Health Data Innovations

MARKET REPORT

Betting on Questionable Data: Healthcare Leaders Can't Rely on Data to Manage Value-Based Care

Survey of 56 hospital and health system leaders shows poor claims data integration is a significant reason VBC success is faltering

Health Data Innovations

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Nearly two-thirds of healthcare organizations are making critical VBC decisions based on data they fundamentally question.

How can your organization overcome data integration challenges to stop losing revenue in value-based care models?

Value-based care (VBC) has transitioned from a new approach to a mainstream strategy for many health systems, with adoption continuing to grow across the healthcare landscape. Yet despite widespread implementation and significant investment, most healthcare organizations may be on shaky ground when it comes to their analysis of key VBC measures.

That shaky ground is the result of a quiet contradiction: Healthcare leaders overwhelmingly recognize that claims data is essential to analyzing their value-based care performance, yet most don't trust the very data they're relying on to make critical strategic decisions.

This paradox has profound implications. Organizations are making multimillion-dollar VBC commitments, negotiating complex contracts, and implementing care management programs based on data they fundamentally question. It's akin to navigating a ship with a compass you don't trust—the destination remains uncertain, and the journey becomes unnecessarily treacherous.

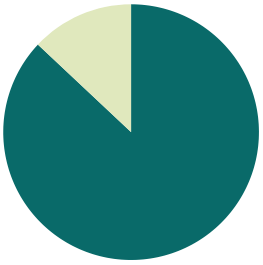
Based on a comprehensive survey of 56 C-suite healthcare leaders—all of whom possess deep knowledge of their organization's VBC strategy—this report examines the data challenges that are systematically undermining VBC analysis across the industry. It also explores a constructive path forward to help healthcare organizations bridge the gap between their VBC aspirations and actual results.

The findings reveal not just the extent of the problem, but also the significant opportunity that exists for organizations willing to address their data integration challenges head-on. In an increasingly competitive healthcare environment, the organizations that solve their data quality issues first will have a decisive advantage in value-based care arrangements.

Key Findings at a Glance

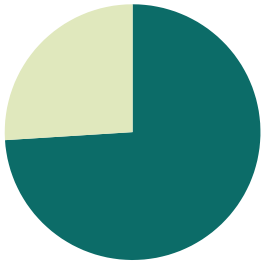
The survey results paint a clear picture of the data confidence crisis plaguing VBC analysis. These statistics reveal the fundamental tension at the core of the VBC performance gap: healthcare organizations are building their value-based care strategies on a foundation they don't fully trust.

Claims data is universally recognized as critical:



87%

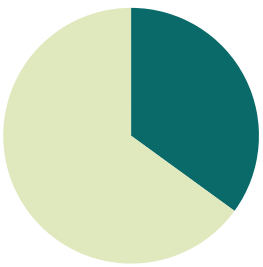
of healthcare leaders say claims data is important to VBC success



74%

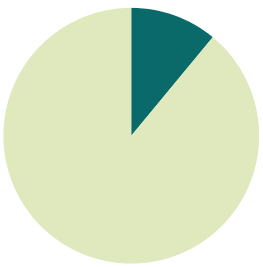
report that their executive leadership relies on claims data to do their job

Yet confidence remains surprisingly low:



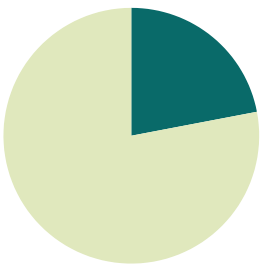
35%

are highly confident in the quality and accuracy of their claims data



11%

rate their data infrastructure as “excellent”

