The Governance Institute

BOARD BRIEFING

Why a busier physician practice can still earn less

More care and higher costs can leave less money after the bills are paid.

5–6 MINUTE READ

In This Briefing

A practice can provide more care while retaining less after expenses. Physician productivity, payments for care, and the cost of keeping services available explain different parts of that result. Community access adds another dimension to the investment.

About Board Briefings

Board Briefings offer deeper explanations of healthcare issues and their implications for governance. Each includes a practical example, authoritative sources, and key questions to support informed board discussion.

What Happened

On September 17, SullivanCotter published benchmarks showing that adult medical specialists' median compensation rose 7.2% between its annual surveys, while recorded productivity rose 2.8%. The comparison covers that specialty group, not every physician or each doctor's individual raise. (1)

For health systems employing these specialists, the comparison raises a question about the cost of providing care. More recorded work does not necessarily bring enough additional payment to cover higher compensation and the other expenses of running a practice.

The Issue, Explained

When a patient leaves an appointment, the visit is over but the financial story continues. The practice records what the doctor did, bills under the patient's coverage, and receives payment later. Salaries, nursing wages, rent, and equipment costs continue in the meantime.

Productivity describes the amount and intensity of physician work. Services receive different weights for the effort involved, so a more demanding service can count more than a simpler one. The measure is called work relative value units, or work RVUs. It records clinical activity, not revenue or improvements in health. (2)

A doctor can increase that total by providing more services or a different mix of services. Neither guarantees an equivalent rise in revenue. The amount collected depends on what was provided and what the patients' insurance arrangements pay. Similar workloads can bring different amounts of money.

Growth has costs of its own. More appointments may require another nurse, longer opening hours, or additional equipment. Any extra revenue has to cover those additions as well as higher physician pay. The practice can bring in more money and still have less left after expenses.

Some responsibilities do not appear in an appointment count. A specialist may teach, answer emergency calls, or advise colleagues treating hospitalized patients. Those commitments differ from a role devoted entirely to scheduled visits. The services and responsibilities behind the totals give a comparison its meaning.

The Issue, Explained (continued)

The timing of employment changes the picture again. A newly hired doctor receives a salary while building a patient schedule. That temporary gap is different from a long-established practice that repeatedly needs more support than planned. Combining the two in an annual average can obscure the difference.

Some support may be deliberate. Employing a specialist can keep important care nearby or make another service possible. Those benefits do not necessarily appear in the practice's own earnings. Shorter waits can be valuable even when the health system must contribute more money to achieve them.

A practice may have an agreed need for financial support and still experience a change in costs or revenue. Those circumstances can coexist. The national benchmark does not separate them for a particular practice. Its own services, payment arrangements, and expenses explain what has changed.

A Practical Example

A hypothetical practice receives $8 million a year. Physician compensation costs $5 million, and staff, space, and other expenses cost $2 million. That leaves $1 million after expenses.

The next year, recorded clinical work increases 3%. Revenue remains $8 million because the mix of services and payments changes. Physician compensation rises to $5.35 million, while other expenses remain $2 million. The practice now has $650,000 left—$350,000 less despite doing more work.

These are illustrative figures, not survey results. If waits for an important specialty also became shorter, that would be a benefit worth recognizing. It would not erase the financial change. The practice has delivered more care while leaving fewer resources available for other needs.

Governance Implications

Physician employment can serve several purposes. A group may be expected to cover its costs, support a wider clinical program, or keep a scarce specialty available locally. The expected financial result depends partly on which benefit the health system intended to provide.

When compensation or other costs rise, continuing that care may require more support. That can affect resources available for other services. Better access and financial sustainability therefore belong in the same assessment, without treating either a busy schedule or a shortfall as the whole result.

The board considers major service commitments and their affordability, while management develops employment arrangements and runs the practices. Linking the care gained with the resources required gives both a clearer basis for understanding the investment. Productivity describes the work; it does not, by itself, establish the value or cost of sustaining it.

Questions for the Board

1. **When reviewing physician investment objectives:**
   What care and access benefits was physician employment intended to provide, and what financial support was anticipated?

2. **When comparing costs and productivity:**
   How do physician responsibilities, payments received, and practice expenses explain results alongside productivity?

3. **When considering ongoing financial support:**
   What evidence shows whether the services gained and the support required remain consistent with the organization’s priorities?

Sources & Further Reading

1. SullivanCotter. Physician Compensation Growth Continues to Outpace Productivity. September 17, 2026. Specialty-group benchmarks, not individual raises or practice earnings.
2. Centers for Medicare & Medicaid Services. Physician Fee Schedule Quick Reference Search Guide. Background on physician-work measures and payment.

