Streamlining Provider Enrollment: Understanding Payer Credentialing, Provider Enrollment, and the Role of Delegated Credentialing

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Learning Objectives

- Describe payer credentialing, provider enrollment, and delegation
- Recognize elements of today's healthcare environment
- Identify key steps in payer credentialing workflows
- Identify opportunities to streamline credentialing and enrollment workflows to reduce delays and revenue risk

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Why Provider Enrollment is a C-Suite Priority

Revenue Protection *RISK*	Delays in enrollment directly delay billing and reimbursement, leading to significant lost revenue and margin erosion.
Regulatory Risk Management *RISK*	Incomplete or inaccurate enrollments can result in audit findings, sanctions, or payer terminations – exposing the organization to compliance and risk.
Enterprise Visibility *REPUTATION & RISK*	Robust enrollment infrastructure supports credentialing, privileging, quality, and workforce planning – enabling integrated decision-making.
Strategic Alignment *GROWTH*	Enrollment timelines impact provider onboarding, patient access, and time-to-care – critical levers in value-based care and network adequacy.
Operational Efficiency *REVENUE & RISK*	Fragmented processes increase administrative burden, create rework, and affect provider satisfaction and retention.

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Revenue Cycle Starts with Enrollment

No enrollment
=
No billing
=
No revenue

Upfront precision prevents downstream denials

- Provider enrollment too often operates in isolation (i.e., disconnected from revenue cycle, compliance, and onboarding decisions)
- Fragmented intake, unclear ownership, and manual handoffs create rework and prevent "clean" first-pass submissions
- Enrollment delays are rarely payer-driven alone most often caused by process variation and incomplete intake
- Streamlining focus: standardize intake plus run credentialing and enrollment prep in parallel enforcing follow-up cadence

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Why Streamlining Provider Enrollment Matters: Process Outcomes

- Streamlined enrollment reduces revenue risk by minimizing delays between provider start date, payer submission, and payer activation
- Integrated workflows reduce duplication across HR, MSSD, Enrollment, and Revenue Cycle improving first-pass submission quality
- Standardized ownership and handoffs create predictable turnaround times and fewer "stalled" files
- Predictable workflows reduce variability and variability is the biggest driver of enrollment delays

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Payer Credentialing

AKA Managed Care Credentialing

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Payer Credentialing

The process of collecting and verifying practitioner information to evaluate professional conduct and competency for network participation.

You may also hear this referred to as **managed care credentialing**

In healthcare, "payer" generally refers to entities other than the patient that finance or reimburse the cost of health services.

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Types of Payers

Federal/ State Government

Medicare, Medicaid, Tricare

Commercial
(Health Plans/MCOs)*

National – Aetna, Blue Cross/Blue Shield plans, United Healthcare, etc.

Regional and state health plans/networks

Workers' Compensation

US Office of Workers' Compensation (Department of Labor)

State Departments of Labor

Medical Provider Networks (MPNs), Plans and PPOs Networks

* focus of this presentation

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Why do Payers Credential?

1. Ensure practitioner has legal authority and relevant training and experience to provide quality care
2. Legal precedent
3. Accreditation/ Regulatory requirements
4. Internal policies and procedures (Requirements are specific to each payer)

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Who is Credentialed?

- Practitioners (physician and non-physician) who have an independent relationship with the organization
  - MD/DO (physicians)
  - DDS/DMD (oral surgeons)
  - DC (chiropractors)
  - DPM (podiatrists)
  - Behavioral health practitioners
  - Rental network practitioners*
  - Other practitioners in payer's credentialing scope
- Do not credential facility-based practitioners (inpatient or facility setting practice only)
- Credentialing approval does not equal billable status

*only if certain criteria met; typically, only if listed in directory

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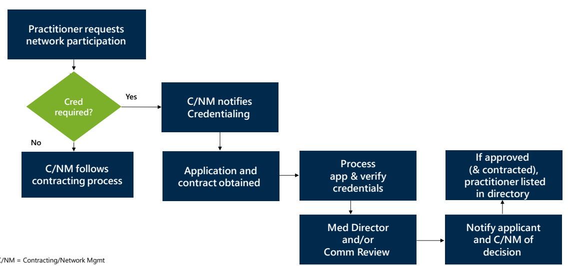
Payer Credentialing Workflow



C/NM = Contracting/Network Mgmt

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Additional Requirements

Credentialing Doesn't stall revenue - fragmented workflows between credentialing and enrollment do!

Re-credentialing is required every 3 years

- Similar process to initial credentialing
- Initial verification time frames apply

In between credentialing cycles, payer must monitor for, collect, review and take appropriate action in cases of poor quality

- Medicare/Medicaid sanctions
- License sanctions or limitations
- Complaints
- Adverse events

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Provider Enrollment

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Provider Enrollment

The process of collecting and submitting required documentation to third-party payers to enroll practitioners into payer networks and allow the provider to bill for services rendered to members (also known as payer enrollment).

