventive Health Care Services;
2. Primary Health Care Services;
3. Home Health Services;
4. Ambulance Services;
5. Outpatient Services;
6. Inpatient Services;
7. Intermediate Care Facilities; and
8. Skilled Nursing Facilities.

Figure 1: HEALTH CARE SERVICES CONTINUUM



1* Partial information since claims are not filed on all visits.
2* No patient specific information is collected.
Sources shown in ALL CAPS indicate that data are available for nearly 100 percent of all individuals.

The services within the Continuum are arranged sequentially according to the level of provider intensity or supervision that is required. For example, preventive health care services, located at the left-hand end of the Continuum in Figure-1, require little or no supervision on the part of health service professionals. In fact, this level of service is generally provided by the individual themselves. A patient in a skilled nursing facility, located at the other end of the Continuum in Figure-1, requires a much higher level of supervision by health service professionals.

The arrangement of the services within the Continuum assumes that as one approaches death the level of health care services required increases. This assumption is true only to a certain extent. In the case of a stillborn child or a person who is killed instantly in an auto accident, the level of health care services provided prior to death did not increase as depicted in the Continuum. However, for many persons this is probably an accurate depiction of their demand for health services throughout their life. In any event, if this is not an accurate depiction it has at least provided a well-ordered representation of the health care services available and thereby identified potential sources of health care information.

C. A DESCRIPTION OF SERVICES WITHIN THE CONTINUUM

As noted previously, each of the services listed within the Continuum requires a different level of provider intensity. The following description of each of these levels of service should further clarify this point as well as indicate if information regarding each service is presently collected.

1. **Preventive Health Care Services** are those activities that a patient undertakes in an effort to prevent the onset of medical problems. Such activities can include altering one's diet, giving up vices that have been proven to be detrimental to one's health such as smoking or drinking, and increasing the amount of exercise that one partakes in. It is unknown if any information is currently collected regarding this health care service.

2. **Primary Health Care Services** are those services, in addition to self care, which provide a minimum of attention by health care professionals. Included in this group of services are self care, school nurses, business health offices, health centers and physician visits.

a. **Self Care** describes those actions taken by the patient themselves to treat a medical disorder. It is unknown if any information is currently collected regarding this health care service.

b. A **School Health Nurse** provides primary health care services to students and faculty in the school setting. Individual school records should contain information regarding this health care service. In addition, the Department of Education collects information in this area.

c. A **Business Health Office** provides primary health care services to the employees of a business. Department of Labor injury reports contain information regarding treatment in the workplace. Workers' Compensation reports would also provide information regarding this health care service.

d. **Health Centers** are usually free-standing facilities offering a broad range of primary health care services for ambulatory patients. Physicians and/or nurses are available or are on-call at health centers. Information regarding treatment at health centers would have to be obtained from the health centers themselves.

e. **Physician Visits** are scheduled visits with a physician for diagnostic or post-diagnostic purposes. Limited information regarding physician visits may be obtained from either the Annual Physician Surveys conducted by the Office of Data, Research, and Vital Statistics, or the Reportable Disease Registries coordinated by the Bureau of Health. Some information may be collected by insurance companies but may not be accessible.

3. **Home Health Services** are those health-related services that are provided in a patient's home rather than a clinic, physician's office, or some other setting. Information regarding services provided by home health agencies could best be found in the agencies' records. A survey of Agencies was attempted by Health Planning in 1984.

4. **Ambulance Services** are those services that provide for the transport of persons in need of health-related services. Information regarding ambulance services is available in the Ambulance Run Reports compiled by the Bureau of Emergency Medical Services.

5. **Outpatient Services** are those services that are performed without a patient having been admitted to a hospital. This includes outpatient clinics, emergency room services, and ambulatory surgery.

   a. **Outpatient Clinics** provide health services for ambulatory patients as prescribed by a health professional outside the clinic. Certain diagnostic tests, therapy services, and counseling services are examples of the many services provided by outpatient clinics. Most outpatient clinics are associated with hospitals. Some information may be collected by insurance companies but may not be accessible.

   b. **Emergency Room Services** include those services that are provided on an emergency basis. These services include both the diagnosis and treatment of medical emergencies. Some information may be collected by insurance companies but may not be accessible.

   c. **Ambulatory Surgery** or day surgery services are provided to ambulatory patients. Patients served by these units undergo surgical procedures that can require operating room facilities and recovery room services, but do not require the patient to remain over-night. The Maine Health Information Center is currently developing a data abstracting system for ambulatory surgery. Some information may be collected by insurance companies but may not be accessible.