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The Governance Institute

BOARD BRIEFING

What a readmission penalty really measures

A payment penalty and a change in current care are different findings.

5–6 MINUTE READ

In This Briefing

Medicare is counting a broader patient group over a shorter period. The resulting penalties affect payment today, but they do not describe only today's care. Understanding the calculation helps connect financial results with the experience of patients.

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What Happened

On October 8, Healthcare Dive reported that 2,334 hospitals—about 80% of those assessed—face Medicare readmission penalties for fiscal 2027. The payment reductions began October 1. More hospitals were penalized than in the previous year. (1)

Medicare also changed which patients and years enter the calculation. It added patients covered through private Medicare Advantage plans and shortened the period of care being measured from three years to two. The national count does not establish how much those changes, or changes in care, contributed to the increase. (2)

The Issue, Explained

A patient leaves the hospital after treatment and returns unexpectedly a few days later. That return is a readmission. Some returns cannot be avoided. Others can reveal a problem with recovery, medication, or the transition home. A return therefore deserves attention without automatically proving that the original care was poor.

Medicare, the federal insurance program mainly for older adults, links some hospital payments to these returns. Its Hospital Readmissions Reduction Program examines unplanned readmissions within 30 days after selected conditions and procedures. Hospitals can lose part of their payment when returns exceed the level expected under the program's calculation. (3)

That calculation does more than count returning patients. It accounts for specified patient characteristics and compares hospitals with peers. The comparison groups reflect how many patients have both Medicare and Medicaid, public coverage for eligible people with limited incomes and other qualifying needs. (3)

Some Medicare patients receive traditional coverage directly through the federal program. Others receive their Medicare benefits through private plans called Medicare Advantage. Adding the latter patients broadens the group whose care is measured. Shortening the period changes which years of experience remain in the result. (2)

A broader group can produce a different overall result even when care for the previously counted patients is unchanged. Dropping an older year can change it again. Neither change determines the direction at every hospital. Real improvements or deterioration can occur at the same time.

The Issue, Explained (continued)

The penalty's financial reach is narrower than its name may suggest. It applies to traditional Medicare's base operating payments for hospital stays, with a maximum reduction of 3%. It is not a reduction of up to 3% in all hospital revenue. Including Medicare Advantage patients in the measure does not apply the same penalty to their plans' payments. (3)

There is a time gap as well. The October reporting describes fiscal 2027 results based on care delivered during 2023–2025. A penalty arriving now is not a score for only the care being delivered now. An improvement introduced later may be helping patients without yet affecting that payment result. (1)

These views answer different questions. The official calculation determines the payment reduction. Similar patients measured consistently over time help reveal changes in care. More recent outcomes describe care after the period used for the penalty. Read together, they show more than any one result alone.

A Practical Example

In this hypothetical report, one group has 100 hospital returns among 1,000 discharges in each of two years. Its raw return rate stays at 10%.

The second year's report adds another group with 75 returns among 500 discharges. Together, there are 175 returns among 1,500 discharges, or about 11.7%. The overall rate rises even though the first group's experience has not changed.

This is not Medicare's risk-adjusted formula or evidence that Medicare Advantage patients have worse outcomes. It shows why the composition of a measure matters. The broader result can reveal care needs that were previously missing, while a consistent comparison answers whether the original group's care improved or worsened.

Governance Implications

A payment reduction affects the financial plan. The experience of patients returning unexpectedly remains a quality concern. A changed calculation makes the relationship between these two results harder to read, but does not make either result unimportant.

An improvement effort follows its own timeline. A follow-up nurse may help patients understand medicines or arrange appointments. Completing more calls records activity; whether patients receive the help they need and avoid preventable returns describes the outcome. Evidence connecting those steps becomes clearer over time.

Clinical leaders and management direct improvement work. The board reviews significant quality findings, resource commitments, and evidence of progress. That discussion is better informed when the historical penalty and current outcomes are both visible. A change in the score and a change in patients' care can occur together, but neither can be inferred from the other alone.

Questions for the Board

1. **When reviewing an annual readmission result:**
   Which patients and years are included, and what has changed in the calculation?

2. **When assessing quality trends:**
   What do similar patients' outcomes measured consistently over time, alongside more recent results, show about care?

3. **When reviewing quality improvement investments:**
   How much payment is affected, and what evidence shows whether improvement investments are helping patients?

Sources & Further Reading

1. Healthcare Dive. Medicare penalizes more hospitals for readmissions. October 8, 2026. Attributed analysis of CMS data; counts not independently recalculated.
2. Centers for Medicare & Medicaid Services. FY 2026 inpatient payment final rule. July 31, 2025. Measurement changes beginning in fiscal 2027.
3. Centers for Medicare & Medicaid Services. Hospital Readmissions Reduction Program. Program scope and payment reductions.

