HLTH 2025 Payer and Provider Insights

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Executive Summary

Payer and Provider Insights

Across the programs, leaders spanning the payer, provider, technology, and policy sectors shared their vision for the future of the U.S. healthcare system, specifically how to move past the overwhelming administrative and financial complexity that is no longer sustainable. A strategic convergence of intelligent automation, data quality, and multi-stakeholder collaboration were the key pillars of their vision. This strategy is built on several key pillars: prioritizing AI investments to tackle the administrative waste that burdens the system, establishing a culture where high-quality data is treated as a strategic asset, evolving fraud and abuse oversight for a new era of digital risk, and re-engineering the entire financial experience to be seamless, empathetic, and truly patient-centered.

The discussions made it clear that while AI holds immense promise, its immediate value lies in empowering, not replacing, humans. The primary focus is on alleviating the administrative burdens that cause clinician burnout and operational friction. However, this promise is entirely dependent on a "data quality first" mindset, which is a challenging, but non-negotiable, prerequisite to building trust in any automated system. As technology creates new efficiencies, it also introduces new risks, forcing a modernization of compliance that leverages data analytics while holding firm to ethical guardrails.

Ultimately, the sessions concluded that collaboration is the key to success. The historically adversarial relationships between payers and providers must give way to transparent partnerships built on shared, high-quality data. The goal is to create a streamlined operational and financial ecosystem that reduces errors, accelerates reimbursement, and, most importantly, rebuilds trust by placing the patient's experience at the heart of every process and investment decision.

Prioritizing AI Investments: Balancing Cost, Impact, and Innovation

Speakers

Benjamin Cassity

Research Director, KLAS Research
(Moderator)

Stacy L. Lloyd

Director, Digital Health and Operations, AMA

Adam Siskind

Principal, ZS

Dr. Andrea Willis

SVP, Chief Medical Officer, BlueCross BlueShield of Tennessee

Intro

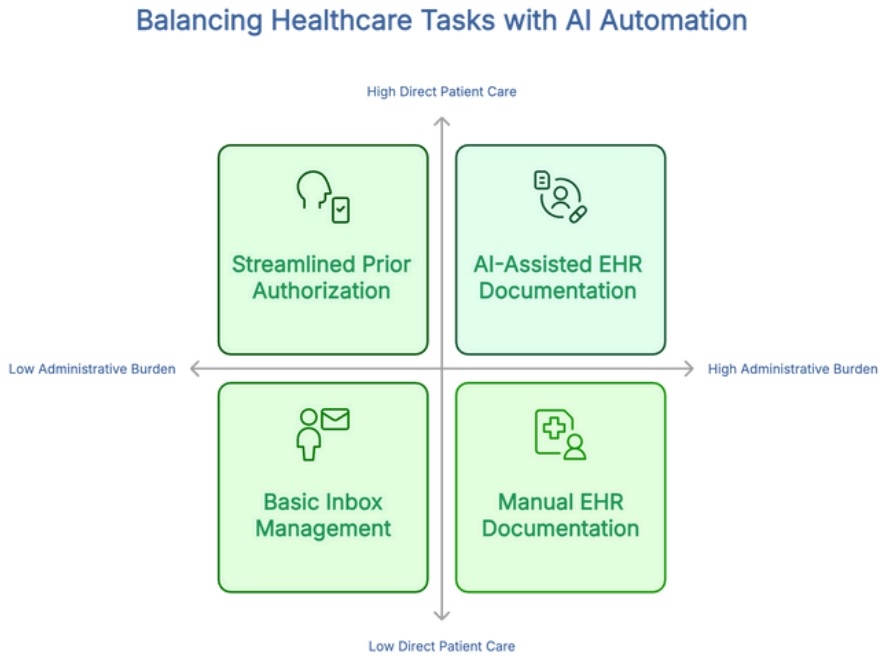
In a landscape saturated with AI hype, how can healthcare leaders cut through the noise to make smart, strategic investments that solve real problems instead of just chasing the next shiny object?

This session convened a panel of leaders from a national payer, a physician advocacy organization, and a leading healthcare consultancy to. Framed by a poignant personal story of system failure, the discussion moved beyond the buzz to address the core challenges of prioritization, trust, and measuring true impact. The panelists explored where AI is making the biggest difference today, how to build a business case that extends beyond simple cost-cutting, and the keysteps organizations must take to build the governance and literacy needed to deploy these powerful tools responsibly and effectively.

1. Start with the Pain: Tackling Administrative Burden

The panel was unanimous that the most significant, immediate, and widely accepted impact of AI in healthcare today is its ability to tackle the administrative burden that plagues the system. While the long-term vision may be AI-driven clinical breakthroughs, the practical reality is that the most pressing need, and the area of highest enthusiasm from clinicians, is automating the tasks that cause burnout and detract from patient care. These include documentation support, managing EHR messages, and streamlining the prior authorization process. The consensus was clear: before aiming for moonshots, organizations should focus their AI investments on solving the core, painful, and costly administrative problems that their teams face every single day.

> *"We're definitely seeing the biggest interest,excitement and enthusiasm around AI, at least among the physician community, in the opportunities that address administrative burdens."*
> - ***Stacy L. Lloyd**, Director, Digital Health and Operations, AMA*



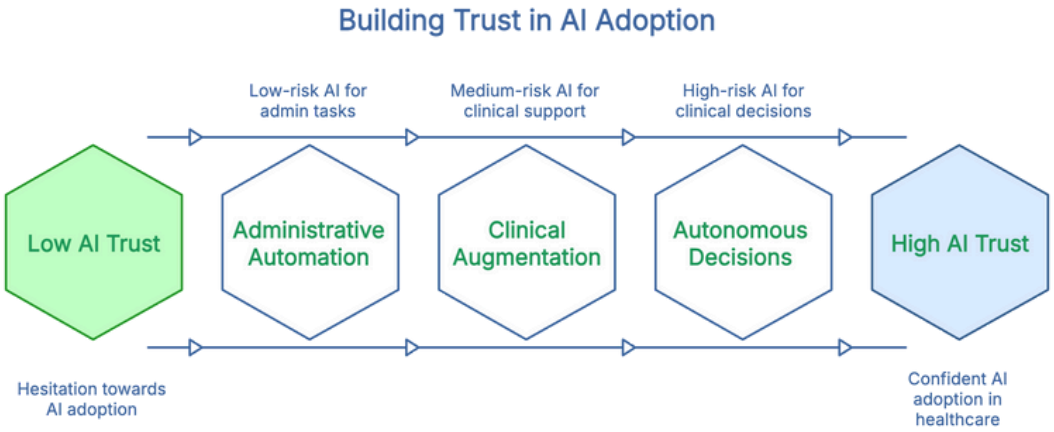
Key Takeaways:

- The primary, proven use case for AI in healthcare today is reducing administrative burden.
- Physician enthusiasm for AI is highest for tools that automate documentation and other non-clinical tasks.
- Prioritizing administrative solutions is a strategic way to address clinician burnout and free up time for patient care.

2. The Trust Deficit: Why Administration Comes Before Clinical

An insight from the discussion was that the focus on administrative tasks is not just a matter of tackling low-hanging fruit; it is a direct consequence of the significant trust deficit that clinicians, particularly in the U.S., have with AI. With physician trust in AI below 40%, deploying these tools in high-stakes clinical decision-making is fraught with risk and resistance. Administrative applications, by contrast, offer a lower-risk environment to build comfort, familiarity, and trust with the technology. The panel argued that starting with administrative use cases is a necessary and pragmatic strategy to build organizational "AI literacy" and gradually earn the credibility required to eventually move into more clinically integrated applications.

