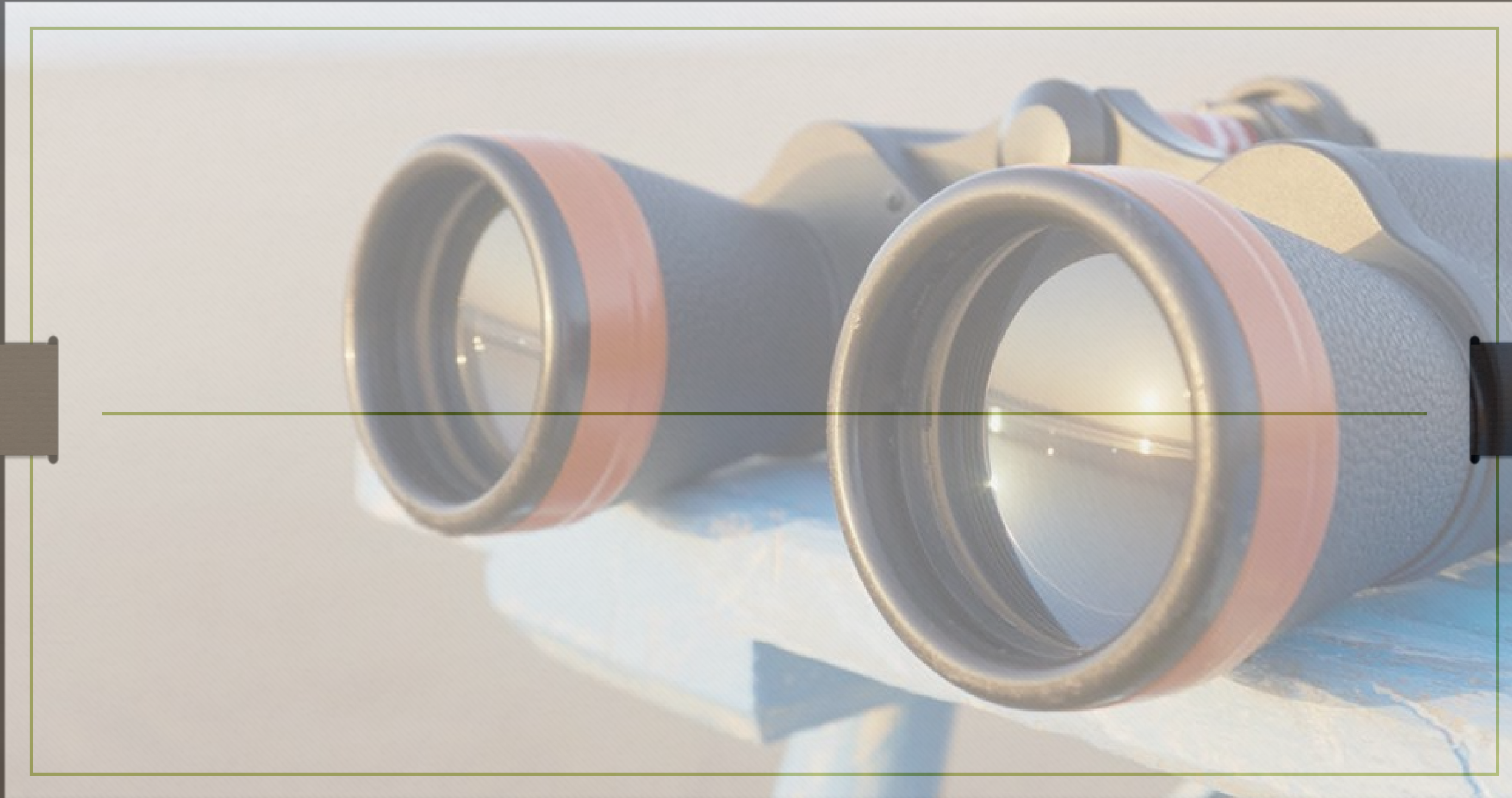
Beyond the Basics



Driving Efficiency, Accuracy, and Enrollment Success

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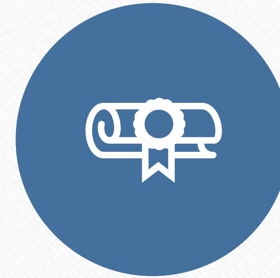
Learning Objectives

Understand how upstream credentialing impacts downstream enrollment results.



