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The Hidden Cost of Provider Credentialing Delays

An Executive Framework for Understanding How Credentialing Influences Healthcare Performance

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A Note From the Author

Report No. 001 argued that credentialing is the first domino, not the whole system. This report is what happens when you actually chase that domino all the way down. I wanted to know, specifically, where a credentialing delay actually goes once it leaves the queue, and the honest answer surprised me even after twenty years of watching operations and risk up close: it touches ten distinct parts of a healthcare organization's performance, and eight of those ten are essentially invisible to the executives accountable for them.

The two that are visible, revenue and productivity, get fixed. The eight that are not, payer relationships, physician retention, competitive advantage, and eventually EBITDA and enterprise value itself, quietly compound in the background until a diligence team finds them for you. This report is the map of all ten, built so you can find them first.

— Marcus J. Frazier

Abstract

Provider credentialing is typically treated as an administrative prerequisite, a compliance step to clear before a clinician can see patients and generate revenue. This report argues that framing understates the problem. Drawing on data published by CAQH, the American Medical Association, the Association for Advancing Physician and Provider Recruitment, AMN Healthcare, NSI Nursing Solutions, and healthcare M&A market research, this report traces how credentialing delays propagate through ten distinct dimensions of organizational performance: revenue, provider productivity, patient access, payer relationships, operational efficiency, physician satisfaction, competitive advantage, organizational growth, EBITDA and margins, and enterprise value.

For a healthcare executive, credentialing is not a back office function to be minimized in a board discussion. It is a variable that touches nearly every line of the income statement, and increasingly, the multiple a buyer is willing to pay at exit. This report introduces the Koru Credentialing Impact Matrix, an executive framework for locating which of these ten dimensions represent visible, already managed risk, and which represent quiet, unmanaged exposure, and closes with the Koru Engagement Model for acting on that diagnosis.

Keywords: provider credentialing, healthcare operations, revenue cycle, EBITDA, enterprise value, physician recruitment, healthcare M&A, patient access

A Note on Sources and Methodology

As in Koru Research Institute's first report, this report distinguishes between two tiers of evidence. The first tier consists of primary data published by CAQH, the American Medical Association, AAPPR, and NSI Nursing Solutions, along with figures reported by AMN Healthcare's published physician access survey. The second tier consists of figures reported by revenue cycle, credentialing, and healthcare M&A advisory publishers. These industry sourced figures are directionally consistent with one another, but are not peer

reviewed, and are identified in the text as industry estimates where they appear. This report also draws on healthcare M&A and private equity transaction commentary to connect credentialing performance to enterprise value, a connection rarely made explicit in either the clinical or financial literature on this subject.

1. Executive Summary

- Credentialing delays cost individual healthcare organizations an estimated $6,000 to $10,000 per provider, per month, in unbillable revenue, an industry estimated range consistent with the findings of Koru Research Institute's first report.
- More than half of medical practices, 54 percent, report claims denials tied specifically to credentialing and enrollment errors, and payers deny approximately 12 percent of all claims nationally, rising to 17 percent in some regions (industry estimates).
- The average new patient physician appointment wait time reached 31 days in 2025, up 19 percent since 2022 and 48 percent since 2004 (AMN Healthcare, 2025 Survey of Physician Appointment Wait Times). A credentialing delay does not occur in isolation, it compounds a patient access crisis already underway.
- Physician vacancies now take a median of 93 to 135 days to fill depending on specialty (AAPPR, 2025 Physician and Provider Recruitment Benchmarking Report), and industry estimates place the cost of an unfilled vacancy at $150,000 to $250,000 per month, a cost that continues to accrue through the full length of the credentialing cycle that follows a successful hire.
- Healthcare M&A due diligence increasingly treats credentialing infrastructure as its own diligence category. Industry advisory sources report that weak credentialing documentation can move deal value into escrow, earnout, or indemnity provisions, directly affecting what a seller ultimately receives.
- Healthcare services EBITDA multiples have recently ranged from approximately 11.5x to 18.3x depending on buyer type and subsector, and buyers reliably discount targets whose earnings depend on inconsistent credentialing and enrollment execution.
- Organizations that treat credentialing speed as a strategic capability, not an administrative afterthought, convert faster hiring into a compounding competitive advantage, because recruitment delay and credentialing delay stack sequentially rather than resolving in parallel.