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BOARD BRIEFING

Why fewer admissions can cost more per stay

Moving routine care elsewhere changes the work and costs that remain.

5–6 MINUTE READ

In This Briefing

Moving routine care to an outpatient setting changes who remains in the hospital. Patient complexity and the cost of keeping staffed beds available help explain why fewer admissions may not bring proportionately lower costs, even when total spending falls.

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What Happened

On October 7, Strata Decision Technology published first-half 2026 findings on changing hospital services. Inpatient gynecology activity fell 8% as more operations to remove the uterus moved to outpatient settings. Other services grew. The report describes how shifting less complex care outward can change the hospital workload that remains. (1)

A lower admission count can reflect a change in where care happens rather than less need for care. The findings illustrate a possible shift in the patients who remain. They do not establish the cause of cost changes at every hospital.

The Issue, Explained

Two patients receive treatment for similar conditions. One goes home that afternoon. The other needs several nights of close monitoring. Only a patient formally admitted appears in the inpatient count. Outpatient care does not require that admission, although some outpatient care can include overnight observation.

As straightforward procedures move to clinics or surgery centers, fewer of those cases remain in the hospital's average. Patients who still require admission may need longer stays or closer attention. The average can become more demanding without every individual patient becoming sicker. Part of the change is who is no longer counted.

Hospitals describe aspects of that complexity through measures of patient mix, often called case mix. These help classify cases for payment and estimate their resource needs. They are not a direct count of nursing hours or a complete account of illness. Documentation and the services offered can change the measures too. (2)

The expenses of running a ward do not follow admissions one patient at a time. Supplies may fall as fewer patients use them. A staffed unit, building, and equipment still cost money while awaiting the next admission. Removing one stay does not remove an entire nursing shift.

That leaves two financial measures answering different questions. Total spending describes what the service costs to operate. Cost per stay divides that spending by the number of admissions. When admissions fall faster than spending, each remaining stay carries a larger share. The ratio can rise even as the total bill falls.

The Issue, Explained (continued)

Fewer admissions do not necessarily mean quieter wards either. Eighty patients staying longer can occupy as many bed-days as 100 patients with shorter stays. Their need for staff attention may differ again. An admission count leaves both duration and intensity out of view.

Some unoccupied capacity may also have a purpose. Emergency arrivals cannot be predicted perfectly, and an available staffed bed can make an unexpected admission possible. Keeping that bed ready costs money. Maintaining needed readiness and retaining capacity with no continuing purpose are different choices.

Time changes the choices available. An expense that cannot sensibly be removed next week may be adjustable through a different service arrangement next year. “Fixed” describes a period and a set of circumstances, not a promise to keep the expense forever.

Meanwhile, the outpatient center has staff, space, and equipment of its own. The system’s full result includes resources added there, resources released at the hospital, and the inpatient capability that remains necessary. Moving a procedure does not settle that wider calculation.

A Practical Example

A hypothetical hospital unit spends $1 million a month keeping its staffed capacity available, plus $5,000 for each admission. With 100 admissions, spending totals $1.5 million, or $15,000 per stay.

Admissions fall to 80. The $1 million remains, while the additional expenses fall to $400,000. Total spending is now $1.4 million—$100,000 less. Dividing by 80 produces a higher cost per stay of $17,500.

Patient needs are held unchanged here to show the arithmetic. More demanding cases could add another effect, while a safe change in capacity could alter future costs. The higher cost per stay does not settle either question. In this example, it accompanies $100,000 less in total spending.

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Governance Implications

An outpatient strategy and the hospital's remaining capacity are parts of the same service commitment. Moving appropriate care outward may release some resources while leaving others necessary for complex or unpredictable treatment. The effect depends on the patients and services involved.

A higher cost per stay can reflect a different mix of patients, fewer stays sharing continuing expenses, higher total spending, or several changes together. Separating those effects makes the result more informative without presuming that efficiency has improved or declined.

Management and clinical leaders organize care and assess capacity. The board considers major service and capital commitments. Decisions about facilities are more useful when they connect the outpatient strategy with the inpatient care still needed. An admission count shows how many stays occurred, not the full resources required to provide them.

Questions for the Board

1. **When reviewing hospital activity:**
   How have patient needs and length of stay changed alongside admissions?
2. **When interpreting hospital costs:**
   What explains changes in total spending and cost per stay, including the cost of maintaining needed capacity?
3. **When considering service and facility plans:**
   How do the combined inpatient and outpatient results inform major service and facility commitments?

