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Details: Follow-up: Letter Report: Physician Office Visit Data Program

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ... PUBLIC HEARING - COMMITTEE RECORDS

2005-06

(session year)

Joint

(Assembly, Senate or Joint)

Committee on Audit...

COMMITTEE NOTICES ...

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State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Helene Nelson, Secretary

APR 19 2005

April 19, 2005

The Honorable Carol A. Roessler, Senate Chairperson
Representative Suzanne Jeskewitz, Assembly Chairperson
All Members
Joint Legislative Audit Committee
State Capitol
Madison WI 53702

Dear Senator Roessler, Representative Jeskewitz and Members of the Committee:

I am writing to provide the Department's perspective on the report of the Legislative Audit Bureau (LAB) about the Physician Office Visit (POV) program. I look forward to the opportunity to discuss this issue again with you.

I understand the concern of the Committee in directing the audit of the POV system. Senator Roessler and other leaders supported the creation of POV reporting as a way to provide publicly transparent information on the range of services performed in physician offices and their prices. This data was intended to assist the public and health care purchasers in making better health care decisions. It has been apparent for some time that the current system has not reached the potential that the Legislature envisioned. We agree that in its current form, the POV system has a number of shortcomings.

It is very timely for the Legislature to consider options -- to improve and maintain the POV system, discontinue it, or structure a transition to replace it. In his 2005-2007 budget, Governor Doyle has recommended that the State collaborate with the private sector in developing a more useful system to replace POV while maintaining POV during a transition period. I urge your consideration of this strategy. It is a smart response to growing concerns about health care costs and the need for transparent, consistent health information to support smarter health care purchasing -- the same goals that the legislative authors hoped POV would achieve.

A brief history of POV may be helpful as you consider the LAB findings and the options for improving, dropping, or replacing POV.

As you recall, the legislation authorizing POV was enacted in spring of 1998. The controversy that surrounded the legislation continued as the former Administration undertook planning and rule-making for the new system -- a process which took the better part of three years. While I do not want to defend this delay in getting started, it is fair to note that the Department attempted to mitigate the impact of conflicting views and to minimize the reporting burden on the physicians and submitter organizations.

The Department began training and initial data collection/testing in 2001 and the first full year of data collection occurred in 2002. At that time, the Department's leadership decided not to release the data in 2002 in order to check the validity of the data. Staff did undertake a number of efforts to address data quality issues -- including design features of the system developed with advice of users, written manuals for users, training of users, technical assistance to users and the redesign of

the data reporting system to respond to the experience of the first group of data submitters. (We recognize that if POV is to be retained, still more should be done to improve data consistency.)

Also in response to concerns and suggestions from initial data submitters, the Department is completing modifications to software to ease submission of data and facilitate editing of data. The intent of the Department was to phase in reporting to all physician groups after these improvements were made (although the decision to do that is now pending).

The Department began this assignment with no national standards for such a reporting system, or any model elsewhere in the country, to guide planning for implementation in Wisconsin. In this context, the creation of the POV system is an accomplishment. For just under \$3 million, the Department has designed and built the first system in the country with the capacity to report on ambulatory care data for all residents. The system is essentially at the point when, with some improvements to assure data consistency, the reporting could be made statewide and public reporting could be developed to capture some benefits from this investment.

Thus, it is particularly timely now to consider the options – whether to move forward, or take another path. Many of the limitations of data consistency and quality cited by LAB can be addressed. However, other concerns about the POV system today flow from the compromises made across competing interests as the program was created in statute and rule. Other issues are inherent in any system that uses claims data – systems that are set up by providers for billing purposes and not for purposes of health care decision-making.

In 2003, a new Governor took a fresh look at the POV system. Governor Doyle took the position in his 2003-2005 budget that if the POV data were not useful, the POV reporting mandate should be eliminated. We at DHFS accordingly put a hold on expanding POV reporting pending the Legislature's consideration of this request. As you know, the Legislature did not adopt the Governor's recommendation to eliminate POV reporting.

As a result, in 2003 and 2004, the Department continued its work to improve the POV system and initiated the first releases of POV data to the public. At the same time, the Governor and the Department conferred with a wide range of parties interested in better health information – businesses and other health care purchasers, insurers, health care organizations, and others. We are working diligently to find a high-road solution to the problems of quality and efficiency in the health care system – one that gets to the root causes of unsafe and costly health care.

On behalf of State government, three State departments -- our Department, the Department of Administration, and the Department of Employee Trust Funds -- have explored the opportunity for new partnerships with the private sector to transition from the current POV system to a replacement system. As a state government, we have a high stake in cost-effective purchasing of health care for low-income beneficiaries and government employees whose costs are paid by the taxpayers. We have a high stake, therefore, in making sure we partner with the private sector in getting good information about both the price and quality of care, including care in physician offices.

For these reasons, the Governor's budget for 2005-2007 proposes that the POV system be maintained while we establish a public and private partnership to build a better system to tell us about ambulatory care provided in Wisconsin. Since there is no other system that collects this kind of cost information currently in place, we do not want to lose ground, and give it up prematurely, before we have assurance that we can develop a better program. I am very

optimistic that a better replacement system can materialize which will allow POV to sunset no later than the end of the 05-07 biennium.

Under the Governor's budget, a newly created Board on Health Care Quality and Patient Safety with both public and private members will provide the leadership to develop a general strategy and plan for statewide automation and information system development for health care in our State. This will go much beyond the current health information reporting to strategies to automate health care decision support systems, and improve the quality and safety of health care as well as its efficiency.

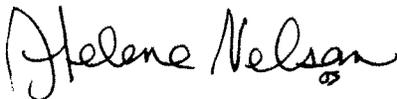
As the Legislature considers the future of POV in this session, I strongly urge that you make those decisions in the context of the truly extraordinary opportunity we have to improve health care through improved health information. Smart solutions to high health care costs include at least these three basic strategies. First, we need to promote healthy lifestyles and prevent illness and disability. Second, we need a substantial effort to transform health care to provide better quality, safer and more cost-effective care. Third, we need a stronger and smarter strategy by health care payers to use their purchasing power to give incentives to both health care providers and consumers to make cost-effective health care decisions.

Without better health information, none of these strategies will work. Furthermore, in some way, information about cost and care efficiency must be a part of this information system development to respond to concerns about the high and growing cost of health care.

Public and private health information and quality improvement initiatives underway in our State are encouraging. There is potential, however, for these various efforts to result in a fragmented and incomplete health information infrastructure. To provide the optimum solution for Wisconsin's health interests, public and private efforts should be linked in a common health information infrastructure with optimum transparency and comparability of information. This will be a key mission of the new Board on Health Care Quality and Patient Safety the Governor has proposed in his budget.

I hope that we will consider the question of whether POV should be continued or discontinued in the context of this broader analysis of how Wisconsin can achieve its goals for a solid health information infrastructure to meet purchaser needs, public health needs, and health care system quality improvement needs. As always, I appreciate the courtesy and diligence of the Committee in considering important issues like this one.

