STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner
JOE MANCHIN III
Governor

JANE L. CLINE
Insurance Commissioner

December 29, 2009

The Honorable Roman Prezioso
Room 439M, Building 1
State Capitol Complex
Charleston, WV 25305

The Honorable Don Perdue
Room 200E-C, Building 1
State Capitol Complex
Charleston, WV 25305

Re: Report on Uniform Credentialing Pursuant to W.Va. Code §16-1A-5

Dear Senator Prezioso & Delegate Perdue:

The following is a joint report on uniform credentialing to be filed with the Legislative Oversight Commission on Health and Resources Accountability on behalf of the Insurance Commissioner and the Secretary of the Department of Health and Human Resources. The report summarizes the activities of the Uniform Credentialing Advisory Committee. Attached to the report is the legislation that was to be developed by the Uniform Credentialing Advisory Committee and reported by the Insurance Commissioner and the Secretary of the Department of Health and Human Resources.

Should you have any questions or need additional information, please do not hesistate to contact me.

Sincerely,

Timothy R. Murphy
Associate Counsel to Insurance Commissioner

TRM/sc

enclosure

cc: John Law, Department of Health and Human Resources
Kathy Lawson, General Counsel, Department of Revenue

West Virginia Department of Health and Human Resources
and
West Virginia Offices of the Insurance Commissioner

Joint Report on Uniform Credentialing of Health Care Practitioners

Presented to the Legislative Oversight Commission on Health and Resources Accountability

Jane L. Cline, Insurance Commissioner
Patsy A. Hardy, Secretary of the Department of Health and Human Resources

January 1, 2010

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JOINT REPORT ON UNIFORM CREDENTIALING OF HEALTH CARE PRACTITIONERS

Offices of the Insurance Commissioner
Department of Health and Human Resources
January 1, 2010

I. Introduction

Credentialing of health care practitioners is required by hospitals, insurance companies, prepaid health plans, third party administrators and other health care entities in order to verify the education, training, experience and competence of the health care practitioners and ensure that they are qualified to treat patients. Although uniform credentialing and recredentialing application forms have been created to reduce duplication and increase efficiency, each credentialing entity continues to perform primary source verification for the practitioners who apply to that entity for affiliation. Moreover, because credentialing entities do not follow a common calendar, practitioners are required to respond to requests throughout the year from various credentialing entities seeking essentially similar information. This duplication of primary source verification is time-consuming and costly..

In response to this concern, H.B. 2885 was enacted by the West Virginia Legislature during its 2009 Regular Session. The bill amended article one-a of chapter sixteen to require the previously-established advisory committee to develop legislation on the uniform credentialing process. In developing the legislation, the advisory committee was to consider a list of topics set forth in the bill and discuss whether to include such topics in the legislation to be presented. Further, the West Virginia Offices of the Insurance Commissioner and the West Virginia Department of Health and Human Resources are to jointly report the legislation to the Legislative Oversight Commission on Health and Resources Accountability on or before January 1, 2010.

The advisory committee was appointed by the Secretary and Insurance Commissioner pursuant to the direction in H.B. 3242 that was enacted in 2001, and members were added as required by H.B. 2885. The committee has made recommendations concerning the development of the proposed legislation and topics to be considered for rulemaking, and has further recommended the creation of a credentialing verification organization. The following report, which summarizes the actions taken by the Secretary, Insurance Commissioner and advisory committee to implement a uniform credentialing process in West Virginia, is intended to fulfill the obligations imposed by H.B. 2885 on the Secretary and Insurance Commissioner to report on the proposed legislation to be introduced and developed by the advisory committee.

The report includes a summary of the topics the advisory committee was charged with discussing and the outcome of those discussions. Please note that within the summary discussion of each legislative consideration there are several dissenting or clarifying positions of various committee members for the record. The report also gives a summary of the topics to be addressed in rulemaking. Attached to this report is a copy of the proposed legislation submitted by the committee.

II. Enabling Legislation

In 2009, W. Va. Code §16-1A-1 et seq. was amended to request the advisory committee to develop proposed legislation regarding the uniform credentialing of health care practitioners. West Virginia Code §16-1A-5 now provides as follows:

> On or before January 1, 2010, the advisory committee established pursuant to section four of this article shall develop legislation that considers the following:
> (1) The establishment of one or more CVOs within the state to provide primary source verification with electronic accessibility on a cost effective and operationally efficient basis.
> (2) The number of CVOs necessary to provide this access for the state.
> (3) The treatment of existing CVOs currently doing business within the state.
> (4) The duties of a CVO and the timelines for completion of its verification duties.
> (5) The procedures for maintaining healthcare practitioner files.
> (6) The payment system to cover the costs of the credentialing program.
> (7) The use and confidentiality of data generated, collected and maintained by a CVO.
> (8) Compliance by CVOs with certificate requirements including NCQA, URAC, Medicare and Medicaid and other state and federal requirements.
> (9) The required use by payors and hospitals of a CVO's primary source
> verification services.
> (10) Credentialing recredentialing requirements as required by payors, hospitals and state and federal law and regulations.
> (11) The use of site visits in credentialing.
> (12) The maintenance, amounts and types of liability insurance to be obtained by a CVO.
> (13) Consideration of existing statutory protections that should be extended to the CVO.
> (14) Privacy considerations.
> (15) If applicable, the terms and conditions of the contract under which a CVO operates in this state and the procedure and criteria upon which a CVO is selected.
> (16) Penalties, if any, for noncompliance.
> (17) Timelines for credentialing, recredentialing and other compliance obligation of payors.
> (18) Reconciliation of the use of forms required by this article with other applicable state and federal laws and regulations."

