

HEALTH CARE PROVIDER CREDENTIALING

WORK GROUP FINAL REPORT

VIRGINIA DEPARTMENT OF HEALTH
OFFICE OF LICENSURE AND CERTIFICATION

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EXECUTIVE SUMMARY

The General Assembly directed the Secretary of Health and Human Resources to convene a work group of key stakeholders in order “to gather information and make recommendations on how the Commonwealth could develop or procure a statewide centralized primary source verification system (CPSVS) that can be relied upon by the Commonwealth and its health carriers, health care providers, hospitals, and health systems for health care provider credentialing.” The Secretary of Health and Human Resources delegated this work group to the Virginia Department of Health (VDH) for implementation. VDH convened a work group that met five times between July 2020 and December 2021.

The work group found that:

- No existing state agency has the current IT capability to build a CPSVS – Neither VDH nor the Department of Health Professions (DHP) have the in-house knowledge or expertise to build a system of the necessary complexity that a CPSVS would entail, and thus procurement of a future CPSVS is recommended.
- DHP and managed care health insurance plan carriers already utilize centralized systems for health care providers’ data – There are already efforts underway to centralize and reduce repetitive data filings by health care providers and the work group recommends that any future CPSVS or centralization efforts support and integrate with these existing systems.
- Pilot program or phased implementation is recommended – Other jurisdictions have attempted centralized credentialing of health care providers, using various models and experiencing varying levels of success. The work group recommends that any future CPSVS be piloted or phased in, but did not make a recommendation about which state had the preferred model.
- No consensus was reached on the “home” of a CPSVS – There are at least four state agencies with varying levels of oversight and involvement in the different components that make up the credentialing process. The work group did not reach a consensus and as a result did not make a recommendation about which existing state agency, if any, were the appropriate “home” for a future CPSVS.

INTRODUCTION

STUDY MANDATE

The General Assembly, in Chapter 849 of the 2020 Acts of Assembly, directed the Secretary of Health and Human Resources to convene a work group of key stakeholders in order “to gather information and make recommendations on how the Commonwealth could develop or procure a statewide centralized primary source verification system [(CPSVS)] that can be relied upon by the Commonwealth and its health carriers, health care providers, hospitals, and health systems for health care provider credentialing.” This work group was delegated to the Virginia Department of Health (VDH). The Managed Care Health Insurance Plan (MCHIP) Unit of the Division of Health Services Planning and Oversight in the VDH Office of Licensure and Certification (OLC) is the unit responsible for state oversight of certificates of quality assurance MCHIP licensees.¹ The State Health Commissioner issues certificates of quality assurance when an MCHIP licensee demonstrates that an MCHIP meets minimum quality standards that include “reasonable and adequate standards and procedures for credentialing and recredentialing the [health care] providers with whom it contracts.”²

WORK GROUP ACTIVITIES

In response to the legislative mandate, VDH convened a work group representing a broad range of perspective and expertise. The work group held four meetings during 2020: on July 6, August 4, August 17, September 9; and one meeting during 2021: December 30.

REPORT OUTLINE

Following the discussion of the study mandate and the health care provider credentialing work group activities, the report provides an overview of health care provider credentialing in Virginia and describes the statutory and regulatory provisions governing health care provider credentialing. A description of centralized health care provider credentialing in other states are included in this report. The work group’s findings conclude the report.

HEALTH CARE PROVIDER CREDENTIALING IN VIRGINIA

Broadly speaking, credentialing is the collection, verification, and assessment of a health care provider's professional qualifications. A credentialing process takes place with the regulator of health care providers, with health insurance carriers, and with medical care facilities. For the regulator of health care providers—which in Virginia is the Department of Health Professions (DHP)—this credentialing process is handled by the applicable regulatory board within the agency (e.g., the Board of Medicine for physicians, the Board of Nursing for licensed practical nurses, etc.). For health insurance carriers, the credentialing process is typically conducted in-house, whereby a health care provider applies to each health insurance carrier separately to be credentialed. When a health insurance carrier approves a health care provider’s credentialing application, it results in that health care provider becoming a part of the carrier’s network and receiving reimbursement at in-network rates. Medical care facilities also utilize a credentialing process as

¹ MCHIP licensees are subject to licensure by the State Corporation Commission’s Bureau of Insurance under Title 38.2 (§ 38.2-100 *et seq.*) of the Code of Virginia. See Va. Code § 32.1-137.1.

