Unofficial Copy 1998 Regular Session
J4 8lr0004

By: **Delegates Goldwater, Eckardt, Nathan-Pulliam, Exum, Harrison, and Love**
Introduced and read first time: January 29, 1998
Assigned to: Environmental Matters

A BILL ENTITLED

AN ACT concerning

Health Maintenance Organizations - Health Care Providers - Definition and Designation of Primary Care Providers

FOR the purpose of defining a certain term and altering a certain definition and certain provisions of law under the Maryland Health Maintenance Organization Act to include individuals and allow individuals, who are licensed, certified, or otherwise authorized to provide health care services, in addition to physicians, to be designated as primary care providers under certain circumstances.

BY repealing and reenacting, with amendments,
Article - Health - General
Section 19-701, 19-705.1, and 19-712(a)
Annotated Code of Maryland
(1996 Replacement Volume and 1997 Supplement)

Preamble

WHEREAS, The federal Balanced Budget Act of 1997 (PL 105-33) contains provisions allowing direct Medicare reimbursement to nurse practitioners regardless of geographic area or practice setting; and

WHEREAS, The new Maryland Medicaid Managed Care Program, known as "HealthChoice", has recognized nurse practitioners as primary care providers; and

WHEREAS, The Maryland General Assembly passed Chapter 605 of the Acts of 1995, better known as the "Patient Access Act", which provided health maintenance organization (HMO) members and subscribers greater access and choice of providers; and

WHEREAS, The intent of the Maryland General Assembly is to support health care providers who are practicing as their licenses allow; and

WHEREAS, The intent of the Maryland General Assembly is to allow HMO members and subscribers the most choice in selecting a primary care provider; and

WHEREAS, This legislation is not intended to interfere with the current relationship between physicians and nurse practitioners; and

WHEREAS, The intent of the Maryland General Assembly is to clarify the laws of Maryland as they relate to allowing HMO members and subscribers the greatest amount of choice in selecting a primary care provider for the provision of their health care needs; now, therefore,

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

Article - Health - General

19-701.

(a) In this subtitle the following words have the meanings indicated.

(b) "Benefit package" means a set of health care services to be provided to a member of a health maintenance organization under a contract that entitles the member to the health care services, whether the services are provided:

(1) Directly by a health maintenance organization; or

(2) Through a contract or arrangement with another person.

(c) "Commissioner" means the State Insurance Commissioner.

(d) "Emergency services" means those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

(1) Placing the patient's health in serious jeopardy;

(2) Serious impairment to bodily functions; or

(3) Serious dysfunction of any bodily organ or part.

(e) (1) "Health care services" means services, medical equipment, and supplies that are provided by a provider.

(2) "Health care services" includes:

(i) Ambulance services;

(ii) Appliances, drugs, medicines, and supplies;

(iii) Chiropractic care and services;

(iv) Convalescent institutional care;

(v) Dental care and services;

(vi) Extended care;

(vii) Family planning or infertility services;

(viii) Health education services;

(ix) Home health care or medical social services;

(x) Inpatient hospital services;

(xi) Laboratory, radiological, or other diagnostic services;

(xii) Medical care and services;

(xiii) Mental health services;

(xiv) Nursing care and services;

(xv) Nursing home care;

(xvi) Optical care and services;

(xvii) Optometric care and services;

(xviii) Osteopathic care and services;

(xix) Outpatient services;

(xx) Pharmaceutical services;

(xxi) Physical therapy care and services;

(xxii) Podiatric care and services;

(xxiii) Preventive medical services;

(xxiv) Psychological care and services;

(xxv) Rehabilitative services;

(xxvi) Surgical care and services;

(xxvii) Treatment for alcoholism or drug abuse; and

(xxviii) Any other care, service, or treatment of disease or injury, the correction of defects, or the maintenance of the physical and mental well-being of human beings.

(f) "Health maintenance organization" means any person, including a profit or nonprofit corporation organized under the laws of any state or country, that:

(1) Operates or proposes to operate in this State;

(2) Except as provided in § 19-703(b) and (f) of this subtitle, provides or otherwise makes available to its members health care services that include at least physician, hospitalization, laboratory, X-ray, emergency, and preventive services, out-of-area coverage, and any other health care services that the Commissioner determines to be available generally on an insured or prepaid basis in the area serviced by the health maintenance organization, and, at the option of the health maintenance organization, may provide additional coverage;

(3) Except for any copayment or deductible arrangement, is compensated only on a predetermined periodic rate basis for providing to members the minimum services that are specified in item (2) of this subsection;

(4) Assures its subscribers and members, the Commissioner, and the Department that one clearly specified legal and administrative focal point or element of the health maintenance organization has the responsibility of providing the availability, accessibility, quality, and effective use of comprehensive health care services; and

(5) Primarily provides services of physicians OR PRIMARY CARE PROVIDERS:

(i) Directly through physicians OR PRIMARY CARE PROVIDERS who are either employees or partners of the health maintenance organization; or

(ii) Under arrangements with one or more groups of physicians OR PRIMARY CARE PROVIDERS, who are organized on a group practice or individual practice basis, under which each group:

1. Is compensated for its services primarily on the basis of an aggregate fixed sum or on a per capita basis; and

2. Is provided with an effective incentive to avoid unnecessary inpatient use, whether the individual physician OR PRIMARY CARE PROVIDER members of the group are paid on a fee-for-service or other basis.

