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2016

# Assessing Payer Perspectives on Health Information Exchange

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## Citation Details

Cross, D. A., Lin, S. C., & Adler-Milstein, J. (2016). Assessing payer perspectives on health information exchange. *Journal of the American Medical Informatics Association*, 23(2), 297-303.

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# Assessing payer perspectives on health information exchange

RECEIVED 6 April 2015  
 REVISED 12 May 2015  
 ACCEPTED 17 May 2015  
 PUBLISHED ONLINE FIRST 3 July 2015

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OXFORD  
 UNIVERSITY PRESS

## ABSTRACT

**Objective** To identify factors that impede payer engagement in a health information exchange (HIE), along with organizational and policy strategies that might effectively address the impediments.

**Materials and Methods** Qualitative analysis of semi-structured interviews with leaders from 17 varied payer organizations from across the country (e.g., large, national payers; state Blues plans; local Medicaid managed care plans).

**Results** We found a large gap between payers' vision of what optimal HIE should be and the current approach to HIE in the United States. Notably, payers sought to be active participants in HIE efforts – both providing claims data and accessing clinical data to support payer HIE use cases. Instead, payers were often asked by HIE efforts only to provide financial support without the option to participate in data exchange, or, when given the option, their data needs were secondary to those of providers.

**Discussion** Efforts to engage payers in pursuit of more robust and sustainable HIE need to better align their value proposition with payer HIE use cases. This will require addressing provider concerns about payer access to clinical data. Policymakers should focus on creating the conditions for broader payer engagement by removing common obstacles, such as low provider engagement in HIE.

**Conclusion** Despite variation in the extent to which payers engaged with current HIE efforts, there was agreement on the vision of optimal HIE and the facilitators of greater payer engagement. Specific actions by those leading HIE efforts, complemented by policy efforts nationally, could greatly increase payer engagement and enhance HIE sustainability.

**Keywords:** health information, exchange, payers, sustainability

## INTRODUCTION

A core goal of the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act is to foster the development of broad-based electronic health information exchange (HIE) across key healthcare stakeholders.<sup>1,2</sup> HIE is a priority within HITECH because of a strong consensus among policymakers that the ability to send and receive clinical data electronically between healthcare stakeholders is central to avoiding medical errors, reducing waste, and improving population health.<sup>3,4</sup> Yet, despite significant national and state-level investment in HIE under HITECH,<sup>5</sup> in addition to investment at local levels over the past decade,<sup>6</sup> HIE is still not widespread.<sup>7,8</sup>

A persistent challenge facing HIE efforts is identifying a sustainable business model.<sup>6,9,10</sup> The challenge stems from a perceived misalignment between those who bear most of the cost for enabling HIE to occur and those who benefit from HIE.<sup>11</sup> As key sources of clinical data, healthcare providers are essential participants in any HIE effort. Direct benefits from HIE accrue to providers, such as reduced time and expense to exchange diagnostic test results, and based on these benefits, providers have been asked to shoulder much of the cost for establishing and participating in HIE efforts.

However, much larger benefits are expected to come from reducing redundant or avoidable utilization enabled by providers having better access to more complete patient information.<sup>3</sup> These benefits would accrue to patients (in the form of better care) and to payers (in the form of lower costs).<sup>12,13</sup> The benefits would accrue to patients and payers from information exchange among providers, *without any need for patient or payer direct involvement in such an exchange.*

We would, therefore, expect payers to actively support HIE efforts, and be willing to pay to promote their formation and ongoing operation. This has not proven true. HIE efforts have struggled to engage payers, and only 40% of HIE efforts in the country have one or more payers providing financial support.<sup>6</sup>

Without greater payer engagement, it will be difficult for HIE efforts to achieve viable business models for long-run sustainability.<sup>14</sup> This has raised questions about what may be holding payers back, and the list of potential factors is long. For example, payers may not be convinced that increased levels of HIE can lead to real healthcare cost savings because busy providers have little incentive to incorporate newly available information into their workflow and decision-making. Alternatively, payers may believe in the benefits from HIE but struggle with which specific HIE efforts to support because multiple HIE efforts may operate in the markets where a given payer has covered lives. Understanding which factors are most salient, and what we might do about them, is critically important to promote payer engagement.