² See Va. Code § 32.1-137.2(C).

part of its process to allow providers to be granted staff privileges³ to provide specific services or care at that facility.

For DHP, the professional qualifications to be reviewed and the minimums to be met are set by a combination of statute and regulation. These qualifications are typically set in a general fashion via statute (e.g., “Has successfully completed all or such part as may be prescribed by the Board [of Medicine], of an educational course of study..., which course of study and the educational institution providing that course of study are acceptable to the Board...”⁴) and the specifics of that requirement are expounded in regulation (e.g., “For licensure in osteopathic medicine. The institution shall be approved or accredited by the American Osteopathic Association Committee on Osteopathic College Accreditation or any other organization approved by the [Board of Medicine]...”⁵). Initial licensure for health care providers most often includes minimum education, examination, employment and/or training, and moral character requirements. Renewal of licensure—the closest analog to recredentialing that exists for licensure—typically also requires evidence of ongoing education and training through minimum hours of continuing professional education. There may also be ongoing reporting obligations placed on licensees that may not be tied to a specific licensure application process, such as reporting felony convictions, adverse administration action taken by another jurisdiction, permanent or temporary loss of hospital privileges, and malpractice judgments and settlements.⁶

The minimum professional standards that a managed care health insurance plan (MCHIP) carrier must review are set in regulation at 12VAC5-408-170, which include:

- Current valid license and history of licensure or certification;
- Status of hospital privileges, if applicable;
- Valid U.S. Drug Enforcement Agency (DEA) certificate, if applicable;
- Information from the National Practitioner Data Bank, as available;
- Education and training, including post graduate training, if applicable;
- Specialty board certification status, if applicable;
- Practice or work history covering at least the past five years; and
- Current, adequate malpractice insurance and malpractice history of at least the past five years.

MCHIP regulations also require that a health care provider be recredentialed at least every three years.⁷ When recredentialing, an MCHIP carrier is required to review a health care provider’s:⁸

- Current valid license or certification;
- Status of hospital privileges, if applicable;
- Current valid DEA registration, if applicable;
- Specialty board eligibility or certification status, if applicable;
- Data from covered person complaints and the results of quality reviews, utilization management reviews and covered persons satisfaction surveys, as applicable; and
- Current, adequate malpractice insurance and history of malpractice claims and professional liability claims resulting in settlements or judgments.

³ See 12VAC5-410-10 for the definition of “staff privileges.”

⁴ Va. Code § 54.1-2930(3).

⁵ 18VAC85-20-121(A)(2)

⁶ See e.g., Va. Code § 54.2-2910.1, 18VAC85-20-280, and 18VAC85-20-290.

⁷ See 12VAC5-408-170(F).

⁸ *Id.*

Compared to DHP and health insurance carriers, hospitals have the greatest latitude in setting the parameters of their credentialing process and criteria for staff privileges. Hospitals licensed in Virginia⁹ are required by regulation to have written bylaws, rules, and regulations that address credentialing, or the granting of staff privileges, which must include requiring a current license to practice in Virginia.¹⁰ With the exception of hospitals owned or operated by the U.S. Department of Veterans Affairs, all hospitals in Virginia regardless of licensure status are certified to participate in Medicare, Medicaid, or both. As a condition of participation, the Centers for Medicare and Medicaid Services require hospitals to include in their bylaws “criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges.”¹¹

There are no other general minimum standards that apply universally to health care providers interested in hospital privileges, though there are specific minimum standards for certain subsets of health care providers. For example, licensed podiatrists and certified nurse midwives licensed as nurse practitioners are required to be credentialed by a hospital based on their “professional license, experience, competence, ability, and judgment, and the reasonable objectives and regulations of the hospital in which such privileges are sought.”¹² Dietitians—who are not subject to licensure in Virginia—cannot be credentialed to order patient diets, including therapeutic diets, and to order laboratory tests to help determine appropriate diets for the patient unless they:¹³

- Have received a baccalaureate or higher degree in nutritional sciences, community nutrition, public health nutrition, food and nutrition, dietetics, or human nutrition from a regionally accredited institution of higher education;
- Have satisfactorily completed a program of supervised clinical experience approved by the Commission on Dietetic Registration of the Academy of Nutrition and Dietetics;
- Have an active registration through the Commission on Dietetic Registration of the Academy of Nutrition and Dietetics;
- Have an active certificate of the Board for Certification of Nutrition Specialists as a Certified Nutrition Specialist;
- Have an active certification as a Diplomate of the American Clinical Board of Nutrition; and
- Have a current license or certificate as a dietitian or nutritionist issued by another state; or
- Have the minimum requisite education, training and experience determined by the Board of Health Professions appropriate for such person to hold himself out to be, or advertise or allow himself to be advertised as, a dietitian or nutritionist.