Recognize common challenges in complex enrollment situations, including acquisitions, joint ventures, Tax ID changes, and multi-State enrollment.

Apply clear strategies to navigate delays, escalations, and payer-specific requirements.

Strengthen payer relationships to improve communication, timelines, and overall outcomes.

Upstream Credentialing, Downstream Enrollment Results

Upstream credentialing quality directly determines downstream enrollment accuracy.

Strong upstream controls reduce downstream cycle times.

Data governance between teams is essential.

Cross-functional communication improves overall provider onboarding outcomes.

Upstream accountability enhances downstream performance metrics.

Example: Upstream credentialing quality directly determines downstream enrollment accuracy.

- Credentialing receives an application where the provider lists three active practice locations, but the credentialing specialist misses the third location noted on the application. That missing location flows into enrollment, and the practice address isn’t enrolled with the payers. The payer denies authorizations for procedures requested at the third missing location. Enrollment must ensure credentialing and the payer updates their systems with the third location. The denied authorizations must be re-submitted.

Example: Strong upstream controls reduce downstream cycle times.

A health system implements a standardized credentialing checklist that includes early verification of CAQH, DEA updates, and malpractice coverage. Because the credentialing packet is complete and validated before it reaches enrollment, payer submissions go out cleanly within days, shortening onboarding time by 20–30% and accelerating first billable dates.

Example: Data governance between teams is essential.

Credentialing captures specialties using free-text entries (“Cardiology,” “Interventional Cardiology,” “Interv Card”). Enrollment systems rely on standardized taxonomy codes, and inconsistencies trigger mapping errors. After both teams adopt a shared taxonomy library and standard naming conventions, submission errors drop and enrollment no longer must chase credentialing for clarification.

Example: Cross-functional communication improves provider onboarding outcomes.

A monthly Credentialing–Enrollment huddle identifies that certain residency verification delays are affecting internal medicine practitioners more than other specialties. By flagging this pattern, credentialing adjusts its outreach sequence, enrollment updates its submission timeline expectations, and the provider onboarding team can give accurate start-date guidance to operations.

Example: Upstream accountability enhances downstream performance metrics.

Credentialing begins tracking "data quality at handoff," measuring completeness and accuracy before files move to enrollment. Within a quarter, error rates fall significantly. Enrollment's first-pass submission success rises, payers respond faster, and leadership sees measurable improvement across participation timelines and provider satisfaction.

Complex Enrollment Situations

Acquisitions and Joint Ventures, Tax ID Transitions, Multi-State Enrollment

Acquisitions

- When one organization purchases or takes ownership of another healthcare entity with the goal of fully integrating the purchased entity into the acquiring organization.
- Driven by strategic goals.
  - Expanding service lines or geographic reach
  - Increase market share or competitive positioning
  - Strengthening financial performance
  - Integrating clinical services or reducing operational duplication
  - Improving access to care or aligning with value-based care models

Acquisitions & Provider Enrollment

Tax ID and NPI Alignment

- New Tax ID
- New Billing Entity
- New Group NPI

Re-enrollment With All Payers

- Medicare reassignment updates
- Medical Assistance (Medicaid) revalidations
- Commercial payer re-contracting or demographic updates
- CAQH and roster alignment

Network Participation and Contracts

- Amendments
- Fee schedule alignment or
- Full renegotiation

Delegated Credentialing Changes

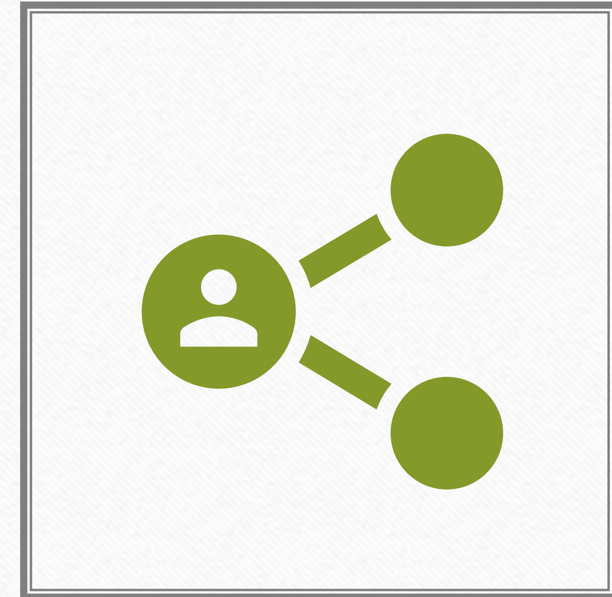
- Delegation agreement my need to be:
  - Terminated
  - Absorbed into the parent's organization's program or
  - Transitioned back to manual credentialing until a new agreement is signed