## OBJECTIVE

To date, there has been no systematic effort to collect national data that captures payer perspectives on HIE. We, therefore, interviewed leaders from 17 diverse payer organizations across the country to answer the following research questions: (1) how do payers conceptualize the optimal approach to HIE and how does the current approach to HIE adhere to, or diverge from, the optimal approach; (2) what factors determine whether or not payers choose to support existing HIE efforts; and (3) what actions could be taken by policymakers and those

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leading HIE efforts to foster greater payer support? We also sought to understand how payer perspectives on HIE are influenced by key payer characteristics. Our findings serve to inform and guide evolving organizational and policy strategies to ensure sustainable approaches to fostering HIE.

## METHODS

### Interviews and Protocol

We created a sampling frame of payer organizations by contacting the 48 HIE efforts that reported on our recent national survey<sup>6</sup> that they receive financial support from one or more payers. We asked these HIE efforts to identify which specific payers were providing support as well as which specific payers had been approached but chose not to provide support or were undecided. We also asked the HIE effort to provide a contact at the payer organization who could best speak to HIE decision-making. This resulted in a list of 67 payers and a contact person for each payer. In order to include a diverse group of payers in our interviews, we stratified the sampling frame based on the key payer characteristics that we hypothesized would shape HIE participation decisions: scope of geographic coverage (local, state/regional, and national) and type of payer (private, for-profit; private, not-for-profit, Medicaid managed care, and public). We then selected 17 payer organizations, with at least one from each category (except the smallest category with only two payers identified) in order to ensure coverage across the categories (Table 1, top panel). We oversampled national, for-profit payers because of their potential to influence federal policy.

We sent an invitation email, along with our interview protocol (described below), to the contact at each selected payer organization. We then followed-up via email or phone to schedule a 60-min phone interview, with the contact or a different person at the payer organization identified by the contact as in the best position to respond to our questions. We interviewed senior executives who were actively involved with and knowledgeable about their organization's HIE strategy and decision making. For private-sector respondents, position titles included: Chief medical officer or medical director ( $n=5$ ); Chief

technology officer, senior vice president of health IT or strategic IT consultant ( $n=4$ ); Executive/senior director-other ( $n=3$ ); and Vice president-other ( $n=2$ ). Respondents for public payers included state Medicaid directors and state employee benefit plan directors. Interviews took place between July and October 2014.

We developed a semi-structured interview protocol that asked broad, open-ended questions, with specific prompts, to elicit detailed description of the payer's perspective on HIE (Online Supplement). Questions fell into four broad categories. First, we asked about optimal HIE and the extent to which the payer's experience with current approaches to HIE adhered to that ideal. Second, we asked each payer to describe their current level of engagement with HIE efforts, the decision-making process, and the factors motivating their decision to support or not support specific HIE efforts. This included a discussion of the expected benefits of HIE that accrue to payers. Third, we asked for their assessment of current federal and state policy efforts to foster HIE. We probed on specific facilitators and barriers related to current policies, market dynamics, new models of care delivery (e.g., accountable care organizations [ACOs]), evidence for HIE impact, and varied approaches to HIE (e.g., health information organizations, the Direct protocol). Finally, we asked about viable approaches for HIE efforts and policy strategies to engage payers going forward. Prior to finalizing the interview guide, we obtained feedback from four national HIE experts to ensure that the questions were comprehensive and clear.