Sincerely,



Helene Nelson
Secretary



Letter Report

**Physician Office Visit
Data Program**

April 2005



Legislative Audit Bureau

22 E. Mifflin St., Ste. 500, Madison, Wisconsin 53703-4225 • (608) 266-2818

Fax: (608) 267-0410 • Web site: www.legis.state.wi.us/lab



STATE OF WISCONSIN

Legislative Audit Bureau

22 E. Mifflin St., Ste. 500
Madison, Wisconsin 53703
(608) 266-2818
Fax (608) 267-0410
Leg.Audit.Info@legis.state.wi.us

Janice Mueller
State Auditor

April 19, 2005

Senator Carol A. Roessler and
Representative Suzanne Jeskewitz, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator Roessler and Representative Jeskewitz:

As requested by the Joint Legislative Audit Committee, we have completed a review of the physician office visit data (POVD) program administered by the Department of Health and Family Services (DHFS). Chapter 153, Wis. Stats., directs DHFS to collect, analyze, and disseminate certain types of health care information. The POVD program is intended to provide a centralized, statewide source of information for outpatient health care services delivered in physician offices.

The program is funded by fees levied on physicians who are licensed and practicing in Wisconsin. Since fiscal year (FY) 1999-2000, DHFS has spent more than \$2.9 million to administer the POVD program and related projects. It is authorized 12.28 full-time equivalent positions for all health care data collection activities, but only 6.2 full-time equivalent DHFS staff worked on physician-related projects, including the POVD program, in FY 2003-04.

We found numerous problems with the program, including serious concerns with the quality, comparability, and comprehensiveness of the data. For example, there are inconsistencies in reported charges, service delivery locations, and types of services being provided. Further, DHFS is collecting information from 13 medical practice groups, representing only 30.9 percent of Wisconsin physicians, and has released data only for 2003. The data it has released have been of limited usefulness to researchers and health care professionals, although this results in part from statutory and other restrictions on data release. DHFS has yet to produce information that is usable by the general public.

In 2005 Assembly Bill 100, the Governor has proposed creating a new Health Care Quality and Patient Safety Board in October 2005. The proposed Board would be responsible for recommending changes to the POVD program, with the goal of replacing it with a new health care information system by July 2007. As it debates the Governor's proposal, the Legislature may wish to direct DHFS to address concerns with the POVD program; alternatively, the Legislature may choose to eliminate the program immediately.

We appreciate the courtesy and cooperation extended to us by DHFS staff as we conducted this review.

Sincerely,

Janice Mueller
State Auditor

JM/KW/ss

PHYSICIAN OFFICE VISIT DATA PROGRAM

1997 Wisconsin Act 231 created the physician office visit data (POVD) program to collect, analyze, and disseminate medical claims data generated from services provided by physicians in outpatient office settings. The program is funded by fees levied on physicians licensed and practicing medicine in Wisconsin and is administered by the Department of Health and Family Services (DHFS), which began collecting physician office visit data in 2002.

Physician office visit data are intended to assist health care purchasers in making informed decisions and to aid health care providers in improving quality and efficiency. Some health care purchasers and recipients also believe that health care costs could be better evaluated and potentially reduced, and quality could be improved, through public access to these data. However, other individuals and groups, including some physicians, have questioned the usefulness of these data because they may not consistently reflect diagnoses, actual charges, or other relevant information. In addition, questions have been raised about the program's cost and the reasons for delays in its implementation. In response to these concerns, and at the request of the Joint Legislative Audit Committee, we:

- analyzed program staffing and expenditures from fiscal year (FY) 1999-2000 through FY 2003-04;
- assessed whether the program is effectively meeting statutory criteria and legislative intent;
- reviewed the extent to which the privacy concerns of patients and health care providers have been addressed;
- reviewed other health care information programs, including those operated privately and in other states; and
- reviewed the roles and responsibilities of other entities involved with the POVD program, including the Board on Health Care Information, the Independent Review Board, and the Department of Regulation and Licensing.

In completing this review, we interviewed DHFS staff, representatives of medical groups required to submit program data, individuals who have signed agreements to obtain the program data, representatives of health care coalitions, and other interested parties.

Program Creation

The POVD program is one of several health care information programs implemented by DHFS and mandated under ch. 153, Wis. Stats. It was created after the 1996 Joint Legislative Council Special Committee on Health Care recommended that the State's health care information collection efforts be expanded to include information about health care provided in physicians' offices on an outpatient basis. DHFS worked with interested parties between 1998 and 2001 to develop administrative rules, which took effect in January 2001, and it began collecting data in 2002. Under the POVD program, DHFS collects information about procedures, diagnoses,

charges for services, patient demographics, and types of payers. Statutes do not specify how the data are to be used, but a user manual developed by DHFS states that the data are intended to “provide a better understanding of health care utilization and expenditures in outpatient office settings in Wisconsin.” DHFS has indicated that the data can be used:

- to analyze charges and service volume by physician specialty and location;
- to evaluate the frequency of diagnoses and procedures and to identify correlations with patient demographics;
- to compare service practices in various care settings and among physicians; and
- to track the incidence and prevalence of diseases.

Staffing, Expenditures, and Revenue

Within DHFS, the POVd program is implemented by the Bureau of Health Information and Policy in the Division of Public Health. The Bureau is authorized 12.28 full-time equivalent (FTE) positions for health care information activities that also include conducting workforce surveys to determine the number and location of various types of health care providers practicing in Wisconsin, assessing fees paid by physicians and other health care providers, and supporting the 11-member Board on Health Care Information. DHFS tracks the number of hours spent by staff on all of its physician-related projects, including the POVd program, through its time reporting system. As shown in Table 1, DHFS estimates that 6.2 FTE staff worked on physician-related projects in FY 2003-04.

Table 1

Estimated Level of Effort for Physician-Related Projects (Based on DHFS Time Reporting System)

Fiscal Year	Estimated Hours	Estimated Number of FTE Staff
1999-2000	839	0.51
2000-01	10,671	6.47
2001-02	14,267	8.65
2002-03	10,940	6.63
2003-04	10,173	6.17

The POVd program and other health care information activities under ch. 153, Wis. Stats., are funded primarily with physician fees. However, fees paid by dentists, chiropractors, and podiatrists fund some survey activities, and DHFS is authorized to recover its costs associated

with releasing physician office visit data through fees. DHFS accounting records do not separate POVD program expenditures from those of other physician-related projects that are funded by physician fees.

In the five-year period shown in Table 2, DHFS spent more than \$2.9 million to administer the POVD program and related projects. Program expenditures were relatively low in FY 1999-2000 because administrative rules were being developed at the time. In FY 1998-99, an additional \$250,000 of general purpose revenue (GPR) funded initial program costs, including a contract with the University of Wisconsin-Madison Center for Health Systems Research and Analysis, which provided assistance in developing the POVD program.

Table 2
DHFS Expenditures for Physician-Related Projects¹

	FY 1999-2000	FY 2000-01	FY 2001-02	FY 2002-03	FY 2003-04
Salary and Fringe Benefits	\$35,630	\$358,121	\$484,582	\$404,054	\$396,750
Information Technology	0	11,248	102,880	282,594	301,092
Other Supplies and Services	11,505	147,347	150,919	92,186	171,859
Total	\$47,135	\$516,716	\$738,381	\$778,834	\$869,701

¹ Includes the physician office visit data program, physician workforce survey, physician fee assessments, and Board on Health Care Information activities.

