



Legislative Fiscal Bureau

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TO: Members
Joint Committee on Finance

FROM: Bob Lang, Director

SUBJECT: Assembly Bill 907: Privatization of the Physician Office Visit Data Program

Assembly Bill 907 would permit the Department of Health and Family Services (DHFS) and the Department of Employee Trust Funds (ETF) to contract jointly with a data organization, which would: (a) collect, analyze, and publicly report certain health care claims information from insurers and administrators; (b) maintain a centralized data repository; and (c) provide DHFS, without charge, health care claims information from insurers and reports requested by DHFS. The activities of the data organization would replace activities DHFS conducts under the physician office visit data (POVD) program. In addition, AB 907 would eliminate the Board on Health Care Information, the Interagency Coordinating Council, and the Independent Review Board, effective July 1, 2006.

On January 13, 2006, the Assembly Health Committee adopted three amendments to AB 907 and recommended the bill for passage by a vote of 13-0.

Assembly Amendment 1 would delete provisions in the bill that would: (a) reduce, from \$75 to \$70, the maximum annual assessment that health care providers that are not facilities pay to support the program; and (b) authorize DHFS to increase the annual assessment above the \$70 statutory maximum with the approval of the Joint Committee on Finance under a 14-day passive review process. Consequently, under the amended bill, DHFS could not assess providers that are not facilities more than \$75 per year to support the program.

Assembly Amendment 2 would require DHFS and ETF to jointly prepare and submit an annual report on the activities of the data organization to the standing legislative committees with jurisdiction over health issues.

Assembly Amendment 3 would delete a provision in the bill that would repeal the requirement that the Council on Birth Defect Prevention and Surveillance coordinate with the early intervention interagency coordinating council to facilitate the delivery of early intervention services to children from birth to age three with developmental needs. This provision was erroneously included in the bill.

BACKGROUND

Physician Office Visit Data Program. 1997 Wisconsin Act 231 directed DHFS to expand its health data collection activities to include data reflecting care delivered in physician offices. Act 231 authorized DHFS to assess physicians up to \$75 annually to support data collection costs.

Pursuant to Act 231, the Board on Health Care Information authorized DHFS to implement physician office visit data collection in phases, following promulgation of administrative rule that took effect in January, 2001. DHFS implemented the first phase, under which DHFS selected 12 large health care organizations to submit data. These organizations were chosen because of their geographical diversity, their large volumes of physician-related data, and their technical capacity to provide data. One smaller clinic also agreed to submit data as part of the first phase of the project. The participating organizations represented over 50% of the state's practicing physicians. The planned second phase of the program, which DHFS has not implemented, would have required data collection from physicians associated with another 11 large and 25 smaller groups. The third and final phase would have required data collection from the remaining independent clinics and self-employed physicians.

By rule, physicians may delegate their responsibility to submit data to DHFS to their medical practice groups or to outside vendors. To date, all physicians who have submitted data have delegated this responsibility.

Administrative rules (HFS 120.14) list the data elements that physicians must submit to DHFS under the POVDP program. These data elements are: (1) patient's birth date; (2) patient's gender; (3) patient's zip code; (4) patient condition related to employment; (5) patient condition related to auto accident; (6) patient condition related to other accident; (7) date of current illness, injury or pregnancy; (8) the first date of illness, if patient has had same or similar illness; (9) primary payer category code; (10) secondary payer category code; (11) medical record or chart number; (12) name of referring physician; (13) identification number of referring physician; (14) patient control number; (15) whether tests were sent to an outside lab; (16) outside lab charges; (17) diagnosis or nature of illness or injury; (18) medical assistance resubmission code; (19) prior authorization number; (20) dates of service; (21) place of service; (22) type of service; (23) codes for procedures, services or supplies; (24) modifiers; (25) charges; (26) days or units; (27) encrypted case identifier; (28) provider employer identification number; (29) patient account number; (30) whether the provider accepts assignment; (31) total charge; (32) name of facility where services were rendered; (33) address of facility where services were rendered; (34) physician's and

supplier's billing name; (35) physician's and supplier's billing address; (36) billing physician's identification number; and (37) performing physician's identification number.

The information DHFS currently collects relating to charges reflect the "retail" prices physicians charge for their services, rather than the actual payment physicians receive for their services, which is typically discounted, based on negotiations between providers and the health plans.

Physicians must submit a record that includes these data elements for each service they render. For example, if a physician provides three different services to a patient during one office visit, the physician must submit three records for that visit. Physicians submit the data elements in an electronic format according to instructions provided in a DHFS-published data submission manual.