2. Introduction: The Executive's Blind Spot

Ask a hospital COO, a medical group CEO, or a private equity operating partner what keeps them up at night, and credentialing rarely makes the list. It is treated as a solved problem, delegated to a department, tracked at the staff level, and escalated only when a specific provider's start date slips. This report argues that this framing is the mistake, not the credentialing process itself.

Consider the healthcare executive as the protagonist of a familiar story: growth capital secured, providers recruited, a market opportunity in front of them, and a single administrative process standing between the plan on paper and the revenue in the bank. Credentialing delay is the obstacle in that story, and it rarely

announces itself as the villain. It hides inside ten different functions at once, revenue, productivity, access, payer relationships, efficiency, morale, competitiveness, growth, margin, and ultimately, valuation, which is precisely why it survives board meeting after board meeting without ever being named as the actual problem.

This report is Koru Research Institute's second, and it follows directly from the first, The Hidden Cost of Healthcare Operational Bottlenecks, which argued that credentialing is the first domino in a longer operational chain. This report goes deeper into that single domino, tracing its financial and strategic consequences across ten dimensions of organizational performance that a healthcare executive, rather than a credentialing specialist, is actually accountable for.

Consider a composite, but familiar, scenario. A behavioral health platform backed by a growth equity investor closes a recapitalization, with the thesis built on adding twelve new clinicians across three states within eighteen months. The clinical hires go well. The capital is deployed on schedule. And eighteen months later, at the board meeting where the investment thesis is supposed to be validated, the revenue is not there, the EBITDA margin has not expanded the way the model predicted, and no single person in the room can point to the exact reason why. The reason, when it is finally traced, is rarely dramatic. It is twelve credentialing files, each moving through its own payer specific timeline, each invisible to the model that assumed a hired provider was a producing provider from day one.

3. Revenue: The Direct Hit

The most immediate consequence of a credentialing delay is the most measurable: a fully hired, fully qualified provider who cannot legally bill for the services they are already capable of delivering. Industry revenue cycle analyses place this cost at approximately $6,000 to $10,000 per provider, per month, figures discussed at greater length, with fuller sourcing caveats, in Koru Research Institute's first report.

The revenue impact does not end once a provider is credentialed. Claims tied to credentialing and enrollment errors are a distinct and persistent category of denial. Industry sources report that 54 percent of medical practices experience claims denials specifically tied to credentialing and enrollment issues, layered on top of a national claims denial rate of approximately 12 percent, which climbs to 17 percent in some regions. A provider data mismatch as small as an incorrect NPI or a lapsed enrollment date can trigger denial of every claim tied to that provider until the discrepancy is resolved.

