Unofficial Copy 1996 Regular Session
J1 6lr2575

By: Senators Young and Bromwell
Introduced and read first time: February 8, 1996
Assigned to: Rules

A BILL ENTITLED

AN ACT concerning

Health - Benefit and Evaluation Requirements

FOR the purpose of requiring certain health insurers and health maintenance organizations to provide inpatient hospitalization coverage for certain persons for a specified minimum length of time under certain circumstances; providing a certain exception; providing for the appeal of certain decisions; providing for the waiver of external review of quality requirements for certain health maintenance organizations under certain circumstances; requiring the Secretary of Health and Mental Hygiene to establish a Unified Credentialing Information System for certain health occupations; requiring the Secretary to adopt certain regulations; requiring a study of certain provisions of law regarding appeals of decisions byhealth maintenance organizations; establishing a Committee to issue recommendations and to issue a report by a certain date; defining certain terms; andgenerally relating to health insurance and health maintenance organization coverage, quality review and evaluation, and health occupational credentialing requirements.

BY repealing and reenacting, with amendments,
Article 48A - Insurance Code
Section 354F, 470H, 477-I, and 490DD(b)
Annotated Code of Maryland
(1994 Replacement Volume and 1995 Supplement)

BY adding to
Article - Health - General
Section 19-703(g)
Annotated Code of Maryland
(1990 Replacement Volume and 1995 Supplement)

BY repealing and reenacting, with amendments,
Article - Health - General
Section 19-705.1
Annotated Code of Maryland
(1990 Replacement Volume and 1995 Supplement)

BY repealing

Article - Health - General
Section 19-1305.4
Annotated Code of Maryland
(1990 Replacement Volume and 1995 Supplement)

BY adding to
Article - Health Occupations
Section 1-211
Annotated Code of Maryland
(1994 Replacement Volume and 1995 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article 48A - Insurance Code

354F.

(A) Every nonprofit health insurer who issues or delivers a health insurance policy to any person in this State under which any hospitalization benefits are provided for normal pregnancy shall provide those benefits for the cost of hospitalization for childbirth to the same extent as the hospitalization benefit provided in the policy for any covered illness.

(B) (1) IN THIS SUBSECTION, "ATTENDING PHYSICIAN" MEANS AN OBSTETRICIAN, PEDIATRICIAN, OR OTHER PHYSICIAN ATTENDING THE MOTHER OR NEWBORN CHILD.

(2) THE HOSPITALIZATION BENEFITS REQUIRED UNDER SUBSECTION (A) OF THIS SECTION SHALL INCLUDE, FOR A MOTHER AND NEWBORN CHILD, COVERAGE FOR A MINIMUM OF:

(I) 48 HOURS OF INPATIENT HOSPITALIZATION CARE FOLLOWING A VAGINAL DELIVERY; AND

(II) 96 HOURS OF INPATIENT HOSPITALIZATION CARE FOLLOWING A CESAREAN SECTION.

(3) A NONPROFIT HEALTH INSURER THAT PROVIDES COVERAGE FOR POSTDELIVERY CARE FOR A MOTHER AND NEWBORN CHILD IN THE HOME IS NOT REQUIRED TO PROVIDE THE MINIMUM LENGTH OF INPATIENT HOSPITALIZATION COVERAGE UNDER PARAGRAPH (2) OF THIS SUBSECTION, UNLESS THE ATTENDING PHYSICIAN, CONSISTENT WITH CRITERIA OUTLINED IN THE MOST CURRENT VERSION OF THE "GUIDELINES FOR PERINATAL CARE" PREPARED BY THE AMERICAN ACADEMY OF PEDIATRICS AND THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, DETERMINES THAT INPATIENT HOSPITALIZATION IS NECESSARY.

(4) (I) IF A NONPROFIT HEALTH INSURER RENDERS AN ADVERSE DECISION CONCERNING COVERAGE UNDER THIS SUBSECTION, AND THE ATTENDING PHYSICIAN BELIEVES THAT THE DECISION WARRANTS AN IMMEDIATE

APPEAL, THE ATTENDING PHYSICIAN SHALL HAVE THE OPPORTUNITY TO APPEAL THE ADVERSE DECISION BY TELEPHONE ON AN EXPEDITED BASIS.

