Ohio | Department of Medicaid

Centralized Credentialing Frequently Asked Questions

September 2022

This frequently asked questions (FAQ) document is designed to provide answers to the most common questions regarding the centralized credentialing initiative at Ohio Department of Medicaid (ODM). This initiative is intended to replace the current credentialing process through Ohio's five current Medicaid managed care plans. Once implemented, providers will work directly with ODM and its contracted credentials verification organization (CVO) to complete primary source verification.

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What is centralized credentialing and why is this initiative being implemented?

Centralized credentialing refers to ODM or its designee leading the credentialing functions for ODM providers.

Today, ODM's five managed care entities (MCE) are responsible for provider credentialing. In this environment, each provider, hospital, practice, and facility perform the same credentialing tasks for each MCE to be reimbursed for Medicaid services rendered.

ODM is moving to a centralized model in which the agency will manage credentials, and providers need apply only once. Centralized credentialing eliminates the need to understand and comply with six unique credentialing processes, easing the administrative burden felt by providers serving Ohio's Medicaid members. In addition to standardizing the process and documentation that is collected, centralized credentialing helps eliminate repetitive work, improve revenue cycle, and lower credentialing costs for hospitals, facilities, providers, and practices.

Why is credentialing important?

Provider credentialing enables medical organizations to verify the credentials of healthcare providers, ensuring they have the required licenses, certifications, and skills to properly care for patients. Federal Centers for Medicare & Medicaid Services (CMS) requires healthcare providers to demonstrate they have the proper qualifications to perform their jobs. The process confirms status of a provider's education, licensing, certifications, and more. It also reviews provider histories, confirming that no regulatory, criminal, or licensing violations exists, and the provider is capable of treating patients. The information collected by Medicaid will serve as the source of truth for the MCEs. As such, it is imperative that providers update their data regularly when there are any changes.

What are benefits of centralized credentialing?

By having a centralized credentialing model, ODM can act as the source of truth for provider data for the Medicaid MCEs. Any updates will be communicated to the MCEs daily, so data aligns between our systems and theirs. Additionally, delegates can be utilized at ODM to provide additional resources to speed up credentialing and provide better data integrity.

What is the Credentials Verification Organization (CVO) and what is its role incredentialing?

ODM has contracted with a National Committee for Quality Assurance (NCQA)-accredited Credentials Verification Organization (CVO) to complete certain credentialing-related tasks. The CVO will be responsible for collecting primary source verifications (licensure, board certification, Drug Enforcement Agency certificate, etc.), monitoring sanctions (the process of reviewing licensing board actions), and participating in the Medicaid Credentialing Committee to inform the agency of best practices and processes. Once the CVO authenticates all required documentation, records will be forwarded to ODM for final determinations.

ODM will follow all NCQA rules and regulations and complete periodic auditing of the CVO to determine compliance. This will include policy review, documentation review, and timeliness considerations.

What is the role of the Medicaid Credentialing Committee, and who makes up that body?

The Credentialing Committee is responsible for making decisions regarding the participation of Medicaid providers, based on their history and training. In addition, this body is responsible for oversight of the credentialing program, to include policy and reporting from the business unit. Voting members are peer practitioners such as doctors and nurses who are uniquely qualified to consider the credentials of applicants. The peer practitioners are drawn from many sources, including internal Medicaid Medical Directors, MCE Medical Directors, and community-based practitioners. The committee will hold the first formal meeting prior to the October 1 launch.

Who needs to be credentialed?

CMS requires credentialing for:

- Home health agencies.
- Hospice facilities.
- Free-standing surgical centers.
- Substance use disorder clinics.
- End-stage renal disease treatment centers.
- Substance abuse rehabilitation facilities.
- All physicians who offer services to an organization's enrollees, including members of physician groups.
- Skilled nursing facilities.
- Hospitals.
- Community mental health centers.
- Radiology centers.
- Residential treatment facilities.
- All other types of healthcare professionals who provide services to the organization's enrollees and who are permitted to practice independently under state law.

For a complete list of providers requiring Medicaid credentials, see OAC 5160-1-42.

Will a provider still need to be credentialed by a Managed Care Entity (MCE)?

