Navigating the Complexities of Clinical Data Exchange: A Survey-Based Analysis by MRO

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Introduction

Earlier this year, MRO and CHIME surveyed more than 180 leaders at health systems to better understand the challenges of bidirectional exchange of clinical data with payers across seven common use cases: prior authorization, risk adjustment, care management, quality reporting and submission, claims adjudication, claims appeals, and payment integrity audits. Respondents were polled on both technical and operational challenges of sharing information with their payer partners.

Regardless of role, respondents generally agreed on many matters, however two use cases — prior authorization and risk adjustment — proved to be a bit of an anomaly on numerous fronts. This suggests that health systems and their vendor partners will want to pay particular attention to these use cases as they modernize clinical data exchange workflows between payers and providers.

This report summarizes the findings of the survey. It pays particular attention to the matters of who's responsible for managing payer data requests, the extent to which EHR access is granted to payers, and whether health systems are amenable to using third-party solutions to automate clinical data exchange. The report also notes other findings of interest, such as the adoption of Fast Healthcare Interoperability Resources (FHIR) application programming interfaces (APIs) to fulfill payer data requests and the differing approaches to data exchange among Epic and non-Epic users.

Survey Methodology and Respondent Profile
• 181 qualified respondents surveyed March 21 to April 30, 2024 • 60% in a healthcare corporate office, 40% in a direct care setting • 79% of respondents in IT and health information management (HIM) • 21% in finance and revenue cycle management (RCM) • 69% in mid-management roles, 31% in executive roles

Key Takeaways

- Both IT and business operations leaders claim responsibility for managing clinical data exchange with payers for prior authorization and risk adjustment. This lack of clear accountability within organizations may make it difficult to optimize processes.
- Nearly 61% of organizations rely on third-party solutions to automate at least one of the seven types of clinical data exchange with payers. That said, a similar percentage use their EHR systems exclusively for this purpose.
- There are discrepancies in how users of Epic's EHR fulfill payer data requests. They are less likely to use it for risk adjustment and more likely to find it challenging to address prior authorization requests.
- More than 65% of respondents grant payers access to the EHR for at least one clinical data exchange use case. Risk adjustment is the least commonly accessed use case.
- Prior authorization data requests are the most difficult to fulfill for two subgroups of respondents: Epic users and organizations that have not substantially adopted FHIR (<50% of exchange requests filled by automated FHIR/API solution).

Who's Responsible for Data Exchange

Determining ownership is critical for any business process, and clinical data exchange is no exception. Setting priorities, establishing best practices, and selecting technology tools becomes more complicated and disagreements rise when multiple decision makers are involved.

IT and HIM ownership	Finance and RCM ownership	Disagreement about ownership
Care management Quality submissions	Claims adjudication Claims appeal Payment integrity audit	Prior authorization Risk adjustment

In our findings, there was clarity about five of the seven core clinical data exchange use cases. For two use cases, though, respondents disagreed.

- **Prior authorization.** While 69% of finance and RCM leaders believed prior authorization was their responsibility, 63% of leaders in IT or health information management (HIM) said it was their responsibility.
- **Risk adjustment.** Similarly, 75% of finance and RCM leaders deemed risk adjustment to be their responsibility, and 63% of IT and HIM leaders said it was theirs.

Risk adjustment generated another data point suggesting that this use case is an anomaly in clinical data exchange. At nearly 17%, risk adjustments led all use cases in the percentage of respondents who either didn't know who was responsible or said it was someone outside the functional areas of IT, HIM, finance, or RCM. This compares to less than 8% for prior authorization, which had the lowest percentage of "Other" or "None of the above" responses.

Allowing Payers Access to EHR Systems

Overall, more than 65% of respondents grant access for at least one of the seven use cases. This indicates it's a common — if not yet widespread — practice.

That said, there's discrepancy among organizations for which use cases they are likely to grant access. Prior authorization and claims appeal use cases ranked highest for allowing payer access to EHRs, at 43% (this isn't surprising, given how both are linked to reimbursement). On the other hand, only 28% allow authorized payers' access for risk adjustment.

Discrepancies appeared in two other circumstances. One was among users of specific EHR systems. Users of Epic – the EHR of choice for nearly 32% of the organizations surveyed – were less likely to allow authorized access for claims appeals, care management, or risk adjustment. However, among organizations that weren't yet allowing authorized access but were willing to consider it, Epic users were more than three times as likely to consider risk adjustment, at 23%, compared to just 7% for non-Epic users.

The other was functional area. Generally, IT and HIM leaders were a bit more willing to allow authorized access than finance and RCM leaders, at 39% to 34% respectively. Their willingness to consider was roughly equal, at 17% and 18% respectively. Two use cases served as the main differentiator.

- **Risk adjustment.** Nearly 31% of IT and HIM leaders allowed authorized access for this use case, compared to just 18% for finance and RCM.
- **Payment integrity audits.** About 38% of IT and HIM leaders allowed authorized access here, compared to about 24% for finance and RCM.

The risk adjustment example highlights the challenges discussed in the previous section about

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determining responsibility for use cases. If multiple functional areas believe risk adjustment is their responsibility, and they disagree about whether authorized payers should be allowed access to the EHR, then two key issues may arise. One, it becomes difficult for organizations to move forward with a clear strategy to grant access or not; and two, this could lead to downstream implications that impact other departments within the organization, such as revenue cycle, compliance, or security.

Why / Why Not Allow Payers Access to EHR

Our survey polled respondents on five common factors that tend to impact decisions to allow (or not allow) authorized payers to access an EHR: cost, volume of requests, efficiency, privacy, and technical requirements. Factors were rated on a 1 to 5 scale, with 1 indicating “No Impact at All” and 5 being “Highly Impacted.”

