HOUSE BILL NO. 2662

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Health and Human Services

on _____)

(Patron Prior to Substitute—Delegate Anthony)

A BILL to amend the Code of Virginia by adding in Chapter 5 of Title 32.1 an article numbered 1.3, consisting of sections numbered 32.1-137.18 through 32.1-137.25, relating to health care credentialing and billing oversight; Hospital Oversight Fund established; Independent Credentialing Review Board established; Medicaid Billing Oversight Task Force established; reports.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Chapter 5 of Title 32.1 an article numbered 1.3, consisting of sections numbered 32.1-137.18 through 32.1-137.25, as follows:

Article 1.3.

Health Care Credentialing and Billing Oversight.

§ 32.1-137.18. Definitions.

As used in this article, unless the context requires a different meaning:

"Credentialing" means the granting of admitting privileges to a health care provider by a hospital. "Credentialing" includes validation through third-party systems and evaluation by internal hospital credentialing committees.

"High-risk credentialing application" means an application for clinical privileges submitted by a health care provider who meets specific risk factors, including verified patterns of malpractice, criminal convictions directly related to medical practice, or repeated suspensions of clinical privilege.

"High-risk provider" means a person who has been granted or is seeking clinical privileges from a hospital who meets criteria indicating potential risk, including prior felony convictions, previous terminations or suspensions for cause, or multiple malpractice settlements within a specified period.

"Hospital oversight fee" means an annual fee assessed on hospitals based on their gross revenue, designated to fund oversight activities, including compliance audits and support for the Department.

§ 32.1-137.19. Hospital Oversight Fund established; hospital oversight fee.

A. There is hereby created in the state treasury a special nonreverting fund to be known as the Hospital Oversight Fund, referred to in this section as "the Fund." The Fund shall be established on the books of the

Comptroller. All funds appropriated for such purpose and any hospital oversight fees received by the Department shall be paid into the state treasury and credited to the Fund. Interest earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used solely for the purposes of credentialing audits, contracting with third-party compliance auditors, supporting staff recruitment and retention for oversight functions, and supporting the development of technology-driven solutions for streamlining initiatives under § 32.1-137.25. Moneys in the Fund shall be prioritized for use supporting compliance initiatives for rural or underserved hospitals. Expenditures and disbursements from the Fund shall be made by the State Treasurer on warrants issued by the Comptroller upon written request signed by the Commissioner.

B. All hospitals operating in the Commonwealth shall pay a hospital oversight fee based on their gross revenue, as determined by the Department, to fund oversight activities. The Department shall adopt regulations to set the hospital oversight fee and may establish a sliding scale hospital oversight fee based on hospital size and financial status. Hospitals designated as critical access hospitals and hospitals with fewer than 100 beds shall pay a reduced hospital oversight fee, as determined by the Department. Hospitals designated as critical access hospitals and hospitals located in medically underserved areas shall be exempt from paying the hospital oversight fee.

C. The Department may contract with accredited third-party auditors to conduct compliance audits and credentialing reviews of hospitals and health care providers, with oversight and final approval provided by the Department. The Department may establish public-private partnerships to support such audits and reviews.

D. The Department shall submit an annual report to the Governor and the General Assembly detailing the use of the Fund, the number of compliance audits and credentialing reviews conducted, key findings of such audits and reviews, corrective actions taken, and recommendations for policy improvements related to audits and reviews conducted and use of the Fund.

E. The Department may issue public-private partnership grants to assist hospitals in achieving compliance with credentials and billing standards.

F. Nothing in this section shall be construed to conflict with or duplicate the requirements of the certificate of public need program as outlined in Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4.

§ 32.1-137.20. Whistleblower protections.

A. Any employee or contractor of a hospital operating in the Commonwealth that, in good faith, reports unsafe medical practices, fraudulent billing, or noncompliance with credentialing standards to the Department or other regulatory authority shall be protected from retaliation by the hospital or its agents. This section is intended to complement protections provided pursuant to § 40.1-27.3 and federal whistleblower protection laws, including the federal Occupational Safety and Health Act of 1970 (P.L. 91-596).

