

March 6, 2026

# Provider Enrollment and Credentialing in Medicaid

*Draft Chapter*

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Medicaid and CHIP Payment and Access Commission

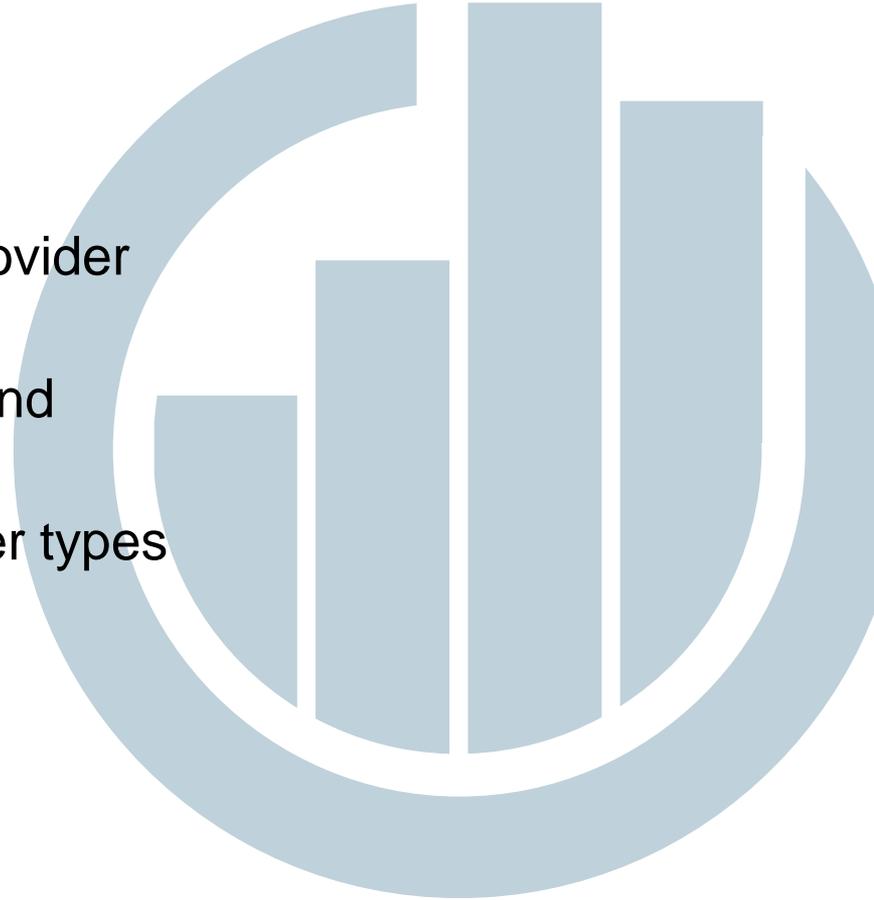
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# Overview

- Background
- Federal requirements for Medicaid provider enrollment and credentialing
- Overview of the provider enrollment and credentialing processes
- Medicaid enrollment for select provider types
- Challenges
- Conclusion and next steps

