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OFFICE OF WEST VIRGINIA SECRETARY OF STATE

WEST VIRGINIA LEGISLATURE
Legislative Rule-Making Review Committee

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August 16, 1999

NOTICE OF ACTION TAKEN BY LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

TO: Ken Hechler, Secretary of State, State Register

TO: Donna S. Quesenberry
Insurance Commission
PO Box 50540
Charleston, WV 25305

FROM: Legislative Rule-Making Review Committee

Proposed Rule: **Quality Assurance Standards for Prepaid Limited Health Service Organizations, 114CSR56**

The Legislative Rule-Making Review Committee recommends that the West Virginia Legislature:

1. Authorize the agency to promulgate the Legislative Rule
   (a) as originally filed ✓
   (b) as modified by the agency ____

2. Authorize the agency to promulgate part of the Legislative rule; a statement of reasons for such recommendation is attached. ____

3. Authorize the agency to promulgate the Legislative rule with certain amendments; amendments and a statement of reasons for such recommendation is attached. ____

4. Authorize the agency to promulgate the Legislative rule as modified with certain amendments; amendments and a statement of reasons for such recommendation is attached. ____

5. Recommends that the rule be withdrawn; a statement of reasons for such recommendation is attached. ____

SCANNED

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Aug 9 1 25 PM '99

OFFICE OF WEST VIRGINIA SECRETARY OF STATE

ANALYSIS OF PROPOSED LEGISLATIVE RULES

Staff Counsel: Rita A. Pauley
Date: August 6, 1999
Agency: Insurance Commissioner
Subject: Quality Assurance Standards for Prepaid Limited Health Service Organizations, 114 CSR 56

PERTINENT DATES

Filed for public comment:	June 8, 1999
Public comment period ended:	July 8, 1999
Filed following public comment period:	July 12, 1999
Filed LRMRC:	July 12, 1999
Filed as emergency:	N/A
Fiscal Impact:	None

ABSTRACT

This proposed new rule implements the provisions of the Prepaid Limited Health Service Organization Act which was passed during the 1999 legislative session. The new rule sets forth the standards for quality assurance programs which must be met by each prepaid limited health service organization prior to the issuance of a certificate of authority to transact insurance business in the State of West Virginia.

Prepaid limited service organization is a public or private organization providing or making available to individuals no more than 4 limited health services. These services may be provided either directly through a panel of providers who are employees or partners of the organization, or by contracts with other providers. These services are prepaid.

The proposed rule is new. The following is a section by section synopsis of the proposed rule.

SCANNED

Section 1 is the standard general section, setting forth the scope, authority, filing date and effective date of the proposed rule.

Section 2 is the definition section.

Section 3 sets forth the goals for a quality assurance program. Prepaid limited health service organizations are to develop quality assurance programs that will assure the provision of appropriate medical services for their members as well as address the effectiveness of quality of care that the members receive. Other goals for quality assurance programs include monitoring of, evaluating and improving the quality of health care. The prepaid limited health service organizations are to develop a systematic process to promote the delivery of medically appropriate care in a timely, efficient and effective manner. They are also to direct members and providers toward the goal of quality, cost effective health care. They are to provide a mechanism for identifying potential utilization issues and referring them to the utilization program.

Section 4 sets forth the requirements for a quality assurance program. Each prepaid limited health service organization is required to develop a quality assurance program which adheres to all applicable to all state and federal laws regulations and rules. Should the commissioner determine that the quality assurance programs should become deficient in addition to any other remedies available, the commissioner may establish a corrective action plan which must be followed as a condition to the issuance or maintenance of certificate of authority for the prepaid limited health service organization.

Each application or renewal of certificate of authority filed with the commissioner must be accompanied by a description of the prepaid health service organization's quality assurance plan. the plan maybe inspected at the commissioner's office pursuant to a Freedom of Information Act request under Chapter 29B of the West Virginia Code.