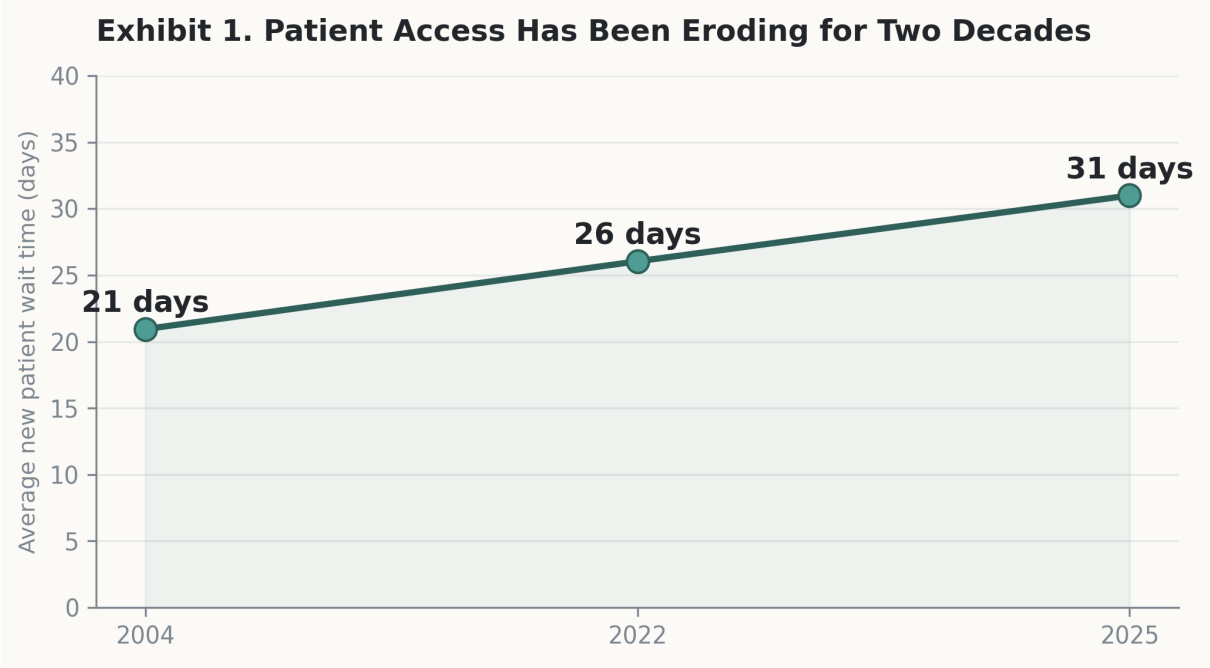
4. Provider Productivity: The Ramp That Never Finishes

Credentialing delay is frequently treated as a fixed, one time cost, a number of days multiplied by a daily revenue rate. In practice, it is the first stage of a longer productivity ramp. Industry analyses of physician recruitment place the average start up cost for a new physician, covering relocation, signing incentives, and onboarding support, at approximately $211,000, separate entirely from the revenue lost during credentialing itself, and it is not unusual for it to take up to two years for a newly hired physician to reach the productivity level of an established colleague.

Credentialing delay effectively extends the front end of that ramp without extending the back end, meaning organizations absorb the full cost of slow productivity growth while also losing the early revenue that would normally offset it. A provider hired to meet a specific demand signal, a new service line, a growing patient population, arrives at that opportunity months behind schedule, and the productivity curve begins from the same zero point regardless of how long the credentialing process took.

5. Patient Access: The Waiting Room Nobody Sees

Patient access is under sustained, well documented strain independent of any single organization's credentialing performance. AMN Healthcare's 2025 Survey of Physician Appointment Wait Times, covering 15 major metropolitan areas and six specialties, found that the average wait time for a new patient appointment reached 31 days, an increase of 19 percent since 2022 and 48 percent since 2004. The Association of American Medical Colleges projects a shortage of up to 86,000 physicians by 2036, and the Health Resources and Services Administration projects a current shortfall of more than 57,000 full time equivalent physicians, growing to over 81,000 by 2035.



Source: AMN Healthcare, 2025 Survey of Physician Appointment Wait Times. 2004 and 2022 values back calculated from the reported percentage increases to the 2025 figure.

Credentialing delay does not cause this shortage, but it compounds it in a specific, avoidable way. Every provider sitting in a credentialing queue rather than an exam room is a unit of physician capacity that already exists, has already been recruited, and has already been paid a signing commitment, sitting idle against a backdrop of a 31 day national average wait time. For an organization competing on patient access as a strategic differentiator, credentialing speed is not a back office metric. It is the mechanism by which recruited capacity actually reaches the patients who are waiting for it.

6. Payer Relationships: When the Network Says No

Credentialing and payer enrollment are frequently discussed as though they were a single process, but they carry distinct risks. A denied enrollment application, whether due to incomplete documentation, a closed panel, or a network adequacy determination, does not simply delay a provider, it can exclude them from a payer network for a full recredentialing cycle, typically two to three years. Common reasons for denial include incomplete documentation, failure to meet payer specific provider standards, and over saturation of a given specialty within a service area, according to healthcare enrollment advisory sources.