### Analysis

All interviews were recorded and transcribed. To facilitate analysis of transcript content, we first created a comparative data table. We identified the key topics covered in the interview guide (which became columns in the table), and then summarized each payer's response to the given topic (with one row per payer). Separate from the comparative data table, transcript content was coded and analyzed using Atlas.ti, a qualitative software tool. The project team developed an initial codebook based on the key topics contained in the interview guide. All three

Table 1: Characteristics of Selected Interview Sample

Selected sample/sampling frame <sup>a</sup>		Geographic Coverage			Total
		National	State/Regional	Local	
Profit Status	Public	—/—	3/6	—/—	3/6
	Medicaid Managed Care	1/11	2/6	1/10	4/27
	Private, For-Profit	5/5	-/2	—/—	5/7
	Private, Not-For-Profit	—/—	4/19	1/8	5/27
	Total	6/16	9/33	2/18	17/67
Participation in HIE efforts/ selected sample <sup>b</sup>		National	State/Regional	Local	Total
Profit Status	Public	—/—	2/3	—/—	2/3
	Medicaid Managed Care	1/1	2/2	1/1	4/4
	Private, For-Profit	2/5	—/—	—/—	2/5
	Private, Not-For-Profit	—/—	3/4	1/1	4/5
Total		3/6	7/9	2/2	12/17

<sup>a</sup> $N=17$  payer organizations selected to participate in interviews from sampling frame of 67 payer organizations with prior contact with one or more HIE efforts.

<sup>b</sup> $N=12$  payer organizations participating in an HIE effort (exchanging data and providing financial support) from 17 payer organizations selected for interview sample.

investigators independently coded the first four interview transcripts, then jointly reviewed and reconciled to ensure consistent application of the codes and identify missing codes. We then revised the codebook, and the final codebook was applied to the remaining transcripts.

The comparative data table and the Atlas.ti database enabled us to pursue complementary analytic approaches to identify key themes. The former enabled us to assess a particular topic within the context of a given interview, while the latter enabled us to identify all instances of a particular code (or combination of codes) across interviews. For each research question, we identified the relevant topic headings from the data table as well as the relevant codes (or groupings of codes). We then extracted and reviewed the subset of data from the data table, and the Atlas.ti query results. This served to identify the key themes, as well as areas of concordance and discordance, that comprise our findings.

## RESULTS

### Overall Value of HIE

All payers acknowledged the need for HIE to address information fragmentation in the healthcare system in order to improve quality and reduce cost. Stated most directly by a state-level, commercial payer respondent: “HIE is the foundation on which we can start making meaningful changes in the healthcare system. [...] We have a long way to go, and, without HIE, it will be hard to change the system.” In addition, payers felt that HIE had recently become a higher priority among both payers and providers due to healthcare reform efforts that focus on population health. For example, ACOs have increased the extent to which providers are seeking information about care that their patients receive outside ACO providers, and payers are seeking to help them by providing them better access to claims data and clinical data when possible.

### Optimal HIE, and the Gap between Optimal HIE and Reality

From the payer perspective, the key obstacle impeding broad payer engagement stems from *how* our country has approached HIE. Payers shared five common principles for what constitutes optimal HIE (Table 2). For each principle, payers felt that HIE has developed in ways that fail to adhere to it.

The first principle is that there should be a single network, or ability to access data through a single connection to a network-of-networks. HIE has instead developed in an ad hoc manner, primarily at the community and state/regional levels. As a result, payers are asked to support multiple HIE efforts. This is particularly true for national and state/regional payers that operate in many different markets; payers with large geographic coverage areas reported receiving a large number of uncoordinated individual participation requests from different HIE efforts. Engaging with multiple external HIE efforts is costly and complex, from both a decision-making and an implementation perspective.

Second, payers should have broad access to clinical data and the ability to contribute their administrative data, within a robust privacy and security framework. Payers felt that clinical and administrative data were complementary and created a complete picture necessary for key HIE use cases from which they derive direct benefit, such as identification of care gaps, performance measurement, and population analytics. Specifically, payers felt that clinical data is rich but narrow, because it is organized around specific encounters while claims data captures the entire episode of care but in limited detail. However, payers felt that HIE has developed in a provider-centric way in which clinical data and provider use cases take precedent over claims data and payer use cases. As a result, payers are often asked to contribute

financially to HIE efforts, but are excluded from exchanging data. Some payers attributed this deprioritization of payer participation to providers’ historical distrust of payers, driven by the fear that data could be used against provider and patient interests (e.g., premiums, screening, and profiling). By excluding payers from exchanging data, payers felt that HIE efforts miss opportunities to gain more complete data, and prevent payers from directly and tangibly benefiting from data exchange.