Statutes require DHFS to base the fees that fund its physician-related projects on anticipated costs, up to a maximum of \$75 per physician per year; actual amounts must be approved by the Board on Health Care Information. All Wisconsin-licensed physicians who practice in Wisconsin must pay the physician fee, regardless of whether they see patients or submit data under the POVD program, unless they are permanently retired or are employed by the federal government. We estimate that fees were levied on 63.5 percent of the 21,395 Wisconsin-licensed physicians in FY 2003-04, while the remaining physicians were exempt.

Assessment of the physician fee began in FY 2000-01, and as shown in Table 3, the amount levied, the number of physicians paying the fee, and assessment revenue have since increased. DHFS indicates that approximately 7.0 to 14.0 percent of each assessment covers the cost of conducting the physician workforce survey, and the remainder supports the POVD program and activities of the Board on Health Care Information. That Board approved a fee of \$70 per physician to cover program operations for FY 2004-05.

Table 3

Revenue from Physician Fees
 FY 2000-01 through FY 2003-04

Fiscal Year	Amount Levied	Number of Physicians Paying ¹	Revenue ²
2000-01	\$65	12,161	\$790,656
2001-02	60	12,244	712,560
2002-03	70	12,327	812,209
2003-04	70	12,936	859,054

¹ Based on the billing year, which is July 1 through June 30.

² Revenue does not exactly equal the product of the amount levied and the number of physicians paying because payments are credited to the fiscal year in which they are received.

We identified 656 physicians who did not pay the fee in FY 2003-04, representing 4.8 percent of the estimated 13,592 physicians on whom the fee was levied. Some of these physicians may have been exempt, but we could not determine why they did not pay the fee because DHFS does not actively pursue collections beyond a single follow-up letter nor does it keep records showing the reasons for unpaid assessments.

DHFS is also authorized to charge fees to recover its costs for releasing the POVD program data. Beginning in 2005, DHFS intends to charge a \$75 fee for each quarter of standard "public use" data and to implement a tiered fee for custom data sets. As shown in Table 4, custom data fees will vary depending on the time necessary to process a request, the number of reporting periods requested, whether the requested information requires calculations, and whether the data will be re-released by the requestor. To date, DHFS has charged a total of \$5,850—to one customer—as a custom data request fee. However, the fee schedule shown in Table 4 was not in place at the time of the request, and the fee was based on estimated staff costs.

Table 4

Proposed Fees for Custom Data Requests

Item	Tier 1 ¹	Tier 2 ²
Nonrefundable Data Processing Fee	\$500	\$ 500
Analyst per Hour Fee ³	60	60
Access Fee per Reporting Period	500	1,000
Additional Data Elements per Reporting Period ⁴		
Noncalculated	50	250
Calculated	250	500

¹ Includes researchers, government, and organizations that do not intend to re-release the data.

² Includes organizations that intend to re-release the data.

³ Hourly fee capped at 40 hours, or \$2,400.

⁴ Represents charges for additional data elements that are not included in the public use data.

Calculated elements include data for which DHFS must perform calculations or manipulations of the data.

DHFS has budgeted \$1.2 million for physician-related projects in FY 2004-05, an increase of 37.9 percent over FY 2003-04 expenditures of \$870,000, and the maximum amount that could be spent on the POVVD program if DHFS were to allocate all 12.28 FTE staff in the Bureau of Health Information and Policy to work on it. However, DHFS acknowledges that the actual effort devoted to the POVVD program will be less than the equivalent of 12.28 FTE staff. Further, DHFS expects to generate only \$920,000 in revenue from physician assessments and from data sales in FY 2004-05.

Chapter 153, Wis. Stats., requires DHFS to levy physician assessments based on the anticipated costs of physician-related projects and Board on Health Care Information activities, minus any carryover funds from the previous year. According to DHFS documents provided to the Board, the FY 2004-05 budget and physician assessment amounts were developed on the assumption there would be no change in the \$70 physician fee. However, we believe the proposed \$1.2 million budget for physician-related projects in FY 2004-05 is unrealistic given past staffing levels, expenditures, and anticipated revenues.

Program Implementation

Although the POVVD program was created to collect comprehensive information that could be used to compare health care costs and services statewide, problems with data quality and completeness limit the program's usefulness. For example, DHFS collects information from only 13 medical practice groups. While these groups include some of the largest practices in Wisconsin, they represent an estimated 30.9 percent of licensed physicians with Wisconsin addresses. In addition, because DHFS has not issued clear guidelines for reporting certain types of data, we found errors and inconsistencies in reporting practices.

In 14 counties, more than 50 percent of licensed physicians reported data. Additional information on reporting in these counties is provided in Table 5. Most of the 15 counties where no physicians reported information have fewer than 25 licensed physicians.

Table 5
Percentage of Physicians Reporting, by County
 (Third Quarter of 2004)

County	Number of Physicians Reporting	Estimated Number of Licensed Physicians	Percentage of Licensed Physicians Reporting
Buffalo	3	3	100.0%
Price	15	16	93.8
Rusk	13	15	86.7
La Crosse	400	529	75.6
Wood	328	495	66.3
Eau Claire	245	380	64.5
Rock	192	308	62.3
Chippewa	51	83	61.4
Trempealeau	14	23	60.9
Barron	51	86	59.3
Lincoln	17	31	54.8
Monroe	24	44	54.5
Sheboygan	95	177	53.7
Dane	1,177	2,271	51.8
All Other Counties	1,783	9,807	18.2
Wisconsin Total	4,408	14,268	30.9
Out of State	206	7,127	2.9

We also identified 206 physicians, from among 7,127 Wisconsin-licensed physicians with out-of-state addresses, who reported data. Presumably, the out-of-state physicians who reported data live outside of Wisconsin but see patients at Wisconsin clinics.

DHFS has identified another 8 large practice groups and 23 smaller groups to include in a second phase of the POV program. Independent clinics and self-employed physicians have been expected to be included in the third and final phase. However, DHFS has not established a timetable for expanding the program beyond the current 13 practice groups, in part because it is developing new software to improve data submission and editing. In addition, uncertainties about the program's future have delayed expansion.

Data Submission Concerns and Errors

Statutes require that individual physicians submit program data to DHFS, but under administrative rules promulgated by DHFS, physicians may delegate this responsibility to their medical practice groups or to outside vendors. All physicians currently submitting data have done so. Although physicians began submitting data in 2002, that was considered a test year by DHFS, and 2002 data have not been released to the public. Data collection was temporarily suspended beginning in October 2004, pending implementation of new data submission software.

As shown in Table 6, on average, 4,374 physicians submitted 3.9 million "records" in each quarter from January 2003 through September 2004. The records include information about more than 5,000 unique medical procedures, and physicians are required to submit a separate record for each service they perform during an office visit. For example, if a physician performed an immunization and a blood test during a single patient visit, two separate records would be created and reported. DHFS estimates that for the period shown in Table 6, 3.9 million records represent a quarterly average of nearly 2.4 million "office visits," with 1.7 procedures per visit.

