HFMA Emerging Healthcare Leaders Summit

October 17, 2025

8:30 am – 4:00 pm

@ Mass General Brigham Assembly Row

4:00 pm – 6:00 pm

@ Lucky Strike Assembly Row

hfma

massachusetts-rhode island chapter

Emerging Healthcare Leaders Summit Agenda

Morning

8:30 - 8:45 **Welcome from HFMA MA RI Chapter President**
Dhara Satija
Mike Tracy

8:45 – 9:45 **Managed Care**
Eric Herbek
Alex Layton
Includes 5 polling questions

9:45 – 10:35 **Healthcare Finance and Reporting**
Marty Dunbar
Includes 5 polling questions

Break **Networking Break and Games**
Peter Markell Conference Rooms

11 – 12:30 **AI in Healthcare: A Multi-Stakeholder Perspective**
Moderator: Dhara Satija, CHC, CFE, CRCR
Panelists: Amanda Centi, Robert G. Martin, Garrett Gillespie, Donna Lewis, RN, MBA, CHC, Paulius Mui, MD
Includes 6 polling questions

Afternoon

Lunch *Peter Markell Conference Rooms*

1:40 – 2:30 **Revenue Cycle Overview**
Mary Beth Remorenko
Keisha Downes
Includes 3 polling questions

Break **Networking Break and Games**
Peter Markell Conference Rooms

2:45 – 3:45 **Career Spotlight Panel Discussion**
Moderator: Mansfield Holmes
Panelists: Abel Delgado, Hari Pillai, Aarti Shukla
Includes 3 polling questions

3:50 – 4:00 **Closing Remarks**
Mike Tracy

4:00 – 6:00 **Offsite Networking Event**
Lucky Strike Somerville

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Emerging Healthcare Leaders Summit
Offsite Networking Event

Please join us for post-conference networking/social event from 4:00 pm – 6:00 pm @ Lucky Strike Assembly Row

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Emerging Healthcare Leaders Summit

Friday, October 17, 2025

8:30 AM - 4:00 PM ET

Mass General Brigham, Assembly Row, Somerville, MA 02145

Welcome

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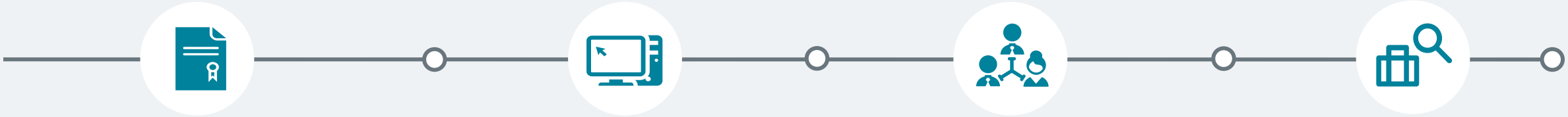
ma-ri chapter

[Chapter Website]

admin@ma-ri-hfma.org

HFMA Opportunities and benefits to explore…

Key Benefits and resources for healthcare professionals



Professional Development

- Certification Program
- Access to more than 70 hours of online education each year
- Discount pricing on all live education events

Unlimited Content

- Focused e-newsletters, articles, webinars and podcasts
- Access to HFMA magazine and HFMA daily newsletters
- Regulatory updates and resources

Community Participation

- Build relationships at both the local and national level with local Chapter membership
- Access to online member directory

HFMA Content

- Access to HFMA Career Center to find candidates or find your next job opportunity
- Career self assessments to identify your strengths and qualities needed for future roles

