

Chapter 7:

# Provider Enrollment and Credentialing in Medicaid

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## Key Points

- Medicaid provider enrollment and managed care credentialing aim to ensure that enrollees receive care from qualified providers and protect the program from fraud, waste, and abuse.
- Providers seeking to deliver services to Medicaid enrollees and receive payment from the program generally must enroll with the state. Providers seeking to participate in a managed care network must be credentialed by the managed care plan, in addition to enrolling with the state.
- Federal regulations describe the process that states must follow to enroll Medicaid providers, which includes conducting screenings, checking federal databases, and entering into a provider agreement. States must deny enrollment to providers who do not meet specified requirements; terminate providers for certain violations (e.g., fraud); and revalidate providers at least every five years.
- States have flexibility to determine aspects of the Medicaid provider enrollment process, such as setting additional enrollment requirements, assigning higher risk levels to certain provider types, or requiring additional screening activities. States can also choose to rely on the results of screenings conducted by Medicare or other states.
- The Centers for Medicare & Medicaid Services (CMS) can conduct its own provider screening or implement additional requirements, such as requiring states to check additional databases. CMS can also impose a temporary enrollment freeze for new providers or provider types it identifies as posing a risk to program integrity, unless the state determines that such action would harm enrollee access to care.
- Medicaid provider enrollment and credentialing must be rigorous enough to ensure provider quality and program integrity. However, complex and sometimes duplicative requirements may present compliance challenges for states and deter providers from participating in Medicaid.
- The structure of a state's credentialing system—whether centralized, standardized, or decentralized—can also have implications for the level of effort required of providers.
- The administrative burden of enrollment and credentialing is often most acute for providers in small practices as well as other non-institutional providers (e.g., doula, community health workers, and school-based health providers) who are newer to the Medicaid program and lack administrative support for these processes. Out-of-state providers may experience additional barriers to Medicaid participation when required to enroll and credential with multiple states and managed care plans.
- Future research could offer additional insight into barriers faced by certain provider types or challenges related to the enrollment and credentialing processes, as well as opportunities to mitigate them.

# CHAPTER 7: Provider Enrollment and Credentialing in Medicaid

The primary responsibility of every state Medicaid agency is to facilitate access to covered health services for its enrollees. To make that care available, each state Medicaid agency must engage various types of health care providers, including medical facilities and individual providers as well as other medical service and equipment suppliers, to participate in the Medicaid program.

Medicaid provider enrollment and managed care credentialing processes aim to ensure that Medicaid enrollees receive care from qualified providers. Provider enrollment is the process by which state Medicaid agencies determine whether health care providers who apply to participate in Medicaid are eligible to deliver services to enrollees and receive payment from the program.<sup>1</sup> This process verifies that providers are appropriately licensed according to state law, are not excluded from federally funded health care programs, and are able to meet any other applicable federal and state requirements.<sup>2</sup>

Providers who deliver services and supplies to managed care enrollees must be credentialed to participate in managed care networks.<sup>3</sup> Credentialing is the process by which managed care plans verify that a provider is qualified to deliver care to the plan's enrollees within the scope of their specialty or provider type.<sup>4</sup>

In addition to ensuring the qualifications of Medicaid providers, the provider enrollment and credentialing processes are key mechanisms for preventing the enrollment of providers who have criminal records related to federal health programs or who have engaged in fraud, waste, or abuse (FWA).<sup>5</sup> Although these processes must be rigorous enough to exclude unqualified providers or those who have engaged in misconduct, overly burdensome enrollment and credentialing requirements could deter providers from participating in Medicaid. Recruiting a sufficient

number and variety of providers is critical to ensuring that enrollees can access appropriate and timely care.

As part of the Commission's continued focus on access to care for Medicaid enrollees, MACPAC partnered with Acumen, LLC to examine federal and state policies as well as the relevant academic and gray literature pertaining to Medicaid provider enrollment and credentialing. This chapter summarizes the findings from that work. It begins with an overview of federal requirements for provider enrollment and credentialing in Medicaid and a step-by-step overview of those processes.<sup>6</sup> Next, the chapter highlights approaches taken by three states (Ohio, Oregon, and Pennsylvania) as well as challenges for states and providers that emerged from the literature. The chapter concludes by summarizing findings and identifying potential topics for future research. It will be important that any future efforts to identify and mitigate challenges associated with the Medicaid enrollment and credentialing processes are informed by direct engagement with providers, managed care plans, and state and federal officials.

## Federal Requirements for Medicaid Provider Enrollment and Credentialing

Medicaid and State Children's Health Insurance Program (CHIP) fee-for-service (FFS) providers as well as managed care network providers are required to enroll with the state Medicaid agency.<sup>7</sup> Federal regulations describe the process that states must follow to enroll providers and have evolved over time as the Medicaid program has grown (Appendix 7A). This process includes steps such as entering into a provider agreement, conducting screening based on perceived risk of FWA, and collecting disclosures of information (CMS 2025a). State Medicaid agencies generally follow Medicare in assigning provider risk levels for provider screening, and states may accept the results of screenings conducted by Medicare and other states. Providers complete enrollment when the state Medicaid agency determines that they have met

all screening requirements and executes an agreement with them (CMS 2016a). The Secretary of the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) oversee parts of the enrollment process and can require or conduct additional screening checks or request information from enrolling providers.

## Screening

As part of the enrollment process, state Medicaid agencies must screen providers based on the risk level assigned to their provider type in Medicare (42 CFR 455.410(a), 42 CFR 455.450).<sup>8</sup> The three risk levels (limited, moderate, and high) reflect the perceived risk of FWA posed by each provider type (CMS 2025a). For example, physicians are a limited risk provider type, whereas newly enrolling home health agencies are considered high risk (42 CFR 424.518). Medicare regulations define screening requirements for each risk level. States must set risk levels for provider types either equal to or greater than those set in Medicare and carry out the corresponding required screening activities (42 CFR 424.518).

States must set risk levels for provider types that Medicare does not recognize. These provider types (e.g., non-emergency medical transportation providers) cannot participate in Medicare and therefore do not have a Medicare risk level assigned to them (CMS 2025a). CMS recommends that states assign risk levels to these providers by considering information similar to that used by CMS to assign Medicare risk levels, such as reports from the U.S. Government Accountability Office and U.S. Department of Health and Human Services Office of the Inspector General (OIG), congressional testimony, and input from law enforcement (CMS 2025a). Federal rules require state Medicaid agencies to raise a specific provider's risk level from low or moderate to high in specified situations.<sup>9</sup>

State Medicaid agencies do not always have to conduct the required screening themselves to enroll a provider in their Medicaid program. State Medicaid agencies can rely on screening activities conducted for enrollment in Medicare or another state's Medicaid program or CHIP (42 CFR 455.410(c)). They also can delegate screening activities to managed care plans or other third parties (CMS 2025a). If state Medicaid agencies delegate screening activities, they must

ensure that screening is not duplicative for network providers participating with several managed care plans (CMS 2025a).

The state Medicaid agency (or third party, if screening is delegated) must complete the screening activities for providers in each risk level (Table 7-1). The screening activities are cumulative across risk levels, which means that all screening activities from every preceding category must be completed (42 CFR 455.450).

If the state Medicaid agency relies on screening activities conducted for enrollment in Medicare or another state's Medicaid program and the risk level of the provider was lower for the other enrollment process than the state's, the state Medicaid agency must perform the remaining screening activities. For example, if Medicare screened the provider as limited risk but the state considers the provider moderate risk, the state Medicaid agency would need to conduct a site visit as required for moderate-risk providers (CMS 2025a).

## Disclosures

Section 1902(a)(78) of the Social Security Act (the Act) requires states to collect basic biographical and practice information from every provider who enrolls in their Medicaid program. This information includes the provider's name, date of birth, Social Security number, specialty, national provider identifier (NPI) (if applicable), federal taxpayer identification number, and state license or certification number (if applicable). These requirements apply to both providers who furnish items and services to enrollees and ordering, referring, and prescribing (ORP) providers (CMS 2025a).<sup>10</sup>

Federal regulations require Medicaid providers to disclose information to the state Medicaid agency about ownership and control, business transactions, affiliations, and relevant criminal convictions. Providers must disclose information about themselves and, when applicable, their managing employees or individuals and organizations with ownership and control interests in the provider. Not all disclosure requirements apply to all providers (e.g., the ownership and control disclosure does not apply to individual providers), and providers must disclose certain information only upon request (42 CFR 455.104–107).

**TABLE 7-1.** Provider Screening Requirements by Risk Level

Risk level	Screening activity	Description
<b>Limited</b>	<input checked="" type="checkbox"/> <b>Enrollment eligibility</b>	Verify that the provider meets federal regulations and state requirements for their provider type
	<input checked="" type="checkbox"/> <b>License verification</b>	Confirm the provider has a non-expired license with no limitations that allows them to practice in the state in alignment with applicable state laws
	<input checked="" type="checkbox"/> <b>Federal database checks</b>	Confirm the provider’s identity and exclusion status by checking the following federal databases: the DEX, DMF, LEIE, NPPES, and SAM <sup>1</sup>
<b>Moderate</b>	<input checked="" type="checkbox"/> <b>Site visit</b>	Conduct a site visit to verify the accuracy of information the provider submitted to the state Medicaid agency and check compliance with federal and state 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>	Require the provider to submit fingerprints

**Notes:** DEX is the Centers for Medicare & Medicaid Services Data Exchange System. DMF is Death Master File. LEIE is List of Excluded Individuals/Entities. NPPES is National Plan and Provider Enumeration System. SAM is System for Award Management.

DEX allows states to share information on providers who have been terminated from state Medicaid programs and also allows states to access the DMF and view Medicare terminations. The DMF is a database of deceased individuals and their Social Security numbers. LEIE is a database of individuals and entities excluded from participating in federal health care programs. The NPPES is the database of all national provider identifiers, unique numbers assigned to practicing health care providers and organizations. SAM is a database that includes a list of individuals and entities excluded from receiving federal contracts.

<sup>1</sup> States must check DEX at enrollment; the DMF at least quarterly, beginning January 1, 2028; the LEIE at least monthly; the NPPES at an unspecified frequency; and SAM at least monthly.