West Virginia Code §16-1A-5 further states that "[o]n or before January 1, 2010, the

department and the commissioner shall jointly report to the Legislative Oversight Commission on Health and Human Resources Accountability proposed legislation to implement the provisions set forth in this article."

III. Advisory Committee Members and Actions

Member	Representing
Bill Maclean	Preferred Provider Organization
Valorie Raines	Third Party Administrators
Patricia Fast	HMO Organization accredited by NCQH
Michelle Coon	HMO Organization accredited by URAC
Shirley Whitley	Hospital with more than 100 beds
Dr. Hoyt Burdick	Practitioner Subject to Credentialing
Barbra Good	WV State Medical Association
Amy Tolliver	WV State Medical Association
Jim Kranz	WV State Hospital Association
Alvita Nathaniel	Practitioner Subject to Credentialing
Brenda Greene	Hospital with less than 100 beds
Carla VanWyck	Indemnity Healthcare Insurer
Julie Williams	Credentials on behalf of Practitioners

The committee held meetings on May 20, 2009, June 9, 2009, July 8, 2009, August 12, 2009, September 2, 2009, September 30, 2009, October 20, 2009, November 4, 2009 and November 20, 2009. The committee met for the purpose of discussing and considering the eighteen topics set forth in House Bill 2885 as they related to the establishment of a statewide Credentialing Verification Organization(s) and a more effective credentialing system; and to develop corresponding legislation.

As a part of its deliberations, the committee contacted and held a lengthy teleconference with state officials of Arkansas who operate the only statewide credentialing verification system in the country; this system was instituted in 1999. Their input and experience, coupled with their statute, formed a foundation for the committee's deliberations and conclusions.

The committee's deliberations and conclusion are summarized below and legislation recommended by the committee is attached.

V. Topics Considered and Discussed by Advisory Committee

(1) The establishment of one or more CVOs within the state to provide primary source verification with electronic accessibility on a cost effective and operationally efficient basis.

The consensus of committee was that the establishment of a centralized credentialing verification process responsible for primary source verification, coupled with uniform recredentialing dates for providers, would produce a faster, more efficient and cost-effective procedure for credentialing providers with payers.

The current credentialing environment involves payers that each use differing credentialing calendars, thereby causing providers to constantly maintain current applications subject to clarification requests and duplicative primary source verification and office site visitation.

The proposed bill would establish a single statewide CVO that would ultimately be responsible for collecting and maintaining all credentialing application information and performing all related primary source verification of such information for all health care practitioners subject to credentialing in West Virginia. It was generally, though not unanimously, perceived that the most efficient and cost effective verification process would be facilitated through a single CVO facilitated by flexible electronic access. ***See:*** **Consideration (2) below.** A single CVO removes duplicate efforts on behalf of both practitioners and credentialing entities. It was recognized, however, that a single CVO could not be expected to immediately process all credentialing information and primary source verification functions for all West Virginia practitioners from the start-up and that a phase-in period for credentialing all practitioners would be necessary. It was agreed that rulemaking would be the preferred means of regulating the phase-in process.

It should be noted that the committee initially preferred the establishment of a state-sponsored CVO affiliated with the State Board of Medicine, similar to Arkansas's system. Upon exploring this concept, it was decided that a privatized CVO brought certain advantages such as an already existing entity with established procedures, experience and computer systems capable of providing quality service more expeditiously and at a lower overall cost and at literally no cost to the State

(2) <u>The number of CVOs necessary to provide this access for the state</u>.

The committee concluded that the selection of one CVO **[See: consideration (1) above]** would provide optimum effectiveness and efficiency in terms of simplicity and elimination of duplicity. The majority of the committee was of the opinion that a single CVO meeting the prescribed operating standard and requirements would be capable of providing adequate CVO access and service to all West Virginia providers and payers as long as there was a sufficient phase-in period for credentialing all practitioners.

Preliminary and ongoing discussions at times embraced the concept of beginning with more than one (2 or 3) selected CVOs, with the number retained reduced to one over time. This concept gave way, however, to the general majority conclusion of the Committee that it would be more effective for one CVO to be selected (for a three-year initial period, subject to renewals) and phase-in period for the mandatory use by practitioners established by rule.