6. **Inpatient Hospital Services** are those services provided to patients admitted to acute care facilities and include services provided in general hospitals and services provided in special hospitals.

   a. **General Hospitals** are those acute care facilities which provide diagnostic, testing, and treatment services to patients admitted to the facility. The Hospital Discharge Data Base maintained by the Maine Health Care Finance Commission provides information for this health care service. Annual Hospital Surveys conducted by the Office of Data, Research, and Vital Statistics also provide information regarding general hospitals. Some information may be collected by insurance companies but may not be accessible.

   b. **Special Hospitals** provide the same services as general hospitals to a specific subsection of the population. Togus V.A. Hospital and the Augusta Mental Health Institute are examples of special hospitals. Annual Hospital Surveys conducted by the Office of Data, Research, and Vital Statistics provide information regarding special hospitals. Some information may be collected by insurance companies but may not be accessible.

7. An **Intermediate Care Facility**, as defined in the 1985 State Health Plan Glossary, is an institution which provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but because of their mental or physical conditions require health-related care and services above the level of room and board. The Medical Claims Data System maintained by the Bureau of Medical Services and Annual Surveys conducted by the Office of Data, Research, and Vital Statistics provide information regarding intermediate care facilities.

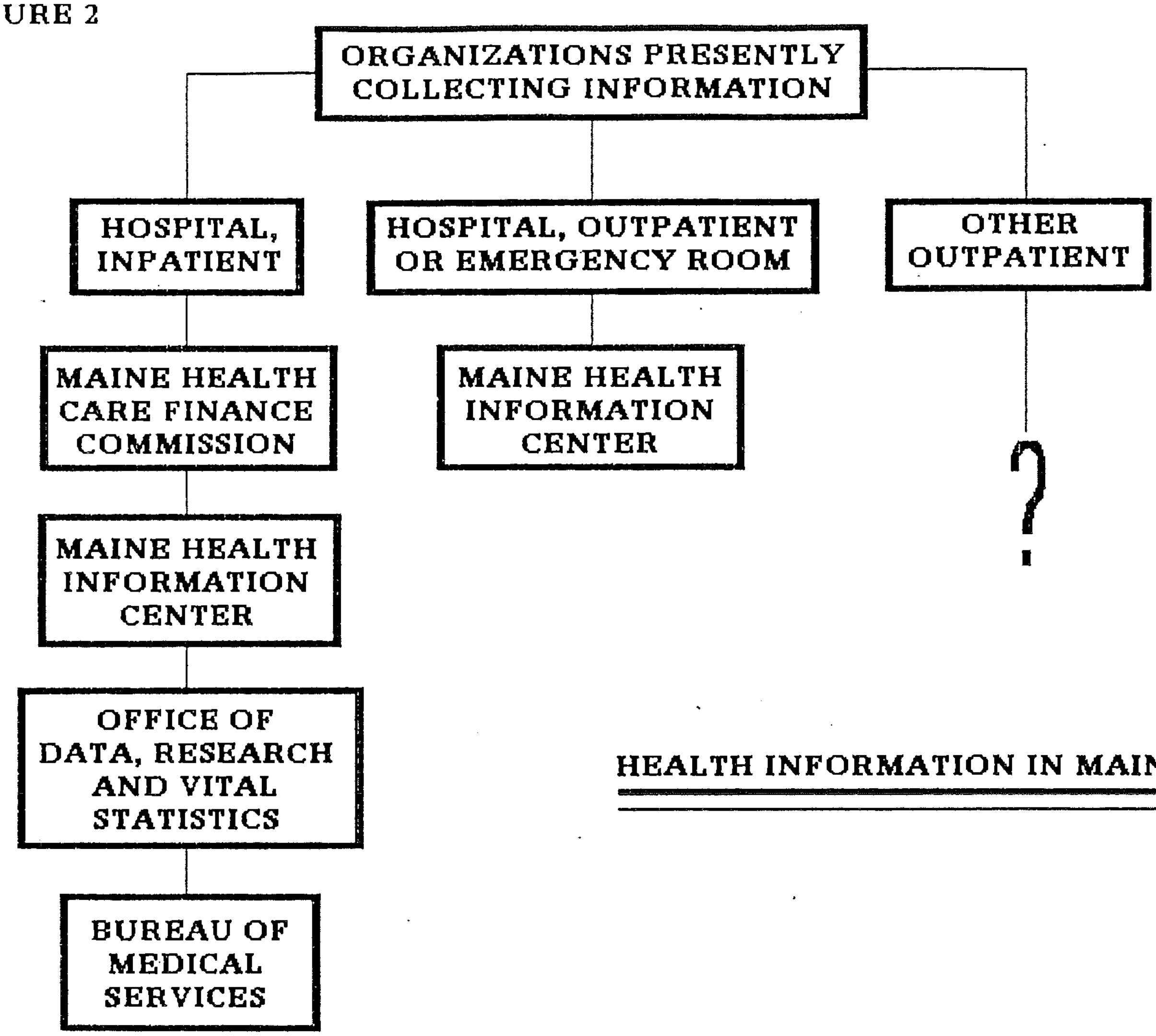
8. A **Skilled Nursing Facility**, as defined in the 1985 State Health Plan Glossary, is an institution or distinct part of an institution which is primarily engaged in providing skilled nursing care and related services for inpatients who require medical or nursing care, or rehabilitation of injured, disabled or sick persons. The Medical Claims Data System maintained by the Bureau of Medical Services and Annual Surveys conducted by the Office of Data, Research, and Vital Statistics provide information regarding intermediate care facilities.