Operational Cleanup Across Systems

- EMRs and billing systems
- Scheduling, referral, and ordering workflows
- Internal directories and provider databases
- Location and taxonomy records

Joint Ventures

- A formal partnership where two or more separate organizations come together to create or co-own a new entity or service line.
- Each partner contributes resources and share in both the risks and financial/operational benefits of the new venture.
- A collaboration to:
  - Expand services without taking on the full cost alone.
  - Improve access to specialized care.
  - Combine strengths.
  - Enter new markets or regions more efficiently.
  - Support strategic growth without a full acquisition or merger.



Joint Ventures & Provider Enrollment

Determining the "Billing Identity" for the Joint Venture

- Which Tax ID and Type II NPI will the Joint Venture use to bill payers?
  - Creating a net-new legal entity with its own Tax ID/Type II NPI
  - Choosing one partner's existing entity
  - A hybrid model depending on service line or location

Re-enrolling or Updating Provider Records with Payers

- Medicare/Medicaid updates
- Commercial payer enrollment changes
- CAQH updates
- Roster realignment

Contracting and Participation Implications

- Often require contract amendments or new payer agreements if:
  - Reimbursement needs to align with the Joint Venture's service model
  - Payers consider the Joint Venture a "new" participating provider group

Delegated Credentialing Considerations

- If one party is delegated and the other isn't the Joint Venture may need to:
  - Obtain its own delegated agreement
  - Fall under one partner's existing delegation or
  - Move to manual credentialing until a new structure is approved

System and Directory Updates

- EMR and billing system
- Scheduling and referral tools
- Provider directories (internal and external)
- Location and taxonomy records

Communication and Coordination Challenges

- Provider enrollment becomes the group responsible for making sure everyone's understanding matches payer requirements.

Tax ID Transitions

- When a healthcare organization changes the legal entity responsible for billing, reimbursement, and/or contracting.
- Can occur because of:
  - Mergers/Acquisitions
  - Reorganizations
  - Compliance or financial restructuring
  - Shifting providers into a new billing entity

Tax ID Transitions & Provider Enrollment

Re-enrolling or Updating Providers with All Payers

Medicare reassignment records

Medicaid plans

Commercial payers

CAQH and delegated rosters

Contracting and Network Participation Impacts

Contract amendments

Fee schedule alignment

New effective dates

New participation agreements

Impacts on Delegated Credentialing

Delegated agreements are tied to old Tax ID

Delegation may be temporarily revoked.

Re-delegation audits may be required.

Roster format and submission may need to be updated.

Claims and participation issues surface if enrollment and delegation aren't aligned.

Operational and System-Wide Updates

EMR's and billing systems

Scheduling and referral applications

Provider Directories

EDI/Clearinghouse Configurations

Location, taxonomy, and billing profiles

Revenue Cycle Risk if the Transition isn't Secquenced Well

If enrollment updates do not go live before billing does, this may cause:

- Claims denials
- Incorrect Payment Routing
- Gaps in network participation
- Backlogs in provider activation

Multi-State Enrollments

Refers to the process of enrolling a healthcare provider or organization with payers, regulatory bodies, and Medicaid programs across more than one U.S. state.

Occurs when a provider practices, bills, or delivers services in multiple states, or when a health system expands its footprint beyond a single state.

Benefits of Multi-State Enrollment

- Expanded patient reach
- Greater flexibility in Staffing and Coverage
- Competitive advantage and market growth
- Stronger telehealth and digital health programs
- Diversified Revenue Streams
- Improved continuity during mergers, acquisitions, or partnerships
- Ability to scale specialized services

What Makes Multi-State Enrollment Unique

Different Medicaid Programs

Different applications

Different revalidation cycles

Different required documents

Different rules for effective dates

Varied Commercial Payer Requirements

Requirements change by region

- Network Participation Rules
- Fee Schedules
- Taxonomy Expectations
- OnBoarding steps

Licensing and Scope Differences

- **A provider must hold a valid license in each state where they:**
  - See patients
  - Offer telehealth
  - Bill for services

Additional Compliance Steps

Some states require:

- State-specific background checks
- Fingerprinting
- State-issued IDs/registrations
- Location-based updates
- Participation in statewide directories

Higher Operational Coordination

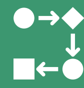
Requires collaboration across:

- Credentialing
- Licensing
- Payer contracting
- Operations
- Telehealth leadership
- Revenue cycle teams

Escalation Strategies & Payer Relationship Management

When to escalate, who to escalate to, and how to communicate effectively with payers during delays.