Aside from this regulatory requirements, many hospitals opt to become accredited by a private organization, such as The Joint Commission or the Center for Improvement in Healthcare Quality (CIHQ). These organizations have accreditation standards that are equivalent to federal requirements and often are more stringent. For example, The Joint Commission permits hospitals to either verify and document a health care provider’s credentials or to utilize a credentials verification organization (CVO) to conduct this on the hospitals behalf;¹⁴ The Joint Commission then also provides 10 principles by which hospitals should judge

⁹ Pursuant to clauses (iv) and (vi) of Va. Code § 32.1-124, medical care facilities owned or operated by an agency of the United States government or by an agency of the Commonwealth are exempt from state hospital licensure. In practical terms, this means that hospitals owned or operated by the U.S. Department of Veterans Affairs and by the University of Virginia are exempt.

¹⁰ See 12VAC5-410-180(E)(7).

¹¹ See 42 C.F.R. § 482.22(c)(6).

¹² See Va. Code § 32.1-134.2.

¹³ See 12VAC5-410-260(F)(1).

¹⁴ See HR 01.01.01 in The Joint Commission 2022 Hospital Accreditation Standards.

a credentials verification organization before relying on information provided by it.¹⁵ Hospitals that have opted to be accredited would jeopardize their accreditation to use systems or processes that are violated these types of standards. Hospitals often seek and maintain accreditation because § 1865(a)(1) of the Social Security Act permits hospitals accredited by an approved national accreditation organization to be exempt from routine surveys by state survey agencies¹⁶ to determine compliance with Medicare conditions.

ATTEMPTS TO CENTRALIZE HEALTH CARE PROVIDER CREDENTIALING

The professional qualifications that are reviewed by the regulator of health care providers, health insurance carriers, and medical care facilities can and do vary as a result of the variable legal minimums for each of these credential bodies are obligated to follow. However, as the prior section discussed, there is often considerable overlap in the information being collected, verified, and assessed by these three credentialing bodies, which a minority of jurisdictions have attempted to address through a CPSVS-like system.

ARKANSAS

1995 Ark. Act 1066¹⁷ created the Centralized Credentials Verification Service (CCVS), which Arkansas housed with its State Medical Board. Arkansas was first in the nation to base this type of system within a licensing agency. This act permitted the Arkansas State Medical Board to release, with a health care provider's written authorization, verification of credentials as needed by credentialing organization.¹⁸ The act further prohibited that information furnished by the CCVS to a credentialing organization could only be used for the purpose of verifying, issuing, and renewing credentials. Four years later, 1999 Arkansas Act 1410¹⁹ repealed and replaced large portions of 1995 Ark. Act 1066. The new act mandated that credentialing organizations and physicians to utilize the CCVS, provided that the CCVS:

- receives certification by the National Committee for Quality Assurance (NCQA)²⁰ as a certified credentials verification organization (CVO);
- demonstrates compliance with the principles for credentials verification organizations set forth by the Joint Commission on the Accreditation of Healthcare Organizations²¹; and
- documents compliance with the Arkansas Department of Health Rules and Regulations applicable to credentialing.

¹⁵ See "credentials verification organization (CVO)" definition in The Joint Commission 2022 Hospital Accreditation Standards.

¹⁶ In Virginia, the Virginia Department of Health serves as the state survey agency pursuant to Va. Code § 32.1-137.

¹⁷ <https://www.arkleg.state.ar.us/Acts/FTPDocument?type=PDF&file=1066&ddBienniumSession=1995%2FR>.

