FINAL BILL REPORT
EHB 1552

C 4 L 20
Synopsis as Enacted

Brief Description: Concerning health care provider credentialing by health carriers.

Sponsors: Representatives Dolan, Doglio, Fey, Senn, Appleton, Robinson, Ryu, Jinkins, Macri and Leavitt.

House Committee on Health Care & Wellness
Senate Committee on Health & Long Term Care

Background:

Health Carrier Credentialing.
Provider credentialing is the process that insurance carriers use to ensure that a health care provider is qualified to provide care and treatment to their members. The Office of the Insurance Commissioner (OIC) is required to designate a lead organization to develop a uniform electronic process for collecting and transmitting the necessary provider-supplied data to support credentialing, admitting privileges, and other related processes. The OIC selected OneHealthPort as the lead organization, which developed the credentialing database, ProviderSource.

Health care providers are required to submit credentialing applications to ProviderSource and health carriers are required to accept and manage credentialing applications from the database. A health carrier must approve or deny a credentialing application submitted to the carrier no later than 90 days after receiving a complete application from a health care provider.

Beginning June 1, 2020, the average response time for the health carrier to make a determination regarding the approval or denial of a provider's credentialing application may not exceed 60 days. If there is a credentialing delegation arrangement between a facility that employs health care providers and a health carrier, then the single credentialing database is not required to be used and the timelines do not apply.

Medicaid Managed Care.
Medicaid is a federal-state partnership with programs established in the federal Social Security Act and implemented at the state level with federal matching funds. Federal law

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provides a framework for medical coverage of children, pregnant women, parents, elderly and disabled adults, and other adults with varying income requirements.

Managed care is a prepaid, comprehensive system of medical and health care delivery, including preventive, primary, specialty, and ancillary health services through a network of providers. Washington's Medicaid managed care system is administered through contracts with managed care organizations (MCOs). The MCOs contract with individual health care providers, group practices, clinics, hospitals, pharmacies, and other entities to participate in their Medicaid plan's network. Persons enrolled in managed care must typically obtain services from providers who participate in the plan's network for the service to be covered.

When a non-participating provider delivers services to an enrollee covered by a state contracted MCO, the plan must pay nonparticipating providers the lowest amounts the systems pay for the same services under the systems' contracts with similar providers in the state. Nonparticipating providers must accept those rates as payment in full, in addition to any deductibles, coinsurance, or copayments due from the patients. Managed care systems must maintain networks of appropriate providers sufficient to provide adequate access to all services covered under their contracts with the state, including hospital-based services.

A locum, or locum tenens, is a person who temporarily fulfills the duties of another. In Washington, a physician may bill Medicaid under certain circumstances for services provided on a temporary basis to their patients by a substitute, or locum tenens, physician. The physician's claim must identify the substituting physician providing the temporary services.

Summary:

Health Carrier Credentialing.
A health carrier may not require a health care provider to submit credentialing information in any format other than the database selected by the Office of the Insurance Commissioner for purposes of collecting and transmitting credentialing information, unless the health care entity utilizes a credentialing delegation arrangement with a health carrier.

If a health carrier approves a health care provider's credentialing application, upon completion of the credentialing process, the health carrier must reimburse a health care provider for covered services provided to the health carrier's enrollee under the following circumstances:

- When credentialing a new health care provider through a new provider contract, the health carrier must reimburse the health care provider retroactively to the date of contract effectiveness if the credentialing process extends beyond the effective date of the new contract.
- When credentialing a provider to be added to an approved and in-use provider contract between the health carrier and the health care provider or the entity for whom the health care provider is employed or engaged, the health carrier must reimburse the health care provider for services beginning when the health care provider submitted a completed credentialing application to the health carrier.

The health carrier must reimburse the health care provider at the contracted rate for the applicable health benefit plan that the health care provider would have been paid at the time the services were provided if the health care provider were fully credentialed by the carrier.

Medicaid Managed Care Substitute Providers.
Hospitals, rural health clinics, and rural providers contracted with a managed care organization (MCO) may use substitute providers to provide services, when:

- a contracted provider is absent for a limited time period for vacation, illness, disability, continuing medical education, or other short-term absence; or
- a contracted hospital, rural health clinic, or rural provider is recruiting to fill an open position.

Managed care organizations must allow for the use of substitute providers and provide payment to substitute providers. A contracted hospital, rural health clinic, or rural provider may bill and receive payment at the contracted rate under its contract with the MCO for up to 60 days.

A substitute provider must enroll in an MCO in order to be reimbursed for services provided on behalf of a contracted provider beyond 60 days. Substitute provider enrollment in an MCO is effective on the later date of when they filed an enrollment application that was approved, or when they first began providing services.

Rural providers are physicians, osteopathic physicians and surgeons, podiatric physicians and surgeons, physician assistants, osteopathic physician assistants, and advance registered nurse practitioners who are located in a rural county.

Votes on Final Passage:

House	98	0	
Senate	48	0	(Senate amended)
House	96	0	(House concurred)

Effective: March 17, 2020 (Section 3)
June 11, 2020