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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE LICENSING & REGULATION
ANALYSIS

BILL #: HB 1881 (PCB HCL 99-05)

RELATING TO: Standardized Credentialing of Health Care Practitioners

SPONSOR(S): Committee on Health Care Licensing and Regulation and Representative Fasano and others

COMPANION BILL(S): SB 2134(s)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE LICENSING & REGULATION YEAS 12 NAYS 0
(2)
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I. SUMMARY:

HB 1881 makes a number of changes to the standardized credentialing process passed in 1998 as HB 4515 for health care practitioners which applied to those licensed under chapters 458, 459, 460, and 461, F.S. (medical, osteopathic medicine, chiropractic medicine, and podiatric medicine physicians, respectively). There are approximately 50,000 physicians licensed in these four professions. The majority, approximately 40,000 are licensed medical physicians.

The principle changes to the current law are:

1) The Department of Health is no longer required to be a credentialing verification entity (CVE) for all health care practitioners in the state. The department will now only serve as a depository for mostly unverified core credentials data and corrections, updates, or modifications to such data. It will be available electronically to any health care entity that is authorized to access the data by the health care practitioner. No one will be able to access the new system without prior approval of the health care practitioner.

2) The definition of “core data” has been changed to accommodate the needs of the health care entities. Also, a CVE is changed to a credentials verification organization (CVO), which is the more common name used in the industry.

3) All practitioners will provide their “core credentials data” and corrections, updates, or modifications to such data to the department instead of a designated CVO. However, a health care practitioner may still designate a CVO. A designated CVO must meet all the time frames established for a practitioner, or face suspension of their license to operate in Florida. Also, a designated CVO is prohibited from releasing any information without prior approval of the practitioner.

4) The time period for reporting certain incidents is changed from within 30 days to within 45 days to coincide with the requirements of profile reporting. Rather than file two reports (profile and credentials update), a credentials report will comply with the requirement to file a profile report.

5) Effective July 1, 2002, no Florida agency may collect or attempt to collect duplicate core credentials data from any practitioner if the information is available from the department. This does not restrict requesting additional information not included in the department’s file.

6) A CVO must maintain liability insurance to meet certification or accreditation requirements.

7) Liability - It is changed to provide that there is no liability against any health care entity or CVO for reliance on data obtained directly from the department.

The DOH is seeking release of the $5 million 1998 appropriations to design and build the new system. The department is also seeking an additional $4.4 million for FY 1999-00 to operate and maintain the system which is expected to be recovered from user fees over several years.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

Prior to 1998 Legislative Session - There was no standardized credentialing process for health care practitioners licensed under chapters 458, 459, 460, and 461, Florida Statutes (medical, osteopathic medicine, chiropractic medicine, and podiatric medicine physicians, respectively). There were approximately 50,000 physicians licensed in those four professions. The majority, approximately 40,000 were licensed medical physicians.

Those four professions were the primary health care practitioners involved in the duplication resulting from the current multiple credentialing process required by the various health care entities (hospitals, managed care groups, health insurance groups and other third-party health care payers).

The duplication involved in credentialing and recredentialing was unnecessarily costly and cumbersome for both the practitioner and the entity granting practice privileges. There was no one group to receive and verify the core credentials of a physician. A health care practitioner's core credentials data was collected, validated, maintained, and stored by each health care entity for which the practitioner applied for practice privileges.

The 1997 Legislature recognized that health care practitioner credentialing activities had increased significantly as a result of health care reform and recent changes in health care delivery and reimbursement systems. To expedite a standardized credentialing system and eliminate duplication, the Legislature in chapter 97-261, Laws of Florida, provided for the appointment of a special task force by the Secretary of Health to study the issue and report back to the 1998 Legislature.

The task force reviewed the issues and made its final report in January, 1998. The following is a summary of their recommendations:

1. A standardized system for collecting and verifying core credentials of health care practitioners through a certified credentials verification entity should be established.

2. Data on individual practitioners should be centrally stored with only one entity. Each entity must meet national standards and be certified by national accrediting organizations. Monitoring procedures should be in place to ensure quality control and maintain continuity in the credentials verification process.