**Sources:** 42 CFR 455.412, 455.432, 455.434, 455.436, and 455.450.

## Provider agreements

State Medicaid agencies must enter into an agreement with all individuals and organizations that provide services to Medicaid enrollees under the state plan (§ 1902(a)(27) of the Act). As part of the agreement, providers must attest that they will (1) keep records of the services they provide to enrollees, (2) share these records with CMS upon request, (3) comply with federal disclosure requirements, and (4) share their NPI with the state and include it on all claims (42 CFR

431.107(b)).<sup>11</sup> The state Medicaid agency executes the agreement once it has conducted federal and state-specific screening activities and collected applicable disclosures (CMS 2025a, 42 CFR 455.104, 42 CFR 455.106). Provider agreements can be retroactive up to one year (42 CFR 431.108). This allows providers to receive payment for services provided to Medicaid enrollees for a limited period before the provider is enrolled in Medicaid.

Managed care plans must enter into a provider agreement with each provider with whom they contract (42 CFR 438.2). This network provider agreement is distinct from the state Medicaid agency provider agreement. Managed care network providers generally must have agreements with managed care plans and state Medicaid agencies, whereas federal rules require only FFS-only providers to enroll with the state Medicaid agency (CMS 2025a).

## Denials

Federal regulations and subregulatory guidance specify circumstances in which state Medicaid agencies must deny the enrollment of providers (mandatory denials) versus when they have the option to do so (discretionary denials). Mandatory denial reasons include but are not limited to failure to submit timely and accurate screening information, failure to comply with screening requirements, criminal conviction related to Medicare or Medicaid within the past decade, and termination from Medicare or the Medicaid program or CHIP of another state (42 CFR 455.416). State Medicaid agencies may exempt a provider from mandatory denial if the denial is “not in the best interests of the Medicaid program,” unless the provider was terminated by Medicare or another state’s Medicaid program (CMS 2025a, 42 CFR 455.416).<sup>12</sup> Examples of discretionary denial reasons include when the provider submitted false or misleading information, the provider billed with a suspended license or misused their billing number, or the state Medicaid agency cannot confirm the provider’s identity (CMS 2025a, 42 CFR 455.416). Regardless of whether the denial is discretionary or mandatory, state Medicaid agencies must inform providers whom they deny enrollment about any state-specific appeal rights (42 CFR 455.422).

## Managed care network-only providers

There may be instances in which a state’s Medicaid FFS program does not recognize certain types of managed care network providers (e.g., an plan’s provider of value-added services, such as nutrition counseling).<sup>13</sup> In these cases, federal rules do not require the provider to enroll with the state Medicaid agency. For example, some managed care plans may

include dietitians in their networks. If dietitians are not eligible to enroll in the state’s FFS program, CMS does not require them to enroll with the state Medicaid agency to serve managed care enrollees (CMS 2025a). However, CMS recommends that, as a best practice, states require these provider types to enroll with the state as Medicaid providers, such as in an “other” or “managed care-only” provider type category (CMS 2025a). Requiring these providers to enroll subjects them to vetting as part of both enrollment and credentialing processes, including screening by the state Medicaid agency, as opposed to credentialing only. This practice can help protect the program from improper payments by ensuring that the state Medicaid agency screens all providers who receive Medicaid payments, including those who are ineligible to participate in FFS.

## Application fee

State Medicaid agencies generally must collect an application fee from enrolling institutional providers (e.g. hospitals, home health agencies) before they execute the provider agreement (42 CFR 455.460). The Medicaid application fee is the same as the Medicare application fee. CMS sets the fee and adjusts it each calendar year according to the Consumer Price Index for all Urban Consumers.<sup>14</sup> CMS can allow states to forgo collecting application fees from certain providers by approving a state’s determination that an exception is needed to maintain enrollee access to care (§ 1866(j)(2)(C)(ii)).

States collect a provider fee when an institutional provider initially enrolls in the state’s Medicaid program, revalidates their enrollment, adds a new practice location, or adds a new owner (CMS 2025a).<sup>15</sup> The application fee subsidizes the cost of required screening activities borne by states and the federal government. Providers who have paid the fee for enrollment in Medicare or another state’s Medicaid program or CHIP do not need to pay the fee a second time when enrolling in a state’s Medicaid program (CMS 2025a). If the enrollment fees collected by the state exceed the cost of screening, the state must pay the excess fees to the federal government (42 CFR 455.460).

## Oversight

CMS has oversight responsibility for state Medicaid agencies' provider screening and enrollment activities and can conduct its own screening or implement additional requirements, as described below:

- **Unannounced site visits.** Enrolled providers must allow CMS or its agents or contractors to perform unannounced site visits of their service locations (42 CFR 455.432).
- **Fingerprint submission.** CMS can ask providers, or any person with at least a 5 percent ownership interest in the provider, to submit fingerprints. The provider must submit fingerprints within 30 days of the request (42 CFR 455.434).
- **Additional database checks.** CMS can require state Medicaid agencies to conduct checks of additional databases beyond those required by federal regulations (42 CFR 455.436(b)).

CMS also provides guidance and technical assistance to states on federal provider enrollment requirements, including by sharing enrollment and screening data and hosting monthly calls to discuss challenges (CMS 2024a). Additionally, CMS can impose a six-month freeze on enrollment of certain providers or provider types it identifies as posing a risk to Medicaid program integrity, though the state Medicaid agency does not have to implement the freeze if it would harm enrollee access to care (42 CFR 455.470(a)). CMS has imposed temporary enrollment freezes on home health agencies in Florida, Illinois, Michigan, and Texas and certain ambulance providers in New Jersey, Pennsylvania, and Texas after determining an increased risk of FWA for these provider types in certain counties (CMS 2018, 2013). Before CMS implemented the enrollment freeze, it confirmed with state Medicaid agencies that doing so would not negatively affect access to care (CMS 2013).

## Out-of-state providers

Medicaid enrollees sometimes seek care from providers in a different state, such as when an out-of-state provider is closer than an in-state provider

or if providers are not available in their state. For example, for enrollees who live near a state border, a metropolitan area with a hospital that provides specialized services might be closer in a bordering state compared to their own state. States must pay for Medicaid services that its enrollees receive in another state in certain circumstances, such as in an emergency, when the care is more readily available in the other state, or when seeking care in the other state is common practice (42 CFR 431.52).

State Medicaid agencies must enroll providers who render, order, refer, or prescribe care to their enrollees, which generally includes out-of-state providers (§ 1902(a)(78) of the Act). States can reimburse for Medicaid services rendered, ordered, or referred by a non-enrolled out-of-state provider when specific criteria are met—for example, if a provider is enrolled in Medicare or another state's Medicaid program. Out-of-state providers who do not meet these criteria must enroll in the state Medicaid program that is paying for the care.

Federal policymakers have considered opportunities to minimize the effect of provider enrollment requirements on timely access to out-of-state care for children with complex health care needs who often need specialized care that is available from a limited number of centers of excellence (e.g., children's hospitals) nationwide. In response to a congressional directive, CMS issued guidance in 2021 recommending that states shorten the enrollment and screening time frame for out-of-state providers for children with medically complex conditions, including by relying on screenings conducted by Medicare and other state Medicaid programs. CMS notes that states may also be able to use information collected by another state, such as federally required disclosures, to streamline enrollment for out-of-state providers (CMS 2021).<sup>16</sup> In separate guidance on best practices for adhering to early and periodic screening, diagnostic, and treatment (EPSDT) requirements, CMS further recommends that states streamline the provider enrollment and screening process to reduce administrative burden for providers who treat children and youth (CMS 2024b).

## Indian Health Care Providers

Indian Health Care Providers (IHCPs) operating through the Indian Health Service must enroll in Medicaid to receive payment for services delivered to American Indian and Alaska Native (AI/AN) Medicaid enrollees. States may not impose additional eligibility requirements on IHCPs seeking to participate in Medicaid. Federal regulations also bar states from requiring that IHCPs enrolling in Medicaid possess a state license, so long as the IHCP meets all applicable licensure requirements (42 CFR 431.110). Managed care plans must pay IHCPs for any covered services delivered to the plan's AI/AN enrollees, even if the IHCP does not participate in the managed care network or is not enrolled in Medicaid (42 CFR 438.14).

## Maintaining provider enrollment

Several federal requirements aim to ensure enrolled providers continue to meet the standards the state Medicaid agency evaluated during the initial enrollment process. This includes processes to periodically revalidate and, if necessary, terminate enrollment.

### Revalidation

State Medicaid agencies must revalidate a provider's enrollment at least once every five years (42 CFR 455.414). The revalidation process is similar to the initial enrollment process in that providers must submit a revalidation application, and the state Medicaid agency must complete the full screening process according to the provider's assigned risk level (CMS 2025a). Similar to initial enrollment, state Medicaid agencies can rely on screening results for revalidation in Medicare or another state's Medicaid agency. Providers do not need to submit a revalidation application if the provider has been revalidated in Medicare (CMS 2025a).

In April 2026, CMS sent a letter to state Medicaid directors requesting that they submit a two-year provider revalidation strategy and notify the agency of their plans to swiftly revalidate high-risk providers.<sup>17</sup> CMS requested that state provider revalidation plans prioritize a comprehensive review and revalidation of Medicaid providers and describe how states enroll providers without NPIs. CMS further encouraged states to increase oversight of providers who pose a high risk of FWA by revalidating their enrollment more

frequently than once every five years as required by federal rules (CMS 2026a). CMS sent a separate letter to governors reiterating the agency's request that states quickly revalidate high-risk Medicaid providers (CMS 2026b).

### Termination

State Medicaid agencies must terminate a provider's agreement "for cause" for specific reasons.<sup>18</sup> Causes for mandatory termination closely mirror the circumstances in which states are required to deny enrollment, such as failure to submit timely and accurate information, criminal convictions related to federal health care programs in the past 10 years, and failure to comply with screening requirements (CMS 2025a).

Similar to enrollment denials, state Medicaid agencies have the discretion to terminate provider agreements for cause for additional reasons that include but are not limited to abuse of billing privileges, billing with a suspended license, improper prescribing practices, and previous patient harm (CMS 2025a).

State Medicaid agencies must report providers whom they terminated for cause to CMS (42 CFR 455.417).<sup>19</sup> The CMS Data Exchange System is the database of terminated providers (including providers terminated from Medicare) and the platform for reporting them. Providers remain in the termination database for the lesser of 10 years or the duration specified by the state that initially terminated them (42 CFR 455.117(a)). Terminated providers cannot reenroll while they are in the termination database, and other state Medicaid programs must terminate or deny their enrollment during this time (42 CFR 455.416-17).