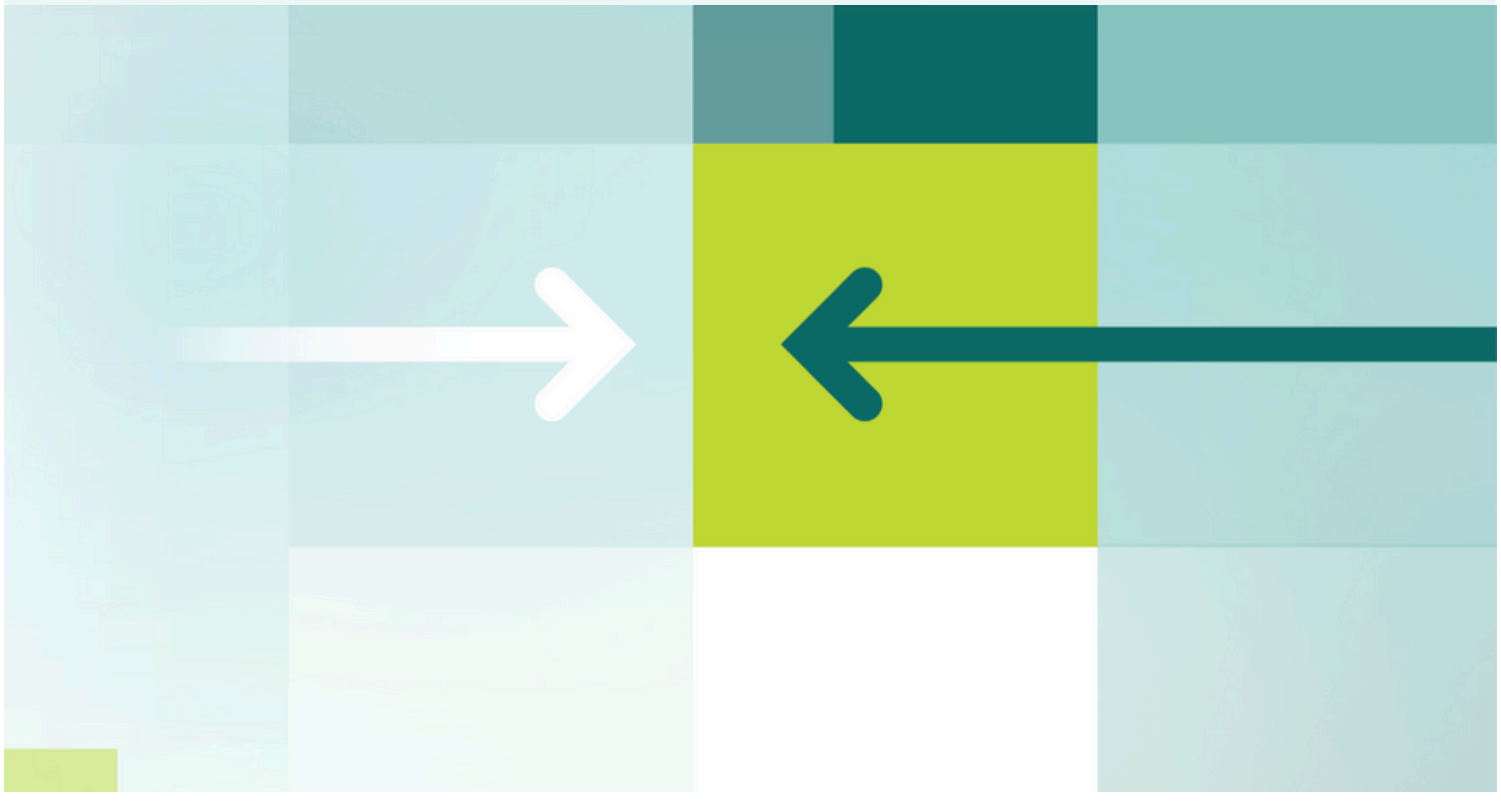


22%

are "very satisfied" or "extremely satisfied" with their current integration processes

PART 1

Critical but Compromised: Why Data is Limiting VBC Success



The Central Role of Claims Data in a Successful VBC Strategy

87%

report that claims data is important to their overall success.

According to the survey respondents, claims data plays a key role in VBC operations and performance.

Eighty-seven percent of healthcare leaders report that claims data is important to their VBC decision-making processes, and 87% also report that it's important to their overall success.

This acknowledgment reflects the reality that claims data serves as a primary source of information for calculating quality measures, assessing network performance, managing care gaps in and out of network, managing utilization patterns, and more—and explains why 82% of organizations are actively integrating payer claims data into their VBC analytics.

It is second only to clinical data from the electronic health records (EHR) when it comes to data sources that are integrated into VBC analytics. While EHR clinical data provides analyses for care provided within their own healthcare system, claims data provides comprehensive insights into care provided in and out of network.

VBC as a Competitive Advantage

When asked how respondents would describe the importance of value-based care in their overall strategy, responses indicated that VBC is **"crucial to their strategy"** due to their competitive environment.

Demonstrating high-quality, cost-effective care can enhance their brand reputation and ultimately, negotiate more favorable payer contracts.

One respondent noted that it's important to the organization because it **"helps prove their cost and quality position."** Another indicated that **"It's a big component of our future growth plans...a big part of our strategy—both for competitive and regulatory reasons."**

The transition from a fee-for-service model, which pays based on the volume of care, creates an environment in which quality becomes the focus. Patients benefit from improvements in care, and payers benefit from lower total costs of care.

74%

indicate that their executive leadership depends on claims data for strategic decision-making.

Executive Decisions Based on Data They Question

The reliance on claims data extends throughout the organizational hierarchy, with 74% of survey respondents indicating that their executive leadership depends on this data for strategic decision-making.

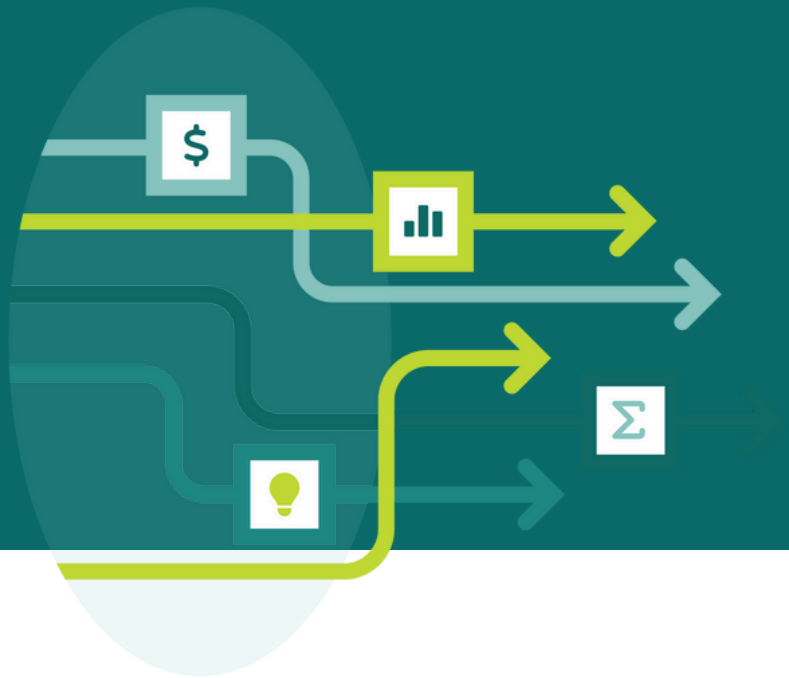
This executive-level dependence means that data quality issues don't just affect operational teams—they directly impact the highest levels of organizational strategy, planning, and management.

- Organizational Strategy
- Planning
- Management

The Confidence Crisis

Despite the widespread recognition of claims data's importance, healthcare leaders express surprisingly low confidence in the data they're using. *A majority—65%—of survey respondents lack confidence in the quality and accuracy of their claims data.* This means that nearly two-thirds of healthcare organizations are making critical VBC decisions based on data they fundamentally question.

That lack of confidence stems from "messy" healthcare claims data and slow and inconsistent, often manual, error-prone processes. More than three in four healthcare leaders characterized the effort of integrating claims data as "somewhat" to "extremely" challenging, a possible indicator that difficulties are not isolated incidents but rather systemic problems.



The path to effective healthcare claims data integration is riddled with nuanced complexities that can overwhelm teams... And often, the final data is inaccurate.

Challenges in Accurate Claims Data Integration: A Critical Opportunity and a Persistent Obstacle

For healthcare administrators managing VBC contracts, accurate claims data integration represents both a critical opportunity and a persistent obstacle.

Getting from Point A—the datasets (medical and Rx claims and eligibility/attribution) provided by payers—to Point B—usable, useful data—is challenging and gets exponentially more challenging when managing multiple contracts across multiple payers.

