By Senator Simon

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A bill to be entitled

An act relating to centralized Medicaid provider credentialing; creating s. 409.9073, F.S.; defining terms; requiring Medicaid managed care organizations operating in this state on or after a specified date to require their providers to comply with specified accreditation requirements; specifying procedures for provider enrollment; requiring the Agency for Health Care Administration to enroll providers within a specified timeframe after receiving a clean application; providing for tolling of such timeframe under certain circumstances; requiring credentialing verification organizations to implement a single credentialing application through a web-based portal; specifying requirements and procedures for provider credentialing; specifying provisions that apply if the agency designates a single credentialing verification organization for provider credentialing; requiring Medicaid managed care organizations to make a determination within a specified timeframe after receiving verified credentialing information; requiring Medicaid managed care organizations to ensure that internal processing systems of the organization are updated within a specified timeframe after a contract with a provider is executed; providing construction; providing that once approved for enrollment, a provider's claims become eligible for payment on the date on which the provider's credentialing application was approved; prohibiting

Medicaid managed care organizations from requiring providers to appeal or resubmit clean claims submitted during a specified period; providing applicability; encouraging relevant provider licensing boards to forward and provide certain information electronically to the agency and credentialing verification organizations; authorizing the agency to adopt rules; providing an effective date.

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

Section 1. Section 409.9073, Florida Statutes, is created to read:

409.9073 Medicaid provider credentialing.—

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

(a) "Clean application" means:

1. For credentialing purposes, a credentialing application submitted by a provider to a credentialing verification organization which:

a. Is complete and correct;

b. Does not lack any required substantiating documentation; and

c. Is consistent with the requirements set by the National Committee for Quality Assurance; or

2. For enrollment purposes, an enrollment application submitted by a provider to the agency which:

a. Is complete and correct;

b. Does not lack any required substantiating documentation;

c. Complies with all provider screening requirements of 42

C.F.R. part 455; and

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

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

(c) "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.

(d) "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 under the Medicaid program.

(2) A managed care organization operating in this state on or after July 1, 2025, for the delivery of Medicaid services shall require its providers to comply with the accrediting requirements of this section.

(3) The agency shall enroll a provider within 60 calendar days after receipt of a clean application for provider enrollment. The credentialing application date is considered the date of enrollment. The time limits established in this section must be tolled or paused for any delay caused by an external entity. Tolling events include, but are not limited to, the screening requirements 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 credentialing verification organization established

under this section shall do all of the following:

(a) Implement a single credentialing application through a web-based portal available to all providers seeking to be credentialed for any Medicaid managed care organization.

(b) Perform primary source verification and credentialing committee review of each credentialing application that results in a recommendation on the provider's credentialing within 30 days after receipt of a clean application.

(c) Notify providers within 5 business days after receipt of a credentialing application if the application is incomplete.

(d) Provide provider outreach and help desk services during common business hours to facilitate provider applications and credentialing information.

(e) 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.

(f) Conduct reevaluation of provider documentation when required by 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 a single credentialing verification organization under this section, all of the following provisions apply:

(a) The contract between the agency and the credentialing verification organization must be submitted to the Department of Management Services for comment and review.

(b) The credentialing verification organization must be

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

(c) The credentialing verification organization must comply with paragraph (6)(b).

(d) The agency must adopt rules necessary to ensure the timely and efficient credentialing of providers.

(6) A Medicaid managed care organization shall do all of the following:

(a) Make a determination within 30 calendar days after it receives verified credentialing information for a provider from a credentialing verification organization designated by the agency.

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

1. The accepted provider contract; and

2. The provider as a participating provider.

(7)(a) This section does not require a Medicaid managed care organization to contract with a provider if the managed care organization and the provider do not agree on the terms and conditions for participation.

(b) This section does not prohibit a provider and a managed care organization from negotiating the terms of a contract before completion of the agency's enrollment and screening process.

(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 claims become eligible for payment

beginning on the date the provider's credentialing application was approved.

(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.

(c) This subsection does not limit the agency's authority to establish the criteria that will allow a provider's claims to become eligible for payment in the event of lifesaving or life-preserving medical treatment, including, but not limited to, an organ transplant.

(9) This section does not prohibit a teaching hospital as defined in s. 408.07 from performing the activities of a credentialing verification organization for its employed physicians, residents, and mid-level practitioners when such activities are delineated in the hospital's contract with a Medicaid managed care organization. The provisions of this section relating to reimbursements and timely action on a credentialing application apply to a credentialing application that has been verified through a teaching hospital under this subsection.

(10) 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.

(11) The agency may adopt rules to implement this section.

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