In addition to the information collected in conjunction with the previously listed health care services, Birth and Death Certificates are also issued and should be considered as part of an overall health care database.

D. HEALTH DATA COLLECTORS

There are presently a number of organizations in the state which collect health data. Certain organizations collect information as part of specific projects or studies, whereas other organizations are concerned with data collection on an ongoing basis. Figure 2 shows various agencies which collect health care information on an ongoing basis and the primary type of health care information they collect.

FIGURE 2



HEALTH INFORMATION IN MAINE

D. SUMMARY

Identifying the various health care services that are available to us throughout our life and arranging them in a systematic fashion makes the task of identifying potentially useful sources of health care information less difficult. There is still much health care information that is not being collected or if it is being collected, it is not accessible for public policy decisions or consumer education

VII. CONCLUSIONS AND RECOMMENDATIONS

A. CONCLUSIONS

An informal survey of the Maine Health Care Finance Commission, the Bureau of Insurance, the Office of Data, Research, and Vital Statistics, and the Bureau of Medical Services indicated that these organizations have focused data collection efforts to date on hospital inpatient data. The Hospital Discharge Data Base maintained by the Maine Health Care Finance Commission provides public policy makers with an excellent source of hospital inpatient information. This data base contains records for all patients discharged from Maine hospitals from 1973 to 1978 and from 1980 to the present. Maine currently, however, does not maintain an outpatient data base containing information from the various outpatient settings, e.g. doctor's offices, rural health centers, and ambulatory centers. As noted previously, 7 of 14 states surveyed have begun collecting or are considering collecting outpatient data.

As procedures shift from the inpatient to outpatient setting (see Table 3 on page 24), **our understanding of the overall health care picture is being diminished due to a lack of information.** This information void renders many important questions unanswerable; To what extent are procedures shifting to the outpatient setting? Are certain procedures being utilized in the outpatient setting that were never utilized in the inpatient setting? Does this shift in procedures affect our health care costs?

In order to answer questions such as these, to provide both health care consumers and providers with adequate information, and to provide policy makers with data upon which to base informed decisions, **information will have to be collected from the outpatient setting.**

In recommending the collection of data from other than the hospital inpatient setting, **the Committee's primary concern is to gather information regarding those procedures and diagnoses which are being shifted from the inpatient to the outpatient setting.** In addition, **the Committee is also concerned with those major diagnoses and procedures that are being developed in the outpatient setting.** The Committee's decision to recommend outpatient data collection **by procedure** as opposed to by all outpatient visits is based on the following:

1. There is not presently a need to record information related to common procedures and diagnoses, e.g. stitching a laceration or diagnosing a common cold. Procedures and diagnoses such as these have commonly been performed on an outpatient basis.

2. Data collection by all outpatient visits would result in an extremely large volume of records that would require a correspondingly large amount of resources to operate and maintain.

Table 3
Selected Procedures Moving from the Inpatient to Outpatient Setting, 1983-1987. Ranked According to the Amount of Change

Procedure	Discharges 1983	Discharges 1987	Change	% Change
Other Intracapsular Extraction of Lens (Cataract Extraction)	1954	18	-1936	99.4%
Excision of Semilunar Cartilage of Knee	782	285	-582	74.4%
Unilateral Repair of Inguinal Hernia - Not Otherwise Specified	663	192	-471	71.0%
Other Local Excision or Destruction of Lesion or Tissue of Skin and Subcutaneous Tissue	460	192	-268	75.5%
Open Biopsy of Breast	279	78	-201	72.0%
Insertion of Intraocular Lens Prosthesis at time of Cataract Removal	160	9	-151	94.4%
Carpal Tunnel Release	194	60	-134	69.1%

Source: Maine Health Care Finance Commission

B. RECOMMENDATIONS

Having completed a Study of the Necessity and Feasibility of Establishing a Health Information Recording System, the Committee recommends the following:

Recommendation 1: The state agency charged with hospital data collection should establish an outpatient data base containing information relating to the provision of outpatient type services in both the hospital and non-hospital setting.