Provider organizations that enter into risk- or value-based contracts typically receive a monthly dataset from payers that includes medical and Rx claims and eligibility data for the people the provider organization is responsible for under the contract, aka the "attributed population."

This data outlines care that has been paid for under the contract, some of which may not be reflected in the provider organization's EHR. By integrating claims data, provider organizations gain a complete picture of all services provided to their attributed population, which can help them better manage performance.

The Challenge with Data

The challenge lies in the data, and how it must be manipulated, transformed, tied together, and summarized in order to be truly useful for any kind of analytics.

The path to effective healthcare claims data integration is riddled with nuanced complexities that can overwhelm teams with other job responsibilities, limited resources, and expertise. And often, the final data is inaccurate.

Healthcare analytics reveal inaccurate insights with poor data quality. VBC management, population health, cost containment initiatives, and quality improvement programs all require clean, integrated data. Unfortunately, healthcare systems often spend significant time and resources on data clean-up and integration, leaving less time for valuable IT, data, and analytics resources to focus on other important work to maximize organizational performance.

Why Claims Data Integration is so Challenging

It is a well-known industry problem. Claims data integration is challenging for a variety of reasons and may be underestimated by healthcare organizations. Here, we detail some of the specific reasons why it can be so challenging. We've categorized them into three categories related to data structure, time, and substance.

Structural Challenges

- Data layouts are unique to each payer
- Layouts can change without notice
- Field order or delimiters can change
- Files may include looping segments, multiple tabs, hidden tabs/columns/rows
- Information may be embedded in file names/headers

Temporal Challenges

- Data may arrive at different times each month
- Full file set may not be delivered at the same time
- Cadence may be different by data type
- Time period in the data differs by payer and/or contract
- Missing records must be interpreted correctly

Substantive Challenges

- New files must be compared with previous files
- Field values must be interpreted correctly
- Payers represent financial information differently
- Claims must be sequenced accurately
- Differences in how payers build and maintain key identifiers must be understood and managed appropriately
- "Final" is only final until new information arrives to change that status
- Data quality impacts the ability to link claims over time and arrive at the "right" summation of costs/utilization

Long Timelines for New Payer Data Integration and Turnaround Times for Regular Updates

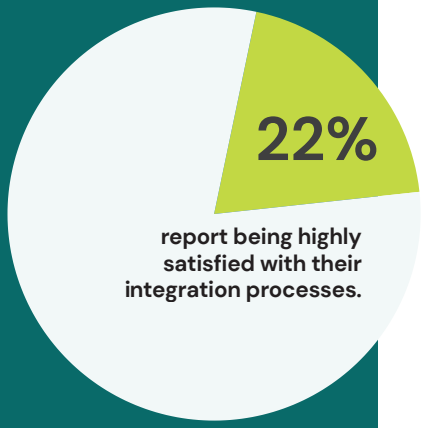
Meanwhile, when organizations need to integrate data from a new payer—a routine occurrence in today's healthcare market—nearly half (45%) report that the process takes five months or longer. This extended timeline means that by the time organizations have access to integrated data, market conditions may have shifted, patient populations may have changed, and critical opportunities for intervention may have passed.

These lengthy integration periods also represent a significant opportunity cost. While internal IT and analytics teams spend months wrestling with data formatting issues, file layout changes, and validation challenges, they're unable to focus on higher-value analysis that could directly improve patient care or organizational performance.

The Satisfaction Gap

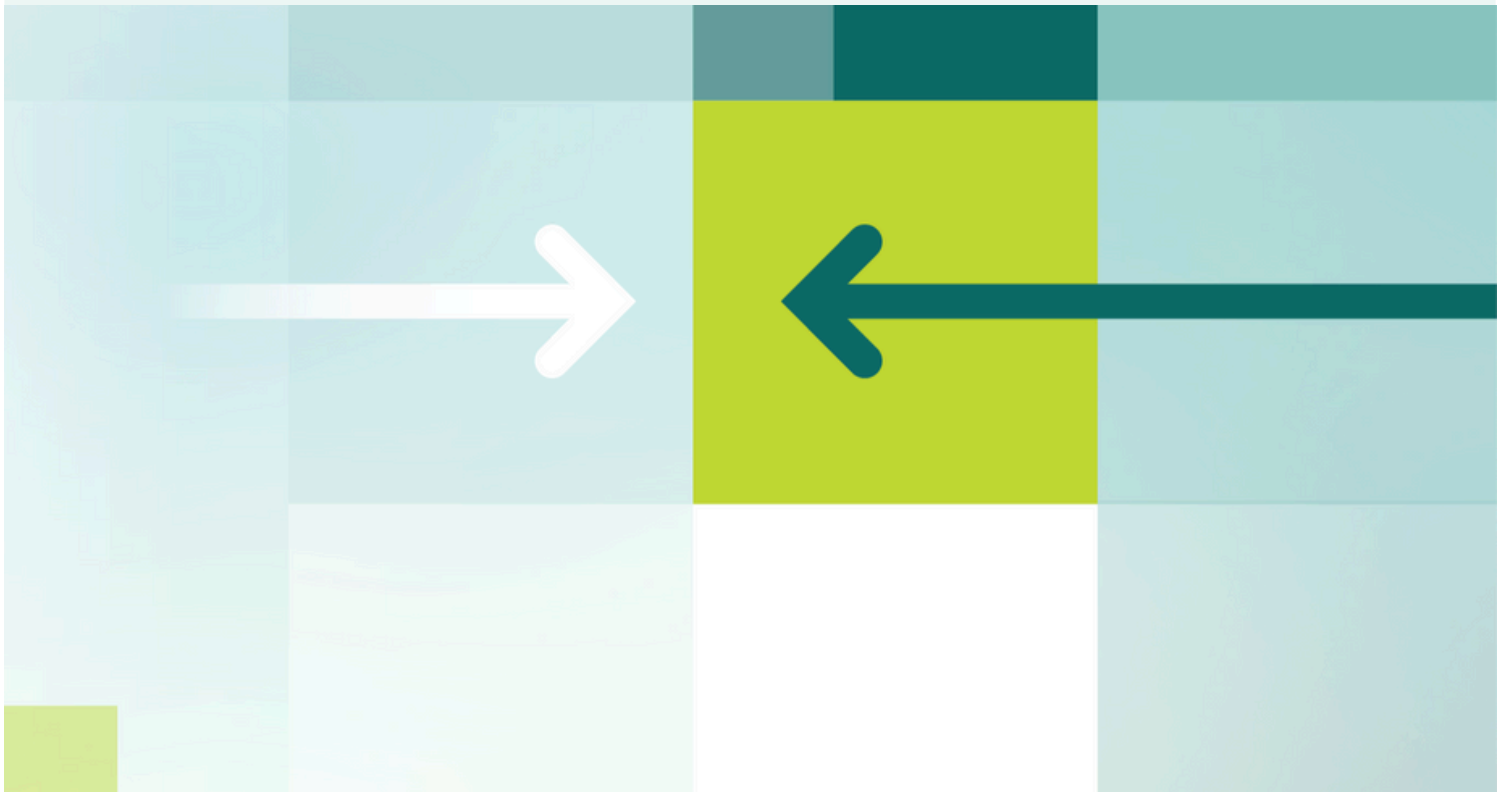
Ultimately, this lack of confidence rolls up to a significant satisfaction gap for claims data integration. Only 22% of healthcare leaders report being "very satisfied" or "extremely satisfied" with their current integration processes. For some, it's a point of direct frustration:

"The integration between EHR and payer data has been too difficult," said one CEO of an independent hospital.

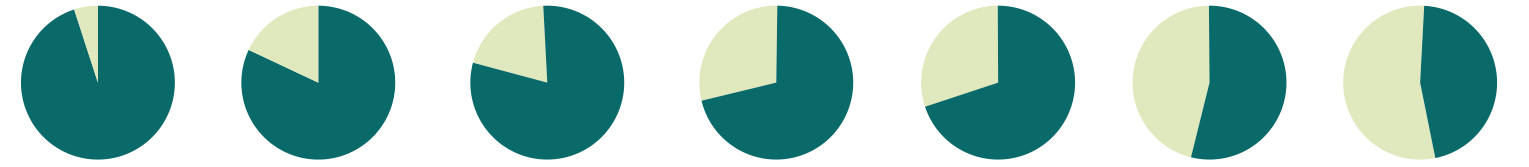


PART 2

Digging Deeper: What Do Hospitals and Health Systems Need to Succeed in VBC?



Data Sources Health Systems Integrate into Analytics for Value-Based Care



95% Clinical data from EHR

82% Payer claims data

80% Admit, Discharge, Transfer (ADT) feeds

71% Pharmacy claims data

70% Social determinants of health data

54% Behavioral health data

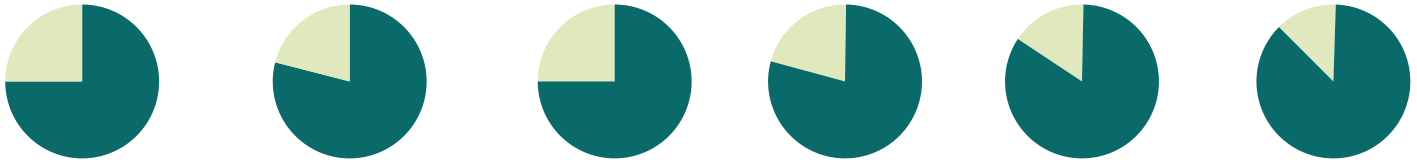
46% Patient-reported outcomes

The Maturity Gap Across VBC Domains

Successful VBC requires organizational maturity across multiple interconnected domains. However, when healthcare leaders assess their own performance in those key VBC areas, their ratings reveal significant opportunities to improve. The vast majority of respondents rate themselves as only "somewhat successful" across critical operational areas.

Critical Areas Where Organizations Struggle

The survey data reveals performance gaps in the following areas that are building blocks to VBC success. Here's where respondents say they are "somewhat" or less successful:



75% Network analysis

79% Cost and utilization management

75% Contract negotiation with commercial payers

79% Closing gaps in care

84% Minimizing leakage

87% Actuarial review and rate setting

The survey did identify two areas where a meaningful percentage of leaders felt "very successful."

Ongoing contract management showed better performance, with 27% of organizations rating themselves as very successful. This suggests that once contracts are in place, many organizations have developed adequate capabilities for managing ongoing relationships and requirements.

More encouragingly, 43% of organizations report being very successful at meeting quality measures. This represents the highest success rate across all measured domains and suggests that healthcare organizations have invested significantly in quality measurement and reporting capabilities. However, relative success in this domain may be partially attributable to the fact that many quality measures are based on clinical data sources that organizations have better control over, rather than primarily on integrated claims data.

How Does Claims Data Support VBC Success?

Understanding the specific ways that high-quality claims data can support VBC success helps illustrate why the current confidence crisis is so problematic for healthcare organizations. Ultimately, poor performance in VBC equates to revenue loss, as reimbursements are tied to key performance measures. Healthcare organizations that aren't able to shore up performance in the following key areas are leaving money on the table and ceding their competitive position.

Quality Measures

Claims data is the primary source of data used to calculate HEDIS measures, as it provides a complete picture of care delivered, regardless of where it was provided. Providers who have ongoing, reliable insight into their HEDIS performance gain a significant advantage in demonstrating their value to payers and can proactively address potential quality issues before they impact contract performance.

Ongoing Contract Management

Claims data provides visibility into performance that allows providers to be strategic about what's included in contracts, identify opportunities to improve performance for more revenue, manage downside risk, and meet compliance goals.

Network Analysis

Claims data enables sophisticated assessment of network adequacy, analysis of referral patterns, and strategic planning for network expansion based on actual utilization patterns. Claims data captures services provided outside of the EHR data, which only captures services provided by the health system. This intelligence is crucial for optimizing provider networks and minimizing leakage.

Minimizing Leakage

Claims data can be used to identify network leakage and related insights, including the best practices of the highest-performing providers. It can also help determine provider reimbursements related to high performance, so as to retain those providers and keep patients in-network.

Contract Negotiation with Commercial Payers

Historical claims data provides the analytical foundation for strategic contract negotiations. It allows providers to understand their actual performance patterns, identify areas of strength and opportunity, and negotiate terms that align with their capabilities and patient population characteristics.

