Guide

reveleer

Fixing the fragmented member record problem

How health plans use a Clinical Data Repository to cut retrieval costs and strengthen audit readiness

Contents

Introduction

Health plans collect large volumes of medical records across risk adjustment, quality, audits, care management, and other programs. Documentation often becomes siloed across teams and vendors. Member records are retrieved multiple times, stored inconsistently, and underutilized.

The consequences are significant. Redundant provider outreach strains the relationship, and duplicate retrieval increases costs. In an environment of heightened audit scrutiny, fragmented records create documentation gaps that increase compliance risk.

A clinical data repository addresses this challenge by creating a single source of truth for member records. It reduces redundant retrieval, minimizes provider abrasion, and makes clinical documentation reusable across programs. Lower costs, stronger audit readiness, and a documentation foundation that supports multiple lines of business follow.

This guide outlines three areas: the cost of fragmented member records, key considerations for building a unified documentation strategy, and criteria for evaluating a clinical data repository.

The cost of fragmented member records

Member charts exist across projects, spreadsheets, EHRs, and shared file drives. Without a centralized repository, no single team has access to a complete member record. The impact of that fragmentation accumulates across every program that depends on clinical documentation.

Duplicate retrieval costs

When records are stored across multiple systems, teams often retrieve the same charts from the same providers. Each request can cost $40 to $75 or more in per-chart fees, excluding internal labor.[1]

Across a large member population, repeated retrieval represents significant avoidable spend. The same chart may be requested multiple times across risk adjustment, quality, and audit workflows.

Operational inefficiency

Fragmented storage requires teams to search across systems to assemble member records. It slows program execution, delays audits, and introduces multiple versions of the same member history. Time spent locating documentation replaces time spent acting on it.

Provider abrasion and reputational risk

Repeated, uncoordinated chart requests from different teams signal a lack of internal coordination to providers, straining relationships with key networks and reducing responsiveness to future requests.

Impact on member care

Fragmented records extend beyond administrative burden and affect the quality of care. When quality, care management, and population health programs operate without a unified member record, interventions are less targeted, care gaps remain open, and total cost of care increases.

Fragmented clinical data is associated with measurable declines in care quality and efficiency:

5X
higher inpatient mortality impacts Stars and quality performance

3.5X
higher ICU utilization increases total cost of care

30%
higher readmissions drive avoidable spend and penalties[3]

Compliance exposure and audit risk

The audit environment facing health plans has changed. CMS audits all eligible Medicare Advantage (MA) contracts annually, with sample sizes ranging from 35 to 200 records per plan based on contract size.[7] Health plans also face oversight from National Committee for Quality Assurance (NCQA) for HEDIS, Office of Inspector General (OIG), and state Medicaid agencies, in addition to internal audit requirements.

When an oversight agency requests documentation to support a submitted diagnosis, health plans must produce the appropriate record, linked to the correct member and date of service, in a defensible format. Fragmented records limit that ability.

Charts retrieved across multiple vendors and stored across disconnected systems introduce gaps between what was coded and what can be produced. Gaps between submitted diagnoses and supporting documentation create direct audit exposure.

Multiple audits, compounding retrieval requests

Audit type	Timing	Record requests
RADV (Risk Adjustment Data Validation)	Quarterly initiation; ongoing year-round	35 to 200 records per plan per year, scaled to contract size
IVA (Initial Validation Audit)	Typically aligned to submission cycles	Sampled to validate coding accuracy prior to submission
HEDIS medical record review	February through May	Thousands of records per plan depending on size and measures
OIG reviews	Year-round; often unannounced	Varies; typically targeted by diagnosis category or provider pattern
Internal compliance audits	Quarterly (conducted by 50 percent or more of plans)	Sampled across member population
State & Medicaid audits	Varies by state; often spring and fall	Varies

Building a unified documentation layer

A unified documentation layer goes beyond a shared drive with improved organization. Health plans require an approach designed for the complexity of payer operations, with clearly defined capabilities.

A solution designed for payer operations must provide a single source of member charts with standardized metadata, appropriate security controls, clear audit trails, and the ability to reuse documentation across risk adjustment, quality, and compliance programs without re-retrieval.

A clinical data repository is designed for this purpose. Unlike EHR add-ons, enterprise content management systems, or internal file shares, it treats charts as member-level records rather than static files. Records are centralized and structured so teams can access and use the same documentation across programs.

Health plans adopt clinical data repositories for three primary reasons:

1. To reduce repeated chart retrieval and storage
2. To limit provider abrasion and retrieval cost
3. To improve access to clinical documentation across risk adjustment, quality, audit, and analytics workflows

The key consideration is whether the approach supports these requirements in practice.

