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Governance Innovation in the Transformation of a Public Health System

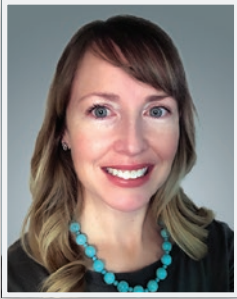## Partnership, Simplicity, and Advocacy: Reimagining the Patient Financial Experience

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ADVISORS' CORNER
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Partnership, Simplicity, Advocacy

As I write this, we are in the midst of what many believe to be the height of the omicron surge. My hope is that by the time you read this, the surge is over and providers can (finally) see a brighter light at the end of this very long tunnel.

How do we keep our momentum going? How do we continue to press on through the noise, when we are exhausted and maybe many of us are losing hope? As I look back at how the pandemic has impacted me, our readers, Americans, the world, and the healthcare system, the more strongly I feel that waiting/hoping to get back to where we were before is fruitless. And that not going back to where we were before is an ok thing—perhaps its better. Maybe this pandemic has given us the courage to truly learn from our mistakes of the past and think differently about solving problems in new ways. In the words of advisor Marian Jennings, don't be afraid to tackle "wicked" problems. That is why we come to the boardroom table.

At The Governance Institute, we work very hard to observe and analyze industry trends that have implications for boards, and then help our readers narrow their focus and quiet the background noise, so they pull up their sleeves and press on with the governance activities that will make the most impact. Let's keep things simple, let's partner with others to do more, and let's advocate for our patients and communities.

Kathryn C. Peisert

Kathryn C. Peisert,
Managing Editor

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Governance Innovation in the Transformation of a Public Health System

By Steve Purves, Valleywise Health

Before 2004, Valleywise Health (formerly known as Maricopa Integrated Health System) was part of Maricopa County government and overseen by the County Board of Supervisors. In 2004, voters approved a referendum to create the Maricopa County Special Health Care District, which today is governed by a five-member board of directors elected by voters within Maricopa County. The members serve four-year staggered terms with no term limits. The district complies with the Arizona open meeting and public record statutes, and board meetings are conducted accordingly and are open to the public.

In 2014, the voters approved a $935 million bond referendum to "reimagine" the entire health system and replace its aging physical infrastructure with a new teaching hospital, clinics, and behavioral health facilities. The project is just over 50 percent completed but has required additional governance oversight of these public expenditures and the creation of an integrated

About Valleywise Health

The Maricopa County Special Health Care District, also known as Valleywise Health, has been serving Maricopa County, Arizona, for over 145 years. Maricopa County encompasses over 9,200 square miles and includes Phoenix, Mesa, Glendale, several other municipalities, and reservations belonging to the Fort McDowell Yavapai Nation, the Gila River Indian Community, and the Salt River Pima-Maricopa Indian Community. Valleywise Health is a public teaching hospital and safety net system that includes the Valleywise Health Medical Center, the Arizona Burn Center, three inpatient behavioral health centers, and a network of ambulatory care facilities.

The ambulatory network includes 12 FQHCs and two multi-specialty clinics located throughout the county. These clinics provide access to primary, specialty, and integrated behavioral healthcare for thousands of uninsured and Medicaid beneficiaries in the community; over 60 percent of patients served by Valleywise Health are either Medicaid beneficiaries or uninsured. In total, the system serves over 500,000 patients each year in the clinics.

program management office to help manage it.

The district board of directors has a fiduciary duty that requires decision making in the best interest of Valleywise Health's mission. As publicly elected officials, board members also have a responsibility to the taxpayers who support the operation of Valleywise Health through a tax levy. Board members are obligated to comply with the Arizona statutes and enabling legislation that apply to the governance of the district. Although plenty of literature exists regarding healthcare governance best practices in the private sector, it can be difficult to deploy those practices in the public arena.

The Challenges of Governance in the Public Arena

Important considerations such as board member selection, board composition and size, committee structure, and the general conduct of board meetings are sometimes proscribed in law for boards of public bodies and prevent them from implementing generally accepted best practices from the private sector. In addition, public governing bodies have significant fiduciary obligations in their oversight of public assets. Ensuring transparency, conducting open meetings, and providing access to records, including minutes, supporting materials, and agendas, makes board operations more complex. Furthermore, these public accountabilities require positive relationships between board members, the CEO, the medical staff, and partners to achieve organizational success. The board's accountability to the public has required focus, discipline, and support provided by the district counsel, the CEO, a chief governance officer, and the senior leadership team.

Adding complexity to the district board's governance role is the oversight of the 12 federally qualified health centers (FQHCs). The Health Resources and Services Administration (HRSA) has federal regulatory oversight of FQHCs and promulgates specific rules for governance of these facilities. Among these rules are

Key Board Takeaways

To improve efficiency and effectiveness, the Maricopa County Special Health Care District Board recommends the following best practices for publicly elected boards:

- **Effective governance structures:** Ensure adequate structures are in place to provide public accountability, for example, governing bodies needed to oversee FQHCs and/or models to generate philanthropic support.
- **A chief governance officer:** A CGO works closely with the CEO and other senior leaders to ensure governing bodies conduct their affairs in strict accordance with the federal, state, and/or local laws.
- **Effective use of consent agendas:** Providing board packets ahead of time and using a consent agenda can help to increase efficient use of meetings.
- **Appropriate use of board executive sessions:** In addition to monthly public board meetings, monthly executive sessions should be held strictly for matters related to state open meeting and public record statutes.
- **Committee of the whole:** If there aren't enough board members to have standing committees, effective agenda planning and use of consent agendas allow more time for important governance issues.

the requirements that there is a governing body overseeing the FQHCs that, among other requirements, is composed of at least nine members with a majority being consumers or "users" of the facilities. However, the composition of the district board is proscribed by Arizona statute; therefore, a separate board structure is needed to ensure compliance with HRSA regulations. The solution to the conflicting requirements was the creation of a governing council to oversee the FQHCs. This relationship between the district board and governing council is outlined in a co-application agreement and was specifically designed to satisfy the regulatory requirements of both entities.