The prepaid health service organization must notify the insurance commissioner prior to making any modification in its quality assurance program. The basic components of a quality assurance program must include organizational arrangements and

delegation of responsibilities for quality management and improvement processes, a documented utilization review program, written policies and procedures for a credentialing and recredentialing physicians and other health care providers, a written policy addressing member's rights and responsibilities, and adoption of practice guidelines for the use of preventive health services.

If a prepaid limited health service organization delegates any of it quality assurance program to contractors, it must still oversee an audit of all of the contracted activities. The prepaid limited health service organization retains the ultimate responsibility for meeting the requirements of this rule.

No prepaid limited health service organization may offer any inducement nor place restriction upon any provider or primary care physician which would limit the communication of medical advice or options available to the member or to act in any way to limit the communication between the physician or patient. No prepaid limited health service organization is allowed to offer any provider or primary care physician an incentive plan as an inducement to deny, release, limit or delay specific, medically necessary and appropriate services.

Diagnosis, treatment or other information regarding the health of the member is confidential and shall not be disclosed under four circumstances. Confidential information may be disclosed, if necessary, to carry out the purpose of the rule and if it is allowed by law; with the express consent of the member; or as provided by statute or court order when required for the production of evidence or for discovery; and in the event of a claim or litigation between the member and the service organization. Prepaid limited health service organizations that release confidential information under one of the rule's exceptions are not liable for the disclosure or any subsequent use or misuse of the information.

Section 5 sets forth the requirement for the quality management and improvement portions of the quality assurance program. Organizational arrangements and responsibilities for quality management and improvement processes must be clearly defined and assigned to appropriate individuals. There must be a detailed, written description of the program which is to be

reviewed annually and updated as necessary. A medical director is required to have a substantial involvement in quality improvement activities. A committee must be created to oversee quality improvement and must include providers as active participants. The quality improvement committee is accountable to the governing body. All findings, conclusions, recommendations, actions taken and results of actions taken as a result of the quality improvement process shall be documented and reported to the appropriate individuals and committees within the organization. Quality improvement information is to be coordinated with other performance monitoring and management functions of the prepaid limited health care services organization. Requirement to participate in quality improvement activities must be included in all provider contracts and employment agreements. The prepaid limited health services organizations are required to monitor and evaluate clinical issues from in-patient facility services, partial facility services or ambulatory services, high volume diagnosis or services, and high risk diagnosis services or other special populations. Such monitoring and evaluation is to reflect members of its covered population.

Prepaid limited health service organizations are required to adopt and use practice guidelines or specific criteria that are reasonable scientific evidence. The guidelines and any updates must be given in writing to all providers. The organization is required to develop and implement mechanisms for assessing performance against the practice guidelines; evaluating member continuity and coordination of care; detecting under- and over-utilization; and assessing patient outcomes. A prepaid limited health service organization must establish written standards for the availability of coordinating providers. The standards must insure that the organization's referral and triage functions are appropriately implemented and monitored.

Section 6 details the requirements for the utilization management program. The utilization management program must at a minimum include performance goals, policies and procedures to evaluate medical necessity, criteria used, information sources, and the process used and approve the provision of limited health services. The utilization management program must have professionally accepted, preestablished criteria for the preauthorization of services and for concurrent review of admissions. A duly licensed physician must conduct a review of the

medical appropriateness of any denial of services. The program must provide that decisions regarding provision of limited health services shall be made in a timely manner depending upon the urgency of the situation. Prepaid limited health service organizations may have policies and procedures in place to evaluate the appropriate use new medical technologies, or new applications of established technologies.

Section 7 provides the requirements for credentialing and recredentialing prepaid limited health service organizations. An organization must ensure that its network has sufficient number and types of providers to meet member's needs. It must have a written plan for maintaining an adequate network to assure the availability of primary care and specialty practitioners. The organizations must have written policies and procedures for the credentialing for all providers that include the original credentialing, recredentialing, recertification and/or reappointment of physicians and other licensed, independent practitioners who fall under its scope of authority and action. In terms of credentialing and recredentialing a prepaid limited health service organization must obtain and review verification of several items from their primary sources. These include such things as verification of a current, valid licensed practice; graduation from medical school or appropriate graduate school; completion of a residency or other specialty training and board certification, if applicable; complete work history; current adequate malpractice insurance; complete professional liability claims history; and other such information. At least once every three years, the prepaid limited health service organization must confirm that the health delivery organization continues to be in good standing with the state and federal regulatory bodies and, if applicable, is reviewed and approved by appropriate accrediting authorities.