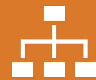
When To Escalate



Repeated delays with no movement after standard follow-up cycles.

Impact to revenue or patient access, such as pending claims, denied billing, or a provider is unable to schedule patients.

Missing or unclear responses from payer representatives after multiple attempts.



Conflicting information received from different reps or departments.

Urgent go-live timelines, onboarding deadlines, or credentialing tied to compliance requirements.

Escalation requested internally by leadership, finance, compliance, or the provider.

Who To Escalate To

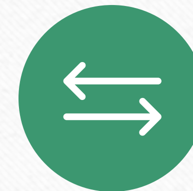
Designated payer provider relations representative assigned to your health plan.

Credentialing/Enrollment supervisor or manager at the payer.

Payer contracting partner (when issues involve participation, rates, or effective dates).

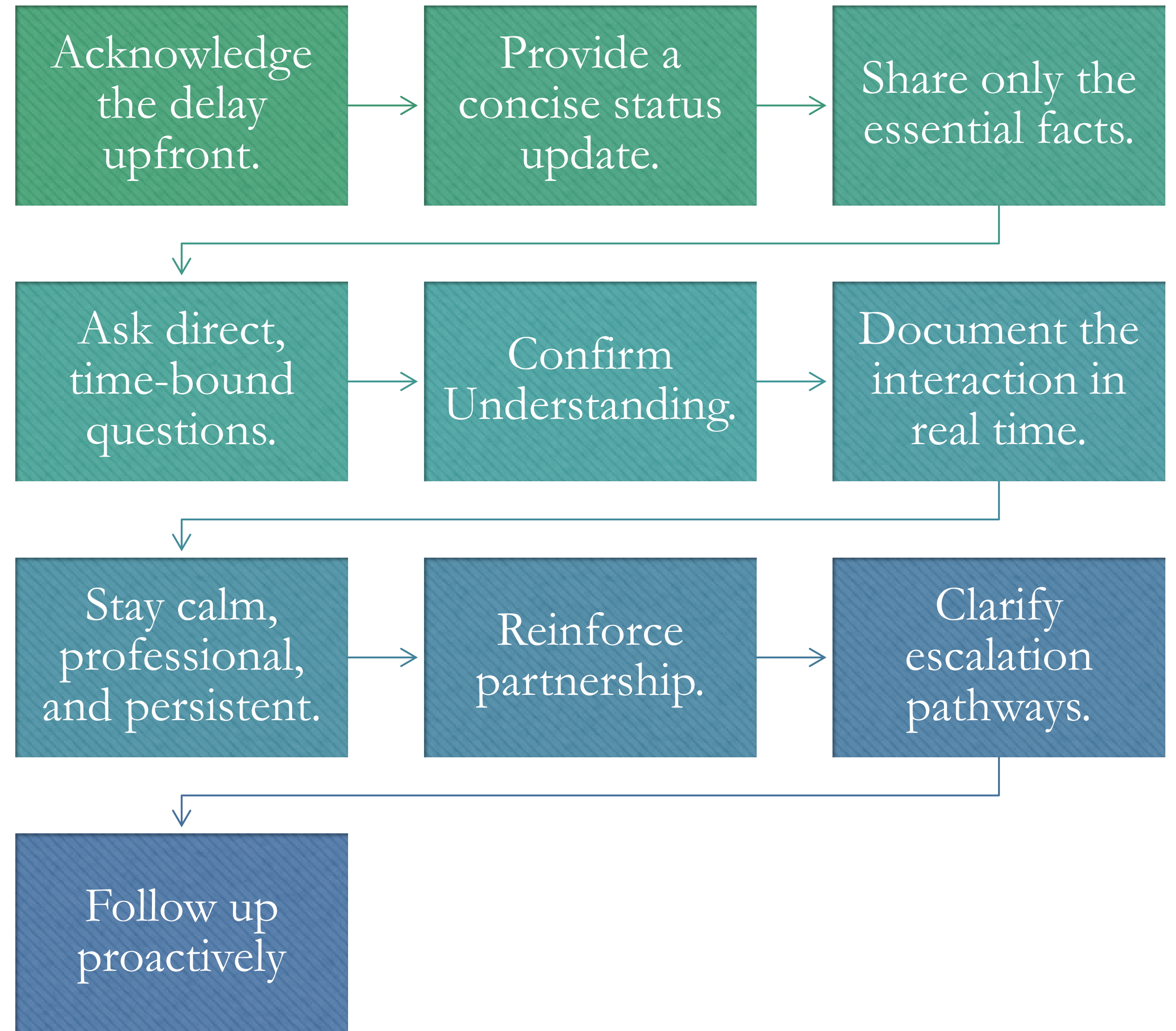
Regional network manager when the payer has market-specific escalation channels.