Another challenge that many public tax-supported hospital systems face is how to generate philanthropic support. At Valleywise Health, the board adopted an innovative approach from a model deployed by a leading university. The model involved the creation of a cooperative services agreement between Valleywise Health and the Valleywise Health Foundation, a private

Partnership, Simplicity, and Advocacy: Reimagining the Patient Financial Experience

By Joseph J. Fifer, FHFMA, CPA, Healthcare Financial Management Association

Consider the term "patient financial experience." It sounds like it's entirely separate from the rest of a healthcare experience, yet nothing could be further from the truth. Consumers simply don't perceive experiences that way. This is easy to understand as it relates to an everyday experience, like grocery shopping. Consumers notice financial aspects of the supermarket experience, such as long checkout lines, high prices, and confusing self-checkout equipment, along with non-financial aspects, such as lower-than-expected quality or limited product selection. They take all aspects of the experience into consideration when choosing where to shop next. Healthcare consumers do the same.

In healthcare, the dividing line between the clinical and the patient financial experience is an artificial one that developed as the nation's payment system became more complex and compartmentalized. To take a more holistic approach, we offer three strategic recommendations in a new report, *The Role of Revenue Cycle in Elevating the Human Experience in Healthcare*:[1]

- Establish and build from a foundation of partnership with consumers.
- Simplify the complex healthcare payment experience.
- Commit to a focus on advocacy.

Establish and Build from a Foundation of Partnership

Hospital billing and payment processes trace their origins to the 1950s, when employer-sponsored health insurance became prevalent in the United States. Legacy healthcare stakeholders are still using business processes designed for a business-to-business marketplace. That's all the more reason why it's imperative to engage consumers when identifying and implementing opportunities for improvement.

A provider organization's commitment to improving the patient financial experience is evidenced by the variety of, and attention to, interactions with patients to learn more about their experiences. To improve health equity, that should include hard-to-engage consumers, such as Medicaid beneficiaries and patients who are receiving financial assistance.

Consumer feedback on the financial experience may be obtained in various ways, ranging from instant one- or two-question pop-up surveys to structured focus groups to patient and family advisory councils. Being smartphone-friendly is an essential component of any experience rating strategy.

To encourage partnership with consumers, board members can ask finance leaders questions like:

- What are consumers telling us about our billing and payment processes?
- What channels do we have in place for obtaining consumer feedback on their financial experience?
- Are applications for financial assistance tracking with changes in our community's socioeconomic indicators?
- Are we getting any feedback about billing and payment on social media?

Because financial experiences are more likely to be a dissatisfier than a satisfier, negative feedback may be viewed as a

Exhibit 1. Experience Touchpoints

ENGAGED PATIENT
Coordination of Care
Coordinated Financial & Clinical Care
Compliant Clinical Documentation

PATIENT EXPERIENCE — CULTURE, PROCESS, COMMUNICATIONS, TECHNOLOGY, METRICS, PEOPLE

Patient Arrival
Validation & Activation
Financial Clearance
Patient Care Delivery
Clinical Documentation & Revenue Recognition
Case/referral Management

ENGAGED CONSUMER
Ease of Access
Improved Consumer Service
Improved Quality

CONSUMER EXPERIENCE — CULTURE, PROCESS, COMMUNICATIONS, TECHNOLOGY, METRICS, PEOPLE

Scheduling
Pre-registration
Insurance Verification
Authorization
Price Estimation
Financial Counseling
Cashiering

CUSTOMER EXPERIENCE — CULTURE, PROCESS, COMMUNICATIONS, TECHNOLOGY, METRICS, PEOPLE

Collection Agency
Self-pay Collection
Customer Service
Third-party Follow-up
Payer Payment Analysis
Denial Processing
Remittance Processing
Claim Processing

SATISFIED CUSTOMER
Appropriate Payment
Effective & Efficient Account Resolution
Decreased Cost to Collect

1 Jason A. Wolf, *The Role of Revenue Cycle in Elevating the Human Experience in Healthcare,* The Beryl Institute and HFMA, October 2021.

The Impact of AI Technologies in Healthcare

By Angel F. Valladares, M.P.H.

Just five years ago, healthcare was considered one of the most poorly digitized sectors of the U.S. economy, believe it or not, next to construction and agriculture.[1] Some of the reasons experts attribute to healthcare's lag in digitization versus other sectors are the older workforce, disincentive to expand data access due to strong privacy regulations, lack of financial incentives to exchange data, and an insufficient rate of true disruption witnessed by other industries. However, the COVID-19 pandemic that began in early 2020, may have at least temporarily disrupted that dynamic.[2] That disruption may have been just enough to cause a significant shift in the rate of technology adoption to allow for runaway digitization in healthcare. One technology experiencing exponential growth, and is the industry's latest buzzword, is the domain of artificial intelligence (AI). AI is the term used to describe the use of computers and technology to simulate intelligent behavior and critical thinking comparable to a human being; it is a *domain* of technologies and not one in and of itself.[3]

AI's footprint in North America is seeing massive growth, particularly from the tech sector, which powers many of the consumer-oriented products we all use today. Targeted advertising on social media, app-based car services like Uber or Lyft, and Alexa, Siri, and Google Home are all based on underlying AI technologies. In fact, AI is now involved in almost 15 percent of the economy in North America; that's over $3.7 trillion! However, despite that very large market footprint, estimates of the market size of AI in healthcare *globally* range from only about $4 billion to $10 billion as recently as 2020.[4]

Despite being a relatively small fraction of the healthcare market, AI's footprint is expected to grow by a factor of 10 over the next five years by most accounts. One of the core drivers for AI's growth is the exponential growth of digital data in healthcare (which AI both takes advantage of and has a hand in producing). Due to the volume and complexity of "big data," we increasingly require more advanced data science to interpret and generate valid and meaningful insights that require AI to conduct. While AI in healthcare is most prominently in use in the life science/biotechnology sector, there are technologies already impacting hospital operations and decision making. The projected growth of the AI market makes it a pivotal time for hospital boards and senior leaders to gain a better understanding of where AI is being developed and deployed for use in clinical care and hospital operations.

