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Health Care Quality and Patient Safety Board (Health and Family Services and Administration)

[LFB 2005-07 Budget Summary: Page 24, #10 and Page 267, #8]

CURRENT LAW

Under current law, the Board on Health Care Information (BHCI) is attached to the Department of Health and Family Services (DHFS). The BHCI consists of 11 members, one of whom must be a record administrator registered by the American Medical Record Association, at least two of whom must be employer purchasers of health care, and five of whom must be or represent health care 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 the Governor must appoint. BHCI members are appointed for four-year terms.

The 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 Chapter 153 of the statutes on health care information; (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 Chapter 153; and (d) provide information to an interagency coordinating council. The BHCI also must approve the amounts assessed by DHFS to physicians for the physician office visit data program (POVD) and to physicians, nurses, and other health care providers for a workforce survey.

GOVERNOR

Eliminate the Board on Health Care Information. Effective October 1, 2005, eliminate the Board on Health Care Information and delete all statutory references to the Board.

Transfer $250,000 annually and 2.2 positions, beginning in 2005-06, to the Department of Administration (DOA) to support the Health Care Quality and Patient Safety Board (HCQPSB), as created in the bill. Provide that: (a) the assets and liabilities of DHFS primarily related to the functions of the Board, as determined by the DOA Secretary, are transferred to DOA; (b) all incumbent employees holding positions in DHFS performing duties primarily related to the Board are transferred to DOA, and that they have all of the same labor and employment relations rights and status following the transfer as they enjoyed immediately before the transfer; (c) all tangible property, including records, of DHFS that is primarily related to the Board is transferred to DOA; (d) all contracts entered into by DHFS in effect that are primarily related to the functions of the Board remain in effect and are transferred to DOA, which must carry out any obligations under the contract until it is modified or rescinded by DOA to the extent allowed under the contract; (e) all rules promulgated by the Board remain in effect until their specified expiration date or until amended or repealed by the new Board; and (f) any matter pending with the Board is transferred to the new Board and all materials submitted to or actions taken by the board with respect to the pending matter are considered as having been submitted to or taken to the new Board.

Suspend Enforcement of Rules. Effective July 1, 2007, prohibit DHFS from enforcing rules promulgated under Chapter 153 relating to the POVD. Also, on the effective date of the bill, prohibit DHFS from enforcing rules relating to any of the following: (a) the collection, from physicians, of health care plan affiliations and updating information, hospital privileges updating information, and workforce and practice information; (b) the collection, from dentists, chiropractors, and podiatrists, of workforce and practice information; and (c) procedures for verification, review, and comment on the information identified under (a) and (b), to adjust the information, and to waive the information collection requirement.

Health Care Quality and Patient Safety Board. Provide $10,250,000 SEG in 2005-06 and $250,000 SEG in 2006-07 and 2.2 positions annually to fund grants and operations of a new Health Care Quality and Patient Safety Board (HCQPSB), first effective October 1, 2005. Attach the Board administratively to DOA.

Health Care Quality Grants and Loans. Authorize the Board to make grants and loans to clinics, health maintenance organizations, hospitals, and physicians for the following purposes: (a) installation of computer-assisted physician order entry, electronic medical records, or other information system infrastructure, including clinical decision support systems, to improve the quality, safety, and efficiency of patient care; (b) development of health information exchanges, integrated health care data repositories, and systems to facilitate the reporting of quality, safety, and efficiency information for purposes of health care system improvement or related purposes by informing consumers and health care purchasers; (c) demonstration, through pilot projects, of

rapid cycle improvements in quality, safety, and efficiency of care; and (d) facilitation of group purchases of medical technology systems by assisting health care providers in forming collaborative agreements for technology. Provide that loan repayments made under this provision would be deposited in the health care quality improvement fund (HCQIF).

Coordinating Council. Require the Interagency Coordinating Council to report at least twice annually to the Board concerning the Council's activities on state health care data collection. Currently, the Council reports to the Health Care Information Board.

