A Modern Approach to Medicaid Provider Enrollment

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State Medicaid agencies face a recurring and intensifying challenge: keeping provider enrollment operations compliant, timely, and accurate amid funding constraints, workforce pressures, and unpredictable volume spikes. Backlogs in revalidation and new enrollment are not isolated failures—they are systemic, industry-wide patterns that demand structural change. This paper examines the root causes, quantifies the risks, and presents a proven path forward built on standardization, automation, and centralized delivery.

The Growing Challenge in Medicaid Provider Enrollment

In April 2026, CMS launched a nationwide revalidation initiative, sending letters to all 50 governors and state Medicaid directors demanding two-year revalidation strategies. The scale of the directive underscores what providers and program operators already know: backlogs are widespread, and states are struggling to keep pace.

Many states face revalidation backlogs numbering in the thousands or tens of thousands—a reflection of just how stretched program resources have become. HHS Office of Inspector General (OIG) investigations have documented cases where providers who should have been terminated remained actively enrolled for extended periods. In one review, nearly 1,000 terminated providers were found still enrolled across state programs, associated with $50.3 million in improper payments. An earlier OIG study found that 12% of providers terminated for cause in 2011 were still participating in other state programs three years later.

One program accumulated more than 20,000 providers overdue for revalidation. With limited staff bandwidth and no dedicated tools, the team tracked these providers primarily through manual spreadsheets. Under those conditions, the backlog became self-reinforcing: the more it grew, the harder it was to manage.

This is not an isolated incident. It's a symptom of structural misalignment between the demands placed on enrollment operations and the tools and capacity available to support them.

Root Causes of Recurring Backlogs

That structural misalignment isn't driven by a single issue, but by four recurring pressures seen across Medicaid programs:

- **Volume Spikes:** The Public Health Emergency during the COVID-19 pandemic deferred millions of revalidations, creating a concentrated surge expected in 2027–2028 as those deferred cycles come due. Seasonal patterns, such as post-graduation application increases, add recurring cyclical pressure.
- **Workforce Constraints:** Turnover is common on provider enrollment teams, leaving new hires to be onboarded regularly, existing staff to bear the burden of passing on expertise, and team members stretched thin when it comes to strategic or operational improvements.
- **Manual, Inconsistent Processes**: Spreadsheet-based tracking, manual document validation, and inconsistent review criteria create bottlenecks. CMS has sent timeliness letters to states with persistent processing problems.
- **Funding Constraints:** State Medicaid agencies are expected to maintain rigorous compliance standards with limited or often static budgets, leaving little room for investment in operational modernization.

Business and Compliance Risks

Unresolved backlogs carry significant downstream consequences. Federal audit findings and corrective action plans create compliance exposure. Provider access suffers when enrollment delays prevent qualified providers from serving Medicaid members. A 2025 report from Medallion1 analyzed over 64,500 enrollment submissions and found that one in four states takes 75 or more days to process applications, with the slowest states exceeding 100 days. Operationally, reactive cleanup efforts consume resources that could be directed toward sustainable improvement, creating a costly cycle that repeats with every volume spike.

How to Break the Backlog Cycle

Breaking the cycle requires a deliberate shift from periodic remediation to proactive, continuous enrollment lifecycle management. This transformation rests on three pillars: standardization, automation, and centralized delivery, with each building on the last. The right starting point is an honest assessment of current operations to evaluate process gaps, quantify backlogs, and benchmark performance to establish a clear baseline.

1. Standardize Workflows

Reducing process variation is foundational. When enrollment items flow through defined, consistent workflows, supported by standard operating procedures, uniform review criteria, and clear KPIs, the system becomes faster and more predictable for providers and agencies alike. This is the phase where organizations define what "good" looks like: documented processes, reporting frameworks for leadership oversight, and measurable performance standards.

In practice: A large Medicaid program experiencing 90+ day application processing delays deployed a standardized intake and triage model that segmented work by complexity and established consistent review criteria. Combined with automation for completeness checks, the program achieved 30–50% faster turnaround times, a significant reduction in pending inventory, and measurably improved provider satisfaction without increasing headcount.

2. Automate Key Processes

With standardized workflows in place, automation amplifies their impact. The volume and compliance demands of modern enrollment make manual processing unsustainable. Business rules engines orchestrate applications through defined workflows. Robotic process automation (RPA) handles repetitive screening tasks such as verifying provider credentials against external databases, reducing manual effort per application.

Emerging AI capabilities are beginning to assist analysts with document review and validation, further accelerating throughput. Automation does not replace human judgment, but it can remove the manual labor that makes it harder for overworked analysts to apply it.

3. Centralize Delivery

The final and most transformative step is moving toward a centralized or shared-service delivery model. Programs that maintain separate, duplicative enrollment operations inevitably face inconsistent outcomes, fragmented reporting, and an inability to flex resources in response to volume changes. Centralization unlocks economies of scale, workforce flexibility, and cross-program consistency.

A common concern is that centralization will sacrifice state-specific nuance. In reality, modern systems and trained teams can manage unique state requirements as configurable exceptions within a common framework. Quality oversight is embedded, ensuring accuracy and compliance across every program served.

In practice: Multiple programs maintaining duplicative enrollment operations with inconsistent outcomes consolidated into a shared-service model with standard SOPs, a pooled workforce, and common systems. The result was a 15–25% reduction in operational costs, improved SLA consistency, and significantly greater resilience to volume spikes.

The Path Forward

Medicaid provider enrollment has reached an inflection point. The pressures driving today's backlogs – rising volume, intensifying regulatory scrutiny, shrinking workforce capacity – are not temporary. They are structural, and incremental fixes will not outpace them. The programs that break the cycle will follow a deliberate progression: standardize first, automate next, centralize to scale.

Start now. Conduct a baseline assessment of backlog depth, cycle times, and process variation. Standardize intake, triage, and review workflows. Identify the highest-volume manual tasks such as credential verification and completeness checks and target them for automation within the first 90 days.

Build momentum. Within six months, deploy workflow automation and business rules orchestration. Pilot centralized delivery across select enrollment functions or regions. Measure what matters: processing time, cost per transaction, audit readiness, and provider experience.

The returns are proven. Programs that have made this shift report faster turnaround, lower operational costs, stronger compliance posture, and dramatically less provider abrasion. These are not theoretical outcomes; they are documented results from programs that chose to act. What's required now is alignment. A commitment to centralized delivery as the operating model and the investment in automation and process redesign to get there.

The question facing every Medicaid agency is no longer whether to modernize enrollment, it's whether they can afford the cost of waiting through another cycle before they start.

Contact our team to learn how Gainwell can support a more sustainable revalidation process.

About Gainwell

Gainwell Technologies is the nation's leading provider of digital and cloud-enabled solutions across all 50 states, US territories, and the human services and public health ecosystem. With our 13,000 experts, practitioners, and clinicians, we are uniquely positioned at the intersection of technology and healthcare providing unmatched value through our suite of innovative products and solutions created to solve our clients' most complex challenges. We are mission-driven and outcome-focused, committed to building trusted, lasting relationships, and delivering results beyond the expected. Learn more about our people and capabilities at gainwelltechnologies.com.