As stated above, there were alternative views. The WVU School of Medicine faculty practice plan ("University Health Associates") and the West Virginia United Health System (WVUHS) believes that 2-3 CVOs should be initially selected, with the number of CVOs reduced to 1 by 2020. It is their belief the providers would select the CVO with whom they wished to work and that this would allow lower prices from CVOs that already serve a portion, but not all of, West Virginia. They further assert that by bringing in existing West Virginia-based CVOs that have existing credentialing files on many providers, physician time in giving

credentials information to a single "new" CVO is reduced and the bid requirements will require those CVOs to provide copies of their files to a single ultimate successor. Lastly they maintain that the use of multiple CVOs creates a back stop if one CVO is not successful. University Health Associates and WVUHS feels that this is essentially a tradeoff with efficiencies for healthcare providers and an initial inefficiency for payers that will need to establish relationships with multiple CVOs (WVUHS is the parent organization of West Virginia University Hospitals, United Hospital Center, City Hospital and Jefferson Memorial Hospital).

In another opinion submitted, Mountain State Blue Cross Blue Shield expressed that if the idea is to simplify the credentialing process, having multiple CVO's would be a concern for them, even as part of a phase in period. They stated that currently primary source verification is completed as part of their normal automated process in one location. Coordinating the efforts with multiple CVO's could delay the process and also add to administrative/system costs associated with processing credentialing applications. It is their belief that if there are multiple CVO's, there would need to be rules to address how the credentialing entities would be notified and track which CVO each practitioner chooses to utilize, and how the practitioner would notify the credentialing entity between credentialing cycles of any change. They also feel that there would be a concern that a CVO may not want to participate initially with the knowledge that at the end of the phase in period, there will be one selected. MSBCBS stated that they would support a phase in period that includes a select/volunteer group of practitioners, as well as a select/volunteer group of credentialing entities (payers), working with one CVO, that would eventually expand to all practitioners and credentialing entities.

As discussed above, it was thought that if the goal was to eventually have a single CVO, starting with one CVO would create less duplicity and confusion than beginning with multiple CVOs and paring down to one over time.

(3) The treatment of existing CVOs currently doing business within the state.

Based on the committee's experience and knowledge, it was believed that about six CVOs currently operate in West Virginia, most of them providing national or regional services with a couple of local CVOs operating primarily within West Virginia only. During the phase- in period, existing CVOs would continue to offer their services in West Virginia on a scaled- down basis until the phase-in of all West Virginia practitioners was achieved.

It was the appraisal of the committee that all CVOs currently serving West Virginia should have an ample opportunity to be the selected statewide CVO, a factor that was taken into consideration in the committee's deliberation of instituting compliance with credentialing requirements and certification by NCQA and other certifying entities. ***See:*** Consideration (8). By requiring the selected CVO to already be certified by NCQA, but allowing enough time between the passage of the legislation and the actual selection of the CVO for interested CVOs to attain accreditation, it was foreseen that any current CVO desiring to compete for selection could be a viable candidate.

(4) The duties of a CVO and the timelines for completion of its verification duties.

The CVO, per the legislation, would be primarily responsible for receipt of all uniform applications, primary source verification of said information, and the updating and maintenance of all information generated by such activities. The CVO would also be responsible for performing all activities required through certification by NCQA and the standards of The Joint Commission, including, but not limited to office site visits.

Credentialing entities, other than health care facilities (due to the additional competency requirements), are required to issue a credentialing decision within sixty days after receiving the statewide CVO's completed report. With respect to affirmative decisions, payments pursuant to the contract would be retroactive to date of decision.

Further, the legislation provides that practitioners are required to comply with any reasonable request for additional information on its application within thirty (30) days.

The legislation also provides that other duties and timelines for completion of verification duties and other pertinent performance standards imposed on the CVO will be addressed by legislative rule.

(5) The procedures for maintaining healthcare practitioner files.

The legislation provides for the maintenance of healthcare practitioner files to be specifically address by legislative rule.

(6) The payment system to cover the costs of the credentialing program.

The cost of the system would be covered by payments from both the credentialing entities (payers) and the health care practitioners. The majority of the cost would be borne by the credentialing entities by fees charged for various services rendered by the CVO. The fee schedule would be facilitated through the RFP contract process and legislative rules to reflect reasonable market prices. The Committee also envisioned that practitioners would be charged a nominal fee ($100.00 or less) for initial form application, again, to be specifically addressed by rule.

In an opinion submitted by Mountain State Blue Cross Blue Shield, they express concern of the payment system. They state that an evaluation of the operational/financial impacts will not be possible for credentialing entities or practitioners until the fees for utilizing the CVO are established. They argue that since there has been a sixty day decision requirement for payers only, this would result in higher costs to payers who may be required to submit the fees multiple times, if the application is denied due to receiving an incomplete application, and the provider re-applies.

(7) The use and confidentiality of data generated, collected and maintained by a CVO.

Credentialing information collected by the CVO shall only be released to credentialing entities upon the authorization of the healthcare practitioner.