Market Pressures Driving Growth of AI in Healthcare

Before providing an overview of what AI in healthcare looks like, it is important to understand the drivers of its growth. The healthcare industry is facing considerable pressures due to several social, policy, and economic developments and trends. Socially, the U.S. population is aging. In fact, seniors will outnumber children by 2035 according to the U.S. Census Bureau.[5] Given that as we age, we tend to need more healthcare services, an aging population will have more demand for care.

On the policy front, the federal government has consistently moved forward across administrations with payment, delivery, and data infrastructure reforms that have changed the landscape. While by no means coordinated to any true extent, federal policy has pushed for a focus on shifting payment from volume to value and has incentivized healthcare

Key Board Takeaways

- When considering AI, ensure the ultimate goals of efficient, more cost-effective, patient-centered care guide decision making.
- Prepare for AI's arrival. For example, consider patients' expectations around AI-assisted virtual care options and the data security measures that would need to be put in place.
- Have a fundamental understanding of AI use cases and value propositions and keep track of maturing technologies.
- Be strategic with AI investments. As with any technology, ensure the organization can accurately track and measure the ROI of an AI product.

Exhibit 1. Market Pressures Driving Growth of AI in Healthcare

Social
- Aging population
- Healthcare staff shortages
- Increased demand from patients and consumerization

Policy
- Pressure to reduce healthcare costs and increase quality
- Pressure on stakeholders to exchange healthcare data

Economic
- Availability of capital in healthcare
- Explosion in data availability
- Decreased cost of improving computing power

Increase in AI Demand
- Provide for novel methods to harness exponential growth in big datasets
- Provide for assistive tools to support clinical delivery in a more efficient way

1 Prashant Gandhi, Somesh Khanna, and Sree Ramaswamy, "Which Industries Are the Most Digital (and Why)?," *Harvard Business Review,* April 1, 2016.
2 Heather Landi, "COVID-19 Has Accelerated the Adoption of AI. Executives from Google Cloud, Suki, and Olive Spell Out Why," *Fierce Healthcare,* August 13, 2020.
3 Paras Malik, et al., "Overview of Artificial Intelligence in Medicine," *Journal of Family Medicine and Primary Care,* July 2019.
4 Sumant Ugalmugle and Rupali Swain, *Artificial Intelligence in Healthcare Market Forecast Report 2021–2027,* Global Market Insights, October 2021; *Artificial Intelligence in Healthcare Market by Offering,* by Technology, by End-Use, and Region Forecast to 2027, Reports and Data, January 2021; *Artificial Intelligence in Healthcare Market Report, 2021–2028,* Grand View Research, May 2021.
5 Deidre McPhillips, "Aging in America, in 5 Charts," Best States, *U.S. News & World Report,* September 30, 2019.

providers to adopt health information technology (HIT) to improve data exchange. Experts would say that the former driver is a reaction to runaway healthcare costs, which have consistently increased at a rate of 3.5 to 6 percent a year—especially the costs of clinical services, healthcare administration, and prescription drugs.[6] The latter focus on HIT adoption has been an attempt to modernize U.S. healthcare infrastructure to reduce administrative costs and more recently, improve data sharing between providers, payers, and patients. To the extent that this HIT adoption has delivered on this promise is still up for debate.[7]

According to Forbes, 90 percent of all the world's data was generated in the last two years alone.

Running concurrently with these major trends is the consumerization and personalization of healthcare to resemble other consumer-focused economic sectors. In other words, patients are asserting more influence and control over their medical needs and wellness. Given the explosion of information available on the Internet, thanks to "Dr. Google,"[8] patients are in return more empowered to search for the services they deem necessary to address their concerns and maintain their well-being. In fact, recent research suggests that up to four in five patients will show up to their healthcare providers having conducted their own diagnosis research.[9]

In response, the market has produced thousands of patient-facing services from telehealth, to wellness management applications, to even personalized digital therapeutics and diagnostics, which are often powered by AI-based machine learning technology. However, the ubiquitous use of these solutions requires an environment supportive of high transmissibility of data between entities and that assumption is challenged by the patchwork of data privacy and security regulations in place.

Where Is AI Changing the Healthcare Paradigm?

The best way to understand the growth and impact of AI in healthcare is to understand where it is already disrupting or projected to have a disruptive effect on the provision of healthcare services. However, it is also important to note that AI use has accelerated substantially in the biotech industry to support drug discovery, clinical trial enhancement, and even post-approval market adoption activities. Moreover, while the overview below will focus solely on AI's impact directly on care delivery and healthcare organization decision making, it is important to recognize AI's acceleration throughout the entire sector.

Outlined below are the key AI-based technologies that have been developed or are being developed to meet the needs of healthcare provider organizations. Each use case includes an overview of the opportunity, the potential impact to care delivery, and what is needed for the promises to be fully achieved.