Third, data should not be treated as a competitive commodity that, when hoarded by either payers or providers, confers advantage. Many payers described the need to approach HIE in a way that “levels the playing field” by encouraging broad participation and sharing of data, and having organizations compete based on how they use data to offer better products and services. However, their experience was that providers and other payers had a data hoarding mentality that limited the breadth of data they were willing to share.

Fourth, payers should contribute to supporting HIE in proportion to the value that they derive. Payers felt that there is an expectation that they should be supporting HIE efforts, even without a clear statement of the value that would be derived from doing so. While there were different perspectives on whether or not that value would need to directly and immediately accrue to the payer, none of the payers felt that they were being offered a clear value proposition in return for their support. As one national payer respondent explained, “Writing the check and just hoping we get savings back, but not being able to prove it, doesn’t work for insurance companies.”

Fifth and finally, payers felt that the value proposition for HIE should be framed around the triple aim of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care. Partly as a result of data hoarding behaviors, many HIE efforts were unable to achieve broad-based, comprehensive sharing of data, and, therefore, approached payers with a narrow value proposition framed around one particular outcome (e.g., reducing diagnostic testing).

### Engagement with HIE Efforts

Despite agreement on the suboptimal state of HIE, there was considerable variation in the decisions that payers ultimately made with respect to supporting HIE efforts, and the perceived value that such engagement generated. Some payers were highly engaged and felt that HIE efforts generated sufficient value for themselves or their covered lives to justify the cost of engagement. Other payers chose not to engage because they felt that current approaches to HIE did not generate value or were not sustainable. These perspectives translated into varied patterns of HIE engagement. Of the 17 payers, 14 payers reported engaging with an HIE effort, either through providing funding, playing a leadership role or participating in data exchange (i.e., sending and/or receiving data). Nine payers were involved in founding HIE efforts, by providing start-up funding and/or leadership. Twelve payers reported that they were currently financially supporting one or more HIE efforts, and the same twelve payers reported exchanging data through an HIE effort, either by receiving data, contributing data, or both. These 12 payers were distributed across all the categories in which we sampled (Table 1, bottom panel). National, for-profit payers were, however, the least likely to be in this group.

Factors that impacted payer assessment of value and the resulting participation decision included some that are outside the control of HIE efforts, and some that are within the control of HIE efforts. The first factor outside the control of HIE efforts was the degree of alignment between the geographies where payers had covered lives and the geographic coverage of HIE efforts. National payers had the greatest misalignment; they would have to engage with many HIE efforts to achieve any meaningful