(g) "Member" means a person who makes a contract or on whose behalf a contract is made with a health maintenance organization for health care services.

(H) "PRIMARY CARE PROVIDER" MEANS A PROVIDER:

(1) WHO IS THE PRIMARY COORDINATOR OF CARE FOR A MEMBER OR SUBSCRIBER; AND

(2) WHOSE RESPONSIBILITY IT IS TO PROVIDE ACCESSIBLE, CONTINUOUS, COMPREHENSIVE, AND COORDINATED HEALTH CARE SERVICES.

[(h)] (I) "Provider" means any person, including a physician or hospital, who is licensed, CERTIFIED, or otherwise authorized in this State to provide health care services.

[(i)] (J) "Subscriber" means a person who makes a contract with a health maintenance organization, either directly or through an insurer or marketing organization, under which the person or other designated persons are entitled to the health care services.

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 to its 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) 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:

(i) 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; and

(ii) Providing a 24-hour toll free telephone access system for use in hospital emergency departments in accordance with § 19-705.6 of this subtitle.

(3) A requirement that any nonparticipating provider shall submit to the health maintenance organization the appropriate documentation of the medical complaint of the member and the services rendered;

(4) A requirement that a health maintenance organization shall have a physician OR PRIMARY CARE PROVIDER available at all times to provide diagnostic and treatment services;

(5) 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 OR PRIMARY CARE PROVIDER; and

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

(6) A requirement that each member shall have an opportunity to select a primary physician from among those available to the health maintenance organization; AND

(7) NOTWITHSTANDING PARAGRAPH (6) OF THIS SUBSECTION, NOTHING IN THIS SECTION MAY BE CONSTRUED TO PREVENT A MEMBER OR SUBSCRIBER FROM HAVING THE OPPORTUNITY TO SELECT A PRIMARY CARE PROVIDER OF THEIR CHOICE 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 member within 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 to prevent a disease if:

(i) The disease produces death or disability and exists in the 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 or immunization 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 that have 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 of health care provided to its members.

(2) The review system shall:

(i) Provide for review by appropriate health professionals of 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) Except as provided in paragraph (5) of this subsection, 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 Secretary.

(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.

(5) (i) The Secretary may accept all or part of a report of an approved accrediting organization as meeting the external review requirements under this subtitle.

(ii) Except as provided in subparagraph (iii) of this paragraph, a report of an approved accrediting organization used by the Department as meeting the external review requirements under this subtitle shall be made available to the public on request.

(iii) The Department may not disclose and shall treat as confidential all confidential commercial and financial information contained in a report of an approved accrediting organization in accordance with § 10-617(d) of the State Government Article.

(iv) The Department may inspect a facility of a health maintenance organization to:

1. Determine compliance with any quality requirement established under this subtitle;

2. Follow up on a serious problem identified by an approved accrediting organization; or

3. Investigate a complaint.

(G) NOTWITHSTANDING THE PROVISIONS OF SUBSECTION (B)(6) AND (7) OF THIS SECTION, NOTHING IN THIS SECTION MAY BE CONSTRUED TO PROHIBIT A HEALTH MAINTENANCE ORGANIZATION FROM DESIGNATING WHICH PHYSICIANS OR PROVIDERS FROM AMONG THOSE AVAILABLE TO THE HEALTH MAINTENANCE ORGANIZATION MAY BE CLASSIFIED AS PRIMARY CARE PROVIDERS.

19-712.

(a) Subject to the provisions of subsection (b) of this section, a person who holds a certificate of authority to operate a health maintenance organization under this subtitle may:

(1) Exercise the power that professional and other corporations, partnerships, associations, or other business entities have under their organizational documents and any laws of this State that do not conflict with this subtitle;

(2) Provide health care services to nonmembers who present themselves on other than a prepaid basis;

(3) Provide health care services on a prepaid basis through licensed, CERTIFIED, OR OTHERWISE AUTHORIZED providers of these services who are under contract with or employed by the health maintenance organization;

(4) Contract with any person to perform, on behalf of the health maintenance organization, functions such as marketing, enrollment, and administration;

(5) Contract for insurance, reinsurance, or indemnity or reimbursement against the cost of health care services provided by the health maintenance organization with:

(i) Any insurance company licensed to do health business in this State; or

(ii) Any hospital, nonprofit health service plan, medical health service, nursing service, optometric service, podiatry service, dental service, pharmaceutical service plan corporation, or similar entity authorized to do business in this State;

(6) Accept from government or private agencies payments that cover all or part of the cost of subscriptions to provide health care services, facilities, appliances, medicines, and supplies;

(7) Buy, lease, construct, renovate, operate, or maintain:

(i) A hospital, medical facility, and ancillary equipment; and

(ii) Property that is reasonably required for its principal office or for any other purpose necessary in the business of the health maintenance organization; and

(8) Offer indemnity benefits that cover out-of-area and emergency services.

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