A bill to be entitled

An act relating to health care provider participation in Medicaid managed care organizations; creating s. 409.9663, F.S.; providing definitions; requiring that health care providers wanting to participate in Medicaid managed care organizations enroll with the Agency for Health Care Administration and be credentialed for and enter into a contract with Medicaid managed care organizations; requiring the agency to enroll health care providers within a specified timeframe under certain circumstances; providing the date of enrollment; providing tolling events; requiring certain health care providers to submit credentialing applications to credentialing verification organizations; providing requirements for such organizations; providing requirements for contracts between the agency and such organizations; providing requirements for contracts between Medicaid managed care organizations and health care providers; encouraging licensing boards to cooperate with the agency and credentialing verification organizations; providing the date on which providers' claims become eligible for payment; prohibiting Medicaid managed care organizations from imposing certain requirements

relating to clean claims within a specified timeframe; providing construction; providing rulemaking authority; providing an effective date.

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

Section 1. Section 409.9663, Florida Statutes, is created to read:

409.9663 Enrollment and credentialing requirements for health care provider participation in managed care organizations.—

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

(a) "Clean credentialing application" means an application submitted by a provider to a credentialing verification organization which:

1. Is complete and correct;

2. Does not lack any required substantiating documentation; and

3. Is consistent with the National Committee for Quality Assurance requirements.

(b) "Clean provider enrollment application" means an application submitted by a provider to the agency for enrollment in the Medicaid program which:

1. Is complete and correct;

2. Does not lack any required substantiating documentation;

3. Complies with all provider screening requirements for the Medicaid program integrity pursuant to 42 C.F.R. part 455; and

4. Is on behalf of a provider who does not have accounts receivable with the agency.

(c) "Credentialing application date" means the date on which a credentialing verification organization receives a clean credentialing application from a provider.

(d) "Credentialing verification organization" means an organization that gathers data and verifies the credentials of providers in a manner consistent with federal and state laws and the requirements of the National Committee for Quality Assurance.

(e) "Medicaid managed care organization" means an entity with which the agency has contracted to serve as a managed care organization as defined in 42 C.F.R. s. 438.2.

(f) "Provider" has the same meaning as the term "health care provider" in s. 381.00321(1).

(2) A provider that wants to participate in a Medicaid managed care organization must:

(a) Enroll with the agency; and

(b) Be credentialed for and enter into a contract with the

Medicaid managed care organization.

(3) The agency shall enroll a provider in the Medicaid program within 60 days after receipt of a clean provider enrollment application. The date of enrollment is the date on which the agency receives the clean provider enrollment application. The time limits established in this subsection shall be tolled for any delay caused by an external entity. Tolling events include, but are not limited to, the screening requirements for the Medicaid program integrity contained in 42 C.F.R. part 455, and searches of federal databases maintained by entities such as the Centers for Medicare and Medicaid Services.

(4)(a) Before seeking to be credentialed for and enter into a contract with a Medicaid managed care organization, a provider must submit a credentialing application to a credentialing verification organization, which shall recommend or refuse to recommend the provider for credentialing.

(b) A credentialing verification organization shall:

1. Implement a credentialing application via a web-based portal available to all providers seeking to be credentialed for any Medicaid managed care organization.

2. Perform primary source verification and credentialing committee review of each credentialing application and recommend a provider's credentialing within 30 days after receipt of a clean credentialing application.

3. Notify a provider within 5 business days after receipt of a credentialing application if the credentialing application is incomplete.

4. Conduct provider outreach and provide help desk services during regular business hours to facilitate credentialing applications and credentialing information.

5. Expeditiously communicate the credentialing recommendation and supporting credentialing information electronically to the agency and to each participating Medicaid managed care organization with which the provider is seeking credentialing.

6. Conduct reevaluation of provider documentation when required pursuant to state or federal law or when necessary for the provider to maintain participation status with a Medicaid managed care organization.

(5) If the agency designates an organization as a credentialing verification organization, the contract between the agency and the credentialing verification organization must require that the credentialing verification organization:

(a) Be reimbursed on a per provider credentialing basis by the agency, with the reimbursement being offset or deducted equally from each Medicaid managed care organizations capitation payment.

(b) Comply with the requirements in paragraph (4)(b).

(6) A Medicaid managed care organization shall:

(a) Determine whether it enters into a contract with a provider within 30 days after receipt of the verified credentialing information from a credentialing verification organization designated by the agency.

(b)1. Within 10 days after executing a contract with a provider, ensure that any internal processing systems of the Medicaid managed care organization have been updated to include:

a. The accepted provider contract; and

b. The provider as a participating provider.

2. In the event that the loading and configuration of a contract with a provider takes longer than 10 days, the Medicaid managed care organization may take an additional 15 days if the Medicaid managed care organization has notified the provider of the need for additional time.

(7) To promote seamless integration of licensure information, the relevant provider licensing boards in this state are encouraged to forward and provide licensure information electronically to the agency and any credentialing verification organization.

(8)(a) For the purpose of reimbursement of claims, once a provider has met the terms and conditions for credentialing and enrollment, the provider's credentialing application date is the date from which the provider's claims become eligible for

payment.

(b) A Medicaid managed care organization may not require a provider to appeal or resubmit any clean claim submitted during the time period between the provider's credentialing application date and the completion of the credentialing process.

(9) This section does not:

(a) Require a Medicaid managed care organization to contract with a provider if the Medicaid managed care organization and the provider do not agree on the terms and conditions for participation.

(b) Prohibit a provider and a Medicaid managed care organization from negotiating the terms of a contract before the completion of the agency's enrollment and screening process.

(c) Limit the agency's authority to establish criteria that allow a provider's claims to become eligible for payment in the event of lifesaving or life-preserving medical treatment, such as an organ transplant.

(d) Prohibit a university hospital from performing the activities of a credentialing verification organization for its employed physicians, residents, and mid-level practitioners if such activities are delineated in the hospital's contract with a Medicaid managed care organization. Subsections (3), (6), (7), and (10), with regard to payment and timely action on a credentialing application, apply to a credentialing application

that has been verified through a university hospital pursuant to this paragraph.

(10) The agency may adopt rules to implement this chapter, including administrative rules to ensure the timely and efficient credentialing of providers.

Section 2. This act shall take effect July 1, 2025.