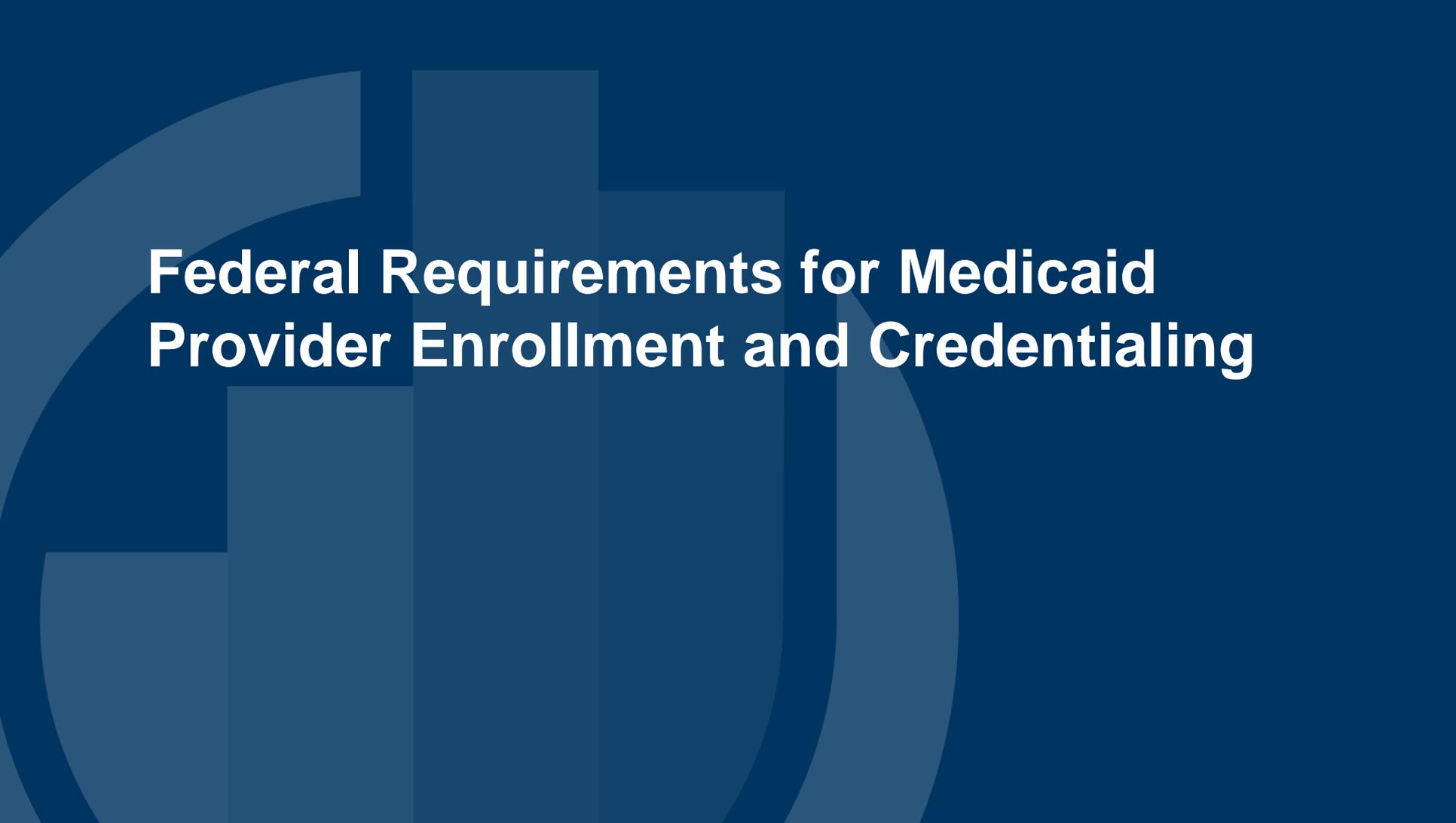


The background features a dark blue field with several overlapping, semi-transparent shapes in a lighter shade of blue. These shapes include a large circle on the left, a vertical rectangle in the center, and a curved shape on the right. The word "Background" is written in white, bold, sans-serif font across the middle of the composition.

**Background**

# Background

- Provider enrollment and credentialing ensure that enrollees receive care from qualified providers, and protect the Medicaid program from fraud, waste, and abuse (FWA)
- **Provider enrollment:** the process by which states determine whether providers are eligible to deliver services to Medicaid enrollees and receive payment from the program
- **Credentialing:** the process by which managed care organizations (MCOs) verify that a provider is qualified to deliver care to the plan's enrollees



# **Federal Requirements for Medicaid Provider Enrollment and Credentialing**

# Screening and Disclosures

- States must screen enrolling Medicaid providers based on the risk level assigned to their provider type in Medicare
  - Risk levels are limited, moderate, and high
  - Medicare regulations describe required screening activities for each risk level
- States must collect biographical and practice information from enrolling providers (e.g., name, date of birth, and National Provider Identifier)
- Providers must disclose information about ownership and control, business transactions, affiliations, and relevant criminal convictions