Table 2: Five Principles of Optimal HIE from the Payer Perspective

<b>Principle 1: Single Network or Single Connection to a Network of Networks</b>
“I would be able to plug into a single HIE network (a network of network effect) and be able to navigate a single individual’s information in its entirety, and have that be available to me with very little overhead.” – <i>National payer with minimal HIE involvement</i>
“Payers are looking for simplicity [. . .]. That single point of connection becomes very important to payers. Having lots of different exchanges is not efficient.” – <i>State Medicaid with extensive HIE involvement</i>
“I’m a little skeptical of the current model because of the fragmentation at the state and regional level. Now if we can get this network of networks effect where we can [. . .] drive some consistency [. . .] that would be truly incredible. It would certainly drive down the complexity associated with this immeasurably.” – <i>National payer with minimal HIE involvement</i>
<b>Principle 2: Inclusion of Clinical and Claims Data</b>
“When you start something that’s a provider based organization, which most HIEs are, they’re almost all provider driven. They do not typically think of health plans as having valuable clinical information. It’s is not a lens that they apply to things and frankly it’s because they see us as a vehicle for payment and management of large pools of risk.” – <i>State-level commercial payer with extensive HIE involvement</i>
“I think one of the keys is that there needs to be cooperation between all the different entities. There isn’t necessarily an adversarial relationship between payers and providers, but it is a business relationship. [. . .] There’s not enough understanding. We both have what the other wants. Why not share?” – <i>National payer with minimal HIE involvement</i>
“[. . .] the holy grail [. . .] is a combined claims and clinical dataset. [. . .] With clinical data you get a good, deep understanding of what happens in a clinical encounter but you don’t know the entire breadth of encounters; you get that from claims data.” – <i>National payer with extensive HIE involvement</i>
<b>Principle 3: Broad Provider and Payer Access to Enable Data to be a Shared Asset, Not a Source of Competitive Advantage</b>
“Organizations have competed on having the data and holding the data on the patient. [. . .] So removing that as a competitive differentiator and having folks compete on quality and cost is where people should be. So the idea that this should be a pre-competitive component is also important to us.” – <i>State-level commercial payer with extensive HIE involvement</i>
“It’s the perception that the data is a competitive differentiator. When I bring up the idea of sharing data among payers for the benefits of the customers, a lot of people quiver in their boots.” – <i>National payer with minimal HIE involvement</i>
“One of the problems we’re seeing now is patient data is being hoarded by providers as a market advantage and not wanting to share it. If we want to be successful the mindset has to change to this is not my data, this is the patient’s data.” – <i>State Medicaid with extensive HIE involvement</i>
“Often, HIEs are directly managed or have indirect oversight by providers who have some consternation about sharing data with payers. [. . .] Something we always have to look at is whether we are going to invest time and money only to have someone pull the rug out from under us.” – <i>National payer with minimal HIE involvement</i>
<b>Principle 4: Stakeholder Support in Proportion to the Value Derived</b>
“I think there should be equitable return. Everyone who contributes to HIE should have proportionate value derived from that HIE.” – <i>National payer with moderate HIE involvement</i>
“If payers could get as much as the give in terms of value, I think most would play along. Should they have a disproportionate share of the funding though? Probably not.” – <i>National payer with minimal HIE involvement</i>
“The problem is that [HIE] hasn’t been developed enough to understand what we’re paying for. It’s a combination of how do you even designate what “fair share” is and how do you bring together all the payers?” – <i>State Medicaid with minimal HIE involvement</i>
“It’s uncomfortable to think that you are investing millions in something that benefits other payers who aren’t contributing, or come in at the end and cash in with a [nominal] investment.” – <i>State-level commercial payer with extensive HIE involvement</i>
<b>Principle 5: Value Proposition tied to the Triple Aim</b>
“[The ideal end goal is] exchange of a wide variety of information to improve efficiency and quality of care in the healthcare system.” – <i>State Medicaid managed care with extensive HIE involvement</i>
“When you’re managing population and individual health, there is a connectivity that needs to occur both at the direct treatment level and the systems that support [direct treatment], with payment and coordination components.” – <i>State Medicaid with minimal HIE involvement</i>
“There should be some alignment around the triple aim and think about the objectives [of HIE]. Are they really trying to transform healthcare in America, or not?” – <i>National payer with moderate HIE involvement</i>

level of “HIE coverage” for their covered lives. This made it hard to justify investment in any given local or state/regional HIE effort. State/regional payers had the least misalignment, and did not identify geographic fragmentation of HIE efforts as an issue. For these payers, there was typically

one (or in some cases a few) HIE efforts with which it made sense to engage in order to achieve broad “HIE coverage.”