** Additional Benefits for Business Partner members and Special Enterprise Organization members*

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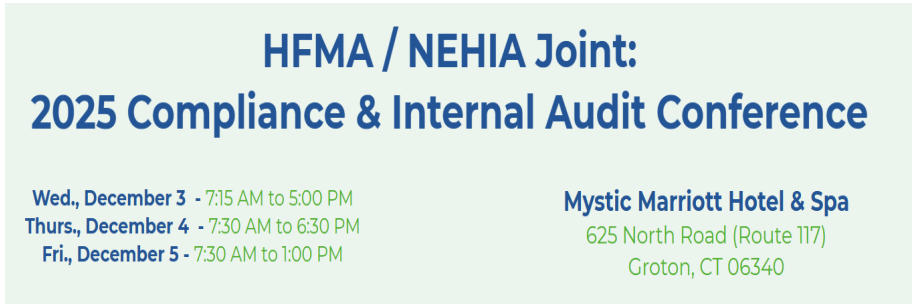
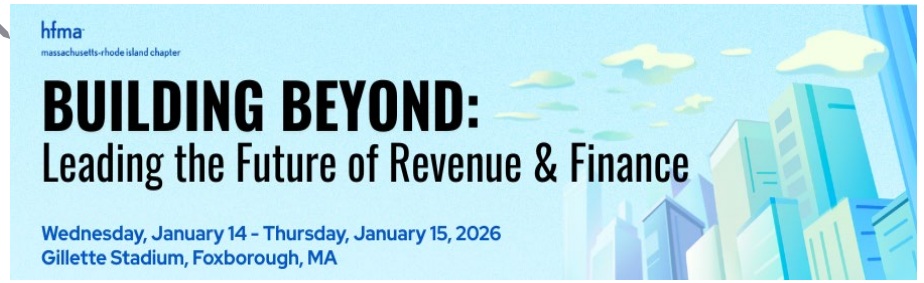
Engage with the HFMA MA-RI Chapter

Participate with the HFMA MA-RI Members

Events





Look out for more information on upcoming events/opportunities. *Please visit the chapter website: https://www.hfma.org/chapters/region-1/massachusetts-rhode-island/ or contact the HFMA general mailbox admin@ma-ri-hfma.org*

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Participate with the HFMA MA-RI Members

HFMA Blog

Are you interested in writing for the HFMA blog?

- Articles can cover a range of topics from educational pieces, member spotlights, social event news, and event recaps
- Submit your articles by emailing **admin@ma-ri-hfma.org**

Volunteer for a Committee

Are you interested in getting more involved?

- We encourage you to volunteer and participate in various chapter committees, networking opportunities, and events
- Reach out to **admin@ma-ri-hfma.org** to share your volunteer interests

For additional information on HFMA MA-RI Chapter, please visit the chapter website: https://www.ma-ri-hfma.org or contact the HFMA general mailbox admin@ma-ri-hfma.org

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Mass General Brigham

Managed Care

Introduction, Strategy, & Challenges/Opportunities

Eric Herbek, Chief Managed Care Officer, Mass General Brigham
Alex Layton, Program Manager PHO Contracting, Cape Cod Healthcare

October 2025

Outline

Introduction to Managed Care
Market Overview – Massachusetts
Managed Care – Mechanics and Strategy
How's it going? Market Dynamics, Challenges, Opportunities

Managed Care Overview

What is Managed Care? Key Responsibilities

Negotiate and manage commercial and government payer contracts

Evaluate key health policy, healthcare payment and market issues including:

- Payer Relationship Management & advocacy for issues of importance to MGB
- System Pricing Strategy
- Hospital and physician reimbursement and financial performance
- Quality performance, incentives, and measurement
- Alternative payment models (e.g. shared savings, bundled payments)
- Terms and conditions that impact MGB operational performance (e.g. delegated services)
- Implementation of fee schedules with payers

Market Overview
Massachusetts

Who is in our market?

Local Payers – Blue Cross Blue Shield, Point32Health (HPHC and THP), MBG Health Plan
Two large players dominate local market