# Provider Screening Requirements

Risk level	Screening Activity	Description
<b>Limited</b>	<input checked="" type="checkbox"/> <b>Enrollment eligibility</b>	Verify that the provider meets enrollment requirements for their provider type
	<input checked="" type="checkbox"/> <b>License verification</b>	Confirm the provider has a license to practice
	<input checked="" type="checkbox"/> <b>Federal database checks</b>	Confirm the provider's identity and exclusion status by checking federal databases
<b>Moderate</b>	<input checked="" type="checkbox"/> <b>Site visit</b>	Conduct a site visit to confirm provider's information and compliance with enrollment requirements
<b>High</b>	<input checked="" type="checkbox"/> <b>Criminal background check</b>	Conduct a criminal background check
	<input checked="" type="checkbox"/> <b>Fingerprinting</b>	Provider submits fingerprints

# Provider Agreements

- Providers must enter into agreement with the state to receive payment for services delivered to enrollees
- The state executes the agreement after completing screening and receiving provider disclosures
  - States must revalidate a provider's enrollment at least once every five years
- States generally must collect an application fee from institutional providers before executing the agreement
- Providers wishing to participate in a managed care network(s) must also enter agreement with the MCO(s)

# Denials, Terminations, and Revalidation

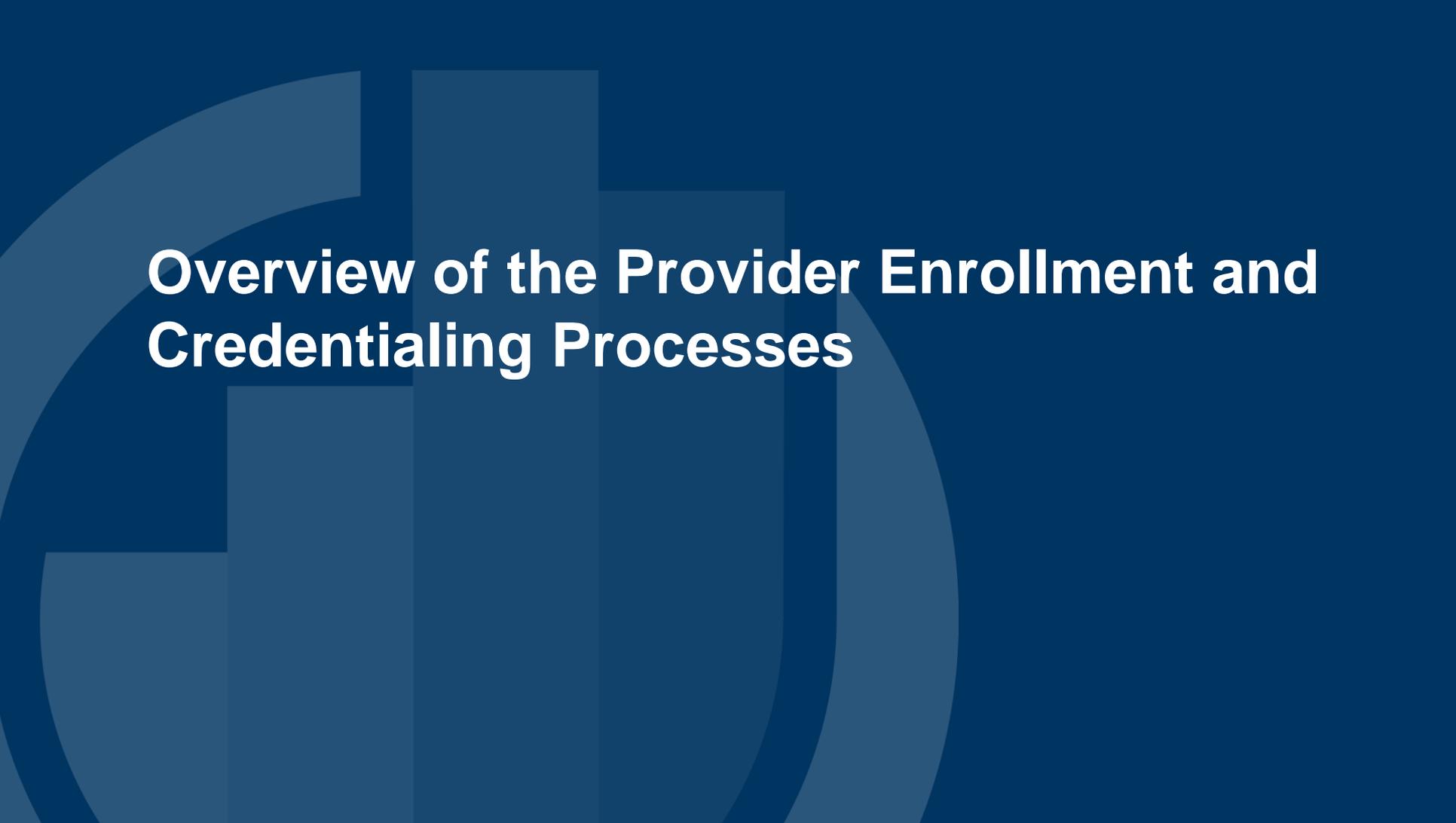
- States must deny enrollment if a provider:
  - does not provide timely and accurate screening information,
  - has a relevant criminal conviction in past 10 years, or
  - has been terminated from Medicare or Medicaid
- States must terminate providers for similar reasons
  - States must report all terminations to the Centers for Medicare & Medicaid Services (CMS) via the Data Exchange (DEX) system
- States must revalidate a provider's enrollment at least once every five years