Sources & Further Reading

1. Strata Decision Technology. Service-Line Insights Are Informing Growth Strategies for Provider Organizations. October 7, 2026. Service patterns vary across providers.
2. Centers for Medicare & Medicaid Services. FY 2026 inpatient payment final rule. July 31, 2025. Background on case classification and payment.

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BOARD BRIEFING

Why insured patients put off care

Paying yesterday's bill does not make tomorrow's appointment affordable.

5–6 MINUTE READ

In This Briefing

A patient can remain insured and current on existing payments while postponing another visit. The decision may never reach an appointment report. Following that experience shows why coverage, collections, and affordable access can tell different stories.

About Board Briefings

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What Happened

On September 17, the Commonwealth Fund reported that 32% of working-age adults with continuous private insurance were paying medical bills or debt over time. Among that group, 30% said the burden led them to delay or avoid needed care. The findings came from a 2025 survey. (1)

These respondents had not lost their coverage. They were still paying for earlier care, and another visit could mean another bill. Insurance remained in place while the household had to decide what it could afford next.

The Issue, Explained

A procedure can be covered by insurance and still leave the patient a substantial bill. The plan pays under its terms, and the household must fit the remaining obligation around housing, food, transport, and other needs. Having insurance and struggling with medical costs are not contradictory experiences.

A deductible is one source of that obligation: the amount a patient pays for specified covered care before the plan begins paying under its terms. Copayments and other patient costs may also apply. Coverage reduces some financial risk without showing how much money a household has available. (2)

A payment plan can make one bill manageable by spreading it across months. It does not necessarily make a second bill affordable. Every installment may arrive on schedule while the patient grows reluctant to accept another expense. The payment record captures an earlier obligation, not the next care decision.

That decision may happen before anyone books an appointment. A patient can postpone calling for recommended follow-up or decline an offered service. No appointment is canceled because none was made. The person has gone without care, but the usual count of missed visits may show nothing.

The survey's definition is important here. It includes medical bills being paid over time, not only overdue debts or amounts sent to collections. The 30% delayed-care finding concerns that subgroup, not all insured adults. It describes respondents' experience rather than the reason for every hospital's missed appointment. (1)

The Issue, Explained (continued)

Uncertainty can add to the burden. A patient may not know what insurance will pay or whether another clinician will send a separate bill. A clearer estimate can resolve confusion. It cannot necessarily supply the money needed to meet the estimate.

Assistance and payment arrangements change different parts of the problem. Assistance may reduce an eligible patient's obligation. Installments spread it out. Either may help while leaving little room for the next expense. Success in collecting a balance is not the same as success in making continuing care affordable.

The hospital still needs revenue to keep services available. That creates a real tension: payments support care, while the household making them may feel unable to return. Looking only at collections misses the second outcome. Looking only at appointments can miss the financial pressure before a visit is requested.

Money is not the only barrier. Work schedules, transport, and a lack of suitable appointments can also prevent a return. Similar gaps in care may therefore require different explanations. Coverage and payment records cannot supply those explanations without understanding why patients did not proceed.

A Practical Example

In this hypothetical case, a patient owes $1,500 after an insured procedure and agrees to pay $125 a month for a year. Every payment arrives on time. Another visit is recommended, but the patient does not book it because a second bill feels unmanageable.

The hospital eventually collects the full balance. There is no default and no canceled appointment, because the next visit was never booked. Yet the patient has gone without recommended care. The payment record describes the earlier treatment, not whether the next service was affordable.

A second patient books the same kind of visit but cancels because it conflicts with work. Both miss care, but only one describes a financial cause. These invented cases show why the same apparent access problem can begin in different places.

Governance Implications

A service's availability does not fully describe access. Patients also need to be able to use it. For care that involves repeat visits, household finances may affect both continuing treatment and the demand assumed in the organization's plans.

Coverage and collection results provide useful information, but cannot explain every postponed visit. Patient accounts can reveal whether the barrier is cost, uncertainty, transportation, or appointment availability. Clearer information, financial assistance, and added capacity address different problems.

Management administers patient financial arrangements and access processes. The board considers the policies, resources, and significant patterns affecting the organization's mission. Understanding those patterns connects the financial plan with care people can realistically obtain. An earlier bill paid in full does not establish that the next needed visit is within reach.

Questions for the Board

1. **When reviewing access to care:**
   What do patients report about barriers to starting or continuing needed care, including care never scheduled?

2. **When reviewing patient financial trends:**
   How do coverage and collection results compare with what is known about patients' ability to afford further care?

3. **When evaluating access and assistance policies:**
   What evidence shows whether the organization's access and assistance commitments are addressing the barriers identified?

