Be it enacted by the General Assembly of the State of Arkansas:

SECTION 1. Arkansas Code § 23-99-411, concerning processing applications of providers, is amended to read as follows:

23-99-411. Processing applications of providers.
   (a)(1)(A) Healthcare insurers shall establish mechanisms to ensure timely processing of requests for participation or renewal by providers and in making decisions that affect participation status.
   (B) These mechanisms shall include, at a minimum, provisions for the provider to receive a written statement of reasons for the healthcare insurer’s denial of a request for initial participation or renewal.
   (2)(A) Healthcare insurers shall make a decision within:
      (i) Ninety (90) Sixty (60) calendar days from the date of submission of a completed application as defined by rule of the Insurance Commissioner for participation or a request for renewal by a physician licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq.; and
(ii) One hundred eighty (180) calendar days from the
date of submission of a completed application as defined by rule of the
commissioner for participation or a request for renewal by any other
provider.

(B) However, when a physician’s credentials are verified
through the Arkansas State Medical Board’s Centralized Credentials
Verification Service under § 17-95-107, the ninety (90) sixty (60) days
specified under subdivision (a)(2)(A)(i) of this section is tolled from the
date an order is received by the Centralized Credentials Verification Service
from the healthcare insurer until the date the healthcare insurer receives
notification by the Centralized Credentials Verification Service that the
file is complete and available for retrieval.

(C)(i) A healthcare insurer shall provide written
acknowledgement to a provider within ten (10) days of the insurer’s receipt
of an application.

(ii)(a) Upon receipt of an application, a healthcare
insurer shall review the application to determine if the application is
complete.

(b) If the application is incomplete, a
healthcare insurer shall notify the applicant provider in writing within
fifteen (15) calendar days that the application is incomplete.

(c) The notice shall include a list of the
items required for the application to be complete.

(d) If the healthcare insurer does not send
the notice within the required timeframe, the application shall be deemed
complete.

(iii) If the information provided by the initial a
complete application, the healthcare insurer’s investigation, or the
Centralized Credentials Verification Service requires the healthcare insurer
to collect more detailed information from the provider to fairly and
responsibly process the application, the time specified under subdivision
(a)(2)(A)(i) of this section is tolled, and the application is suspended from
the date a written request for the information is sent to the provider until
the request is fully and completely answered and sent to the healthcare
insurer by the provider.
(iv) If application information specified under subdivision (a)(2)(C)(ii) of this section is missing and not received within ninety (90) days of notification by the healthcare insurer or if the request is not fully answered within ninety (90) days of the date it was sent, the healthcare insurer, in its discretion, may treat the application as abandoned and deny it.

(v) The request and response under this section shall be sent by regular mail or other means of delivery as may be allowed by rules adopted by the commissioner.

(3)(A) If a physician is already credentialed by the healthcare insurer but changes employment or changes location, joins a new group or clinic, or opens an additional location, the healthcare insurer shall only require the submission of such additional information, if any, as is necessary to continue the physician's credentials based upon the changed employment, location, new group or clinic, or additional location.

(B) The healthcare insurer shall not require a new application or recredentialing application due solely to the changes listed in subdivision (a)(3)(A) of this section.

(C) Any change listed in subdivision (a)(3)(A) of this section shall be reflected within the healthcare insurer's system within thirty (30) calendar days of written notification by the physician of the change.

(4) Healthcare insurers shall promptly notify providers:

(A) Of any delay in processing applications; and

(B) The reasons for a delay in processing applications.

(5)(A) A healthcare insurer shall notify a physician in writing at least ninety (90) days before the deadline to submit a recredentialing application.

(B)(i) The healthcare insurer shall give the physician written notice at least forty-five (45) calendar days prior to terminating the physician for failure to submit a recredentialing application.

(ii) If the physician submits the recredentialing application during the forty-five-day period, the termination shall not take effect.

(C) During the forty-five-day period, the healthcare insurer shall not represent to the policyholder, plan members, or the general
public that the physician has been or will be terminated from the network
unless the termination is for some reason other than failure to obtain
recredentialing.

(D) If a termination occurs for any reason, the healthcare
insurer shall formally notify the physician in writing of the effective date
of the termination and the basis for the termination.

(6) For payment purposes, a healthcare insurer shall treat an
applicant physician as a participating physician from the date of submission
of a completed application once an applicant physician has been approved
through an insurer’s credentialing process.

(7) Written notice under this section may be provided by
electronic means for a provider who supplies an electronic mailing address to
the healthcare insurer.

(8) The commissioner may adopt rules to ensure that covered
healthcare claims submitted by patients or their providers are not negatively
affected by delays in processing participation applications.

(9) In addition to any legal remedies or actions that may be
brought against a healthcare insurer by the commissioner, a fine of one
thousand dollars ($1,000) per day shall be imposed for each day exceeding the
sixty (60) days under subdivision (a)(2)(A)(i) of this section.

(10) The commissioner shall adopt rules to implement this
subsection.

(b) Nothing in this This section shall does not prevent a provider or
a healthcare insurer from terminating a participating provider contract in
accordance with its terms.

/approved 04/07/2015

/s/Bledsoe