## Provider credentialing

Provider credentialing is a component of a managed care plan's selection of network providers designed to ensure that such providers are qualified to care for Medicaid enrollees (42 CFR 438.214).<sup>20</sup> Federal regulations set forth requirements for provider credentialing as part of a broad set of policies to improve the quality of managed care at a time when managed care network providers were not yet required to enroll with the state (67 FR 40989). States must develop credentialing policies for their managed care plans based on parameters described

in federal regulations, which are less specific than federal enrollment and screening requirements (42 CFR 438.214) (Table 7-2). Federal credentialing requirements apply only to managed care network providers and not to providers who participate in FFS only.

### State flexibilities

Federal requirements represent the minimum activities state Medicaid agencies must complete to enroll and screen providers and to establish policies for managed care credentialing of network providers. States have the flexibility to implement additional screening requirements (42 CFR 455.452). Examples of ways states can leverage this flexibility include the following:

- requiring more frequent revalidation (i.e., more frequently than every five years);
- checking databases not required by federal regulations, such as the Provider Enrollment, Chain, and Ownership System (PECOS) and state-specific databases (e.g., lists of providers excluded from the state’s Medicaid program);<sup>21</sup>
- requiring providers to obtain professional liability insurance;
- implementing risk levels and screening requirements that are stricter than Medicare’s; and

- requiring moderate- and high-risk provider types recognized by Medicare (e.g. ambulance service suppliers, home health agencies) to enroll in and be screened by Medicare (CMS 2025a, Division of TennCare 2022).

States also have the flexibility to set “reasonable” standards for Medicaid provider qualifications (42 CFR 431.51(c)(2)). These state-specific standards may influence decisions regarding provider enrollment denial and termination decisions (CMS 2025a). For example, states may require additional credentials or certifications to enroll as a certain provider type, and states may deny enrollment to providers who fail to meet these standards.<sup>22</sup>

Additionally, under Section 1135 of the Act, CMS can temporarily waive federal provider enrollment and screening requirements to help states respond to public health emergencies (PHEs) by, for example, making it easier for providers to care for Medicaid enrollees in states where they were not previously enrolled in Medicaid (MACPAC 2020b) (Box 7-1). In cases when both the president has declared a disaster or emergency and the HHS Secretary has declared a PHE, states can request to temporarily waive certain federal Medicaid requirements through Section 1135 waivers (MACPAC 2020b; § 1135 of the Act). CMS may issue waivers in response to state requests or may issue blanket waivers that apply to all providers in an affected area (MACPAC 2020b).

**TABLE 7-2. Federal Requirements for Provider Credentialing**

Topic	Requirement
<b>Uniform credentialing</b>	Each state must establish a uniform policy for credentialing and recredentialing providers. In this context, “uniform” means that states must develop and apply these policies in a consistent way that engenders equitable outcomes, prevents discrimination, and allows managed care plans to create networks that fulfill their enrollees’ needs. States set the foundation of credentialing and recredentialing requirements that managed care plans must follow and can allow plans to establish the specifics of their policies.
<b>Documented process</b>	Managed care plans are required to document their credentialing and recredentialing processes. These processes are typically documented in managed care provider manuals.

**Notes:** Managed care plans are managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, as defined in 42 CFR 438.2.

**Sources:** 42 CFR 438.214, CMS 2016a.

## Overview of the Provider Enrollment and Credentialing Processes

This section describes how states and managed care organizations operationalize the provider enrollment and credentialing processes.

### Provider enrollment process

Although the Medicaid provider enrollment process is complex and varies by state, it generally consists of the steps described below and further detailed in Figure 7-1.

#### Step 1: Provider applies for enrollment

A provider applies for Medicaid participation. In the application, providers submit requested information about their licensure and professional certifications as well as applicable disclosures regarding ownership and control, business transactions, criminal convictions, and affiliations. The documentation requested by the state may vary by provider type. Some provider types must also pay an application fee.

#### Step 2: State reviews application

The state must review whether the provider meets state and federal requirements for participation in

Medicaid. This includes reviewing the provider's licensure and certification and proof of insurance as well as confirming the provider has paid any required enrollment fees. States may request additional information or revisions to the application.

#### Step 3: State completes screening

The state must complete a risk-based screening process for the provider based on their provider type. For provider types that are recognized by Medicare, states must assign a risk level that is the same as or higher than the Medicare risk level defined in federal regulations (42 CFR 424.518). States can describe risk levels in state statute or publish them online.

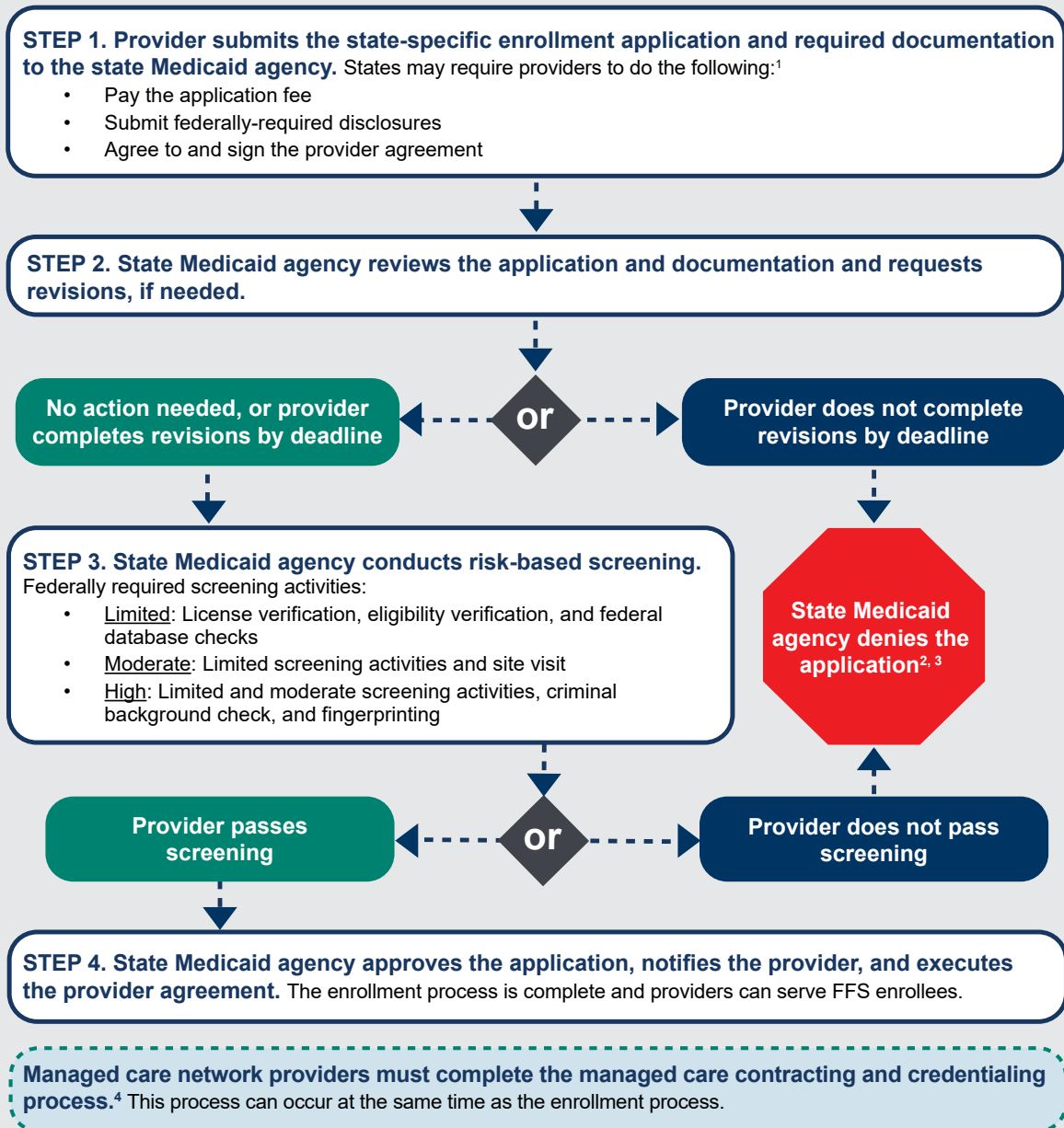
#### Step 4: State executes provider agreement

The enrollment process is complete when the state Medicaid agency executes an agreement with the provider. Although the provider may submit a signed provider agreement during the initial application submission in step 1, the execution of the agreement occurs at the end of the enrollment process when providers can begin receiving Medicaid payment for covered services delivered to enrollees. A provider must revalidate their enrollment with the state regularly (CMS 2025a).

### BOX 7-1. Section 1135 Waivers during the COVID-19 Public Health Emergency

Section 1135 of the Act allows the Secretary of the U.S. Department of Health and Human Services to waive or modify numerous federal Medicaid requirements during an emergency, including certain conditions of provider participation. During the COVID-19 public health emergency (PHE), all 50 states and the District of Columbia had approved Section 1135 waivers to facilitate provider participation in Medicaid and address anticipated workforce shortages, though states' use of these flexibilities varied and was not documented on a national level (Manetto et al. 2020). The approved waivers allowed states to provisionally enroll providers who were enrolled with Medicare or another state Medicaid agency for the duration of the PHE. For providers not already enrolled in Medicare or another state's Medicaid program, states were permitted to waive certain screening requirements, including payment of application fees, criminal background checks, site visits, and licensure requirements, to help with enrollment. States were also permitted to temporarily halt provider revalidation. The Centers for Medicare & Medicaid Services generally expected provider revalidation to resume at the end of the PHE. States were required to screen and enroll providers who had been provisionally enrolled or otherwise terminate them from their Medicaid programs within six months of the end of the PHE (CMS 2025c).

**FIGURE 7-1. Medicaid Provider Enrollment Process**



**Notes:** FFS is fee for service. Managed care refers to managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, as defined in 42 CFR 438.2.

<sup>1</sup> The enrollment application is a common vehicle for meeting these requirements, but states may choose to meet these requirements at a different part of the process.

<sup>2</sup> The state Medicaid agency must notify providers denied enrollment of any state-specific rights to appeal the decision (42 CFR 455.422).

<sup>3</sup> Per 42 CFR 455.416(d), providers denied enrollment due to failure to submit information in a timely manner must restart the enrollment process from step 1.

<sup>4</sup> Being enrolled with the state Medicaid agency does not require managed care-only providers to serve fee-for-service enrollees (42 CFR 438.602(b)(1)).

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

The managed care credentialing process may occur either during or after the enrollment process, depending on state rules and regulations. Some managed care credentialing processes may require outputs of the enrollment process (e.g., a state provider ID), which requires the provider to complete the state agency enrollment process first.