> *"In the U.S., physicians mistrust AI. The amount of distrust in AI is less than 40%... That mistrust leads to a lot of barriers. Where can you overcome the barriers? You can overcome the barriers in areas that are more administrative, where it's not around patient care."*
> ***- Adam Siskind, Principal, ZS***



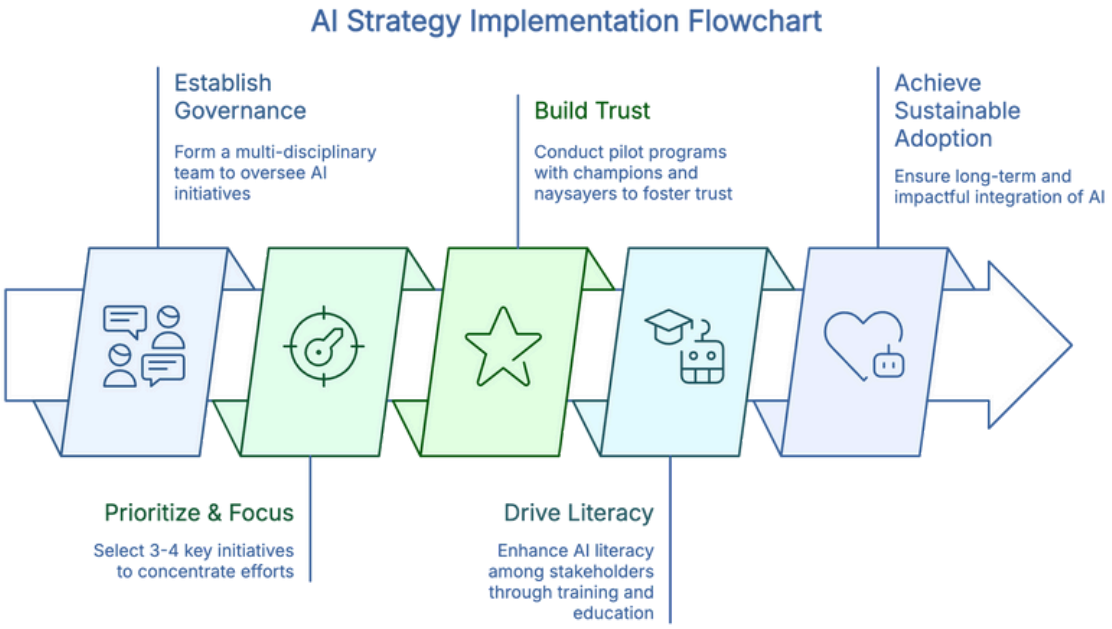
Key Takeaways:

- Low clinician trust in AI is a major barrier to adoption in clinical settings.
- Administrative tasks provide a lower-risk "training ground" to build organizational comfort and trust in AI.
- Successful AI strategy requires a phased approach, starting where the risk is lowest and the need is clearest.

3. Redefining ROI: Beyond Cost Savings to "Return on Health"

The panel challenged the narrow view that the ROI of AI should be measured solely in terms of cost savings or time reduction. A more holistic and accurate approach is to consider the broader "Return on Health," which encompasses value streams across the entire organization. For example, while ambient AI for documentation may not always lead to a significant decrease in total time spent in the EHR, its true value is often found in the reduction of clinician cognitive load, decreased feelings of burnout, and an increased sense of "joy in practice." This, in turn, leads to a better patient experience, as the physician can be more present and engaged. Leaders must look beyond simple financial metrics to measure the full impact of their AI investments on clinician well-being, patient satisfaction, and care quality.

> *"What we actually haven't seen is a significant decrease in time in the EHR. But we're seeing less feelings of burnout, we're seeing more joy in practise... It's improving their experience with care delivery."*
> - ***Stacy L. Lloyd**, Director, Digital Health and Operations, AMA*



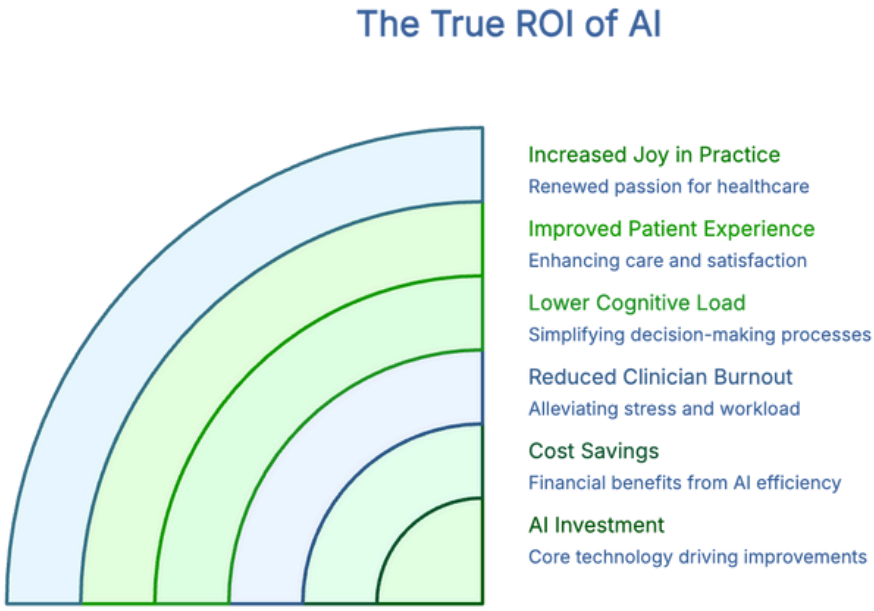
Key Takeaways:

- The ROI of AI should be measured holistically, including its impact on clinician well-being, not just financial metrics.
- Tools like ambient AI deliver significant value by reducing cognitive load, even if they don't drastically cut time in the EHR.
- Improved "joy in practice" is a critical, though less tangible, return on investment that leads to better care and retention.

4. The Strategic Blueprint: Focus, Governance, and Literacy

The panel concluded by outlining a strategic blueprint for successful AI implementation. The first principle is to focus: organizations should resist the urge to invest in dozens of disparate AI projects and instead choose three or four high-impact initiatives where it can make a difference The second is to establish governance. A strong, multidisciplinary governance structure is essential for evaluating tools, aligning them with strategy, ensuring flexibility, and establishing ethical guardrails. The final piece is building organizational literacy and trust. This involves being transparent with clinicians about what tools are being used, providing thorough training, and creating feedback loops. A particularly effective strategy is to pilot new tools with a mix of enthusiastic champions and respected naysayers, as their collective endorsement is the most powerful driver of wider adoption.

> *"Choose where to play and be amazing executing three or four really, really impactful initiatives... you need to be amazing at some place first. And that's the only way to do that is - by choosing what not to do as opposed to trying to be everywhere."*
> - ***Adam Siskind**, Principal, ZS*



Key Takeaways:

- A successful AI strategy requires ruthless prioritization; trying to do everything leads to doing nothing well.
- A formal governance structure is a non-negotiable prerequisite for managing AI investments responsibly.
- Building trust through transparency, education, and inclusive piloting is the key to driving lasting adoption.

Conclusion

The session provided a clear, pragmatic roadmap for healthcare leaders navigating the complex and often-hyped world of AI. The resounding message was that AI is not a magical solution, but a powerful tool whose success depends entirely on a thoughtful, human-centered strategy.

The journey begins with a relentless focus on solving the real, painful administrative problems that burden clinicians. It requires a patient and deliberate approach to building trust, starting in low-risk areas before moving to more complex clinical applications. And it demands a broader definition of success, one that measures return not just in dollars saved, but in the restoration of joy and purpose to the practice of medicine. By adhering to a disciplined strategy of focus, governance, and trust-building, organizations can harness the true power of AI to create a more efficient, effective, and humane healthcare system.