Closing Gaps in Care

Claims data analysis allows providers to see the most comprehensive picture of care, which allows them to proactively reduce gaps in care, particularly for chronic conditions. Care gaps show discrepancies between best practices and actual care. They are not only significant for the delivery of optimal care and value, but also important because the financial penalties that may be linked to them in VBC contracts affect the organization's bottom line. Analyzing claims data enables a more comprehensive view of patient care and, therefore, more accurate reporting.

Cost and Utilization Management

Claims data can be used for identification of high-cost diagnoses, providers, and patients, which can in turn be used to address poor performers that may be unnecessarily contributing to high costs.

Actuarial Review and Rate Setting

Claims data helps with stratifying populations by risk, forecasting utilization and costs, and benchmarking based on historical costs of care across providers, in or out of network.

The Missing Piece

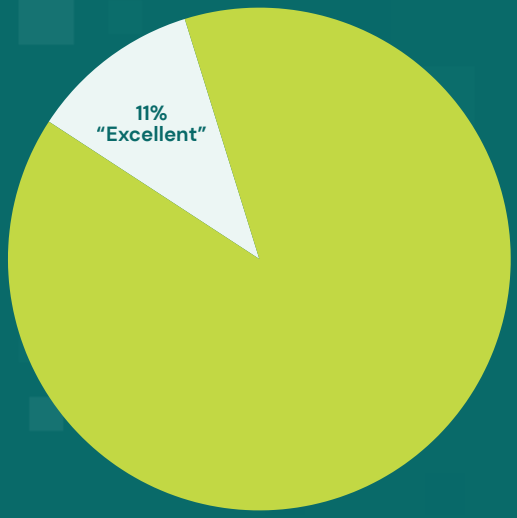
Critically, only 11% of respondents rate their organization's data infrastructure as "excellent." This infrastructure gap creates a ripple effect that impacts performance across all VBC domains.

Without top-tier data infrastructure, organizations struggle to perform the sophisticated analyses required for:

- Network optimization
- Utilization management
- Contract negotiation
- Leakage minimization
- Care gap management
- Actuarial assessment

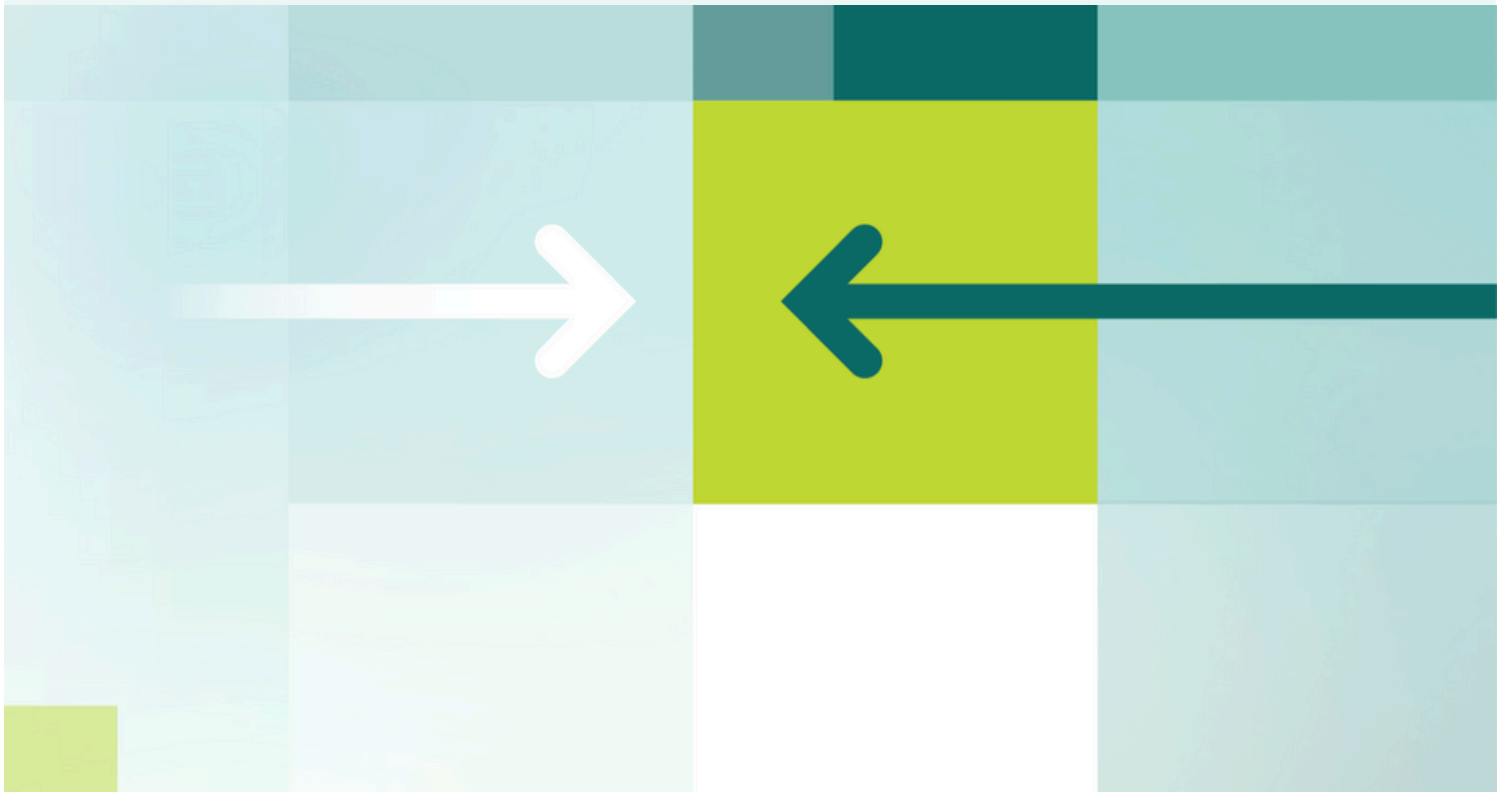
The data foundation that supports these activities must be robust, reliable, and readily accessible—characteristics that may be lacking in many organizations, even as they transition to a growing number of VBC contracts.

How would you rate your organization's current data infrastructure to support VBC contracts?