Recommendation 2: This information should be collected by procedure, regardless of where the procedure is performed, i.e. in the hospital, in a physician's office, or in a free standing clinic.

Recommendation 3: At least annually, the state agency charged with hospital data collection should compile a list of procedures which must be reported when performed.

Recommendation 4: The outpatient data base established by the state agency charged with hospital data collection should be of such a nature that patient confidentiality is not disclosed.

Recommendation 5: The data collection recommended by this Committee should be collected in such a manner as to minimize the number of documents that must be processed by providers. If necessary, the state agency charged with hospital data collection should have the rule-making authority to develop a uniform data format for the submission of data.

Recommendation 6: The state agency charged with hospital data collection should be able to sub-contract for data collection, storage, and retrieval.

Recommendation 7: The state agency charged with hospital data collection should be permitted to design and implement pilot information reporting systems and to develop proposals for the modification, refinement, or expansion of existing information reporting systems.

Recommendation 8: Additional staff, either full or part time, required to carry out the recommendations of this Committee should be funded by the state agency charged with hospital data collection. Additional expenses should be funded by the General Fund.

Recommendation 9: The state agency charged with hospital data collection should work in collaboration with the Mandated Benefits Advisory Commission in the evaluation of the costs and benefits of both existing and future health care benefits mandated by the Legislature.

C. BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

The Blue Ribbon Commission on Health Care Expenditures is presently conducting a thorough investigation of health care in Maine. Included in this investigation is an analysis of the health care regulatory scheme. The structure of the present health care regulatory agency, the Maine Health Care Finance Commission, may change as a result of the Blue Ribbon Commission's recommendations. It is the intent of this Committee that the data collection recommended by this study be carried out by the state agency charged with hospital data collection.

VIII. MANDATED BENEFITS AND UNINSURED INDIVIDUALS

A. INTRODUCTION

In addition to determining the necessity and feasibility of a health information recording system, the Committee was also given two additional responsibilities:

1. Consult with the Mandated Benefits Advisory Commission, as established pursuant to the Maine Revised Statutes, Title 24, sec. 2325-B, regarding the establishment of a data collection system designed to monitor the cost of mandated benefits.
2. Consider a data collection system for monitoring information on uninsured individuals in the state.

B. MANDATED BENEFITS

The first meeting of the Mandated Benefits Advisory Commission was held on September 19, 1988. This meeting was organizational in nature with little substantive work being undertaken. The Commission is in the process of identifying the data elements needed to evaluate both proposed mandated benefits and existing mandated benefits. The Commission also chose to focus on mandated benefits for substance abuse, mental illness, and chiropractic services. The starting date of the Mandated Benefits Advisory Commission precluded the Committee from consulting with them in reference to a mandated benefits data collection system and thus this issue was not addressed in this study. A list of current mandated benefits are included in Appendix E.

C. UNINSURED INDIVIDUALS

Presently, there are at least four other studies or activities underway in the state which address the problem of uninsured individuals. In view of their activities and in order not to duplicate their efforts, the Committee chose not to invest valuable resources into this problem but rather to rely on the experience, research, and insight provided by the following groups:

1. Commissions

The Special Commission on Access to Health Care, as established pursuant to PL, Chapter 347 AN ACT to Provide Health Care Benefits to Uninsured Individuals, is to investigate as part of its charge the problem of inadequate access to health care. In addition, this Commission is to make recommendations regarding the possibility of private and public medical insurance programs for individuals who cannot purchase health insurance.

2. Demonstration Projects

   a. The Maine Managed Care Insurance Plan Demonstration, as established pursuant to 22 MRSA, §3188, is a 3 year developmental project established to design, implement, and test a managed care insurance program designed to make comprehensive insurance available at an affordable price for small business. This program will include a sliding scale premium based on an enrollee's ability to pay.

   b. The High Risk Insurance Organization, as established pursuant to 5 MRSA, chapter 379, is a nonprofit entity established to provide health insurance to persons who are otherwise unable to obtain health insurance for medical reasons.