Better Data, Better Care: Enhancing Quality and Usability of Patient Data

Speakers

Colin Hung

CMO and Editor, Healthcare IT Today

Moderator

Charlie Harp

CEO, Clinical Architecture

Viet Nguyen, MD

Chief Standards Implementation Officer, HL7 International

Lauren Riplinger

Chief Public Policy & Impact Officer, AHIMA

Intro

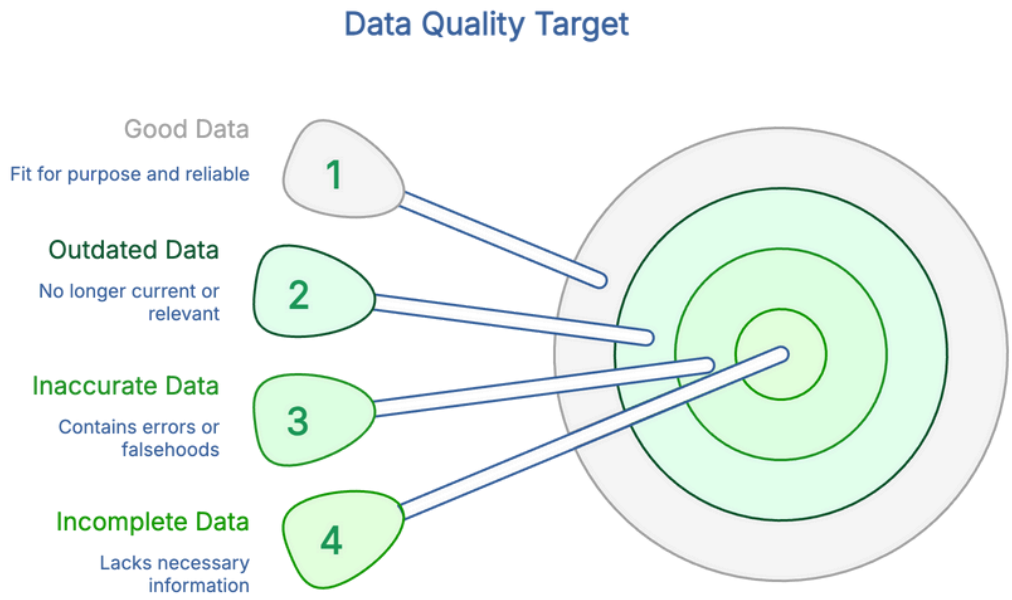
In an industry drowning in data, why do we still struggle to find the information that truly matters? How do we transform our vast, messy data streams into a high-quality, trustworthy asset that can power the next generation of healthcare?

This session assembled a panel of leading experts in health information management, data standards, and clinical architecture to tackle the foundational challenge of data quality. The discussion cut through the buzz around AI and analytics to focus on the essential prerequisite for their success: clean, accurate, complete, and timely data. The panelists defined what "good data" truly means, explored the severe consequences of bad data, and debated the strategies, standards, and cultural shifts required to move the industry from a state of data chaos to one of data clarity and confidence.

1. Defining "Good Data": A Matter of Context, Timeliness, and Trust

The panel established that "good data" is not an absolute, but a highly contextual concept. Its quality can only be judged against its intended use case. Data that is perfectly sufficient for demographic analysis may be dangerously incomplete for clinical decision support. The key attributes of good data are that it is accurate, complete, and timely, but most importantly, it must be usable and fit for purpose. The discussion moved beyond a simple binary of good versus bad to describe data quality as a continuum. "Good data" represents the tipping point where the information becomes reliable enough to act upon with confidence, whether for direct patient care, population health analytics, or training an AI model.

> *"Data quality is a continuum going from poor to excellent data. Good data is the tipping point at which the data is usable."*
>
> - ***Charlie Harp,*** *CEO, Clinical Architecture*



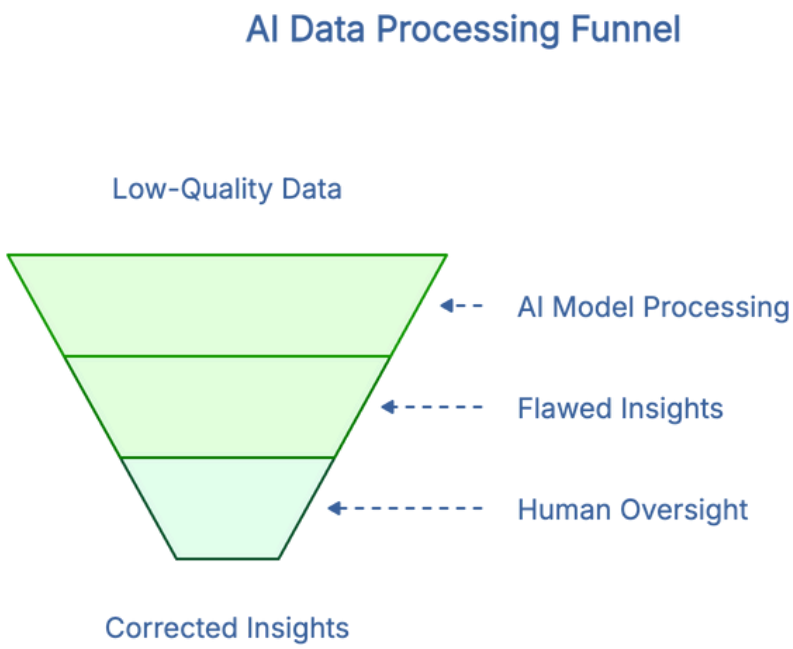
Key Takeaways:

- The quality of data is subjective and must be evaluated based on its specific use case.
- The core attributes of good data are accuracy, completeness, and timeliness, which together create usability.
- Good data is not about perfection, but about reaching a threshold of quality that makes it trustworthy for a given task.

2. The Danger of "Artificial Stupidity": AI's Dependence on Data Quality

A central theme was the risk of building advanced AI models on a foundation of poor-quality data. The panel warned that AI acts as an "accelerant," meaning it will amplify and scale the biases and errors inherent in the data it is trained on. Feeding unreliable data into these systems does not lead to artificial intelligence; it leads to "artificial stupidity" at a massive scale, potentially leading to flawed decisions, wasted resources, and patient harm. This reality underscores the need to clean up healthcare's data infrastructure before fully embracing AI for critical use cases. The conversation stressed that a "human-in-the-loop" remains a non-negotiable safeguard to validate AI outputs and mitigate the risks of a system built on imperfect data.