The data files compiled by DHFS for public use do not include all the data DHFS collects. The POV data available for public use does not identify specific patients, employers, or health care providers. Current law restricts the use of certain patient data elements, specifically related to employment, date of illness and zip code of residence, and provides sanctions for the inappropriate use of data. Further, DHFS will not release data for public use until physicians or their delegated designees have affirmed that the data are accurate and complete. Additionally, no public reports identifying everything that a specific physician has submitted is available, under the requirements of current statute and rule.

Board on Health Care Information. The Board on Health Care Information (BHCI) advises DHFS with regard to the collection, analysis, and dissemination of health care information, which includes data collected from hospitals, ambulatory surgery centers, physicians, and certain other kinds of health care providers. The Board is directed to: (a) approve all rules proposed by DHFS to implement the health care information program; (b) provide oversight related to a report on uncompensated health care services and a consumer guide to assist consumers in selecting health care plans and providers; (c) develop the overall strategy and direction for implementing the health care information program; and (d) provide information to the Interagency Coordinating Council. The BHCI also must approve the amounts assessed by DHFS to physicians for the POV program and to physicians, nurses, and other health care providers for a workforce survey.

The Board is attached to DHFS. The BHCI consists of 11 members, including: (a) a record administrator registered by the American Medical Record Association; (b) at least two employer purchasers of health care; and (c) five health care providers or representatives of providers, including one registered nurse, two physicians, and two hospital representatives. Additionally, the State Medical Society of Wisconsin may recommend BHCI membership for five physicians, one of whom must be appointed by the Governor. BHCI members are appointed for four-year terms.

Independent Review Board. The Independent Review Board reviews requests for data elements, other than those available for public use data files, which may include information on the name of a health care provider or the patient's month and year of birth or zip code. Without the Board's approval, unless not required under administrative rules, DHFS may not release requested data elements. In addition, the Board must approve any databases of information from health care providers that DHFS sells or distributes.

The Independent Review Board is attached to DHFS and consists of five members, including: (a) the Commissioner of Insurance or his or her designee; (b) a statistician or researcher; (c) a medical ethicist of the University of Wisconsin system or the Medical College of Wisconsin; (d) an expert in the issues relating to privacy; and (e) a purchaser of health care. The members are appointed for four-year terms.

Interagency Coordinating Council. The Council serves as a means of increasing the efficiency and utility and facilitating the effective functioning of state agencies in activities related to health care data collection. The Council advises and assists state agencies in the coordination of health care data collection programs and the exchange of information related to health care data collection and dissemination, including agency budgets for health care data collection programs, health care data monitoring and management, public information and education, health care data analysis and facilities, research activities, and the appropriation and allocation of state funds for health care data collection. The Council is required to establish methods and criteria for analyzing and comparing complaints filed against health care plans and grievances filed with health maintenance organizations, without requiring the collection of information beyond information that is already collected by state agencies. Finally, the Council is required to report at least twice annually to the Board on Health Care Information, concerning the Council's activities.

The Interagency Coordinating Council is attached to the Department of Administration (DOA) and consists of eight members, including: (a) the Secretary of the Department of Employee Trust Funds, or his or her designee; (b) a representative of the unit in DHFS that deals with health statistics; (c) a representative of the unit in DHFS that deals with the medical assistance program; (d) a representative of the unit in DHFS that deals with health care information; (e) a representative of the unit in the University of Wisconsin system that deals with health statistics research analysis; (f) a DOA representative; and (g) a representative from the Office of the Commissioner of Insurance. The members are appointed for four-year terms.

SUMMARY OF AMENDED BILL

Contract with Data Organization. AB 907, as amended, would permit DHFS and ETF to contract jointly with a data organization to collect, analyze, and publicly report certain health care claims information with respect to the cost, quality and effectiveness of health care, in language that is understandable by lay persons and to develop and maintain a centralized data repository. The organization would provide DHFS health claims information and reports without charge.

The bill defines a "data organization" as a nonstock, nonprofit corporation that, in its capacity as a public health authority, represents health care consumers, insurers, administrators, and health care providers and that is formed specifically to: (a) create a centralized claims repository for Wisconsin with credible and useful data elements for the purposes of quality improvement, health care provider performance comparisons, ready understandability, and consumer decision making; and (b) use the information it collects to develop and disseminate unified public reports on health care quality, safety, and efficiency.