Members of the Health Care Quality and Patient Safety Board. Create the HCQPSB as a nine-member Board with the following membership: (a) the Secretary of DHFS, or designee; (b) the Secretary of the Department of Employee Trust Funds, or designee; (c) the Secretary of DOA, or designee; (d) a physician holding a license approved by the Medical Examining Board; (e) a representative of hospitals; (f) an employer purchaser of health care; (g) a representative of the insurance industry; (h) a representative of health maintenance organizations; and (i) one member representing the public interest. Specify that the members of the Board who do not serve because of their government positions would serve staggered four-year terms. Provide for initial terms of such members, and specify that the initial appointment would be made on the first day of the fourth month beginning after the effective date of the provision. Specify that the chair of the Board would be designated biennially by the Governor.

Board Responsibilities and Authority. Require the Board to: (a) report to the Governor by January 1, 2006, and at least annually thereafter, on its plans, activities, accomplishments, and recommendations; (b) assess on an annual basis the extent to which health care providers in the state use automated information and decision support systems; (c) assess on an annual basis options and develop a plan and specific strategies to achieve automation of all health care systems in Wisconsin by 2010 (or as soon as practicable); and (d) administer the new health care quality improvement fund. Authorize the Board to accept gifts, grants, bequests, and devises to be used in the execution of its functions.

Provide that DHFS, and the Independent Review Board under the agency, may promulgate only those rules under Chapter 153 that are first approved by the Board. Provide that the Wisconsin Health and Educational Facilities Authority may not provide financial assistance to a hospital or health facility or institution, unless such an entity demonstrates to the Board that it is making progress to improve medical information systems technology.

Studies Undertaken by the Board. Require the Board to study and make recommendations to the Governor, by March 1, 2006, concerning the feasibility of creating a centralized physician information database, including the feasibility of a joint public-private effort.

By October 1, 2006, require the Board to do all of the following: (a) make a recommendation regarding DHFS rulemaking relating to claims data; (b) promote the collection and availability of information regarding the quality and price of health care required to enable

consumers and health care purchasers to make wise health care choices; and (c) foster the creation and evolution of public-private health care partnerships, agreements on standard health care data sets and reporting protocols, and transparency of health information for purchasing purposes, including the development of an integrated health care data repository.

Development of Plans and Strategies. By January 1, 2007, require the Board to develop plans and strategies to do the following: (a) provide the loans and grants authorized under the bill; (b) deploy health care information systems technology for health care quality, safety, and efficiency within a reasonable time using reasonable investments; and (c) consider the extent to which an integrated and interoperable system or underlying technology is the most cost-effective. This consideration would have to include an assessment of the benefits of the system in terms of its rapid deployment to medical care practitioners, promotion of accurate and appropriate shared information about patients among the providers, standardization of performance indicators, and the provision of public reporting of quality, safety, and efficiency data for consumer and health care purchaser decision making.

DISCUSSION POINTS

Health Care Quality Grants and Loans

1. Numerous studies have identified the benefits health care providers, including clinics, hospitals, HMOs and physicians, can realize, and have realized, by increasing their use of information technology (IT) in delivering health care services. Several recent publications have summarized these findings, and provided recommendations for policymakers.

In Crossing the Quality Chasm: A New Health System for the 21st Century (2001), the Institute of Medicine (IOM) identified the "enormous" potential IT systems have to improve the quality of health care, citing studies concluding that: (a) automated order entry systems can reduce errors in drug prescribing and dosing; (b) automated reminder systems improve compliance with clinical practice guidelines; (c) IT improvements can make health care more "patient centered" by facilitating access to clinical knowledge through understandable and reliable Web sites; (d) investments in IT can improve timeliness of information by providing patients and providers immediate access to automated clinical information, diagnostic and treatment results; and (e) clinical decision support systems have been shown to improve efficiency by reducing redundant laboratory tests.