Population health management:

- **Opportunity:** Machine learning[10] algorithms may be deployed to facilitate real-time feedback on provider performance and insights on community health to manage patient populations. AI can also be deployed in the form of virtual assistants[11] to enhance patient engagement tools in support of patient self-management.
- **Impact:** Streamlined patient registration and intake, alignment with patient preferences (which are continuing to transition to virtual interactions versus traditional phone calls), triaging patients based on reported symptoms and needs, and finally more real-time care management for patients with complex diseases.
- **What's needed:** Healthcare providers need to more actively manage the data that is being provided by patients to inform future patient engagement strategies. This is also a very saturated market and organizations should diligently assess

Exhibit 2. AI Use Cases and Main Impacts

AI Use Cases	Main Impacts	Maturity Level
Population Health Management	• Insights on practice-level outcomes • Increased patient engagement	
Remote Patient Monitoring	• Potentially reduce adverse events • More effective use of biometric data	
Clinical Decision Support	• Real-time clinical decision support • Delivery of personalized patient care	
Extraction of Clinical Data	• Reduce clinician administrative burden • Better access to unstructured datasets	
Revenue Cycle Management	• Holistic and more efficient revenue cycle management and operations	
Imaging (neural networks)	• Pattern detection for patient diagnosis • Improve efficiency of radiology practice	

Some Solutions At-Scale   Mostly Point Solutions   Mostly Pilot-Phase Solutions

6 Apoorva Rama, "Policy Research Perspectives: National Health Expenditures, 2019: Steady Spending Growth Despite Increases in Personal Health Care Expenditures in Advance of the Pandemic," American Medical Association, May 2021.

7 Robert Rudin and Paul Shekelle, "What Have We Learned About Leveraging Health Information Technology to Improve Health System Performance?," RAND Corporation.

8 Riza Conroy, "What Your Doctor Wants You to Know About 'Dr. Google,'" The Ohio State University, Wexner Medical Center, February 15, 2019.

9 *The Consumerization of Healthcare,* Econsultancy and Adobe, February 2019.

10 Sara Brown, "Machine Learning, Explained," MIT Sloan School of Management, April 21, 2021.

11 Adam Miner, Arnold Milstein, and Jefferey Hancock, "Talking to Machines About Personal Mental Health Problems," *JAMA,* October 3, 2017.

Barriers to Development of AI

The main barriers to significant development of AI in the recent past have included:

- Healthcare lacking proliferation of environment-awareness technologies (e.g., sensors)
- The right volume of *digital* data necessary to require complex analytics that AI supports
- Lack of business models mature enough to use AI effectively
- A lack of true demand for broad and deep data insights to drive decision making
- A general dearth in sufficient computer processing power to support AI implementation

However, the market pressures shared in this article have pushed the industry far enough along that most of these barriers have been overcome and there is now sufficient momentum to support a burgeoning AI market in healthcare.

options that best meet the needs of the patient populations under their care.

Remote patient monitoring:
- **Opportunity:** AI can substantially increase the value of implementing remote patient monitoring (RPM). For instance, machine learning algorithms can be developed and deployed, built upon analysis of large data sets, to better identify patient populations who would best respond to RPM. Further, RPM on its own generates real-time biometric data at a staggeringly higher volume and frequency that can improve learning algorithms to better guide care teams with treatment decision making.
- **Impact:** Ultimately, this technology enhanced by AI is promising to improve patient outcomes by reducing avoidable events, thereby offsetting healthcare costs associated with complications, avoidable admissions, and additional ED utilization.
- **What's needed:** If RPM is to deliver on these promises, AI technology will be required to integrate newly generated data into clinical workflows, accurate predictions, and effective

patient identification. This means that the right EHRs and clinical data systems capable of interfacing with AI technologies will need to be in place before seamless integration and subsequently improved care can be achieved.

Today, algorithms are already outperforming radiologists at spotting malignant tumors, and guiding researchers in how to construct cohorts for costly clinical trials.

Clinical decision support:
- **Opportunity:** AI in the form of predictive analytics may be deployed to leverage contextual information on patients to provide more personalized, patient-centric care that considers data on external factors previously inaccessible to provider systems (e.g., social determinants of health and consumer data).
- **Impact:** This would enable providers to leverage the powerful insights generated from AI-based models to not only implement best practices but iteratively improve on process.
- **What's needed:** For clinical decision support to truly be enhanced in various disease areas, underlying clinical data that is often siloed or not readily available to support advanced analytics will need to be transformed or generated if non-existent. This will require complementary technologies like RPM, wearable devices, and specific types of AI like natural language processing to function in unison, which will necessitate the appropriate computing power to support.

Extraction of clinical data (natural language processing):
- **Opportunity:** Natural language processing (NLP)[12] may be used to translate unstructured clinical notes or even voice recordings of patient consultations into relevant, structured data that can easily be embedded in EHRs.
- **Impact:** As a result, NLP may reduce administrative burden in the form of clinical documentation, which is often

cited as a reason for clinician burnout. In addition, it may increase the utility of clinical data to support real-world clinical insight generation for research and process improvement.
- **What's needed:** Training datasets that are as unbiased and balanced as possible to support maximum model validity and reduce bias risks will be needed. That will require advanced data analytics capabilities to enable iterative evaluation and post-hoc improvements to established models to better fit model performance to diverse patient communities.

Revenue cycle management (RCM):
- **Opportunity:** Existing use cases of AI in RCM are mostly focused on patient payment estimation modeling and eligibility and benefits verification. In the near term, AI is maturing to support prior authorization and payment amount and timing estimation.
- **Impact:** Once many of these solutions mature (which is projected to happen quickly), they will transition from point solutions solving just one problem to end-to-end support of RCM. In that state, hospitals will benefit from being able to better manage RCM holistically.
- **What's needed:** Simply stated, these solutions are not mature enough yet. Most of the offerings on the market support one single solution and do not articulate a clear ROI making their up-front investment costs questionable.