3. **Other Organizations**

   a. Consumers for Affordable Health Care is a consumer organization established in July of 1988 with the intent of assuring that all citizens in Maine have access to health care. As an initial task, a study was undertaken to determine the extent to which persons in Maine are unable to obtain health insurance. "Who are the Uninsured: Demographics of the Uninsured in Maine" studies the demographics of those persons unable to obtain health insurance. In addition, this organization is monitoring the progress of the demonstration projects listed previously.

   b. Other organizations such as the Maine Chamber of Commerce and Industry are also undertaking studies related to this issue.

APPENDIX A

LD 2358, AN ACT to Insure Adequate Rate Filing Information from Health Insurers

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-EIGHT

H.P. 1719 - L.D. 2358

AN ACT to Study the Necessity and Feasibility of Establishing a Health Information Recording System.

Emergency preamble. Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, increases in the cost of medical care have resulted in increased costs to users of medical services, increasing numbers of Maine citizens without health insurance and record losses to the health insurance industry; and

Whereas, the cost of health insurance has significant impact on employers and the economy of the State; and

Whereas, presently, the Legislature does not have the information required to study possible solutions to the escalating costs of insurance premiums to Maine businesses and consumers and losses to health insurers; and

Whereas, in order for this study to be completed by December 15, 1988, work must begin as soon as possible after the adjournment of the Second Regular Session of the 113th Legislature; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine as follows:

Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Act.

	1987-88	1988-89
LEGISLATURE		
Study Commission - Funding		
Personal Services	$1,485	$3,410
All Other	4,455	5,100
Total	$5,940	$8,510

Provides for the per diem, travel and related expenses of a 9-member subcommittee to conduct a study of the necessity and feasibility of establishing a health information recording system, authorized by the Legislative Council. Also provides funds for a limited-period contractual consultant.

Emergency clause. In view of the emergency cited in the preamble, this Act shall take effect when approved.

2-1408

APPENDIX B

Committee Amendment H-716, AN ACT to Study the Necessity and Feasibility of Establishing a Health Information Recording System

L.D. 2358

(Filing No. H- 716)

STATE OF MAINE
HOUSE OF REPRESENTATIVES
113TH LEGISLATURE
SECOND REGULAR SESSION

COMMITTEE AMENDMENT "A" to H.P. 1719, L.D. 2358, Bill, "AN ACT to Insure Adequate Rate Filing Information from Health Insurers."

Amend the bill by striking out all of the title and inserting in its place the following:

'AN ACT to Study the Necessity and Feasibility of Establishing a Health Information Recording System.'

Further amend the bill by striking out everything after the title and inserting in its place the following:

'**Emergency preamble.** Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, increases in the cost of medical care have resulted in increased costs to users of medical services, increasing numbers of Maine citizens without health insurance and record losses to the health insurance industry; and

Whereas, the cost of health insurance has significant impact on employers and the economy of the State; and

Whereas, presently, the Legislature does not have the information required to study possible solutions to the escalating costs of insurance premiums to Maine businesses and consumers and losses to health insurers; and

Whereas, in order for this study to be completed by December 15, 1988, work must begin as soon as possible after the adjournment of the Second Regular Session of the 113th Legislature; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine as follows:

Sec. 1. Study established. The Joint Standing Committee on Banking and Insurance shall study the necessity and feasibility of establishing a health information recording system. The committee shall study what data is currently being collected, what additional data is needed, what the source of information should be, the method of collecting this data, how the data should be used and the costs and benefits of a data collection system. The committee shall also propose a system for collecting and monitoring data on uninsured individuals and mandated benefits in order to determine the costs to Maine businesses, health insurers, consumers and the State and the impact on the Maine economy. The committee shall consult with the Mandated Benefits Advisory Commission as established pursuant to the Maine Revised Statutes, Title 24, section 2325-B.

Sec. 2. Findings. The committee shall report its findings and any recommended legislation to the Legislature by December 15, 1988. The committee shall report its preliminary findings to the Blue Ribbon Commission on Health Care Expenditures by September 15, 1988.

Sec. 3. Staff assistance. The committee shall request from the Legislative Council sufficient staff assistance, including limited-period contractual assistance, to carry out these duties.

Sec. 4. Meetings. A subcommittee of 5 members of the committee appointed by the chairmen of the committee, one member from the joint standing committee of the Legislature having jurisdiction over human resources and 2 members from the joint standing committee of the Legislature having jurisdiction over economic development shall meet up to 10 times to study the issues through examination of information and consultation with staff and recognized experts in the health insurance field, in health cost containment, in the business community and in the provider community. The Senate chairman and House chairman will serve as cochairmen of the subcommittee. The chairman of the Blue Ribbon Commisson on Health Care Expenditures shall be an ex officio member of the subcommittee. The subcommittee shall meet once with the full committee to present its findings.