The proposed legislation provides that all information collected by the CVO shall be confidential in nature and exempt from disclosure pursuant to subpoena or discovery and the Freedom of Information Act except in appeals of credentialing decisions, peer review (subject to protection afforded peer review information), matters before professional licensing boards or other federal regulatory authority and upon authorization to release by the healthcare practitioner to whom information relates.

(8) Compliance by CVOs with certificate requirements including NCQA, URAC, Medicare and Medicaid and other state and federal requirements.

The selected CVO shall, at a minimum, be certified by NCQA, be able to demonstrate compliance with The Joint Commission's standards for credentialing and all federal and state credentialing regulations.

(9) The required use by payors and hospitals of a CVO's primary source verification services.

After substantial discussion, the prevailing opinion of the committee was that in order to accomplish the goals of simplifying and effectively streamlining the credentialing system for healthcare practitioners, it is necessary that all credentialing entities, i.e. health care facilities, payers and networks, be required to utilize the statewide CVO. Without mandatory use by all credentialing entities, advantages of the statewide CVO will be diminished. As noted above, (considerations (1) and (2)), due to the practical necessity of a phase in period for all practitioners, dates on which the use of the CVO is mandatory for different classes of practitioners will be established by rule. It was the thought of the committee that in time the various state medical and professional boards may utilize the CVO for its information verification.

There was discussion that hospitals in general, or in the alternative, hospitals meeting certain criteria, be excepted from the mandatory use requirement. However, the majority decision of the committee was to not exempt anyone from mandatory use of the CVO.

In a minority opinion submitted by University Health Associates and WVUHS, it was expressed that providers should be permitted to use or not use the CVO at their election. They felt that this would allow providers that do not wish to pay CVO fees and believe their current process is efficient and acceptable to continue on this basis. They also felt that this would allow groups with delegated credentialing authority, that is, groups that both collect and maintain credentialing information and make actual credentialing decisions under agreements with payers to continue to do so. It is their belief that this approach would be less expensive for both those providers and the payers (University Health Associates has this two level function in operation now and does not charge payers for the service). They maintain that an internal two level function of this nature almost certainly operates more quickly than even a well run independent CVO, thus reducing the length of time for a given provider to be fully credentialed and be able to both provide care to West Virginia citizens and to be paid for doing so.

In another opinion submitted supporting the majority decision of the committee regarding mandatory usage for providers, Mountain State Blue Cross Blue shield stated that since the

rationale for developing legislation is to promote administrative simplification for physicians who require credentialing by multiple credentialing entities, that they do not support a provider (practitioner) "opt out". It is their belief that if there is anticipation that the CVO will provide simplification and eliminate duplication for practitioners, then there should also be an expectation for this to be true for the credentialing entities required to use the CVO. They believe that if some providers choose to "opt out", credentialing entities would need to develop processes for the practitioners that choose the CVO and those who do not choose to use the CVO. Further, they feel that if credentialing entities are required to utilize a centralized CVO instead of its current automated process, the process should be consistent for all providers (practitioners).

(10) Credentialing and recredentialing requirements as required by payors, hospitals and state and federal law and regulations.

The proposed legislation only addresses the use of the statewide CVO for the primary source verification of credentialing information contained within the uniform credentialing form. The data type and form of information provided to users will be specifically addressed in the contractual agreements between the CVO and credentialing entities in order to meet the entities' requirements.

As the CVO is only required to verify information, its activities do not involve or effect any requirements or limitations upon other credentialing requirements that affect the ultimate credentialing decision of the payers or health care facilities.

(11) The use of site visits in credentialing.

The legislation provides that the CVO will be responsible for site visits if requested to do so by the credentialing entity.

(12). The maintenance, amounts and types of liability insurance to be obtained by a CVO.

The legislation provides that the CVO would be required to maintain an errors and omissions insurance policy in an amount deemed adequate by the Secretary and Insurance Commissioner. The committee was of the opinion that an amount of coverage between $2-3 million per occurrence would probably be adequate and obtainable.

(13) Consideration of existing statutory protections that should be extended to the CVO.

The principle existing statutory protection extended to the Statewide CVO pertains to the confidentiality provisions afforded peer review information and proceedings.

(14) Privacy considerations.

Privacy concerns regarding practitioner credentialing information was deemed to be adequately covered by the confidentiality and release section of the bill, which provides that, with few exceptions, there may be no release of credentialing information without practitioner's

authorization. Additionally, upon the termination a particular CVO's contract, all credentialing information is to be returned to the Secretary and Commissioner to the extent allowed by law.

(15) If applicable, the terms and conditions of the contract under which a CVO operates in this state and the procedure and criteria upon which a CVO is selected.

The Committee was of the opinion that the specific terms and conditions of the contract should be addressed in the RFP process which will be under the oversight of the DHHR Secretary and the Insurance Commissioner with advice of the committee and will reflect performance standards prescribed by legislative rules proposed prior to January 1, 2012.

(16) Penalties, if any, for noncompliance.