Even after enrollment succeeds, ongoing data accuracy determines whether that relationship functions. Industry analyses attribute 10 to 30 percent of first pass claim denials to provider data inaccuracies, mismatched NPIs, incorrect billing addresses, or misaligned specialty codes between an organization's records and a payer's enrollment database. Every payer relationship an organization holds is only as reliable as the credentialing data underneath it, a fact that becomes visible only when a claim is denied, well after the underlying error was made.

7. Operational Efficiency: The Administrative Undertow

The 2025 CAQH Index found that electronic transactions and improved data exchange helped the healthcare industry avoid an estimated $258 billion in administrative costs in 2024, with a further $21 billion in savings still available through fuller automation of manual and partially manual transactions, credentialing and enrollment among them. Administrative complexity, as documented in the peer reviewed literature, remains the single largest identified category of waste in the U.S. health care system.

Credentialing sits inside this administrative undertow rather than apart from it. Staff time spent chasing missing documentation, resubmitting denied applications, and manually reconciling provider data across systems is time not spent on the scheduling, prior authorization, and billing functions examined in Koru Research Institute's first report. An organization that treats credentialing as an isolated task, rather than one node in a connected administrative system, tends to understaff and under automate it precisely because its downstream costs are distributed across other departments' budgets rather than its own.

8. Physician Satisfaction: The Burnout Multiplier

Administrative burden is a well established driver of physician burnout. The most recent AMA Prior Authorization Physician Survey found that administrative work of this kind consumes an average of 13 hours of physician and staff time per week, and 94 percent of surveyed physicians say this category of work contributes to burnout. Credentialing, particularly recredentialing, periodic revalidation, and the repeated documentation demands that follow a provider through their career, sits within this same category of administrative burden, even though it is rarely named separately in physician satisfaction research.

The relationship runs in both directions. A recruitment source consulted for this report noted that when the hiring and onboarding process is administratively frustrating, providers reasonably infer that the organization's day to day operations will be frustrating as well, before they have seen a single patient. Credentialing delay is frequently a new physician's first substantive experience of an organization's

operational culture, and it shapes retention risk well before it shapes clinical performance.

9. Competitive Advantage: Speed as Strategy

Physician recruitment and credentialing delay do not occur independently, they stack. AAPPR's 2025 Physician and Provider Recruitment Benchmarking Report found a median time to fill of 93 days for primary care physicians and up to 135 days for specialists, with the organization's leadership noting that physician searches now average nearly four months to signing, and specialty searches can extend to a year or more. Industry recruitment analyses place the cost of an unfilled physician vacancy at $150,000 to $250,000 per month.

A 90 to 120 day credentialing cycle does not run concurrently with recruitment, it begins only once a candidate has signed, meaning the two delays are additive. An organization that recruits in 125 days and credentials in 90 days takes over seven months from opening a search to generating revenue from that hire. A recruitment industry publication put it directly: in a market where physicians and advanced practitioners often hold multiple competing offers, healthcare hiring timelines are no longer a back office metric, they are a defining competitive advantage. Credentialing speed is the second half of that advantage, and it is the half most organizations do not manage with the same urgency as the recruitment search itself.