The second factor outside the control of HIE efforts was payer decision-making processes, which also varied by payer type. National



Table 3: Payer HIE Use Cases

Use Case	Number of Payers Citing Use Case	Examples
Payer-led Care Management	14	Identifying gaps in care Managing authorization Facilitating care continuity
Payer-led Population Health Analytics	9	Sending list of patients overdue for preventive or chronic care Generating ACO metrics
Payer-led Quality Reporting	7	Generating metrics for HEDIS (Healthcare Effectiveness Data and Information Set, a performance measurement program for health plans), Pay-for-Performance and State reporting requirements
Payer-led Provider Profiling	7	Creating provider-level or practice-level performance metrics
Payer-led Patient Profiling	4	Identifying: High-risk patients Frequent utilizers Drug-seekers
Provider-led Care Coordination (with benefits that accrue to payers)	7 – additional 6: <i>possible under certain circumstances</i>	Reducing duplicative services Reducing readmissions Identifying and managing high utilizers

payers had complex decision-making processes around HIE engagement. They attributed this to the fact that they are large organizations with many levels of approval and different HIE participation criteria at each level. As a respondent from a national payer (that chose not participate in an HIE effort) explained, “Local health plans could decide whether to invest or not; the decision-makers are all up and down one hallway. In my company, those people are scattered to all 4 points of the company.” State/regional and local payers did report more decision-making agility than national payers, which they attributed to having a small, well-defined team tasked with making HIE participation decisions and established criteria for when they would participate.

#### Making the Business Case to Payers to Support HIE Efforts

In response to factors under the control of HIE efforts, payers identified several strategies that could be employed to overcome barriers to payer value realization and increase engagement. First, payers identified specific use cases that could be supported by HIE efforts and would generate the return on investment needed to justify payer HIE engagement (Table 3). Most of these use cases required direct payer participation in bidirectional data exchange. Payers were largely skeptical about the extent to which they accrued benefits from provider-centric HIE. As one state level, commercial payer respondent noted, reflecting on the idea that payers reap benefits from having provider-to-provider HIE in their markets, “I have yet to see anything that says ‘you can expect to get XYZ savings or quality increases’ that isn’t a tower of assumptions that’s getting tall enough to teeter.”

Specifically, payers sought access to data from HIE efforts to expand their analytic capabilities beyond what claims data can offer. The most commonly cited use case was using clinical data to strengthen payer-led case management. Richer, more-timely clinical data would enable payers to better manage gaps in patient care and coordinate care following emergency department visits or hospital admissions. Other commonly cited payer HIE use cases included improved reporting for HEDIS and other quality monitoring programs (which would avoid the substantial cost of manual chart review), and providing

better data for ACOs and other value-based care delivery reform efforts. To ensure that HIE efforts support payer use cases, payers wanted to be involved in HIE governance and decision-making on technical architecture, data use policies, and other strategic issues.

Second, payers suggested that HIE efforts could serve as a forum in which to strengthen bridges between payers and providers. Payers reported a lack of trust between payers and providers in many communities, with relationships that can be tense due to the nature of business relations and territorial feelings about patient information and care decisions. Payers felt that HIE efforts provided an ideal setting to shift towards a more collaborative, trusting relationship. They suggested that this could be specifically facilitated by stronger integration of payers into the leadership of HIE efforts.

Third, payers sought assurance that HIE efforts would be sustainable. Payers were concerned that their investment in HIE would not generate long-term value because most HIE efforts did not have a sustainable business model. Many respondents mentioned that the ability of an HIE effort to support its operations outside of state and federal grants was important, particularly given that HITECH funding for HIE through the State HIE Cooperative Agreement Program recently ended. Payers also focused on markers of sustainability related to provider engagement, and specifically the need to see evidence of buy-in from senior leadership of local provider organizations.

Payers recognized their role in sustainability, and stressed that they would be willing to pay “their fair share” for data access, but wanted to know that other stakeholders were also contributing in a way that would keep HIE efforts sustainable in the long term. Payers sought funding mechanisms that were fair, transparent and set up the HIE effort to be operationally self-sustaining. Most payer organizations acknowledged the slow and costly initial stages of HIE development, and were willing to shoulder a disproportionate share of costs upfront. They were generally accepting of a long time horizon for achieving more equitable cost sharing as well as operational sustainability. However, payers looked for commitment to these principles by HIE efforts as indication that payers were considered true partner organizations and not solely a funding mechanism.

