WEST VIRGINIA LEGISLATURE

2026 REGULAR SESSION

Committee Substitute

for

House Bill 4335

By Delegates Worrell and Hite

[Originating in the Committee on Health and Human

Resources; Reported on January 19, 2026]

A BILL to amend and reenact the Code of West Virginia, 1931, as amended, by adding a new section, designated §9-5-34; and to repeal §16-1A-1, §16-1A-2, §16-1A-3, §16-1A-4, §16-1A-5, §16-1A-6, §16-1A-7, §16-1A-8, §16-1A-9, and §16-1A-10, relating to Medicaid providers; establishing expedited enrollment timelines for the state's agent; establishing a uniform credentialing requirement for managed care organizations; requiring the exclusive use of electronic submissions; and directing the Department of Human Services to implement a unified statewide credentialing platform.

Be it enacted by the Legislature of West Virginia:

CHAPTER 9. HUMAN SERVICES

ARTICLE 5. MISCELLANEOUS PROVISIONS.

§9-5-34. Medicaid provider enrollment and credentialing; expedited timelines; electronic submission; and unified system.

(a) By July 1, 2026, the Department of Human Services or its agent shall complete enrollment determinations for Medicaid providers within five business days of receipt of a completed application.

(1) The department or its agent shall permit multiple people to be logged into the system.

(2) The agent shall be accredited by the National Committee for Quality Assurance.

(3) In the event that required documentation is incomplete, the applicant shall be notified electronically within two business days with a detailed explanation of the missing materials and provided a secure link to submit missing materials.

(4) Failure of the agent to meet the enrollment standard shall be reportable to the department and included in quarterly performance audits.

(b)(1) By July 1, 2026, a Medicaid managed care organization shall complete provider credentialing within 60 calendar days of receipt of a clean and complete application.

(2) A Medicaid managed care organization may request a one-time extension of no more

than 30 days, only upon written justification to the department and notice to the applicant.

(3) Upon failure to meet required timelines, a Medicaid managed care organization shall be subject to penalties established in the contract, including corrective action plans, monetary sanctions, or credentialing-by-default at the discretion of the department.

(c) (1) By July 1, 2026, the Office of the Insurance Commissioner shall prescribe the credentialing application form used by the Council for Affordable Quality Healthcare in electronic format. The standard credentialing form shall be as simple, straightforward, and easy to use as possible, having due regard for those credentialing forms that are widely in use in the state by the Medicaid managed care organizations and that best serve these goals.

(2) A Medicaid managed care organization may not fail to use the applicable standard credentialing form when initially credentialing or recredentialing providers in connection with policies, health care contracts, and agreements providing basic health care services, specialty health care services, or supplemental health care services.

(3) A Medicaid managed care organization may not require a provider to provide any information in addition to the information required by the applicable standard credentialing form in connection with policies, health care contracts, and agreements providing basic health care services, specialty health care services, or supplemental health care services.

(4) The credentialing process described in this section does not prohibit a Medicaid managed care organization from limiting the scope of any participating provider's basic health care services, specialty health care services, or supplemental health care services.

(d) Beginning July 1, 2026, enrollment and credentialing applications, renewals, documents, and supporting materials submitted by providers participating in Medicaid or a Medicaid managed care plan shall be submitted exclusively by electronic means.

CHAPTER 16. PUBLIC HEALTH.

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.

[Repealed.]

§16-1A-3. Definitions.

[Repealed.]

§16-1A-4. Advisory committee.

[Repealed.]

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

[Repealed.]

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

[Repealed.]

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

[Repealed.]

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

[Repealed.]

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

[Repealed.]

§16-1A-10. Immunity.

[Repealed.]

NOTE: The purpose of this bill is to establish uniform and expedited credentialing standards for Medicaid providers and require electronic submission of credentialing applications. The bill further directs the Department of Human Services to transition to a unified statewide electronic credentialing system.

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