10. Organizational Growth: The Ceiling You Can't See

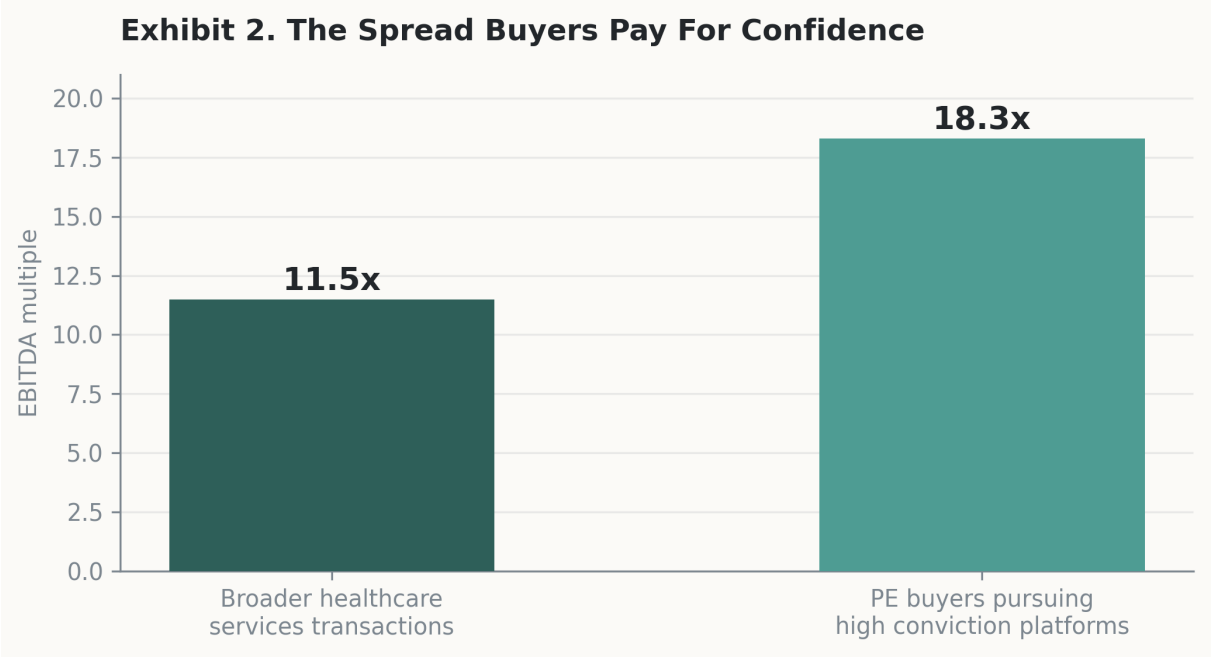
Growth capital, whether from a health system's own balance sheet, a private equity platform investment, or a philanthropic grant, is typically deployed against a specific assumption: additional providers will generate additional revenue on a predictable timeline. Credentialing delay breaks that assumption without breaking the underlying growth thesis, which is what makes it dangerous. The organization has not made a bad decision, it has simply failed to account for a 90 to 120 day gap between hiring and revenue that compounds across every provider added during a growth phase.

This compounding effect scales with ambition. An organization adding one provider absorbs one delayed revenue ramp. An organization adding five providers simultaneously, the exact scenario in which growth capital is typically deployed and investor expectations are highest, absorbs five parallel delays, each with its own documentation requirements, payer specific timelines, and points of failure. Organizational growth plans that model provider additions as instantaneous revenue events are, in practice, modeling a ceiling they cannot see until the capital has already been spent.

11. EBITDA and Margins: What Diligence Actually Finds

Healthcare services EBITDA multiples have recently ranged from approximately 11.5x in broader healthcare services transactions to a median of 18.3x for private equity buyers pursuing high conviction platforms, according to recent M&A market data. Underneath every multiple is a diligence process that increasingly treats credentialing as its own line of inquiry, separate from clinical quality and separate from financial statements. Advisory sources covering healthcare staffing and services transactions note that sponsors and lenders need confidence that EBITDA is real, repeatable, and sufficient to support debt and reinvestment, and that credentialing workflows, licensure files, and compliance documentation should be

prepared with the same discipline as financial statements.



Source: recent healthcare M&A market data on EBITDA multiples by buyer type and subsector, as cited in this report's references.

When that discipline is absent, the consequence is rarely a collapsed deal, it is a discounted one. Weak documentation, according to the same advisory sources, does not typically kill a transaction, but it moves value into escrow, earnout, indemnity, or tighter closing conditions, structures that shift risk back onto the seller rather than reducing the headline price outright. An organization's EBITDA can be entirely accurate and still be treated as less trustworthy by a buyer if the credentialing infrastructure underneath it cannot demonstrate that the earnings are repeatable at scale.