## Managed care credentialing process

Federal regulations require that states establish their own credentialing policies, and thus, they vary in how they carry out the credentialing and recredentialing processes (42 CFR 438.214(b)(1)). Credentialing includes activities such as verifying a provider's license, education, practice history, and any sanctions from state agencies or licensing boards (CMS 2025a, OIG 2013). The details of this process depend, in part, on the organization of each state's credentialing system. Some states have a centralized credentialing process, in which providers can complete a single application to credential with multiple managed care plans. Other states have a standardized process, in which providers submit a separate application with standardized information to each managed care plan with which they wish to participate. Other states have a decentralized credentialing process, in which providers submit plan-specific credentialing applications to each managed care plan.

The state's chosen approach to credentialing affects the experience of providers by, among other things, determining whether providers send materials to the state Medicaid agency or managed care plan, how many applications they need to submit to participate with multiple managed care plans, and whether they must submit different information and documentation to become credentialed by different managed care plans. State requirements for managed care plans to receive accreditation by the National Committee for Quality Assurance (NCQA) can also affect credentialing requirements and provider experience.<sup>23</sup> Despite state variation, the credentialing process generally consists of a few key steps, which are detailed below and in Figure 7-2.

### Step 1: Provider applies for credentialing

A provider applies for participation with an managed care plan. This involves submitting a credentialing application and any supporting documentation required by the state or managed care plan. Credentialing is part of the overall contracting process.

### Step 2: Credentialing entity reviews application

The credentialing entity reviews a provider's application. The credentialing entity might be the state Medicaid agency, the managed care plan, or a contractor.

### Step 3: Credentialing entity verifies information

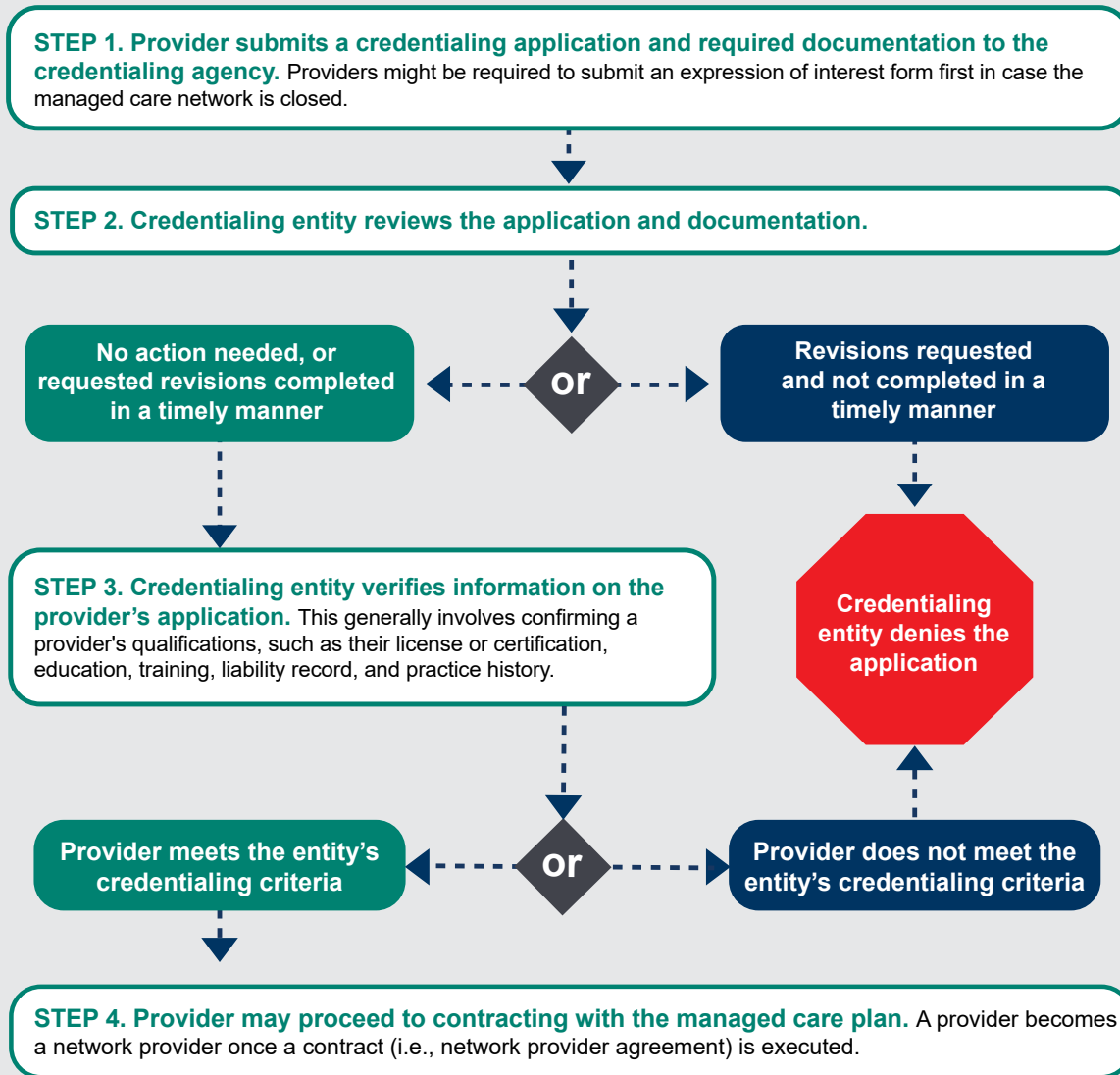
The credentialing entity verifies the accuracy of the information and documentation provided in the credentialing application. This review process may involve activities such as verifying a provider's license, education, practice history, and any sanctions from state agencies or licensing boards (CMS 2025a, OIG 2013).

### Step 4: Credentialing requirements are met

Providers who meet the credentialing criteria and any additional requirements set by the state or managed care plan may contract with the managed care plan. The provider becomes a network provider once the managed care plan executes the contract (i.e., the network provider agreement).

As described earlier, whether providers can concurrently complete the enrollment and credentialing processes varies by state and by managed care plan (for states without centralized credentialing). Under federal law, managed care plans can execute network provider agreements before providers complete the screening and enrollment process but must terminate the agreement if the state denies the provider's application or 120 days have passed and the state has not executed the provider agreement (42 CFR 438.602(b)(2)).

**FIGURE 7-2.** Medicaid Managed Care Provider Credentialing Process



**Note:** Managed care plans are managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, as defined in 42 CFR 438.2.

**Source:** CMS 2025a.

## Provider Enrollment and Credentialing in Three States

Although federal regulation sets certain requirements for enrollment and credentialing, states may implement and operationalize these requirements in different ways. This section discusses how three states—Ohio, Oregon, and Pennsylvania—implement the provider enrollment and credentialing processes, based on review of state laws and publicly available information as well as resources from state Medicaid agency websites, provider portals, and managed care plans. In selecting these states for analysis, MACPAC considered factors such as the structure of their credentialing systems, the number of managed care plans operating within the state, and the presence of large population centers along their borders, which may increase the need for enrollees to seek care across state lines.

### Provider enrollment process

Ohio, Oregon, and Pennsylvania have used the flexibilities granted to them by Medicaid statute and regulations to establish provider enrollment processes that vary in some ways. There are differences, for instance, in their screening and documentation requirements, their treatment of certain provider types (e.g., out-of-state providers), and their use of additional databases as part of the screening process.

#### Initial application

States determine what information to collect in the provider's initial application. Ohio, Oregon, and Pennsylvania require different forms and documentation based on provider type. In each state's online applications, the form displays components relevant to the provider type selected. For example, Ohio's online application guides providers through a series of pages and questions based on their selected provider type (ODM 2022a). Similarly, the state requires different providers to submit specific credentials or licensure proof. Pennsylvania's Medicaid agency website includes a list of provider types and outlines required documentation for each type. For instance, among other documents, physician assistants must provide a document from

Pennsylvania's Department of State that verifies their licensure and lists the physicians they will work with, which must be signed by those physicians (Pennsylvania DHS 2025a). Each of the three states also collects applicable disclosures as part of the initial application.

#### ORP and managed care network-only providers

States may have different enrollment applications for ORP providers and managed care network-only providers. In Ohio and Oregon, ORP providers enroll as a specific provider type (e.g., as a non-payable provider in Oregon) (OHA 2025a, ODM 2022a). In contrast, Pennsylvania requires that ORP providers enroll according to their provider type (e.g., psychiatrist or physician assistant) (Pennsylvania DHS 2022a, 2016a). Similarly, states may have different enrollment requirements for managed care network-only providers. In Ohio, network-only providers (and all other providers) complete enrollment and credentialing through a single online application hosted by the state (ODM 2025a). In Oregon, network-only providers enroll as "non-payable" providers. Pennsylvania does not appear to have an application specific to network-only providers, based on a review of publicly available documents (Pennsylvania DHS 2025a).<sup>24</sup>

#### Out-of-state providers

Ohio, Oregon, and Pennsylvania require out-of-state providers to enroll in their Medicaid programs to receive payment for services rendered to their Medicaid enrollees. Pennsylvania further requires that out-of-state providers be enrolled in their home state's Medicaid program.<sup>25</sup> The three states also require out-of-state providers to be licensed or certified by their home state.<sup>26</sup>

Oregon requires some out-of-state providers (e.g., certain telehealth and behavioral health providers) to have an Oregon license (OHA 2024a). For these out-of-state providers or providers relocating to Oregon from another state, the process to get an Oregon license may be complicated because Oregon does not participate in the Interstate Medical Licensure Compact (IMLC) (OMB 2025). Although states have their own medical licensing processes, the IMLC eases the burden of medical licensing for physicians who practice in multiple states by allowing eligible physicians to complete one application to become

licensed in any state that participates in the compact (IMLC 2021). Thus, in Oregon, physicians who need an Oregon license to enroll in Medicaid must go through the state's licensing process. To streamline the process, the state implemented expedited endorsement, which allows physicians with a current license in another state to enroll without the state verifying their core credentials with the credentialing body (OMB 2025).

