Interoperability and Data Fragmentation:
The CFO Cost Model for 2026

Executive summary

Interoperability is no longer an IT housekeeping issue. For finance leaders, it is a margin, working-capital, and operating-capacity issue. When data does not move cleanly across intake, authorization, documentation, billing, and care delivery, organizations absorb avoidable labor, denial rework, delayed cash, duplicate testing, and mounting integration overhead. The central CFO question for 2026 is not whether to digitize more; it is where to remove the special effort that is still embedded in revenue and clinical workflows.

What matters to CFOs right now

The hospital sector is operating on thin fundamentals. In Kaufman Hall's national dataset, the median year-to-date operating margin index closed December 2025 at roughly 1.3% including allocations. In that environment, slow cash conversion, higher denial rates, or expanded manual work can erase performance quickly.

Against that backdrop, interoperability has become a finance issue. CAQH reported that the U.S. healthcare system avoided an estimated $258 billion in administrative costs in 2024 through electronic transactions and improved data exchange, but still has about $21 billion of annual savings opportunity remaining in manual and partially manual transactions.

Two implications follow. First, there is still a sizable pool of recoverable margin trapped in administrative and cross-system workflow friction. Second, automation and AI are being layered into workflows faster than underlying data flows are being stabilized, creating new cost centers in exception handling, supervision, and rework.

Where the money is being lost

Administrative labor that never comes out

CAQH's 2025 Index is one of the clearest recent benchmarks because it measures transaction volume, method, cost, and completion time across more than 600 provider organizations and health plans representing 63% of insured lives.

Administrative cost avoidance increased 17% year over year through automated transactions. Even so, the remaining savings opportunity tied to manual and partially manual transactions remains large.

Operationally, that means organizations are still paying for work that should have become straight-through processing long ago. The problem is not a lack of dashboards. It is the persistence of special effort in high-volume processes such as eligibility, claims, and prior authorization.

Denials and cash-conversion friction

Denials are no longer routine revenue-cycle noise. They are a system-level drag on cash and labor. HFMA has highlighted denial administration as a major affordability and sustainability issue, citing nearly 12% of patients' claims denied and $25 billion in unnecessary spending associated with denial administration.

Experian Health's 2025 State of Claims survey adds the most useful operating detail: 41% of providers report denial rates of 10% or higher; missing or inaccurate data is the top driver at 50%, followed by authorizations at 35% and incomplete or inaccurate registration data at 32%; and 90% of denied claims are reworked with at least some human review before resubmission.

When intake data, authorization status, clinical documentation, and billing workflows are not aligned across systems, organizations pay twice: once to deliver care and again to correct data and fight for payment.

Avoidable utilization, duplicate testing, and capacity leakage

Clinical interoperability also has a direct utilization and throughput signature. A California Health Care Foundation synthesis reported that emergency departments with HIE access saw 9% to 25% reductions in CTs, X-rays, and ultrasounds, and that HIE use was associated with cost savings of nearly $2,000 per patient through reduced unnecessary testing and admissions.

The exact dollar figure will vary by setting, but the mechanism is consistent: fragmented data forces defensive duplication. That duplication consumes scarce clinical capacity, especially in emergency and inpatient environments where throughput is already under strain.

Integration maintenance drag

A core 2026 insight is that the industry's main interoperability bottleneck is no longer sending or receiving data. It is integrating data into the workflow where work actually happens.

ASTP reported that by 2025, 96% of hospitals could electronically send information, 93% could receive it, and 94% could find or query it, but only 79% could integrate received information into the EHR without manual entry.

That gap matters because manual integration shows up as recurring operating expense: interface maintenance, upgrades, exception queues, vendor coordination, testing cycles, and downstream workarounds. The cost often lands across IT, revenue-cycle labor, and clinical productivity rather than in the original business case.

AI and automation supervision costs

CAQH reports that more than half of health plans and a quarter of provider organizations are already using AI tools in administrative workflows. Yet the large remaining savings opportunity from manual transactions shows that adoption and friction are coexisting.

