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Every Call is Time Patients Don't Get Back.

The burden of provider directory verification calls on practices and on patients

THE PROBLEM

Provider directories help patients find care. But keeping them current requires something clinicians and staff already have too little of: time. Federal rules require health plans to verify directory information at least once every 90 days[1], and because plans manage this process independently, a single practice may be asked to verify the same information repeatedly. On average, a practice responds to requests associated with 20 health plan contracts, each through separate platforms, formats, and timelines. This fragmented, manual approach to directory maintenance cost practices $2.8 billion annually.[2] Those requests are most often by phone.

Scrutiny of directory reliability has intensified. Audits by the Centers for Medicare & Medicaid Services (CMS) have documented widespread inaccuracies in Medicare Advantage directories, including incorrect phone numbers, practice locations, and information about whether clinicians are accepting new patients with at least one error in roughly half of the listings reviewed.[3] A U.S. Senate Finance Committee secret shopper study of behavioral health networks was able to schedule an appointment only 18% of the time.[4] Inaccurate information does more than inconvenience: it sends people to dead ends, delays access to care, and contributes to unexpected costs.[5]

Policymakers have raised expectations on both sides of the exchange. Alongside the verification duties placed on plans, the No Surprises Act has required clinicians and health care facilities, beginning in 2022, to maintain business processes ensuring the timely provision of directory information.[6] The Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Final Rule[7] and a growing body of state action[8] push in the same direction.

Yet a fundamental tension remains. Stakeholders want better information faster, but many of the processes used to maintain it still depend on manual outreach and repeated requests to practices. To understand what this looks like from inside a practice, DataSpring Insights asked the staff who field these calls about their experience.

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90 days

WHAT WE FOUND

VERIFICATION CALLS AREN'T MINUTES. THEY'RE HOURS.

Directory verification may seem routine, but the time adds up fast. More than one-quarter of practices received **15 or more verification calls a month**, and **40%** of those calls take more than **15 minutes** on average. For those practices, that means at least four hours every month spent on verification calls alone.

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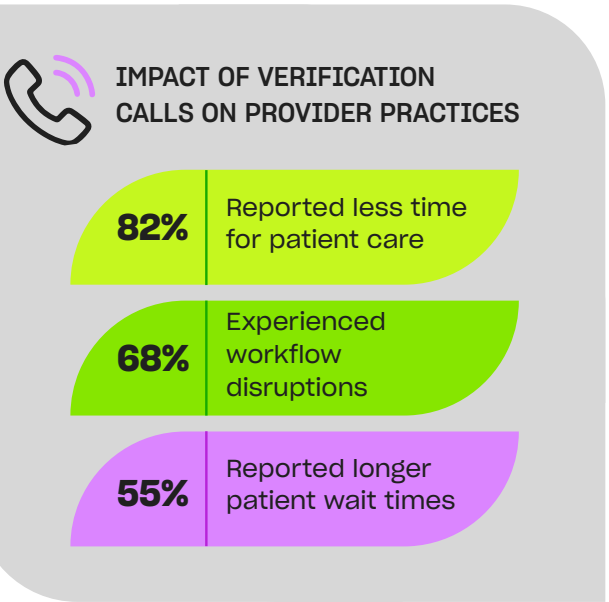
The effects extend beyond the administrative burden itself, with clear consequences for patient care. **82%** of respondents said verification calls leave **less time for patient care**, while **68%** cited greater workflow disruption and **55%** noted **longer patient wait times**.



HALF OF PRACTICES ARE STILL VERIFYING INFORMATION BY PHONE.

Much of this work lands on the front lines. **Nearly half of verification requests still happen by phone**, and **more than half of calls** are handled by front desk staff. The same people scheduling appointments, answering questions, and keeping practices moving are also stopping to confirm directory information.

LOOKING AHEAD

The burden here is not verification itself, it is the duplication of it. Lack of standardized data elements between health plans and states, and consolidated asks of practices impact patient care, staff burden, and data quality.[9] When a practice can confirm pre-populated information once, for all plans, rather than repeatedly for each, repetitive manual outreach drops and staff time returns to patient-focused work.

METHODOLOGY

Responses were collected from over 80 clinicians and practice staff over one week in August 2026 via phone interviews and online surveys. Sample was drawn from MD/DOs who attested to their directory information within the prior six months.

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CONVENING INDUSTRY TO REDUCE DUPLICIATIVE, BURDENSOME WORK

Call verification is a symptom of a larger challenge: fragmented approaches to provider data. The Provider Data Collective, a DataSpring-convened initiative that brings health plans, professional associations, and accreditation organizations together to align on provider data quality standards, is working to establish a common framework for how provider data is measured and maintained. Greater consistency can reduce the variability that drives duplicative outreach today that consumes time for clinicians and their staff.

ENDNOTES

1. H.R.3630 – No Surprises Act | Congress.
2. The Hidden Cause of Inaccurate Provider Directories | CAQH
3. Online Provider Directory Review Report | CMS.
4. Majority Study Findings: Medicare Advantage Plan Directories Haunted by Ghost Networks | Senate Committee on Finance.
5. Surprise Billing in Private Health Insurance: Overview of Federal Consumer Protections and Payment for Out-of-Network Services | Congress.
6. H.R.3630 – No Surprises Act | Congress.
7. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality | Department of Health and Human Services.
8. Directory Assistance: Maintaining Reliable Provider Directories for Health Plan Shoppers | California Healthcare Foundation.
9. Provider Directories: What Impacts Accuracy | CAQH