> *"An AI is heavily biased by not only the data that it's trained upon, but the data that it's prompted with. And in healthcare, we all agree that the data that we're moving around is not the highest quality... Really, what we're doing is accelerating a data quality problem."*
> - ***Charlie Harp**, CEO, Clinical Architecture*



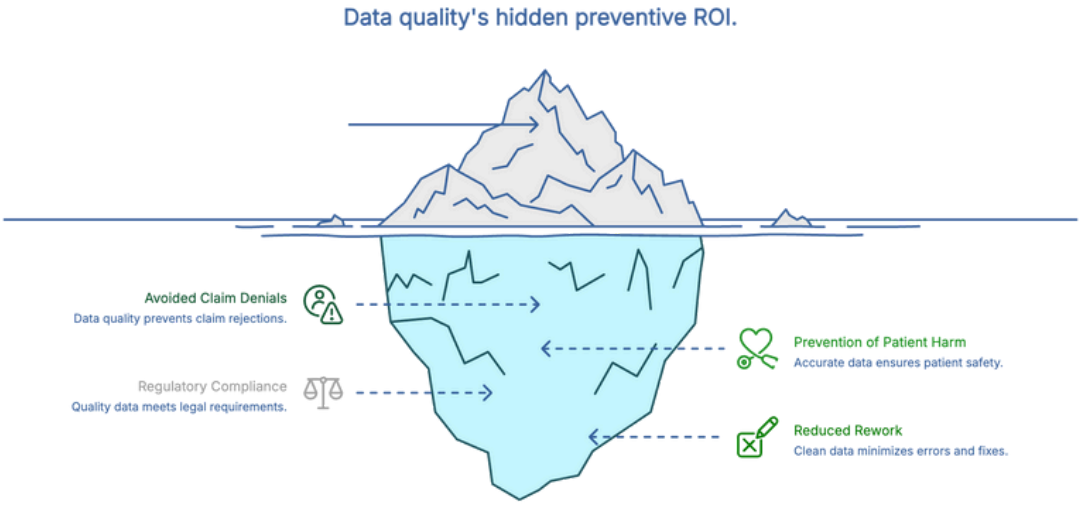
Key Takeaways:

- The current state of healthcare data presents a significant risk for the widespread deployment of AI in critical functions.
- Maintaining a "human-in-the-loop" is an essential safety measure to validate AI-driven recommendations and catch errors.

3. Making the Case for an Invisible Investment

The panel addressed a core challenge in advocating for data quality initiatives: the work is largely invisible, and its value is often only recognized in its absence i.e. when a failure occurs. Unlike a new building or a flashy technology, the ROI of data quality is in the prevention of bad outcomes (like patient harm or denied claims) rather than the creation of new, billable ones. The panel argued that leaders must make the case for this "lifestyle choice" by connecting it to tangible financial and regulatory pressures. Upcoming mandates, such as electronic prior authorization, will make the financial consequences of poor data immediately apparent when claims are denied. By framing data quality not as a cost center but as a prerequisite for maximizing reimbursement and avoiding regulatory penalties, organizations can build a compelling business case for this essential, foundational work.

> *"It's kind of like operating against bad intelligence, right? Sometimes you won't know until you're so far down the road that you've made so many bad decisions that you look back and say, wow, why did I make those bad decisions? And it's because you had bad data."*
> - ***Charlie Harp,*** *CEO, Clinical Architecture*

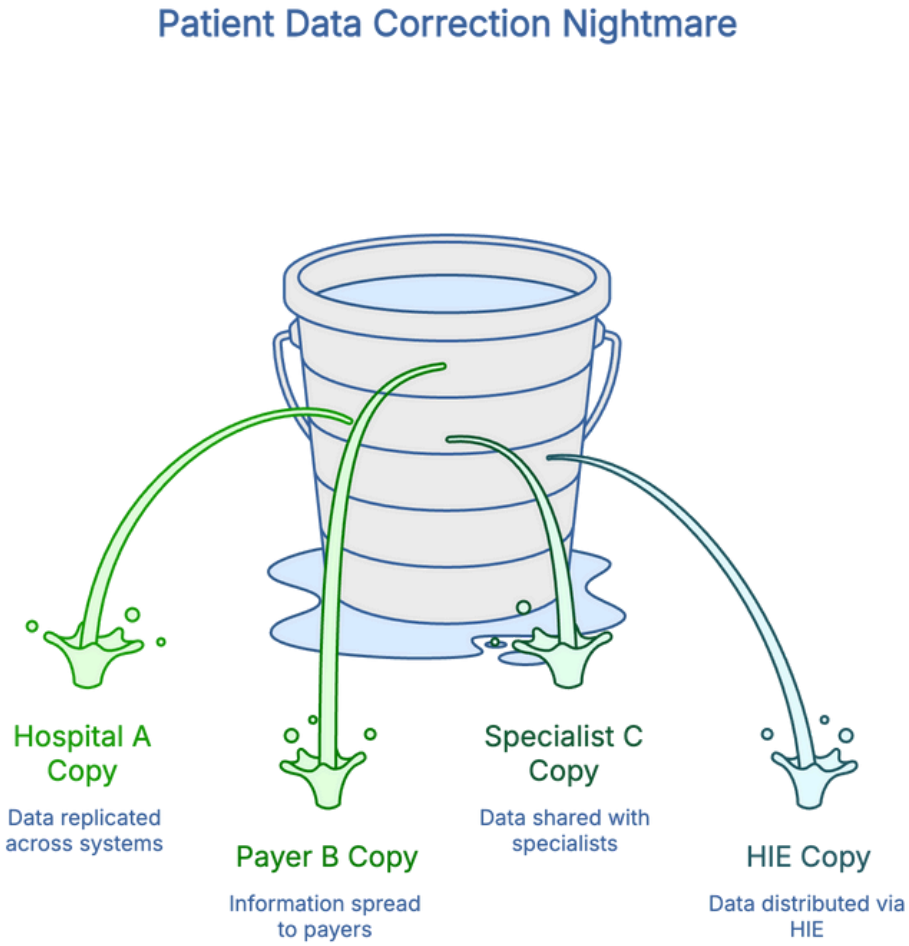


Key Takeaways:

- Investing in data quality is a "preventive" measure whose ROI is often invisible until a failure occurs.
- The business case for data quality can be made by linking it to tangible outcomes like maximizing reimbursement and ensuring regulatory compliance.
- Upcoming regulations like electronic prior authorization will make the financial impact of poor data impossible to ignore.

4. The Patient's Role in a Fragmented Data World

The panel explored the difficult question of how patients can be empowered to correct the inaccurate data that circulates about them in a fragmented and siloed healthcare system. While patients have a legal right under HIPAA to amend their records, the practical reality is a nightmare. Incorrect data, once entered, can be replicated and shared across countless systems, with no central "clearinghouse" to make a correction. The panel encouraged patients to be proactive by using patient portals and tools like Apple's HealthKit to aggregate and review their own data. However, they acknowledged that the systemic problem of data fragmentation means there is currently no simple solution.



Key Takeaways:

- It is currently extremely difficult for patients to correct inaccurate data about them due to system fragmentation.
- Patients can and should use available tools to monitor their records, but this is a temporary workaround, not a systemic solution.
- The lack of a central data steward or "clearinghouse" is a fundamental gap in the healthcare data infrastructure.

Conclusion

The session served as a reminder that in the rush to embrace AI and advanced analytics, the industry cannot afford to neglect the basics. The panelists made it clear that high-quality data is not a "nice to have," it is the absolute, non-negotiable foundation upon which the future of a safe, efficient, and intelligent healthcare system must be built.

The work of improving data quality is difficult, often invisible and requires continued investment and a well-defined culture around data governance. It is a shared responsibility that extends from health information professionals to standards bodies, technology vendors, and even patients themselves. Without this collective commitment to getting the data right, the promise of a better, data-driven future for healthcare will remain just that: a promise.