Sec. 5. Reimbursement. Legislative members of the committee participating in the study shall receive the legislative per diem, as set forth in the Maine Revised Statutes, Title 3, section 2, for days of attendance at committee meetings. All members of the committee participating in the study shall receive expenses as set forth in the Maine Revised Statutes, Title 3, section 2.

Sec. 6. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Act.

	1987-88	1988-89
LEGISLATURE		
Study Commission - Funding		
Personal Services	$1,980	$3,410
All Other	6,800	5,100
Total	$8,780	$8,510

Provides for the per diem, travel and

Pag

related expenses of an 9-member subcommittee to conduct a study for the Joint Standing Committee on Banking and Insurance. Also provides funds for a limited-period contractual consultant.

Emergency clause. In view of the emergency cited in the preamble, this Act shall take effect when approved.'

STATEMENT OF FACT

This amendment establishes a subcommittee of the Joint Standing Committee on Banking and Insurance to study the necessity and feasibility of establishing a health information recording system. In addition to the 5 members from the Joint Standing Committee on Banking and Insurance, there will also be one member from the Joint Standing Committee on Human Resources and 2 members from the Joint Standing Committee on Economic Development. The chairman of the Blue Ribbon Commission on Health Care Expenditures will serve as an ex officio member. Such a study is necessary because of the increasing cost of health insurance premiums and increasing losses of health insurers. If it is found that such a data recording system is necessary and feasible, the committee will recommend legislation for implementing such a system. The committee will report its preliminary findings to the Blue Ribbon Commission on Health Care Expenditures.

Reported by the Committee on Banking and Insurance
Reproduced and distributed under the direction of the Clerk of the House
4/14/88 (Filing No. H-716)

APPENDIX C

Private and Special Law, Chapter 138, AN ACT to Study the Necessity and Feasibility of Establishing a Health Information Recording System

APPROVED
MAY 2 '88
BY GOVERNOR

CHAPTER
138
P & S LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-EIGHT

H.P. 1719 - L.D. 2358

AN ACT to Study the Necessity and Feasibility of Establishing a Health Information Recording System.

Emergency preamble. Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, increases in the cost of medical care have resulted in increased costs to users of medical services, increasing numbers of Maine citizens without health insurance and record losses to the health insurance industry; and

Whereas, the cost of health insurance has significant impact on employers and the economy of the State; and

Whereas, presently, the Legislature does not have the information required to study possible solutions to the escalating costs of insurance premiums to Maine businesses and consumers and losses to health insurers; and

Whereas, in order for this study to be completed by December 15, 1988, work must begin as soon as possible after the adjournment of the Second Regular Session of the 113th Legislature; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine as follows:

Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Act.

	1987-88	1988-89
LEGISLATURE		
Study Commission - Funding		
Personal Services	$1,485	$3,410
All Other	4,455	5,100
Total	$5,940	$8,510

Provides for the per diem, travel and related expenses of a 9-member subcommittee to conduct a study of the necessity and feasibility of establishing a health information recording system, authorized by the Legislative Council. Also provides funds for a limited-period contractual consultant.

Emergency clause. In view of the emergency cited in the preamble, this Act shall take effect when approved.