¹⁸ The act defined credentialing organization as "a health care organization that uses a process to collect and verify information pursuant to licensure and accreditation rules and regulations concerning the professional background of the health care provider who is applying for practice privileges before allowing that provider to practice in affiliation with that organization and defining the type and extent of the provider's privileges in the credentialing organization." This definition was subsequently repealed and replaced with "a hospital, clinic, or other health care organization, managed care organization, insurer or health maintenance organization" by 1999 Arkansas Act 1410.

¹⁹ <https://www.arkleg.state.ar.us/Acts/FTPDocument?type=PDF&file=1410&ddBienniumSession=1999%2FR>.

²⁰ NCQA provides, among services, certification for credentials verification organizations.

²¹ In 2007, Joint Commission on Accreditation of Healthcare Organizations underwent a name change and is now called "The Joint Commission."

The mandate did not become effective until 2001 when CCVS met the qualifications described above. CCVS has continued to meet these minimums since 2001. However, the CCVS has not been expanded to other health care provider types in Arkansas and thus remains limited to only physicians.

OREGON

Oregon Senate Bill 604 in 2013²² required the Oregon Health Authority to establish a statewide program, the Oregon Common Credentialing Program (OCCP), built around a database to “to simplify credentialing processes, reduce burden on practitioners, and eliminate duplication” since it recognized “there is broad consensus that the concept of centralizing credentialing information has merit.”²³ Oregon suspend the OCCP in 2018 because “[t]his project ended up being more complex, more expensive, and has taken considerably longer to implement than anyone predicted” because of “significant challenges in designing a program that addressed the complexities of business practices while meeting accrediting entity standards for credentialing.”²⁴ These problems were compounded by the fact that the OCCP was intended to be solely fee-supported and no startup funding was appropriated by the Oregon legislature so the initial development costs had to be borne by the Oregon Health Authority, resulting in a \$5.5 million budget shortfall. The struggles of the OCCP also led to diminished stakeholder support over time.²⁵

Oregon ultimately passed House Bill 2078 in 2021²⁶ to repeal OCCP.

WASHINGTON

2009 Wash. Laws 298²⁷ established streamlined and uniform administrative procedures for payors and providers of health care services through one or more lead organizations.²⁸ Currently, OneHealthPort is the lead organization under Washington state law that has been designated by the Washington insurance commissioner “to coordinate development of processes, guidelines, and standards to streamline health care administration and to be adopted by payors and providers of health care services operating in the state.”²⁹ OneHealthPort, as the lead organization, was also tasked with developing, by December 31, 2010, “a uniform electronic process for collecting and transmitting the necessary provider-supplied data to support credentialing, admitting privileges, and other related processes[.]”³⁰

Subsequently, 2016 Wash. Laws 123³¹ was enacted to require physicians, health insurance carriers, and medical care facilities to use a single credentialing platform called ProviderSource operated by OneHealthPort; this legislation had a delayed enactment date of June 1, 2018. The provisions of the bill are not applicable to hospitals or medical groups with delegated credentialing arrangements or to health plans that are not regulated by the Washington’s Office of the Insurance Commissioner³². The bill requires every

²² <https://olis.oregonlegislature.gov/liz/2013R1/Downloads/MeasureDocument/SB604/Enrolled>.

²³ <https://www.oregon.gov/oha/HPA/OHIT-OCCP/Pages/FAQs.aspx>.

²⁴ *Id.*

²⁵ *Id.*

²⁶ <https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2078/Enrolled>.

²⁷ <https://lawfilesext.leg.wa.gov/biennium/2009-10/Pdf/Bills/Session%20Laws/Senate/5346-S2.SL.pdf?cite=2009%20c%20298%20C%2%A7%206>.

²⁸ “Lead organization” means a private sector organization or 34 organizations designated by the Washington insurance commissioner to lead development of processes, guidelines, and standards to streamline health care administration and to be adopted by payors and providers of health care services operating in the state. *See* Wash. Rev. Code § 46.165.010(3).

²⁹ *See* Wash. Rev. Code § 48.165.030.

³⁰ *See* Wash. Rev. Code § 48.165.035.

³¹ <https://lawfilesext.leg.wa.gov/biennium/2015-16/Pdf/Bills/Session%20Laws/House/2335-S2.SL.pdf>.