# Provider Credentialing

- Federal regulations require states to develop credentialing processes within certain parameters:
  - Uniform credentialing: states must establish credentialing policies that are equitable, prevent discrimination, and allow MCOs to build networks that meet enrollees' needs
  - Documented process: MCOs must document their credentialing and recredentialing processes
  - MCOs may contract with provider types that are not recognized by a state's fee-for-service (FFS) program, these providers must be credentialled but generally do not need to enroll in FFS

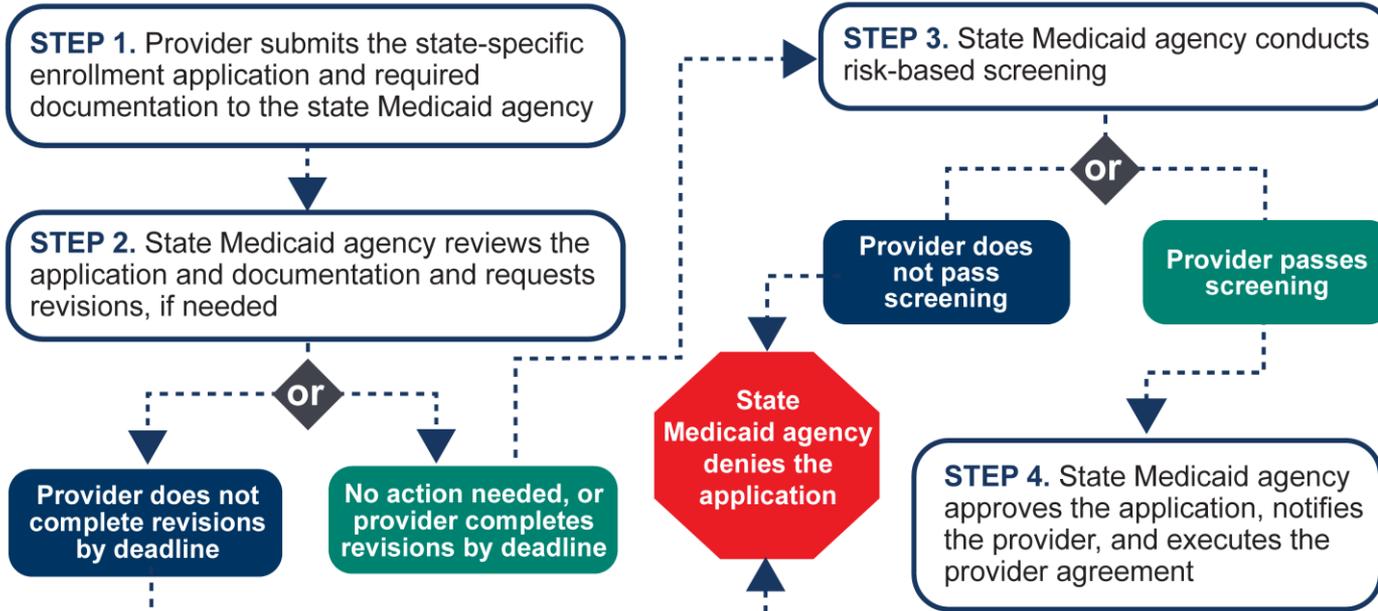
# State Flexibilities

- States can implement additional requirements for provider enrollment, such as:
  - Requiring more frequent revalidation
  - Checking databases not required by federal regulations, such as the Provider Enrollment, Chain, and Ownership System (PECOS)
  - Implementing risk levels and screening requirements that are stricter than Medicare
- States also have the flexibility to set “reasonable” standards for Medicaid provider qualifications
- States have discretion to set additional denial and termination conditions



# Overview of the Provider Enrollment and Credentialing Processes

# Medicaid Provider Enrollment Process



**MCO network providers must go through the MCO contracting and credentialing process**

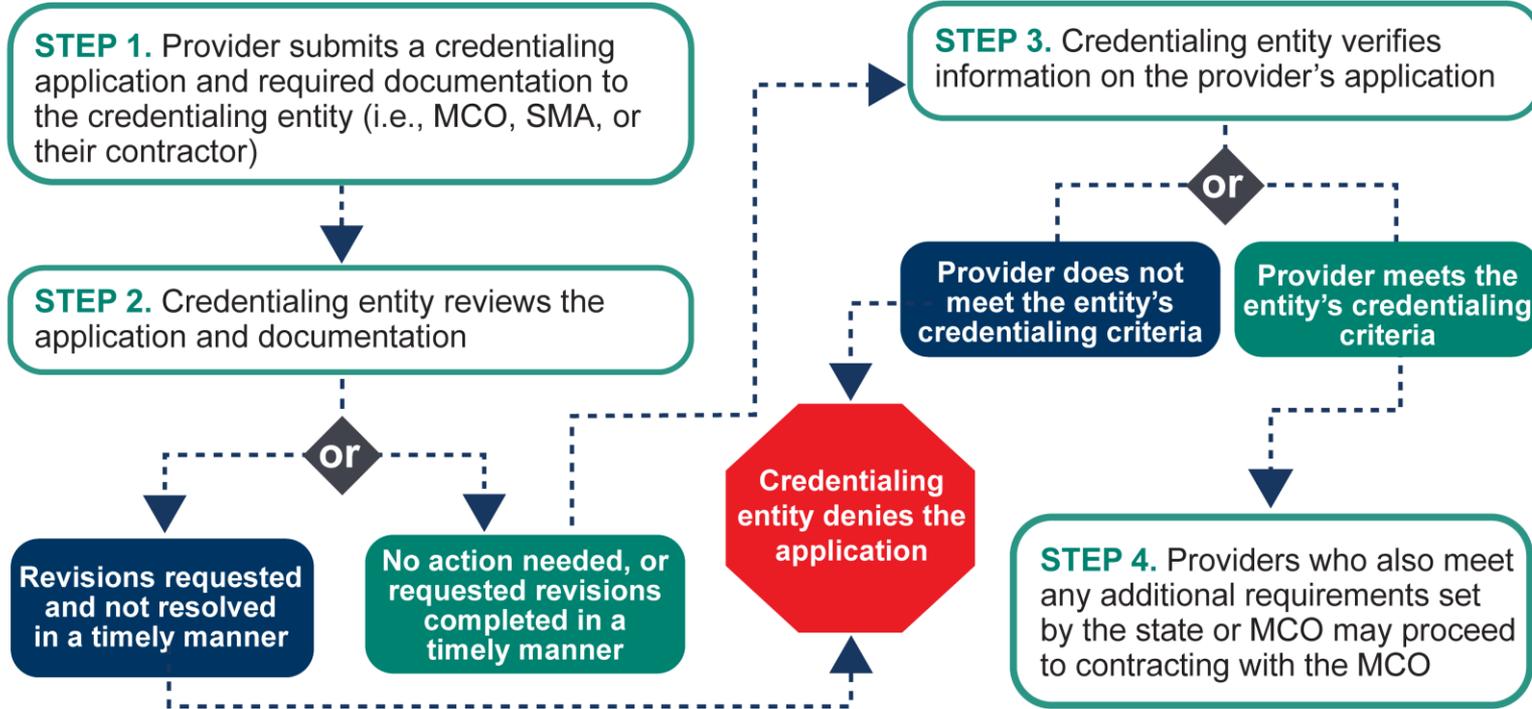
**Notes:** MCO is managed care organization.