3. Health care entities should be held harmless and should not be liable if they rely on data obtained from a certified credentials verification entity.

4. Core credentials data should be collected only once by a certified credentials verification entity. However, a health care entity may obtain additional information if required by the entity's credentialing process.

5. All efforts should be made in the legislation to minimize costs to health care practitioners as well as to health care entities.

6. Credentials verification entities should be required to establish procedures to ensure primary source verification of core credentials, whenever possible. Exceptions should be allowed only in accordance with standards outlined by national accrediting organizations.

7. Health care practitioners should have an opportunity to review the core credentials data before it is stored in the data bank of an entity.

8. The credentials verification entity must collect the core credentials data on a standardized form. The data must be updated whenever the practitioner's status changes; otherwise at least quarterly.

Passage of chapter 97-273 relating to physician profiling provided for the Department of Health to gather much of the core credentialing data. It provided for the department to compile certain information submitted in a physician profile of each licensee and to make those profiles available to the public. The profiles were to be developed for the following four practitioners, medical,

osteopathic, chiropractic, and podiatric physicians. The profiles were mailed out by the department in February, 1999, and are to be returned to the department by April 15, 1999, and compiled and available to the public over the Internet beginning July 1, 1999. However, prior to release of the profile over the Internet, the department is required to allow the practitioner 30 days to review and make factual corrections. In 2000, the department is to recommend other professions, if any, that should be added to the profiling requirements of s. 455.565, F.S.

Applicants for licensure or relicensure in the four professions are required to submit a set of fingerprints, and pay certain fees. Applicants for relicensure are not required to submit a set of fingerprints until after January 1, 2000. The department must submit the fingerprints to the Department of Law Enforcement for a national criminal background check (includes FBI). Failure to comply within 30 days of notice of noncompliance, may result in a citation and a fine of up to $50 for each day of noncompliance.

The department was authorized to issue emergency orders suspending the license of a medical or osteopathic physician who failed to comply with certain financial responsibility requirements of the appropriate chapter.

It provided that liability actions and information in the possession of the department relating to bankruptcy proceedings of specified practitioners are public records. The department was required to make this information available upon request. Insurers were required to report professional liability claims and actions. The time frame for reporting was 45 days.

1998 Legislative Action - As a result of the Task Force report, the Legislature passed HB 4515 (ch. 98-226, Laws of Florida). HB 4515 provided for standardized credentialing of physicians licensed under chapters 458, 459, 460, and 461, F.S. (medicine, osteopathic medicine, chiropractic medicine, and podiatric medicine, respectively). Provision was made for other health care practitioners to participate provided they meet the profiling requirements of s. 455.565, F.S. **The effective date of this law is July 1, 1999.**

It provided a statement of intent about the current duplication in credentialing and how it was unnecessarily costly and cumbersome for both the practitioner and the entity granting practice privileges. It further provided for the establishment of a mandatory credentials verification program. Definitions were provided for implementation of a standardized program with standardized forms.

Once a health care practitioner's core credentials data was collected and validated by a "credentials verification entity" (CVE), the health care practitioner was not required to resubmit this initial data when applying for practice privileges with health care entities. Timely updating of this information, no less than quarterly was required. A CVE was required to be certified by a quality assurance program from one of several national accreditation organizations. The practitioner may select a "designated" CVE responsible for responding to all inquiries about said practitioner. A health care entity may use either the designated CVE or the Department of Health to obtain current credentials data on a practitioner applying for privileges with such entity. This law required the Department of Health to become a credentials verification entity and to meet the quality standards required for private CVEs. Any additional information required by such entity may be collected from a primary source, or the designated CVE. The department, in consultation with a thirteen-member advisory council, was to develop standard forms for the reporting of initial data for credentialing and periodic updating for recredentialing purposes.

Liability - Under current law, a health care entity is held harmless and is not liable if it relies on data obtained from a CVE or the department as a CVE. All CVEs, other than the department, are required to maintain liability insurance coverage. Any CVE that does business in Florida must be certified and registered with the department.

At the time of passage, the total potential savings to the private sector were not available. However, according to several health care entities, the savings were to be substantial.