From Gray Areas to Red Flags: Hot Topics in Fraud & Abuse

Speakers

Randi Seigel, JD

Partner, Manatt Health

Moderator

Richard Golfin III

Chief Compliance & Privacy Officer, Alameda Alliance for Health

Scot Hasselman

Partner, Reed Smith LLP

Raul G. Ordonez III

Vice President and Chief Compliance Officer, Jackson Health System

Intro

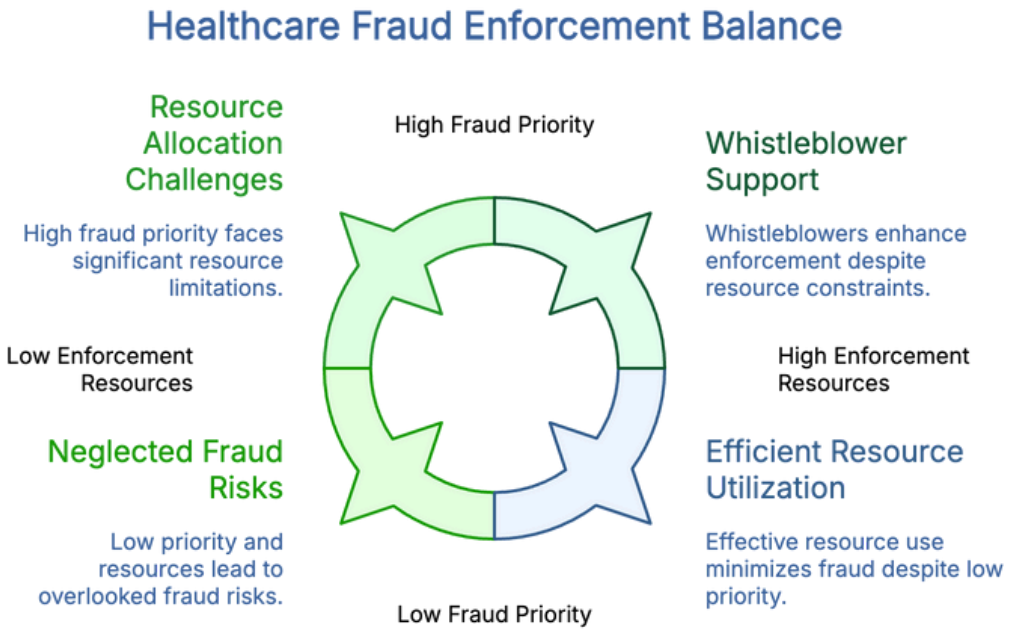
New technologies, payment models, and digital behaviors are reshaping healthcare delivery and creating risks. How are compliance leaders adapting their strategies to protect their organizations and patients?

This session convened a panel of legal and compliance experts from the provider, payer, and advisory sides of the industry to offer a candid perspective on the current state of healthcare fraud and abuse. The discussion moved beyond textbook definitions to explore the real-world challenges keeping leaders up at night. The panelists dissected the paradox of heightened enforcement priorities clashing with resource constraints, the emerging risks in digital health and social media, and the enduring importance of foundational compliance principles in a world of increasing complexity.

1. An Enforcement Paradox: High Ambition Meets Resource Constraints

A primary theme of the discussion was the apparent paradox in the current federal enforcement environment. On one hand, the administration has declared healthcare fraud its number one criminal priority, signaling intense focus and scrutiny. On the other hand, government agencies like the Department of Justice and the FBI are reportedly facing significant staffing shortages, with some estimates suggesting a 25-30% reduction in key divisions. This creates an environment of uncertainty for compliance leaders. While the reduced "person power" might suggest a lower immediate risk of investigation, the panel stressed that this is not a reason for complacency. The void is increasingly being filled by private forces, such as data-mining whistleblowers who are financially incentivized to find and report misconduct, meaning the threat of enforcement remains potent, even if its source is shifting.

> *"On the one hand, the current administration has clearly stated that health care, fraud and abuse is going to be one of their number one priorities...I think the other side of it is the application of that and the ability to actually really achieve those goals."*
> - ***Scot Hasselman**, Partner, Reed Smith LLP*



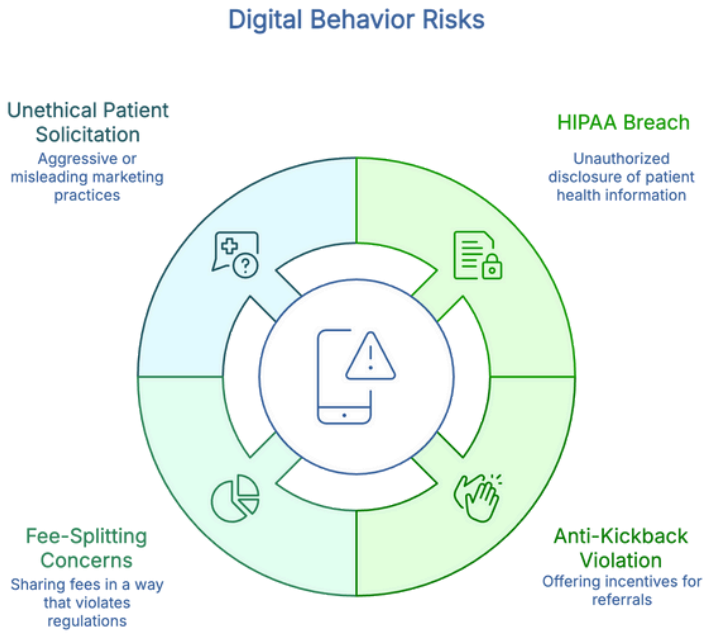
Key Takeaways:

- There is a significant disconnect between the federal government's stated focus on healthcare fraud and its current resource levels.
- The role of private whistleblowers, often leveraging data analytics, is becoming increasingly important in enforcement.
- Organizations cannot afford to lower their compliance guard, as the overall risk environment remains high despite federal staffing issues.

2. The New Frontier of Risk: Digital Health and Social Media

The panel identified the rapidly expanding digital landscape as a new and challenging frontier for compliance. The rise of clinicians building personal brands and promoting services on platforms like TikTok and Instagram creates a host of risks. These range from obvious HIPAA violations (e.g., filming videos with PHI in the background) to more nuanced and novel fraud and abuse concerns. For example, a social media "influencer" who is also a Medicare beneficiary receiving a free device to promote could potentially trigger anti-kickback concerns. The panel agreed that while many of these scenarios are new, the legal principles are not. The key for organizations is to proactively educate their workforce on how old-school rules about referrals, inducements, and privacy apply in these new-school digital contexts.

> *"Given the rise in clinicians building personal brands and occasionally obtaining patients or referring patients through promoting their services through platforms like TikTok, Facebook... how can healthcare organizations proactively shape a culture of compliance?"*
> - ***Randi Seigel**, JD (reading an audience question)*



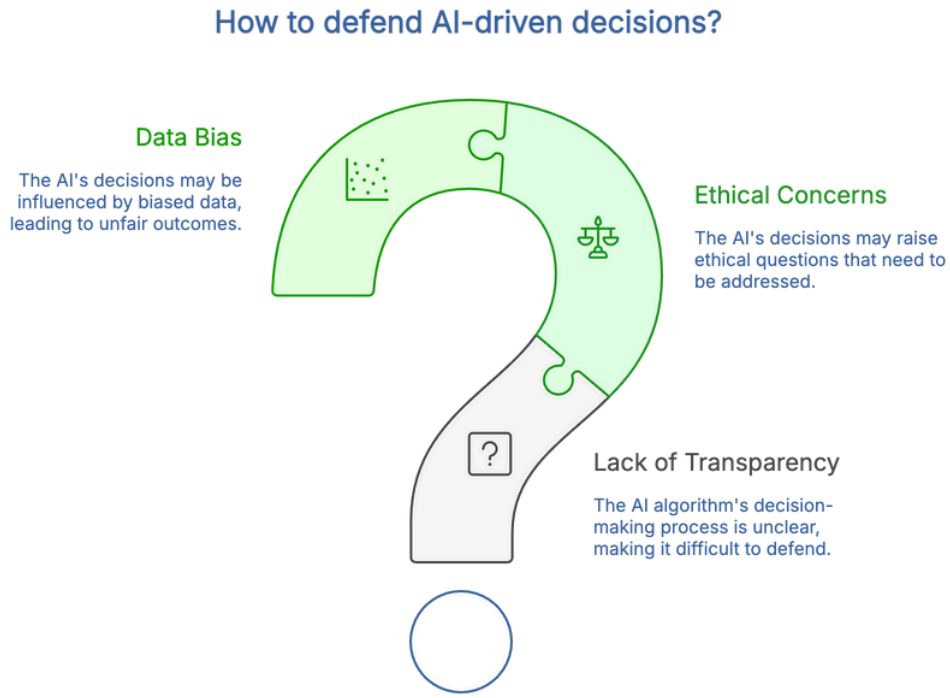
Key Takeaways:

- The use of social media by clinicians is creating a new and complex set of compliance and reputational risks.
- Organizations must proactively apply traditional fraud and abuse principles to these modern digital marketing and branding activities.
- Education on privacy, professional boundaries, and anti-kickback rules in the context of social media is now essential.