(II) AN EXPEDITED APPEAL SHALL CONSIST OF AN IMMEDIATE AND TIMELY REVIEW BETWEEN THE ATTENDING PHYSICIAN AND THE MEDICAL DIRECTOR OF THE NONPROFIT HEALTH INSURER OR PHYSICIAN AUTHORIZED TO ACT IN THE ABSENCE OF THE MEDICAL DIRECTOR.

(III) IF A DECISION REGARDING THE EXPEDITED APPEAL IS NOT RENDERED IN SUFFICIENT TIME TO ALLOW THE MOTHER AND NEWBORN THE BENEFITS UNDER PARAGRAPH (2) OF THIS SUBSECTION, THEN THE NONPROFIT HEALTH INSURER MAY NOT RENDER AN ADVERSE DECISION.

(5) A NONPROFIT HEALTH INSURER MAY NOT DENY, LIMIT, OR OTHERWISE IMPAIR THE PARTICIPATION OF A HEALTH CARE PRACTITIONER ON ITS PANEL FOR:

(I) ADVOCATING FOR THE INTERESTS OF A MOTHER OR NEWBORN THROUGH THE REVIEW OR APPEALS PROCESS OF THE NONPROFIT HEALTH INSURER; OR

(II) THE INPATIENT ADMISSION OF A MOTHER OR NEWBORN INFANT IN COMPLIANCE WITH THIS SECTION.

(C) This [provision] SECTION may not be construed[, however,] to require any insurer to provide benefits for pregnancy or childbirth in any policy.

470H.

(A) Every insurer who issues or delivers an individual health insurance policy to any person in this State under which any hospitalization benefits are provided for normal pregnancy shall provide those benefits for the cost of hospitalization for childbirth to the same extent as the hospitalization benefit provided in the policy for any covered illness.

(B) (1) IN THIS SUBSECTION, "ATTENDING PHYSICIAN" MEANS AN OBSTETRICIAN, PEDIATRICIAN, OR OTHER PHYSICIAN ATTENDING THE MOTHER OR NEWBORN CHILD.

(2) THE HOSPITALIZATION BENEFITS REQUIRED UNDER SUBSECTION (A) OF THIS SECTION SHALL INCLUDE, FOR A MOTHER AND NEWBORN CHILD, COVERAGE FOR A MINIMUM OF:

(I) 48 HOURS OF INPATIENT HOSPITALIZATION CARE FOLLOWING A VAGINAL DELIVERY; AND

(II) 96 HOURS OF INPATIENT HOSPITALIZATION CARE FOLLOWING A CESAREAN SECTION.

(3) AN INSURER THAT PROVIDES COVERAGE FOR POSTDELIVERY CARE FOR A MOTHER AND NEWBORN CHILD IN THE HOME IS NOT REQUIRED TO PROVIDE THE MINIMUM LENGTH OF INPATIENT HOSPITALIZATION COVERAGE UNDER PARAGRAPH (2) OF THIS SUBSECTION, UNLESS THE ATTENDING PHYSICIAN, CONSISTENT WITH CRITERIA OUTLINED IN THE MOST CURRENT VERSION OF THE

"GUIDELINES FOR PERINATAL CARE" PREPARED BY THE AMERICAN ACADEMY OF PEDIATRICS AND THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, DETERMINES THAT INPATIENT HOSPITALIZATION IS NECESSARY.

(4) (I) IF AN INSURER RENDERS AN ADVERSE DECISION CONCERNING COVERAGE UNDER THIS SUBSECTION, AND THE ATTENDING PHYSICIAN BELIEVES THAT THE DECISION WARRANTS AN IMMEDIATE APPEAL, THE ATTENDING PHYSICIAN SHALL HAVE THE OPPORTUNITY TO APPEAL THE ADVERSE DECISION BY TELEPHONE ON AN EXPEDITED BASIS.

(II) AN EXPEDITED APPEAL SHALL CONSIST OF AN IMMEDIATE AND TIMELY REVIEW BETWEEN THE ATTENDING PHYSICIAN AND THE MEDICAL DIRECTOR OF THE INSURER OR PHYSICIAN AUTHORIZED TO ACT IN THE ABSENCE OF THE MEDICAL DIRECTOR.