Table 6

Summary of Physician Office Visit Data (January 2003 through September 2004)

Reporting Period	Number of Records of Procedures	Number of Estimated "Office Visits"	Number of Physicians Reporting
2003 Quarter 1	3,214,176	1,934,366	4,220
2003 Quarter 2	3,760,734	2,316,006	4,334
2003 Quarter 3	3,882,076	2,317,641	4,062
2003 Quarter 4	4,073,562	2,395,462	4,201
2004 Quarter 1	4,381,010	2,581,106	4,612
2004 Quarter 2	4,169,154	2,548,460	4,576
2004 Quarter 3	4,002,497	2,421,151	4,614
Total	27,483,209	16,514,192	--
Average	3,926,173	2,359,170	4,374

Few practice groups reported difficulty in submitting physician office visit data to DHFS electronically. However, some practice groups questioned the statutory provision that, in the interest of patient privacy, restricts DHFS from collecting all of the data captured on standardized claims forms used by physicians, which are known as "uniform patient billing

forms." According to some practice groups, the requirement that data be extracted, rather than submitted in a readily available format, creates unnecessary work and expense.

In addition, some practice groups have indicated that it is difficult to correct errors after the data have been submitted. Currently, the practice groups transfer data to the DHFS database at least quarterly, and the database generates an automatic error log for records that appear to be incorrect or improperly coded. We found that, overall, quarterly error rates ranged from 1.1 to 3.3 percent of records submitted. However, error rates varied among practice groups, and we found unusually high error rates—6.3 percent, 8.3 percent, 11.5 percent, and 24.6 percent—for four different groups in four different reporting periods. DHFS has indicated that because of staffing constraints, its review of error reports ended in October 2003. During our audit, DHFS investigated the high error rates and attributed them primarily to the use of incorrect or nonstandard procedure codes. Another commonly identified reporting error resulted from submitting data under a physician license number that is not recognized in the POVD database. Often, this error occurs because DHFS has not obtained updated information from the Department of Regulation and Licensing about newly hired physicians or physicians who changed practices.

DHFS does not require physicians to correct errors that are identified after data are submitted. Instead, physicians or practice groups may prepare written explanations that are appended to the data. Because physicians do not resubmit data after errors are identified, high error rates raise questions about the usefulness of some quarterly program data. As noted, DHFS plans to implement a new data submission and editing process in April 2005 that should make it easier for the practice groups to correct errors.

Inconsistencies in Reporting

From interviews with representatives of the 13 medical practice groups that currently submit program data, we found that claims information is reported inconsistently. Specifically:

- some practice groups report charges for services that reflect the Medicare allowable amount, while others report their retail prices, including one instance in which different facilities within the same practice group report charges for Medicare claims differently;
- practice groups do not submit comprehensive data across the various types of outpatient care settings, such as physician offices, rural and public health clinics, and outpatient hospital care;
- at least four of the practice groups submit some data for services provided by health care providers other than physicians, including nurse practitioners and physician assistants, despite the fact that DHFS has limited the POVD program to services provided by physicians;
- some of the practice groups reportedly submit data about ancillary procedures—such as laboratory, radiology, and physical therapy services—only when these procedures are ordered by the physician, while others stated that they submit all of the claims data for these types of services provided within their practice group;

- practice groups may not be submitting diagnoses codes uniformly, because the forms used for billing purposes can contain more than one diagnosis and physicians may legitimately code the principal diagnosis differently; and
- some practice groups submit in-house procedure codes that are not standardized, in addition to nationally recognized codes, to track certain procedures and services.

Such inconsistencies raise questions about the usefulness of program data for comparing service utilization, practice patterns, and charges among clinics and physicians. We found that DHFS has issued inadequate guidance to ensure consistency in reporting for some of the data it collects. For example, neither statute nor administrative code defines the term "office setting," and DHFS defines that term inconsistently in its data submission manual. In one section of the manual, 15 federally defined place-of-service codes are listed as office settings; in another section, only 6 codes are so identified. In addition, although the data submission manual requires physicians to submit data for ancillary services such as laboratory work, these services may occur in settings that have not been defined to be physician offices, and therefore may not be reported.

Further, DHFS has not conducted validation studies to ensure that all submitters are coding diagnoses and procedures uniformly. DHFS acknowledges that there are variations in how physician office visit data have been reported, but it believes that reporting practices and consistency will improve over time as the data are made available to outside users and these users pressure the submitters to become consistent.

Even if DHFS were to address the inconsistencies we identified in data reporting practices, data collected under the POVd program may not be appropriate for comparing physician charges among different types of facilities, because practice groups submit information about physician services provided in outpatient settings only, and not in inpatient settings such as hospitals and emergency departments. Although ch. 153, Wis. Stats., requires the collection of information about services provided in inpatient settings, these charges, currently collected by the Wisconsin Hospital Association under the terms of a contract with the State, represent facility charges, not professional charges for physician services. As a result, the physician charges collected through the POVd program cannot be directly compared to hospital charges.

Finally, the practice groups reported that they submit charge data that reflect the "retail" price of their services, rather than the discounted price negotiated by health plans, because the groups view their actual costs as proprietary information. Critics of the POVd program contend that the retail price does not provide health care consumers with useful information about actual costs because retail prices are rarely paid by health care purchasers.

Availability and Use of Physician Office Visit Data

Chapter 153, Wis. Stats., requires DHFS to make program data available in a variety of formats, including standard data sets for public use, standard reports for the public, and custom reports prepared by special request. We found that while safeguards are in place to ensure the protection of patient privacy, DHFS has not developed standard reports to assist the public in

making health care decisions. Further, public use data are available only for calendar year 2003, and few individuals who have requested public use data have found the information useful.

Patient and Provider Privacy

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 establishes standards to protect personally identifiable health information, and DHFS designed the POVVD program to comply with all HIPAA requirements. Furthermore, ch. 153, Wis. Stats., and ch. HFS 120, Wis. Adm. Code, prohibit DHFS from collecting patients' names, addresses, telephone numbers, employment information, and social security numbers and restrict the use and release of certain patient-identifiable data, including date of illness, age, and zip code of residence. Patient-identifiable data are also not subject to inspection, copying, or receipt under the State's open records law.

Public use data files released by DHFS can contain information about procedures and diagnoses, charges and payer type, patient age in five-year intervals, gender, county of residence, practice site, and calendar quarter of service. However, they cannot include information that would allow for the identification of specific patients, employers, or health care providers. Chapter 153, Wis. Stats., allows DHFS to release certain additional information through custom reports and data compilations only after approval by a five-member Independent Review Board. Additional data elements that may be made available are described in Appendix 2 and include information such as patient zip codes, physician identifiers, dates of service, places of service, whether the condition was the result of a work-related accident, and more detailed information about procedures. Although DHFS has the authority to promulgate administrative rules specifying circumstances under which additional data elements may be released without review by the Independent Review Board, DHFS has not promulgated rules for this purpose. Instead, both DHFS and the Independent Review Board have decided to handle requests for these data on a case-by-case basis.