PART 3

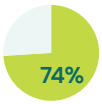
Unlocking Opportunities for Improvement: Where Healthcare Leaders Can Gain Clarity



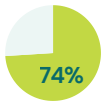
Acknowledging Widespread Dependence

First, it's important to understand that claims data dependencies extend far beyond traditional analytics teams. Claims data is relied upon by a diverse array of critical organizational functions; a majority of survey respondents reported that the following internal teams rely on these datasets:

Quality Improvement Teams: These teams depend on claims data to measure and manage quality performance, track improvement initiatives, and demonstrate compliance with VBC quality requirements.



Population Health Teams: Population health initiatives require comprehensive claims data to identify high-risk patients, track population-level trends, and design targeted interventions.



Executive Leadership: The high percentage of executive reliance on claims data underscores its strategic importance and explains why data quality issues can impact organizational decision-making at the highest levels.

Care Management Teams: Care managers need claims data to identify patients requiring interventions, track the effectiveness of care management programs, and coordinate care across providers.

Clinical Leadership: Clinical leaders use claims data to understand practice patterns, identify opportunities for clinical improvement, and assess the impact of clinical initiatives.

Finance Teams: Financial analysis and forecasting for VBC arrangements require comprehensive claims data to assess financial performance and predict future costs.

Operations Leadership: Operational optimization in VBC depends on claims data insights to improve efficiency and effectiveness across care delivery processes.

This widespread organizational dependence on claims data means that quality and integration issues don't just affect one department—they create system-wide challenges that can impact organizational performance across multiple domains. That's why it's all the more important to get to the root cause of shaky confidence in claims data.

The Top Claims Data Integration Challenges Healthcare Organizations Need to Solve—And How

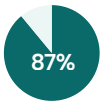
Top Challenges

Healthcare organizations face several specific technical and operational challenges in claims data integration. Addressing these challenges is essential for building the confidence and capabilities needed for VBC success:

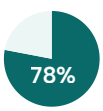
Accurately Integrating and Validating Data: Data integration involves combining information from multiple payers with different formatting standards, coding conventions, and data quality levels. Validation requires sophisticated processes to ensure data accuracy and completeness.

Identifying and Eliminating Duplicate Claims: Duplicate claims can significantly skew analyses and lead to incorrect conclusions about utilization patterns, costs, and patient populations. Organizations need a specific system to track received, late, missing, and duplicate files.

Keeping Up with Frequently Changing Payer File Layouts: Payers regularly modify their data layouts, requiring ongoing technical adjustments that can be resource-intensive and error-prone. Because even a small change in a payer file layout can make a meaningful difference downstream, organizations need both technical expertise and industry knowledge to track any and all changes.



Matching Claims to Patient Records: Accurate patient matching is essential for comprehensive analytics and correct attribution but requires sophisticated algorithms and ongoing maintenance.



Tracking File Receipt and Timely Processing: Without reliable tracking mechanisms, organizations may miss critical data deliveries or experience delays that impact their analytical capabilities.

The strain on internal resources

Overcoming these integration challenges requires significant internal resources, particularly from IT teams that may face retention challenges, time constraints, and/or lack the specialized healthcare data expertise needed for effective claims data management. As one respondent put it when asked to describe the biggest challenge related to integrating data, **"Creating data feeds to integrate our EMR with the payers is the most difficult, along with finding time for our IT staff to work on these projects, in addition to normal daily work."**

Right now, **only 11% of organizations currently use dedicated third-party vendors** to integrate their claims data, indicating that the vast majority are still attempting to manage integration internally.

However: **One-third of healthcare leaders directly acknowledge that a lack of internal healthcare data expertise is holding back their organizations.** This skills gap is particularly problematic because effective claims data integration requires not just technical capabilities, but also deep understanding of healthcare data content, standards, payer requirements, and clinical workflows.

The Changing Investment Landscape

Despite the current challenges, there are encouraging signs that healthcare leaders are recognizing the need for new approaches to claims data integration. Even for those participants who are not leveraging payer claims data today, 90% indicate they are somewhat-to-extremely likely to invest in new solutions to help integrate payer claims data in the future.

This high percentage suggests that organizations are beginning to understand that their current approaches to claims data integration are inadequate for their VBC ambitions. The willingness to invest in new solutions creates opportunities for organizations to fundamentally improve their data capabilities and, by extension, their VBC performance.

90%

of healthcare leaders indicate they are somewhat-to-extremely likely to invest in new solutions to integrate payer claims data in the future.

Healthcare Claims Data Integration Solutions

Our research suggests that health systems are moving toward value-based care to increase competitive advantage. However, to effectively implement and manage contracts, respondents indicate that they need better claims data integration but are faced with internal limitations as noted above. Health systems can implement solutions with the following options:

- **Build Internally:** Organizations are faced with internal resource constraints, including a lack of complex data expertise, old, outdated systems and limited time from IT resources. When asked about the biggest challenges with data integration, one respondent said, **"Resource delays in our IT department for any needed build."**

  IT resources are tasked with several projects and competing priorities, and data integration requires a special skillset, resources, automation tools, and streamlined processes. Many tools do ingestion and data mapping but do not have claims file rules, which is the number one cause of data issues. Claims data complexities further exacerbate issues with internal efforts and are an ongoing problem as data is received from multiple payers in different layouts, on different update schedules, and tend to require manual intervention.

  Internal build efforts can take months or years and distract IT teams from core operations and work on other revenue-generating opportunities. While it is tempting for health systems to manage internally with existing resources, they often find that after spending months on data integration efforts, investments often fail to deliver timely, accurate data, which frustrates multiple stakeholders. Without quality data, data scientists are not working at the top of their license and health systems are not optimizing performance.

- **Use Analytics Vendors:** Organizations may contract with analytics vendors that include claims data integration services, which are not a core competency. After contracting with an analytics vendor to conduct data integration, health systems may find that timelines extend past internal deadlines for implementation of the analytics. Once the data is in the system, there can be data quality issues that result in suboptimal analyses and, therefore, suboptimal performance.

- **Partner with a Data Integration Vendor:** By working with a vendor that solely focuses on claims data as its core competency, healthcare systems can offload data complexities and the time-consuming effort required to manage inbound and outbound files. In looking for a data integration partner, health systems should ensure that they have proven processes, deep expertise, payer data experience, and long-term client relationships with a high client retention rate.

Solving Claims Data Challenges for Health Systems

Solving data integration challenges is not easy.

Working with a company that has a deep understanding of the complexities of the data can fast-track data availability and alleviate the internal burden of sorting through data issues.