The IOM report indicated that a key component of these IT applications is the automation of patient-specific clinical information. In 1991, IOM recommended the nationwide implementation of computer-based patient records. The IOM report indicated that the automation and linking of data on services provided to patients in ambulatory and institutional settings, including data on encounters, procedures, and ancillary tests, would provide a rich source of information for quality measurement and improvement purposes.

However, the report cites four barriers to the automation of clinical information: (a) privacy concerns; (b) the slow progress that has been made in the development and adoption of national standards for the definition, collection, coding and exchange of patient medical information; (c) the significant costs incurred by health care organizations to purchase and install new technologies, including transitional costs and education and training costs; and (d) human factors, such as the reluctance of providers to embrace new technologies, and the potential altering of clinician and patient relationships that may result as more information is automated and available to patients.

While recognizing the potential benefits of improved IT systems, the IOM report indicated that the evidence that supports these benefits varied by type of application. The report provided several reasons, such as the fact that many of these applications are in the early developmental stage, that they rely on computerized patient information that may not be available, and regulatory and legal impediments.

2. In October, 2003, the U.S. General Accounting Office (now the Government Accountability Office) issued a report that identified 20 examples of IT initiatives that resulted in reported cost savings or other benefits, such as shorter hospital stays and faster communication of test results. With respect to clinical care functions, organizations reported benefits that included fewer medication errors, faster communication of clinical care and test results, reduced costs of documenting clinical care, improved quality of care, more accurate and complete medical documentation, and reductions in length of hospital stays. With respect to administrative functions, organizations reported decreases in staff costs, improvements in processing information and financial management, and improved communications. The report also identified some of the lessons these organizations learned by adopting IT initiatives, including the need to redesign business processes and workflows, ensure "ownership" of IT initiatives to facilitate the adoption of technologies and its benefits, and to ensure that staff are adequately trained.

3. In an article that appeared in the July/August 2003 issue of *Health Affairs*, Goldsmith, Blumenthal and Rishel described the U.S. health care system as "mired in a morass of paper records and bills, fax transmittals and unreturned phone messages." The authors cited an estimate that 17 percent of physicians in office-based practices have computerized their patient records.

The authors indicated that less than 10 percent of U.S. providers have adopted computerized patient records (CPRs, which are also referred to as electronic medical records), and less than five percent have adopted computerized physician order entry (CPOE) systems. The administration estimates that between 15 and 31 percent of Wisconsin physicians use CPRs. In making its estimate, the administration has relied on a national survey, the results of which were published in the March, 2005, issue of the journal *Advance Data From Vital and Health Statistics*. The study found that during 2001-03, electronic medical records were used less often in physician offices (17 percent), than in hospital emergency settings (31 percent).

CPOE is a computer application that accepts a physician's orders, including orders for medications, laboratory and other diagnostic tests, for diagnostic and treatment services electronically, rather than the physician recording them on an orders sheet or prescription pad. The computer can compare the orders against standards for dosing, check for allergies or interactions with other medications, and warn the physician about potential problems. Consequently, a CPOE system does not merely replace a paper system -- it makes relevant information available at the time the order is received and applies rules-based logic to help the physician make optimal ordering decisions.

Goldsmith, Blumenthal and Rishel, in their *Health Affairs* article noted that, by not adopting available technologies, health systems continue to incur costs due to illegible prescriptions, unconfirmed verbal orders, missed telephone calls, and lost medical records that place patients at risk. However, the authors indicated that, because of the lack of uniform technical standards and both financial and regulatory barriers to physicians adopting these tools, CPRs offered by different vendors will not interface easily with current computer systems in hospitals and physician offices.

The authors noted the high cost of adopting these technologies -- a larger hospital's conversion to a CPOE system may cost as much as $30 million, a 200-bed hospital could expect to spend between $1 million and $7 million. In addition to these capital costs, the authors indicated that health systems invest significant staff time in choosing and implementing CPOE systems. Such investments must be weighed against investments in other capital and operations costs. The authors also noted that hospitals have varying degrees of access to capital, and thus, varying abilities to invest in such systems.