Based on this definition, DHFS and ETF would jointly contract with the Wisconsin Health Information Organization (WHIO) to perform these functions. WHIO, which was created based on the work of the Wisconsin Collaborative for Healthcare Quality, includes hospitals, specialty physician groups, employers, and labor organizations. The nine founding members of WHIO are Blue Cross Blue Shield of Wisconsin, the Greater Milwaukee Business Foundation on Health, Humana, The Alliance, UnitedHealthcare of Wisconsin, the WEA Trust, WPS Health Insurance, the Wisconsin Collaborative for Healthcare Quality, and the Wisconsin Medical Society.

DHFS would be authorized to use program revenue (PR) currently budgeted to support general program operations for its health care information activities and the costs of compiling special reports to also support a joint contract with ETF and the data organization. The revenue that supports these activities is derived from the annual physician assessment and fees DHFS assesses for special data compilations and reports. The bill would authorize ETF to expend up to \$150,000 from its benefit and coverage payments appropriation, to contract jointly with DHFS for data collection, analysis, and reporting activities.

As a condition of the contract, AB 907 would require that: (a) at least during the period of the contract, the data organization would include as voting members on its board of directors, the DHFS and ETF Secretaries or their designees; and (b) the data organization provide matching funds, which could include in-kind contributions, as specified in the contract. The bill would specify that the contract could be terminated if DHFS and ETF if the agencies determine that the data organization is not in compliance with the contract.

The bill would permit the contracted data organization to request health care claims information from insurers and administrators and would prohibit the contracted data organization from sharing health care claims data that it collects unless the sharing is in compliance with federal standards for information transactions.

The bill would allow the data organization to request, analyze, and publicly report, in language that is understandable to laypersons, health care claims information, as adjusted for case mix and severity, from insurers and administrators. The data organization could obtain these data from these sources through sampling techniques in lieu of collection of data on all insureds, and data collection procedures would minimize unnecessary duplication and administrative burdens. The organization would be required to specify how the data should be submitted to it, which could include standard electronic format. The bill would specify that, upon the data organization's

request, insurers and administrators could provide (but would not be required to provide) health care claims information to the data organization for the preparation of reports and the development and maintenance of a central data depository.

The data organization would be required to provide orientation and training to insurers and administrators that submit data to explain the process of data collection and analysis and the procedures for data verification, comment, interpretation, and release. In addition, the organization would, to the extent possible and upon request, assist members of the public in interpreting data in health care information disseminated by the data organization.

DHFS Authority to Collect Health Care Information Data. Beginning 60 days after the effective date of the contract, DHFS would be required to stop collecting, for calendar quarters that occur after that date, health care information submitted by physicians under rule, except information necessary for the consumer guide and assessments to fund operations of DHFS. The bill would eliminate the current provisions that require DHFS to study, and based on the results, develop and implement a voluntary system of health care plan reporting that enables purchasers and consumers to assess the performance of health care plans and the health care providers, other than hospitals and ambulatory surgery centers, that are employed or reimbursed by the health care plans.

Beginning on the date, if any, that the Secretaries of DHFS and ETF determine that the data organization is not in compliance with the contract, as it pertains to the performance of the collection and public reporting of information regarding the cost, quality, and effectiveness of health care, including the development and maintenance of a centralized data repository, or determine that there is insufficient statewide participation under the requirements of the contract, the Secretaries could modify or terminate the contract with the data organization.

If the contract is terminated, the Secretaries would be required to recommend to the Department of Administration that DHFS use a competitive request-for-proposal (RFP) process to solicit offers from other organizations for performance of the services required of the data organization under the terminated contract. If no organization responds to the RFP or if a successor cannot be achieved, DHFS would then collect health care information, as specified under current administrative rules. In addition, DHFS: (a) could request health care claims information, which could be voluntarily provided by insurers or administrators; (b) would be required to analyze and disseminate, or contract for the performance of analysis or dissemination of, the health care information; and (c) could analyze and disseminate (or contract for the performance of analysis and dissemination of) the health care claims information.

In this situation, DHFS would have the authority and responsibilities that would have otherwise been provided to the contracted entity. The bill specifies that the DHFS rules relating to health care information from health care providers, other than hospitals and ambulatory surgery centers, would only apply if the contract is terminated and DHFS is collecting the health care claims data. In addition, DHFS would include in its legislative reports on health care providers any reports concerning health care claims information that DHFS collects or contracts to collect.

Patient-Identifiable Data. The bill would allow DHFS to release patient-identifiable data to an agent of the contracted data organization who is responsible for this data, in order to store the data and ensure the accuracy of the information in the organization's database or to create a calculated variable that is derived from the patient-identifiable data. The bill would define a "calculated variable" as a data element that is computed or derived from an original data item or derived using another data source. In addition to the reasons specified under current law, the bill would allow DHFS to release patient-identifiable data to an agent of DHFS or an agent of the contracted entity to create a calculated variable that is derived from the patient-identifiable data.