2-1408

APPENDIX D

State Health Information Systems Survey Questions

STATE HEALTH INFORMATION SYSTEMS
SURVEY QUESTIONS

State: ____________________

Organization: ____________________

1. *Does your state have a centralized health information recording system?*

2. *From whom is health information collected?*

3. *Is this information collected on a voluntary or mandatory basis?*

4. *Are data providers compensated for their activities?*

5. *At what intervals are the data updated?*

6. *What are the goals of this system?*

7. *Are these goals articulated in statute?*

8. *Has this system been evaluated to date?*

9. *When was the establishment of this system authorized?*

10. *When did this system begin collecting data?*

11. *What is done with the information collected?*

12. Are hospital revenues regulated in your state?

APPENDIX E

Current Mandated Benefits

HISTORY OF MANDATED HEALTH INSURANCE BENEFITS

YEAR ENACTED	BENEFIT	TYPE OF CONTRACT AFFECTED	TYPE OF MANDATE	STATUTORY REFERENCE	
				TITLE 24	TITLE 24-A
1975	Maternity benefits provided to married women must also be provided to unmarried women.	All Contracts	Mandated Coverage	S. 2318	S. 2741 S. 2832
1975	Coverage of children must be made available to unmarried women on the same basis as married women.	All Contracts	Mandated Offer	S. 2318	S. 2742 S. 2833
1975	Must include benefits for dentists' services to the extent that the same services would be covered if performed by a physician.	All Contracts	Mandated Coverage	S. 2303A	S. 2437
1975	Family coverage must cover any children born while coverage is in force from the moment of birth, inclucing treatment of congenital defects.	All Contracts	Mandated Coverage	S. 2319	S. 2743 S. 2834
1975	Must include benefits for psychologists' services to the extent that the same services would be covered if performed by a physician.	All Contracts	Mandated Coverage	S. 2303	S. 2744 S. 2835
1977	Benefits must be made available for home health care services.	All Contracts	Mandated Offer	S. 2320	S. 2745 S. 2837
1979	Benefits must be made available for the services of chiropractors if comparable services would be covered if performed by a physician.	Groups of 50 or more. Extended to all groups in 1981.	Mandated Offer	S. 2303B	S. 2840
1979	Benefits must be made available for outpatient health care services of certified rural health clinics.	Blue Cross and Blue Shield	Mandated Offer	S. 2324	
1981	Benefits must be made available for the services of optometrists if the same services would be covered if performed by a physician.	All Groups	Mandated Offer	S. 2331	S. 2841
1981	Benefits must be made available for treatment of alcoholism by licensed or certified treatment facilities subject "reasonable limitations".	All Groups	Mandated Offer	S. 2329	S. 2842
1983	Benefits must be included for treatment of alcoholism and drug dependency, subject to "reasonable limitations".	Groups of more than 20	Mandated Coverage	S. 2329	S. 2842
1983	Benefits must be included for Mental Health Services, subject to "reasonable limitations".	Groups of more than 20	Mandated Coverage	S. 2325A	S. 2843
1983	Benefits must be included for the services of social workers and psychiatric nurses to the extent that the same services would be covered if performed by a physician.	All Contracts	Mandated Coverage	S. 2303	S. 2745 S. 2835
1986	Benefits must be included for the services of chiropractors to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services.	All Contracts	Mandated Coverage	S. 2303C	S. 2840A S. 2748
1987	Benefits must be made available for cardiac rehabilitation expenses.	Groups of 20 or more	Mandated Offer	S. 2333A	S. 2845

Source: Bureau of Insurance 6492m

APPENDIX F

Recommended Legislation

FIRST REGULAR SESSION

ONE HUNDRED AND FOURTEENTH LEGISLATURE

Legislative Document No.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY NINE

AN ACT Relating to the Collection of Specified Health Care Information.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §381, sub-§2, ¶D is enacted to read:

D. It is further the intent of the Legislature that a uniform system of reporting outpatient health care data shall be established; that information be collected from both the hospital and non-hospital setting regarding specified procedures and diagnoses; that this information be collected in such a manner as to provide meaningful health care information to providers and consumers; that this information be collected in such a manner that consumer and provider utilization of services can be monitored; that the information be collected in such a manner that outpatient service charges can be monitored; and that the information collected be available as a basis of determining public health policy.

Sec. 2. 22 MRSA §382, sub-§8-A is enacted to read:

8-A. Major Ambulatory Service. Major ambulatory service means surgical, chiropractic methodologies or medical procedures, including diagnostic procedures and therapeutic radiological procedures, which require special facilities such as operating rooms or suites or special equipment such as fluoroscopic equipment or computed tomographic scanners, or a post-procedure recovery room or short-term convalescent room.

Sec. 3. 22 MRSA §390, as enacted by PL 1983, c. 579, §10, is amended to read:

§390. Enforcement

Upon application of the commission or the Attorney General, the Superior Court shall have full jurisdiction to enforce all orders of the commission and the performance by ~~health care facilities~~ providers of health care of all duties imposed upon them by this chapter and any valid regulations adopted pursuant to this chapter.

Sec. 4. 22 MRSA §391, sub-§6, is enacted to read:

6. Non-hospital data collection expenses. The funds required to support the collection, storage, and analysis by the commission of data from providers of health care other than hospitals shall be provided through appropriations from the General Fund and not by means of the assessment provided for in subsection 1.

Sec. 5. 22 MRSA §394, sub-§2, ¶C, as enacted by PL 1983, c. 579, §10, is amended to read:

C. A completed uniform hospital discharge data set, or comparable information, for each patient discharged from the facility after June 30, 1983; and for each major ambulatory service listed pursuant to subsection 11 occurring after January 1, 1990.