B. Retaliation under this section includes termination, demotion, suspension, threats, harassment, or any other adverse employment action.

C. The Department shall establish a confidential reporting mechanism for whistleblowers and ensure appropriate follow-up on reported concerns.

D. An employee or contractor that experiences retaliation may file a complaint with the Department, which shall investigate and, if warranted, impose penalties or corrective actions against the hospital.

E. The protections provided in this section shall apply specifically to whistleblower activities concerning violations related to credentialing, billing oversight, or other provisions of this article.

§ 32.1-137.21. Health care provider credentialing database.

A. The Department shall establish and maintain a statewide health care provider credentialing database. Such database shall operate in collaboration with existing systems, including the National Practitioner Data Bank and any systems utilized by the Department of Health Professions. Such database shall be accessible to hospitals and regulatory authorities.

B. Hospitals shall submit the following information regarding each credentialing decision to the health care provider credentialing database:

1. The name and qualifications of the health care provider;

2. Whether such credentialing decision resulted in the health care provider being granted clinical privileges, being denied clinical privileges, or having his clinical privileges revoked or suspended; and

3. Any disciplinary actions taken by the hospital related to the health care provider.

C. Hospitals may request technical assistance from the Department for integrating their credentialing data with the statewide health care provider credentialing database and any applicable federal systems.

D. The health care provider credentialing database shall be used solely for regulatory purposes and

oversight. The Department shall maintain the confidentiality of information in the credentialing database to the extent possible and in accordance with state and federal laws.

E. The Department shall issue an annual report that summarizes health care provider credentialing trends and identifies patterns or concerns related to credentialing of high-risk providers.

F. The health care provider credentialing database shall emphasize tracking trends and risks specific to high-risk providers practicing in the Commonwealth of Virginia.

G. The Department shall ensure that the credentialing database integrates with existing databases to minimize duplication in accordance with § 32.1-137.25.

§ 32.1-137.22. Independent Credentialing Review Board; composition; duties.

A. The Independent Credentialing Review Board (the Review Board) is hereby established under the Office of the Secretary of Health and Human Resources. The Review Board shall consist of seven members appointed by the Governor and shall include two representatives from the Board of Medicine, two representatives of hospital associations, one patient advocacy representative, one legal expert in health care regulation, and one representative from the Department.

B. Members of the Review Board shall serve a term of four years and all members may be reappointed for one additional term. Vacancies shall be filled in the same manner as the original appointments and shall be for the unexpired terms.

C. The Review Board shall support hospital credentialing processes, specifically in cases involving high-risk providers, offering nonbinding guidance to supplement existing hospital frameworks.

D. Hospitals shall submit all high-risk credentialing applications from providers to the Review Board within 30 days of receipt for the Review Board's review and approval or disapproval. The Review Board shall issue a decision on each high-risk credentialing application within 60 days of such submission. Decisions of the Review Board may be appealed in accordance with the provisions of the Administrative Process Act (§ 2.2-4000 et seq.).

E. The Review Board may recommend temporary suspension of clinical privileges for any high-risk provider pending review of his high-risk credentialing application if such action is deemed necessary to protect patient safety.

F. The Review Board shall review its processes biennially in collaboration with the Department to streamline operations and align with § 32.1-137.25.

G. Nothing in this section shall be construed to conflict or interfere with the process of issuing certificates of public need pursuant to Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4.

§ 32.1-137.23. Public-private partnerships for compliance audits.

A. The Department may contract with accredited third-party auditors to conduct compliance audits of hospitals on behalf of the Department. Such accredited third-party auditors shall adhere to guidelines established by the Department and submit their reports directly to the Department.