3. AI in Compliance: The Black Box Dilemma

While acknowledging the potential of AI to enhance fraud detection and prevention, the panel raised a critical concern: the "black box" problem. Many AI vendors offer powerful solutions but cannot provide auditable, traceable, or transparent explanations for how their algorithms arrive at a particular outcome or conclusion. This lack of transparency is a major risk for compliance departments, which must be able to defend and justify their actions to regulators. The consensus was that while AI can be a powerful tool for analyzing structured data (like claims) to flag outliers, its use becomes far riskier when it starts to influence clinical pathways or automate decisions without a clear, auditable trail. The inability to "see inside the box" remains a significant barrier to the full adoption of AI in high-stakes compliance functions.

> *"For AI and compliance in particular... most of the AI delivery models... they all still provide you an outcome from a black box... If it's not auditable, if it's not traceable, if we can't see how that outcome was made, then that is the biggest risk."*
> *- **Richard Golfin III**, Chief Compliance & Privacy Officer, Alameda Alliance for Health*



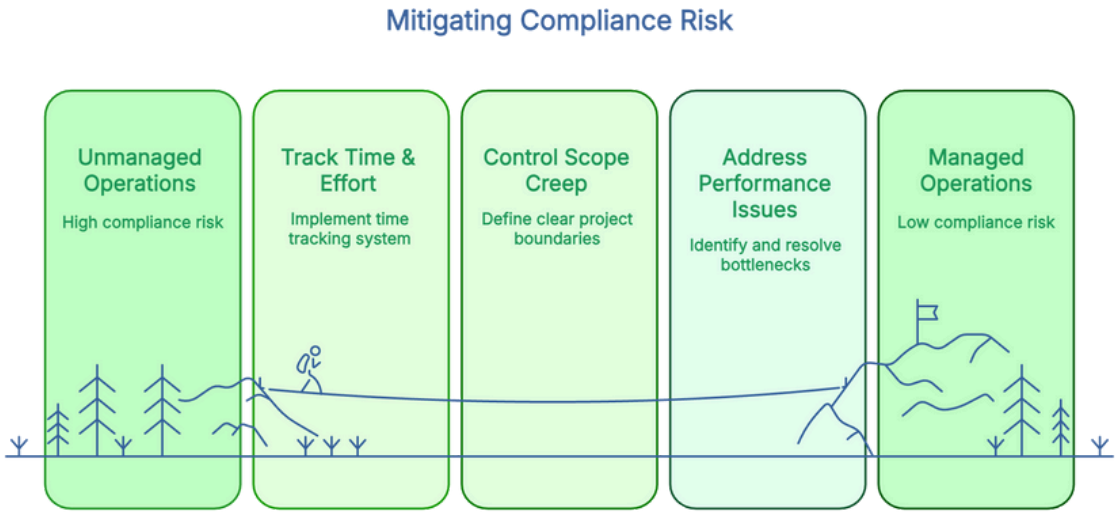
Key Takeaways:

- A primary risk of using AI in compliance is the lack of transparency and auditability in how algorithms make decisions.
- This "black box" problem makes it difficult for organizations to defend AI-driven actions to regulators.
- The immediate, safer value of AI in compliance is in augmenting human review of structured data, not in autonomous decision-making.

4. Back to Basics: The Enduring Importance of Post-Deal Oversight

Amidst discussions of new technology and emerging risks, the panel brought the focus back to a fundamental area of compliance: post-contract operational oversight. A common pitfall is to invest immense energy ensuring a new physician arrangement or partnership is compliant on the front end (e.g., fair market value, commercial reasonableness) and then assuming everything will operate as planned. The reality is that compliance failures often happen in the operationalization of a deal when a physician overextends themselves and fails to fulfill their contracted hours, for example. This can create significant Stark Law and anti-kickback risks. The panel stressed that compliance must shift from a "pre-deal" focus to a continuous, "post-deal" monitoring process to ensure that arrangements are being executed in practice exactly as they were designed on paper.

> *"Something I've come to realize is maybe more energy needs to be put into not just the front end of the deal, but understanding how that deal is being operationalized because a lot of compliance issues come up from instances when the arrangement is not operationaliszd how it was designed."*
> *- **Raul G. Ordonez III**, Vice President and Chief Compliance Officer, Jackson Health System*



Key Takeaways:

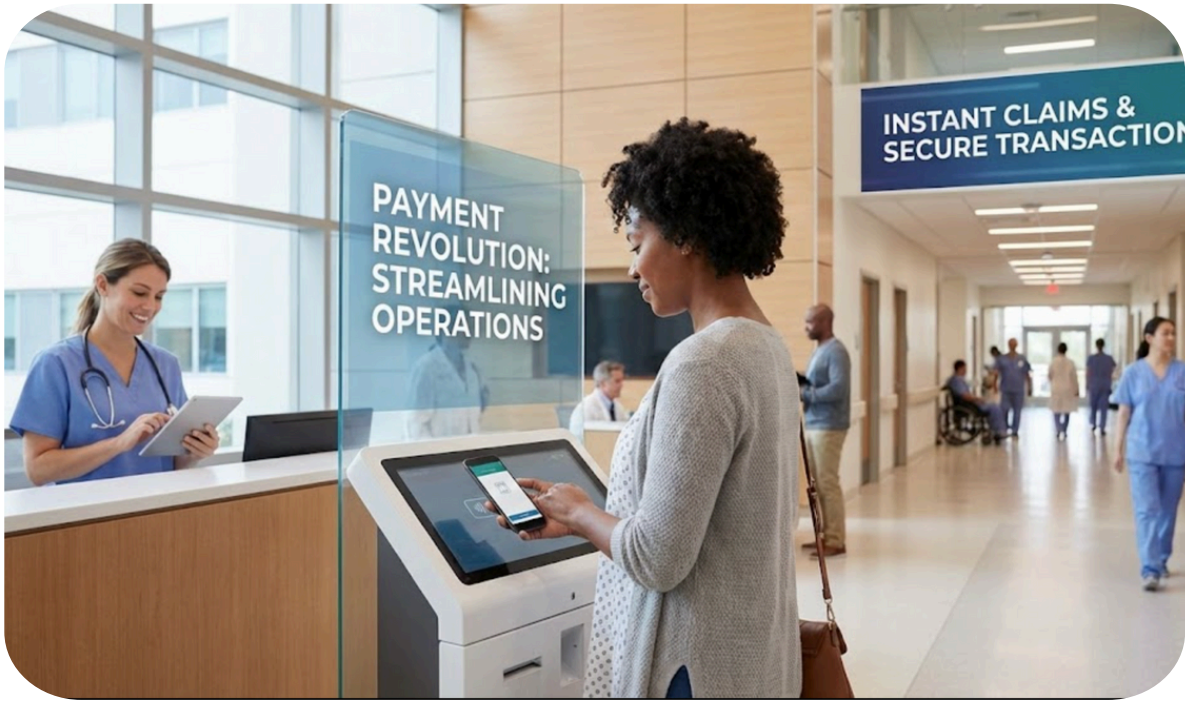
- A major compliance risk lies in the failure to monitor the ongoing operations of contracts and physician arrangements.
- Organizations must invest in "post-deal" compliance to ensure arrangements are being implemented as intended.
- This includes tracking fundamentals like time and effort to validate that the terms of compliant agreements are being met in reality.