And some will refer to provider enrollment as only the process for enrolling with Medicare/ Medicaid, using the term payer credentialing to refer to commercial enrollment.

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Provider Enrollment

Provider enrollment is not credentialing, but some similar tasks are performed in collecting and reviewing application data.

- Timely and accurate enrollment with payers can be challenging for integrated delivery systems
  - CINs, ACOs
  - Hospital-owned provider-based clinics and physician practices

Some organizations may include other functions in the scope of 'enrollment'.

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Provider Enrollment (continued)

Understanding the requirements of the payer can facilitate an ***effective enrollment process:***

- CMS provides its PECOS system for electronic enrollment and revalidations
- Payers primarily use CAQH ProView for application data
- State Medicaid plans have varying processes
- Unique participation requirements by health plans
- While application platforms are electronic, payer processing and turnaround times remain plan-specific and largely manual

Understanding what payers require (and why) can make the process much easier and efficient.

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Provider Enrollment Challenges

Symptoms of Fragmented Workflows

VOLUME

Each provider may require **10-20+ payer enrollment**

Workflow breakdown: no payer matrix/no standardized routing rules

APPLICATIONS

Multiple forms, CAQH, redundant data collection

Workflow breakdown: duplicate intake requests and inconsistent data sources

REQUIREMENTS

Criteria varies among payers
No payer-specific rules engine

Workflow breakdown: no "clean file" standard and inconsistent document packages

TIMELINESS

Payers may take **30-180+ days** depending on payer, delegation status, completeness, market

Workflow breakdown: undefined follow-up cadence and unclear escalation triggers

COMMUNICATION

Between payer, provider and enrollment specialist; no shared visibility

Workflow breakdown: no shared status tracker; updates live in emails and spreadsheets

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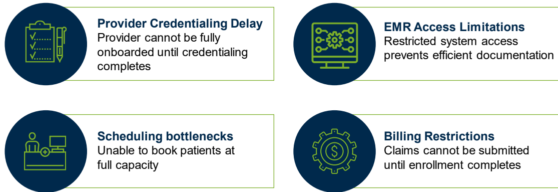

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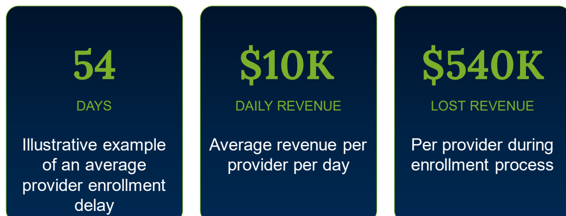

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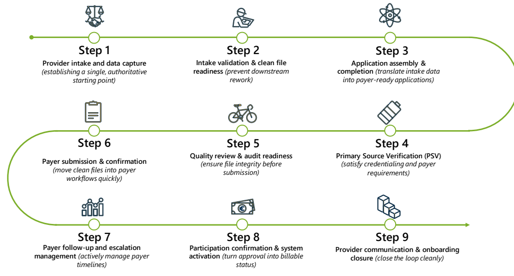
Streamlined Provider Enrollment Onboarding Process



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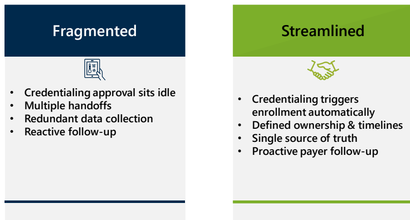
Enrollment Workflow: Fragmented vs. Streamlined



- Credentialing approval sits idle
- Multiple handoffs
- Redundant data collection
- Reactive follow-up

- Credentialing triggers enrollment automatically
- Defined ownership & timelines
- Single source of truth
- Proactive payer follow-up

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What is Delegated Credentialing?

- Merriam Webster Dictionary: To give (control, responsibility, authority, etc.) to someone; to trust someone with (a job, duty, etc.)
- NCQA: delegation occurs when an organization gives another entity the authority to carry out a function that it would otherwise perform
- Payers vary in the scope of delegated activities that occur, if any

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When is Delegated Credentialing Strategic?

- You're already doing the work
- You want more leverage with Payers
- You need to shorten time-to-revenue
- You're ready for risk-based or delegated contracting
- You're growing fast
- You have mature internal infrastructure

Delegation is not a shortcut – it is enabled by standardized, audit-ready enrollment workflows

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What do Payers Expect?

1 Accreditation-Ready Credentialing Processes

Documented policies and procedures that meet or exceed standards set by NCQA, URAC, and relevant state regulations.

2 File readiness, information integrity, and ongoing monitoring

Demonstrated ability to maintain ≥98% file accuracy rates, robust data integrity practices, proactive compliance monitoring, and adherence to all applicable regulatory standards.

