

CF 7r2081

By: Delegates Weir, Guns, and Billings

Introduced and read first time: January 31, 1997

Assigned to: Environmental Matters

A BILL ENTITLED

1 AN ACT concerning

2 **Managed Care Organizations and Health Maintenance Organizations - Access to**
3 **Services**

4 FOR the purpose of requiring managed care organizations and health maintenance
5 organizations to promote timely access to and continuity of health care services for
6 enrollees and members by providing a certain telephone access system, providing
7 authorization at the initial telephone access for enrollees and members who do not
8 have an assigned primary care provider, and providing for the reimbursement of the
9 medical or surgical provider or specialist on call at a hospital if a telephone access
10 system is not established or if an enrollee's or member's primary care provider or
11 the specialist needed by an enrollee or member cannot be determined within a
12 reasonable time; providing for the effective date of this Act; and generally relating
13 to the promotion of access to and continuity of health care services provided by
14 managed care organizations and health maintenance organizations.

15 BY repealing and reenacting, with amendments,
16 Article - Health - General
17 Section 15-103(b)(9)
18 Annotated Code of Maryland
19 (1994 Replacement Volume and 1996 Supplement)

20 BY repealing and reenacting, with amendments,
21 Article - Health - General
22 Section 19-705.1(b)(2)
23 Annotated Code of Maryland
24 (1996 Replacement Volume and 1996 Supplement)

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

27 **Article - Health - General**

28 15-103.

29 (b) (9) Each managed care organization shall:

2

1 (i) Have a quality assurance program in effect which is subject to the
2 approval of the Department and which, at a minimum:

3 1. Complies with any health care quality improvement system
4 developed by the Health Care Financing Administration;

5 2. Complies with the quality requirements of applicable State
6 licensure laws and regulations;

7 3. Complies with practice guidelines and protocols specified by
8 the Department;

9 4. Provides for an enrollee grievance system, including an
10 enrollee hotline;

11 5. Provides a provider grievance system;

12 6. Provides for enrollee and provider satisfaction surveys, to be
13 taken at least annually;

14 7. Provides for a consumer advisory board to receive regular
15 input from enrollees;

16 8. Provides for an annual consumer advisory board report to be
17 submitted to the Secretary; and

18 9. Complies with specific quality, access, data, and performance
19 measurements adopted by the Department for treating enrollees with special needs;

20 (ii) Submit to the Department:

21 1. Service-specific data by service type in a format to be
22 established by the Department; and

23 2. Utilization and outcome reports, such as the Health Plan
24 Employer Data and Information Set (HEDIS), as directed by the Department;

25 (iii) Promote timely access to and continuity of health care services for
26 enrollees, INCLUDING:

27 1. PROVIDING A 24-HOUR TOLL FREE TELEPHONE ACCESS
28 SYSTEM:

29 A. FOR ENROLLEES AND PROVIDERS TO DETERMINE, WITH
30 ONE TELEPHONE CALL TO A CURRENT ROSTER, THE PRIMARY CARE PROVIDER
31 ASSIGNED TO AN ENROLLEE; AND

32 B. FOR PROVIDERS TO DETERMINE, WITH ONE TELEPHONE
33 CALL TO A CURRENT ROSTER, EACH SPECIALTY PROVIDER CONTRACTED TO BE ON
34 CALL FOR EACH MANAGED CARE ORGANIZATION AT EACH HOSPITAL IN THE STATE
35 FOR EACH DAY OF THE MONTH;

4

1 (xii) Provide or arrange to provide all Medicaid-covered services
2 required to comply with State statutes and regulations mandating health and mental
3 health services for children in State supervised care:

4 1. According to standards set by the Department; and

5 2. Locally, to the extent the services are available locally;

6 (xiii) Submit to the Department aggregate information from the quality
7 assurance program, including complaints and resolutions from the enrollee and provider
8 grievance systems, the enrollee hotline, and enrollee satisfaction surveys;

9 (xiv) Maintain as part of the enrollee's medical record the following
10 information:

11 1. The basic health risk assessment conducted on enrollment;

12 2. Any information the managed care organization receives that
13 results from an assessment of the enrollee conducted for the purpose of any early
14 intervention, evaluation, planning, or case management program;

15 3. Information from the local department of social services
16 regarding any other service or benefit the enrollee receives, including assistance or
17 benefits under Article 88A of the Code; and

18 4. Any information the managed care organization receives
19 from a school-based clinic, a core services agency, a local health department, or any other
20 person that has provided health services to the enrollee; and

21 (xv) Upon provision of information specified by the Department under
22 paragraph (19) of this subsection, pay school-based clinics for services provided to the
23 managed care organization's enrollees.

24 19-705.1.

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

26 (2) A requirement that a health maintenance organization shall have a
27 system for providing a member with 24-hour access to a physician in cases where there is
28 an immediate need for medical services, AND FOR PROMOTING TIMELY ACCESS TO
29 AND CONTINUITY OF HEALTH CARE SERVICES FOR MEMBERS, [including providing
30 24-hour access by telephone to a person who is able to appropriately respond to calls
31 from members and providers concerning after-hours care] INCLUDING:

32 (I) PROVIDING A 24-HOUR TOLL FREE TELEPHONE ACCESS
33 SYSTEM:

34 1. FOR MEMBERS AND PROVIDERS TO DETERMINE, WITH
35 ONE TELEPHONE CALL TO A CURRENT ROSTER, THE PRIMARY CARE PROVIDER
36 ASSIGNED TO A MEMBER; AND

37 2. FOR PROVIDERS TO DETERMINE, WITH ONE TELEPHONE
38 CALL TO A CURRENT ROSTER, EACH SPECIALTY PROVIDER CONTRACTED TO BE ON

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1 CALL FOR EACH HEALTH MAINTENANCE ORGANIZATION AT EACH HOSPITAL IN THE
2 STATE FOR EACH DAY OF THE MONTH;

3 (II) PROVIDING AUTHORIZATION AT THE INITIAL TELEPHONE
4 ACCESS FOR MEMBERS WHO DO NOT HAVE AN ASSIGNED PRIMARY CARE
5 PROVIDER; AND

6 (III) PROVIDING FOR THE REIMBURSEMENT OF THE MEDICAL OR
7 SURGICAL PROVIDER ON CALL FOR UNASSIGNED PATIENTS GENERALLY OR THE
8 APPROPRIATE SPECIALIST ON CALL FOR THE HOSPITAL ON THAT DATE IN THE
9 EVENT A TELEPHONE ACCESS SYSTEM IS NOT ESTABLISHED, OR IF A MEMBER'S
10 PRIMARY CARE PROVIDER OR THE SPECIALIST NEEDED BY A MEMBER CANNOT BE
11 DETERMINED WITHIN A REASONABLE TIME, AS DETERMINED BY THE
12 CIRCUMSTANCES OF THE CASE IN THE JUDGMENT OF THE TREATING EMERGENCY
13 PHYSICIAN, BUT NOT EXCEEDING 30 MINUTES AFTER THE INITIAL DOCUMENTED
14 CALL TO THE TELEPHONE ACCESS SYSTEM, WITH REIMBURSEMENT FOR
15 NONCONTRACTING PROVIDERS AS PROVIDED IN § 19-710.1 OF THIS SUBTITLE;

16 SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect
17 January 1, 1998.