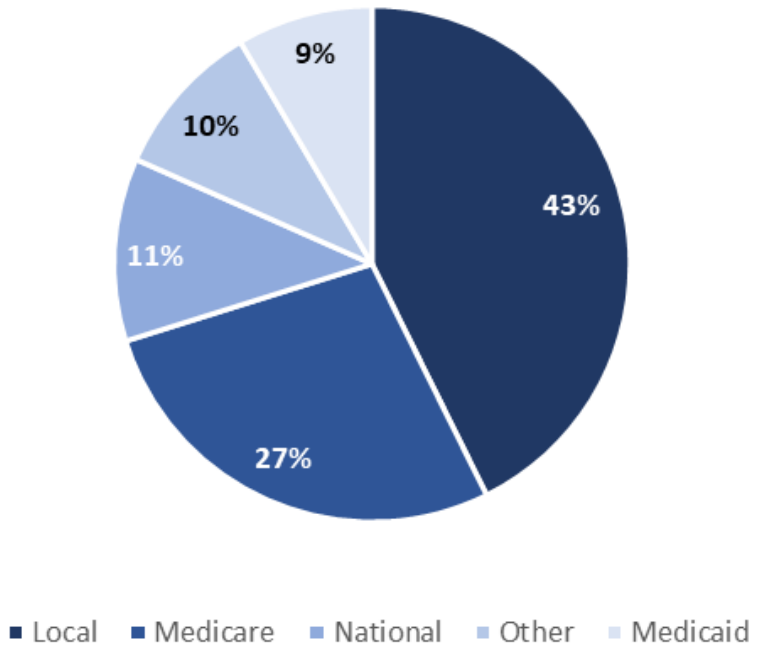
National Carriers – United, CIGNA, Aetna
Major national membership but small presence in Massachusetts

Medicare – Covers elderly and disabled
- Government sets reimbursement and payment rates
- Medicare Advantage – offered by commercial plans; *33% of Massachusetts enrollment & growing**

Medicaid – Covers low-income persons for medical and long-term care
- Government sets reimbursement and payment policies
- Accountable Care Organizations, including MGB/MGBHP
- Managed Medicaid – offered by commercial payers

Other – Self-pay patients (both uninsured and those who choose to pay themselves), worker's compensation, international, and other small payers

Net Patient Service Revenue by Payer Group



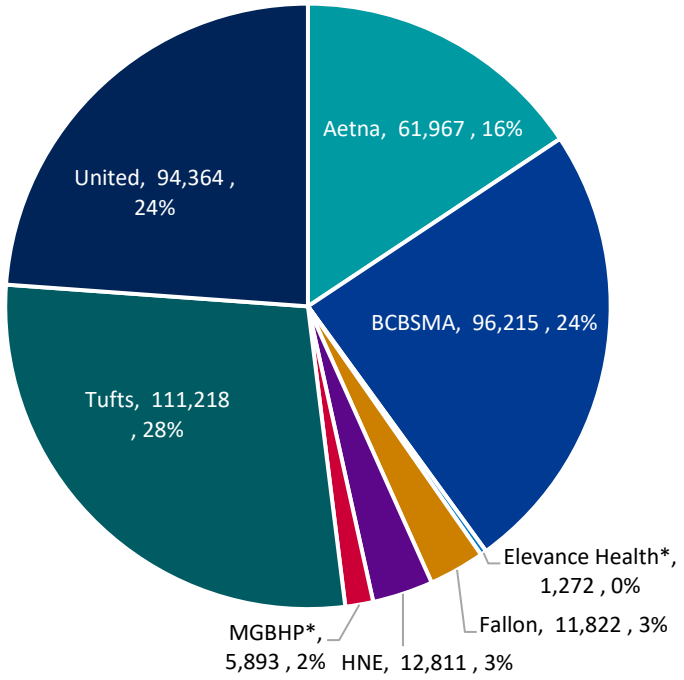
Note these are estimated based on MGB FY25 Revenue

