WEST VIRGINIA LEGISLATURE

2020 REGULAR SESSION

Introduced

House Bill 4642

FISCAL NOTE

BY DELEGATES ROHRBACH, HILL AND PORTERFIELD

[Introduced January 31, 2020; Referred to the Committee on Banking and Insurance then Health and Human Resources]

A BILL to repeal §16-1A-1 and §16-1A-4 of the Code of West Virginia, 1931, as amended; to amend and reenact §16-1A-2, §16-1A-3, §16-1A-5, §16-1A-6, §16-1A-7, §16-1A-8, and §16-1A-9; all relating to uniform credentialing for health practitioners; removing legislative findings; eliminating the advisory committee; and providing sole authority to implement to the Insurance Commissioner.

Be it enacted by the Legislature of West Virginia:

ARTICLE 1A. UNIFORM CREDENTIALING FOR HEALTH CARE PRACTITIONERS.

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

[Repealed.]

§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 and~~ The Insurance Commissioner shall ~~jointly~~ propose rules for legislative approval in accordance with the provisions of §29A-3-1 *et seq*. 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.

For the purposes of this article, the following definitions apply:

~~(a)~~ "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.

~~(b)~~ "Credentialing entity" means any health care facility, as that term is defined in §16-2D-2 of this code, or payor or network that requires credentialing of health care practitioners.

~~(c)~~ "Credentialing Verification Organization" means an entity that performs primary source

verification of a health care practitioner's training, education, experience; “statewide credentialing verification organization” means the credentialing verification organization selected pursuant to the provisions of §16-1A-5 of this code.

~~(d)~~ “Health care practitioner” or “practitioner” means a person required to be credentialed using the uniform forms set forth in the rule promulgated pursuant to the authority granted in §16-1A-2 of this code.

~~(e)~~ “Insurance Commissioner” or “Commissioner” means the Insurance Commissioner of the State of West Virginia as set forth in §33-2-1 *et seq*. of this code.

~~(f)~~ “Joint Commission” 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.

~~(g)~~ “National Committee for Quality Assurance” or “NCQA” is a private, 501(c)(3) not-for-profit organization that evaluates and certifies credentialing verification organizations.

~~(h)~~ “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.

~~(i)~~ “Payor” means a third party administrator as defined in §33-46-2 of this code and including third party administrators that are required to be registered pursuant to §33-46-13 of this code, any insurance company, health maintenance organization, health care corporation, or any other entity required to be licensed under chapter 33 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)~~ “Primary source verification procedure” means the procedure used by a credentialing verification organization to, in accordance with national committee for quality assurance standards, collect, verify and maintain the accuracy of documents and other credentialing information submitted in connection with a health care practitioner's application to be credentialed.

~~(k) "Secretary" means the Secretary of the West Virginia Department of Health and Human Resources as set forth in chapter sixteen, article one of this code~~

~~(l)~~ "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 §16-1A-2 of this code.

§16-1A-4. Advisory committee.

[Repealed.]

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

~~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 credentialing verification organization that ~~will~~ shall, beginning no later than July 1, ~~2015~~ 2020, be the sole source for primary source verification for all credentialing entities. The credentialing verification organization 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 credentialing verification organization 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 §16-1A-9 of this code.

§16-1A-6. Contract with statewide credentialing verification organization; requirements.

The ~~Secretary and~~ Insurance Commissioner shall assure that:

(1) Any contract executed with a credentialing verification organization 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 credentialing verification organization's operations no less often than prior to every renewal.

(2) A credentialing verification organization selected pursuant to this article must, at a minimum, be certified by the national committee for quality assurance, 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 credentialing verification organizations organized within the State of West Virginia.

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

(a) The statewide credentialing verification organization shall provide electronic access to the uniform credentialing application forms developed pursuant to §16-1A-2 of this code.

(b) A health care practitioner seeking to be credentialed must attest to and submit a completed uniform application form to the statewide credentialing verification organization and must provide any additional information requested by such credentialing verification organization: *Provided,* That a failure to comply with a reasonable request for additional information within 30 days may be grounds for the statewide credentialing verification organization 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 is considered to prevent a credentialing entity from collecting or inquiring about information unavailable from or through the statewide credentialing verification organization or from making ~~inquires~~ inquiries to the National Practitioner Data Bank.

(d) A credentialing entity other than a health care facility must issue a credentialing decision within 60 days after receiving the statewide credentialing verification organization's completed report and, with respect to affirmative credentialing decisions, payments pursuant to the contract shall be retroactive to the date of the decision.

(e) If the statewide credentialing verification organization fails to maintain national committee for quality assurance 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 credentialing verification organization, is being suspended.

(f) Notwithstanding any other provision of this code, credentialing entities may contract with the statewide credentialing verification organization or another credentialing verification organization to perform credentialing services, such as site visits to health care practitioners' offices, in addition to those services for which the statewide credentialing verification organization 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 credentialing verification organization 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 credentialing verification organization 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 credentialing verification organization from any source is confidential in nature, is exempt from disclosure pursuant to subpoena or discovery, is exempt from disclosure under the provisions of §29B-1-1 *et seq*. 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 credentialing verification organization 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 §30-3C-3 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 credentialing verification organization.

(e) Upon the expiration of the contract with a statewide credentialing verification organization, 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 credentialing verification organization 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 rules for legislative approval in accordance with the provisions of §29A-3-1 *et seq*. of this code. ~~on or before June 1, 2011~~ The legislative rules must include, but shall not be limited to, the following matters:

(1) Performance standards for the evaluation of the statewide credentialing verification organization;

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

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

(4) Duties of the statewide credentialing verification organization 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 credentialing verification organization;

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

(9) Procedures and criteria for the bidding and selection of the statewide credentialing verification organization.

NOTE: The purpose of this bill is to provide sole authority to the Insurance Commissioner to implement uniform credentialing for health care practitioners.

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