Section 8 sets forth the members rights and responsibilities. A prepaid limited health service organization must demonstrate commitment to treating members with respect by developing written policies giving members the right to the following: voice grievances about the organization or the care provided; have information concerning the organization, its services, the providers, and the members rights and responsibilities; participate in decision making regarding limited health services; be treated with respect and recognition of their dignity and need for privacy; and permit the provider or other person designated by the member or

a court to make and enforce all health care decisions which the member could make if he or she had the capacity or were competent. All policies on members rights and responsibilities must be provided in writing in clear and concise to all members and participating providers. These policies must include such things as how to submit a claim for covered services; how to obtain primary and specialty care; what is included in after hours and emergency coverage; how to obtain out-of-area coverage and how to appeal decisions which adversely the members.

Section 9 explains the requirements for preventive health services. A prepaid limited health service organization is required to adopt guidelines for the use of preventive health services based on reasonable medical evidence and the full service population. The guidelines and all updates must be provided in writing to all providers and members. The guidelines shall be developed or adopted with the participation of providers and must include a mechanism for periodic updates.

Section 10 sets forth the requirement for handling treatment records. A prepaid limited health service organization must require its providers to have an organized treatment record keeping system. The records must be maintained in a manner that is current, detailed, organized and permits effective patient care and quality review. The prepaid limited health service organization must have written standards for treatment records, the systemic review for conformance and the institution of correction action when standards are not met.

Section 11 is a general severability and anti-discrimination section.

AUTHORITY

Statutory authority: W.Va. Code, §33-2-10, which provides, in part, as follows:

§33-2-10.

> The commissioner is authorized to promulgate and adopt such rules and

regulations relating to insurance as are necessary to discharge his duties and exercise his powers and to effectuate the provisions of this chapter and to protect and safeguard the interests of policyholders and the public of this state.

ANALYSIS

I. HAS THE AGENCY EXCEEDED THE SCOPE OF ITS STATUTORY AUTHORITY IN APPROVING THE PROPOSED LEGISLATIVE RULE?

No.

II. IS THE PROPOSED LEGISLATIVE RULE IN CONFORMITY WITH THE INTENT OF THE STATUTE WHICH THE RULE IS INTENDED TO IMPLEMENT, EXTEND, APPLY, INTERPRET OR MAKE SPECIFIC?

Yes.

III. DOES THE PROPOSED LEGISLATIVE RULE CONFLICT WITH OTHER CODE PROVISIONS OR WITH ANY OTHER RULE ADOPTED BY THE SAME OR A DIFFERENT AGENCY?

No.

IV. IS THE PROPOSED LEGISLATIVE RULE NECESSARY TO FULLY ACCOMPLISH THE OBJECTIVES OF THE STATUTE UNDER WHICH THE PROPOSED RULE WAS PROMULGATED?

Yes.

V. IS THE PROPOSED LEGISLATIVE RULE REASONABLE, ESPECIALLY AS IT AFFECTS THE CONVENIENCE OF THE GENERAL PUBLIC OR OF PERSONS AFFECTED BY IT?

Yes.

VI. CAN THE PROPOSED LEGISLATIVE RULE BE MADE LESS COMPLEX OR MORE READILY UNDERSTANDABLE BY THE GENERAL PUBLIC?

No.

VII. WAS THE PROPOSED LEGISLATIVE RULE PROMULGATED IN COMPLIANCE WITH THE REQUIREMENTS OF CHAPTER 29A, ARTICLE 3 AND WITH ANY REQUIREMENTS IMPOSED BY ANY OTHER PROVISION OF THE CODE?

Yes.

VIII. OTHER.

Counsel has suggested technical modifications.