Finally, the authors recommend that the federal government provide matching funds for clinical systems development based on provider's fiscal capacity and effort, and to provide technical assistance to enable providers to convert their records to electronic format.

4. The provisions in AB 100 relating to the purposes for which the Board could distribute grants and loans are intended to provide the new Board maximum flexibility in determining which projects to fund, after reviewing available literature on the costs and benefits of these types of projects and considering a wide variety of proposals that could result in improvements in health care quality. Potential grant applicants have different abilities to support these projects -- some may be able to repay a loan or provide matching funds with ongoing sources of revenue. Others, such as organizations that are encouraging health care providers to report health care quality, safety and efficiency information (such as the Wisconsin Collaborative for Healthcare Quality, for example), may be less able to repay a loan.

On the other hand, if the Committee decides to approve the Governor's proposal to provide funding to support the types of healthcare quality improvement projects specified in AB 100, the Committee could amend the bill to ensure that the funding is targeted in a manner that ensures recipient cost-sharing and demonstrations of need. For example, the Committee could: (a) specify that all funding provided by the Board be provided as loans, rather than grants; (b)

require a 50% match requirement for all grant or loan recipients; or (c) require all grant and loan recipients to demonstrate that they could not implement these health care quality improvement projects in the absence of the state assistance.

5. Alternatively, the Committee could determine that funding should not be provided for these activities for several reasons. First, some may object to the funding source the Governor has recommended for the program -- the health care quality improvement fund, supported largely from moneys transferred from the injured patients and families compensation fund and the proceeds from revenue obligation bonds. Second, some would argue that, given the state's fiscal constraints, the state should not at this time provide financial assistance for certain types of projects, such as: (a) the installation of CPOE systems that health care providers are currently funding in the absence of state support; or (b) the collection, dissemination and exchange of health care information that is currently being done through ongoing governmental and nongovernmental efforts.

Location of Oversight Board

6. DHFS estimates that approximately 0.10 FTE is devoted to staffing the BHCI and DHFS. Under the administration's proposal, 2.20 PR FTE would be transferred to DOA to support the activities of the HCQPSB, including a research analyst position, a program assistant position, and a portion of a position for IT support. Under the bill, the HCQPSB, in addition to assuming the BHCI's existing responsibilities under Chapter 153 of the statutes, would undertake a number of studies, assess on an annual basis the extent to which health care providers in the state use automated information and decision support systems, develop a plan and specific strategies to achieve automation of all health care systems in Wisconsin by 2010 (or as soon as practicable); and administer the new health care quality improvement fund. Additionally, the HCQPSB could accept gifts, grants, bequests, and devises to be used in the execution of its functions.

7. The current 11-member BHCI has no state agency representative, whereas the proposed nine-member HCQPSB would have three state agency representatives -- one each from DOA, DHFS, and ETF. While the BHCI and proposed HCQPSB each has members representing health care purchasers, physicians, and hospitals, the BHCI's membership is more heavily weighted toward health care providers.

8. One of the rationales advanced for the attachment of the HCQPSB to DOA is that one member of the nine-member Board would be the Secretary of DOA, or the Secretary's designee. It is the administration's intent that, given the emphasis on IT initiatives, the administrator of DOA's Division of Enterprise Technology (or other high-ranking Division employee) would be the Secretary's designee on the Board. Presumably, this individual could then make available the Division's staff to provide guidance on IT issues, including evaluating the IT components of the grant and loan proposals submitted to the Board by clinics, health maintenance organizations, hospitals and physicians.

9. Currently, the Division is responsible for managing the state’s IT resources and using technology to improve government efficiency. The Division: (a) provides computer services

to state agencies and some local governments; (b) operates a statewide voice, data, and video telecommunications network; (c) in cooperation with state agencies, develops strategies, policies, and standards for state government-wide use of IT resources; (d) provides training, research, and print and mail services to other state agencies; and (e) provides statewide computer systems for district attorneys and coordinating electronic information sharing among the courts, district attorneys, and justice agencies at the state and local levels. The administrator of the Division is considered the state's chief information officer. The Division recovers the costs of providing IT services through fees charged to users.