If a provider is participating with a managed care entity for Medicaid-only credentials or MyCare credentials, the credentialing process will be done through ODM. Providers who participate in Medicaid's fee-for-service (FFS) model also must complete this process. They will not be credentialed at the MCE level. However, providers participating in non-MyCare Medicaid programs are mandated by CMS to be credentialed by the MCEs. Additionally, a provider will still need to contract with a given MCE to participate with them.

Once a provider is credentialed, what happens next?

Medicaid is implementing a new Provider Network Management (PNM) module to record and house all information needed to verify a provider's credentials. Providers will be given instructions during the enrollment and revalidation process, including information needed for third-party verification and how to submit documents via ODM's secure provider portal.

What is the Provider Network Management (PNM) module?

The PNM module is a part of a larger effort to modernize ODM's management information systems. This modernization roadmap, developed in accordance with CMS guidance, includes a transition to a modular system called the Ohio Medicaid Enterprise System (OMES) that will support ODM in meeting several modernization goals. Ultimately, Medicaid Information Technology System (MITS) will be retired.

How often will providers be required to seek credentialing through Medicaid?

Per CMS and NCQA rules, a provider is required to go through the process at initial enrollment and every 36 months thereafter.

Who will reach out if further credentialing information is needed?

Providers will receive requests for information directly from the PNM module and be able to access their application to provide the information through ODM's secure portal. Additionally, ODM's CVO may contact providers directly via email to address and correct any credentialing issues or discrepancies.

What options are available if I am denied by the Medicaid Credentialing Committee?

If a provider is denied for credentialing and believes this to be in error, they will need to appeal to the Medicaid Credentialing Committee in writing within 30 days of the denial. At that time, they will have the opportunity to come before the committee and address the denial, as well as provide additional information that may not have been utilized to make the credentialing decision.

Medicaid has a dedicated credentialing e-mail address, Credentialing@medicaid.ohio.gov, through which providers can submit questions and comments.

Are any other credentialing entities included in the program?

Medicaid will also utilize delegated credentialing. Providers who are currently credentialed through a delegated group need to have a contract with ODM that allows these functions performed to be valid. If the group you are with is not a delegate, you will have to go through the centralized credentialing process. If you have questions regarding the delegate status of your medical group, contact your credentialing representative.

Will there be new fees or costs under the new Medicaid centralized credentialing model?

There are no additional fees for the centralized credentialing model.

Any information or a timeline on when training or additional informational webinars will be scheduled would be appreciated.

Training information can be found on the PNM and Centralized Credentialing page of the managedcare.medicaid.ohio.gov website.

For credentialing, is the effective date the date the application is approved or the date the application is submitted?

For both credentialed and non-credentialed providers, the effective date can be made retroactive [up to one year contingent on their license and NPI (National Provider Identifier) effective dates].

What is the process for a licensure upgrade, e.g., an LSW (Licensed Social Worker) gets an LISW (Licensed Independent Social Worker)?

Providers changing or upgrading specialty types in their current provider type can submit this as a specialty update. Providers who are changing provider types require a new application. If providers are upgrading from a non-credentialed type to a credentialed one, they will be required to go through the credentialing process.

How will the initial credentialing for behavioral health (BH) providers be handled? What is the time frame/plan for getting BH providers credentialed initially?

For newly enrolling BH providers, all provider types that require credentialing will be credentialed through ODM's Centralized Credentialing program. For currently enrolled BH providers, ODM will receive information from the MCPs and CAQH (Council for Affordable Quality Healthcare). MCPs will provide the recredentialing date if available. CAQH will provide the additional provider details and qualifications (if available) to populate the provider's record in PNM. For providers that may not have been credentialed by the MCPs, ODM is going to use the provider's revalidation date to initiate an opportunity for the provider to submit the necessary information for credentialing. ODM will pair up revalidation dates with recredentialing dates to minimize the administrative impact to providers during the transition and ongoing.

Will agencies be able to verify provider status for an unaffiliated provider in the PNM fornew hires?

Group administrators can access the PNM secure portal to search for active providers for affiliation with their agency.

How will the transition to the PNM impact enrollment? Are any changes with the process/information needed?

One noticeable change will be for providers that require credentialing; the application process will include standard provider enrollment questions and more extensive questions for the credentialing process. Provider enrollment requirements are essentially the same as they are today.

Will there be a limit on the number of provider administrator accounts in PNM?

Providers can have only one provider administrator and almost infinite agent accounts.