For finance leaders, the implication is straightforward: AI should be treated as an amplifier of workflow and data quality, not as a substitute for fixing them. If automation is layered onto unstable processes, the burden simply shifts into review time, exception handling, escalations, and downstream rework.

Why the cost problem persists

The modern health IT estate is a layered environment: EHR, lab, imaging, pharmacy, scheduling, portals, payer interfaces, HIE and TEFCA connectivity, analytics platforms, and a fast-growing set of

workflow-specific SaaS and AI tools. Connectivity has improved materially, but three structural gaps keep the cost problem alive.

- Integration has not kept pace with exchange. Send, receive, and query rates are high, but workflow-level integration remains under 80%.
- Standards-based APIs are still not the dominant integration method for many operational use cases, particularly administrative workflows.
- National exchange frameworks are scaling, but local operational interoperability, including mapping, governance, and workflow integration, remains inconsistent.

Policy and regulatory drivers that change the CFO playbook

A finance-led interoperability strategy in 2026 has to line up with compliance timelines because regulation is now defining what good interoperability looks like and where automation ROI is most likely to hold.

United States

The CMS Interoperability and Prior Authorization Final Rule shifts prior authorization and payer APIs from discretionary projects into requirements. Impacted payers were required to implement certain provisions by January 1, 2026, with API requirements largely due by January 1, 2027.

The July 2025 HTI-4 final rule also attached real labor economics to standards-based workflow automation, estimating $19 billion in labor savings over ten years from efficiencies in electronic prescribing, real-time prescription benefit, and electronic prior authorization functionality.

Canada

In Canada, policy direction is also becoming more explicit. Health Canada's February 2026 release on the Connected Care for Canadians Act noted that only 29% of primary care providers currently share patient information electronically outside their practice and identified administrative burden as a material workforce issue.

At the legislative level, Bill S-5 signaled a sharper stance on interoperability and data blocking. In parallel, CIHI's CACDI work and Canada Health Infoway's CA Core+ profiles continue to push standardized information flow as the basis for connected care.

For finance leaders, that changes procurement, contracting, and integration risk. Vendor interoperability is moving from preference to expectation.

What CFOs should do now

A practical response is to treat interoperability as a margin and working-capital program rather than a technical upgrade. The evidence points to four immediate actions.

1. Build a leakage P&L.

Map avoidable labor, denial rework, delayed cash, duplicate utilization, and integration overhead to specific workflow handoffs. The objective is to make fragmented data flow visible in finance terms.

2. Measure integration, not just connectivity.

Most organizations can already send and receive data. The harder question is whether data lands inside the workflow that drives revenue and care. Track integration rates across intake, eligibility, authorization, documentation, and claim submission.

3. Track denial causes at the data-field level.

Denials often originate in missing or inaccurate information upstream. A finance-grade scorecard should connect denial categories to the exact fields, handoffs, and systems that created them.

4. Account for human-in-the-loop burden in AI programs.

Every AI workflow should measure exception rates, review minutes, escalation volume, and downstream rework. If those measures are not visible, ROI is probably overstated.

The priority workflow corridors

- Prior authorization digitization and payer APIs, where regulation and ROI are converging directly.
- Patient access and app-based exchange, where adoption has improved but remains uneven.
- Third-party tool integration for telehealth, remote monitoring, scheduling, intake, quality reporting, and related workflows that still depend heavily on non-standard methods.

Conclusion

Interoperability failure behaves like a cost multiplier. It expands labor, slows cash, increases denials, and consumes clinical capacity. In a low-margin environment, those losses are not abstract. They are financeable and, in many cases, recoverable.

The 2026 finance mandate is therefore clear: stop treating interoperability as background infrastructure and start treating it as an operating-margin program with explicit workflow targets, measurable burden reduction, and disciplined governance.

Selected sources referenced

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