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 require the Commissioner to negotiate and enter into contracts with a nonprofit organization to collect, analyze and publish certain data and findings related to health care providers and health maintenance organizations that 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 collection and dissemination of these data and as prescribed in the Code. This chapter serves to (i) establish the policies and procedures for the compiling, storing and making available to consumers the HEDIS or any other quality of care or performance information set approved by the Board pursuant to this section; (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. 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 5-407-50. Reporting Requirements for HMO Data

A. Every HMO shall make available to the commissioner those HEDIS or any other quality of care or performance information set, or a subset thereof

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

12 VAC 5-407-60. 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 5-407-70. Exemption from Reporting

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

B. An HMO may, in writing, petition the commissioner for an exemption. The commissioner, at his/her discretion, may grant a waiver from reporting the HEDIS or any other approved quality of care or performance information set . In considering a petition for waiver, the commissioner may give due consideration to the HMO's (i) sample size; (ii) 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/she deems appropriate.

C. An HMO which can demonstrate that it does not meet NCQA's minimum sample size requirements to collect statistically valid information on at least fifty (50)% of the HEDIS effectiveness of care measures or performance information sets approved by the Board shall be exempt from reporting the HEDIS quality of care or performance sets during the reporting period. The HMO shall submit documentation to the Commissioner each reporting period to demonstrate that it meets the criteria for obtaining an exemption from reporting.

D. Options for Data Submission

   a. The Commissioner may purchase HEDIS data from NCQA that includes all HMO's operating in the Commonwealth that submit HEDIS data to NCQA.

   b. HMOs that did not submit data directly to NCQA must submit the performance information sets approved by the Board to the Non-profit organization in accordance with the timeframes established by the Commissioner.

12 VAC 5-407-80. 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 whose performance information set is audited by an NCQA- certified HEDIS compliance auditor will have a notice to that effect published with their HEDIS data.

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

12 VAC 5-407-90. Process for Data Submission

A. Before March 1 of each year, the Commissioner shall submit to each HMO in writing the process required for data submission, obtaining a waiver from reporting and the amount of the fee to be paid. HMOs providing HEDIS or any other quality of care or performance information set directly to the Commissioner shall submit the data by September 15 of each year.

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

12 VAC 5-407-100. 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. The Commissioner may purchase HEDIS data on behalf of all the actively licensed HMOs in the Commonwealth that are participating in HEDIS and divide the cost among the HMOs. Each HMO shall pay its share of the cost to the Board for purchase of the HEDIS data directly from NCQA. The remainder of the cost

associated with making the data available 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 per year.

C. The payment of such fees shall be on September 15 of each year. 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.

D. 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 approved by the board for making available 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.

E. HMOs shall be entitled to receive relevant and appropriate HMO data as defined by and from the nonprofit organization, with input from the HMO Industry at no charge.

12VAC5-407-110. 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 12VAC5-407-70 and that has not paid the assessed fees by September 15. The late fee may not be assessed until completion of a thirty (30) day grace period for submitting the data.

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.

Article 3

Duties of the Board and the Nonprofit Organization

12VAC5-407-120 Contract with the Non-Profit Organization

A. The commissioner shall negotiate and contract with a nonprofit organization pursuant to §32.1-276.4 of the Code for compiling, storing, and making available to consumers the data submitted by HMOs pursuant to 12VAC5-407-50 and 12VAC5-407-60.

B. The nonprofit organization shall assist the Board in developing a summary plan and budget to collect and make available HMO HEDIS or any other quality of care performance information set results for consumers. The nonprofit organization shall present the summary plan and budget on a biennial basis to the Board for approval. The Commissioner, at his or her discretion shall also review the summary plan on a periodic basis to determine its effectiveness.

C. The nonprofit organization shall collect the HEDIS data in the most cost-effective manner available.

D. The nonprofit organization will prepare a biennial summary plan in identifying the measures selected for reporting. The summary plan shall include:

    a. The rationale for selecting each measure to be made available to consumers

b. The goal of reporting each measure

c. The cost and benefit of collecting the measures and making them available to consumers

d. The scope of dissemination of information in paper or electronic format and the target audience.

E. The nonprofit organization shall prepare an biennial budget which includes a cost benefit analysis of purchasing HEDIS data from NCQA or obtaining the information performance sets directly from the HMOs.

F. The nonprofit organization will present the summary plan and budget to the Board for review an approval on a biennial basis.

G. The nonprofit organization shall organize, present and make available to consumers all data required by the board to be reported to the commissioner.

12VAC5-407-130. Biennial Evaluation

A. The Board shall evaluate biennially the impact and effectiveness of collecting and making available HEDIS or any other quality of care or performance information set, 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 HEDIS or any other quality of care or performance information set requirements.

12VAC5-407-140. 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.