ARKANSAS SENATE

90th General Assembly - Regular Session, 2015

Amendment Form

Subtitle of Senate Bill No. 934

TO IMPROVE THE INSURANCE PANEL PARTICIPATION PROCESS FOR HEALTHCARE PROVIDERS.

Amendment No. 1 to Senate Bill No. 934

Amend Senate Bill No. 934 as originally introduced:

Delete everything after the enacting clause and substitute the following:

"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.

~~(ii)~~(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.

~~(iii)~~(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, ~~or~~ 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 one hundred twenty (120) 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)(A) If a physician joins a group or clinic already credentialed as a participating provider and applies to the healthcare insurer to be a participating provider, the healthcare insurer shall treat, for payment purposes only, the applicant physician as if the applicant physician is a participating provider in the network of the healthcare insurer when the applicant physician provides services to the plan members of the healthcare insurer, including:

(i) Authorizing the applicant physician to collect copayment from members; and

(ii) Making payments to the applicant physician.

(B) Pending approval of the application of the physician, the healthcare insurer may exclude the applicant physician from its directory or other listings of participating physicians.

(C)(i) If upon completion of the credentialing process the healthcare insurer determines that the applicant physician does not meet the credentialing requirements of the issuer:

(a) The healthcare insurer may recover from the applicant physician or the medical group of the applicant physician an amount equal to the difference between payments for in-network and out-of-network benefits; and

(b) The applicant physician or the medical group of the applicant physician may retain any copayments collected or in the process of being collected as of the date the insurer's notice of determination is received by the applicant physician or the medical group of the applicant physician.

(ii)(a) A member of the health benefit plan of the healthcare insurer is not responsible and shall be held harmless for the difference between in-network copayments paid by the member to an applicant physician who is determined to be ineligible and the insurer's charges for out-of-network services.

(b) The applicant physician and the medical group of the applicant physician shall not charge the member for any portion of the fee of the physician that is not paid or reimbursed by the healthcare insurer.

(7) 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.

(8) 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.

~~(6)~~(9) 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."

The Amendment was read the first time, rules suspended and read the second time and _____

By: Senator Bledsoe

JMB/JMB - 03-16-2015 08:54:03 _____

JMB348 **Secretary**