Department of Legislative Services

Maryland General Assembly
2010 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 723 (Senator Munson)
Finance Health and Government Operations

Health Insurance - Clinically Integrated Organizations

This bill authorizes insurers, nonprofit health service plans, and health maintenance organizations (HMOs) (carriers) to enter into a contract with a "clinically integrated organization" to pay for the coordination of covered services to qualifying individuals and specified incentives to promote the efficient, medically appropriate delivery of covered medical services to qualifying individuals. A clinically integrated organization that enters into an agreement with a carrier for incentive payments authorized under the bill must, after discussing parameters and analytical methods with the Maryland Health Care Commission (MHCC), submit an evaluation of its program to MHCC within three years of the agreement's effective date. MHCC must then summarize the evaluation, including any recommendations for legislative action, and submit the summary to the House Health and Government Operations and Senate Finance committees. Finally, the bill requires carriers to share medical information about covered individuals with a clinically integrated organization and its members under certain circumstances.

The bill takes effect July 1, 2010.

Fiscal Summary

State Effect: Special fund expenditures increase minimally, as early as FY 2011 for MHCC to consult about evaluation parameters and then review any clinically integrated organization evaluations submitted. Future years reflect costs associated with reviewing additional evaluations and summarizing those evaluations for specified legislative committees.

Local Effect: The bill does not materially affect local government finances.

Small Business Effect: None.

Analysis

Bill Summary: The bill defines a "clinically integrated organization" as a joint venture between a hospital and physicians that:

- has received an advisory opinion from the Federal Trade Commission (FTC) or its staff and has been established to evaluate and improve the practice patterns of the health care providers and create a high degree of cooperation, collaboration, and mutual interdependence among the health care providers who participate in the joint venture to promote the efficient, medically appropriate delivery of covered medical services; or
- is accountable for total spending and quality and the Insurance Commissioner determines meets the criteria established by the federal Department of Health and Human Services for an accountable care organization.

The Insurance Commissioner, in consultation with MHCC, may adopt regulations specifying the types of permissible payments and incentives for clinically integrated organizations. A carrier must file a copy of its contract with a clinically integrated organization with the Insurance Commissioner, and if the contract includes a provision to pay a bonus or other incentive that does not comply with State law, the Insurance Commissioner must provide a copy of the contract to MHCC. Contracts provided to the Insurance Commissioner and MHCC are confidential and privileged.

Current Law: The Health Occupations Article defines an "alternative health care system" as a system of health care delivery other than a hospital or related institution. It includes an HMO; preferred provider organization; independent practice association; community health center that is a nonprofit, freestanding ambulatory health care provider governed by a voluntary board of directors and that provides primary health care services to the medically indigent; freestanding ambulatory care facility; or any other health care delivery system that utilizes a medical review committee.

A medical review committee evaluates and seeks to improve the quality of health care provided by health care providers; evaluates the need for and the level of performance of health care provided by health care providers; evaluates the qualification, competence, and performance of health care providers; or evaluates and acts on matters that relate to the discipline of any health care provider. A medical review committee can be a State or federal entity, a health care provider professional association, a professional standard review organization, or other group permitted by law. There are 15 types of entities afforded medical review committee status.

Generally, a medical review committee's proceedings, records, and files are confidential and not admissible or discoverable. However, if a civil action is brought by a party to a medical review committee's proceedings who claims to be aggrieved by the committee's decision, the records and files would be subject to discovery.

Under the federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, "covered entities," including carriers, health care clearinghouses, and health care providers, may not use or disclose protected health information, except either as the privacy rule permits or as an individual authorizes in writing. Covered entities may disclose protected health information without an individual's authorization for such purposes as treatment, payment, health care operations, and public interest activities.

Background: TriState Health Partners, Inc. (TriState), a physician-hospital organization based in Hagerstown, Maryland, requested that FTC's Bureau of Competition review its proposal to integrate and coordinate the provision of medical care services to patients by TriState's more than 200 physician members, as well as with the Washington County Hospital. The FTC opinion letter, issued April 2009, indicated that staff would not recommend that FTC challenge the organization's proposed clinical integration program at that time, and concluded that the proposed cooperation among doctors and a hospital had the potential to lower health care costs and improve quality of care.

State Expenditures: Special fund expenditures increase minimally, as early as fiscal 2011 but within three years, for MHCC to consult about evaluation parameters and then review any clinically integrated organization evaluations submitted. Future years reflect costs associated with reviewing additional evaluations and summarizing those evaluations for specified legislative committees. MHCC anticipates the number of evaluations submitted to be relatively small; with up to two agreements entered into in the first year and increasing in later years to as many as 16. However, the exact number cannot be determined at this time.

MHCC advises that the cost associated with reviewing evaluations will be minimal and that summarizing each evaluation will cost approximately $2,000.

Additional Information

Prior Introductions: None.

Cross File: HB 1093 (Delegate Donoghue) - Health and Government Operations.

Information Source(s): CareFirst Blue Cross/Blue Shield, Department of Budget and Management, Maryland Health Insurance Plan, Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Legislative Services

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