Public Use Data and Custom Data Requests

DHFS has released public use data only for 2003, although data have also been collected for the first three quarters of 2004. As of January 1, 2005, DHFS has completed public data use agreements with 37 different data requestors from 24 different organizations, including 4 DHFS employees. As shown in Table 7, health care providers were the most frequent requestors, with 17 of the 37 requestors identifying themselves in this group.

Table 7

Public Use Data Requestors, by Organization Type
As of January 1, 2005

Type of Organization	Number of Organizations	Number of Individuals	Percentage of Total
Health Care Providers	11	17	46.0%
Medical or Insurance Consultants	5	5	13.5
Academic Researchers	4	5	13.5
Employer Coalition	1	4	10.8
State Agency (DHFS)	1	4	10.8
Software Vendors	2	2	5.4
Total	24	37	100.0%

We interviewed representatives of 19 organizations that requested public use data to determine the purposes for which they had requested data and whether the data met their needs. Of the five organizations that reported they found the data useful, four health care providers compared their charges with those of other providers or used the data to locate potential business opportunities, and one consultant used the data to evaluate charges for worker's compensation claims. The most commonly cited reason for the public use data not being useful was the absence of information, such as physician identifiers or more detail about procedures. As noted, some of this information cannot be released in the public use data because of statutory and other restrictions.

DHFS and the Independent Review Board have approved only two custom data requests. One of these requests was from a group of University of Wisconsin researchers analyzing variations in colon cancer screening procedures. The second was made by a group representing a coalition of employers and health care purchasers who intend to identify variations in practice patterns and charges in order to negotiate better rates with health care providers. Because analysis of the custom data sets is ongoing, we cannot confirm whether these data have proven useful for their requestors' purposes.

Standard Reports

One of the purposes for collecting and disseminating health care information stated in 1997 Wisconsin Act 231 is to provide information that can assist purchasers and the public in making informed health care purchasing decisions. Due to the technical nature of the information contained in the public use data files, it is unlikely that individuals without a medical background would find the information useful in this format. Chapter 153, Wis. Stats., requires DHFS to release standard reports that could assist in the dissemination of information to the public in language understandable to laypersons. However, DHFS has not published any standard reports, and agency officials indicate it has no plans to do so.

Future Considerations

Rising health care costs have led to an increased interest in making information about health care costs, utilization, and quality publicly available. Despite limitations, supporters of the POVVD program believe that claims data can provide useful information about health care utilization and practice patterns, and they argue that because these data are easier to collect than medical records, the data provide a useful proxy for the complete information found only in medical records. Critics of the POVVD program contend that medical claims data are generated for billing, not clinical purposes, and that the data do not provide evidence of medical outcomes that can be used to measure quality. Further, some health care providers have expressed concern that without adequate procedures to adjust for patient case severity and risk factors, these data could be misused by those wishing to compare the performance of individual physicians. Nonetheless, as consumer-directed health care plans become more prevalent, consumers and purchasers are likely to continue to request more and better information in order to make informed health care decisions.

A number of other efforts are underway in Wisconsin and nationally to publicly report health care costs, quality, and patient safety information, including some efforts to collect and report information about services provided by physicians. These efforts include government-mandated programs, voluntary private-sector initiatives, and public-private partnerships. In order to provide the Legislature with information about other sources for obtaining health care information, we reviewed examples of publicly available health care data, which are summarized below and in Appendix 3.

National Health Care Information and Quality Measurement Efforts

The National Quality Forum is a nonprofit organization that has developed quality measures for hospital care and that is in the process of establishing quality measures for physician services. The group's voluntary standards have been used by other organizations, including the federal government. Similarly, the Joint Commission on Accreditation of Healthcare Organizations—an independent, nonprofit organization that accredits more than 15,000 health care organizations in the United States—establishes performance standards for health care organizations that include hospitals, nursing homes, ambulatory surgery centers, laboratories, and health care networks.

The National Committee for Quality Assurance is a nonprofit organization that establishes standards and collects data to evaluate the performance of health plans. These data are publicly available through the Health Plan Employer Data and Information Set, which includes a standardized survey of consumers' experiences that evaluates plan performance in areas such as customer service, access to care, and claims processing. These data and standards are used by the Wisconsin Department of Employee Trust Funds, which manages health care plan options for employees of the State of Wisconsin.

The Leapfrog Group is a member organization of more than 160 private and public health care purchasers working to reduce preventable medical mistakes and to improve the quality and affordability of health care. The group uses voluntary surveys to evaluate hospitals based on four areas of quality and patient safety practices. Survey results are made publicly available.

The measures used by the Leapfrog Group include patient safety indicators such as computer-based physician order entry, which allows hospital staff to enter medication orders electronically; nationally recognized standards for hospital safe practices; and standards of care for certain high-risk procedures.

The federal Agency for Health Care Research and Quality has established a national clearinghouse of quality measures and administers the Consumer Assessment of Health Plans project, which uses questionnaires to assess health plans and services and produces reports to assist consumers in selecting health plans. It also implements the Healthcare Cost and Utilization project, which is a federal-state-industry partnership that coordinates the data collection efforts of states, hospital associations, private organizations, and the federal government and makes data on patient care provided in hospitals, emergency departments, and ambulatory surgery centers available to the public. These data are designed for use in analyzing the cost and quality of health services, medical practice patterns, access to health care programs, and outcomes of treatments.

The federal Centers for Medicare and Medicaid Services (CMS) has initiated quality initiatives for home health care, nursing homes, hospitals, and physicians. The Doctor's Office Quality project began in 2004 to measure the quality of care provided in physician offices. It is currently testing physician-level performance measures and incentives for encouraging participation, and it expects to release information in 2005. Similarly, CMS has undertaken the Hospital Quality Initiative to standardize hospital data and performance measures and to recognize and financially reward top-performing hospitals. In 2005, CMS launched "Hospital Compare," a Web site that allows users to compare hospitals based on quality measures. CMS also makes information available to the public and the health care industry as summary reports and data files. One of the advantages of the CMS projects is that they contain a large national data set of claims information for health care provided to Medicare and Medicaid patients in both inpatient and outpatient settings. One of the drawbacks is that these data represent only individuals served by the Medicare and Medicaid programs.

Many states collect health care information from hospitals, but only Maine has attempted to capture information similar to that of Wisconsin's POVVD program. The Maine Health Data Organization, which is an independent state agency, collects information about charges and services provided by physicians in outpatient settings from approximately 150 licensed health insurers and health plan administrators, rather than directly from physicians. It has also entered into a partnership with a nonprofit organization to create the Maine Health Data Processing Center, which collects, analyzes, and disseminates information. The Center began collecting data in 2003 and expects to release data to the public for the first time in 2005.

Wisconsin-Based Health Care Information and Quality Measurement Efforts

A number of Wisconsin-specific health care information efforts are also underway. Chapter 153, Wis. Stats., requires the collection and dissemination of health care information about hospitals, emergency departments, and ambulatory surgery centers. This information was collected by DHFS until responsibility was shifted under 2003 Wisconsin Act 33. Beginning in 2004, the Wisconsin Hospital Association Information Center—a wholly owned subsidiary of the Wisconsin Hospital Association—assumed responsibility for collecting hospital inpatient

discharge data and other information under a contract with the Wisconsin Department of Administration. In February 2005, some of this information was made available to the public free of charge through a Web site known as PricePoint.