Imaging (neural networks):
- **Opportunity:** Neural networks, which mimic the way neurons in the brain signal to one another, support deep learning[13] that can recognize patterns in imaging data. AI deployment in support of radiology can take shape in two forms: 1) a machine learning algorithm that follows predefined criteria supported in clinical guidance documents to assist a radiologist's decision making more readily, and 2) using either supervised or unsupervised deep learning on large volumes of imaging data to extract patterns and insights likely to be missed by a human expert alone.
- **Impact:** These algorithms may detect and identify rapidly declining disease

12 "What Is Medical or Clinical NLP?" Lexigram.
13 "Deep Learning vs. Machine Learning," Western Governors University, February 5, 2020.

states, quantify lesions on previous and current scans, and predict morbidity and mortality from a series of images.

- **What's needed:** Currently, AI-supported imaging technology is expensive, and the ROI is not generated quickly given the learning curve required of radiologists. In addition, many available technologies in this area suffer from "black box syndrome" in that some deep learning platforms may not provide sufficient transparency to clinical experts to trust the insights generated.

Challenges and Risks with AI Use

After reading the overview above, anyone would likely assume that AI may be a silver bullet to the various challenges faced by healthcare providers. However, as with any burgeoning technology, there are challenges as well as risks with adoption. For AI technology specifically, here are some of the major associated challenges and risks to consider.

AI Use Risks

"Garbage in, garbage out" is a critical issue in AI technology associated with the quality of the underlying training data for model development and improvement. Readily available, fit-for-purpose data is still hard to come by given that many datasets are generated in siloes and there is still poor adherence to data standards. Bad data could influence your AI platform and provide you with inaccurate insights, poorly impacting your organization's decision making.

Also, without a diverse and representative sample in the data used to develop algorithms irrespective of AI modality, there is a high risk of perpetuating bias and inequities that are already present in the healthcare system today. This is quite relevant when AI models are applied to different populations, they will need to be modified to better fit the nuances of each respective patient community.

AI Use Challenges

For more advanced use cases, consider the need for appropriate computer processing power (e.g., imaging), reliable broadband connections (e.g., remote patient monitoring), and

technical literacy and familiarity by both providers and patients. In some settings, these resource requirements will prove to be major access barriers to AI adoption. Oftentimes, some of the most challenging patients are least likely to meet the minimum requirements for technology adoption. Disparities in data and technological infrastructure will reflect unequal access to innovation.

The black box problem is also often an adoption barrier for even some of the most well-developed AI tools. If providers are unable to understand the process undertaken by an AI tool to generate insights or if the insights are not translated appropriately to achieve maximum interpretability, then the tools will not live up to their purpose or promise.

The Board's Role

No matter what type of AI is being considered, what's important is for hospital boards and executives to ensure the ultimate goals of efficient, more cost-effective, patient-centered care guide decision making. AI in healthcare is coming no matter what, so hospital leaders should get ahead of the curve by preparing for its arrival, if they have not done so already. A few things to consider include:

- Forward-thinking patients (especially those with chronic conditions) now expect to have access to convenient AI-assisted virtual care options. Hospitals and health systems that haven't yet adapted long-term to this shift in preferences are likely to see major financial impacts.
- Data security will become increasingly important as siloes are broken down and data is more freely exchanged between business units. Securing the systems from hackers and malware and making sure that their self-maintenance functions are reliable will be critical.

It's also important to note that not all AI is created the same. Hospital leaders should have a fundamental understanding of AI use cases and value propositions and keep track of maturing technologies, for example:

- Engage vendors early in the exploration process and ask questions regarding how they use AI in their products, what data will need to be in a ready state for the models

to function properly, what efficiencies should be expected as a result of implementation, and so on.
- Also, consider not just what rules and logic an offering's AI is based on but how service providers improve upon the logic by incorporating new components or rules; avoid signing up for a black box service.

The board and management need to be strategic with investments in AI. It can get expensive fast, so hospital executives should ensure they can accurately track and measure the ROI in an AI product, as with any technology:

- Conduct a top-down assessment of existing technological capacity and data needs of the organization before investing in any one technology.
- Assess resource needs to find and retain the staff needed to support these systems, amid a general shortage of data scientists.
- When engaging with vendors, determine an opportunity to conduct a pilot phase to be able to evaluate the potential impacts to the organization and its constituents, especially.

AI is certainly a very promising technology that is purported to bring much-needed efficiencies and improvements to the U.S. healthcare system. However, it is important to recognize that our understanding of the short- and long-term impacts of AI in healthcare are still highly dependent on how market pressures evolve and the timeline of maturity for many of the use cases. For hospital leaders specifically, now is the time to become familiar with AI use cases and properly assess what resources and skills will be necessary to deploy available technologies. Ultimately, just like any major investment, a strategic approach with a clear assessment of benefits and risks will increase the value-add of AI solutions and minimize any potential negative impacts.

Oh, the Irony: An Unwelcome Surprise for Providers Implementing the No Surprises Act

By Anne M. Murphy, Arent Fox LLP

In late December 2020, Congress passed the No Surprises Act (the Act), which went into effect January 1, 2022.[1] As a general matter, the Act is designed to limit the phenomenon of patients receiving a "surprise bill" when an out-of-network healthcare provider—whether a clinician or facility—seeks to recover from the patient the difference between a payer's out-of-network reimbursement and the provider's billed charges.

The Act received bipartisan support. In keeping with this, both the American Hospital Association (AHA) and the American Medical Association (AMA) have generally supported the goals of the Act. Many patients were surprised by large bills received directly from providers, unaware at the time they received services that the care was being provided, in whole or in part, by out-of-network healthcare providers. According to advocates of the Act, patients were unfairly put in the middle of disputes between providers and payers as to reimbursement for out-of-network healthcare services. Despite this broad consensus regarding the Act, however, there has been controversy regarding certain provisions of the implementation rules.

