CHAPTER 407

POLICIES AND PROCEDURES FOR HEALTH MAINTENANCE ORGANIZATION QUALITY OF CARE DATA

Article 1

Definitions and general information

12 VAC 5-407-10. Definitions

The following words and terms, when used in this chapter, shall have the following meaning unless the context clearly indicates otherwise:

"Board" means State Board of Health.

"Code" means the Code of Virginia.

"Commissioner" means the State Health Commissioner.

"Consumer" means any person (i) whose occupation is other than the administration of health activities or the provision of health services, (ii) who has no fiduciary obligation to a health care institution or other health agency or to any organization, public or private, whose principal activity is an adjunct to the provision of health services, or (iii) who has no material financial interest in the rendering of health services.

"Department" means the State Department of Health.

"Health maintenance organization" or "HMO" means any person who undertakes to provide or to arrange for one or more health care plans pursuant to Chapter 43 (§ 38.2-4300 et seq.) of Title 38.2 of the Code.

"HEDIS" means the Health Plan Employer Data and Information Set, a set of standardized performance measures sponsored, supported and maintained by the National Committee for Quality Assurance.

"NCQA" means the National Committee for Quality Assurance.

"Nonprofit organization" means a nonprofit, tax-exempt health data organization with the characteristics, expertise, and capacity to execute the powers and duties set forth for such entity in this chapter.

12 VAC 5-407-**2**0. Statement of General Policy

The Commonwealth of Virginia has recognized the need of consumers and purchasers of health insurance to have information on the quality of care provided by HMOs licensed in the Commonwealth.

12 VAC 5-407-30. Purpose of regulations

Sections 32.1-276.4 and 32.1-276.5 of the Code requires the nonprofit organization to collect, analyze and make public certain data and findings relating to health care providers and health maintenance organizations which operate within the Commonwealth of Virginia. Section 32.1-276.5 of the Code authorizes the board to promulgate regulations necessary to carry out its responsibilities, as they relate to the dissemination of these data and as prescribed in the Code. This chapter serves to (i) establish the policies and procedures for the collection and submission of quality of care data by HMOs; (ii) establish the policies and procedures for exemption from these requirements; (iii) establish procedures for the collection of fees associated with the collection and publication of the quality of care data; and (iv) establish the duties of the Board and the non-profit organization for these purposes.

12 VAC 5-407-40. Administration of Regulations

A. The board has the responsibility for promulgating regulations pertaining to the quality of health maintenance organizations.

B. The commissioner is the executive officer for the State Board of Health and is vested with the authority of the board when it is not in session, pursuant to Sections 32.1-18 and 32.1-20 of the Code, subject to the rules and regulations of and review by the board.

12 VAC 5-407-50. Applicability

This chapter shall apply to all HMOs with an active license to operate in this Commonwealth.

Article 2

Quality of Care Data Reporting

12 VAC 5-407-60. Reporting Requirements for Health Plan Data

A. Every HMO shall make available to the commissioner those HEDIS measures, or a subset thereof, that are required by NCQA for accreditation.

B. The board may contract directly with NCQA to purchase the selected HEDIS measures on behalf of the HMOs.

12 VAC 5-407-70. Exception to HEDIS Reporting

A. The board may approve and require quality of care data other than the HEDIS measures provided that reasonable notice is given to the HMOs in writing.

12 VAC 5-407-80. Exemption from Reporting

A. Every HMO with an active license in the Commonwealth shall be required to submit HEDIS or other approved quality of care data approved by the board unless granted a written exemption by the commissioner.

B. A HMO may, in writing, petition the commissioner for an exemption. The commissioner, at his discretion, may grant a waiver of the HEDIS or other approved

quality of care data. In considering a petition for waiver, the commissioner may give due consideration to the HMO's (i)number of covered lives, (ii) length of operating experience in Virginia, (iii) accreditation status with respect to NCQA or other national accrediting organizations; or (iv) any other relevant factors he deems appropriate.