The legislation provides that any penalties for noncompliance will be addressed by legislative rule.

(17) Timelines for credentialing, recredentialing and other compliance obligation of payors.

Timelines contained in the legislation include 30 days for practitioners to supply additional information requests and a requirement that credentialing decisions be made by credentialing entities within 60 days of receipt of a complete credentialing report from the CVO. Performance standards, including timelines for the CVO, will be addressed by rule and enforced through its contract.

Mountain State Blue Cross Blue Shield's representative opined that setting time limits on the payers to issue a credentialing decision may decrease the flexibility to work with practitioners who submit incomplete applications or require more investigation for clarification to complete the credentialing process. He noted that although it is being assumed that the payers will have a completed application when it is transferred from the CVO, a practitioner's failure to complete the application prior to its release to the payer could result in denial of the application. He also noted that if the application is denied, the practitioner would be required to re-apply, which could lead to additional cost to the practitioner and the payers (as a result of the CVO fees). MSBCBS is currently regulated by the Love Settlement, which requires that all BCBS plans make a credentialing decision within 90 days of a completed application. And MSBCBS recommends that this be considered in the West Virginia legislation as a more reasonable approach. The representative also suggests that there should be a definition of a "completed application" included in the bill.

(18) Reconciliation of the use of forms required by this article with other applicable state and federal laws and regulations.

The Uniform Credentialing Form Advisory Committee, established in this article, meets regularly, no less than once a year, with the purpose to update the respective forms and to

conform them to applicable state and federal laws and regulation.

(19) Other considerations not raised by House Bill 2885.

(a) The committee was of the opinion that a common recredentialing date is extremely important to a simplified and more efficient credentialing process and therefore included this concept in the bill as a matter to be addressed by legislative rule. It should be noted that any established common recredentialing date would not apply to "health care facilities" because they operate under different parameters such as privilege confirmation.

In comments submitted by MSBCBS, it was suggested that establishing common re-credentialing dates for practitioners may cause operational impacts for payers insofar as most practitioners would need to be pulled forward to meet the requirement of re-credentialing every three years. MSBCBS noted that since its process is automated, a common date would require some manual processes in order to comply; it also would result in issues with balancing work volumes for the payers. MSBCBS stated that all payers would need to evaluate operational impacts. In addition, it asserts that there are situations when the Credentials Committee will require that a practitioner be re-credentialed in one year based on information reviewed or at any other time that notification is received of changes to licensure, consent orders, etc.; as such, there should be some exceptions established with the CVO, for these types of situations.

(b) The legislation provides limited immunity to credentialing entities that rely on CVO-verified information to the extent that the CVO's negligence in verifying information may not be imputed to the credentialing entity unless the credentialing entity knew or should have known that the information was incorrect. This immunity does not extend to damages arising from the entities' credentialing decisions.

VI. Topics to be Considered in Rulemaking

The recommended legislation provides that the DHHR Secretary and Insurance Commissioner, in consultation with the advisory committee, shall propose legislative rules on or before January 1, 2012 to address:

(1) Performance standards for the evaluation of the statewide CVO;

(2) Manner of compliance with credentialing standards and regulations;

(3) Penalties, including, fines, for violations of this article;

(4) CVO duties and timelines;

(5) Procedures for maintaining practitioner files;

(6) Payment system to cover costs of credentialing program

(7) Use and confidentiality of data; and

(8) Methodology and process regarding common recredentialing date.

VII. Conclusion

The Secretary of the Department of Health and Human Resources and the Insurance Commissioner hereby submit this joint report to the Legislative Oversight Commission on Health and Human Resources Accountability. For the reasons set forth in this report, the Secretary and Commissioner respectfully request that the legislation proposed to implement uniform credentialing in West Virginia be considered.

A BILL to amend and reenact §16-1A-1,§16-1A-2, §16-1A-3, §16-1A-4 and §16-1A-5 of the Code of West Virginia, 1931, as amended, and to amend said code by adding thereto five new sections, designated §16-1A-6, §16-1A-7, §16-1A-8, §16-1A-9 and §16-1A-10, all relating to credentialing of health care practitioners.

Be it enacted by the Legislature of West Virginia:

That §16-1A-1, §16-1A-2, §16-1A-3 §16-1A-4 and §16-1A-5 of the Code of West Virginia, 1931, as amended, be amended and reenacted; and that said code be amended by adding thereto five new sections, designated §16-1A-6, §16-1A-7, §16-1A-8, §16-1A-9 and §16-1A-10, all to read as follows:

ARTICLE 1A. UNIFORM CREDENTIALING FOR HEALTH CARE PRACTITIONERS.

§16-1A-1. Legislative findings; purpose.

(a) The Legislature finds:

(1) Credentialing, required by hospitals, insurance companies, prepaid health plans, third party administrators, provider networks and other health care entities, is necessary to assess and verify the education, training and experience of health care practitioners to ensure that qualified professionals treat the citizens of this state.