Sources & Further Reading

1. The Commonwealth Fund. How Medical Bills and Debt Impact Americans with Private Insurance. September 17, 2026. The delay finding concerns the subgroup paying bills or debt over time.

2. HealthCare.gov. Deductible. Background on a common patient payment obligation.

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The Governance Institute

BOARD BRIEFING

Why a busy clinic can bring in less revenue

A change in payment can alter the return on care patients still need.

5–6 MINUTE READ

In This Briefing

A hospital-owned clinic could attract the patients expected in its plan while receiving less for affected services. The explanation lies in payment rules as well as demand. Location, expenses, and the share of care covered determine the possible effect.

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What Happened

On September 29, Elevance Health announced new policies to verify where hospital services are delivered and apply the relevant off-campus rates to specified care away from the main campus. The insurer plans to introduce individual policies across its businesses during 2026 and 2027. (1)

For affected clinics, the announcement could change what care earns without changing patients' need for it. The scope matters: this is one insurer's approach to certain services, not a reduction in every hospital outpatient payment.

The Issue, Explained

A patient visits a clinic several miles from a hospital. The hospital's name is on the door, and the hospital owns the service. But the visit takes place away from its main campus. Ownership and location are different facts, and payment rules can depend on both.

Outpatient care includes appointments and procedures without an inpatient admission. A hospital may provide that care on its main campus or at another location. Its ownership does not guarantee that every service receives the same payment in both places.

Elevance says it will require hospitals to identify the physical place of care, check that information against hospital addresses, and apply off-campus rates in specified circumstances. It also addresses certain laboratory work performed elsewhere. The company describes billing accuracy and affordability as its goals, not benefits already demonstrated for every patient. (1)

For a clinic, revenue depends on how much care is provided and what is received for each service. More visits create more opportunities for payment. If the average payment falls enough, however, the extra appointments may not replace the revenue lost.

Those extra visits also need resources. More nursing time, supplies, or space can raise expenses. A clinic might receive less revenue overall, or it might receive more revenue but retain less after expenses. Neither outcome is visible from the appointment book alone.

The share of visits affected matters as much as the rate. A policy may reach only selected services or insurance plans. Applying it to every visit would exaggerate the effect, while a small systemwide average could conceal a substantial change for one important service.

The Issue, Explained (continued)

The change also arrives in stages. A policy notice alters expectations. A forecast estimates the possible effect. Later, actual claims and payments show what happened. An announced risk and a financial loss already recorded are not the same finding.

The original investment plan assumed particular demand, payment, expenses, and access benefits. A clinic that sees the expected patients but receives less per visit has a different financial pattern from one with fewer visits than anticipated. Payment changes, service use, and costs may also change together.

The clinic may still make care easier to reach or support a wider program. Those benefits remain relevant if payment changes, alongside the resources needed to continue providing them. Actual payments and operating results will show more than the announcement alone about the commitment required.

A Practical Example

A hypothetical clinic receives $200 for each of 1,000 visits, generating $200,000. In the next period, visits increase to 1,100 but average payment falls to $170. Revenue is now $187,000. The clinic has 10% more visits and $13,000 less revenue.

Now suppose only 200 of those 1,100 visits receive the lower payment. The other 900 still receive $200. Revenue becomes $214,000. The same $30 rate difference produces a different total because fewer visits are affected.

These are illustrative rates, not Elevance’s actual payments or a forecast. The calculations exclude expenses and the value of improved access. They show why both the payment difference and the share of care affected determine the revenue result. Patient demand alone answers neither question.

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Governance Implications

A clinic expansion rests on expectations about patient demand, payment, costs, and access. Patients arriving as expected support one part of that plan. A different payment rate can change another part without establishing whether the investment as a whole is meeting its objectives.

Financial results may reflect changes in reimbursement, service use, operating expenses, or several factors together. Their relative effects matter when considering further expansion or continuing support. An announced policy is not evidence of a loss at every clinic, and patient volume alone does not establish the return.

Management evaluates contracts and operates the services. The board reviews major investments, affordability, and access commitments. A clear account of what has changed supports those different responsibilities. The continuing question is what care the clinic provides and what resources that care requires under the payments it receives.

Questions for the Board

1. **When reviewing an outpatient investment:**
   How have patient demand, payment per service, and operating costs changed from the investment plan?

2. **When assessing a payer policy change:**
   Which services and plans are affected, and what is forecast rather than already reflected in payments?

3. **When considering further outpatient commitments:**
   What do the revised financial and access expectations mean for major outpatient commitments?

Sources & Further Reading

1. Elevance Health. New Policies To Improve Billing Transparency and Help Lower Health Care Costs. September 29, 2026. A policy announcement, not measured results for each clinic or patient.