July 1, 1998, to present - During the summer of 1998, and up to approximately November 1, 1998, the department attempted to implement the provisions of HB 4515. Several meetings were held with the Credentials Advisory Council, and the department held numerous meetings with the various groups involved in credentialing health care practitioners. However, it became evident to the

department that they could not meet all of the requirements to be a fully certified CVE since the national certification program was not designed for a state agency.

With that policy decision being made, the health care industry (mostly hospitals and HMOs) decided they wanted to continue with their current credentialing process with as few changes as possible. It was decided that the department would serve as a central depository of all health care practitioner's core data, and any corrections, updates, or modifications. The data maintained by the department would in most instances be unverified data, and it would be the responsibility of each health care entity to electronically obtained the information from the department, and primary source verify the data the way they had done in the past.

The principle difference is that each health care practitioner will no longer be required to submit the same core data to every health care entity that wanted it. Once the data is available from the department, a health care practitioner will no longer be required to supply it to all of the entities with whom they have a relationship. The average health care practitioner maintains a relationship with an estimated 25 health care entities.

Once that decision was reached, the department began working with a consultant to assist them in developing a system that would meet these requirements in a timely fashion. According to the department, a prototype of this system will be available July 1,1999, and the system will be fully operational by December 31, 1999. As of this date, the various health care entities around the state will be able to electronically obtain all of the necessary data on Florida's approximately 50,000 health care practitioners.

B. EFFECT OF PROPOSED CHANGES:

The principle changes to the current law are:

- The Department of Health is no longer required to be a CVE for all health care practitioners in the state. The department will now only serve as a depository for mostly unverified core credentials data and corrections, updates, or modifications to such data. It will be available electronically to any health care entity that is authorized to access the data by the health care practitioner. No one will be able to access the new system without prior approval of the health care practitioner. CVOs gathering data on a health care practitioner must get the core credentials data from the department the same as a health care entity.

- The definition of "core data" has been changed to accommodate the needs of the health care entities. Also, a credentials verification entity (CVE) is changed to a credentials verification organization (CVO), which is the more common name used in the industry.

- All health care practitioners will provide their "core credentials data" and corrections, updates, or modifications to such data to the department instead of a designated CVO. However, a health care practitioner may still designate a CVO, who must provide the data to the department as agent for the practitioner. A designated CVO must meet all the time frames established for a practitioner, or face suspension of their license to operate in Florida. Also, a designated CVO is prohibited from releasing any information on his client without prior approval by the practitioner.

- The time period for reporting certain incidents is changed from within 30 days to within 45 days to coincide with the requirements of profile reporting. Rather than file two reports (profile and credentials update), a credentials report will comply with the requirement to file a profile report.

- Effective July 1, 2002, no Florida agency may collect or attempt to collect duplicate core credentials data from any practitioner if the information is available from the department. This does not restrict the right of any state agency to request additional information not included in the department's file, which is deemed necessary for the agency's specific credentialing purposes.

- Liability insurance requirements will no longer be established by the department for CVOs. It requires each CVO to maintain liability insurance appropriate to continue their certification or accreditation requirements.

- Previously, no civil, criminal, or administrative action could be instituted, and there was no liability against any health care entity for reliance on any data obtained from a CVO. This is changed to provide that there is no such action against a CVO or any health care entity for reliance on data obtained directly from the department.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

Yes. The department is authorized to adopt rules related to credentialing.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

While it should minimize the work for health care practitioners, there should be minimal change on the various health care entities. Instead of getting most of the data for credentialing from the practitioner, they will get it from the department electronically.

(3) any entitlement to a government service or benefit?

No.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

No.

b. Does the bill require or authorize an increase in any fees?

No. The current law provides for user fees to pay the cost of any data collected electronically from the department.

c. Does the bill reduce total taxes, both rates and revenues?

No.

d. Does the bill reduce total fees, both rates and revenues?

No.

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

N/A

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

Yes. All costs of this legislation will be paid by beneficiaries, the same as in the current law.