### Retroactive enrollment

All three states permit retroactive enrollment, which permits the effective date of a provider's enrollment to precede the date of the application submission. This allows providers to submit claims and receive payment for services that they provided to Medicaid enrollees for a period before the provider was enrolled in Medicaid. In Ohio and Oregon, providers can enroll retroactively for up to a year, the maximum period allowed under federal law (ODM 2025a, PacificSource Community Solutions 2024, 42 CFR 431.108). In Pennsylvania, enrolling providers must submit documentation explaining why they are requesting retroactive enrollment beyond 30 days before the application submission (Pennsylvania DHS 2022b).<sup>27</sup>

### Defining risk levels

Once providers submit an enrollment application, states assign a risk level to the applying provider based on their provider type and carry out the appropriate screening activities according to state and federal law. Ohio, Oregon, and Pennsylvania generally use the Medicare risk levels for Medicaid providers. For provider types not in Medicare, Pennsylvania publishes a list of provider types associated with moderate- and high-screening risk levels; the state considers non-Medicare provider types not on that list as limited risk (Pennsylvania DHS 2016b). Similarly, Ohio categorizes a few non-Medicare provider types as high risk, including supplemental transportation and wheelchair vans.<sup>28</sup> Oregon's administrative rules do not provide clear guidance on risk levels for provider types that do not enroll in Medicare (OHA 2021).<sup>29</sup>

### Screening

States have options for alleviating some of the administrative burden of screening providers, including relying on screening activities conducted by another

entity or delegating screening activities to a third party. Oregon and Pennsylvania use screenings conducted by Medicare, and Pennsylvania uses screenings conducted by other states' Medicaid programs and CHIP, so that providers enrolled in those programs do not have to undergo additional screening (OHA 2025b, Pennsylvania DHS 2024a). States may also subcontract parts of the screening process; both Ohio and Pennsylvania contract with private firms to conduct provider site visits (Ohio Council 2023, Pennsylvania DHS 2016b).

States may perform database checks beyond those required by federal regulations. For example, Ohio state code lists federal databases and state-specific registries (e.g., an abuser registry maintained by the Ohio Department of Developmental Disabilities) that the state Medicaid agency must check. Pennsylvania requires checks of PECOS as well as its own list of providers excluded from participating in the state's Medicaid program (Pennsylvania DHS 2017). All three states maintain such lists, though Ohio and Oregon do not require the state Medicaid agency to check them during the provider screening process, according to a review of publicly available sources.<sup>30</sup> A description of databases that states may check as part of the provider screening process, as well as those that are federally required, is included in Table 7B-1 in Appendix 7B.

### Approval and revalidation

After the state completes screening activities and approves the provider's application, the state executes the provider agreement, and the provider becomes enrolled in Medicaid. No federal regulations dictate how long states should take to enroll providers. Ohio, Oregon, and Pennsylvania do not provide a timeline for reviewing provider enrollment applications, while Pennsylvania estimates 30 days for processing revalidation applications. Ohio notes that the timeline depends on the number of provider applications it has received (ODM 2022a). For providers denied enrollment, each of the three states has an appeals process. For example, in Oregon, providers must submit an appeal to the Oregon Health Authority's Health Systems Division in writing within 180 days that includes the reason the provider disagrees with the denial decision.<sup>31</sup>

After initial enrollment, providers must periodically revalidate their enrollment. Ohio, Oregon, and Pennsylvania require that providers revalidate their enrollment at least as often as every five years, the minimum frequency required under federal law. However, Ohio requires some providers to revalidate every three years to align with the recredentialing process (i.e., credentialing renewal) to reduce administrative burden (ODM 2025c). The materials and documentation required for revalidation vary by state. Ohio requires most providers to only update their existing information (ODM 2022b). By contrast, providers in Oregon must resubmit a completed enrollment form and provider agreement, and providers in Pennsylvania must resubmit a completed enrollment application (OHA 2025c; Pennsylvania DHS 2024a, 2016c).

## Managed care credentialing process

Ohio, Oregon, and Pennsylvania take different approaches to managed care provider credentialing. This section details the credentialing and recredentialing processes for Medicaid managed care providers in each of the three states.

### Centralized credentialing

Centralized credentialing allows providers to credential with multiple managed care plans through a single credentialing application. Relative to decentralized and standardized credentialing, centralized credentialing is the least administratively burdensome method of credentialing in states with multiple managed care plans, as providers submit only one application, removing the need to undergo separate credentialing processes with multiple plans.

Ohio uses a centralized credentialing process wherein providers submit a single enrollment and credentialing application. In Ohio, providers must complete the enrollment process before credentialing (ODM 2022c). The state contracts with an NCQA-certified credentials verification organization to complete certain credentialing tasks, such as monitoring for provider sanctions and collecting primary source verifications like licensure or Drug Enforcement Administration (DEA) certificates (ODM 2025b). The state has assembled a credentialing committee that oversees the credentialing program and approves or denies provider credentialing applications (ODM 2023).

### Standardized credentialing

Standardized credentialing systems require providers to submit separate credentialing applications to each managed care plan they wish to participate in and require all plans to follow the same application process. In standardized systems, providers submit the same form and documentation for each managed care plan, removing the need to fill out multiple plan-specific credentialing forms. Relative to centralized credentialing, standardized credentialing may be more time consuming for providers, who need to submit separate applications to each plan they want to contract with.

Oregon requires all coordinated care organizations (CCOs) (the term used for managed care plan in Oregon) to use a standardized credentialing form.<sup>32</sup> The form has fields for providers to input a variety of information, including sections for board and other certifications; practice and employment information; educational history; health care license, registration, and certificate numbers; hospital and health care facility affiliations; professional practice and work history; peer references; and continuing medical education.<sup>33</sup> Along with the completed standardized credentialing form, Oregon requires providers to submit copies of their license, DEA or controlled substance registration certificate, Educational Commission for Foreign Medical Graduates certification (if applicable), and documentation of a professional liability policy or certificate (OHA 2024b).

### Decentralized credentialing

In decentralized credentialing systems, providers must complete separate credentialing processes with each managed care plan; these processes and the required forms and supporting documentation may differ by plan. Compared to centralized credentialing (as in Ohio) and standardized credentialing (as in Oregon), decentralized credentialing may require more time and effort on the part of providers, particularly those seeking to contract with multiple plans.

Pennsylvania has decentralized credentialing and relies on managed care plans to conduct credentialing. Providers in Pennsylvania can begin the managed care credentialing process before they enroll with the state, though to complete the process, they must have a Medicaid identification number, which the state issues once the provider is enrolled (Pennsylvania

DHS 2024b). Pennsylvania requires managed care plans to complete the credentialing process within 60 calendar days of receiving a completed application (Pennsylvania DHS 2025b). If a plan denies a provider's credentialing application, they must share the rationale for the decision with the provider (Pennsylvania DHS 2024b).

Pennsylvania has defined the type of information that managed care plans must verify (such as licensure and malpractice coverage) when credentialing providers (Pennsylvania DHS 2024b). Some health plans in the state rely on the Council for Affordable Quality Healthcare and other vendors to complete the credentialing process.<sup>34</sup> Some have a credentialing committee to help make credentialing decisions; for one large insurer, this committee is national and covers all of the carrier's health plans (UnitedHealthcare 2025). Managed care plans must submit a monthly report to the Pennsylvania Department of Human Services with details about applications received, under review, or decided within the month. Plans submit similar information every two years to the Pennsylvania Insurance Department, in addition to information about providers terminated from the plan for "reasons of quality."<sup>35</sup>

### Recredentialing

Providers must recredential (i.e., renew their credentialing) regularly. There is no federally required timeline for recredentialing (42 CFR 438.214). However, Ohio, Oregon, and Pennsylvania all require recredentialing every three years. This process generally involves verifying that a provider's data, licensure or certification, and personal information is correct and up to date. As with the initial credentialing process, the type of information required of providers and the process for submitting it (e.g., to the state or to managed care plans) varies.

## Medicaid Enrollment for Select Provider Types

Some providers who are newer to Medicaid or who practice in non-medical or non-institutional settings may be particularly affected by the complexities of the Medicaid provider enrollment and credentialing

because they have less experience and familiarity with these processes compared to traditional medical providers. Moreover, some states require them to take additional steps to enroll or credential. This section discusses the enrollment and credentialing processes for four such provider types—school-based services providers, doulas, community health workers (CHWs), and peer support specialists—in Ohio, Oregon, and Pennsylvania.

### School-based services providers

School-based services are Medicaid-covered services provided in schools by personnel who are employed by or contracted with a school or local education agency (LEA). Most states cover school-based services for students with disabilities pursuant to an individualized education program (IEP) or an individualized family service plan (IFSP), though most states do not require their LEAs to bill Medicaid for those services (ED 2024).<sup>36</sup> As of 2023, 25 states cover school-based services for students without an IEP/IFSP.<sup>37</sup> Like most states, Ohio, Oregon, and Pennsylvania provide school-based services through FFS delivery systems and carve these services out of managed care contracts (HSC 2023b). In each of the three states, LEAs enroll as Medicaid providers, and, because they do not contract with managed care plans, credentialing requirements do not apply.

In addition to the LEAs, individual school-based services providers must enroll in Medicaid if they order or render reimbursable services to Medicaid enrollees and if the state recognizes them as Medicaid providers.<sup>38</sup> Non-school-based providers who order or refer Medicaid services to be performed by a school-based services provider must also enroll, in accordance with federal requirements. Each of the three states provides specific support and training materials for enrolling these school-based services providers. Oregon, for instance, provides an enrollment guide, frequently asked questions, and videos to support school-based services providers through the Medicaid provider enrollment process (OHA 2025d). Ohio and Oregon also help with the enrollment of LEAs by allowing them to apply via an electronic portal, whereas Pennsylvania required paper applications until March 2025.

Ohio, Oregon, and Pennsylvania delegate to LEAs some responsibility for screening school-based services providers. In Ohio, LEAs are responsible for ensuring that employees or contractors who provide Medicaid services undergo and successfully complete criminal background checks according to Ohio state code.<sup>39</sup> In Oregon, LEAs must document the credentials and qualifications of their medical staff and the manner in which the LEA checked and periodically rechecked the HHS OIG's Medicaid provider exclusion list to confirm staff are eligible to provide Medicaid services.<sup>40</sup> In Pennsylvania, LEAs must screen employees and contractors providing Medicaid services to check for exclusion from federal health care programs (Pennsylvania DHS 2024c).