## Creating a Conducive Policy Environment to Foster Payer Engagement in HIE

Payers also identified several policy actions that could overcome barriers to payer value realization and increase engagement. There were mixed opinions on the impact of recent policy efforts to promote HIE under the HITECH Act. Most payers felt that the Meaningful Use program moved HIE forward by catalyzing electronic health record adoption rates – an enabling component for HIE – and by including HIE-focused criteria in Stage 2 Meaningful Use. The State HIE Cooperative Agreement Program also provided a welcome influx of money to build and enhance HIE infrastructure.

However, respondents felt that HITECH did not go far enough in supporting HIE development or increasing provider engagement in HIE. Stages 1 and 2 Meaningful Use criteria set a low bar that was perceived to be insufficient to drive real gains in provider participation in HIE efforts and routine use of exchanged data in clinical decisions. Payers thought that federal and state governments were well positioned to incentivize and increase provider participation in HIE efforts. Future stages of Meaningful Use that require connecting to local HIE efforts would be ideal, but were seen as unachievable in the absence of robust interoperability standards. Other suggestions included expanding the use of state Medicaid contracts that required managed care entities to contribute data to local or state HIE efforts, as well as extending this approach to Medicare Advantage contracting.

Nearly all respondents wanted the federal government to be more active in setting and enforcing interoperability standards in order to improve the quality and usability of data. This would generate value for all participating stakeholders using exchanged data. As one respondent stated, “The standards become a limiting factor. [ . . . ] a lot of the big HIEs are starting to deal with that, but [ . . . ] for the real value-added data - [data to] drive down readmissions and provide better outcomes - the pipelines for *that* kind of data don't have support.” Many payers were critical of the federal government's promotion of Direct, which allows for email-like transactions between provider electronic health record systems. Respondents noted that, when it comes to Direct functionality, the technology is not advanced enough, “mirroring email. [and] not much better than fax.” Direct provides a useful stopgap for providers to communicate in the absence of robust HIE, but it does not support activities that are value-generating for payers, especially when provider uptake is limited.

Payers were cautiously optimistic regarding the effects of the Affordable Care Act on HIE development. Respondents acknowledged that ACOs and other value-based payment models promoted under the Affordable Care Act encourage providers as well as payers to think more about HIE for population health management, risk management, and outcomes monitoring. Most respondents felt that the momentum from the Affordable Care Act was driving HIE forward, though some payers expressed concern that ACOs would give rise to proprietary HIE efforts within health systems or managed care networks and crowd out community-based HIE efforts. These payers said that they were “waiting on the sidelines” until they could determine which approach to HIE would prove sustainable.

## DISCUSSION

Despite widespread agreement on the value of HIE and substantial investment in HIE efforts over the past decade, broad-based electronic HIE is still not widespread. Payers are a critical stakeholder whose engagement and support can spur HIE development and full realization of potential HIE benefits to transform care delivery. While existing studies call for active inclusion of payers as key partners<sup>15–17</sup> and have provided some empirical evidence of a business case for payer

involvement,<sup>13,18</sup> there has been very little qualitative exploration of payer expectations, needs, and approach to HIE engagement.<sup>19,20</sup> This study offers the first set of data focused exclusively on the specific factors impeding payer engagement in HIE efforts, and what actions could overcome these impediments. Most strikingly, we found strong agreement across 17 diverse payer organizations – in their vision of what constitutes optimal HIE and in their perspective that the current approach to HIE does not adhere to the vision. This misalignment limits broad payer support for HIE efforts. Going forward, increasing engagement of payers will require that HIE efforts allow payers to become central participants in data exchange, including providing and receiving data. Further, HIE efforts will need to consider strategies for how to overcome resistance from providers to payer participation and promote more collaborative relationships. Policymakers can facilitate this transition by driving greater provider engagement in order to increase the volume of electronic clinical data that is exchanged and by promoting standards that improve data quality and usability.