In addition, the Wisconsin Hospital Association has initiated CheckPoint, a voluntary effort to report on the quality of hospital care. Under this effort, information is collected from 122 Wisconsin hospitals that are evaluated on both clinical measures and error-prevention practices, including those used in treating common causes of hospitalization such as heart attack, congestive heart failure, and pneumonia. CheckPoint also provides information about progress toward meeting five national error prevention goals endorsed by the National Quality Forum. CheckPoint's Web site is designed to provide access to performance information for each hospital and allows for comparison among hospitals.

The Wisconsin Collaborative for Healthcare Quality is a coalition of health care organizations and employers that formed in October 2002 to develop a set of common measures for evaluating health care outcomes and to publicly report on the performance of their organizations against these measures. This initiative is voluntary and relies on nationally accepted performance standards. Unlike many other initiatives, the Collaborative attempts to provide information about the continuum of health care delivered from the physician office to the inpatient hospital setting. In April 2005, the Collaborative published its most recent report, which evaluates participating organizations against the selected quality measures. The Collaborative intends to partner with the Wisconsin Hospital Association to integrate its measures with information available from CheckPoint.

Finally, a number of employer coalitions throughout Wisconsin collect, analyze, and disseminate health care information to benefit their members. One of these efforts is the nonprofit Employer Health Care Alliance Cooperative, which is a health care purchasing cooperative. The Alliance collects claims information from member employers in order to compare health care costs and has used hospital information collected by the Bureau of Health Information and Policy to create a report on hospital quality that is available to the public.

2005 Assembly Bill 100

2005 Assembly Bill 100, the 2005-07 biennial budget bill, includes a proposal that would replace the Board on Health Care Information with a new entity, the Health Care Quality and Patient Safety Board, which would be attached to the Department of Administration. The proposal would require the new board to evaluate current health care information programs and propose a new health care information system to replace the POVd program by July 1, 2007. DHFS would continue to operate the POVd program while the new board considers options for improving the collection and dissemination of physician-level health care information. The proposed budget would continue the physician assessment through the 2005-07 biennium.

DHFS officials indicate that the POVd program should be continued in the short-term. They believe the program could serve as a bridge to a new health care information system that could address the needs of health care purchasers, payers, patients, and providers and could help to ensure that the \$2.9 million investment made in the program to date is safeguarded. However, if the program is continued, the Legislature may wish to direct DHFS to address the concerns about data quality, comparability, and comprehensiveness. Alternatively, the Legislature may choose to eliminate the POVd program immediately.

As it deliberates, the Legislature may wish to note that:

- Only 30.9 percent of Wisconsin-licensed physicians currently participate in the POVd program, and there are no plans to increase that number.
- There are serious concerns with the quality and consistency of data submitted under the program, and the errors and inconsistencies limit the usefulness of reported data in evaluating health care costs and quality and in making meaningful comparisons among physicians.
- Information on services provided by physicians has not yet been made available to the general public in an easily understandable format, which was a principal goal when the POVd program was created in 1998.
- Public use data have been of limited value to those few individuals who attempted to use them, as only 26.3 percent of the organizations we surveyed indicated satisfaction with the utility of the data they received.

If the Legislature chooses to continue the POVd program either in its present form or as part of a new health care information system, we believe DHFS should implement immediate changes that include:

- developing procedures to ensure that data are submitted consistently and accurately, including clarifying the place-of-service codes and types of ancillary services that are required to be reported;
- working directly with individual practice groups to identify and correct data submission errors;
- developing and publishing standard reports that are understandable by individuals without medical backgrounds;
- making program data available in a more timely fashion;
- entering into a memorandum of understanding with the Department of Regulation and Licensing to improve the timeliness of updating physician information and to improve the assessment process; and
- reporting to the Joint Legislative Audit Committee by November 30, 2005, regarding the status of implementing these suggested changes.

■ ■ ■ ■

Appendix 1

List of Medical Practice Groups Submitting Data

Practice Group	Location of Headquarters	Number of Physicians Reporting in Third Quarter of 2004
Aurora Health Care	Milwaukee	706
Beloit Clinic, SC	Beloit	59
Covenant Health Care System, Inc.	Milwaukee	122
Dean Health System	Madison	418
Franciscan Skemp Health Care	La Crosse	150
Group Health Cooperative of South Central Wisconsin	Madison	41
Gundersen Lutheran Health Plan	La Crosse	353
Luther-Midelfort Mayo Health System	Eau Claire	200
Marshfield Clinic	Marshfield	778
Medical College of Wisconsin	Milwaukee	604
Mercy Health System	Janesville	128
ThedaCare/TouchPoint Health Plan	Appleton	104
University of Wisconsin Medical Foundation	Madison	951

Appendix 2

Overview of Physician Office Visit Data Elements

Data Element/Subset Name	Released in Public Use Files	Released with Independent Review Board Approval	May Not Be Released
Physician Affiliated Organization			
Organization ID	■		
Organization Name	■		
Employer Identification Number (EIN)			■
Physician's Name and Identification			
Name (last, first, middle, suffix)		■	
Wisconsin Physician License Number (WPIN)		■	
National Provider Identifier (NPI)		■	
Employer Identification Number (EIN)		■	
Unique Physician Identification Number (UPIN)		■	
Clinic or Service Facility Information			
Facility Name	■		
Facility Type		■	
Street Address 1	■		
Street Address 2	■		
City Name	■		
State Code	■		
Zip Code	■		
Patient Information			
Birth Date			■
Age in Years		■	
Age Group	■		
Gender	■		
Zip Code of Residence		■	
County of Residence	■		
Payer Information			
Primary Payer Category	■		
Secondary Payer Category	■		
Diagnosis			
Principal Diagnosis	■		
Diagnosis 2	■		
Diagnosis 3	■		
Diagnosis 4	■		

Data Element/Subset Name	Released in Public Use Files	Released with Independent Review Board Approval	May Not Be Released
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Diagnosis (continued)

- Diagnosis 5
- Diagnosis 6
- Diagnosis 7
- Diagnosis 8

Service Date

- Date of Service
- Service Year
- Service Quarter

Place of Service

Procedure and Modifiers

- Procedure Code
- Modifier 1
- Modifier 2
- Modifier 3
- Modifier 4

Procedure Charges Information

- Days or Units Basis Type
- Quantity
- Procedure Charges
- Total Charge in a Claim

Whether the Provider Accepts Assignment

- Assignment in General
- Medicare Assignment

Outside Lab Information

- Tests Were Sent to an Outside Lab
- Outside Lab Charges

**Patient Condition Related to Employment,
Auto Accident, or Other Accident**

- Condition Related Cause 1
- Condition Related Cause 2
- Condition Related Cause 3

Whether a Patient is Pregnant

Date of Current Illness, Injury, or Pregnancy

- Onset of Current Symptom/Illness
- Date of Accident
- Date of Last Menstrual Period