What to look for in a clinical data repository

Not all clinical data repositories are built for the complexity of health plan operations. When evaluating a solution, health plans should look for the following capabilities.

A single, member-based record

The repository must store one version of each chart per member, with charts maintained at the member level rather than tied to individual projects or retrievals. A single version ensures teams work from a consistent, longitudinal record. Member-level organization supports consistency across programs.

Intelligent chart intake

Clinical data repositories support bulk upload and accept multiple file types. Artificial intelligence supports chart intake by attaching incoming files to the correct member and extracting key metadata. Teams spend less time sorting files and correcting misfiled records.

Interoperability-ready architecture

The repository supports import and export of charts across systems, including analytics platforms, health information exchanges, audit workflows, and internal data warehouses. Documentation moves across programs and remains accessible

Fast, flexible chart access and reuse

Operations, clinical, and audit teams need to locate documentation quickly. The ability to search across member, provider, group, and date of service is required. Without it, teams revert to manual search or initiate new retrieval requests.

AI and NLP enrichment

Optical character recognition (OCR) and natural language processing (NLP) extract structured data from unstructured records and improve chart searchability and downstream analytics. Artificial intelligence (AI) enrichment operates as a defined feature with specified outputs, validation methods, and use cases. Health plans need visibility into what is extracted, how it is validated, and where it is applied before relying on the output.

Security, compliance, and audit trails

HIPAA-compliant infrastructure is a baseline requirement. Clinical data repositories require role-based access controls and chart-level audit logs that capture who accessed a record, when access occurred, and how the record was used across programs.

Clinical Data Repository Checklist

Use this checklist when evaluating clinical data repository vendors or assessing whether your current documentation approach is ready for the audit environment ahead. Each section reflects the capabilities health plans need to consolidate charts, reduce duplicate retrieval, and support risk, quality, and compliance programs from a single, member-level record.

A single, member-based record

- ☐ One version of each chart per member (not per project or retrieval)
- ☐ Embedded into risk, quality, retrieval, and audit workflows

Intelligent chart intake

- ☐ Bulk upload via UI, SFTP, and API
- ☐ Multiple file types accepted (PDFs, images, XML, etc.)
- ☐ Charts auto-matched to the right member
- ☐ AI to capture key metadata (provider, group, date of service)

Interoperability-ready architecture

- ☐ Integrations with EMRs, HIEs, and existing analytics platforms
- ☐ Import/export via SFTP and open APIs
- ☐ Connections to analytics, audit workflows, and data warehouses

Fast, flexible chart access and reuse

- ☐ Robust search by member, provider, group, and date of service
- ☐ Charts shared across risk adjustment, quality, RADV, and audit programs

AI and NLP enrichment

- ☐ OCR and NLP to make unstructured charts searchable
- ☐ Defines what data is extracted, how it's validated, and where it applies
- ☐ Transparent, traceable AI-powered insights

Security, compliance, and audit trails

- ☐ HIPAA-compliant infrastructure
- ☐ Role-based access controls
- ☐ Chart-level audit logging
- ☐ Complete access and usage history

How Reveleer Clinical Data Repository supports a unified approach

Reveleer Clinical Data Repository is designed for health plans that manage charts across multiple programs and vendors. It supports a shift from project-based retrieval to a member-level documentation model that can be used across risk adjustment, quality, audit, and care management workflows.

Reveleer Clinical Data Repository:

- Reduces duplicate chart retrieval and associated vendor and provider costs
- Limits provider abrasion by consolidating requests across teams
- Speeds audits and submissions through metadata-driven search
- Establishes a reusable, member-level record for each chart

Each chart becomes a single, member-linked record that can be accessed across programs, with a documented audit trail and no repeated retrieval.

Unify your documentation approach

Reveleer supports health plans across risk adjustment, quality, and compliance workflows, including RADV, IVA, and HEDIS medical record review. The platform connects data acquisition, member-level documentation, and analytics to support audit readiness and program execution.

See how Reveleer Clinical Data Repository supports a unified documentation approach.

Request Demo

Sources

1. "Medical Record Retrieval Pricing." On-Call Legal. Available at: https://www.oncalllegal.com/medical-record-retrieval-pricing/.

2. "Assessing the Accuracy of Automated Abstraction of Quality-of-Care Indicators From Electronic Health Records Compared With Human Abstraction." BMJ Quality & Safety, published online 22 Jan. 2026. Available at: https://qualitysafety.bmj.com/content/early/2026/01/22/bmjqs-2025-019112.

3. "CMS Rolls Out Aggressive Strategy to Enhance and Accelerate Medicare Advantage Audits." CMS Newsroom, 21 May 2025. Available at: https://www.cms.gov/newsroom/press-releases/cms-rolls-out-aggressive-strategy-enhance-accelerate-medicare-advantage-audits.