³² *Id.*

health insurance carrier and medical care facility to utilize ProviderSource as the sole data source for credentialing and privileging decisions, though the legislation did permit these entities to manage the details of their credentialing and privileging processes.³³ Like the Arkansas model, this remains limited to physicians as this time.

GEORGIA

In 2011, the Georgia Department of Community Health (DCH)—which is that state’s Medicaid agency—engaged a consulting firm to undertake a comprehensive assessment of Georgia’s Medicaid program; as part of these redesign efforts for Medicaid, DCH launched an initiative to centralize credentialing for its Medicaid care management organizations (CMO), rather than taking other states’ approach of centralizing credentialing for all health insurance carriers for a single health care provider type (i.e., physicians).³⁴ Georgia’s centralized credentialing for Medicaid does not obligate any CMO to select or retain any health care provider in their network.³⁵ There were previous cooperative efforts by Georgia Hospital Association, the Georgia In-House Counsel Association, the Georgia Association Medical Staff Services, the Georgia Association of Health Plans, and the Medical Association of Georgia to create a Uniform Healthcare Practitioner Credentialing Application Form (UHPCAF) and the Uniform Practitioner Healthcare Credentialing Reappointment Form.³⁶ These forms were intended to reduce “the paperwork burden for practitioners applying for hospital privileges or for participation in a healthplan [*sic*] by eliminating the need to fill out a different application for each hospital and healthplan [*sic*]. Instead, the same application can be submitted to any hospital and healthplan [*sic*] in Georgia that accepts the uniform application.”³⁷ The form’s usage is voluntary by both health care providers and the health plans and hospitals; while Part 1 of the form is identical for hospitals and health plans, Part 2 is variable since health plans and individual hospitals may require different information.³⁸

Three other jurisdictions have followed Georgia’s lead by centralizing credentialing for Medicaid only—North Carolina in 2019³⁹ and Mississippi⁴⁰ and Ohio⁴¹ in 2022.

KEY FINDINGS OF THE WORK GROUP

NO EXISTING STATE AGENCY HAS THE CURRENT IT CAPABILITY TO BUILD A CPSVS

DHP has an online application system for its various health care provider applications. However, this system was not built in-house by the agency or by the Virginia Information Technology Agency (VITA), but rather was procured from a third party vendor. VDH has even less capacity than DHP to build a CPSVS. The VDH MCHIP Unit presently lacks any type of automation or IT capabilities. Applications are PDFs that have to be printed and mailed to VDH for processing. Payment processing is similarly lacking any IT

³³ <https://www.onehealthport.com/credentialing/about-providersource>.

³⁴ See Department of Community Health, MCAC Meeting Schedule, CMO Network Adequacy, 2nd Quarter 2012 (Nov. 7, 2012), available at <http://dch.georgia.gov/mcac-meeting-schedule>

³⁵ <https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/NOTICES/FAQ%20%20Georgia%20Centralized%20Credentialing%20%202021-07-2015%20164539.pdf>.

³⁶ <http://www.georgiacredentialing.org/>.

³⁷ <http://www.georgiacredentialing.org/FAQ.html>.

³⁸ *Id.*

³⁹ <https://medicaid.ncdhhs.gov/blog/2019/04/01/centralized-provider-credentialing>

⁴⁰ Ulmer, Sarah, *Medicaid to utilize centralized credentialing process for managed care providers this summer*, Y’all Politics (Apr. 18, 2022), <https://yallpolitics.com/2022/04/18/medicaid-to-utilize-centralized-credentialing-process-for-managed-care-providers-this-summer/>

⁴¹ <https://managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing>.

capabilities, as MCHIP carriers have to submit paper checks by mail to VDH. While VDH has begun preliminary efforts to automate some of the work units—including MCHIP—in OLC, these efforts are aimed at issuance and renewal of licenses and certificates and not at the data health care providers provide for credentialing. VDH’s automation efforts, like DHP’s, are focused on procurement and not in-house IT development or development by VITA.

The work group found that development of a CPSVS was not currently practicable and that any efforts to move forward with a CPSVS should concentrate on procurement.