(2) ~~Currently, a credentialing application form has~~ Although uniform credentialing and recredentialing application forms have been created to reduce duplication and increase efficiency, ~~Each health care~~ each credentialing entity ~~performs~~ continues to perform primary source verification for the practitioners who apply to that entity for affiliation. Moreover, because credentialing entities do not follow a common calendar, practitioners are required to respond to requests throughout the year from various credentialing entities seeking essentially similar information. This duplication of primary source verification is time consuming and costly.

(3) The Secretary of the Department of Health and Human Resources and the Insurance Commissioner share regulatory authority over the entities requiring credentialing.

(b) The purpose of this article is to continue the advisory committee previously established to assist in developing a uniform credentialing process ~~and to develop legislation regarding the use of uniform credentialing through one or more credentialing verification organizations in this state~~ through the development of

rules to govern how a single credentialing verification organization will operate in this state and, except with respect to health care facilities, the establishment of a common credentialing calendar.

§16-1A-2. Development of uniform credentialing application forms and the credentialing process.

Notwithstanding any provision of this code to the contrary, the ~~secretary of the department of health and human resources~~ Secretary of the Department of Health and Human Resources and the ~~insurance commissioner~~ Insurance commissioner shall jointly propose rules for legislative approval in accordance with the provisions of article three, chapter twenty-nine-a of this code governing the development and use of uniform application forms for credentialing, recredentialing or updating information of health care practitioners required to use the forms and the improvement of the credentialing process, including creation of a credentialing verification organization and a uniform recredentialing calendar.

§16-1A-3. Definitions.

(a) ~~"Commissioner" is the Office of the Insurance Commissioner~~ "Credentialing entity means any health care facility, as that term is defined in subsection (j), section two, article two-d of this chapter, or payor or network that requires credentialing of health care practitioners.

(b)"Credentialing Verification Organization" or "CVO" ~~is a~~

~~Credentialing Verification Organization which~~ means an entity that performs primary source verification of ~~all~~ a health care ~~practitioners'~~ practitioner's training, education, ~~and~~ experience; "statewide CVO" means the CVO selected pursuant to the provisions of section five of this article.

(c) ~~"The department is the~~ "Secretary" means the Secretary of the West Virginia Department of Health and Human Resources;

(d) "Health care ~~practitioners~~ practitioner or "practitioner" means ~~those established pursuant to section two of this article in legislative rule~~ a person required to be credentialed using the uniform forms set forth in the rule promulgated pursuant to the authority granted in section two, article one-a of this chapter .

(e) "Joint Commission" ~~is an independent not-for-profit organization that evaluates and accredits more than 15,000 health care organizations and programs in the United States~~, formerly known as the Joint Commission on Accreditation of Healthcare Organizations or JCAHO, is a private sector, United States-based, not-for-profit organization that operates voluntary accreditation programs for hospitals and other health care organizations.

(f) ~~"NCQA" means the~~ "National Committee for Quality Assurance" or "NCQA" ~~which~~ is a private, 501(c)(3) not-for-profit organization ~~dedicated to improving health care quality~~ that evaluates and certifies CVOs.

(g) "Primary source verification procedure" means the

procedure used by a ~~credentialing organization~~ CVO to, in accordance with NCQA standards, collect, verify and maintain the accuracy of documents and other credentialing information submitted ~~to it by a health care practitioner who is applying for affiliation with a health care entity~~ in connection with a health care practitioner's application to be credentialed

(h) ~~"URAC" means the American Accreditation Healthcare Commission~~ "Credentialing" means the process used to assess and validate the qualifications of a health care practitioner, including but not limited to, an evaluation of licensure status, education, training, experience, competence and professional judgment.

(i) "Payor" means ~~an insurer, prepaid health plan, hospital service corporation,~~ a third party administrator as defined in ~~article forty-six, chapter thirty-three of this code~~ section two, article forty-six , chapter thirty-three of this code and including third party administrators that are required to be registered pursuant to section thirteen, article forty-six, chapter thirty-three of this code., ~~or any other entity that reimburses health care practitioners for medical services~~ any insurance company, health maintenance organization, health care corporation or any other entity required to be licensed under chapter thirty-three of this code and that, in return for premiums paid by or on behalf of enrollees, indemnifies such enrollees or reimburses health care

practitioners for medical or other services provided to enrollees by health care practitioners.

(j) "Uniform application form" or "uniform form" means the blank uniform credentialing or recredentialing form developed and set forth in a joint procedural rule promulgated pursuant to section two of this article.

(k) "Network" means an organization that represents or contracts with a defined set of health care practitioners under contract to provide health care services to a payor's enrollees.

§16-1A-4. Advisory Committee.

