By Senator Gruters

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A bill to be entitled

An act relating to health care provider credentialing; creating s. 456.48, F.S.; defining the term "health insurer"; requiring the Financial Services Commission, in consultation with the Agency for Health Care Administration, to adopt a certain standard form by rule for the verification of credentials of specified health care professionals; requiring health insurers and hospitals to use only the form to verify such credentials; creating s. 456.481, F.S.; defining terms; providing applicability; specifying requirements for applicants to qualify for expedited credentialing and for certain payments; requiring managed care plans to treat applicants as participating providers in their respective health benefit plan networks for certain purposes; authorizing a managed care plan to exclude applicants from its participating provider directory or listings while their applications are pending approval; specifying a managed care plan's right to recover certain amounts from an applicant under certain circumstances; prohibiting certain charges by an applicant or the applicant's medical group to a managed care plan enrollee; providing construction; creating s. 627.444, F.S.; defining the term "health insurer"; specifying requirements and procedures for, and restrictions on, health insurers and their designees in reviewing credentialing applications; authorizing a civil cause of action for applicants

against health insurers or designees under certain circumstances; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 456.48, Florida Statutes, is created to read:

456.48 Standardized credentialing application.—

(1) As used in this section, the term "health insurer" means an authorized insurer offering health insurance as defined in s. 624.603, a managed care plan as defined in s. 409.962, or a health maintenance organization as defined in s. 641.19(12).

(2) The Financial Services Commission, in consultation with the Agency for Health Care Administration, shall adopt by rule a standardized credentialing form for verifying the credentials of an applicant licensed under chapter 458, chapter 459, chapter 461, or chapter 466. In prescribing a form under this section, the commission shall adopt the most current version of the credentialing application form provided by the Council for Affordable Quality Healthcare, Inc.

(3) Notwithstanding any other law, effective January 1, 2021, or 6 months after the effective date of the rule adopting the standardized credentialing form, whichever is later, a health insurer or a hospital licensed pursuant to chapter 395 shall use only the standardized credentialing form that was approved by the commission to verify the credentials of an applicant licensed under chapter 458, chapter 459, chapter 461, or chapter 466.

Section 2. Section 456.481, Florida Statutes, is created to

read:

456.481 Expedited credentialing process.—

(1) As used in this section, the term:

(a) "Applicant" means a person licensed under chapter 458, chapter 459, chapter 461, or chapter 466 who is applying for expedited credentialing under this section.

(b) "Enrollee" means an individual who is eligible to receive health care services under a managed care plan.

(c) "Managed care plan" means an insurer issuing a health insurance policy pursuant to s. 627.6471 or s. 627.6472, a managed care plan as defined in s. 409.962, or a health maintenance organization as defined in s. 641.19(12).

(d) "Medical group" means an entity through which health care services are provided to individuals by two or more persons licensed under chapter 458, chapter 459, chapter 461, or chapter 466, and which receives reimbursement for such services.

(e) "Participating provider" means a person licensed under chapter 458, chapter 459, chapter 461, or chapter 466 who has contracted with a managed care plan to provide services to enrollees.

(2) This section applies only to an applicant who joins an established medical group that has a current contract in force with a managed care plan.

(3) To qualify for expedited credentialing under this section and for payment under subsection (4), an applicant must:

(a) Be licensed in this state by, and be in good standing with, the Board of Medicine, the Board of Osteopathic Medicine, the Board of Podiatric Medicine, or the Board of Dentistry, as applicable;

(b) Submit all documentation and other information required by the managed care plan as necessary to enable the managed care plan to begin the credentialing process to include an applicant in its health benefit plan network; and

(c) Agree to comply with the terms of the managed care plan's participating provider contract in force with the applicant's established medical group.

(4) After submission by the applicant of the information required by the managed care plan, and for payment purposes only, the managed care plan shall treat the applicant as if the applicant were a participating provider in its health benefit plan network when the applicant provides services to the managed care plan's enrollees, including:

(a) Authorizing the applicant to collect copayments from enrollees;

(b) Making payments to the applicant; and

(c) Authorizing services provided by the applicant.

(5) Pending the approval of an application submitted under this section, the managed care plan may exclude the applicant from the managed care plan's directory of participating providers or any other listing of participating providers.

(6) If, on completion of the credentialing process, the managed care plan determines that the applicant does not meet the managed care plan's credentialing requirements:

(a) The managed care plan may recover from the applicant or the applicant's medical group an amount equal to the difference between payments for in-network benefits and out-of-network benefits; and

(b) The applicant or the applicant's medical group may

retain any copayments collected or in the process of being collected as of the date of the managed care plan's determination.

(7) An enrollee in a managed care plan is not responsible, and must be held harmless, for the difference between the in-network payment to the applicant and the out-of-network charge of the applicant or the applicant's medical group for the service provided to the enrollee. The applicant and the applicant's medical group may not charge the enrollee for any portion of the applicant's fee which is not paid or reimbursed by the enrollee's managed care plan.

(8) A managed care plan that complies with this section is not subject to liability for damages arising out of or in connection with, directly or indirectly, payment by the managed care plan to an applicant pursuant to subsection (4).

Section 3. Section 627.444, Florida Statutes, is created to read:

627.444 Credentialing.—

(1) As used in this section, the term "health insurer" means an authorized insurer offering health insurance as defined in s. 624.603, a managed care plan as defined in s. 409.962, or a health maintenance organization as defined in s. 641.19(12).

(2) A health insurer or its designee must provide electronic or written acknowledgement to an applicant within 10 calendar days after the health insurer or its designee receives the applicant's application.

(3)(a) Upon receipt of an application, a health insurer or its designee must promptly review the application to determine whether it is complete. The health insurer or its designee must

conclude the credentialing process within 30 calendar days after the date the health insurer or its designee receives a completed application.

(b) If the health insurer or its designee determines that the application is incomplete, the health insurer or its designee must so notify the applicant in writing within 10 calendar days after the date the health insurer or its designee received the application. The written notice must include a detailed list of all items required to complete the application. If the health insurer or its designee does not send the notice within such period, the application is deemed complete.

(c) If the health insurer or its designee notifies the applicant of an incomplete application in accordance with paragraph (b), the period under paragraph (a) is tolled and the application is suspended from the date on which the notice was sent to the applicant until the date on which the health insurer or its designee receives the required information from the applicant.

(d) The health insurer or its designee may request only that information necessary for the health insurer or its designee to fairly and responsibly evaluate the application.

(4) An applicant may bring an action in a court of appropriate jurisdiction against a health insurer or its designee for a violation of this section.

Section 4. This act shall take effect July 1, 2020.