3 Strong Governance

Formal credentialing committee with qualified medical leadership, documented decision criteria, and clear appeals processes.

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Risks to Anticipate & Keys to Success

Risks

- > **audit failure = contract suspension**
- > **resource burden if not fully staffed or trained**
- > **multi-payer complexity (each plan has unique criteria)**

Keys to Success

- > **Clear file governance & version control**
- > **credentialing software that supports audit traceability**
- > **dedicated liaison for payer relationships**

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MSSDs & Enrollment Optimization

Identify KPIs and TAT

The table below compares leading practice for average turnaround time for the five basic steps for the credentialing & privileging and enrollment workflows.

	Credentialing and Privileging Workflow		Enrollment Workflow *without Delegation*		Enrollment Workflow *with Delegation*	
STEP 1	Release of Application to Practitioner/Portal Access	2-4 DAYS	Application to Practitioner/Portal Access	2-4 DAYS	Release of Application to Practitioner/Portal Access	2-4 DAYS
STEP 2	Application completed/Returned for processing	7 – 10 DAYS	Application completed/Returned for processing	2-5 DAYS	Application completed/Returned for processing	7 – 10 DAYS
STEP 3	Primary Source Verification	21 DAYS	Submit to Payer	2-4 DAYS	Primary Source Verification	21 DAYS
STEP 4	Auditing	7 – 10 DAYS	Confirmation/Follow up	7 – 14 DAYS	Auditing	7 – 10 DAYS
STEP 5	Committee Recommendation/Board Approval	30 DAYS	Participation Confirmed	60 - 120 DAYS	Committee Approval **Does not include payer load time*	Same Day Approval
Total Days on Average	75 DAYS		110 DAYS		45 DAYS	

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Disadvantages of Delegation

Payer

- Loss of control – regardless of the delegation, the payer is ultimately responsible
- Resources still required to perform oversight audits
- Potential impact on accreditation survey results

Delegated entity

- Additional responsibilities based on health plan requirements
- Resources to support oversight audits
- Does not fully eliminate provider enrollment activities

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Key Takeaways: Streamlining Provider Enrollment

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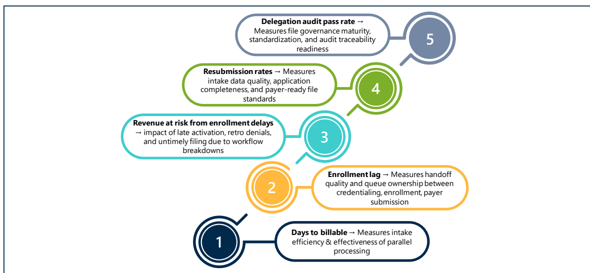
Leading Indicators of Streamlined Credentialing & Enrollment



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Questions to ask within your organization?

- Is the provider enrollment process as efficient and timely as it can be?
- Are there opportunities for provider enrollment and credentialing to be aligned and integrated to achieve more efficiencies and timelier reimbursement?
- Are your credentialing P&Ps reflective of payer requirements?
- Can delegation with payers be obtained?

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Future State Maturity Model

Maturity increases when intake becomes standardized, handoffs become owned, status becomes visible, and KPIs drive follow-up. Not when payers move faster.

Level 1
Fragmented and manual processes
- Credentialing and enrollment managed separately; sequential handoffs
- Manual tracking (emails/spreadsheets), limited visibility
- Reactive follow-up; unclear escalation triggers

Level 2
Standardized workflows
- Documented process + role clarity; basic standardization
- Intake checklist + "clean file" readiness expectations
- Consistent document package requirements

Level 3
Integrated systems
- Single source of truth for provider status + shared tracker
- Enrollment triggered automatically; parallel prep work reduces lag
- Defined follow-up cadence + handoff SLAs (e.g., enrollment lag)

Level 4
Delegated + optimized
- Delegated with select payers, faster activation timelines
- Audit-ready file governance + traceability; high file integrity
- KPI-managed performance (resubmissions, audit pass rate)

Level 5
Strategic, data-driven onboarding
- Predictive, proactive planning tied to start dates and capacity
- Performance monitoring tied to revenue risk and access outcomes
- Scalable model supporting growth, M&A, and retention

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LEADING PRACTICE FRAMEWORK

Overall Compliance
Integration Collaboration Communication
Practitioner Onboarding Optimization
Value Realization
Practitioner Experience

Long-lasting, meaningful impact:
- Accelerated revenue captured with reduced duplication and turn-around times
- Full compliance with external and internal requirements
- Optimization of resources resulting in cost savings
- Increased scalability through integrated workflows
- Creates competitive edge and marketing advantage
- Increased practitioner satisfaction, alliance and retention

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Questions?

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Thank you!

Tina Turner, MBA,CPMSM, CPCS, CPM
Senior Consultant
tturner@greeley.com

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