The bill would specify that "patient-identifiable data" does not include calculated variables that are derived from patient-identifiable data and the dissemination of which does not permit patient identification. The bill includes references to insurers and administrators, together with health care providers, with respect to the submission of patient identifiable data.

Health Care Provider Assessment. Under current law, the assessment on physicians is determined by DHFS by October 1 of each year, based on the estimated total amount of expenditures for DHFS in that fiscal year for data collection, database development and maintenance, generation of data files and standard reports, orientation and training, and maintaining the Board on Health Care Information (BHCI). The bill would expand the expenditure total to include a reference to the cost of contracting with a data organization. DHFS would no longer need to obtain approval from the BHCI on the assessment amount, since the bill would eliminate the BHCI.

The bill would delete the requirement that DHFS assess health care plans who voluntarily agree to supply health care data to be used in public data files and standard reports for health care plans. In addition, the bill would repeal a provision that prohibits DHFS from selling or distributing databases of information, from health care providers who are not hospitals or ambulatory surgery centers, which are able to be linked with public use data files, unless first approved by the Independent Review Board, since the bill would eliminate the Independent Review Board.

Definitions. The bill defines a "public health authority," for the purposes of the health data information collection program, as DHFS or a person acting under a grant of authority from, or contract with, DHFS. The bill changes the cross-reference for the definition of an "insurer" and includes a cross-reference to define "administrator."

Eliminating Boards and Councils. The bill would eliminate the Board on Health Care Information, the Interagency Coordinating Council, and the Independent Review Board, on July 1, 2006, and deletes all references to these agencies on that date. The bill would specify that items or actions that under current law would need to be approved by the Independent Review Board would instead be subject to approval by DHFS.

FISCAL EFFECT

The bill would authorize DHFS and ETF to contract jointly with a data organization to collect, analyze, and publicly report certain health care claims information from insurers and administrators. This contract would be supported with assessments collected by DHFS from physicians that are currently supporting the POVVD program and, under this bill, would be redirected to this authorized contract. In addition, ETF would be authorized, but not required, to allocate up to \$150,000 SEG to support this contract. This is funding that is not currently being used to support the POVVD program.

In its fiscal note, DHFS indicated that since this health care data will be managed by a contracted entity, there would be a resulting workload reduction of 5.83 PR positions. These positions are not eliminated in AB 907. However, the need for these positions could be reviewed as part of the Committee's 2007-09 biennial budget deliberations if the contracted data organization performs the health information functions currently conducted by these staff.

AB 907 would eliminate the Board on Health Care Information, the Interagency Coordinating Council, and the Independent Review Board, as of July 1, 2006. These boards and council are not appropriated funds directly to support their activities, and therefore, cost savings are not expected from the elimination of these entities.

POSSIBLE MODIFICATION TO THE BILL

Under the bill, ETF would be authorized to expend up to \$150,000 SEG from an "all moneys credited" continuing appropriation account for benefit coverage payments to support the contract with a data organization, as described previously. Under current law, the ETF appropriation specified in the bill is authorized to receive all moneys credited to the public employee trust fund for payment from the appropriate accounts and reserves of the fund of the benefits, contributions, insurance premiums, and refunds authorized by Chapter 40 of the statutes (Public Employee Trust Fund) for the respective benefit plans. The estimated disbursements under this appropriation account are not included in the Chapter 20 appropriation schedule. This appropriation account operates as a sum sufficient clearing account for the payment of benefits authorized under Chapter 40, including retirement annuities, health and other insurance premiums, disability benefits, and survivor benefits. It is not an appropriation account under which ETF general program operational expenses are budgeted. Under current law, ETF has a separate SEG annual appropriation account for health insurance data collection and analysis contracts [s. 20.515(1)(ut)], which would appear be the appropriate place to budget the \$150,000 SEG of data collection contract costs authorized under AB 907.

Therefore, the Committee could amend the bill by deleting the provision authorizing ETF to expend up to \$150,000 from the SEG clearing account appropriation for benefit coverage payments [s. 20.515(1)(r)] for the data collection contract, and instead, appropriate \$150,000 in one-time

moneys in 2006-07 to ETF's SEG appropriation account for health insurance data collection and analysis contracts [s. 20.515(1)(ut)], and would modify the appropriation language to permit these payments. The provision of one-time funding in 2006-07 would allow the Legislature to review this program in the 2007-09 biennial budget deliberations, if ongoing expenditure authority is requested.

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