10. Attaching the Board to DOA is intended to recognize the broader mission of the HCQPSB in comparison to the BHCI, and to facilitate the IT system evaluations. Arguably, these types of evaluations could still be provided to the Board, regardless of where in state government the Board is housed administratively. As a result of the membership structure of the Board, DOA would still be involved in evaluations of the proposals involving IT system, but the new Board could be attached to DHFS, since that agency maintains most of the health care data the state collects.

The Physicians Office Visit Database

11. The physician office visit data program (POVD) is intended to provide a centralized, statewide source of information for outpatient health care services delivered in physicians' offices. Chapter 153 of the statutes directs DHFS to collect, analyze, and disseminate medical claims data generated from services provided by physicians in outpatient settings. The POVD is funded by fees levied on physicians practicing in Wisconsin and was intended to provide a public data source to aid health care consumers in making informed decisions, and also to help health care providers improve quality and efficiency. Physicians licensed in Wisconsin paid $70 in 2003-04 to fund the POVD and a related workforce survey. Fees paid by dentists, chiropractors and podiatrists also funded some workforce survey related activities. Additionally, DHFS is authorized to charge fees to recover its costs for releasing POVD data. For 2004-05, DHFS anticipates revenue of $904,800 based on 12,926 paid assessments.

12. The DHFS Bureau of Health Information and Policy administers the POVD. DHFS is authorized 12.28 PR FTE to perform such activities as implementing the POVD and workforce surveys on physicians and other health care providers, updating publications such as the consumer guide to health care, and supporting the BHCI. DHFS estimates that it devotes the equivalent of 6.0 FTE annually to the POVD. Further, DHFS estimates that it devotes 0.50 FTE to updating the consumer guide to health care.

13. As noted in a recently completed audit by the Legislative Audit Bureau (LAB), some physicians, and others, have questioned the usefulness of the POVD data, and have complained about the program's cost and delayed implementation. LAB analyzed DHFS staffing and expenditures related to the POVD, and assessed whether the POVD was effectively meeting statutory criteria and legislative intent.

14. The LAB audit found numerous problems with the POVD program, including problems with data quality and completeness that limit the program's usefulness. DHFS has been phasing in data collection, opting to collect data from 13 practice groups chosen mainly on the bases of their large volumes of data, information technology capabilities, and geographic diversity. LAB estimates that these practice groups represent approximately 31 percent of licensed physicians with Wisconsin addresses, although all Wisconsin-licensed physicians pay an annual assessment to support the program. DHFS does not intend to expand the number of physicians reporting in the 2005-07 biennium, citing uncertainty over the program's future and the fact that BHCI is developing new software to improve data submission and editing. Additionally, the LAB found high error rates among data submitted by some practice groups and sporadic monitoring of the errors at DHFS. DHFS plans to implement a new data submission and editing process in 2005 that should make it easier for practice groups to correct errors.

15. LAB interviews with representatives from the 13 practice groups currently submitting data revealed problems and inconsistencies in reporting, even within practice groups. These problems and inconsistencies included: (a) reporting charges reflecting the Medicare allowable amount for some services, but the retail price for others; (b) failure to submit comprehensive data across outpatient care settings; (c) submitting data to the POVD regarding services provided by health care practitioners other than physicians, such as nurse practitioners and physician assistants; and (d) failure to submit uniform diagnosis and procedure codes. As noted by the LAB, these inconsistencies raise questions about the collected data's usefulness for comparing services and charges among practice groups and physicians.

16. The LAB audit suggests that one reason for the data's limited usefulness may be attributable to inadequate guidance from DHFS, citing as an example a lack of specificity in administrative code regarding the phrase "office setting," and inconsistencies in DHFS' data submission manual regarding examples of office settings. Additionally, DHFS has not conducted validation studies in an effort to ensure that all practice groups are coding diagnoses and procedures uniformly. According to LAB, DHFS has acknowledged variations in how POVD data have been reported, but believes that reporting practices and consistency will improve over time, as the data are made available to outside users and the users pressure submitters to become consistent.