Each of the five factors fell into the category of Somewhat Impacted, ranging from 3.02 for the cost to facility to 3.42 for privacy. Dividing responses into two buckets — the 65% of organizations that allow access for at least one use case, and the 35% of organizations that don’t allow access — offered differing perspectives.

Not allowing access. Privacy and technical requirements seem to be the two impact factors influencing the decision of organizations to not allow authorized access for payers. For these organizations, the impact factor for privacy was 3.87 compared to 3.28 for organizations allowing access, a difference of 0.59. For technical requirements needed to support a solution authorizing access, the impact factor was 3.52 for organizations not allowing access, compared to 3.25 for those allowing access.

Allowing access. Organizations allowing payers authorized access to the EHR said efficiency was an impact factor of 3.34, compared to 3.17 for organizations not allowing access. This indicates improving efficiency (and correspondingly reducing administrative burden) seems to be an important motivation for allowing authorized payers access to the EHR.

Use of Third-Party Solutions

Though less than 40% of survey respondents rely exclusively on third-party automation solutions to support clinical data exchange with payers, about 61% rely on a third-party solution for at least one of the seven data exchange use cases.

As with the question of EHR access, we polled survey respondents about the factors influencing their use of third-party automation solutions on a 1 to 5 scale, with 1 indicating “No Impact at All” and 5 being “Highly Impacted.” In this case, we asked about nine factors. Four factors were similar to the question of allowing payers EHR access — cost, volume of requests, privacy, and technical requirements. Five factors were unique to the use of third-party solutions — ability to use a solution for multiple purposes, availability of technical support, payer requirements for data sharing, regulatory mandates, and mergers and acquisitions by the provider organization.

Each of the nine factors fell into the category of Somewhat Impacted, ranging from 3.02 for cost to 3.42 for privacy and payer requirements. Again, dividing respondents into the buckets of users and non-users of third-party solutions offered differing perspectives.

Organizations **not using a third-party solution** for payer data exchange, and therefore exclusively using their EHR system, cited payer requirements and privacy concerns as the factors that most impacted their decision. This is generally consistent with the reasoning of organizations that have chosen not to allow authorized payers to access their EHR systems.

Meanwhile, organizations **using third-party solutions** said technical requirements and availability of IT support were the most important factors. This seems to indicate these organizations not only trust external partners to manage this important workflow but also benefit from the support available from their third-party solution provider.

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Other Key Findings

Survey responses offered additional insights in three key areas.

Use of FHIR APIs. About half of provider organizations use FHIR APIs to fulfill between 50% and 90% of payer data requests, and about 10% of provider organizations use FHIR APIs for more than 90% of payer data requests. The percentages are roughly similar for Epic users compared to users of other EHR systems.

Most challenging data requests. When rating the challenge of data exchange use cases on a scale from 1 to 5, care management (2.92) ranked as the least challenging and claims appeals (3.29) ranked as the most challenging. When regarding these challenges in the context of FHIR API utilization, organizations using FHIR APIs for less than half of data exchange requests found prior authorization and claims submission more challenging than their peers using FHIR APIs more frequently.

Other differentiators for Epic users. Organizations using Epic were more likely to deem prior authorization use cases to be challenging than non-Epic users. Epic users were more likely to use their EHR exclusively to fulfill care management and quality submissions requests, while non-Epic users were more likely to rely on their EHR to fulfill risk adjustment requests. Finally, claims adjudication and risk adjustment were the most likely data exchange use cases for a third-party solution among Epic users.

Conclusion

For many data points, the results of MRO's survey of health system IT and business leaders on the challenges of clinical data exchange with payers further confirmed existing suspicions.

- Organizations that don't allow payers authorized access to their EHRs, as well as organizations that don't work with third-party automation solutions, largely do so out of concerns for data privacy.
- Organizations using Epic tend to have different needs than peers using other EHR systems. However, these differences are nuanced and largely relate to individual use cases rather than a strategic approach to clinical data exchange.
- Data exchange use cases that fall squarely into financial and revenue cycle management are understood to be "owned" by business operations, while use cases that are more clinical in nature are understood to be the responsibility of IT teams.

The most interesting findings from our survey center on the use cases of prior authorization and risk adjustment. Here, the challenges begin at a strategic level, as both IT and business operations seem to think they "own" responsibility for fulfilling these requests. Even more troubling is the notion that one in six organizations aren't sure who's responsible for risk adjustment data exchange.

The issues trickle down to a tactical level in a few ways:

- IT and HIM leaders are more likely to allow authorized access to EHR systems for risk adjustment than finance and RCM. This can make it difficult to standardize workflows and monitor possible positive or negative outcomes that may follow.
- Organizations are less likely to allow authorized EHR access for risk adjustment data exchange. This can potentially make the process less efficient.
- Prior authorization is more challenging for organizations not using FHIR APIs to fulfill most of their data exchange requests. It's also more challenging for organizations using Epic. Regardless of the challenge's source, the result can cause delays in approvals that impact patient care as well as revenue.

Clinical data exchange with payers is increasingly critical for hospitals and health systems to improve financial outcomes and reduce administrative costs. Provider organizations face several struggles in getting data exchange with payers right; the results of this survey show the combination of internal resources and EHR systems, though valuable, may be insufficient to fully meet their current and future needs. Third-party partners with purpose-built, automated workflows are well positioned to help provider organizations overcome the most common obstacles to efficient and effective clinical data exchange.

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