Key Provisions of the Act

The Act governs three health service delivery situations: 1) emergency services, 2) non-emergency services furnished by out-of-network providers at in-network facilities, and 3) air ambulance services. The Act does not apply to services provided at an out-of-network facility that has no contractual relationship with the covering payer. It does apply, however, to ancillary or other services provided by out-of-network providers at an in-network facility. For example, the Act's provisions may apply to services delivered to a patient at an in-network hospital by out-of-network anesthesiologists or radiologists. It also may apply if a facility is in-network for certain specialized services but out-of-network for other services.

The Act generally bars balance billing by out-of-network providers in the three circumstances described above. Instead, out-of-network charges to patients are limited in the following ways:

1. Patient payments are capped at the patient's cost-sharing requirement for in-network care, according to a process described in the Act. For example, if a patient has a 20 percent co-pay requirement for the care if provided in-network, that same 20 percent co-pay applies to the care if provided out-of-network.

2. The health plan/payer must pay the out-of-network provider an "out-of-network rate," as described in the Act. This rate will be determined by state law, if applicable, by agreement between the provider and payer or, if no agreement is reached, through a rate determined by independent dispute resolution (IDR).

Several features of the Act are important to note:

- In addition to a bar on balance billing, the provisions related to emergency services require payers providing such coverage to do so without prior authorization and regardless of whether a facility is out-of-network. Payers cannot deny claims for emergency services based on an aftercare assessment.

- Patients can waive the Act's protections for non-emergency services, but with significant limitations. Waiver generally is not allowed for certain ancillary services such as emergency medicine, anesthesiology, pathology, and radiology; services provided by hospitalists, assistant surgeons, and intensivists; and services arising from unanticipated clinical complications. Where a waiver can be sought, a provider must do so via a detailed written patient consent provided at least 72 hours before a scheduled appointment or three hours before a same-day appointment. That written consent must contain certain information, including what in-network providers are available and a good faith cost estimate of the total amount of proposed out-of-network care.

- Providers must provide to patients and the public a one-page, plain language explanation of the Act.

- The Act is being enforced primarily by the States. If States do not provide adequate enforcement, CMS may step in. In addition, CMS will have audit and investigatory authority.

Controversy Regarding the Rules Implementing the Act

While there is wide agreement on the goals of the Act, and on the provisions of the Act itself, substantial controversy has emanated from interim final rulemaking promulgated by several federal agencies to implement the Act. This rulemaking has taken place in two parts (collectively, the Rules).[2]

The second installment of the Rules, published on October 7, 2021, offers details regarding the IDR process for resolving payer/provider reimbursement disputes. While the provisions are quite technical, they can be summarized as follows:

In the event the parties cannot reach an agreement on reimbursement for

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> ### Key Board Takeaways
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> - The No Surprises Act will have a significant and immediate impact on permitted patient billing. Board members should be informed by the executive team as to how each hospital is implementing the Act to understand the compliance, operational, and financial impacts.
> - Litigation has been filed by the AHA and the AMA challenging implementation rules. Board members should, through the executive team and legal counsel, monitor the litigation's progress. Although the litigation does not currently delay implementation of the Act, its outcome will have important policy and financial consequences for each hospital and for the healthcare system as a whole.

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1 "Rules Committee Print 116–68 Text of the House Amendment to the Senate Amendment to H.R. 133," December 21, 2020; "Detailed Summary of No Surprises Act," AHA, January 14, 2020.

2 Caroline Turner English and Alison Lima Andersen, "No More Surprise Medical Bills: First 'No Surprises Act' Rule Issued," Arent Fox, July 12, 2021; Caroline Turner English and Alison Lima Andersen, "No More Surprise Medical Bills: Second 'No Surprises Act' Rule Issued, But More Remains to Be Done," Arent Fox, December 2, 2021.

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501(c)(3) organization. The agreement set forth the specific obligations of the foundation to generate defined levels of philanthropic support in exchange for a defined level of overhead support provided by Valleywise Health. This arrangement has promoted increasing levels of accountability between the organizations. Since its inception in 2018, the Valleywise Health Foundation has increased its annual fundraising by over 100 percent.

Key Success Factors for the Board
Beyond the innovative governance structures, the following were key success factors that helped the board navigate an extraordinarily complex environment:
- **The chief governance officer** (CGO): The role of the CGO was formalized in 2017. This position has accountability to the board. The CGO ensures the governing bodies conduct their affairs in strict accordance with the Arizona statutes and with the HRSA. The CGO works closely with the CEO and senior staff to facilitate communication with board members and to facilitate effective meetings of the district board and governing council.
- **Effective use of consent agendas**: There are many approval items for the board to consider at each monthly board meeting. Board packets are sent to board members a week ahead of the meeting. During that time, the CGO and senior staff address questions from board members regarding consent agenda items to make more efficient use of the time spent in board meetings.
- **Appropriate use of board executive sessions**: In addition to the monthly public board meetings, there is a monthly executive session reserved strictly for matters that are allowed by Arizona statutes.
- **Committee of the whole**: Because there are only five board members, the board does not have standing subcommittees. Although it is unusual for most hospital or health system boards to not have subcommittees, effective agenda planning and use of consent agendas allow more time for reports and discussion on quality, finance, and other important governance issues. The CEO also has monthly meetings with board members to fully brief them before public meetings to ensure there are no surprises.

As a complex public teaching hospital and safety net system of care undergoing tremendous change, it was essential for the district board to find ways to improve governance efficiency and effectiveness. The coronavirus pandemic further tested the ability of the district to react quickly and still comply with the numerous rules that apply to how publicly elected boards conduct their business in Arizona. Although the health system had to drive operational and clinical innovation to fulfill the promise of a new and vibrant public hospital system for Maricopa County, so too, did it require innovation in the boardroom.