(III) IF A DECISION REGARDING THE EXPEDITED APPEAL IS NOT RENDERED IN SUFFICIENT TIME TO ALLOW THE MOTHER AND NEWBORN THE BENEFITS UNDER PARAGRAPH (2) OF THIS SUBSECTION, THEN THE INSURER MAY NOT RENDER AN ADVERSE DECISION.

(5) AN INSURER MAY NOT DENY, LIMIT, OR OTHERWISE IMPAIR THE PARTICIPATION OF A HEALTH CARE PRACTITIONER ON ITS PANEL FOR:

(I) ADVOCATING FOR THE INTERESTS OF A MOTHER OR NEWBORN THROUGH THE REVIEW OR APPEALS PROCESS OF THE INSURER; OR

(II) THE INPATIENT ADMISSION OF A MOTHER OR NEWBORN INFANT IN COMPLIANCE WITH THIS SECTION.

(C) This [provision] SECTION may not be construed[, however,] to require any insurer to provide benefits for pregnancy or childbirth in any policy.

477-I.

(A) Every insurer who issues or delivers a group or blanket health insurance policy under which any hospitalization benefits are provided for normal pregnancy shall provide those benefits for the cost of hospitalization for childbirth to the same extent as the hospitalization benefit provided in the policy for any covered illness.

(B) (1) IN THIS SUBSECTION, "ATTENDING PHYSICIAN" MEANS AN OBSTETRICIAN, PEDIATRICIAN, OR OTHER PHYSICIAN ATTENDING THE MOTHER OR NEWBORN CHILD.

(2) THE HOSPITALIZATION BENEFITS REQUIRED UNDER SUBSECTION (A) OF THIS SECTION SHALL INCLUDE, FOR A MOTHER AND NEWBORN CHILD, COVERAGE FOR A MINIMUM OF:

(I) 48 HOURS OF INPATIENT HOSPITALIZATION CARE FOLLOWING A VAGINAL DELIVERY; AND

(II) 96 HOURS OF INPATIENT HOSPITALIZATION CARE FOLLOWING A CESAREAN SECTION.

(3) AN INSURER THAT PROVIDES COVERAGE FOR POSTDELIVERY CARE FOR A MOTHER AND NEWBORN CHILD IN THE HOME IS NOT REQUIRED TO PROVIDE THE MINIMUM LENGTH OF INPATIENT HOSPITALIZATION COVERAGE UNDER PARAGRAPH (2) OF THIS SUBSECTION, UNLESS THE ATTENDING PHYSICIAN, CONSISTENT WITH CRITERIA OUTLINED IN THE MOST CURRENT VERSION OF THE "GUIDELINES FOR PERINATAL CARE" PREPARED BY THE AMERICAN ACADEMY OF PEDIATRICS AND THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, DETERMINES THAT INPATIENT HOSPITALIZATION IS NECESSARY.

(4) (I) IF AN INSURER RENDERS AN ADVERSE DECISION CONCERNING COVERAGE UNDER THIS SUBSECTION, AND THE ATTENDING PHYSICIAN BELIEVES THAT THE DECISION WARRANTS AN IMMEDIATE APPEAL, THE ATTENDING PHYSICIAN SHALL HAVE THE OPPORTUNITY TO APPEAL THE ADVERSE DECISION BY TELEPHONE ON AN EXPEDITED BASIS.

(II) AN EXPEDITED APPEAL SHALL CONSIST OF AN IMMEDIATE AND TIMELY REVIEW BETWEEN THE ATTENDING PHYSICIAN AND THE MEDICAL DIRECTOR OF THE INSURER OR PHYSICIAN AUTHORIZED TO ACT IN THE ABSENCE OF THE MEDICAL DIRECTOR.

(III) IF A DECISION REGARDING THE EXPEDITED APPEAL IS NOT RENDERED IN SUFFICIENT TIME TO ALLOW THE MOTHER AND NEWBORN THE BENEFITS UNDER PARAGRAPH (2) OF THIS SUBSECTION, THEN THE INSURER MAY NOT RENDER AN ADVERSE DECISION.