Health Data Innovations (HDI) has been integrating claims data since 2010 and works with health systems that contract with multiple payers under a variety of risk-based agreements. HDI takes on the burden of managing claims file issues so healthcare teams can focus on their jobs.

HDI's SINGULAR FOCUS is healthcare data integration powered by domain expertise and proven processes to deliver high-quality, trusted data.

Health systems typically work with multiple payers under various risk-based contracts. We manage multiple inbound feeds and understand each dataset's unique structure and content. We have experience with more than 3,500 formats from over 600 sources, including CMS, commercial and Medicare Advantage health plans, third-party administrators, pharmacy benefit managers, laboratories, health and wellness vendors, survey and health risk assessment companies, and medical management providers.

HDI delivers consistent, cleansed, and vetted data in a client-required standardized format–or in formats required by analytics or electronic health record vendors. Health systems can seamlessly load and use the data—empowering them to make confident, data-driven decisions without the headache of messy or inconsistent information.

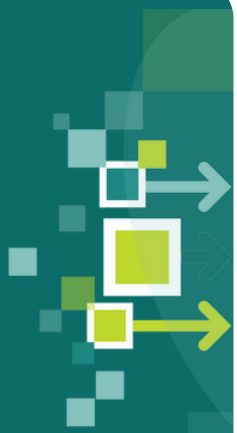
Our goal is to unburden health systems of these complexities and enable them to optimize performance and improve operational efficiency—freeing them to focus on what matters most: managing healthcare, not wrangling data.

Rapid implementation and turnaround times

For new implementations, HDI integrates claims data in three weeks. For ongoing data integrations, updates are typically delivered within 24 hours.

As health systems move forward with the fast-paced, market momentum around value-based care, to remain competitive, it is vital to find a solution that:

- **Prioritizes data quality**
- **Delivers rapid implementation – days or weeks, not months or years**
- **Provides ongoing updates quickly—*typically within 24 hours***
- **Adds resources with deep healthcare data expertise**
- **Unburdens technical or quality teams of data complexities and error-prone manual processes**



Conclusion: Who Will Have a Data-Driven Advantage?

The survey paints a clear and urgent picture:

Healthcare leaders across the industry are making critical strategic decisions based on data they fundamentally don't trust.

The implications extend far beyond data management. Organizations that continue to operate with low confidence in their claims data will find themselves at a persistent disadvantage in VBC arrangements. They will make conservative decisions when aggressive action is warranted, miss opportunities for proactive interventions, and struggle to demonstrate their value to payers and patients. Ultimately, this also **results in a loss of revenue.**

Conversely, organizations that address their data integration challenges head-on will gain a decisive competitive advantage. They will be able to make confident, data-driven decisions about network optimization, care gap interventions, utilization management, and contract negotiations. They will identify opportunities that their competitors miss and respond more quickly to emerging challenges and opportunities.

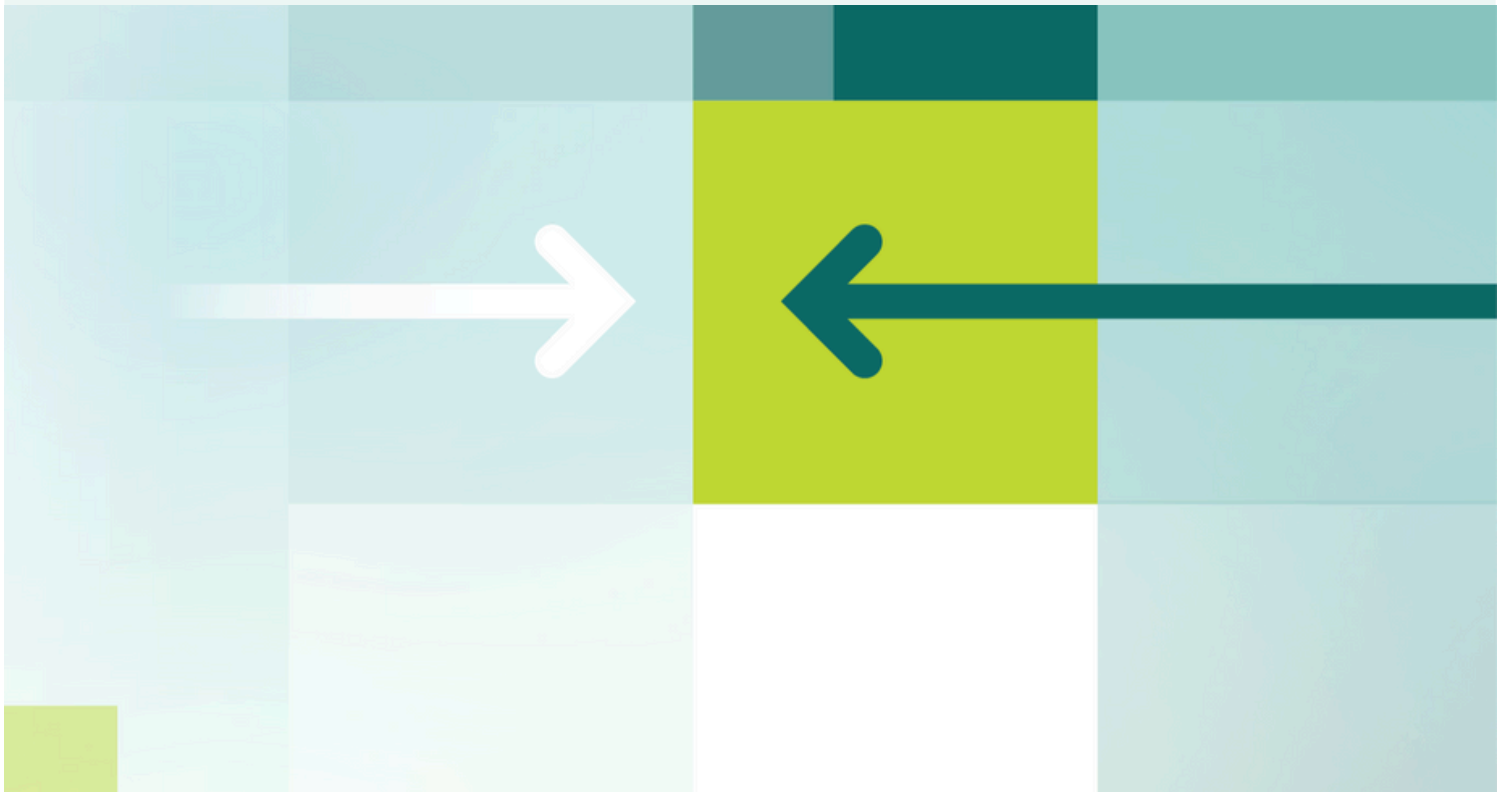
The path forward requires more than incremental internal improvements to existing processes. Healthcare organizations need a partner who can deliver accurate, integrated, and analytically ready data using proven processes and deep healthcare expertise. The complexity of modern claims data integration—with its constantly changing payer requirements, sophisticated validation requirements, and integration challenges—demands specialized capabilities that most healthcare organizations cannot efficiently develop internally.