Appendix 3

Selected Sources of Health Care Information

April 2005

Source of Information	Types of Data Available	Free Web-Based Query	Data Sets Available for Purchase
Physician Office Visit Data Program <i>http://dhfs.wisconsin.gov/healthcareinfo/pov/</i>	Physician Office		■
Joint Commission on Accreditation of Health Care Organizations <i>http://www.jcaho.org/quality+check/</i>	Hospital, Ambulatory Surgery, Laboratory	■	■
National Committee for Quality Assurance <i>http://www.ncqa.org/</i>	Health Plan	■	■
Leapfrog Group <i>http://www.leapfroggroup.org/</i>	Hospital	■	■
Agency for Health Care Research Health Care Cost and Utilization Project <i>http://hcup.ahrq.gov/HCUPnet.asp</i>	Hospital, Ambulatory Surgery, Emergency Department	■	■
Hospital Compare—Centers for Medicare and Medicaid Services <i>http://www.hospitalcompare.hhs.gov/</i>	Hospital	■	■
PricePoint <i>http://www.wipricepoint.org/</i>	Hospital	■	■
CheckPoint <i>http://www.wicheckpoint.org/</i>	Hospital	■	
The Collaborative <i>http://www.wiqualitycollaborative.org/</i>	Hospital, Physician Office, Health Plan	■	



Physician Office Visit Data (POVD) Audit

- DHFS collects, analyzes, and disseminates certain types of health care information.
- Funded by fees levied on physicians who are licensed and practicing in Wisconsin.
- DHFS has spent more than \$2.9 million to administer the POVD program and related projects.
- Numerous problems with the program, including serious concerns with the quality, comparability, and comprehensiveness of the data.
 - For example, there are inconsistencies in reported charges, service delivery locations, and types of services being provided.
 - Further, DHFS is collecting information from 13 medical practice groups, representing only 30.9 percent of Wisconsin physicians, and has released data only for 2003.

Limited usefulness to researchers and health care professionals
DHFS has yet to produce information that is usable by the general public.

- In Gov's budget he proposed creating a new Health Care Quality & Patient Safety Board in Oct. '05. The proposed Board would be responsible for recommending changes to the POVD program, with the goal of replacing it with a new health care information system by July 2007.
- Legislature may wish to direct DHFS to address concerns with the POVD program; alternatively, the Legislature may choose to eliminate the program immediately.

POVD Program:

- 1997 Wisconsin Act 231 created the physician office visit data (POVD) program
- DHFS began collecting physician office visit data in 2002.
- Intended to assist health care purchasers in making informed decisions and to aid health care providers in improving quality and efficiency.
- Questioned the usefulness of these data because they may not consistently reflect diagnoses, actual charges, or other relevant information.
- Questions have been raised about the program's cost and the reasons for delays in its implementation.

Program Creation:

- POVD program created after the 1996 Joint Legislative Council Special Committee on Health Care recommended that the State's health care information collection efforts be expanded to include information about health care provided in physicians' offices on an outpatient basis
- Began collecting data in 2002.
- Information about procedures, diagnoses, charges for services, patient demographics, and types of payers.

Staffing, Expenditures, and Revenue:

- DHFS tracks the number of hours spent by staff on all of its physician-related projects. DHFS estimates that 6.2 FTE staff worked on physician-related projects in FY 2003-04.
- Funded primarily with physician fees. However, fees paid by dentists, chiropractors, and podiatrists fund some survey activities.
- DHFS accounting records do not separate POVD program expenditures from those of other physician-related projects that are funded by physician fees.
- DHFS spent more than \$2.9 million to administer the POVD program during 5 year period.
- Statutes require DHFS to base the fees that fund its physician-related projects on anticipated costs, up to a maximum of \$75 per physician per year; actual amounts must be approved by the Board on Health Care Information.
- Approximately 7 to 14 % of each assessment covers the cost of conducting the physician workforce survey and the remainder supports the POVD program and activities of the Board on Health Care Information.
 - That Board approved a fee of \$70 per physician to cover program operations for FY 2004-05.
- We identified 656 physicians who did not pay the fee in FY 2003-04, representing 4.8 percent of the estimated 13,592 physicians on whom the fee was levied.

- DHFS does not actively pursue collections beyond a single follow-up letter nor does it keep records showing the reasons for unpaid assessments.
- To date, DHFS has charged a total of \$5,850—to one customer—as a custom data request fee.
- DHFS has budgeted \$1.2 million for physician-related projects in FY 2004-05, an increase of 37.9 percent over FY 2003-04 expenditures of \$870,000.
- Assessment amounts were developed on the assumption there would be no change in the \$70 physician fee.
- Believe the proposed \$1.2 million budget for physician-related projects in FY 2004-05 is unrealistic given past staffing levels, expenditures, and anticipated revenues.

Program Implementation:

- Problems with data quality and completeness limit the program's usefulness.
 - Ex. DHFS collects info from only 13 medical practice groups.
 - Represent an estimated 30.9% of licensed physicians
- DHFS has not issued clear guidelines for reporting certain types of data; we found errors and inconsistencies in reporting practices.

Physicians Reporting Data:

- Collected information from the physicians in 13 medical practice groups since 2002.
- Physicians selection was approved by the Board on Health Care Information
- Compared physicians who reported data in the third quarter of 2004 with licensed physicians prepared by Reg. and Licensing.
- Not all of the licensed physicians would be expected to report program data because not all may see patients in an office setting;
- In 14 counties, more than 50 % of licensed physicians reported data.
- Most of the 15 counties where no physicians reported information have fewer than 25 licensed physicians.
- We also identified 206 physicians, from among 7,127 Wisconsin-licensed physicians with out-of-state addresses.
- Presumably the out-of-state physicians see patients at Wisconsin clinics.
- DHFS has identified another 8 large practice groups and 23 smaller groups to include in a second phase of the POVd program. Independent clinics and self-employed physicians have been expected to be included in the third and final phase.
- DHFS has not established a timetable for expanding the program.

Data Submission Concerns and Errors:

- Physicians may delegate this responsibility to their medical practice groups or to outside vendors. All physicians currently submitting data have done so.
- 4,374 physicians submitted 3.9 million "records" in each quarter from January 2003 through September 2004.
- Dr.'s who performed an immunization and a blood test during a single patient visit, 2 separate records would be created and reported.
- Quarterly average of nearly 2.4 million "office visits," with 1.7 procedures per visit.
- Some practice groups questioned the statutory provision that, in the interest of patient privacy, restricts DHFS from collecting all of the data captured on standardized claims forms used by physicians,
- Requirement that data be extracted, rather than submitted in a readily available format, creates unnecessary work and expense.
- Difficult to correct errors after the data have been submitted - transfer data to the DHFS database at least quarterly, and the database generates an automatic error log for records that appear to be incorrect or improperly coded.
 - Quarterly error rates ranged from 1.1 to 3.35 of records submitted.
 - Unusually high error rates—6.3 percent, 8.3 percent, 11.5 percent, and 24.6% for four different groups in four different reporting periods.
 - DHFS says staffing constraints stopped review of error reports in October 2003.
- DHFS does not require physicians to correct errors that are identified after data are submitted.
 - May prepare written explanations that are appended to the data.
 - High error rates raise questions about the usefulness of some quarterly program data.

inconsistencies in Reporting:

- Some practice groups report charges for services that reflect the Medicare allowable amount, while others report their retail prices.
- Do not submit comprehensive data across the various types of outpatient care settings (ex. rural and public health clinics)
- At least 4 of the practice groups submit some data for services provided by health care providers other than physicians (ex. Physician assistants)
- Some of the practice groups reportedly submit data about ancillary procedures (ex. Lab)
- Practice groups may not be submitting diagnoses codes uniformly
- Some practice groups submit in-house procedure codes that are not standardized
- Such inconsistencies raise questions about the usefulness of program data for comparing service utilization, practice patterns, and charges among clinics and physicians.
- DHFS has issued inadequate guidance to ensure consistency in reporting for some of the data it collects.
- Neither statute nor administrative code defines the term "office setting"
- DHFS defines that term inconsistently in its data submission manual
- 15 federally defined place-of-service codes are listed as office settings; in another section, only 6 codes are so identified.
- DHFS has not conducted validation studies to ensure that all submitters are coding diagnoses and procedures uniformly.
- DHFS believes that reporting practices & consistency will improve over time as the data are made available to outside users and these users pressure the submitters to become consistent.
- Data collected under the POVd program may not be appropriate for comparing physician charges among different types of facilities, because practice groups submit information about physician services provided in outpatient settings only, and not in inpatient settings such as hospitals and emergency departments.
 - Wisconsin Hospital Association under the terms of a contract with the State, represent facility charges, not professional charges for physician services.
 - Physician charges collected through the POVd program cannot be directly compared to hospital charges.
- Submit charge data that reflect the "retail" price of their services, rather than the discounted price negotiated by health plans.
- Critics of the POVd program contend that the retail price does not provide health care consumers with useful information about actual costs because retail prices are rarely paid by health care purchasers.

Availability and Use of Physician Office Visit:

- DHFS to make program data available in a variety of formats
- Standard data sets for public use, standard reports for the public, and custom reports prepared by special request.
- Public use data are available only for calendar year 2003, and few individuals who have requested public use data have found the information useful.

Patient and Provider Privacy:

- Prohibit DHFS from collecting patients' names, addresses, telephone numbers, employment information, and social security numbers and restrict the use and release of certain patient-identifiable data, including date of illness, age, and zip code of residence.
- DHFS has the authority to promulgate administrative rules specifying circumstances under which additional data elements may be released without review by the Independent Review Board; DHFS has not promulgated rules for this purpose. Instead, both DHFS and the Independent Review Board have decided to handle requests for these data on a case-by-case basis.

Public Use Data and Custom Data Requests:

- Released public use data only for 2003, although data have also been collected for the first three quarters of 2004.
- Health Care Providers represent 46% of total public use data requestors
- We interviewed representatives of 19 organizations
- 5 organizations that reported they found the data useful, four health care providers compared their charges with those of other providers or used the data to locate potential business opportunities
- Most commonly cited reason for data not being useful -- absence of information, such as physician identifiers or more detail about procedures. (some of info cannot be released)

Standard Reports:

- Provide information that can assist purchasers and the public in making informed health care purchasing decisions.
- Technical nature of the information contained in the public use data files, it is unlikely that individuals without a medical background would find the information useful
- Requires DHFS to release standard reports that could assist in the dissemination of information to the public in language understandable to laypersons. However, DHFS has not published any standard reports, and agency officials indicate it has no plans to do so.

Future Considerations:

- Rising health care costs have led to an increased interest in making information about health care costs, utilization, and quality publicly available.
 - Supporters of the POVD program claim:
 - data can provide useful information about health care utilization and practice patterns,
 - data provide a useful proxy for the complete information found only in medical records.
 - Critics of the POVD program claim:
 - medical claims data are generated for billing, not clinical purposes, and that the data do not provide evidence of medical outcomes that can be used to measure quality,
 - concern that without adequate procedures to adjust for patient case severity and risk factors, these data could be misused by those wishing to compare the performance of individual physicians.

National Health Care Information and Quality Measurement Efforts:

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- National Committee for Quality Assurance is a nonprofit organization establish standards and collect data that is used by ETF.
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- Federal Agency for Health Care Research & Quality has established national clearinghouse of quality measures & administers Consumer Assessment of Health Plans project.
- Federal Centers for Medicare and Medicaid Services (CMS) has initiated quality initiatives for home health care, nursing homes, hospitals, and physicians.
- Many states collect health care information from hospitals, but only Maine has attempted to capture information similar to that of Wisconsin's POVD program.
 - collects information about charges and services provided by physicians in outpatient settings from approximately 150 licensed health insurers and health plan administrators, rather than directly from physicians.
 - partnership with a nonprofit organization to create the Maine Health Data Processing Center
 - Collecting data in 2003 and expect to release data this year.

WI-Based Health Care Information & Quality Measurement Efforts:

- Wisconsin-specific health care information efforts are also underway.
- 2003 Wisconsin Act 33 Wisconsin Hospital Association—assumed responsibility for collecting hospital inpatient discharge data and other information under a contract with DOA - Web site known as PricePoint.
- Wisconsin Hospital Association has initiated CheckPoint, a voluntary effort to report on the quality of hospital care.
- Wisconsin Collaborative for Healthcare Quality develop a set of common measures for evaluating health care outcomes and to publicly report on the performance of their organizations against these measures.

Budget Bill:

- **Proposal that would replace the Board on Health Care Information with a new entity, the Health Care Quality and Patient Safety Board attached to DOA.**
 - **Require the new board to evaluate current health care information programs and propose a new health care information system to replace the POVd program by July 1, 2007. DHFS would continue to operate the POVd program while the new board considers options for improving the collection and dissemination of physician-level health care information. The proposed budget would continue the physician assessment through the 2005-07 biennium.**
- **DHFS officials indicate that the POVd program should be continued in the short-term to serve as a bridge to a new health care information system.**
- **If the program is continued, the Legislature may wish to direct DHFS to address the concerns about data quality, comparability, and comprehensiveness.**
- **Alternatively, the Legislature may choose to eliminate the POVd program immediately.**

As it deliberates, the Legislature may wish to note that:

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- There are serious concerns with the quality and consistency of data submitted under the program, and the errors and inconsistencies limit the usefulness of reported data in evaluating health care costs and quality and in making meaningful comparisons among physicians.
- Information on services provided by physicians has not yet been made available to the general public in an easily understandable format, which was a principal goal when the POVd program was created in 1998.
- Public use data have been of limited value to those few individuals who attempted to use them, as only 26.3 % of organizations surveyed indicated satisfaction with of data received.

If the Legislature chooses to continue the POVd program either in its present form or as part of a new health care information system, we believe DHFS should implement immediate changes that include:

- developing procedures to ensure that data are submitted consistently and accurately, including clarifying the place-of-service codes and types of ancillary services that are required to be reported;
- working directly with individual practice groups to identify and correct data submission errors;
- developing and publishing standard reports that are understandable by individuals without medical backgrounds;
- making program data available in a more timely fashion;
- entering into a memorandum of understanding with the Department of Regulation and Licensing to improve the timeliness of updating physician information and to improve the assessment process; and
- reporting to the Joint Legislative Audit Committee by November 30, 2005, regarding the status of implementing these suggested changes.