WEST VIRGINIA LEGISLATURE
SECOND REGULAR SESSION, 2010

ENROLLED

COMMITTEE SUBSTITUTE
FOR
House Bill No. 4176

(By Delegates Perdue, Border, Hatfield, Staggers, Moore, Moye and Rodighiero)

Passed March 11, 2010

In Effect Ninety Days From Passage
AN ACT 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 providing for uniform credentialing for health care practitioners; establishing a single statewide credentialing verification organization and a uniform recredentialing calendar; setting forth legislative findings, defining terms; increasing the membership of the advisory committee; authorizing the Secretary and Insurance Commissioner to, no later than July 1, 2015, select and contract with a qualified credentialing verification organization that will be the sole source for primary source verification for all credentialing entities; reviewing operations of the statewide credentialing verification organization; setting forth qualifications for a credentialing verification organization; giving preference to a credentialing verification organization organized within this state; suspending mandatory use of statewide credentialing verification organization by credentialing entities by the
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Secretary and Insurance Commissioner for certain failures of the statewide credentialing verification organization; setting forth an application process; providing for the confidentiality of information and exceptions; setting forth legislative rulemaking authority; providing for the establishment by rule of penalties; and granting immunity to credentialing entity for reliance upon information provided by the statewide credentialing verification organization.

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 (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 (2) 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.

(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 through the development of legislative 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 and the 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.

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 subsection (j), section two, article two-d of this chapter, 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 section five of this article.

(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 section two, article one-a of this chapter.

(e) "Insurance Commissioner” or “Commissioner” means the Insurance Commissioner of the State of West Virginia as set forth in article two, chapter thirty-three 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 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, 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) “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 section two of this article.

§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 fourteen 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, the state association of licensing boards 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 association, the association of licensing boards and the state medical association 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.

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, beginning no later than July 1, 2015, 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 section ten of this article.

§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 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 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 thirty 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 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 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 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 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 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 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
article three, chapter twenty-nine-a 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.
§16-1A-10. Immunity.

(a) If the statewide credentialing verification organization certifies that information in an application has been verified according to its primary source verification procedures, any negligence by the statewide credentialing verification organization 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.

(b) This article may not be interpreted as requiring a credentialing entity as defined in this article, to grant medical staff appointment to any practitioner nor may it be interpreted as requiring a credentialing entity to permit any practitioner to provide patient care or as requiring a payor or network to reimburse a practitioner for services.
That Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

Chairman Senate Committee

Chairman House Committee

Originating in the House.

In effect ninety days from passage.

Clerk of the Senate

Clerk of the House of Delegates

President of the Senate

Speaker of the House of Delegates

The within __ approved this the ___ day of __________, 2010.

Governor
PRESENTED TO THE GOVERNOR

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