* Source: CHIA Enrollment Trends, March 2025

Medicare Advantage in Massachusetts

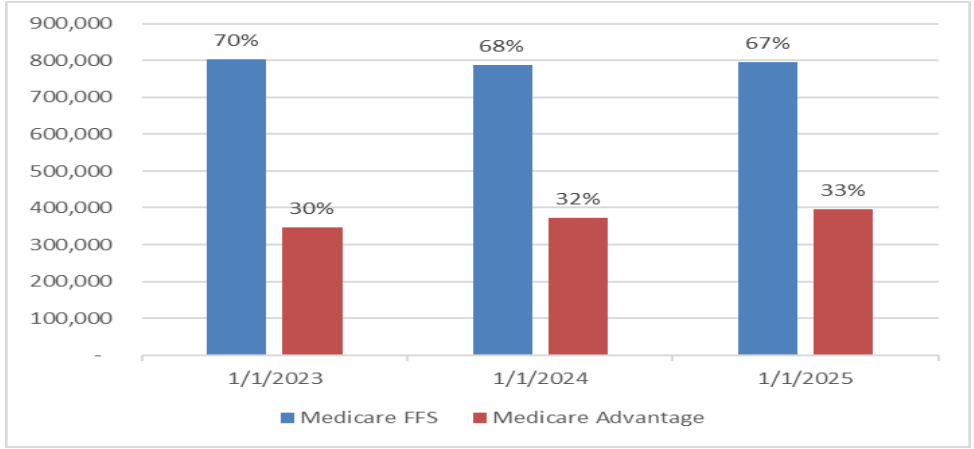
Dynamic market Nationally and in Massachusetts, with significant recent changes and new entrants