(a) The Secretary of the Department of Health and Human Resources and the Insurance Commissioner shall jointly establish an advisory committee to assist them in the development and implementation of the uniform credentialing process in this state. The advisory committee shall consist of thirteen appointed members. Six members shall be appointed by the Secretary of the Department of Health and Human Resources: One member shall represent a hospital with one hundred beds or less; one member shall represent a hospital with more than one hundred beds; one member shall represent another type of health care facility requiring credentialing; one member shall be a person currently credentialing on behalf of health care practitioners; and two of the members shall represent the health care practitioners subject to credentialing. Five members shall be representative of the

entities regulated by the Insurance Commissioner that require credentialing and shall be appointed by the Insurance Commissioner: One member shall represent an indemnity health care insurer; one member shall represent a preferred provider organization; one member shall represent a third party administrator; one member shall represent a health maintenance organization accredited by URAC; and one member shall represent a health maintenance organization accredited by the national committee on quality assurance. The Secretary of the Department of Health and Human Resources and the Insurance Commissioner, or the designee of either or both, shall be nonvoting ex officio members. Upon the effective date of this legislation, the state hospital association and state medical association shall each designate to the department one person to represent their respective associations and members and those designees shall be appointed to the advisory committee by the secretary of the department.

(b) At the expiration of the initial terms, successors will be appointed to terms of three years. Members may serve an unlimited number of terms. When a vacancy occurs as a result of the expiration of a term or otherwise, a successor of like qualifications shall be appointed. Representatives of the hospital and medical associations shall serve for three-year terms.

(c) The advisory committee shall meet at least annually to review the status of uniform credentialing in this state, and may

make further recommendations to the Secretary of the Department of Health and Human Resources and the Insurance Commissioner as are necessary to carry out the purposes of this article. Any uniform forms and the list of health care practitioners required to use the uniform forms as set forth in legislative rule proposed pursuant to section two of this article may be amended as needed by procedural rule.

§16-1A-5. Credentialing Verification Organization.

~~(a) On or before January 1, 2010, the advisory committee established pursuant to section four of this article shall develop legislation that considers the following:~~

~~(1) The establishment of one or more CVOs within the state to provide primary source verification with electronic accessibility on a cost effective and operationally efficient basis;~~

~~(2) The number of CVOs necessary to provide this access for the state;~~

~~(3) The treatment of existing CVOs currently doing business within the state;~~

~~(4) The duties of a CVO and the timelines for completion of its verification duties;~~

~~(5)The procedures for maintaining healthcare practitioner files;~~

~~(6) The payment system to cover the costs of the credentialing program;~~

~~(7) The use and confidentiality of data generated, collected and maintained by a CVO;~~

~~(8) Compliance by CVOs with certificate requirements including NCQA, URAC, Medicare and Medicaid and other state and federal requirements;~~

~~(9) The required use by payors and hospitals of a CVO's primary source verification services;~~

~~(10) Credentialing recredentialing requirements as required by payors, hospitals and state and federal law and regulations;~~

~~(11) The use of site visits in credentialing;~~

~~(12) The maintenance, amounts and types of liability insurance to be obtained by a CVO;~~

~~(13) Consideration of existing statutory protections that should be extended to the CVO;~~

~~(14) Privacy considerations;~~

~~(15) If applicable, the terms and conditions of the contract under which a CVO operates in this state and the procedure and criteria upon which a CVO is selected;~~

~~(16) Penalties, if any, for noncompliance;~~

~~(17) Timelines for credentialing, recredentialing and other compliance obligation of payors;~~

~~(18) Reconciliation of the use of forms required by this article with other applicable state and federal laws and regulations.~~

~~(b) On or before January 1, 2010, the department and the commissioner shall jointly report to the Legislative Oversight Commission on Health and Human Resources Accountability proposed legislation to implement the provisions set forth in this article.~~

The Secretary and the Insurance Commissioner shall, with the advice of the advisory committee, take such steps as are necessary to select and contract with a CVO that will, beginning no later than July 1, 2015, be the sole source for primary source verification for all credentialing entities. The CVO selected shall be responsible for the receipt of all uniform applications, the primary source verification of the information provided on such applications, and the updating and maintenance of all information generated by such activities. The dates on which the use of this statewide CVO is mandatory with respect to the credentialing of the different classes of health care practitioners shall be determined by emergency and legislative rules promulgated pursuant to the authority in section ten of this article.

§16-1A-6. Contract with statewide CVO; requirements.

The Secretary and Insurance Commissioner shall assure that:

(1) Any contract executed with a CVO shall be for an initial contract period of at least three years, subject to renewals, and the secretary and Insurance Commissioner shall, in consultation with the advisory committee, periodically review the statewide CVO's operations no less often than prior to every renewal.

(2) A CVO selected pursuant to this article must, at a minimum, be certified by NCQA, be able to demonstrate compliance with the joint commission's standards for credentialing and with all federal and state credentialing regulations, and maintain an errors and omissions insurance policy in amounts deemed to be adequate by the Secretary and Insurance Commissioner.

(3) Preference shall be given to CVOs organized within the state of West Virginia.

§16-1A-7. Verification process; suspension of requirements.

(a) The statewide CVO shall provide electronic access to the uniform credentialing application forms developed pursuant to section two of this article.