(5) AN INSURER MAY NOT DENY, LIMIT, OR OTHERWISE IMPAIR THE PARTICIPATION OF A HEALTH CARE PRACTITIONER ON ITS PANEL FOR:

(I) ADVOCATING FOR THE INTERESTS OF A MOTHER OR NEWBORN THROUGH THE REVIEW OR APPEALS PROCESS OF THE INSURER; OR

(II) THE INPATIENT ADMISSION OF A MOTHER OR NEWBORN INFANT IN COMPLIANCE WITH THIS SECTION.

(C) This [provision] SECTION may not be construed[, however,] to require any insurer to provide benefits for pregnancy or childbirth in any policy.

490DD.

(b) A carrier [that reimburses a health care practitioner on an aggregate fixed sum basis or on a per capita basis] may not reimburse the health care practitioner in an amount less than the sum or rate negotiated in the carrier's provider contract with the health care practitioner.

Article - Health - General

19-703.

(G) (1) IN THIS SUBSECTION, "ATTENDING PHYSICIAN" MEANS AN OBSTETRICIAN, PEDIATRICIAN, OR OTHER PHYSICIAN ATTENDING THE MOTHER OR NEWBORN CHILD.

(2) AS PART OF ITS HOSPITALIZATION SERVICES PROVIDED TO MEMBERS AND SUBSCRIBERS, A HEALTH MAINTENANCE ORGANIZATION SHALL PROVIDE PAYMENT FOR THE COST OF INPATIENT HOSPITALIZATION CARE FOR A MOTHER AND NEWBORN CHILD FOR A MINIMUM OF:

(I) 48 HOURS OF INPATIENT HOSPITALIZATION CARE FOLLOWING A VAGINAL DELIVERY; AND

(II) 96 HOURS OF INPATIENT HOSPITALIZATION CARE FOLLOWING A CESAREAN SECTION.

(3) A HEALTH MAINTENANCE ORGANIZATION THAT PROVIDES COVERAGE FOR POSTDELIVERY CARE FOR A MOTHER AND NEWBORN CHILD IN THE HOME IS NOT REQUIRED TO PROVIDE THE MINIMUM LENGTH OF INPATIENT HOSPITALIZATION COVERAGE UNDER PARAGRAPH (2) OF THIS SUBSECTION, UNLESS THE ATTENDING PHYSICIAN, CONSISTENT WITH CRITERIA OUTLINED IN THE MOST CURRENT VERSION OF THE "GUIDELINES FOR PERINATAL CARE" PREPARED BY THE AMERICAN ACADEMY OF PEDIATRICS AND THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, DETERMINES THAT INPATIENT HOSPITALIZATION IS NECESSARY.

(4) (I) IF A HEALTH MAINTENANCE ORGANIZATION RENDERS AN ADVERSE DECISION CONCERNING COVERAGE UNDER THIS SUBSECTION, AND THE ATTENDING PHYSICIAN BELIEVES THAT THE DECISION WARRANTS AN IMMEDIATE APPEAL, THE ATTENDING PHYSICIAN SHALL HAVE THE OPPORTUNITY TO APPEAL THE ADVERSE DECISION BY TELEPHONE ON AN EXPEDITED BASIS.

(II) AN EXPEDITED APPEAL SHALL CONSIST OF AN IMMEDIATE AND TIMELY REVIEW BETWEEN THE ATTENDING PHYSICIAN AND THE MEDICAL DIRECTOR OF THE HEALTH MAINTENANCE ORGANIZATION OR PHYSICIAN AUTHORIZED TO ACT IN THE ABSENCE OF THE MEDICAL DIRECTOR.

(III) IF A DECISION REGARDING THE EXPEDITED APPEAL IS NOT RENDERED IN SUFFICIENT TIME TO ALLOW THE MOTHER AND NEWBORN THE BENEFITS UNDER PARAGRAPH (2) OF THIS SUBSECTION, THEN THE HEALTH MAINTENANCE ORGANIZATION MAY NOT RENDER AN ADVERSE DECISION.

(5) A HEALTH MAINTENANCE ORGANIZATION MAY NOT DENY, LIMIT, OR OTHERWISE IMPAIR THE PARTICIPATION OF A HEALTH CARE PRACTITIONER ON ITS PANEL FOR:

(I) ADVOCATING FOR THE INTERESTS OF A MOTHER OR NEWBORN THROUGH THE REVIEW OR APPEALS PROCESS OF THE HEALTH MAINTENANCE ORGANIZATION; OR

(II) THE INPATIENT ADMISSION OF A MOTHER OR NEWBORN INFANT IN COMPLIANCE WITH THIS SECTION.