School-based services providers can face confusion and unclear state guidance regarding which providers must enroll in Medicaid and the process for enrolling. Federal regulations require rendering and ORP providers to enroll in Medicaid, even if they are not submitting claims to Medicaid (42 CFR 455.410). Although this requirement is not new, recent CMS guidance clarified that this requirement applies to school-based services providers, including those whose LEAs submit claims for the services they render (CMS 2023). This clarification, and the recent expansion of school-based Medicaid to students without an IEP/IFSP in many states, has introduced additional perceived administrative burden for school-based services providers who must enroll.<sup>41</sup>

School-based services providers may experience difficulty enrolling if they are not traditional health care providers who have previously enrolled in Medicaid. Schools are not traditional health care settings and may not have the institutional knowledge and resources available to guide providers through the enrollment process. Guidance from states can therefore be a key resource for school-based services providers to clarify who must enroll and the process for doing so. Oregon states that supervisory-level recognized providers who work for or contract with an LEA must enroll as a Medicaid provider (OHA 2025e). Similarly, Pennsylvania guidance specifically notes that all physicians and other practitioners who order and prescribe school-based services must enroll in Medicaid (Pennsylvania DHS 2024c). In Ohio, the

published guidance available online is unclear about the need for ORP or rendering school-based services providers to enroll in Medicaid.

## Doulas

Doulas are trained professionals who provide guidance and support to women and families before, during, and after childbirth. As of 2022, 27 state Medicaid programs covered doula services, and 9 were in the process of implementing coverage (Chen 2022). Coverage of doula services is relatively new for many state Medicaid programs. As a result, doulas may lack prior experience becoming an enrolled Medicaid provider and the institutional and administrative support to navigate and complete the enrollment and credentialing process with ease. Furthermore, because doulas historically provided services to their clients on an individual basis as independent contractors, they may be unaccustomed to working with health plans and unfamiliar with Medicaid billing practices (Chen 2022).

Ohio, Oregon, and Pennsylvania allow doulas to enroll as Medicaid providers and bill the program directly (OHA 2025f, ODM 2024a, Pennsylvania DHS 2024d). Each state permits doulas to enroll as Medicaid providers if they meet state-specific doula certification requirements. Doulas in Ohio must be certified by the state board of nursing (either through a certifying organization or experience), and doulas in Oregon must have a traditional health worker certification (OHA 2025f, ODM 2024a). In Pennsylvania, doulas must be certified as a perinatal doula from the Pennsylvania Certification Board (Pennsylvania DHS 2024d).

Both Ohio and Pennsylvania provide specific resources for doulas to navigate the enrollment process. For example, Pennsylvania provides a training video, slide deck, and enrollment frequently asked questions page for doulas (Pennsylvania DHS 2025c, Pennsylvania DHS 2024e). Oregon provides a billing guide for doulas with some enrollment instructions as well as online guidance on becoming a certified doula (OHA 2025f).

## CHWs

CHWs are public health workers who connect individuals in their communities to health and social services (APHA 2025). CHWs typically share socioeconomic and cultural backgrounds with their clients and may also share other lived experiences, including similar health conditions and social needs. Some of these experiences, such as prior struggles with substance use disorder (SUD) or involvement with the criminal justice system, may present barriers to enrollment as a Medicaid provider (MACPAC 2022). CMS requires that CHW services provided as a preventive service be recommended by a licensed provider; the services must be either ordered or supervised by a licensed provider, depending on the regulatory authority through which the states provide CHW services (D'Alessandro et al. 2024, 42 CFR 440.130, 42 CFR 440.60). As of 2022, 29 states allowed Medicaid payment for services delivered by CHWs (Haldar and Hinton 2023).

Ohio, Oregon, and Pennsylvania have different rules regarding whether CHWs can enroll in and directly bill Medicaid and whether they need supervision. In Ohio, CHWs do not enroll in Medicaid, but managed care organizations (MCOs) must provide CHW services by contracting either directly with CHWs or with agencies employing them (NASHP 2025a). In Oregon, CHWs enroll as a non-payable provider type, since they are a rendering provider that must work and bill under the supervision of a licensed provider. The state's CHW billing guide provides instructions on how they should enroll in Medicaid (OHA 2024c). In Pennsylvania, CHWs cannot enroll in Medicaid, but the state requires MCOs to provide CHW services (NASHP 2025b).

## Peer support specialists

Peer support specialists, who are individuals with lived experience of a mental health or SUD condition, help individuals engage with and stay in behavioral health care. These providers perform various services, such as connecting enrollees to resources and helping them navigate care systems, in a variety of settings (e.g., community organizations, outpatient centers, carceral facilities, emergency rooms) (SAMHSA 2024). As of

2022, 39 states and the District of Columbia covered Medicaid peer support services (KFF 2022). Federal regulations require Medicaid peer support specialists to have completed some form of training and certification, though states set the minimum training and certification requirements for these providers to participate (CMS 2024d).

Ohio, Oregon, and Pennsylvania cover peer support specialists and have related certification pathways but have different policies on their enrollment as Medicaid providers. In Ohio, peer support specialists cannot enroll. Instead, enrolled community behavioral health agencies list their affiliated certified peer support specialists and bill for their services (ODM 2024b). In Oregon, peer support specialists enroll in Medicaid as non-payable providers and other enrolled organizations (e.g., primary care clinics and behavioral health organizations) bill for their services (OHA 2025h). Oregon provides a billing guide for peer support specialists, which includes instructions on how to enroll in Medicaid.<sup>42</sup> Finally, in Pennsylvania, peer support specialist agencies enroll in Medicaid and bill for their staffs' services (Pennsylvania DHS 2024e). To enroll, these agencies must submit a peer support service description and a supplemental provider agreement in addition to application documents required of other mental health and SUD treatment providers in the state (Pennsylvania DHS 2021).

## Challenges

MACPAC's review of the literature identified a number of challenges states face when enrolling Medicaid providers. States may experience difficulty completing the required screening and verification processes within the 60-day timeline CMS recommends due to the volume of applicants and the time and resources required to complete the screenings (CMS 2025a, GAO 2019). Difficulty accessing and using federal databases and needing to conduct manual reviews to reconcile inconsistent provider information across sources can further hinder this process (GAO 2019). Federal and state government agency reports confirm that some states do not consistently implement

required enrollment processes. Previous audits have found state payments to providers who were either not enrolled or did not meet enrollment requirements as well as issues with state compliance with enrollment and screening requirements (Dodaro 2024, OSC 2024, OIG 2020).<sup>43</sup> These payments are considered improper because they were not compliant with federal regulations and do not necessarily indicate fraud (i.e., intentional deception or misrepresentation).

The literature also points to challenges facing providers enrolling in Medicaid, as described below.

## Provider burden

The enrollment and credentialing process can be complex and burdensome for providers. Challenges are often most acute for providers in small practices as well as other non-institutional providers (e.g., CHWs, doulas) who are newer to the Medicaid program and lack administrative support for enrollment and credentialing (Moore et al. 2020). Lengthy enrollment and credentialing processes can impose financial hardships for these smaller providers by delaying their ability to bill Medicaid for services delivered to enrollees.

In states with standardized or decentralized credentialing, the administrative burden associated with separate credentialing processes for each managed care plan can discourage providers from participating in more than one managed care network (Allen et al. 2022). Providers may experience additional barriers to credentialing when managed care plans request information beyond what is required by the state's uniform credentialing policy. Furthermore, the enrollment and credentialing processes can be duplicative. For example, some credentialing checks, such as license verification, may also overlap with federally required screening checks (OIG 2013). Additionally, providers seeking to participate in Medicaid may also enroll in commercial plans, whose enrollment requirements may duplicate elements of Medicaid enrollment and credentialing.

## Barriers for out-of-state providers

Although federal law allows states to use screenings performed by another state Medicaid program or Medicare, states often rely solely on their own

screening process and do not fully leverage data sharing processes to identify when Medicare or another state has screened a provider (Manetto et al. 2020, 42 CFR 455.410). This can lead to duplicative screening for providers that want to serve enrollees outside their state (CHOP 2023, CMS 2022, MACPAC 2020a). When Medicaid patients live near a state border or require specialized care, they may need to travel across state lines to access care (Osamn 2024). In these cases, the provider is required to enroll with the Medicaid program in the patient's home state and be credentialed by the enrollee's managed care plan, if applicable, to receive payment. The requirement to separately enroll and credential with multiple states and managed care plans can burden providers and delay time-sensitive care (Manetto et al. 2020).

## Supervisory relationship requirements

Some providers must be supervised by another licensed provider to bill Medicaid. Although these requirements vary by state, supervision is sometimes required for newer types of providers, non-medical providers, limited license holders, or individuals in training. For example, Minnesota requires doulas to be supervised by another Medicaid-enrolled provider (Platt and Kaye 2020). The additional time, effort, and challenges associated with building a supervisory relationship may deter some providers from participating in Medicaid. Providers subject to these requirements may need to provide documentation of these relationships as part of the enrollment process (Pennsylvania DHS 2025a).

## Conclusion

The Medicaid provider enrollment and managed care credentialing processes help ensure that only qualified providers render care to enrollees and bill Medicaid for that care, protecting the program from FWA. These processes must be rigorous enough to exclude unqualified providers and those who have committed misconduct. However, complex requirements may present implementation and compliance challenges for states and prevent some providers from participating in Medicaid. The way states operationalize these requirements, including the structure of their credentialing systems, can affect the level of effort

required of providers. Medicaid enrollment and credentialing may be particularly challenging for providers who render services that are newer to Medicaid or who practice in small groups, including those in rural areas.

Further examination of these challenges could help identify potential opportunities to mitigate them. Through interviews with providers and other stakeholders, this research could offer additional insight into barriers faced by certain provider types or challenges related to specific parts of the enrollment and credentialing processes as well as their effects on provider participation, state administrative burden, and program integrity.

## Endnotes

<sup>1</sup> The term “provider” refers to both individual and institutional providers as well as suppliers of medical equipment (CMS 2025a). Rendering providers (i.e., providers who render care to patients directly) and ordering, referring, and prescribing (ORP) providers must be enrolled to receive payment for services delivered to Medicaid enrollees (42 CFR 438.602(b), 42 CFR 455.410).

<sup>2</sup> Not all providers who can enroll in Medicaid are licensed. Many provider types who participate in state Medicaid programs, such as community health workers, are not subject to state licensure requirements.

<sup>3</sup> Federal rules require provider credentialing in managed care but do not require it of providers serving Medicaid fee-for-service (FFS) enrollees only (42 CFR 438.214(b)).

<sup>4</sup> The federal enrollment, screening, disclosure, and credentialing requirements apply to providers participating with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) (42 CFR 438.602). Additionally, these requirements apply to primary care case management (PCCM) when the primary care case manager is not already enrolled with the state Medicaid agency (42 CFR 438.602). Federal ownership and control interest disclosure requirements also apply to MCOs, PIHPs, PAHPs, PCCM, and to health insuring organizations (42 CFR 455.101, 42 CFR 455.104).