(b) A health care practitioner seeking to be credentialed must attest to and submit a completed uniform application form to the statewide CVO and must provide any additional information requested by such CVO: *Provided*, That a failure to comply with a reasonable request for additional information within thirty days may be grounds for the statewide CVO to submit its report to any credentialing entity with identification of matters deemed to be incomplete.

(c) Except as provided in subsection (d) of this section, a credentialing entity may not require a person seeking to be credentialed or recredentialed to provide verification of any information contained in the uniform application: *Provided*, That

nothing in this article shall be deemed to prevent a credentialing entity from collecting or inquiring about information unavailable from or through the statewide CVO or from making inquires to the National Practitioner Data Bank.

(d) A credentialing entity other than a health care facility must issue a credentialing decision within sixty days after receiving the statewide CVO's completed report and, with respect to affirmative credentialing decisions, payments pursuant to the contract shall be retroactive to the date of such decision.

(e) If the statewide CVO fails to maintain NCQA certification or, in the opinion of the Secretary and Insurance Commissioner, is unable to satisfy compliance with the joint commission's standards or federal and state credentialing regulations, the Secretary and Insurance Commissioner may, under terms and conditions deemed necessary to maintain the integrity of the credentialing process, notify credentialing entities that the requirement, relating to the mandatory use of the statewide CVO, is being suspended.

(f) Notwithstanding any other provision of this code, credentialing entities may contract with the statewide CVO or another CVO to perform credentialing services, such as site visits to health care practitioners' offices, in addition to those services for which the statewide CVO is the sole source.

§16-1A-8. Release and uses of information collected; confidentiality.

(a) Upon execution of a release by the health care practitioner, the statewide CVO shall, under terms established in rule, provide the credentialing entity with electronic access to data generated.

(b) In order to assure that information in its files is current, the statewide CVO shall establish processes to update information as required by credentialing entities.

(c) Except as provided in subsection (d) of this section, all information collected by the statewide CVO from any source is confidential in nature, is exempt from disclosure pursuant to subpoena or discovery, is exempt from disclosure under the provisions of article one, chapter twenty-nine-b of this code, and shall be used solely by a credentialing entity to review the professional background, competency and qualifications of each health care practitioner applying to be credentialed.

(d) Credentialing information received by a credentialing entity from the statewide CVO shall not be disclosed except:

(1) In appeals of credentialing decisions or to peer review and quality improvement committees: *Provided,* That such information shall be afforded the same protection from disclosure as is provided to other records used in proceedings subject to section three, article three-c, chapter thirty of this code;

(2) In any matter in which an action or order of a professional licensing board or other state or federal regulatory

authority is at issue, including any proceeding brought by or on behalf of a health care practitioner or patient or by a regulatory body that challenges the actions, omissions or conduct of a credentialing entity with respect to credentialing decision; or

(3) When authorized by the health care practitioner to whom the credentialing information relates: *Provided*, That the health care practitioner's authorization shall only permit disclosure of information that he or she provided directly to the statewide CVO.

(e) Upon the expiration of the contract with a statewide CVO, all information collected in connection with the duties under such contract shall be delivered to the Secretary and Insurance Commissioner to the extent allowed by law and subject to any legal requirements applicable to the sources of such information.

(f) The statewide CVO may enter into contractual agreements to define the data type and form of information to be provided to users and to give users assurances of the integrity of the information collected.

§16-1A-9. Rulemaking; fees; penalties.

The Secretary and Insurance Commissioner, in consultation with the advisory committee, shall propose legislative rules on or before January 1, 2012, that must include, but not be limited to, the following matters:

(1) Performance standards for the evaluation of the statewide CVO;

(2) The manner in which the statewide CVO must demonstrate compliance with credentialing standards and regulations;

(3) Penalties, including fines, for violations of any provisions of this article;

(4) Duties of the statewide CVO and the timelines for completion of its verification duties and services;

(5) Procedures for maintaining healthcare practitioner files;

(6) The payment system to cover the costs of the credentialing program;

(7) The use and confidentiality of data generated, collected and maintained by the statewide CVO; and

(8) Except with respect to health care facilities, the methodology for determination and communication of the common recredentialing date for a practitioner.

§16-1A-10. Immunity.

If the statewide CVO certifies that information in an application has been verified according to its primary source verification procedures, any negligence by the statewide CVO in its collection and verification of such information may not be imputed to a credentialing entity that receives such information and, further, such credentialing entity is not liable for damages arising from its reliance on such information in its credentialing process unless the credentialing entity knew or should have known such information was incorrect: *Provided*, That a credentialing

entity is otherwise liable as provided by law for damages arising from its credentialing decisions.

NOTE: The purpose of this bill is to establish a credentialing process in this state.

Strike-throughs indicate language that would be stricken from the present law, and underscoring indicates new language that would be added.

§16-1A-6, §16-1A-7, §16-1A-8, §16-1A-9, and §16-1A-10, are new, therefore underscoring and strike-throughs have been omitted.