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BOARD BRIEFING

The hidden stakes of a hospital–insurer standoff

The contract deadline can change a patient's plans before the contract changes.

5–6 MINUTE READ

In This Briefing

Some public network threats become withdrawals; many end in agreement. Either outcome leaves questions about payment, patient access, and continuing services. Understanding the alternatives reveals why the contract announcement is only one part of the result.

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What Happened

On September 23, Health Affairs published research finding that roughly 28% of public threats to end hospital–insurer network relationships resulted in withdrawal. Most threats did not. The study examined commercial insurance relationships with contracts ending during 2021–2025. (1)

The study shows that some public warnings become actual departures. Patients may also face uncertainty while negotiations continue. Those possible effects require a separate explanation, because the study did not measure how many people changed providers or postponed care.

The Issue, Explained

A patient has treatment booked for next month. A notice arrives saying the hospital may no longer participate in the patient's insurance network by then. The medical need has not changed. The practical choice has: wait for an agreement or arrange care somewhere else?

An insurer's network includes providers that agree to terms for treating its members. Hospital payment is part of that agreement. As renewal approaches, the parties may disagree about rates or other conditions. Either side may warn that participation could end if they do not reach agreement.

That warning describes a possibility, not a completed withdrawal. It can put pressure on the negotiations while leaving patients uncertain about their doctors, planned treatment, and costs. A later deal can keep the hospital in the network without reversing an appointment already moved. (2)

The percentages describe two different groups. About 8% of the relationships examined involved a public threat, and approximately 28% of those threats became withdrawals. That is not a finding that 28% of all hospital contracts failed or a forecast for the next negotiation. (1)

The research measures threats and withdrawals, not the number of patients whose care changed. It also found public disputes among some profitable hospitals and national insurers. A warning alone therefore does not establish either party's financial circumstances or the merits of its proposed terms. (1)

The Issue, Explained (continued)

A hospital needs revenue to maintain services. An insurer must consider the cost of coverage for employers and members. Those responsibilities can lead to different views of an acceptable payment. The alternatives available in the particular negotiation determine how that disagreement can be resolved.

Accepting an offer may preserve immediate network access while limiting the resources available for services. Rejecting it may avoid those terms while risking lost revenue and disruption for patients. Neither choice necessarily improves the hospital's finances or patients' experience. The actual terms and alternatives matter.

The same percentage increase can mean different things in different contracts. The services included, agreement length, and share of patients involved all affect its value. A major relationship for one specialty may represent only a small share of the whole system.

An agreement can keep the hospital in the network, while some patients may already have changed plans during the uncertainty. A withdrawal can change where care is obtained and what it costs. The effect varies with coverage and individual circumstances. The signature and the patient experience remain related, but distinct, outcomes.

A Practical Example

In this hypothetical case, a patient needs treatment soon after a public contract deadline. Worried about whether the hospital will remain in the network, the patient books an appointment with another provider.

The hospital and insurer reach agreement before the deadline. The patient keeps the new appointment anyway. A second patient waits for the outcome and continues at the original hospital without interruption.

No network withdrawal occurred. A report saying "agreement reached" would describe the contract but not the first patient's changed plans. This is an illustration, not a result measured by the study. It shows why the final announcement cannot fully describe what happened before it.

Governance Implications

A major insurer relationship connects the financial plan with patients' access to care. Its significance depends on the services, people, and alternatives involved. An agreement or separation alone does not establish whether the outcome meets the organization's needs.

Management conducts negotiations. The board's role concerns significant strategic, financial, and service commitments, rather than the bargaining itself. Understanding the trade-offs gives context for that oversight without presuming that either party should accept particular terms.

After the deadline, payment terms, network participation, and patients' ability to continue care reveal different aspects of the outcome. A deal may resolve the contract while leaving other concerns to address. The most useful account follows both the agreement and the care it makes possible.

Questions for the Board

1. **When reviewing major payer relationships:**
   What would the realistic contract alternatives mean for significant services, finances, and patient access?

2. **During a public contract dispute:**
   What assurance is available about accurate patient information and continuity of care while the outcome is uncertain?

3. **After a major contract decision:**
   What do the agreed terms, network participation, and patient experience show about the outcome?

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2. Brown University School of Public Health. Healthcare's high-stakes game of brinkmanship threatens patient care. September 24, 2026. The authors' institutional account of the study.

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BOARD BRIEFING

Who checks AI before it acts on a patient?

Human oversight means different things before and after a prescription is sent.

5–6 MINUTE READ

In This Briefing

A clinician can check a proposed prescription before it is issued or review it afterward. Those arrangements offer different opportunities to catch an error. Utah's limited pilots make the distinction concrete as software takes on more responsibility in care.

