SENATE BILL REPORT
EHB 1552

As Passed Senate - Amended, March 6, 2020

Title: An act relating to health care provider credentialing by health carriers.

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

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

Brief History: Passed House: 2/17/20, 98-0.
Committee Activity: Health & Long Term Care: 2/28/20, 2/28/20 [DP, DNP, w/oRec].
Floor Activity:
Passed Senate - Amended: 3/06/20, 48-0.

Brief Summary of Amended Bill

- Prohibits health carriers from requiring a health care provider to submit credentialing information in a format other than through the database selected by the Office of the Insurance Commissioner.
- Requires health carriers to reimburse a health care provider for covered health care services provided to the carrier's enrollees during the credentialing process under certain circumstances.
- Permits hospitals, rural health clinics, and rural providers to use substitute providers in certain circumstances.
- Requires Medicaid Managed Care Organizations (MCOs) to reimburse substitute providers that provide services to MCO beneficiaries.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: Do pass.
Signed by Senators Cleveland, Chair; Randall, Vice Chair; O'Ban, Ranking Member; Conway, Dhingra, Frockt, Keiser, Rivers and Van De Wege.

Minority Report: Do not pass.
Signed by Senator Muzzall.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Minority Report: That it be referred without recommendation.
Signed by Senator Becker.

Staff: Evan Klein (786-7483)

Background: Provider credentialing is the process that insurance carriers use to collect, verify, and assess whether a health care provider meets relevant licensing, education, and training requirements. 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.

Washington's Medicaid managed care system is administered through contracts with 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 the non-participating provider no more than the lowest amount paid for that service under the health care system's contracts with similar providers in the state. The payment must be accepted as payment in full and the provider may not balance bill the patient except for any deductible, copayment, or coinsurance.

Summary of Amended Bill: A health carrier may not require a health care provider to submit credentialing information in any format other than through database selected by the OIC for purposes of collecting and transmitting credentialing information. This requirement does not apply to health care entities that utilize credentialing delegation arrangements.

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

- when credentialing a new provider through a new provider contract, the carrier must reimburse the provider for covered services provided to an enrollee retroactively to the contract's effective date, if the credentialing process extends beyond the effective date of the new contract; and

- when credentialing a provider being added to an approved and in-use provider contract where a relationship exists between the carrier and a provider or entity for whom the provider is employed, the carrier must reimburse the provider for covered services provided to enrollees during the credentialing process, beginning with when the provider submitted a completed credentialing application.

The carrier must reimburse the provider at the contracted rate that the provider would have been paid at the time the services were provided if the provider were fully credentialed by the carrier. The carrier is not required to reimburse for services:

- that are not benefits or services covered by the carrier's health benefit plan; or
- rendered by a provider who's provider credentialing application is not approved or who does not enter into a contractual relationship with the carrier.

Hospitals, rural health clinics, and rural providers 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.

MCOs 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 a MCO in order to be reimbursed for services provided on behalf of a contracted provider beyond 60 days. Substitute provider enrollment in a MCO is effective on the latter of the date they filed an enrollment application that was approved, or the date they first began providing services. A substitute provider may not bill for the same services provided as a substitute and once enrolled with a MCO.

Nothing obligates a MCO to enroll any substitute provider who requests enrollment if they do not meet the organizations enrollment criteria.

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. Substitute providers include physicians, osteopathic physicians and surgeons, podiatric physicians and surgeons, physician assistants, osteopathic physician assistants, and advance registered nurse practitioners.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: The bill contains several effective dates. Please refer to the bill.

Staff Summary of Public Testimony: PRO: When provider offices need to hire a new physician, the provider must get credentialed by a carrier to receive reimbursement. This process can take up to 90 days. During that time, the provider and their office cannot get paid for services being provided to enrollees, which leaves offices in a difficult financial situation. This bill will ensure providers can get paid for services provided during the credentialing process. The focus had been on the timeline for credentialing, but the focus has changed to ensure providers can be retroactively paid.

OTHER: There is a question about what constitutes the starting point for retroactive reimbursement, and a possible desire for some clarity about when a contract has been completed. The concern is that a provider might in good faith believe their application is complete, but that an insurer may wait to respond to the provider and later notify them the application is not complete. This would again leave providers in a situation where they are unable to receive payment for certain services provided. The bill before the committee is otherwise well worked and a good compromise. The hope is to keep this bill moving, but potentially clarify when a contract is deemed completed as the bill moves to the floor.

Persons Testifying: PRO: Representative Laurie Dolan, Prime Sponsor; Sean Graham, Washington State Medical Association.

OTHER: Lisa Thatcher, Washington State Hospital Association; Chris Bandoli, Association of Washington Healthcare Plans.

Persons Signed In To Testify But Not Testifying: No one.