The Governance Institute thanks Steve Purves, President and CEO, Valleywise Health, Phoenix, for contributing this article. He can be reached at steve.purves@valleywisehealth.org.

Oh, the Irony…

out-of-network services, either party can seek IDR by an approved independent dispute resolution entity (IDRE). An IDR process will be binding arbitration, and the rate selected by the IDRE will be final. In resolving the payment dispute, according to the Rules, the IDRE "must" select the offer closest to the "qualifying payment amount" (QPA). The QPA generally is the median contracted in-network rate paid by the payer for comparable services in that geographic area. In addition, the Rules impose a requirement that the IDRE only consider "credible information" about non-QPA factors, whereas no such credibility requirement is associated with the QPA.

While additional information may be considered by the IDRE in resolving the dispute, the Rules create a strong presumption in favor of the IDRE selecting the rate closest to the QPA. In contrast to the Rules, the Act itself indicates the IDRE may consider a number of factors other than the QPA in selecting the payment amount. This provision in the Rules, which has been characterized as a "thumb on the scale" of the IDR process in favor of payers, has engendered widespread objection, not only from the health provider sector, but also from leadership of the Ways and Means Committee and from over 150 members of Congress.[3]

On December 9, 2021, the AMA, AHA, and individual provider plaintiffs filed suit in federal court, challenging these IDR provisions as contrary to the Act, and seeking to stay their implementation. The plaintiffs assert the IDRE should have latitude under the Act to consider equally a variety of factors in resolving a payment dispute, including the QPA and the provider's training and experience, patient acuity, complexity of care, relative market shares of the parties, contract history of the parties over the prior four years, previous good faith efforts to negotiate in-network rates, and in the case of a facility, its teaching status, case mix, and scope of services.[4] The IDR provisions in the Rules have been characterized as contrary to the Act and resulting in incentivizing payers to lower median in-network reimbursement and creating narrower networks to the detriment of providers.

Conclusion
While there remains uncertainty regarding the IDR provisions of the Act, it went into effect January 1, 2022. Hospitals and other healthcare facilities should comply with the requirements in the Act and in the Rules, while closely monitoring the challenge to the IDR provisions.

The Governance Institute thanks Anne M. Murphy, Partner, Arent Fox LLP, for contributing this article. She can be reached at anne.murphy@arentfox.com.

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3   See letters from the Ways and Means Committee and members of Congress (available at www.gnyha.org/wp-content/uploads/2021/10/2021.10.04-REN-KB-Surprise-Billing-Letter80.pdf and https://wenstrup.house.gov/uploadedfiles/2021.11.05_no_surprises_act_letter.pdf).

4   See cases filed at www.ama-assn.org/system/files/ama-v-hhs-as-filed-complaint.pdf and www.ama-assn.org/system/files/ama-v-hhs-as-filed-stay-motion-and-brief.pdf.

Partnership, Simplicity, and Advocacy…
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positive, in that it helps highlight areas for improvement. Negative feedback on social media, however, may be an indicator that consumers are not feeling heard by hospital representatives.

Simplify the Payment Experience

Healthcare billing and payment and insurance is complex and loaded with jargon. Board members who don't work in the healthcare industry may not be familiar with the financial experience touchpoints. **Exhibit 1** on page 4 depicts the touchpoints on the journey from engaged consumer (before a healthcare encounter) to engaged patient (during the encounter) to satisfied customer (after the encounter). Revenue cycle basics should be an element of board education.

For consumers, business processes related to billing and payment should be described in everyday terms that are easy to understand. This is one of the cornerstones of the Healthcare Financial Management Association's industry-consensus best practices for improving the patient financial experience.[2] Simplification should be a priority for the full range of communication modalities that consumers use, ranging from smartphones and patient portals to in-person consultations with financial counselors.

To convey that simplicity should be a priority, board members can ask finance leaders questions like:

- Walk me through what a consumer would do to get an estimate of their out-of-pocket responsibility. Are there plans in the works to make that process easier?
- What parts of our billing and payment processes are most confusing for patients, in the view of our frontline revenue cycle staff?
- What would you do to simplify the patient financial experience, if you had the resources?

Commit to a Focus on Advocacy

Many hospitals and health systems have a mission that centers around serving the organization's patients and communities. Revenue cycle, or financial services, should be an integral part of that mission. Reframing the revenue cycle mindset from one focused on collections to one that offers financial services to consumers—and advocates for them—is a game changer. It opens the door to a more consumer-centered future for the organization. And it's a prerequisite for legacy stakeholders who intend to compete with healthcare disrupters, many of whom are not just consumer-oriented but consumer-obsessed. Legacy stakeholders have a lot of catching up to do. Additionally, bringing revenue cycle staff into the fold with other team members who are mission-driven can enhance job satisfaction and fight burnout.

To spark a discussion about the value of a patient advocacy mindset, board members can ask finance leaders questions like:
- In your view, what does it mean to value patients in their role as healthcare consumers?
- How does patient education fit into revenue cycle processes?
- Are there aspects of the patient financial experience that feel like an "us-versus-them" mentality? If so, what are the barriers to changing that?

Moving Forward

Financial considerations loom larger in healthcare than they do in many other consumer purchases. In the supermarket, an unpleasant payment experience is often just an inconvenience. In healthcare, it can have lasting impacts, influencing a person's health choices long after a transaction is over. By recognizing that the financial experience is integrated with the clinical experience, adopting a consumerism mindset, and engaging with hospital finance leaders on these topics, board members can benefit their patients, communities, and organizations.

