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By: Senators Dorman and Hafer
Introduced and read first time: January 30, 1997
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Managed Care Organizations and Health Maintenance Organizations - Access to Services

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

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

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

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

Article - Health - General

15-103.

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

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

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

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

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

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

5. Provides a provider grievance system;

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

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

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

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

(ii) Submit to the Department:

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

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

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

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

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

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

2. PROVIDING AUTHORIZATION AT THE INITIAL TELEPHONE ACCESS FOR ENROLLEES WHO DO NOT HAVE AN ASSIGNED PRIMARY CARE PROVIDER; AND

3. PROVIDING FOR THE REIMBURSEMENT OF THE MEDICAL OR SURGICAL PROVIDER ON CALL FOR UNASSIGNED PATIENTS GENERALLY OR THE APPROPRIATE SPECIALIST ON CALL FOR THE HOSPITAL ON THAT DATE IN THE EVENT A TELEPHONE ACCESS SYSTEM IS NOT ESTABLISHED, OR IF AN ENROLLEE'S PRIMARY CARE PROVIDER OR THE SPECIALIST NEEDED BY AN ENROLLEE CANNOT BE DETERMINED WITHIN A REASONABLE TIME, AS DETERMINED BY THE CIRCUMSTANCES OF THE CASE IN THE JUDGMENT OF THE TREATING EMERGENCY PHYSICIAN, BUT NOT EXCEEDING 30 MINUTES AFTER THE INITIAL DOCUMENTED CALL TO THE TELEPHONE ACCESS SYSTEM, WITH REIMBURSEMENT FOR NONCONTRACTING PROVIDERS AS PROVIDED IN § 19-710.1 OF THIS ARTICLE;

(iv) Demonstrate organizational capacity to provide special programs, including outreach, case management, and home visiting, tailored to meet the individual needs of all enrollees;

(v) Provide assistance to enrollees in securing necessary health care services;

(vi) Provide or assure alcohol and drug abuse treatment for substance abusing pregnant women and all other enrollees of managed care organizations who require these services;

(vii) Educate enrollees on health care prevention and good health habits;

(viii) Assure necessary provider capacity in all geographic areas under contract;

(ix) Be accountable and hold its subcontractors accountable for standards established by the Department and, upon failure to meet those standards, be subject to one or more of the following penalties:

1. Fines;

2. Suspension of further enrollments;

3. Withholding of all or part of the capitation payment;

4. Termination of the contract;

5. Disqualification from future participation in the Program; and

6. Any other penalties that may be imposed by the Department;

(x) Subject to applicable federal and State law, include incentives for enrollees to comply with provisions of the managed care organization;

(xi) Provide or arrange to provide primary mental health services;

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

1. According to standards set by the Department; and

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

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

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

1. The basic health risk assessment conducted on enrollment;

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

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

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

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

19-705.1.

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

(2) 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, AND FOR PROMOTING TIMELY ACCESS TO AND CONTINUITY OF HEALTH CARE SERVICES FOR MEMBERS, [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] INCLUDING:

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

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

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

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

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

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

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