**Source:** 42 CFR 431.107, 438.602(b)(1), 455.104-107, 455.410, 455.422, 455.450, and 455.460.

# State Variation in Provider Enrollment

- Aspects of the provider enrollment process may vary by state
- MACPAC examined provider enrollment process in OH, OR, and PA
- In these states, we found differences related to the following:
  - Enrollment requirements for MCO network providers
  - Licensure requirements for out-of-state providers
  - Reliance on screenings conducted by Medicare or other states
  - Additional database checks (e.g., PECOS, state-maintained registries)
  - Revalidation requirements

# Managed Care Provider Credentialing Process



**Notes:** MCO is managed care organization.

**Source:** CMS 2025.

# State Variation in Managed Care Credentialing

- The credentialing process varies depending on the structure of the state's credentialing system
- Decentralized credentialing (PA)
  - Providers must complete separate credentialing processes with each MCO
- Standardized credentialing (OR)
  - Providers submit the same form and documentation for each MCO
- Centralized credentialing (OH)
  - Providers can use a single application to credential with multiple MCOs

# Medicaid Enrollment for Select Provider Types

# Enrollment Policies for Select Provider Types

- **School-based services providers:** Medicaid-covered services provided in schools by personnel employed by or contracted with a school or local education agency
  - Generally must enroll in Medicaid
  - Provided through FFS in OH, OR, and PA, so providers do not need to credential
- **Doulas:** trained professionals who guide and support individuals and families before, during, and after childbirth
  - OH, OR, and PA permit doulas to enroll as Medicaid providers if they meet state certification requirements

# Enrollment Policies for Select Provider Types, cont.

- **Community health workers (CHWs):** individuals who connect enrollees in their communities to health and social services
  - Do not enroll in FFS in OH and PA, but MCOs must cover CHW services
  - In OR, CHWs enroll as a non-payable provider type, and work and bill under supervision of licensed providers
- **Peer support specialists:** individuals with lived experience of a mental health illness or substance use disorder who help patients engage in behavioral health care
  - Do not enroll in OH; enrolled behavioral health providers bill for their services
  - Enroll as non-payable provider in OR; enrolled providers bill for their services
  - Peer support specialist agencies enroll and bill for their staff's services in PA



# Challenges

# Challenges

- Administrative complexities
  - States may have difficulty completing enrollment within recommended timeframe
  - Enrollment and credentialing can be complex and burdensome
    - Challenges may be greater for non-traditional provider types (e.g., doulas, CHWs) and providers credentialing with multiple MCOs
- Supervisory relationship requirements
  - Time and effort required to build a supervisory relationships may deter some providers from enrolling
- Barriers for out-of-state providers
  - Requirement to separately enroll with multiple states can be challenging for providers
  - Lack of state reliance on screenings conducted by Medicare or other states can result in duplicative screening

# Conclusion and Next Steps

- Medicaid provider enrollment and credentialing help ensure that only qualified providers render care to enrollees and bill Medicaid
- The way states operationalize these processes, including the structure of their credentialing systems, can affect provider participation and access to care
- Further examination of the challenges identified could surface potential opportunities to mitigate them
- Staff will update the draft chapter based on Commissioner feedback and finalize it for publication in the June 2026 report

# Discussion Questions

- Are there areas where Commissioners would like to see further clarification in the chapter?
- Are there challenges with provider enrollment and credentialing that Commissioners are interested in further exploring in future work?
- Do provider enrollment and credentialing requirements strike the right balance between safeguarding program integrity and ensuring sufficient access to care for enrollees?

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