17. In addition to identifying inconsistencies in data reporting, the LAB audit raises questions of data utility even if it were to be reported consistently. For example, POVD data are to be collected from physicians in outpatient settings only, not from services rendered in hospitals or emergency room settings. Data regarding services rendered in hospitals and ambulatory surgery centers are collected by the Wisconsin Hospital Association Information Center, a subsidiary of the Wisconsin Hospital Association (WHA), under a contract with the state beginning in 2004. WHA made the information available free on the Internet in February, 2005. Also, practice groups reported that they submit charge data to the POVD that reflects the "retail" price of their services, rather than the discounted price paid by health plans or actual costs, citing proprietary reasons. The administration reports that under its proposal, the broader mission of the HCQPSB will include examining options for a more comprehensive database that may include outpatient physician data and data from hospitals and ambulatory surgery centers.

18. The LAB audit also found that DHFS failed to develop standard reports that would help consumers make health care decisions. The technical nature of the information contained in POVD public use data files would likely limit its usefulness to persons without a medical background. DHFS has released public POVD data only for 2003, however, no standard reports attempting to provide information in a format understandable to ordinary consumers have been published. DHFS has completed public data use agreements with 37 data requestors. Additionally, while POVD public use data are sufficiently protective of patient privacy in the wake of the Health Insurance Portability and Accountability Act (HIPAA), the lack of detail in the data has limited its usefulness to some who have requested the data. Moreover, as the LAB audit reports, POVD critics contend that the medical claims data to be collected by the POVD are generated for billing purposes, not clinical purposes, and thus the data do not provide evidence of medical outcomes that can be used to measure quality, and in fact could be misused by those wishing to compare physician performance without first adjusting for patient case severity and risk factors. Largely on these bases, some argue that it appears the POVD has done little to advance the goal of the legislation creating it, namely to collect and disseminate health care information in a manner that will meet the needs of consumers in selecting health care plans and providers.

19. DHFS and the administration report that the sunset of the POVD rules effective July 1, 2007, as provided in AB 100 is meant to coincide with the development of a replacement system that is "more robust, efficient, and usable." The administration reports that the DHFS Secretary and the Secretary of Employee Trust Funds have been meeting with health care industry leaders, insurers, and other health care purchasers to explore creating an integrated ambulatory care information base to replace the POVD, consistent with the direction in AB 100 to study and make recommendations concerning the feasibility of creating a centralized physician information database, including through a joint public and private effort.

20. The administration further notes that it is optimistic that the public-private collaboration already underway, together with the framework created in AB 100, will produce a replacement system for the POVD that is superior and meets the goal of providing information to consumers regarding the quality and price of health care that will enable them to make wise health care choices.

21. The LAB report also notes that there are a number of national health care information and quality measurement efforts designed to establish quality measures for physician services, evaluate the performance of health plans, improve the quality and affordability of health care, and assist consumers in selecting health care plans. These include initiatives by nonprofits such as the National Quality Forum, the National Committee for Quality Assurance, and the Leapfrog Group, as well as the federal Agency for Health Care Research and Quality. In addition a number of Wisconsin-specific health care information efforts are also underway. These include: (a) a program initiated by the Wisconsin Hospital Association, called CheckPoint, which involves a voluntary effort to report on the quality of hospital care; (b) an effort by a coalition of health care organizations called the Wisconsin Collaborative for Healthcare Quality, which evaluates participating health care organizations with regard to a number of nationally accepted performance standards; and (c) efforts by employer coalitions throughout the state, such as the nonprofit

Employer Health Care Alliance Cooperative, a health care purchasing cooperative that collects data from member employers to compare health care costs. DHFS asserts that, despite its shortcomings, the POVD is the only existing comprehensive approach to assessing the quality and costs associated with care delivered by physicians in outpatient settings. Further, DHFS states that if the POVD were eliminated, the state would forgo the opportunity to collect data on service and cost data on care delivered by 31 percent of the state's physicians in the biennium.

