On the 2019 healthcare board agenda

Board and audit committee agendas should continue to evolve in 2019 amid the game-changing implications of technology innovation, sector consolidation, new entrants, margin compression, demand for an enhanced customer experience, and changing political, risk, and regulatory environments. While delivering affordable, quality healthcare will continue to pose daunting challenges for companies, the industry, and the country, industry reorganization and consolidation as well as digital innovation will create opportunities for healthcare organizations with the vision and ability to move quickly. Navigating the year ahead—and positioning the organization for the future—will require a careful balance of near-term focus, agility, and long-term thinking.

Drawing on insights from our work and interactions with directors and healthcare leaders over the past 12 months, we've highlighted seven items for healthcare boards and audit committees to consider as they focus their 2019 agendas on the critical challenges at-hand and on the road ahead:

— Help ensure the organization understands and leverages the strategic value of risk management activities.

— Recognize that connecting digital disruption with risk management and strategy is more important—and more challenging—than ever.

— Understand the strategic implications of accelerating consolidation in healthcare—horizontal, vertical, and virtual.

— Analyze scenarios for potentially building, buying, partnering, or aligning with health plans.

— Monitor how the organization is maintaining the quality and integrity of its regulatory reporting.

— Continue to refine boardroom discussions about cybersecurity and data privacy as risk management issues.

— Assess, monitor and reinforce culture as a strategic asset and critical risk.

Help ensure the organization understands and leverages the strategic value of risk management activities.

Risk management as a defensive function—to identify, monitor, and manage risks critical to the organization and its stakeholders—continues to be essential. Yet, for healthcare payers, providers, and life sciences organizations to survive and thrive in an increasingly competitive and disruptive environment, innovation (whether by incremental improvements or wholesale changes to the business model) calls for an ever-smarter focus on both the downside and upside of risk. This may require a significant shift in mindset and culture, particularly for organizations focused intensely on regulatory compliance and risk-mitigation.

Leveraging risk management as a strategic tool to improve decision-making hinges on having a common (and current) understanding of the organization's risk profile and philosophy: How do we think about risk and reward? What risks are acceptable, and how do they align with the business strategy? What are the black-line issues where we won't compromise, no matter how low the probability? Does the organization have a common "risk language"?

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How is leadership—in the C-suite and the boardroom—keeping pace with developments in the operating environment (including disruptive forces outside the industry that could impact healthcare organizations) to ensure robust discussions about existential threats, competitive advantages, and where the organization is placing its bets? The challenge: to continually refine and focus the decision-making process on taking profitable risks, consistent with the mission of the organization and the expectations of its patients and other stakeholders.

Recognize that connecting digital disruption with risk management and strategy is more important—and more challenging—than ever.

Advances in digital technologies such as cloud computing, robotic process automation, machine learning, artificial intelligence (AI), and blockchain—and the speed of these advances—are disrupting business models and transforming how healthcare organizations do business. As discussed in the 2018 NACD Blue Commission Report, *Adaptive Governance: Board Oversight of Disruptive Risks*, traditional enterprise risk management processes may not be designed to address the disruptive risks posed by these digital advances, or to assess the continuing validity of key assumptions on which an organization's strategy and business model are based. Help management reassess the healthcare organization's processes for identifying the risks and opportunities posed by digital advances and for assessing their impact on the company's strategy. Does management have an effective process to monitor technology changes in the external environment? Does the process provide early warning that adjustments to strategy might be necessary?

Also, understanding how the healthcare organization collects, protects, analyzes, and uses data and complies with HIPAA and other healthcare laws has become table stakes for broader, potentially game-changing questions: What are the goals of the company's digital strategy and how can the use of big data and advanced analytics help drive the business? Does the company have the right tools, technology, resources, and talent to develop a quality big data program? How do we determine what information drives value for the organization—e.g., insights into patients, consumers, employees, suppliers, business processes? Do we manage the data in a responsible, ethical manner?

Help the healthcare organization test its strategic assumptions and keep sight of how the big picture is changing by connecting dots, thinking differently, and staying agile and alert to what's happening in the world. In short, digital disruption, strategy, and risk should be hardwired together in boardroom discussions.

Understand the strategic implications of accelerating consolidation in healthcare—horizontal, vertical, and virtual.

The flurry of mergers and proposed transactions across the healthcare continuum (setting aside those driven by tax reform) highlights ongoing efforts to "reset" the way healthcare works. After years of trying to rein in costs and improve quality, players in and outside the sector are looking to more transformational efforts to solve the underlying challenges of costs and incentives, quality, compliance, and competitiveness. Time will tell whether the recent wave of transactions and announcements will translate into lasting improvements to the system. However, it is clear that a fragmented system and lack of interoperability and transparency is hobbling progress—for individual healthcare organizations and the sector.

Boards and management should be watching these events closely. Actively assess the organization's current footing, and whether a move to consolidate would be beneficial. Are there opportunities for clinical innovation and business process transformation, enhancing the customer experience through virtual care platforms, addressing potential margin compression (as a result of commodity care carve-outs and complex care pricing pressures), and creating new economic value pools to take capitated risk and achieve smart growth?

Consolidation will continue to reshape the industry. Consider the significance and velocity of changes underway, understand the broader context, and assess the organization's ability to execute on scenarios that look promising (or imperative).

Analyze scenarios for potentially building, buying, partnering, or aligning with health plans.

According to a recent Oliver Wyman study, nearly 200 health systems have entered into partnerships or joint ventures with health plans over the last four years. The decision to build, buy, partner, or align is a complex one for management and the board. Factor in required investment, regional dynamics, and short- and long-term risks within and outside the organization.

