



Before the First Patient: The Administrative Effort of Credentialing, Enrollment, and Recredentialing

The hours practices spend getting clinicians into networks and keeping them there.



WHAT PRACTICE STAFF REPORT

502

502 hours a year

practices devote to
initial credentialing
and enrollment

18

18 hours to credential

and enroll one clinician
with one health plan

60%

**60% say credentialing
or enrollment has been
delayed** or denied by
bad data

Before a clinician can see patients as part of a health plan's network, the plan must formally establish who they are, whether they are qualified to practice, and where they practice. This begins with credentialing and enrolling with a health plan, and continues through recredentialing, the periodic process of confirming that the information on file remains accurate. Each step serves a distinct purpose: credentialing verifies that the clinician is qualified to provide care; enrolling establishes the terms and contract under which that care is covered; and recredentialing confirms that both remain current as licenses, practice locations, and other key demographic information change. Together, these processes help protect patients from unqualified care, give plans a reliable record of their networked clinicians, and prevent clinicians that are sanctioned for fraud or patient harm from participating in the networks patients rely on.

A new DataSpring, powered by CAQH, Insights survey of clinical and administrative practice staff finds that meeting these requirements consumes months of staff time to complete annually, that most of the work happens before a credentialing application is ever submitted, and that inaccurate or missing information has delayed or resulted in denied applications for the majority of respondents.

WHAT THESE PROCESSES ARE FOR

Credentialing and enrollment run in sequence; recredentialing repeats for as long as the clinician-health plan relationship lasts. Each is governed by its own requirements and its own timeline.

INITIAL CREDENTIALING IS VERIFICATION OF THE CLINICIAN'S PROFESSIONAL HISTORY, DEMOGRAPHICS, AND QUALIFICATIONS.



Before a clinician begins a credentialing application, the clinician researches health plans and reviews participation and eligibility requirements. Upon receiving an application, the plan confirms education, training, licensure, board certification, and other credentials, typically with the primary source. National Committee for Quality Assurance (NCQA) requires primary source verification and requires it to be complete before a clinician joins a network.¹



ENROLLMENT IS THE CLINICIAN'S ADMISSION TO THE HEALTH PLAN'S NETWORK.

Once the clinician's qualifications are verified, the plan completes the enrollment and contracting process. This includes assigning the clinician to the appropriate networks and products, linking them to a tax identification number (TIN), service locations, and taxonomy codes, and enabling them to bill the plan. Enrollment determines whether claims are paid at in-network rates and whether the clinician appears in the plan's directory. For Medicaid, enrollment also involves federal screening requirements, including checks against exclusion and fraud databases.²

RECREREDENTIALING IS MAINTENANCE.



Credentials expire, licenses lapse, sanctions are issued, and clinicians change practices. Clinicians are recredentialed at least every three years,¹ while federal rules require Medicare and Medicaid fee-for-service (FFS) clinicians to revalidate their enrollment information at least every five years with off-cycle revalidations at the discretion of the Centers for Medicare & Medicaid Services (CMS) or the state Medicaid agency.³



REPEATED EFFORT, UNCERTAIN RETURN

The information one plan needs to credential a clinician is largely the same information required by every plan. Yet each plan collects it separately, using its own format and on its own schedule. The American Medical Association (AMA) describes the result plainly: for some physicians, credentialing means submitting the same information dozens of times across the organizations they are affiliated with, in slightly different formats each time.⁴ MACPAC's June 2026 Report to Congress reaches a parallel conclusion for Medicaid, finding that the administrative burden of enrollment and credentialing is often most acute for clinicians in small practices.² The alternative is to collect the information once and enable every organization that needs it to access the same record, as with the DataSpring CAQH Provider Data Portal profile.⁵ This does not eliminate the requirement for credentialing; it reduces the number of times a clinician must provide the same information.

Repetition is not the only consideration. Credentialing and enrollment are separate steps, and completing the first does not guarantee the second. A plan may credential a clinician and still decline to contract with it if its panel is closed to new participants in that specialty or service area.⁶ The survey shows this gap: practices report being credentialed with a median of 14 health plans while holding a median of 7 unique contracts, and 13% report no unique contracts at all. **Practices are credentialing into relationships that never materialize.** This is wasted effort and time.



PRACTICES ARE CREDENTIALING INTO RELATIONSHIPS THAT NEVER MATERIALIZE.