12 VAC 5-407-90. Audited Data Required

A. Data submitted by HMOs is required to be verified by an independent auditing organization with no financial interest in or managerial association with the HMO.

B. HMOs not accredited by NCQA may submit audited HEDIS measures so long as those measures have undergone a compliance audit by an NCQA-certified HEDIS compliance auditor.

C. HMOs whose data are not audited by NCQA-certified auditors will have a notice to that effect published with their quality information data.

12 VAC 5-407-100. Process for Data Submission

A. Before December 1, the Commissioner shall submit to each HMO in writing the process required for data submission. The HMO shall provide as directed the HEDIS or other quality information by September 15 of each year.

B. The non-profit organization shall publish annually the quality information data before December 31.

12 VAC 5-407-110. Fees

A. For each HMO required to provide information pursuant to this chapter, the board shall prescribe a reasonable fee to cover the cost of collecting and making available such data. Each HMO shall pay for the cost to the department for purchase of the

HEDIS data directly from NCQA. The remainder of the cost associated with making the data available on the Internet shall be divided among the participating HMOs in a tiered format based on the number of enrollees per HMO.

B. Fees described in subdivision A, above, shall not exceed $3,000 per HMO.

C. The payment of such fees shall be on September 15. The nonprofit organization providing services pursuant to an agreement or contract as provided in § 32.1-276.4 of the Code shall be authorized to charge and collect the fees prescribed by the Board in this section when the data are provided directly to the nonprofit organization. Such fees shall not exceed the amount authorized by the board.

C. The nonprofit organization providing services pursuant to an agreement or contract as provided in § 32.1-276.4 of the Code shall be authorized to charge and collect reasonable fees for the dissemination of the HEDIS data or other approved quality of care data; however, the commissioner, the State Corporation Commission, and the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services shall be entitled to receive relevant and appropriate data from the nonprofit organization at no charge.

12VAC5-407-120. Late charge.

A. A late charge of $25 per working day shall be paid to the board by an HMO that has not received an exemption from the commissioner as provided for in 12VAC5-407-80 and that does not submit a complete filing of the quality of care data required by 12VAC5-407-60 and 12VAC 5-407-70 pursuant to the times established in 12VAC5-407-100.

B. Late charges may be waived by the board, in its discretion, if an HMO can show that an extenuating circumstance exists. Examples of an extenuating circumstance include, but are not limited to, the installation of a new computerized system, a bankruptcy proceeding, or change of ownership in the HMO.

C. The board may also assess a late charge of $25 per working day on any fees paid by HMOs after the due dates.

Article 3

Duties of the Board and the Nonprofit Organization

12VAC5-407-130 Contract with the Non-Profit Organization

A. The commissioner shall negotiate and contract with a nonprofit organization authorized under § 32.1-276.4 of the Code for compiling, storing, and making available to consumers the data submitted by HMOs pursuant to 12VAC5-407-60 and 12VAC5-407-70.

B. The nonprofit organization shall assist the board in developing a quality of care data set for such HMOs and shall, at the commissioner's discretion, periodically review this information set for its effectiveness.

C. Via the Internet, the nonprofit organization shall make available to consumers all data required by the board to be reported to the commissioner.

12VAC5-407-140. Biennial Evaluation

A. The board shall evaluate biennially the impact and effectiveness of the quality of care data and the appropriateness of the fee structure. This evaluation shall be completed by October 1.

B. As part of the biennial evaluation, the board may consult with the HMOs and the non-profit organization to determine whether changes should be made to the quality of care data requirements.

12VAC5-407-150. Other Duties of the Board

A. The board shall:

a. Maintain records of its activities relating to the dissemination of data reported by HMOs; and

b. Collect and account for all fees, as described in this chapter, and deposit the moneys so collected into a special fund from which the expenses attributed to this chapter shall be paid.