EDI/Clearinghouse support teams if the delay impacts claims setup or routing.



Internal partners (contracting, revenue cycle, operations) to align messaging before escalating externally.

How To Communicate Effectively With Payers During Delays



Overall Highlights

- Upstream credentialing quality is the foundation of accurate, timely enrollment. Strong controls, shared data standards, and clear handoffs reduce rework and accelerate provider activation.
- Cross-functional partnerships—credentialing, enrollment, operations, contracting—strengthen onboarding outcomes and improve provider and patient access.
- Acquisitions, joint ventures, and Tax ID transitions require coordinated payer updates, contract alignment, and system-wide cleanup to protect revenue and participation status.
- Multi-state enrollments introduce varied rules, licensing requirements, and compliance steps, emphasizing the need for structured workflow coordination.
- Effective escalation relies on knowing when to escalate, aligning internally first, and communicating with payers clearly, concisely, and professionally.
- Consistent documentation, stable data governance, and proactive communication underpin smoother submissions, faster payer responses, and reduced operational risk.

Open Forum

Best Practices

Maryland Medical Assistance Type II NPI Un-Collapsing: Implementation Checklist Draft

Step	Actions
Confirm Scope & Affected Locations	• Identify all practice locations currently sharing a single Type II NPI. • Validate whether any locations fall under the exemptions (e.g., hospitals, specific provider types).
Secure New NPIs	• Obtain a unique NPI for each service location through NPPES. • Ensure teams understand not to modify existing Maryland Medicaid accounts until official notification from MDH.
Prepare Data & Documentation	• Collect correct service location details, including ZIP+4, to ensure alignment with ePREP. ZIP mismatches are a major cause of denials. • Validate tax ID, billing address, and legacy enrollment details for accuracy prior to submission.
Submit NPIs to MDH	• Provide MDH with the required spreadsheet or requested documentation for new NPIs. • Track and retain MDH confirmation emails once updates are completed in billing and enrollment systems.
Update Internal Systems	• Integrate new NPIs into billing, claims, EHR, practice management, and credentialing systems. • Confirm each location's service-facility NPI is correctly entered for claims submission. • Update internal provider rosters and downstream files (if required by payors).
Notify and Coordinate With Payors	• Inform MCOs and additional payors of updated NPI data to avoid billing disruption. • Confirm payor systems have successfully applied updates before billing under the new NPI.
Communicate with Providers & Staff	• Provide guidance to administrative, billing, and clinical teams about NPI changes and timing. • Share the operational impact—Maryland Medicaid's goal is to reduce claim denials linked to shared NPIs and inaccurate enrollment records.
Validate Readiness Before Claims Go Live	• Run test claims or internal validations to confirm: • Correct NPI pairing (billing vs. service location) \ Correct ZIP+4 and address alignment with ePREP \ No unintended claim edits or rejections • Confirm state registration of each new NPI is complete before submitting claims.
Monitor Post-Implementation Performance	• Track claim acceptance and denial trends by location. • Monitor for any address/NPI mismatches flagged by payors. • Set a routine cadence (monthly/quarterly) for reviewing NPI accuracy across all systems.
Maintain Ongoing Compliance	• Update NPIs immediately when adding, moving, or closing locations. • Ensure all roster files and payor directories reflect current NPI data. • Continue monitoring MDH transmittals for further updates or additional provider-type changes.