Conclusion

The session provided a nuanced and clear-eyed view of the fraud and abuse landscape, revealing a world where foundational risks endure even as new digital threats emerge. The key takeaway for leaders is that an effective compliance program in 2025 and beyond must be ambidextrous: it must remain relentlessly focused on the fundamentals of medical necessity, proper coding, and contract oversight, while also adapting to the new realities of AI, digital health, and social media.

While the enforcement environment may be in flux, the underlying principles of compliance are not. The panel's consensus was clear: a strong "tone at the top," a culture where employees feel safe to report concerns, and a vigilant focus on the operational details of day-to-day business are, and will remain, the unshakable foundations of a resilient and effective compliance program.

The Payment Revolution: Streamlining Healthcare Operations



Speakers

Sarah Ahmad

CEO, CAQH

Moderator

Dr. Clyde Watkins

Chief Medical Officer, Village Medical Georgia

Yusuf Qasim

President, Payments, Zelis

Nick Zafirson

VP, Partnerships, Cedar

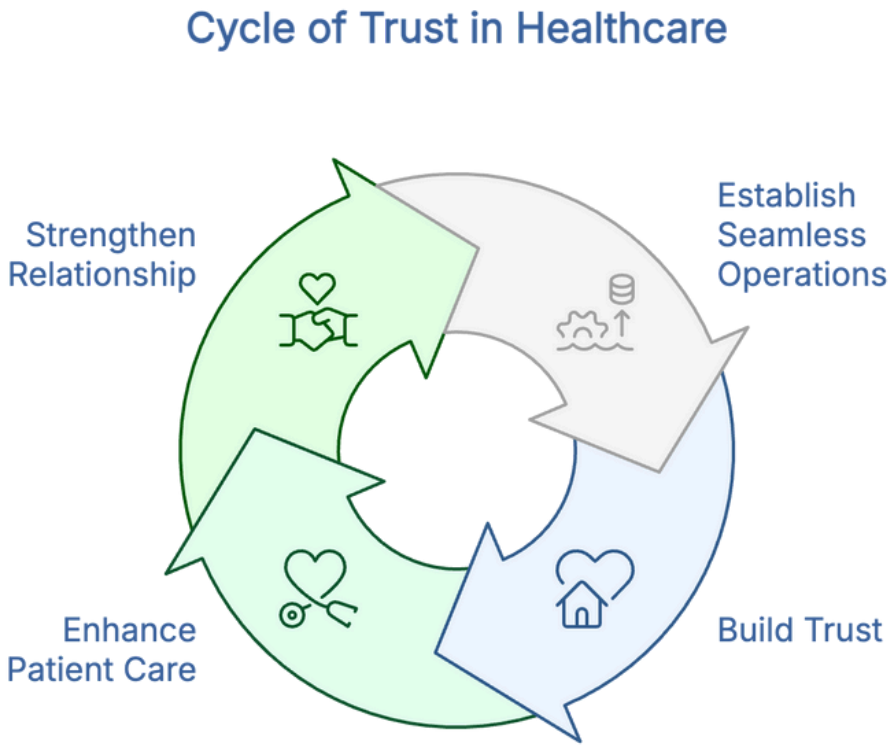
Intro

When a simple medical bill can cause more confusion and distress than the procedure itself, how can we re-engineer the financial experience to be as seamless, compassionate, and trustworthy as the clinical care it supports?

This session brought together a diverse panel, a frontline physician, a payer-provider fintech leader, and a patient payment platform executive,to tackle the immense friction in healthcare's administrative and financial workflows. The discussion moved beyond the technicalities of claims processing to explore the profound impact that broken payment systems have on the patient-provider relationship, health equity, and the overall cost of care. The panelists shared their visions for a future defined by radical collaboration, intelligent automation, and a relentless focus on creating a financial experience that is simple, empathetic, and, in the words of one panelist, "boring" in the best possible way.

1. The Foundation of Trust: Seamless Operations as a Prerequisite for Care

A powerful opening theme from the panel's physician was that seamless, invisible back-end operations are the unsung heroes of the patient-provider relationship. The foundation of this relationship is trust, which is built over years within the sanctity of the exam room. However, this trust is incredibly fragile and can be instantly shattered by downstream administrative chaos, like a surprise bill, a denied claim, or an endless phone tree. When the payment and operational systems work perfectly, they are "boring" and unnoticed, allowing the clinician and patient to focus entirely on health and healing. When they fail, the explosion of confusion and frustration is funneled directly back to the physician's office, eroding trust and distracting from clinical care. The core message was that the work of streamlining payments is not just an administrative function; it is an essential act of protecting the therapeutic alliance.



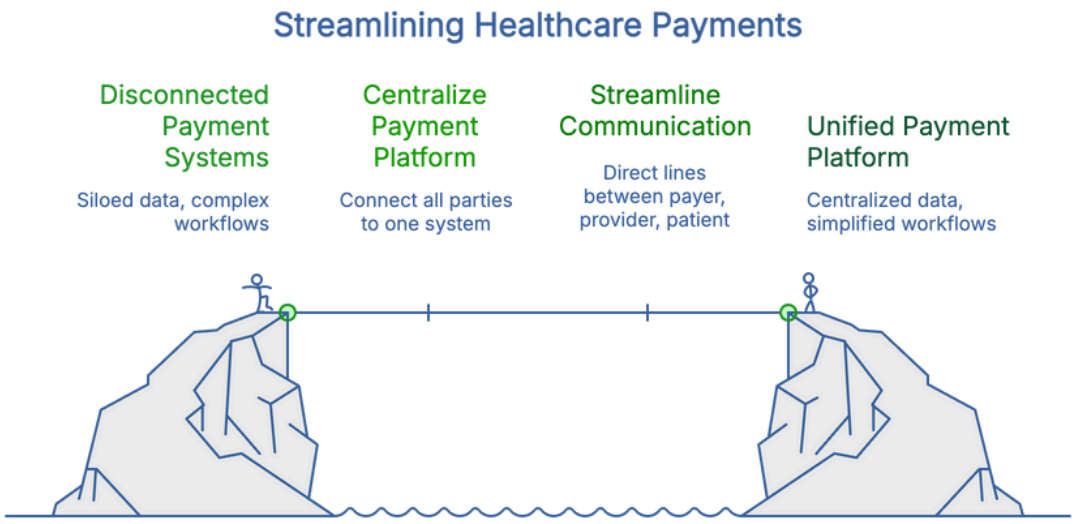
Key Takeaways:

- Administrative and financial friction directly erodes the trust that is foundational to the patient-provider relationship.
- The goal of payment operations should be to become so seamless and reliable that they are invisible to both patient and provider.
- Every member of the operational team is a part of the patient's broader healthcare team, and their work directly impacts the clinical experience.