Payer Penetration in Massachusetts

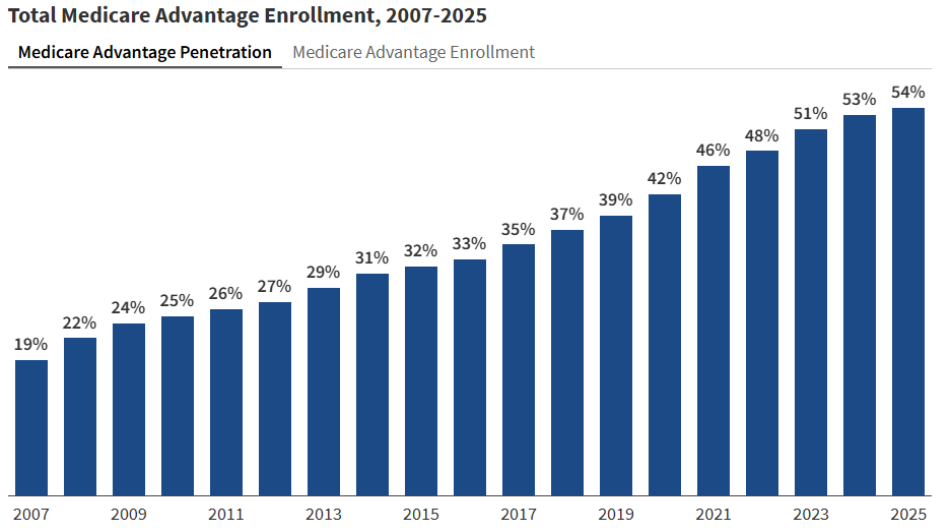


Source: CHIA Enrollment Trends Databooks, March 2025

Medicare Advantage vs. Medicare FFS - Massachusetts



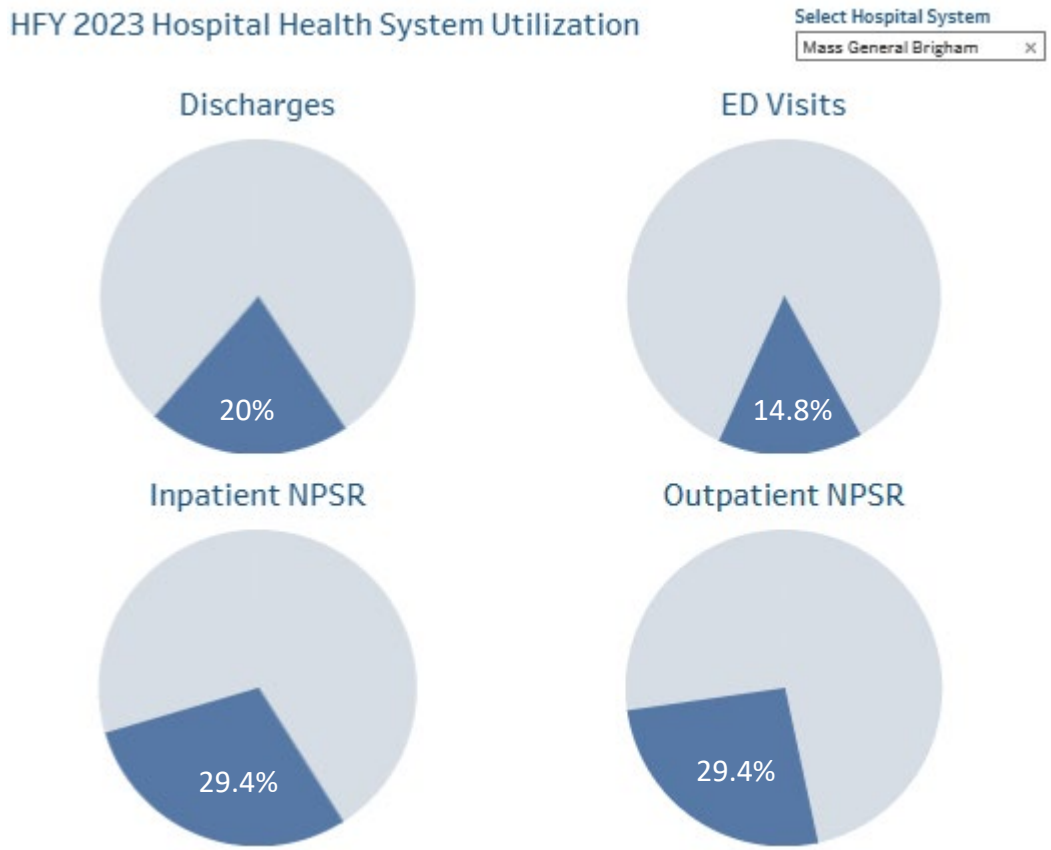
Medicare Advantage – National Penetration



Source: KFF Foundation

Hospital Volume is highly concentrated in Mass, with MGB & BILH accounting for ~39% of discharges

Hospital System	Discharges	% of Discharges
Baystate Health	28,690	7.46%
Berkshire Health Systems	6,713	1.75%
Beth Israel Lahey Health	69,890	18.18%
BMC Health System	24,099	6.27%
Brown University Health	7,407	1.93%
Cape Cod Healthcare	11,571	3.01%
Heywood Healthcare	2,357	0.61%
Independent Health System	75,739	19.70%
Lawrence General Hospital and Affiliates	10,786	2.81%
Mass General Brigham	82,162	21.37%
Tenet Healthcare	11,518	3.00%
Tufts Medicine	23,582	6.13%
UMass Memorial Health Care	29,977	7.80%
Grand Total	**384,491**	**100.00%**



Source: CHIA Massachusetts Acute Care Hospital Inpatient Discharge Data, March 2025

Primary Medicare Payment Systems

Inpatient Prospective Payment System (IPPS)

Governs rates, sets policy, and reporting requirements for all **acute care and long-term acute hospitals.**

Outpatient Prospective Payment System (OPPS)

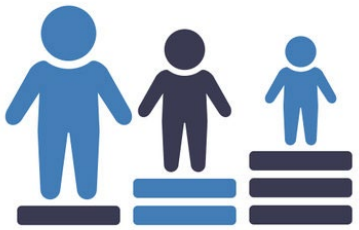
Governs rates, sets policy, and reporting requirements for all **all outpatient hospitals and ambulatory surgical centers.**

Physician Fee Schedule (PFS)

Governs rates for physicians, as well as key policies for physician-based practices, including telehealth.

Recent, Cross-Cutting Policy Changes

Health-related Social Needs



Equity

Primary Care and Population Health

State Plans: MassHealth and ConnectorCare

Acute Hospital RFA	MassHealth ACO Program
• Serves as the **contract between MGB and MassHealth.** • Outlines the **hospital assessment** (which funds the waiver) and return of hospital assessment via **payments for hospital programs/activities (e.g,. CQI).** • **Focus on bolstering the BH system**, mitigating the ED boarding crisis of individuals seeking IP psych beds.	• **Primary-care based risk model.** ACO is driven by the participating PCPs. • PCPs paid on a PMPM basis. • **Primary Care practices** receive a risk-adjusted **subcapitated payment** for its members + a PMPM add-on to support integrated services. • **All other services are paid on an FFS basis** from MGBHP (the payer partner).