Underlying our findings is the insight that payers have largely reacted to emerging approaches to HIE, rather than attempting to shape HIE policies or lead the formation of HIE efforts. When asked, most payers were willing to take a leadership role in HIE efforts. However, in many of the domains in which payers were critical of current approaches to HIE, they had not taken proactive steps to reshape the approach. While not all payers that we interviewed are in a position to have a large impact on policy or market approaches to HIE, many payers are in such a position (such as the large, national payers that were the least likely to support HIE efforts). But, they chose not to use their influence in this domain. This suggests that, while HIE may be perceived as valuable on the margins, it is not essential to payers' core business. In turn, this makes it challenging to garner broad payer support.

Nonetheless, we identified specific strategies that are likely to increase payer engagement. This suggests that increasing payer engagement is feasible; it does not, however, mean that doing so is easy or without consequences. For HIE efforts, the key question is whether pursuing these strategies and increasing payer engagement will affect the degree to which providers find HIE participation attractive. This is a challenging balancing act. Ideally, both providers and payers would shift away from norms of information opaqueness and data hoarding to valuing transparency, openness, and sharing. While payers claim to have the right intentions for seeking greater access to clinical data, as long as reimbursement rates are regularly renegotiated, providers have reason to be skeptical of payer involvement in HIE. The key to breaking this stalemate may lie in the rise of ACOs and other risk-based contracting approaches, especially if they are negotiated for multiple years at a time. For providers, this increases the value of more timely access to claims data, as well as decreases the need to limit payer access to clinical data (to prevent profiling or impede fee negotiations). HIE efforts with provider organizations that have taken on risk-based contracts may, therefore, be particularly well-positioned to increase payer engagement.

There are several actions that policymakers can take to promote payer engagement, including continuing to push on the use of standards to promote interoperability, as outlined in the recently released Shared Nationwide Interoperability Roadmap.<sup>21</sup> Increasing provider engagement in HIE will largely depend on what is included in the final Stage 3 Meaningful Use criteria; if HIE criteria are substantially ramped-up (and expanded beyond Directed exchange), this will serve to bolster payer confidence in HIE sustainability and utility, and will likely result in greater engagement. More broadly, expanding Centers for Medicare and Medicaid Services (CMS) ACO demonstrations (and working in parallel to ensure that these do not result in proprietary HIE

approaches crowding out community-based HIE approaches) may help create the conditions in which all stakeholders see the benefit of investing in robust, sustainable HIE.

### Limitations

We attempted to include in our sample a diverse group of payers featuring different experiences with, and perspectives on, HIE. However, the perspectives captured in our results likely reflect those that are most engaged with HIE, because we created a sampling frame based on payers with at least some contact with HIE efforts, and because we interviewed contacts who were closest to HIE decision-making in their organization. This is also reflected by the fact that many of the payers that were identified by one HIE effort as “not participating,” were participating in a different HIE effort (which we learned during the interview). Ultimately, only three payers in our sample had never engaged with an HIE effort. Nonetheless, because little is known about payer perspectives on HIE, interviewing those with the most HIE experience serves to generate more informative results. A second limitation is that we were unable to verify the accuracy of statements made by payers in the interviews (e.g., reports of provider resistance to payer engagement in HIE efforts). In future work, it will be important to assess the generalizability of our findings, and identify misalignments between payer perspectives and those of other HIE stakeholders.

### CONCLUSION

Achieving sustainable approaches to HIE is essential to ensure that the large national investment in health IT over the past decade translates into improved care. This study provides the first in-depth assessment of payer perspectives on HIE, and identifies key actions that can be taken by HIE efforts and policymakers to increase payer engagement in the pursuit of sustainable approaches to HIE. To the extent that such actions occur, the long-anticipated benefits from HIE may finally become a reality.

### FUNDING

This work was supported by the California HealthCare Foundation grant #18107.

### COMPETING INTERESTS

None.

### ACKNOWLEDGEMENTS

We want to acknowledge Jennifer Bordenick, Prashila Dullabh, Will Ross, and Ashish Jha for their feedback on our interview protocol.

### SUPPLEMENTARY MATERIAL

Supplementary material is available online at <http://jamia.oxfordjournals.org/>.

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