2. The Aspiration to Be "Boring": Unifying a Fragmented Payment System

The speakers lamented the current state of healthcare payments as a noisy, fragmented, and frustrating "mess" for all stakeholders. With payers and providers using different "data languages," legacy systems, and a patchwork of third-party vendors, the entire process is rife with errors, rework, and wasted effort. The panel advocated for an audacious goal: to unify the end-to-end payment experience and make it as simple and predictable as a consumer transaction at Starbucks. This requires moving away from proprietary, siloed systems and embracing a collaborative model where payers, providers, and technology partners work together on shared platforms with a single source of truth. The discussion highlighted emerging partnerships aimed at connecting the Explanation of Benefits (EOB) directly to the patient's bill, a seemingly obvious but technically complex step toward creating a truly unified and understandable financial journey.

> *"Payers and providers need to trust the system. They need to start to unlock and share that data because ultimately that's what's going to streamline a lot of what we're doing."*
>
> *- **Yusuf Qasim,** President, Payments, Zelis*



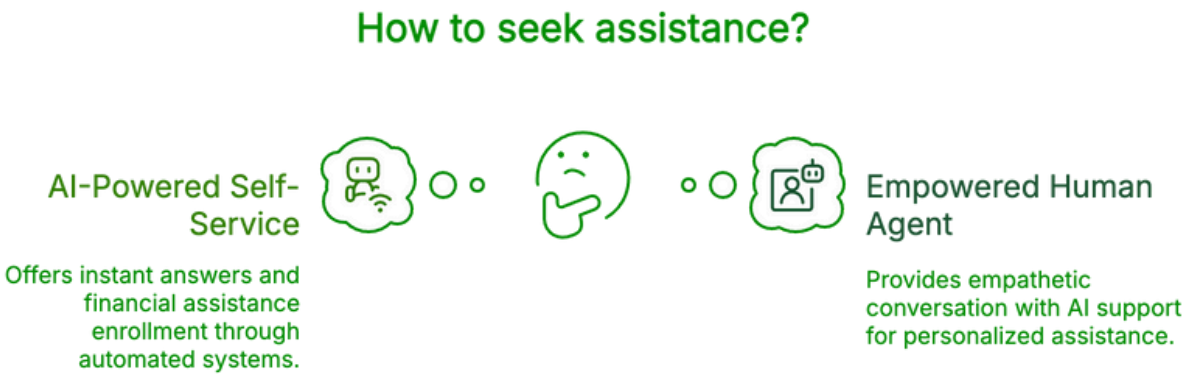
Key Takeaways:

- The healthcare payment system is plagued by legacy technology and a lack of data interoperability between payers and providers.
- The industry should aspire to create a unified, end-to-end payment experience that is simple and predictable for all parties.
- Collaboration and partnership between stakeholders are essential to breaking down silos and building this unified system.

3. Beyond Speed to Empathy: AI in the Patient Financial Experience

The discussion framed the role of AI in the payment process not just as a tool for speed and efficiency, but as a vehicle for delivering empathy at scale. The panelists observed that when patients call a provider's billing office, they are rarely calling to pay faster; they are calling because they are confused or cannot afford their bill. AI can transform this experience in two key ways. First, conversational AI can instantly answer low-to-medium complexity questions and, more importantly, guide patients on a personalized path to affordability by connecting them with untapped resources like manufacturer copay assistance programs or Medicaid enrollment support. Second, AI can act as a "co-pilot" for human call center agents, automating account research and recommending next steps, which frees the agent to be fully present and empathetic in their conversation with the patient.

> *"Most of the time when patients call in, they're not looking to pay faster. They're scared or they're confused or they can't afford the bill that's in front of them."*
>
> - ***Nick Zafirson**, VP, Partnerships, Cedar*



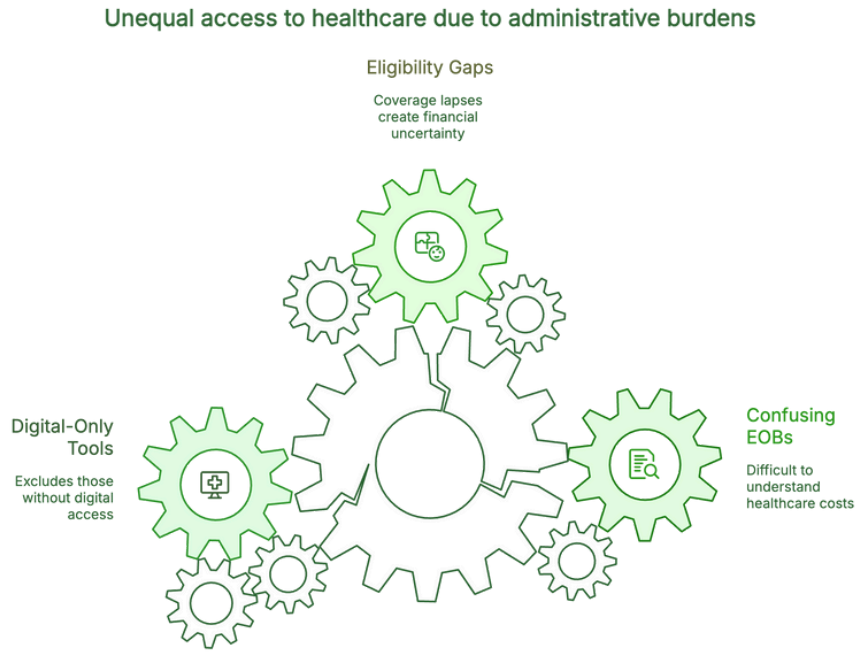
Key Takeaways:

- AI's role in the patient's financial experience should be focused on providing empathetic support, not just transactional efficiency.
- AI can personalize the financial journey by connecting patients with affordability resources they might not be aware of.
- By acting as a co-pilot for human agents, AI can free them from administrative tasks to focus on complex, high-empathy interactions.

4. The Unseen Inequities: How Broken Operations Impact Vulnerable Populations

The panel concluded with a powerful reminder that the friction and failures of the healthcare administrative system do not affect everyone equally; they disproportionately harm the most vulnerable populations. A patient on Medicaid who loses their eligibility due to a paperwork error, a person in a rural area without broadband access who cannot use a digital payment tool, or a patient with low health literacy who cannot decipher an EOB all face significant barriers to care created by a system not designed with them in mind. The work of streamlining eligibility verification, ensuring payment processes work for those with digital divides, and creating simple, understandable financial communications is therefore not just an operational improvement, it is a matter of health equity. The panel urged innovators to recognize that their work has a profound impact on ensuring that everyone, regardless of their circumstances, can access and afford the care they need.

> *"Health equity... is really important because... everyone deserves to have good healthcare. So to the degree that you are doing work with eligibility and with streamlining the payment process for someone on Medicaid, or in a vulnerable population, that is hugely important."*
> - ***Dr. Clyde Watkins, Jr.**, Chief Medical Officer, Village Medical Georgia*



Key Takeaways:

- The complexities and failures of the payment system disproportionately harm vulnerable, low-income, and rural populations.
- Streamlining administrative processes like eligibility verification is a critical component of advancing health equity.
- Innovators must design solutions that are accessible to all, accounting for challenges like the digital divide and low health literacy.

Conclusion

The session made a compelling case that a revolution in healthcare payments and operations is not only possible, but essential. The current system, with its legacy technology, fragmented workflows, and lack of collaboration, is failing patients, providers, and payers alike. The way forward, as illuminated by the panel, is one of radical partnership and a patient-centered redesign of the entire financial experience.

By embracing technology to create a unified, empathetic, and "boring" system, the industry can remove the administrative friction that erodes trust and distracts from care. This is not merely an exercise in improving efficiency; it is a fundamental part of the mission to deliver higher-quality, more equitable, and more humane healthcare to all.