- Federal **Inflation Reduction Act (IRA)** continued healthcare marketplace subsidies through 2024**.**
- MassHealth submitted an 1115 Demonstration Amendment to CMS in October 2023 requesting authority to expand its **premium assistance program up to 500% FPL (currently at 300%).**
- **Connector enrollment expected to remain steady.**

Regulatory Environment

How does this impact payer negotiations?

Center for Cost Information & Analysis (CHIA)

- Independent state agency whose mission is to serve as a steward of Massachusetts health information to promote a more transparent and equitable health care system that effectively serves all residents of the Commonwealth.

Health Policy Commission (HPC)

- State agency working to improve the affordability of health care for all residents of the Commonwealth.
- Policy Recommendations
- Reviews development proposals, mergers, affiliations

Cost Growth Benchmark

- The Health Policy Commission established a Health Care Cost Growth Benchmark (3.6% for 2024)
- Revisited annually by HPC Board

Knowledge Check

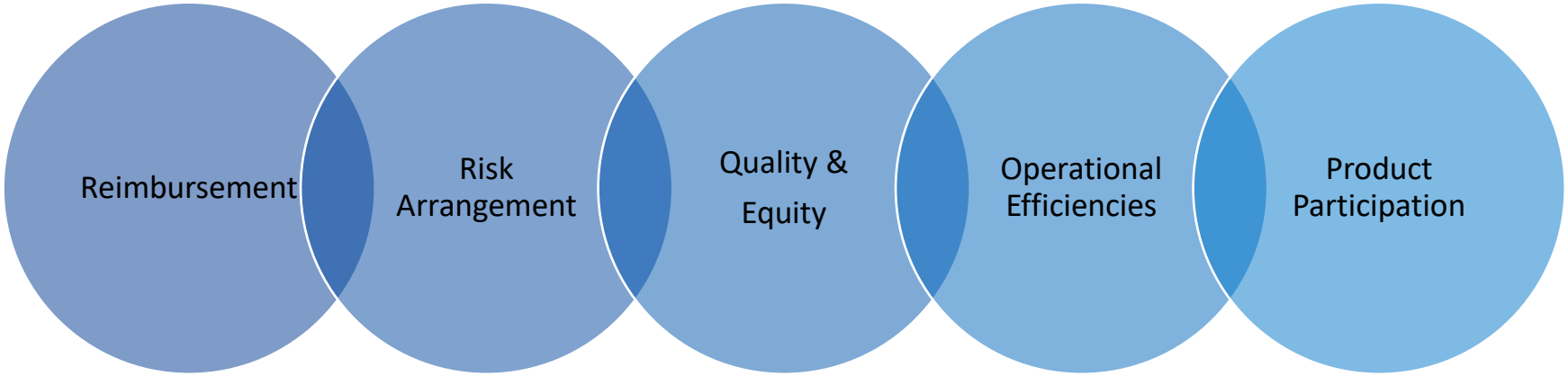
Who is the largest payer for most providers in Massachusetts?

a) BCBS MA
b) Point32Health
c) Medicare
d) Masshealth

Mechanics & Strategy

What's included in a contract?