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What Happened

On October 5, Utah announced an expansion of its healthcare artificial intelligence pilots, including prescription refills from August AI and selected acne treatments from Nolla Health. Both begin with clinician review before prescriptions proceed. These are limited tests, not evidence that independent AI prescribing has proved safe. (1), (2)

August AI was authorized October 2, although its demonstration had not begun in the state register. Nolla's pilot became active October 5. Later stages can reduce the amount of review only with further written state approval. (2)

The Issue, Explained

A patient asks for another supply of an existing medicine. Software gathers information and prepares a proposed refill. A clinician checks it, changes it if necessary, and decides whether it should proceed. The software has helped with the work, but a person has made the decision.

In a different arrangement, software might be permitted to authorize the refill within a defined process, with a clinician reviewing it afterward. The service would still have human oversight. It would not have the same opportunity for that person to stop an error before the prescription is issued.

Utah is testing narrowly defined versions of this change. August AI's pilot concerns selected maintenance medicines an adult already takes under an established plan, not unrestricted new prescribing or dose changes. Nolla's pilot concerns selected adults with mild to moderate acne and a limited set of medicines applied to the skin. (2)

The launch safeguards are specific. August AI starts with a licensed provider checking refills before they proceed. Nolla starts with two licensed physicians reviewing every prescription before it is sent. Later phases may use review afterward or sampling, subject to separate state permission. (2)

Those checks are part of the authorized arrangement, not an incidental extra. Permission to test that arrangement does not establish that it has succeeded, or authorize the same use elsewhere. The development is consequential because it explores clinical authority, not because clinicians have simply been removed.

The Issue, Explained (continued)

A review also depends on the circumstances in which it takes place. The clinician needs relevant information, time, and authority to intervene. Voluntary federal AI guidance emphasizes clear responsibilities and evaluation suited to the intended use. It does not prescribe one review arrangement for every clinical task. (3)

An overall accuracy score can hide the error that matters most. A tool may answer many harmless questions correctly while making mistakes in the smaller set that leads to a prescription. The proportion of correct answers does not explain the seriousness of the remaining errors.

Benefits also extend beyond the speed of the first step. Faster preparation may save time while checking exceptions or answering patients' questions adds work elsewhere. The gain depends on whether the whole service delivers appropriate care more reliably or sooner.

A limited rollout can produce evidence before the software's role expands. Its pace alone does not establish whether adoption is appropriate. The more relevant question is whether results support the specific authority being granted. New software versions, different medicines, or a broader patient group can change what earlier testing establishes.

A Practical Example

Two hypothetical services use tools that make the same mistake in a refill recommendation. At the first, a clinician checks every proposal before it is sent and catches the error. At the second, the refill proceeds and the error is found during later review.

The tools could have identical accuracy in a test set. Both services could say a clinician oversees the software. Only the first arrangement offers that particular opportunity to stop the error before it reaches the patient.

This is not an incident reported in either Utah pilot. It isolates the importance of timing without deciding that one method fits every task. The seriousness of the possible error, the reliability of the check, and the benefit of quicker care all remain relevant.

Governance Implications

Using software to prepare information is different from permitting it to authorize a treatment step. The latter changes the responsibilities attached to the care process. Expected time savings need to be understood alongside the clinical action, the people affected, and the safeguards around it.

Clinical and operating leaders evaluate and manage individual uses. The board oversees significant safety risks, accountability, and major investments. That does not require trustees to approve individual prescriptions. It requires a clear understanding of the responsibilities attached to the organization's commitments.

Evidence from a narrow use may support a next step without establishing suitability for every clinical decision. Results on safety and access, together with authority to change or pause a use, make expansion more understandable. The relevant assurance is not simply that a person is involved, but what that person can review and when.

Questions for the Board

1. **When reviewing clinical AI strategy:**
   Which significant clinical AI uses prepare information, and which can authorize or initiate an action affecting care?

2. **When assessing clinical AI safeguards:**
   How are clinical accountability and opportunities to detect or stop errors maintained as the software's role changes?

3. **Before considering broader clinical AI use:**
   What results and approvals would support broader authority, and what findings would lead to a pause or narrower use?

Sources & Further Reading

1. Utah Department of Commerce. Healthcare AI pilot expansion. October 5, 2026. Announcement of the limited healthcare pilots.

2. Utah Office of Artificial Intelligence Policy. Authorized Pilots. Pilot boundaries and review stages; later phases require written approval.

3. National Institute of Standards and Technology. Generative Artificial Intelligence Profile. July 26, 2024. Voluntary guidance, not approval of the pilots.

Board Briefings provide governance education and do not constitute legal, clinical, accounting, or investment advice.

