State of Arkansas
92nd General Assembly
Regular Session, 2019

A Bill

HOUSE BILL 1954

By: Representative M. Gray
By: Senator Teague

For An Act To Be Entitled

AN ACT TO AMEND THE ARKANSAS HEALTH CARE CONSUMER ACT; AND FOR OTHER PURPOSES.

Subtitle

TO AMEND THE ARKANSAS HEALTH CARE CONSUMER ACT.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

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

(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) 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) ~~a~~ 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~~

(b) A physician assistant licensed under § 17-

105-101 et seq.; or

(c) An advanced practice registered nurse licensed under § 17-87-302; 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 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 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, a physician assistant, or an advanced practice registered nurse is already credentialed by the healthcare insurer but changes employment or 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~~ participating provider'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, physician assistant, or advanced practice registered nurse of the change.

(4) Healthcare insurers shall promptly notify providers:

(A) Of any delay in processing applications; and

(B) Of the reasons for a delay in processing applications.

(5)(A) A healthcare insurer shall notify a physician, a physician assistant, or an advanced practice registered nurse in writing at least ninety (90) days before the deadline to submit a recredentialing application.

(B)(i) The healthcare insurer shall give the physician, physician assistant, or advanced practice registered nurse written notice at least forty-five (45) calendar days ~~prior to~~ before terminating the physician, physician assistant, or advanced practice registered nurse for

failure to submit a recredentialing application.

(ii) If the physician, physician assistant, or advanced practice registered nurse 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, physician assistant, or advanced practice registered nurse 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, physician assistant, or advanced practice registered nurse 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~~ provider 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.