12. Enterprise Value: The Discount Nobody Names

Enterprise value is, in the simplest terms, a bet on an organization's ability to keep doing in the future what it has done in the past, at scale, without unusual risk. Credentialing infrastructure speaks directly to that bet. Buyers in healthcare staffing and services transactions reportedly view strong credentialing and compliance systems as both a risk control asset and an integration advantage, meaning well run credentialing does not just avoid a discount, it can be a source of value in its own right, particularly for platforms planning to execute multiple add on acquisitions.

The reverse is equally true, and rarely stated as plainly in a boardroom as it is in a diligence report. An organization with slow, inconsistent, or poorly documented credentialing is communicating, whether it intends to or not, that its revenue base is harder to verify, its scalability is harder to underwrite, and its integration risk is higher than a comparable organization with clean credentialing infrastructure. That gap shows up as a lower multiple, a larger escrow, or a longer earnout, a discount that is real, that is paid by the seller, and that is rarely traced back to its actual source: an administrative process most executives were told not to worry about.

For an investor evaluating a platform investment or an add on acquisition, credentialing infrastructure is a legible, checkable proxy for a harder to observe question: how disciplined is this organization's operating rhythm generally. A management team that treats credentialing as a strategic capability, with clean documentation, predictable timelines, and a system rather than a set of individual heroics, is signaling the same discipline an investor hopes to find in its revenue recognition, its coding practices, and its compliance posture more broadly. The inverse signal is just as reliable, and considerably more common.

13. The Ten Dimensions at a Glance

Table 1 below summarizes the ten dimensions examined in this report alongside the single most representative figure for each, intended as a quick reference for executives who need the whole picture in one place before deciding where to look more closely.

Dimension	Key Figure	Source
Revenue	$6,000 to $10,000 lost per provider, per month of delay	Industry estimate
Provider Productivity	Up to 2 years to reach full productivity; ~$211,000 average startup cost	Industry estimate
Patient Access	31 day average new patient wait time, up 19% since 2022	AMN Healthcare, 2025
Payer Relationships	54% of practices report credentialing related denials	Industry estimate
Operational Efficiency	$21B in still addressable administrative savings	CAQH Index, 2025
Physician Satisfaction	94% say administrative burden contributes to burnout	AMA Survey, 2024
Competitive Advantage	93 to 135 days median time to fill a physician vacancy	AAPPR, 2025
Organizational Growth	Delays compound across every provider added in a growth phase	Koru Research Institute analysis
EBITDA and Margins	11.5x to 18.3x EBITDA multiples; weak files move value to escrow	Healthcare M&A market data
Enterprise Value	Credentialing quality treated as a distinct diligence category	Healthcare M&A advisory sources

Table 1. The Ten Dimensions at a Glance

14. The Koru Credentialing Impact Matrix

Applying the Koru Bottleneck Matrix, introduced in Koru Research Institute's first report, specifically to credentialing produces a striking pattern. The dimensions with the highest financial severity, EBITDA, enterprise value, and payer relationship durability, are consistently the ones with the lowest organizational

visibility. They do not appear on a monthly dashboard. They appear in a diligence report, a renegotiated payer contract, or a physician's exit interview, months or years after the credentialing decision that caused them.

Severity vs. Visibility	Low Organizational Visibility	High Organizational Visibility
High Financial Severity	**Blind Spots** EBITDA and enterprise value impact, payer relationship erosion, and physician retention risk. Rarely discussed in board materials because they surface months or years after the credentialing decision that caused them.	**Known Fires** Direct revenue loss and delayed provider productivity. Visible immediately in monthly financials, which is exactly why these two dimensions dominate executive attention over the other eight.
Low Financial Severity	**Background Noise** Minor data entry inconsistencies and one off documentation errors. Worth monitoring, not worth resourcing ahead of the categories above.	**Distractions** Individual provider complaints about credentialing paperwork. Visible and irritating, but rarely the organization's most expensive credentialing problem.

Table 2. The Koru Credentialing Impact Matrix

Revenue and provider productivity, by contrast, sit in the known fires quadrant precisely because they are visible fast, a missed billing cycle shows up in next month's financials. That visibility is exactly why organizations already manage these two dimensions reasonably well, and why the remaining eight receive comparatively little executive attention despite carrying, in aggregate, greater financial exposure. An executive using this matrix should ask a specific question: which of these ten dimensions has my organization never actually measured, and is that absence of measurement a sign that the problem is small, or simply a sign that no one has looked.