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

N/A

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

No. Current law prohibits health care entities from obtaining data on health care practitioners once it is filed with the department or a designated CVO.

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

(1) Who evaluates the family's needs?

N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

N/A

(5) Are families penalized for not participating in a program?

N/A

b. Does the bill directly affect the legal rights and obligations between family members?

N/A

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

Section 455.557, Florida Statutes

E. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 455.557, Florida Statutes, to revise the standard credentialing law passed in 1998. The principle changes made to the current law are:

The Department of Health is no longer required to be a CVE for all health care practitioners in the state. The department will now only serve as a depository for mostly unverified core credentials data and corrections, updates, or modifications to such data. It will be available electronically to any health care entity that is authorized to access the data by the health care practitioner. No one will be able to access the new system without prior approval of the health care practitioner. CVOs gathering data on a health care practitioner must get the core credentials data from the department the same as a health care entity.

The definition of "core data" has been changed to accommodate the needs of the health care entities. Also, a credentials verification entity (CVE) is changed to a credentials verification organization (CVO), which is the more common name used in the industry.

All health care practitioners will provide their "core credentials data" and corrections, updates, or modifications to such data to the department instead of a designated CVO. However, a health care practitioner may still designate a CVO, who must provide the data to the department as agent for the practitioner. A designated CVO must meet all the time frames established for a practitioner, or face suspension of their license to operate in Florida. Also, a designated CVO is prohibited from releasing any information on his client without prior approval by the practitioner.

The time period for reporting certain incidents is changed from within 30 days to within 45 days to coincide with the requirements of profile reporting. Rather than file two reports (profile and credentials update), a credentials report will comply with the requirement to file a profile report. Also, the provision that every practitioner must file a quarterly update if no data changes had been filed, is deleted.

Effective July 1, 2002, no Florida agency may collect or attempt to collect duplicate core credentials data from any practitioner if the information is available from the department. This does not restrict the right of any state agency to request additional information not included in the department's file, which is deemed necessary for the agency's specific credentialing purposes.

Liability insurance requirements will no longer be established by the department for CVOs. It requires each CVO to maintain liability insurance appropriate to continue their certification or accreditation requirements.

Previously, no civil, criminal, or administrative action could be instituted, and there was no liability against any health care entity for reliance on any data obtained from a CVO. This is changed to provide that there is no such action against a CVO or any health care entity for reliance on data obtained directly from the department.

Section 2. Provides an effective date of upon becoming a law.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

See Fiscal Comments.

2. Recurring Effects:

See Fiscal Comments.

3. Long Run Effects Other Than Normal Growth:

None.

4. Total Revenues and Expenditures:

See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

None. According to the department, the changes proposed to the existing law should not cost the private sector (health care entities) any additional money.

2. Direct Private Sector Benefits:

Indeterminate. Presently, there was the potential savings to the health care entity from reducing the number and cost of credentialing a health care practitioner. In the past, each health care entity would primary source verify the credentials of each health care practitioner with whom they maintained a relationship. **It has been stated that the average practitioner has a relationship with 25 health care entities. This means that the same data is gathered and primary source verified 25 times under the current system. The present law proposed to reduce the 25 times to one time, thus the potential savings to the various health care entities**. The

revision to the 1998 law will result in going back to the old system of each health care entity gathering the same data and primary source verifying it for each practitioner with which they maintain a relationship. This results in the potential for the same data being verified 25 times.

3. Effects on Competition, Private Enterprise and Employment Markets:

None.

D. FISCAL COMMENTS:

According to the Department of Health, the revised system will not cost the state any additional funds. In 1998, the department was appropriated approximately $5 million and 7 FTEs to implement the new system July 1, 1999. The department states that they can implement the revised system with a prototype available July 1, 1999, and a fully operational system by December 31,1999. Annual maintenance costs on the revised system will be the same as on the original system. The cost of the revised system will be recovered from user fees over a period of years, the same as was planned for the original system. The department is seeking budget authority of $4.4 million for fiscal year 1999-2000 to operate and maintain the new system.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not reduce the authority that municipalities or counties have to raise revenues in the aggregate.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

None.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

None.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE LICENSING & REGULATION:

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