<sup>5</sup> Medicaid regulations define fraud and abuse. Fraud is defined as intentional deception or misrepresentation, and

abuse is defined as provider practices that are unsound and result in unnecessary costs or reimbursement for medically unnecessary services (42 CFR 433.304, 42 CFR 455.2). Waste is not defined in federal regulation but includes inappropriate use of services and resources; it is not criminal or intentional but results in unnecessary costs to Medicaid (MACPAC 2018).

<sup>6</sup> Although many of the federal Medicaid provider enrollment and credentialing requirements also apply to the State Children’s Health Insurance Program (CHIP), this chapter focuses on requirements for Medicaid providers.

<sup>7</sup> The screening and enrollment requirements described in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) and the Centers for Medicare & Medicaid Services 2011 final rule originally applied only to Medicaid and CHIP FFS providers (including both rendering and ORP providers) and providers in non-risk-based managed care models (CMS 2025a, 2011a). In a May 2016 final rule, CMS applied the federal screening and disclosure requirements to all remaining providers, including managed care network providers, starting in July 2018 (CMS 2025a, 2016a). The 21st Century Cures Act (Cures Act, P.L. 114-255), enacted in December 2016, set January 2018 as the implementation deadline for applying these requirements (superseding the July 2018 deadline set by the May 2016 final rule) (CMS 2025a, 2016a).

<sup>8</sup> The state Medicaid agency must also “confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of federal databases” (42 CFR 455.436).

<sup>9</sup> The state Medicaid agency must raise a provider’s risk level to high when the provider has: (1) an existing Medicaid overpayment, (2) a payment suspension due to a credible allegation of FWA, or (3) an exclusion from participating in Medicaid (including exclusions from other states) within the past decade (42 CFR 455.450(e)). States must also raise the risk level to high when the state Medicaid agency or CMS has lifted a temporary freeze on the enrollment of that provider type within the past six months. Medicaid overpayments refer to situations in which a state Medicaid agency paid a provider an amount that exceeded the allowable amount (42 CFR 433.304).

<sup>10</sup> ORP providers are health care providers who order a service (such as an X-ray) for a patient, refer a patient to another provider, or prescribe a medication to a patient without rendering the service or medication to the patient.

<sup>11</sup> Providers must also attest to their compliance with the advance directive requirements for certain facilities and provider types specified in 42 CFR 489, Subpart I, and 42 CFR 417.436(d).

<sup>12</sup> Federal regulations and guidance do not describe the circumstances in which states may determine that a mandatory denial is not in the best interests of the Medicaid program (CMS 2025a, 42 CFR 455.416).

<sup>13</sup> Value-added services are non-medical services provided voluntarily by managed care plans outside of covered contract services and cannot be built into managed care rates (KFF 2024).

<sup>14</sup> The fee for calendar year 2026 is \$750 (CMS 2025b).

<sup>15</sup> Provider types considered institutional by Medicare are also considered institutional by Medicaid and must pay an application fee when enrolling (CMS 2025a, 42 CFR 455.460). If a Medicaid provider type is not recognized by Medicare, states must determine whether that provider type is institutional based on definitions in the Medicaid Provider Enrollment Compendium (CMS 2025a).

<sup>16</sup> The Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16) required the HHS Secretary to issue guidance to states regarding best practices for coordinating care provided by out-of-state providers for children with medically complex conditions, including opportunities to streamline provider enrollment and screening.

<sup>17</sup> CMS requested that state provider revalidation strategies address high-risk providers referenced at 42 CFR 455.450.

<sup>18</sup> For-cause terminations refer to providers terminated for reasons related to fraud, integrity, and quality (CMS 2025a). Not all terminations are for cause, but only for-cause terminations need to be reported to the CMS Data Exchange database of terminated providers (42 CFR 455.417(d)). An example of a non-for-cause termination is when a state terminates a provider's enrollment due to inactivity (CMS 2011b).

<sup>19</sup> States must report terminations when the provider has exhausted state appeal rights or the appeal deadline has passed (CMS 2025a).

<sup>20</sup> Credentialing is part of the provider selection process. Managed care plans must consider two other factors in their provider selection process: non-discrimination and exclusion status. First, plans cannot discriminate against providers who

either serve high-risk populations or practice in a specialty that “require[s] costly treatment” when making decisions about whether to include providers in their networks (42 CFR 438.214(c)). Second, plans cannot contract with providers who are excluded from participating in federal health care programs (42 CFR 438.214(d)). Although these required provider selection factors are not explicit credentialing requirements, managed care plans might assess them as part of the credentialing process. Additionally, states can establish additional requirements for provider selection (42 CFR 438.214(e)).

<sup>21</sup> PECOS is an online platform managed by CMS that facilitates enrollment for Medicare providers and suppliers (CMS 2024c).

<sup>22</sup> States may establish provider standards or take action against Medicaid providers only for reasons relating to the fitness of the provider to perform covered medical services or to appropriately bill for those services, and with supporting evidence of the provider's failure to meet the state's reasonable provider standards (CMS 2016b).

<sup>23</sup> Twenty-seven states require that health plans serving Medicaid enrollees be accredited by NCQA (NCQA 2026a). NCQA standards evaluate plans on credentialing and recredentialing, among other areas (NCQA 2026b).

<sup>24</sup> The state has a separate provider enrollment application for “capitation” that appears to be used for specific types of managed care programs (Pennsylvania DHS 2025a).

<sup>25</sup> See 55 Pa. Code § 1101.42 (2024). <https://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/055/chapter1101/s1101.42.html&d=reduce>.

<sup>26</sup> See 55 Pa. Code § 1101.42 (2024). <https://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/055/chapter1101/s1101.42.html&d=reduce>. See Ore. Admin. Rule 410-120-1180 (2023). <https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=306653>. See Ohio Admin. Code 5160-1-11 (2021) <https://codes.ohio.gov/ohio-administrative-code/rule-5160-1-11>. Oregon also considers providers in certain cities within 75 miles of its border (i.e., contiguous areas) as in-state providers.

<sup>27</sup> See 55 Pa. Code § 1101.82 (2024). <https://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/055/chapter1101/s1101.82.html&d=reduce>.

<sup>28</sup> See Ohio Admin. Code 5160-1-17.8 (2020). <https://codes.ohio.gov/ohio-administrative-code/rule-5160-1-17.8>.

<sup>29</sup> See Ore. Admin. Rule 410-120-1260 (2024).

<https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=310113>.

<sup>30</sup> In Ohio and Oregon, these lists appear to be an additional source that Medicaid providers can check when making decisions about who to employ or enter into ownership agreements with. Representatives from Oregon told MACPAC that the state requires checks of CMS's DEX to determine if enrolling providers have been terminated by Medicare or other state Medicaid programs, though this is not explicitly listed in state regulations.

<sup>31</sup> See Ore. Admin. Rule 410-120-1560 (2023).

<https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=300887>.

<sup>32</sup> See Ore. Admin. Rule 410-141-3510 (2024).

<https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=318515>.

<sup>33</sup> The Oregon Advisory Committee on Physician Credentialing Information, which is composed of hospital representatives, health care practitioners, and representatives of health service contractors, maintains the standard credentialing and recredentialing forms (OHA 2023).

<sup>34</sup> See 28 Pa. Code § 9.761 (2024). <https://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/028/chapter9/subchapLtoc.html&d=reduce>.

CAQH is a non-profit organization that helps streamline the credentialing process and other administrative functions for health plans (PPS 2026).

<sup>35</sup> The report to the Pennsylvania Insurance Department is required of all health maintenance organizations licensed in the state, not just Medicaid managed care organizations.

<sup>36</sup> Under the Individuals with Disabilities Education Act (IDEA, P.L. 101-476), children with disabilities are eligible to receive educational and related services that will help them achieve their educational goals, as documented in each child's IEP, or for infants and toddlers (children younger than age three), the IFSP. States can draw down federal funds under Medicaid to pay for school-based health and related services required by IDEA.

<sup>37</sup> In 2014, CMS clarified that states can receive federal matching funds for medically necessary services for any Medicaid-eligible student, regardless of whether those services are identified in an IEP/IFSP or provided at no cost to other students (CMS 2014). This policy is commonly referred to as the "free care policy reversal."

<sup>38</sup> Some state Medicaid programs do not recognize certain school-based services provider types, such as school psychologists or school social workers, as Medicaid providers.

<sup>39</sup> See Ohio Admin. Code 5160-35-02 (2026). <https://codes.ohio.gov/ohio-administrative-code/rule-5160-35-02>.

<sup>40</sup> See Ore. Admin. Rule 410-133-0120 (2025).

<https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=321725>.

<sup>41</sup> As of October 2023, 25 states have amended their state plans or otherwise expanded coverage to include school-based services that are not part of an IEP/IFSP, as a result of the free care policy reversal. Eighteen states expanded coverage for all services identified as medically necessary, while the remaining states cover a more limited set of services, often including behavioral health care (HSC 2023a).

<sup>42</sup> To enroll in Medicaid in Oregon, peer support specialists must be certified as traditional health workers (OHA 2025g).

<sup>43</sup> For example, a GAO audit found that nearly a quarter of improper Medicaid payments in 2020 (\$17.8 billion) were due to states' non-compliance with provider screening and enrollment requirements (Dodaro 2024). Another audit by the HHS OIG found that 40 state Medicaid agencies made \$50.3 million in payments to 584 terminated providers from July 2018 through June 2019, and at least \$62.3 billion in capitation payments to plans under contracts that did not include provisions to exclude terminated providers from participating in Medicaid managed care, as required by the Cures Act (OIG 2020).