THE HOURS BEHIND ESTABLISHING & MAINTAINING A CLINICIAN-PLAN RELATIONSHIP

Practices report spending, on average, **nearly two months, or 502 hours, annually** on initial credentialing and enrollment. This work applies only to clinicians joining a plan for the first time. Recredentialing is a separate, recurring requirement that applies to every clinician-plan relationship within a practice on a three-year cycle. Practices report spending an average of **two and a half months, or 592 hours**, annually reviewing, updating, and attesting to clinician information. Together, these activities represent **roughly half of a full-time position**.

While the overall annual totals are similar, the two look very different when measuring **per clinician, per plan**. Credentialing and enrolling one clinician with one plan takes an average of **18 hours, more than two full workdays**. Recredentialing that clinician with that same plan takes **5 hours** and recurs at least every three years for the life of the relationship.

The difference between the two processes is the amount of information that must be produced and submitted. Initial credentialing builds a record from nothing. The practice assembles and presents a full professional history, education, training, licensure, board certification, work history, malpractice history, and sanctions. The plan then verifies each item with the source that issued it. When information cannot be verified, practices must field follow-up calls to resolve the issue.¹

A first-time relationship also requires clinicians and staff to identify which plans to pursue, confirm requirements, establish eligibility, negotiate and execute a contract, and follow up with the plan until the clinician is loaded

into the patient-facing health plan directory and billable. Recredentialing requires none of this. The clinician record already exists; the work involves reviewing the information held by the plan, identifying and correcting changes, and attesting to its accuracy.

Per clinician, per plan, recredentialing is the lighter task. Across the practice each year, however, it is the larger commitment. Initial credentialing is a cost the practice absorbs once for each new clinician and each new plan. Recredentialing is ongoing: every clinician in the network must be recredentialed repeatedly for as long as the relationship continues. The greater commitment is not the cost of growth, but the ongoing effort required to maintain the plan relationships the practice already has.

HALF THE WORK HAPPENS BEFORE AN APPLICATION IS SUBMITTED.

Of the 502 annual hours spent on initial credentialing and enrollment, 270 hours, **54%**, are spent determining which plans to enroll with, confirming each plan's requirements, and verifying eligibility. Completing and submitting applications accounts for 87 hours (17%) while undergoing credentialing reviews and contracting accounts for 145 (29%). The bulk of the burden occurs before any form is completed - in the research and verification required simply to determine where to apply.

MUCH OF THE WORK LANDS ON CLINICIANS.

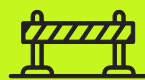
Credentialing responsibilities often fall to those directly involved in patient care and other administrative tasks.⁷ **More than half of the clinicians** surveyed said they personally complete tasks associated with the credentialing process. Across all respondents, 69% reported handling credentialing themselves and 47% reported that other staff do. Only 8% use a vendor, indicating that credentialing responsibilities largely remain within the practice and must be accommodated alongside existing clinical and operational demands.

BAD DATA DOES NOT JUST SLOW CREDENTIALING — IT STOPS IT

Sixty percent of respondents report that initial credentialing or enrollment has been **delayed or denied** because information was inaccurate or missing, potentially affecting network adequacy and patients' ability to find appropriate care. Only 24% say it never has.

The remaining 16% do not know, and that gap is telling. Practices rarely receive an explanation for why an application is slow. A file may sit for weeks while a plan reconciles a license number, an address, or a taxonomy code against its own records, and the practice sees only elapsed time. Unless the plan calls to request a correction, a data problem and ordinary processing time look the same. The 60% is likely a floor rather than a ceiling, practices know when an application was denied, but not always when it was delayed, or why.

The delays that result are widely reported. A November 2025 MGMA Stat poll found that roughly one-third of medical groups had a backlog in new-hire credentialing, payer recredentialing, or reappointments, most often due to delays in payer enrollment and verification.⁸ A 2025 industry survey found that 60% of executives said slow enrollment processes negatively impacted revenue, with provider groups feeling the strain the most.⁹ The opportunity cost is not abstract. The average annual net revenue generated across 19 specialties is approximately \$2.4 million,¹⁰ equivalent to roughly \$9,000 for each working day a provider is on the payroll but not yet billable.



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FEWER CLINICIANS, HEAVIER PER-CLINICIAN LOAD

Every practice faces the same requirements, but not every practice has the same capacity to meet them. Larger practices spend more total hours on these tasks, as expected given their greater clinician volume. Measured per clinician, the relationship inverts. A clinician or staff member in a practice with **fewer than five clinicians** devotes roughly **seven times** as many hours annually to **initial credentialing and enrollment** tasks as a counterpart in a **larger practice**, and about **two times** as many hours to **recredentialing**.