Sec. 6. 22 MRSA §394, sub-§2-A is enacted to read:

2-A. Additional information on major ambulatory services. Pursuant to rules adopted by the commission for form, medium, content, and time for filing, each provider of health care shall file with the commission a completed data set, comparable to data filed by health care facilities under subsection 2, paragraph C, for each major ambulatory service listed pursuant to subsection 11 occurring after January 1, 1990. This subsection shall not be construed to require duplication of information also required to be filed under subsection 2.

Sec. 7. 22 MRSA §394 sub-§3, as enacted by PL 1983, c. 579, §10, is amended to read:

3. **Storage of ~~discharge~~ data.** The commission may, subject to section 386, subsection 6, contract with any entity, including an independent data organization, to store discharge data filed with the commission and comparable data filed with the commission with respect to major ambulatory services. For purposes of this subsection, "independent data organization" means an organization of data users, a majority of whose members are neither providers of health care, organizations representing providers of health care, nor individuals affiliated with those providers or organizations, and whose purposes are the cooperative collection, storage and retrieval of health care information.

Sec. 8. 22 MRSA §394, sub-§7, as enacted by PL 1983, c. 579, §10, is repealed and replaced to read:

7. More than one licensed health facility operated.

A. Where more than one licensed health facility is operated by the reporting organization, the information required by this chapter shall be reported for each health facility separately.

B. When a provider of health care operates in more than one location, the commission may require that information be reported separately for each location.

Sec. 9. 22 MRSA §394, sub-§9, as enacted by PL 1983, c. 579, §10, is amended to read:

9. Verification. If a further investigation is considered necessary or desirable to verify the accuracy of information in reports made ~~by health care facilities~~ under this chapter, the commission may examine further any records and accounts as the commission may by regulation provide. As part of the examination, the commission may conduct a full or partial audit of all such records and accounts.

Sec. 10. 22 MRSA §394, sub-§11 is enacted to read:

11. Major ambulatory services list. Beginning on October 1, 1989, and at least annually thereafter, the commission shall by rule prepare a list of major ambulatory services for which data is to be collected pursuant to section 381, subsection 2, paragraph D. The commission shall distribute the list to those providers of health care that are required to file information under subsection 2 or 2-A.

Sec. 11. 22 MRSA §395, sub-§7 is enacted to read:

7. Development of health care information systems. In addition to the commission's authority to obtain information to carry out the specific provisions of this subchapter, the commission may require providers of health care to furnish information with respect to the nature and quantity of services provided, to the extent necessary to develop proposals for the modification, refinement, or expansion of the systems of information disclosure established under this subchapter. The commission's authority under this subsection includes the design and implementation of pilot information reporting systems affecting selected categories of providers of health care, or representative samples of providers.

Sec. 12. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Act.

	1989-90	1990-91
Maine Health Care Finance Commission		
All Other	$12,000	$12,600
Capital	4,800	
Total	$16,800	$12,600

Provides funds to cover the non-health providers' share of the cost of collecting certain outpatient data. Funds will be used to edit data, purchase a computer and office furniture, and cover general operating expenses.

Sec. 13. Allocation. The following funds are appropriated from Other Special Revenue funds to carry out the purposes of this Act.

	1989-90	1990-91
Maine Health Care Finance Commission		
Positions	(1)	(1)
Capital	$37,371	$37,659

Allocates funds for a Research Assistant II to collect and analyze outpatient data. This allocation will cover the hospitals' share of the data collection.

FISCAL NOTE

Enactment of this bill will result in an increase of $37,371 to the Maine Health Care Finance Commission Fund. The Maine Medicaid Program Fund will be assessed approximately $4,485 to fund its share of the hospital assessment. The Dept. of Human Services has indicated that it can absorb this cost within current appropriations.

STATEMENT OF FACT

Currently, the State of Maine collects a broad array of health care information relating to the cost of and provision of inpatient services. In recent years, however, many procedures and diagnoses that were commonly conducted only on an inpatient basis are now routinely being performed in an outpatient setting, e.g. hospitals, doctor's offices, and ambulatory care centers. In order to track the cost of and utilization of these procedures and diagnoses, it is necessary to begin collecting information from the outpatient setting. This bill gives the Maine Health Care Finance Commission the authority to collect information from the outpatient setting regarding specified procedures. In addition, the Commission is required to at least annually prepare and distribute to those providers of health care that are required to report information a list of major ambulatory services, i.e. those procedures that are subject to reporting requirements. The Commission is also empowered to conduct studies regarding the development of health information reporting systems.