19-705.1.

(a) The Secretary shall adopt regulations that set out reasonable standards of quality of care that a health maintenance organization shall provide toits members.

(b) The standards of quality of care shall include:

(1) (i) A requirement that a health maintenance organization shall provide for regular hours during which a member may receive services, including providing for services to a member in a timely manner that takes into account the immediacy of need for services; and

(ii) Provisions for assuring that all covered services, including any services for which the health maintenance organization has contracted, are accessible to the enrollee with reasonable safeguards with respect to geographic locations.

(2) (i) A requirement that a health maintenance organization shall have a system for providing a member with 24-hour access to a physician in cases where there is an immediate need for medical services, including providing 24-hour access by telephone to a person who is able to appropriately respond to calls from members and providers concerning after-hours care;

(ii) To meet this requirement for off-hour services, the health maintenance organization may provide for access to a physician who doesnot have a contract with the health maintenance organization or a facility, such as a hospital emergency room; and

(iii) If a physician who does not have a contract with a health maintenance organization is used or a facility that is not connected with a health maintenance organization is used, the health maintenance organization shall:

1. Develop and publicize procedures to assure that the health maintenance organization is notified of the services and receives adequate documentation of the services;

2. Develop and provide informational materials to all subscribers and enrollees of the health maintenance organization that clearly describe and inform subscribers and enrollees of their potential responsibility for payment for services rendered by a health care provider, including a physician or hospital, that does not have a written contract with the health maintenance organization; and

3. Develop and provide specific information to all subscribers and enrollees of the health maintenance organization that clearly describes the procedures to be followed for emergency services, including:

A. The appropriate use of hospital emergency rooms;

B. The appropriate use, location, and hours of operation of any urgent care facilities operated by the health maintenance organization;and

C. The potential responsibility of subscribers and enrollees for payment for emergency services or nonemergency services rendered in a hospital emergency facility pursuant to § 19-710(q) of this subtitle;

(3) A requirement that a health maintenance organization shall have a physician available at all times to provide diagnostic and treatment services;

(4) A requirement that a health maintenance organization shall assure that:

(i) Each member who is seen for a medical complaint is evaluated under the direction of a physician; and

(ii) Each member who receives diagnostic evaluation or treatment is under the direct medical management of a health maintenance organization physician who provides continuing medical management; and

(5) A requirement that each member shall have an opportunity toselect a primary physician from among those available to the health maintenance organization.

(c) (1) The health maintenance organization shall make available and encourage appropriate history and baseline examinations for each memberwithin a reasonable time of enrollment set by it.

(2) Medical problems that are a potential hazard to the person's health shall be identified and a course of action to alleviate these problems outlined.

(3) Progress notes indicating success or failure of the course of action shall be recorded.

(4) The health maintenance organization shall:

(i) Offer or arrange for preventive services that include health education and counseling, early disease detection, and immunization;

(ii) Develop or arrange for periodic health education on subjects which impact on the health status of a member population; and

(iii) Notify every member in writing of the availability of these and other preventive services.

(5) The health maintenance organization shall offer services toprevent a disease if:

(i) The disease produces death or disability and exists inthe member population;

(ii) The etiology of the disease is known or the disease can be detected at an early stage; and

(iii) Any elimination of factors leading to the disease orimmunization has been proven to prevent its occurrence, or early disease detection followed by behavior modification, environmental modification, or medical intervention has been proven to prevent death or disability.

(d) (1) To implement these standards of quality of care, a health maintenance organization shall have a written plan that is updated and reviewed at least every 3 years.

(2) The plan shall include the following information:

(i) Statistics on age, sex, and other general demographic data used to determine the health care needs of its population;

(ii) Identification of the major health problems in the member population;

(iii) Identification of any special groups of members thathave unique health problems, such as the poor, the elderly, the mentally ill, and educationally disadvantaged; and

(iv) A description of community health resources and how they will be used.

(3) The health maintenance organization shall state its priorities and objectives in writing, describing how the priorities and objectives relating to the health problems and needs of the member population will be provided for.