As more organizations recognize the true cost of depending on data they can't trust, the competitive landscape for VBC will fundamentally shift. Organizations that continue to tie up internal resources trying to manage the complexity of claims data integration will find themselves falling further behind as VBC adoption accelerates and performance standards rise. As one hospital CEO described the importance of VBC to their organization: **"Being prepared and proactive will be needed to survive within the next few years."**

The race to build reliable, confident data capabilities is just beginning. The organizations that move decisively to address their data integration challenges will position themselves not just to succeed in current VBC arrangements, but to lead the industry as VBC becomes the dominant model for healthcare delivery.

The question is not whether healthcare organizations will eventually solve their claims data challenges—the economic pressures and competitive dynamics make this inevitable. **The question is which organizations will solve these challenges first and gain the lasting advantages that come with being data-driven in an industry that is increasingly defined by its ability to demonstrate measurable value.**

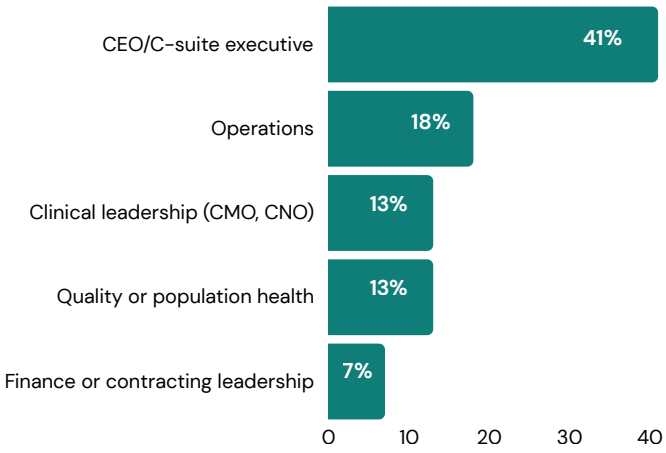
Appendix



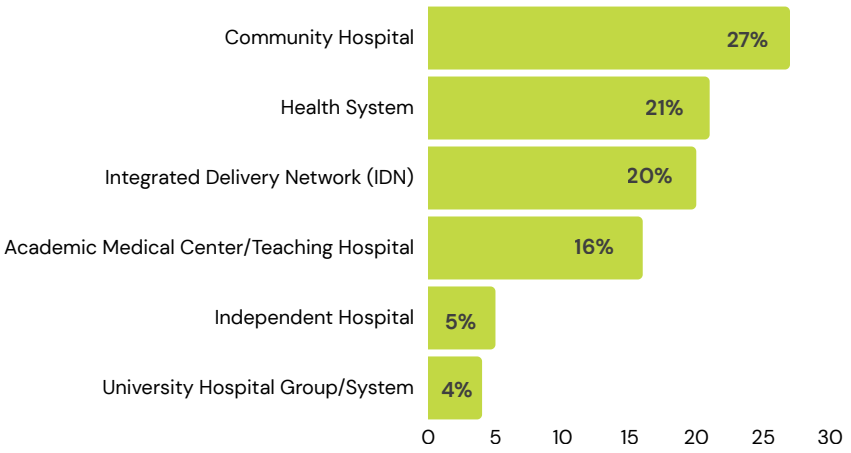
Survey Demographics

Health Data Innovations worked with Sage Growth Partners to conduct an independent survey in Q3 2025. Survey respondents represented hospital and health system leaders who are knowledgeable about their organization's VBC strategy and work with or have influence over how data is used to drive that VBC strategy.

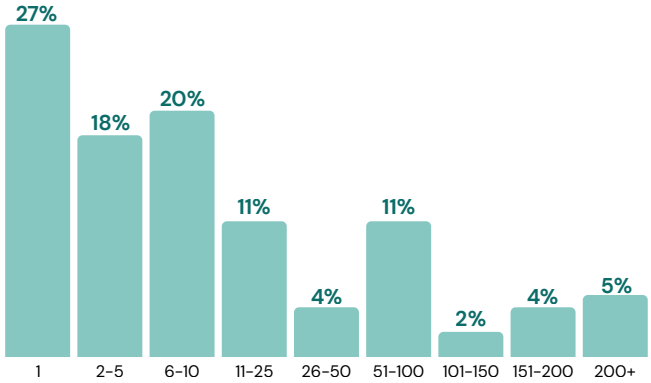
Which of the following most closely represents your role? (n=56)



Which of the following best describes the type of hospital or health system you work for? (n=56)



How many hospitals are currently in your organization? (n=56)



What is your organization's annual net patient revenue? (n=56)

Health Data Innovations

About Health Data Innovations

Health Data Innovations (HDI) simplifies the complexity of data integration, empowering healthcare organizations to confidently harness accurate, consistent, and analytically ready data. HDI manages multiple inbound data feeds and standardizes diverse datasets using proven processes and deep healthcare expertise. As a trusted partner, HDI enables clients to make informed, data-driven decisions that optimize performance and improve operational efficiency—freeing healthcare professionals to focus on what matters most: managing healthcare, not wrangling data. For more information, visit hd-innovations.com.

sage

About Sage Growth Partners

Sage Growth Partners is a healthcare advisory firm with deep expertise in market research, strategy, and communications. Founded in 2005, the company's extensive domain experience ensures that healthcare organizations thrive amid the complexities of a rapidly changing marketplace. For more information, visit www.sage-growth.com.

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