The Governance Institute

BOARD BRIEFING

Why hospital closures are not just a rural concern

A hospital building can stay open after inpatient care disappears.

5–6 MINUTE READ

In This Briefing

Hospital closures are not confined to rural communities, and a building may remain open after inpatient care ends. Following the services and patients, rather than facility names alone, reveals what changes for access and for neighboring health systems.

About Board Briefings

Board Briefings offer deeper explanations of healthcare issues and their implications for governance. Each includes a practical example, authoritative sources, and key questions to support informed board discussion.

What Happened

On October 8, JAMA published research identifying 432 hospital closures and 216 openings during 2010–2025. Urban and rural closure rates were not significantly different in the study. Closure meant the loss of inpatient services, including facilities converted to other kinds of care. (1)

Of the affected hospitals, 117 retained outpatient services. Patients could still obtain some care at the same address while needing another hospital for admission. The study therefore describes changes in available services as well as complete closures. (1)

The Issue, Explained

A patient needs several days of treatment, a staffed bed, and overnight monitoring. The local facility still offers appointments and tests. It may even provide emergency assessment. None of that guarantees the patient can stay there for the hospital care now required.

The research counted both complete shutdowns and facilities that stopped inpatient care while retaining other services. A conversion can preserve valuable local care without replacing everything that disappeared. The patient's route changes even when the building looks much the same. (1)

That route can become difficult in a city as well as in a rural community. Several hospitals close together on a map do not guarantee an available bed, the right specialty, or care covered on the same insurance terms. Rural patients may face much longer travel. The barriers differ, but neither geography makes access automatic.

The statistical finding needs the same care. The study did not establish a significant difference between urban and rural closure rates. It did not prove that every community faces equal risk. The result challenges a rural-only account without making all local circumstances alike. (1), (2)

A facility count also treats unlike losses as equal. A small community hospital and a large referral center each add one closure, although they serve different numbers of patients and perform different roles. Losing a site may change the region's ability to provide particular care in ways the total cannot show.

The Issue, Explained (continued)

An opening elsewhere does not necessarily replace that lost role. A new hospital may serve another city or offer different services. It improves the national count without necessarily helping the patient who needs a bed here. Openings and closures cannot be subtracted to determine whether a community has a workable alternative.

Depending on the services lost and the alternatives nearby, the change may affect a system whose own finances remain sound. A neighboring hospital might receive its transfers, provide specialist care, or serve people it has little room to absorb. A change in that provider can alter the surrounding network.

Additional patients may create a need for beds, staff, or services beyond earlier plans. In another setting, existing providers or a partnership may be able to meet the need. The closure announcement does not establish which response is appropriate or how much demand any one system will receive.

The research describes a historical period, not a sudden wave of closures this month or proof that a recent policy caused the pattern. Its contribution is a wider view of where inpatient care has disappeared and a more practical way to understand what preserving access requires.

A Practical Example

A hypothetical community hospital stops admitting patients but keeps emergency and diagnostic services. A person can still be assessed locally. When several days of treatment are needed, that person must transfer to another hospital.

If a nearby receiving hospital has an appropriate bed and staff, the transfer may proceed smoothly. If it is full, the same service change creates a different experience. The original building looks much the same in both cases.

A new hospital opening in another part of the state adds one to the national count without necessarily resolving this transfer. These invented circumstances show why access depends on available services and reliable connections, not simply whether a hospital symbol remains on a map.

Governance Implications

A health system's service commitments can rely partly on care available elsewhere. Changes in that network may affect regional access, demand, and future investment needs even when the organization's own services remain unchanged.

The consequences depend on which care disappears and where patients can go. Meeting additional demand may require resources, while a partnership or another arrangement may preserve access differently. A neighboring closure is not, by itself, a case for acquisition or expansion.

Management assesses service needs and possible responses. The board considers major strategic commitments, their resource requirements, and their community benefit. Those decisions are better informed by the care that remains available than by a facility count alone. Preserving a building and preserving dependable access can be different achievements.

Questions for the Board

1. **When reviewing regional service strategy:**
   Which services elsewhere in the region are important to the organization's care commitments?

2. **When a neighboring hospital changes services:**
   What care remains and what realistic alternatives are available to patients?

3. **When considering a major regional response:**
   What community benefit, resources, and continuing responsibilities would a major proposed response involve?

Sources & Further Reading

1. Calianos JE and colleagues. Longitudinal Trends and Characteristics of Hospital Closures and Openings. JAMA, October 8, 2026. Closure includes loss of inpatient care.

2. Harvard T.H. Chan School of Public Health. Hospital closures on the rise in both rural and urban areas. October 8, 2026. Institutional account of the same study.

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