(4) (i) The health maintenance organization shall provide at the time membership is solicited a general description of the benefits and services available to its members, including benefit limitations and exclusions, location of facilities or providers, and procedures to obtain medical services.

(ii) The health maintenance organization shall place the following statement, in bold print, on every enrollment card or application: "If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative before signing this application or card".

(5) The plan shall contain evidence that:

(i) The programs and services offered are based on the health problems of and the community health services available to its member population;

(ii) There is an active program for preventing illness, disability, and hospitalization among its members; and

(iii) The services designed to prevent the major health problems identified among child and adult members and to improve their general health are provided by the health maintenance organization.

(e) (1) The health maintenance organization shall have an internal peer review system that will evaluate the utilizational services and the quality ofhealth care provided to its members.

(2) The review system shall:

(i) Provide for review by appropriate health professionalsof the process followed in the provision of health services;

(ii) Use systematic data collection of performances and patient results;

(iii) Provide interpretation of this data to the practitioners;

(iv) Review and update continuing education programs for health professionals providing services to its members;

(v) Identify needed change and proposed modifications to implement the change; and

(vi) Maintain written records of the internal peer review process.

(f) (1) [The] EXCEPT AS PROVIDED IN SUBSECTION (G) OF THIS SECTION, THE Department shall conduct an external review of the quality of the health services of the health maintenance organization in a manner that the Department considers to be appropriate.

(2) The external review shall be conducted by:

(i) A panel of physicians and other health professionals that consists of persons who:

1. Have been approved by the Department;

2. Have substantial experience in the delivery of health care in a health maintenance organization setting, but who are not members of the health maintenance organization staff or performing professional services for the health maintenance organization; and

3. Reside outside the area serviced by the health maintenance organization;

(ii) The Department; or

(iii) A federally-approved professional standards review organization.

(3) The final decision on the type of external review that is to be employed rests solely with the Department.

(4) The external review shall consist of a review and evaluation of:

(i) An internal peer review system and reports;

(ii) The program plan of the health maintenance organization to determine if it is adequate and being followed;

(iii) The professional standards and practices of the health maintenance organization in every area of services provided;

(iv) The grievances relating specifically to the delivery of medical care, including their final disposition;

(v) The physical facilities and equipment; and

(vi) A statistically representative sample of member records.

(G) (1) THE SECRETARY MAY WAIVE THE REQUIREMENTS OF SUBSECTION (F) OF THIS SECTION FOR A HEALTH MAINTENANCE ORGANIZATION THAT HAS BEEN ACCREDITED BY A NATIONALLY RECOGNIZED ACCREDITING ENTITY IF THE SECRETARY DETERMINES THAT THE EXTERNAL REVIEW STANDARDS OF THE ACCREDITING ENTITY ARE SUBSTANTIALLY EQUIVALENT TO THE REQUIREMENTS OF THE STATE.

(2) A HEALTH MAINTENANCE ORGANIZATION THAT SEEKS A WAIVER FROM THE SECRETARY UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL:

(I) SUBMIT A COPY OF THE ACCREDITATION APPLICATION, INITIAL ACCREDITATION CERTIFICATE, AND ALL SUBSEQUENT APPLICATIONS OR RECERTIFICATIONS TO THE SECRETARY;

(II) MAKE THE FINAL REPORT BY THE ENTITY ON THE HEALTH MAINTENANCE ORGANIZATION AVAILABLE FOR INSPECTION BY THE SECRETARY; AND

(III) SUBMIT TO THE DEPARTMENT, AND MAKE PUBLIC, A COPY OF ANY SUMMARY REPORTS MADE BY THE ENTITY.

(3) (I) EXCEPT AS PROVIDED IN PARAGRAPH (2)(III) OF THIS SUBSECTION, ALL INFORMATION, DOCUMENTS, AND COPIES OBTAINED BY OR DISCLOSED TO THE SECRETARY OR ANY OTHER PERSON UNDER THIS SUBSECTION SHALL BE CONFIDENTIAL AND MAY NOT BE:

1. RELEASED TO THE PUBLIC WITHOUT THE PRIOR WRITTEN CONSENT OF THE HEALTH MAINTENANCE ORGANIZATION THAT IS AFFECTED BY THE CONFIDENTIAL MATERIAL; OR

2. SUBJECT TO SUBPOENA.

(II) IF THE SECRETARY DETERMINES THAT THE INTERESTS OF THE PUBLIC WILL BE SERVED BY THE PUBLICATION OF ANY MATERIAL THAT IS CONFIDENTIAL UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH, THE SECRETARY MAY PUBLISH ALL OR PART OF THE MATERIAL THAT THE SECRETARY DEEMS APPROPRIATE IF NOTICE AND AN OPPORTUNITY TO BE HEARD IS GRANTED TO THE HEALTH MAINTENANCE ORGANIZATION OR ITS AFFILIATES AFFECTED BY THE MATERIAL.