As a result, organizations need to think through potential scenarios and related investment models, including the most common: 1) the traditional provider-owned HMO that can bear risk and work with primary care and specialty physician services (which has proven resilient in the current market); 2) entering the insurance market with an ACA or Medicare advantage product based on capabilities of an affiliated provider network (the network assumes limited risk and works with the health system to deliver limited products to

the market); 3) a provider/health plan alliance model in which health systems enter into strategic partnerships with larger regional or national health plans in exchange for preferred network placement (a shared-risk model that offers a provider higher volumes from a network that is high-performing based on quality measures).

In thinking through the scenarios in the context of the organization's strategy and risk appetite, the board should consider issues such as: What is our competitive position in the market relative to health plans? Do we have the required capabilities to take on risk and other health plans competencies? Would we have effective input in governing joint ventures, partnerships, etc.? What are our long-term and short-term expectations for the proposed venture? Are there adequate controls over data quality tied to provider compensation and premium revenue? What is the true cost of exiting such a health plan arrangement?

Monitor how the organization is maintaining the quality and integrity of its regulatory reporting.

The focus on quality metrics—by the Centers for Medicare & Medicaid Services (CMS), commercial insurance companies, clinical registries, federal regulatory agencies, and state departments of health, as well as by consumers deciding where to seek care—continues to accelerate. Today, a health system may report more than 500 measures to a multitude of registries, and "quality" reporting is now required for providers participating in the Quality Payment Program (QPP).[1] As the Office of Inspector General noted in its review of CMS' QPP, "We identified program integrity as an emerging challenge. The QPP relies on clinicians to submit their own performance data, including self-attestations. Providers may mistakenly submit inaccurate data, or could even potentially submit falsified data (for example, attesting to activities they did not perform) to receive a positive payment adjustment.) The risk is that healthcare organizations could ultimately face new False Claims Act cases alleging misreported quality data.

Given this focus on quality metrics, compliance functions should be working with quality and risk management departments to monitor, assess, and audit the quality reporting functions across the organization. Audits of quality reporting can help assess the accuracy and completeness of quality data reported to or from external agencies, such as CMS or the National Health Safety Network, while supporting internal performance improvement.

Are we confident that our internal controls over quality reporting (ICOQR) are on par with our internal controls over financial reporting (ICOFR)? Are problems that are identified being remediated? Do the board's audit and quality committees exchange ideas and information to ensure that both the relevance and reliability of reported measures are being overseen effectively? Take time to discuss how management assesses and continually seeks to improve data quality. Are quality reporting activities adequately resourced (people, skills, and budget)?

Continue to refine boardroom discussions about cybersecurity and data privacy as *risk management* issues.

Cyber threats continue to grow more sophisticated and aggressive, with implications for nearly every facet of business. Hacks at major companies punctuate the new reality that any organization on the grid is vulnerable. Boardroom discussions should be moving beyond prevention to *detection, containment, and response*—and to addressing cybersecurity as an enterprise-wide business issue that affects strategy, compliance, M&A, and relationships with vendors, suppliers, and customers. A robust and frank boardroom dialogue is vital to helping the healthcare organization learn to live with cyber risk and making cybersecurity a core competency across the business.

How frequently is the maturity of the healthcare organization's cybersecurity risk management framework evaluated? How is the healthcare organization keeping up with regulatory changes and new legal requirements? Is the healthcare organization staying abreast of industry practices and connecting with law enforcement? Does the healthcare organization have an incident readiness and response plan that has been reviewed and tested particularly given the increase in ransomware incidents? Is the board getting the information it needs (cyber dashboard) to oversee cybersecurity efforts?

What risks does the use of big data pose, and who is responsible for making decisions about the use of data? Data privacy rules such as California's Consumer Privacy Act and HIPAA require rigorous assessments of healthcare organizations' data practices. Indeed, with data privacy linked so tightly to trust and reputation, a running reality check is essential: "just because we can doesn't mean we should."

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[1] Created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) – with respect to both the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs) tracks

Assess, monitor, and reinforce culture as a strategic asset and critical risk.

Corporate culture is front and center for companies, shareholders, regulators, employees, and customers—as it should be for every board. Headlines of sexual harassment, price gouging, shady sales practices, and other wrongdoing—with corporate culture as the culprit—have put boards squarely in the spotlight: Where was the board? And what is it doing to fix the culture?

Given the critical role that corporate culture plays in driving a company's performance and reputation—for better or for worse—we see boards taking a more proactive approach to understanding, shaping, and assessing corporate culture. Among the messages we hear: Have a laser focus on the tone set by senior management and zero tolerance for conduct that is inconsistent with the healthcare organization's values and ethical standards, including any "code of silence" around such conduct. Be sensitive to early warning signs and verify that the organization has robust whistle-blower and other reporting mechanisms in place and that employees are not afraid to use them.

Understand the organization's *actual* culture—the unwritten rules, versus those posted on the breakroom wall. Use all the tools available—surveys, internal audit, hotlines, social media, walking the halls, and visiting facilities—to monitor the culture and see it in action. Recognize that the tone at the top is easier to gauge than the mood in the middle and the buzz at the bottom. How does the board gain visibility into the middle and bottom levels of the organization? Do employees have the confidence to escalate bad behavior and trust their concerns will be taken seriously? Make sure that incentive structures align with strategy and encourage the right behaviors, and take a hard look at the board's own culture for signs of groupthink or discussions that lack independence or contrarian voices. Focus not only on results, but also on the behaviors driving them.

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