The reason is structural. Per-plan requirements do not scale down. A small practice faces the same applications, verifications, and recredentialing cycles often with fewer resources and economies of scale. MACPAC's June 2026 Report to Congress documents the same dynamic in Medicaid. It finds the burden of enrollment and credentialing most acute for clinicians in small practices and others who lack administrative support for the work, noting that lengthy processes impose financial hardship on those clinicians by delaying their ability to bill for care already delivered.²



LOOKING AHEAD

Credentialing and recredentialing serve patients by verifying the qualifications and information needed to access care and ensuring that information remains accurate. Enrollment serves a different purpose, enabling clinicians to be paid and supporting practice operations. All are necessary, but

the administrative work they require takes time away from patient care and adds to a cumulative regulatory and administrative burden that 77% of medical groups cite as a major contributor to physician burnout.¹¹

While verification is at the core of the credentialing and enrollment process, much of the reported effort is associated with the work surrounding it. This work often stems from varying plan requirements. Because they differ, each application must be researched separately before it can be completed, which accounts for more than half the time these tasks consume. Because information is assembled plan by plan rather than maintained in one place, it is often incomplete or missing when shared with a plan resulting in a delayed or denied application and practice rework.

In smaller practices, a limited number of staff members, often clinicians, absorb these responsibilities. The requirements do not diminish with practice size, but the resources available to manage them do, resulting in a higher burden per clinician. Meaningful relief does not require a redesign of the process; it requires reducing the administrative burden created by variation across plans.

- Standardize the information collected and define what constitutes a complete application, so preparation is straightforward rather than a research exercise.
- Verify information closer to its source and keep it current between events, allowing credentialing requests to draw from an accurate record rather than trigger a new collection cycle.
- Align the timing of credentialing, recredentialing, and directory verification, which often request the same data elements on different schedules.
- Establish consistent measures of completeness and accuracy so gaps can be identified and corrected before they result in a denied application.

Together, these changes would reduce duplication and ease the administrative burden on practices. This is a shared responsibility across health plans, clinicians, and practice staff, and the benefits are shared as well. Practices would see faster enrollment and fewer hours diverted from patient care. Plans would benefit from faster network onboarding and more reliable clinician data. Patients would have greater confidence in the information they use to find care and better access to clinicians when they need them.



METHODOLOGY

Responses were collected from over 50 clinical and administrative practice staff over three weeks in July - August 2026 via online surveys. Sample was drawn from MD/DOs who attested to their directory information within the prior six months. Delegated groups were not included in the sample. The majority of respondents identified their role as clinical, not administrative.

Endnotes

1. National Committee for Quality Assurance, Credentialing and Recredentialing (CR) standards, Health Plan Accreditation. [A Comprehensive Guide to NCQA Credentialing Programs - NCQA](#)
2. MACPAC, "Provider Enrollment and Credentialing in Medicaid," Chapter 7, June 2026 Report to Congress on Medicaid and CHIP. [Chapter 7 Provider Enrollment and Credentialing in Medicaid](#)
3. 42 C.F.R. § 424.515, Requirements for reporting changes and updates to, and the periodic revalidation of Medicare enrollment information. [ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-P/section-424.515. .eCFR :: 42 CFR Part 424 -- Conditions for Medicare Payment](#)
4. AMA solution cuts credentialing burdens for doctors, hospitals. [AMA solution cuts credentialing burdens for doctors, hospitals | American Medical Association](#)
5. DataSpring, Provider Credentialing Solutions. [Provider Credentialing Solutions | DataSpring](#)
6. Contracting and Credentialing with Health Plans. [Contracts and Credentialing with Health Plans - MN Dept. of Health](#)
7. DataSpring, powered by CAQH, [The DataSpring Index Report](#)
8. MGMA Stat, Confronting credentialing, reappointment crunch time in your medical practice, November 2025. [Confronting credentialing, reappointment crunch time in your medical practice](#)
9. 2025 State of Payer Enrollment and Credentialing Report. [The 2025 State of Payer Enrollment and Credentialing Report | Medallion](#)
10. 2019 Physician Inpatient/ Outpatient Revenue Survey, AMN Healthcare / Merritt Hawkins. [DocHdl10nPPMSVR01tmpTarget](#)
11. MGMA 2026 Regulatory Burden Report, [MGMA 2026 Reg Burden Report.pdf](#)