(4) THE SECRETARY MAY INSPECT A HEALTH MAINTENANCE ORGANIZATION FACILITY:

(I) FOR THE PURPOSE OF A COMPLAINT INSPECTION; AND

(II) TO INVESTIGATE A SERIOUS PROBLEM IDENTIFIED IN AN ACCREDITATION REPORT.

[19-1305.4.

(a) Except as provided in subsection (b) of this section, the criteria and standards used by a private review agent or health maintenance organization in performing utilization review of hospital services related to maternity and newborn care, including length of stay, shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

(b) A private review agent or health maintenance organization may authorize a shorter length of hospital stay for services related to maternity and newborn care provided the newborn meets the criteria for medical stability in the "Guidelines for

Perinatal Care" and the private review agent or health maintenance organization authorizes for the mother and child an initial postpartum home visit which would include the collection of an adequate sample for the hereditary and metabolic newborn screening, when indicated.]

Article - Health Occupations

1-211.

(A) IN THIS SECTION, "SYSTEM" MEANS THE UNIFIED CREDENTIALING INFORMATION SYSTEM.

(B) THE SECRETARY SHALL ADOPT REGULATIONS ESTABLISHING A UNIFIED CREDENTIALING INFORMATION SYSTEM THAT IS AVAILABLE FOR ALL INDIVIDUALS LICENSED UNDER THIS ARTICLE.

(C) THE SYSTEM SHALL BE ADMINISTERED BY ONE OR MORE PROFESSIONAL ASSOCIATIONS OR OTHER ENTITIES DESIGNATED BY THE SECRETARY THROUGH REGULATIONS.

(D) THE SECRETARY, IN CONSULTATION WITH APPROPRIATE ENTITIES, INCLUDING NATIONALLY RECOGNIZED ACCREDITING ORGANIZATIONS, SHALL ESTABLISH THE PROCEDURES FOR THE COLLECTION AND DISTRIBUTION OF CREDENTIALING INFORMATION UNDER THIS SECTION.

(E) (1) THE SECRETARY MAY TEST THE TRUTH AND ACCURACY OF INFORMATION UNDER THIS SECTION BY:

(I) ESTABLISHING A PRIMARY SOURCE VERIFICATION PROCEDURE; OR

(II) AUTHORIZING A CREDENTIALING ORGANIZATION TO RELY UPON CREDENTIALING INFORMATION PROVIDED BY THE SYSTEM.

(2) THIS SUBSECTION MAY NOT BE CONSTRUED TO PROHIBIT A CREDENTIALING ORGANIZATION FROM USING THE PRIMARY SOURCE VERIFICATION PROCEDURE OF THAT ORGANIZATION.

(F) THE SECRETARY SHALL ESTABLISH THE SYSTEM NO LATER THAN JANUARY 1, 1997.

SECTION 2. AND BE IT FURTHER ENACTED, That a study to evaluate the use and effectiveness of existing provisions of law regarding patient and provider grievance appeal mechanisms for the appeal of decisions by health maintenance organizations shall be conducted by a Committee consisting of: three representatives of theMedical and Chirurgical Faculty of Maryland; three representatives of the Maryland Association of Health Maintenance Organizations; two members of the Senate Finance Committee, appointed by the President of the Senate; and two members of the House Economic Matters Committee, appointed by the Speaker of the House of Delegates. The President and the Speaker shall appoint the co-chairmen of the Committee. Staffing shall be provided by the Department of Legislative Reference and the Department of Fiscal Services. The Committee shall issue recommendations from the study and shall report its

findings to the Senate Finance Committee and House Economic Matters Committee by October 15, 1996.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 1996.