22. If the Committee decides to maintain the POVD program, it could modify the Governor's proposal as recommended in the LAB audit report. Specifically, the Committee could require DHFS to implement immediate changes, including: (a) developing procedures to ensure that data are submitted consistently and accurately, including clarifying in administrative rule the place-of-service codes and types of ancillary services that are required to be reported; (b) working directly with individual practice groups to identify and correct data submission errors; (c) developing and publishing standard reports that are understandable by individuals without medical backgrounds; (d) making program data available in a more timely fashion; (e) 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 (f) reporting to the Joint Legislative Audit Committee by November 30, 2005, regarding the status of implementing these suggested changes.

23. Alternatively, for the reasons cited in the April, 2005, LAB report, the Committee may choose to eliminate the POVD program immediately, delete 6.0 FTE in the DHFS Bureau of Health Care Information and Policy, and associated salary and fringe expenditure authority.

24. In summary, under the alternatives presented below, the Committee may: (a) approve all of the Governor's provisions relating to this item (Alternatives A1, B1, and C1); (b) modify the Governor's recommendations (Alternatives A2, B2, C2, or C3); or (c) delete all of the Governor's provisions relating to this item (Alternatives A3, B3, and C4).

ALTERNATIVES

1. Approve, modify, or delete the Governor's proposal by adopting one or more of the alternatives within each group.

A. Health Care Quality Grants and Loans

1. Approve the Governor's recommendations relating to health care quality grants.

2. Modify the Governor's recommendations by choosing one or more of the following:

a. Specify that all funding provided by the Board be provided as loans, rather than grants.

b. Require a 50% match requirement for all grant or loan recipients.

c. Require that all grant or loan recipients demonstrate that they could not implement the health care quality improvement projects in the absence of state assistance.

3. Delete all funding and provisions relating to health care quality grants and loans.

Alternative A3	**SEG**
2005-07 FUNDING (Change to Bill)	**-** $10,000,000

B. Creation of the Health Care Quality and Patient Safety Board

1. Adopt the Governor's recommendations that relate to the creation and responsibilities of the Health Care Quality and Patient Safety Board, its attachment to DOA, and the transfer of $250,000 SEG and 2.20 SEG positions from DHFS to DOA.

2. Modify the Governor's recommendations by attaching the new Board to DHFS, rather than DOA, and retaining the positions to support the new Board in DHFS.

3. Delete the provision, and retain the current Health Care Information Board.

C. Physician Office Visit Data Program

1. Adopt all of the Governor's recommendations relating to the POVD program.

2. Delete the provision prohibiting DHFS from enforcing rules promulgated under Chapter 153 relating to the POVD effective July 1, 2007. In addition, modify the program by requiring that DHFS implement the following changes with respect to the physicians office visit data (POVD) program: (a) develop procedures to ensure that data are submitted consistently and accurately, including clarifying in administrative rule the place-of-service codes and types of ancillary services that are required to be reported; (b) work directly with individual practice groups to identify and correct data submission errors; (c) develop and publish standard reports that are understandable by individuals without medical backgrounds; (d) make program data available in a more timely fashion; (e) enter 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 (f) report to the Joint Legislative Audit Committee by November 30, 2005, regarding the status of implementing these suggested changes.

3. Repeal the program, effective July 1, 2005. Repeal the POVD assessment fee, and delete 6.0 PR positions in DHFS, effective July 1, 2005 and delete $330,800 PR in 2005-06 and 2006-07 to reflect this change. Reduce estimated revenue to DHFS by $891,300 in 2005-06 and $893,500 in 2006-07.

Alternative C3	**PR**
2005-07 REVENUE (Change to Bill)	**-** $1,784,800
2005-07 FUNDING (Change to Bill)	**-** $330,800
2006-07 POSITIONS (Change to Bill)	**-** 6.00

4. Delete all provisions relating to the POVD.

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