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# APPENDIX 7A: Federal Requirements

**TABLE 7A-1.** Timeline of Federal Medicaid and CHIP Enrollment, Screening, and Disclosure Policies and Requirements as of May 2025

Policy or requirement	Effective date	Applicable to	Reference
Certain entities must disclose information about ownership and control	October 1978; amended versions effective March 2011 and January 2024	Disclosing entities, fiscal agents, and managed care plans <sup>1</sup>	42 CFR 455.104
State Medicaid agencies must have an agreement with Medicaid providers	October 1978; amended versions effective October 1979, April 1992, and July 2010	All Medicaid providers and organizations furnishing services under the state plan	42 CFR 431.107
State plans must pay for services provided to beneficiaries out of state (under certain circumstances)	October 1978	Out-of-state providers	42 CFR 431.52
Providers must disclose information about business transactions and persons convicted of crimes	October 1978	All Medicaid providers who have an agreement with the state Medicaid agency	42 CFR 455.105-106
Provider agreements can be retroactive for up to one year if certain conditions are met	September 1997	Accredited providers who have met all federal and state (when applicable) requirements, as determined by CMS	42 CFR 431.108
Each state must establish their own uniform credentialing and recredentialing policies	June 2003 <sup>2</sup>	MCO, PIHP, or PAHP network providers	42 CFR 438.214
Managed care plans must follow a documented process for credentialing and recredentialing	June 2003	MCO, PIHP, or PAHP network providers	42 CFR 438.214
State Medicaid agencies must screen all enrolled providers	March 2011; amended version effective October 2021	All FFS and non-risk-based managed care rendering and ORP providers	42 CFR 455.410

**TABLE 7A-1.** (continued)

Policy or requirement	Effective date	Applicable to	Reference
State Medicaid agencies must enroll all ORP providers	March 2011	All FFS and non-risk-based managed care rendering and ORP providers	42 CFR 455.410
State Medicaid agencies must complete certain enrollment and screening activities	March 2011	All FFS and non-risk-based managed care rendering and ORP providers	42 CFR 455.412, 455.434, and 455.436
State Medicaid agencies can require additional screening or impose temporary moratoria	March 2011	All FFS and non-risk-based managed care rendering and ORP providers	42 CFR 455.452 and 455.470
State Medicaid agencies must terminate enrolled providers or deny enrollment to providers under specific circumstances	March 2011; amended version effective January 2024	All FFS and non-risk-based managed care rendering and ORP providers	42 CFR 455.416
Medicaid provider enrollment and screening requirements and disclosure of affiliation requirement apply to CHIP providers	March 2011; amended version effective November 2019	All FFS and non-risk-based managed care rendering and ORP CHIP providers	42 CFR 457.990
State Medicaid agencies must revalidate the enrollment of providers who were enrolled as of March 25, 2011, by March 24, 2016	Guidance issued December 2011	Providers enrolled as of March 25, 2011	CMS 2011b
State Medicaid agencies must begin implementing the fingerprint-based background check requirement	Guidance issued June 2015	All FFS and non-risk-based managed care rendering and ORP providers designated as high risk	CMS 2015
States must complete the initial set of revalidations by September 25, 2016 (instead of March 24, 2016)	Guidance issued January 2016	All FFS and non-risk-based managed care rendering and ORP providers enrolled on or before September 25, 2011	CMS 2016c

**TABLE 7A-1.** (continued)

Policy or requirement	Effective date	Applicable to	Reference
State Medicaid agencies must comply with (or have a compliance plan approved by CMS for) the fingerprint-based criminal background check screening requirement by June 1, 2016	Guidance issued January 2016	All FFS and non-risk-based managed care rendering and ORP providers designated as high risk	CMS 2016d
CMS interpretation of federal statute is that provider agreements are equivalent to provider enrollment applications in Medicaid <sup>3</sup>	May 2016	N/A	CMS 2016a
States must require managed care plans to submit information on ownership and control	July 2017	Managed care plans	42 CFR 438.604
States must screen, enroll, and collect disclosures from all managed care network providers	January 2018	Managed care network providers	42 CFR 438.602
Providers must disclose information about affiliations with providers who have a disclosable event	March 2020	Medicaid and CHIP providers enrolling for the first time	42 CFR 455.107
States must select an option for the disclosure of affiliations requirement; they can choose to require it at initial enrollment or upon request	March 2020	N/A	42 CFR 455.107
States must allow Medicare-enrolled providers to enroll for determining Medicare cost sharing	October 2021	All Medicare-enrolled providers (including provider types the state does not recognize)	42 CFR 455.410
States allowed to change their selection of the disclosure of affiliation option from upon request to at initial enrollment	January 2023	N/A	42 CFR 455.107

**TABLE 7A-1.** (continued)

Policy or requirement	Effective date	Applicable to	Reference
Regulations established for the DEX provider termination database, reasons that require a provider to be added to it, and the process for determining how long terminated providers remain in the database	January 2024	Terminated Medicaid and CHIP providers	42 CFR 455.417
Nursing facilities must disclose additional information such as members of their governing body, officers, directors, members, partners, trustees, and managing employees	January 2024	Medicaid nursing facility providers	42 CFR 455.104

**Notes:** Managed care plans are managed care organizations (MCOs), prepaid inpatient health plans (PIHPS), prepaid ambulatory health plans (PAHPs), and primary care case management (PCCM). CMS is Centers for Medicare & Medicaid Services. FFS is fee for service. ORP is ordering, referring, and prescribing. CHIP is State Children’s Health Insurance Program. N/A is not applicable. DEX is Data Exchange System.

<sup>1</sup> Disclosure requirements at 42 CFR 455.104 apply also to health insuring organizations.

<sup>2</sup> Although the effective date of the regulation was August 2002, states had until June 2003 to come into compliance.

<sup>3</sup> Provider enrollment applications are not explicitly required by federal regulations but are referenced in Medicare and Medicaid program integrity statute. CMS equated the reference to “applications [for providers] to enroll” in Medicaid in Section 1128J(e) of the Social Security Act to the provider agreement with the state Medicaid agency (§ 1128J(e) of the Social Security Act and CMS 2016a).

**Sources:** 42 CFR 431.52, 431.107, 431.108, 438.214, 438.602, 438.604, Part 455 Subpart E, 455.104, 455.105–106, 455.410, 455.416, 455.417, 457.990; CMS 2016a, 2016b, 2016c, 2015, 2011b.

**TABLE 7A-2. Federal Disclosure Requirements and Applicability as of May 2025**

Topic	Timing	Disclosures	Applicability
Ownership and control	<ul style="list-style-type: none"> <li>• Before executing the provider agreement</li> <li>• Upon request by the state Medicaid agency during revalidation</li> <li>• Within 35 days of a change in ownership</li> </ul>	<ul style="list-style-type: none"> <li>• Personal information (e.g., name, address, tax identification number) of individuals and corporations with an ownership or controlling interest in the disclosing entity</li> <li>• Any personal relationships between people with ownership and control interests in the disclosing entity</li> <li>• Whether the owner also has an ownership or control interest in any other disclosing entity; if so, the name of the disclosing entity</li> <li>• Personal information about managing employees of the disclosing entity (e.g., name, Social Security number)</li> </ul>	<ul style="list-style-type: none"> <li>• Disclosing entities, which include all providers except individuals or those who are part of a group of individuals</li> <li>• Fiscal agents (i.e., state Medicaid agency contractors that process claims)</li> <li>• Managed care entities (i.e., MCOs, PIHPs, PAHPs, PCCM, HIOs)</li> </ul>
Business transactions	<ul style="list-style-type: none"> <li>• Within 30 days upon request from the HHS Secretary or the state Medicaid agency</li> </ul>	<ul style="list-style-type: none"> <li>• Ownership information about subcontractors with which the provider has had business transactions greater than \$25,000 in the past year</li> <li>• Certain business transactions between the provider and wholly owned supplier or subcontractors within the past five years</li> </ul>	<ul style="list-style-type: none"> <li>• All Medicaid providers that enter into an agreement with the state Medicaid agency</li> </ul>

**TABLE 7A-2.** (continued)

Topic	Timing	Disclosures	Applicability
Persons convicted of crimes	<ul style="list-style-type: none"> <li>Before the provider agreement is executed or renewed, or upon request by the state Medicaid agency</li> </ul>	<ul style="list-style-type: none"> <li>Ownership information about subcontractors with which the provider has had business transactions greater than \$25,000 in the past year</li> <li>Certain business transactions between the provider and wholly owned supplier or subcontractors within the past five years</li> </ul>	<ul style="list-style-type: none"> <li>All Medicaid providers that enter into an agreement with the state Medicaid agency</li> </ul>
Affiliations	<ul style="list-style-type: none"> <li>States can choose whether to require this disclosure upon request or at the time of initial enrollment</li> </ul>	<ul style="list-style-type: none"> <li>The identity of any person who has ownership or control interest in, or is an agent or managing employee of, the provider who has been convicted of a crime related to their involvement in federal health programs</li> </ul>	<ul style="list-style-type: none"> <li>All Medicaid providers that enter into an agreement with the state Medicaid agency</li> </ul>

**Notes:** MCO is managed care organization. PIPHP is prepaid inpatient health plan. PAHP is prepaid ambulatory health plan. PCCM is primary care case management. HIO is health insuring organization. HHS Secretary is Secretary of the U.S. Department of Health and Human Services. CHIP is State Children's Health Insurance Program.

**Source:** 42 CFR 455.104-107.

# APPENDIX 7B: Databases

**TABLE 7B-1. Databases Used to Screen Medicaid Providers**

Database	Contents	Frequency of federally required checks	Administered by
<b>Federally required</b>			
DMF	Deceased individuals with Social Security numbers	At enrollment and revalidation <sup>1</sup>	SSA
LEIE	Individuals and entities excluded from participating in federal health care programs due to criminal convictions for health care fraud and other health care–related crimes	At enrollment and revalidation, then at least monthly	HHS OIG
NPPES	National provider identifiers, unique numbers assigned to practicing health care providers and organizations	At enrollment and revalidation	CMS
SAM exclusions list <sup>2</sup>	Individuals and entities excluded from receiving federal contracts	At enrollment and revalidation, then at least monthly	GSA
DEX	Providers who have been terminated from Medicaid or Medicare, plus data from DMF and PECOS	N/A	CMS
<b>Optional</b>			
PECOS	Medicare provider enrollment data	N/A	CMS
State-maintained databases	Providers terminated from a state's Medicaid program	N/A	State agencies

**Notes:** DMF is Death Master File. SSA is Social Security Administration. LEIE is List of Excluded Individuals/Entities. HHS OIG is U.S. Department of Health and Human Services Office of Inspector General. NPPES is National Plan and Provider Enumeration System. CMS is Centers for Medicare & Medicaid Services. SAM is System for Award Management. GSA is General Services Administration. DEX is Data Exchange System. PECOS is Provider Enrollment, Chain, and Ownership System. N/A is not applicable. The list of optional databases was identified through a review of publicly available documents in select states and is not meant to be exhaustive.

<sup>1</sup> P.L. 119-21, an act to provide for reconciliation pursuant to Title II of H. Con. Res. 14, requires states to check the DMF quarterly to determine if a provider is deceased and to disenroll any deceased providers, effective January 1, 2028.

<sup>2</sup> The regulation specifies the Excluded Parties List System, which was replaced by SAM.

**Sources:** MACPAC and Acumen, LLC, 2025, analysis of publicly available documents in Ohio, Oregon, and Pennsylvania; CMS 2025a, GAO 2019.