15. The Koru Engagement Model, Applied to Credentialing

Koru Research Institute's first report introduced the Koru Engagement Model, a three stage methodology moving from diagnosis to execution to sustained performance. Applied specifically to credentialing, Insight™ means running the Credentialing Impact Matrix above against an organization's actual data, not an assumption, to determine which of the ten dimensions are genuinely blind spots. Execute™ means rebuilding the credentialing and enrollment function itself, primary source verification, CAQH maintenance, payer specific enrollment tracking, so that the known fires stop recurring. Optimize™ means instrumenting the blind spots, building the reporting that connects credentialing performance to payer relationship health, physician retention, and, ahead of any future transaction, EBITDA quality.

The sequence matters. Organizations that jump directly to Execute™, hiring a credentialing vendor without first running the diagnostic, tend to fix the known fires and leave the blind spots exactly where they were, which is the same failure pattern documented across both of Koru Research Institute's reports to date.

16. Limitations of This Report

This report synthesizes published data rather than presenting new primary research, and several of its figures originate from industry sources rather than peer reviewed literature, as disclosed in the methodology note above, most notably the per provider revenue loss estimates, the cost of vacancy figures, and the credentialing denial statistics. Where a figure could be corroborated by a primary source, such as AAPPR's recruitment benchmarking data, AMN Healthcare's published survey, or the CAQH Index, that source is cited directly.

The connection this report draws between credentialing performance and enterprise value is directional and qualitative, grounded in advisory commentary from healthcare M&A and private equity sources rather than a controlled study isolating credentialing as a variable in transaction pricing. Readers evaluating a specific transaction or a specific organization's numbers should treat the EBITDA and enterprise value sections as a framework for the right diligence questions to ask, not as a substitute for that diligence itself.

This report is, like its predecessor, authored by the founder of a healthcare operations firm, and the Koru Credentialing Impact Matrix and the Koru Engagement Model reflect that firm's own diagnostic and operating approach. Readers should evaluate the underlying data on its own terms, independent of the frameworks offered to interpret it.

Future research from Koru Research Institute will examine specific components of this analysis in greater depth, including a planned report quantifying the relationship between credentialing cycle time and payer contract renegotiation outcomes, and a comparative analysis of credentialing performance across organizations of different sizes and ownership structures.

17. Conclusion: The Executive's Real Question

Every healthcare executive already knows credentialing takes too long. Far fewer can say, with data, what that delay actually costs their organization across all ten dimensions examined in this report, not just the revenue line that shows up first. That gap between knowing credentialing is slow and knowing what slow credentialing actually costs is itself the finding of this report.

The organizations that outperform are not the ones with zero credentialing delay, an unrealistic standard given payer timelines outside any single organization's control. They are the ones that have measured their own exposure honestly across revenue, productivity, access, payer relationships, efficiency, satisfaction, competitiveness, growth, margin, and value, and have stopped treating credentialing as a department's problem to solve quietly in the background. It is an executive question, and it deserves an executive's attention.

Return to the behavioral health platform introduced in Section 2, the twelve clinicians, the eighteen month growth thesis, the board meeting where nobody could explain the gap. The difference between that outcome and a successful one was never the quality of the clinical hires or the size of the capital deployed. It was whether someone, before the capital went out the door, had already mapped how twelve separate

credentialing timelines would actually move through ten different parts of the business. That is the work this report is meant to make visible, and it is the work the Koru Engagement Model is built to carry out.

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Koru Health works with medical groups, behavioral health organizations, urgent care networks, Federally Qualified Health Centers, and private equity portfolio companies to diagnose and rebuild the operational systems that determine whether healthcare organizations can scale.

Koru Research Institute is the research and publishing arm of Koru Health, based in New York, NY. Its mission is to bring rigorously sourced, transparently cited analysis to questions that healthcare executives are otherwise left to answer with vendor marketing or internal anecdote. This is the second report in an ongoing series.

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