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FHIR and its transformative potential for payers: A new era in data exchange

In today's healthcare landscape, data is the lifeblood of decision-making. Yet, the challenge remains: How can payers and providers collaborate in real time to make better decisions that benefit everyone, including providers, payers and patients? Despite decades of technological advances, the friction in sharing data continues to undermine efficiency, inflate costs and diminish care outcomes.

Enter FHIR® (Fast Healthcare Interoperability Resources)—a transformative, open communication standard that holds immense promise for payers, advancing collaboration with providers and positioning them for success in the evolving value-based care era.

A rocky start with FHIR

Payers may still have reservations about FHIR, given the initial reception to the first interoperability mandates, such as the Patient Access API, which saw limited adoption and few tangible benefits. Many are understandably skeptical about the upcoming mandate which will require payers to provide APIs for providers' systems to integrate for prior authorizations and give in-network providers easier access to member data. However, payers that adopt a forward-looking, clear-eyed approach to FHIR will find themselves at an advantage, driving innovation while others are stalled by skepticism.

Rather than getting bogged down in the technical intricacies of FHIR, let's focus on its high-level business implications, particularly its potential to improve payer-provider collaboration and drive operational improvements.

The current landscape: X12 and its limitations

To appreciate the potential of FHIR, we must first understand the current data exchange standards between payers and providers, primarily X12 Electronic Data Interchange (EDI). For the last 20 years, X12 has been the workhorse supporting core operations like eligibility verification, claim submissions and prior authorization. It's an established system with widespread adoption, processing billions of transactions annually. Cognizant, for example, handles 4.4 billion such transactions per year, and the CAQH (The Council for Affordable Quality Healthcare®) Index estimates that X12's integration and automation have saved the industry $187 billion annually in administrative costs.[1]

However, X12 is rooted in an outdated insurance paradigm. While it has been effective for transactional exchanges, it's ill-equipped to handle the complexity of today's care coordination, contracts and reimbursement models. Value-based care, risk adjustment, the determination of medical necessity and real-time decision-making demand more dynamic data exchanges. In recent years, workarounds for X12's limitations, such as fax machines, portal uploads and manual file exchanges, have been mired in inefficiency. Archaic and low-end approaches need to be replaced with enterprise-grade processes and practices.

Quick-fix provider tech vendor platforms may alleviate some of today's pain, but they come with significant downsides: They shift the burden to the payer, lack openness to all EHR products, have proprietary limitations, and often fall short on compliance while introducing hidden costs and complexities.

The promise of FHIR: Real-time bi-directional data exchange

This is where FHIR steps in, not as a replacement for X12, but as a complementary solution that addresses the shortcomings of existing data exchange protocols. Unlike X12, which is primarily a one-way transactional model, FHIR facilitates real-time, bidirectional data exchange, supporting more complex workflows and a richer set of clinical data.

One key capability enabled by FHIR is prior authorization. Under the Da Vinci Project—a collaborative initiative advancing healthcare interoperability—FHIR introduces streamlined processes like Coverage Requirements Discovery (CRD) and Documentation Templates and Rules (DTR), which allow providers to check and submit authorizations in near real time. This alone can drastically reduce the estimated twelve hours per week that physicians and their staff spend working on prior authorization requests.[2]

Another area where FHIR shines is care coordination. Approximately one-third of US patients experience care gaps due to inefficient data sharing between payers and providers. FHIR enables the seamless exchange of clinical data, allowing providers to access accurate, up-to-date patient information at the point of care. This reduces the likelihood of missed preventive screenings or duplicated tests, improving outcomes and reducing costs for both parties.

FHIR in action: A real-world example

Consider the issue of quality measures. Providers often struggle with compliance in part due to misunderstandings of the specific criteria set by different insurers. FHIR can automate the exchange of data needed for quality measurement, making it easier for providers to meet these targets while reducing the administrative burden on both sides.

Furthermore, up to 30% of conditions that could affect risk adjustment scores are underdocumented by providers, leading to inaccuracies in reimbursement.[3] By using FHIR to integrate payer and provider systems, real-time clinical data can ensure more accurate risk assessments, better documentation and more appropriate reimbursements.

Why payers should choose open, standards-based solutions for provider data exchange

For too long, providers have been forced to make decisions based on incomplete information, leading to inefficiencies and poor outcomes. FHIR offers a new model—an integrated, automated, real-time data exchange that ensures providers have the information they need to make optimal decisions at the "moments that matter," those critical decision points in the care continuum.

Transitioning to proprietary, closed EHR platforms may alleviate some immediate challenges, but this is only a stopgap measure. These platforms shift the burden to the payer, lock providers into proprietary solutions and fail to advance industry-wide compliance. The return on investment for open, standards-based, FHIR-agnostic solutions is clear. As providers and payers increasingly need operating efficiency in value-based care models, the ability to exchange data seamlessly and in near real time will become a competitive advantage. Those who embrace FHIR will see lower administrative costs, improved compliance and better patient outcomes, while those who delay, risk falling behind.

Embrace the future of interoperability

FHIR represents not just the next iteration of data exchange, but the future of healthcare interoperability. By enabling real-time, bidirectional data flows, it bridges the gaps between payers and providers, reduces inefficiencies and empowers both parties to make smarter, more informed decisions.

The road to broad FHIR adoption won't be short, but for payers willing to see beyond the immediate challenges, the rewards will be immense. As we move from fragmented data exchanges to a more integrated, real-time model, those who lead the charge with FHIR will be at the forefront of a healthcare revolution.

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[1] 2022 CAQH Index: A Report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings., CAQH, 2022.
[2] 2021 AMA Prior Authorization Physician Survey. American Medical Association, 2021.
[3] "Risk Adjustment Documentation and Diagnosis Coding." AAPC, January 29, 2024.

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World Headquarters
300 Frank W. Burr Blvd.
Suite 36, 6th Floor
Teaneck, NJ 07666 USA
Phone: +1 201 801 0233
Fax: +1 201 801 0243
Toll Free: +1 888 937 3277

European Headquarters
280 Bishopsgate
London
EC2M 4RB
England
Tel: +44 (01) 020 7297 7600

India Operations Headquarters
5/535, Okkiam Thoraipakkam,
Old Mahabalipuram Road,
Chennai 600 096 India
Tel: 1-800-208-6999
Fax: +91 (01) 44 4209 6060

APAC Headquarters
1 Fusionopolis Link,
Level 5 NEXUS@One-North,
North Tower, Singapore 138542
Phone: + 65 6812 4000

WF3131452