> *The Governance Institute thanks Joseph J. Fifer, FHFMA, CPA, President and CEO, Healthcare Financial Management Association, for contributing this article. He can be reached at jfifer@hfma.org.*

2   HFMA, "Healthcare Dollars & Sense."

Addressing "Wicked Problems"…
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5. **Anticipate at the outset the potential for "sunsetting" the collaborative partnership**. While wicked problems, sadly, are long-lasting, that does not mean that a partnership should continue indefinitely. Like other "mission-related" initiatives where no financial return is expected, collaboration can take on a life of its own. Agree upfront to "what would constitute partnership success" and when. Consider entering into a time-limited relationship wherein all parties agree to

reassess its value at a specified point. This can both foster greater accountability and allow a participant to drop out gracefully.

Conclusion

Hospitals and systems are facing more "wicked" problems than ever. Meeting these challenges alone is no longer an option. Boards have a responsibility to help their organizations explore and oversee new partnerships to meet their strategic goals. With clear-eyed, skilled

executive leadership and a supportive board, organizations can cultivate partnerships that will help them meet the myriad challenges of a future healthcare system that likely will look very different from today's.

> *The Governance Institute thanks Marian C. Jennings, M.B.A., President, M. Jennings Consulting, and Governance Institute Advisor, for contributing this article. She can be reached at mjennings@mjenningsconsulting.com.*

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Addressing "Wicked Problems": The Board's Role

By Marian C. Jennings, M.B.A., M. Jennings Consulting

Countless articles over the past two years have explored the impact of the COVID-19 pandemic on seemingly every facet of our healthcare system—declining hospital and physician office volumes concurrent with intense capacity pressure elsewhere in the system; severe workforce challenges across the spectrum from physicians/clinical staff to lower-skilled employees; scrutiny around the diversity, equity, and inclusion of leadership, staff, and the patients we serve; and increasing pressure to address pressing community health needs.

Although the pandemic certainly accelerated or exacerbated the above challenges, it also has exposed the myriad structural issues at their heart. Longstanding challenges also have begun to collide with new ones emerging as the mission of health systems and hospitals increasingly is reframed from "providing excellent, patient-centered care to [predominantly sick] patients" to "providing value over volume, improving health, resolving health inequities, and addressing social determinants of health in our communities."

For instance, COVID-19 has disproportionately affected communities with high levels of poverty and underlying health conditions, filling needed beds and intensive care units while at the same time driving down hospital volumes/revenues from elective procedures that often subsidize crucial care for the same at-risk populations. Clearly, our community mission calls us to address these larger societal issues—but how, when most of our payments still are based on care encounters that typically begin when a patient walks through one of our myriad front doors, whether virtual, physician office, ambulatory center, or the hospital itself?

What Are "Wicked Problems"?

As this example illustrates, the collision of traditional and new challenges for hospitals and health systems has created what may be considered "wicked problems," that is, problems that are hard or impossible to solve because of incomplete, contradictory, and changing requirements that are often difficult to recognize.

While these problems can seem overwhelming, the first step toward addressing any of them is to recognize that no hospital or system, regardless of its size and financial strength, can effectively address a wicked problem alone but instead must build effective strategic partnerships or collaborative relationships to tackle them together. This article focuses predominantly on creating effective, durable relationships.[1]

Don't Be Afraid to Tackle Wicked Problems

Most wicked problems are systemic and have been building for years or decades (e.g., enormous predicted shortages of physicians and staff). But they won't go away on their own, and if they could impair your long-term mission, vision, or viability, we recommend that, working with management, the board:

1. **Identify your organization's most pressing "wicked" problems.** Identify the one or two top-priority complex problems for which a local, regional, and/or national collaborative relationship may help meet a strategic goal (e.g., improve maternal-fetal health outcomes both by partnering with trusted community leaders and local FQHCs and participating in a national, grant-funded pilot program; create a pipeline for a diverse future workforce by developing relationships with local high schools, youth groups, and community colleges). Understand that a partnership is a vehicle to address a wicked problem; it is not an end in itself.
2. **Honestly assess how desirable a collaborative partner you would be to others.** Do local or regional leaders/organizations trust you? Is your hospital or system known to be collaborative, or does it default to a "command and control" approach? Do providers of grant funding know about you; would your presence in a collaborative increase the likelihood of obtaining such funding? Identify what, if any, cultural changes could make your organization more attractive to potential partners, including payers or granting agencies/foundations.
3. **Clearly define your organization's role in collaboratively addressing a wicked problem.** Most collaboratives value consensus and risk having "too many cooks in the kitchen." At the outset, clearly define your primary role(s) within the group: as a catalyst, convener, leader, or active participant. The roles of other participants should be similarly clear and agreed upon. The hospital or system should avoid being viewed primarily as a funder with deep pockets.
4. **Recognize that collaboration will consume valuable executive leadership time.** Decision making often is slow, sometimes glacially so, in a strategic partnership. With management already overstretched, the board needs to heed the CEO's advice about which potential relationships are worth the effort. There should be a return—demonstrable progress in addressing the wicked problem—that justifies the investment of time and any monies.

Key Board Takeaways

Tips for Collaborating to Address "Wicked Problems"

- Clearly articulate your own goals in addressing a complex problem—what do we want, need, and bring of value to a partnership? What are the characteristics of our preferred partners?
- Collaboratively formulate a clear common statement of intent and vision for the partnership, measures of success agreed on by all parties, and a practical action plan.
- Never underestimate culture, and remember there is no substitute for trust in a relationship.
- Prepare for stumbles along the way.
- Ensure all parties understand (and accept) their roles in the collaborative.
- Remember that structure facilitates success. Look for successful examples. Ensure that the structure is strong enough to deliver results.

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1   For additional information on the larger spectrum of partnership models, see Anu Singh, "New Partnership Models Respond to the Impacts of COVID-19 Pandemic, *BoardRoom Press,* The Governance Institute, December 2021.