B. The Department shall maintain a publicly available list of accredited third-party auditors with which the Department has contracted and the findings of any such accredited third-party auditors.

C. Audits conducted by accredited third-party auditors pursuant to this section shall not assess the necessity or appropriateness of services already approved by a certificate of public need obtained pursuant to Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4. Audits shall focus on patient safety and compliance with credentialing standards.

D. The Department shall publish summary reports of audit findings, including key compliance issues identified and corrective actions taken. Such summary reports shall comply with the provisions of § 32.1-127.1:03 and the federal Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.).

§ 32.1-137.24. Medicaid Billing Oversight Task Force; report.

A. The Medicaid Billing Oversight Task Force (the Task Force) is hereby established within the Office of the Attorney General, in partnership with the Department.

B. The Task Force shall develop systems to enhance existing fraud detection efforts by the Centers for Medicare and Medicaid Services and Medicaid Fraud Control Units with a focus on identifying fraud patterns specific to Medicaid in the Commonwealth. The Task Force shall, in partnership with the Department, develop and implement automated data systems to enhance health care provider credentialing oversight, fraud detection, and audit processes. Such systems shall use advanced analytics and machine learning to reduce manual workload and improve efficiency.

C. The Task Force shall submit an annual report to the General Assembly on findings, corrective actions taken, and recommendations for policy changes related to Medicaid billing oversight. Such report shall include the number of audits conducted, the types of fraud detected, and any financial recoveries made.

D. The Task Force shall collaborate with the Department of Medical Assistance Services to ensure any

data analytics systems developed pursuant to this section complement existing fraud detection programs.

E. The Task Force shall host annual stakeholder meetings to evaluate and discuss improvements to Medicaid billing oversight and share results from fraud detection initiatives.

§ 32.1-137.25. Streamlining oversight processes; report.

A. The Department shall conduct an annual review of all credentialing, billing oversight, and compliance processes established under this article to identify opportunities to streamline administrative requirements, reduce duplication, and enhance efficiency.

B. The Department shall consult with hospitals, health care providers, and other stakeholders to ensure that oversight processes:

1. Minimize administrative burdens on hospitals while maintaining patient safety and fraud prevention standards;

2. Avoid redundancy with existing federal and state systems, including the National Practitioner Data Bank, any systems utilized by the Department of Health Professions, and any systems utilized by the Centers for Medicare and Medicaid Services; and

3. Facilitate timely decision-making in credentialing and billing oversight to prevent unnecessary delays in health care delivery.

C. The Department shall report annually to the General Assembly on streamlining oversight processes. Such report shall include:

1. Recommendations for improving and streamlining oversight processes;

2. Actions taken to implement such recommendations; and

3. Any cost savings or increases in efficiency achieved by streamlining oversight measures.

D. The Department may establish an advisory committee composed of representatives from hospitals, health care providers, patient advocacy organizations, and other relevant stakeholders to provide guidance on streamlining oversight processes and ensuring that they align with best practices.

E. The Department shall develop technology-driven solutions, including the use of advanced analytics and automated systems, to reduce manual workloads and improve efficiency of credentialing and billing oversight.

F. The Department shall review any new regulations or processes implemented pursuant to this article after three years to assess their effectiveness and ensure that they do not impose unnecessary administrative

burdens on health care facilities or providers.

2. That the health care provider credentialing database established by § 32.1-137.21 of the Code of Virginia, as created by this act, shall be implemented in phases. The Department of Health (the Department) shall implement the health care provider credentialing database for high-risk providers, as defined in § 32.1-137.21 of the Code of Virginia, as created by this act, and hospitals with a history of compliance issues, as determined by the Department, by July 1, 2026. The Department shall fully implement the health care provider credentialing database for all hospitals by July 1, 2028, using a phased approach that prioritizes underserved regions of the Commonwealth. The Department shall incorporate streamlining mechanisms described in § 32.1-137.25 of the Code of Virginia, as created by this act, into its phased implementation plan.