DHP AND MCHIP CARRIERS ALREADY UTILIZE CENTRALIZED SYSTEMS FOR HEALTH CARE PROVIDERS’ DATA

The work group did acknowledge that there are already efforts underway to make data more portable and usable between different entities and across state lines. The DHP Board of Medicine—as a member of the Federation of State Medical Boards (FSBM)—encourages but does not require applicants for licensure as a physician to use the FSMB’s Federation Credentials Verification Service (FCVS),^{42, 43} which is a blockchain-based system, when applying for licensure. The FCVS allows a physician to establish a confidential, lifetime professional portfolio that can be forwarded, at the physician’s request, to any entity that has established an agreement with the FCVS, which does include private and commercial entities. DHP estimates that approximately 50% of its licensed physicians utilize FCVS, but usage of the FCVS does cost the physician \$375. The FCVS does meet The Joint Commission’s 10 principles for a primary source verified credentials verification organization.⁴⁴ The FCVS also has an application programming interface (API) that allows state medical boards’ IT systems to communicate with it.

Similarly, MCHIP carriers have the option to utilize CAQH, formerly the Council for Affordable Quality Healthcare, which provides an online portal that stores provider information in a secure database. This system allows health care providers to self-report and share a wide range of demographic and professional information with participating health plans. Access to this secured information is granted to health insurance companies during the credentialing process to make acquiring up-to-date provider information more efficient, through the work group does recognize that the self-reported nature of the data does require primary source verification by the carriers. Also, unlike FCVS, the use of CAQH is free to health care providers because MCHIP carriers pay to participate in accessing this information. The Virginia Association of Health Plans confirmed that all of its membership utilizes CAQH for credentialing.

The work group was unable to identify similar solutions to CAQH or FCVS being widely utilized by the majority of Virginia hospitals at this time and recognized that this may be an opportunity for future improvements for hospitals to either “plug-in” to existing solutions and/or to create a means and methods to directly share privileging information either between hospitals or between hospitals and MCHIP carriers. The work group did recommend that future changes or improvements to the portability and universality of health care provider data used in credentialing and privileging processes should support and integrate with existing systems like FCVS and CAQH and avoid costly efforts that “reinvent the wheel.”

PILOT PROGRAM OR PHASED IMPLEMENTATION IS RECOMMENDED

As discussed above in the *Attempts to Centralize Health Care Provider Credentialing* section, efforts by other states to date have not yet achieved a truly universal system for all credentialing efforts across all

⁴² Virginia is one of 43 jurisdictions that accepts physician information via the FCVS.

⁴³ Jurisdictions’ state medical boards that require applicants to use FCVS are Kentucky, Louisiana, Maine (doctors of medicine only), Massachusetts, Nevada (doctors of osteopathic medicine only), New Hampshire, Ohio, Rhode Island, South Carolina, Utah (doctors of medicine or osteopathic medicine only), the Virgin Islands, and Wyoming

⁴⁴ https://www.fsmb.org/siteassets/fcvs/fcvs_tjc_principles-updated-10_2017.pdf.

provider types and all entities involved in the credentialing process. Some programs limit scope by restricting it to a single health care provider type (i.e., physicians) and others have restricted it to a type of health insurance plan (i.e., Medicaid). While the work group did not reach a consensus on which pilot program model or phased approach would be most practicable in Virginia, it did recognize the value in an incremental approach to avoid the logistical and budgetary issues that Oregon encountered. The work group also reiterated its finding that a pilot program or phased implementation should be in support of and integrate with existing solutions.

NO CONSENSUS WAS REACHED ON THE “HOME” OF A CPSVS

The work group recognizes that there are silos of information between state agencies, MCHIP carriers, and hospitals about health care providers. A number of data inputs that flow into the credentialing processes are not possessed by existing state agencies, but rather by third parties. For example, VDH’s role in regulating MCHIP carriers and hospitals are aimed at minimum standards for the credentialing and privileging process; VDH does not receive any data inputs such as a healthcare provider’s work history as those are provided to the MCHIP carriers or hospitals without passing through VDH. DHP has an online application system for its various health care provider applications and as a result would have educational information about a provider and the provider’s licensure status, but would not, for example, have information about a provider’s privileges at different hospitals. As noted in Footnote No. 1, oversight for MCHIP carriers are shared between VDH and the State Corporation Commission’s Bureau of Insurance. Similarly, if the General Assembly wished to attempt centralized credentialing of Medicaid, that involves fourth agency, the Department of Medical Assistance Services. The work group did not reach any consensus and declined to recommend any existing state agency be the “home” of a CPSVS.