MGB's contracts include elements beyond reimbursement and risk



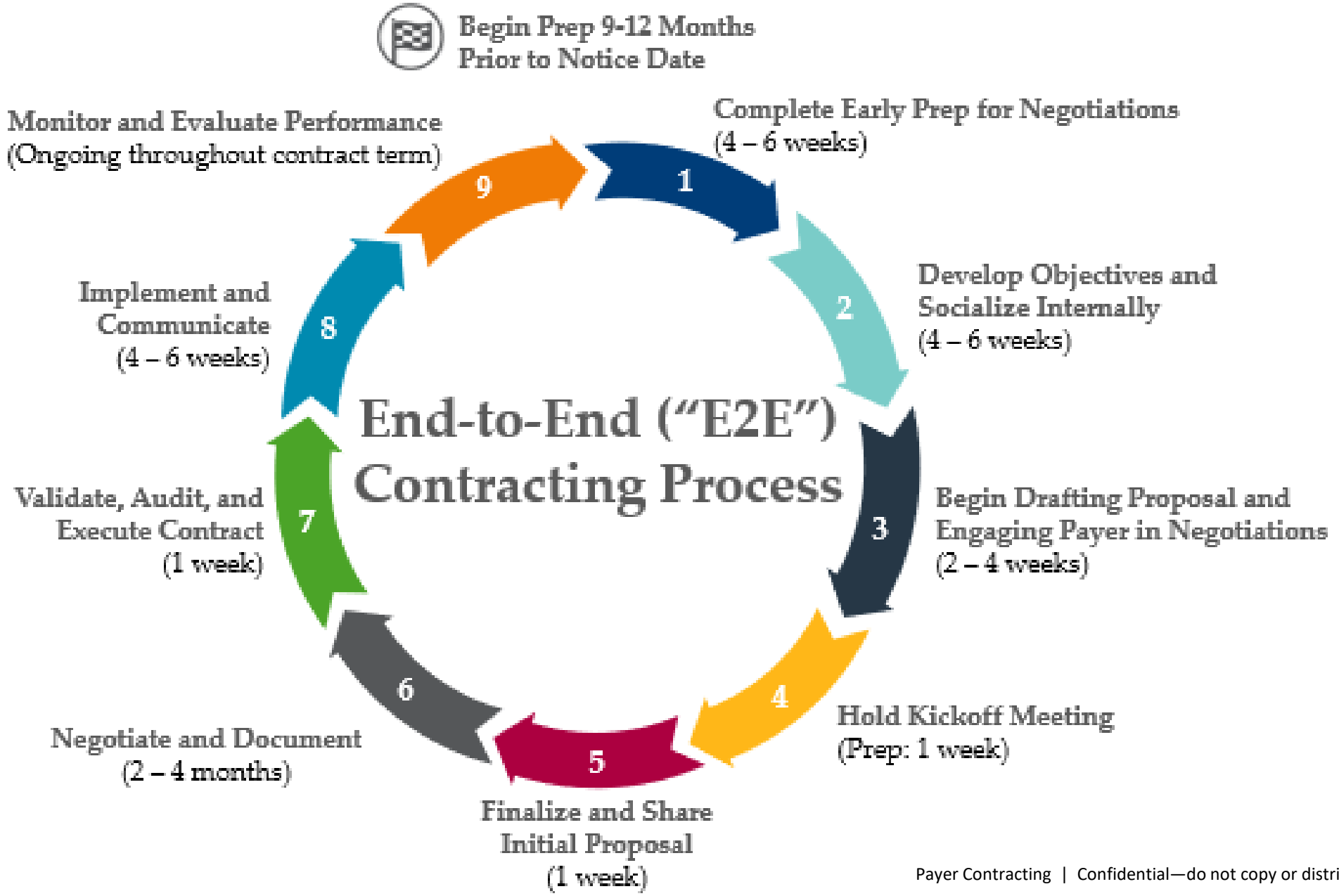
- Covered providers and entities
- Payment methodologies
- Annual increases
- Adjustments (e.g., inflation)
- Advance strategic pricing goals
- New Innovations in care

- Population
- Target methodology
- Risk share
- Maximum risk

- Hospital measures
- Ambulatory measures
- Patient-Reported Outcome Measures

- Administrative simplification
  - Reduce duplicate claim denials
  - Increase the number of utilization review nurses for review of IP admissions

- Opt out ability
- Tiered networks
- Limited networks
- Reference pricing


Begin Prep 9-12 Months Prior to Notice Date
Complete Early Prep for Negotiations (4 – 6 weeks)
Develop Objectives and Socialize Internally (4 – 6 weeks)
Begin Drafting Proposal and Engaging Payer in Negotiations (2 – 4 weeks)
Hold Kickoff Meeting (Prep: 1 week)
Finalize and Share Initial Proposal (1 week)
Negotiate and Document (2 – 4 months)
Validate, Audit, and Execute Contract (1 week)
Implement and Communicate (4 – 6 weeks)
Monitor and Evaluate Performance (Ongoing throughout contract term)
End-to-End ("E2E") Contracting Process
1
2
3
4
5
6
7
8
9

Fee For Service

Fee For Service is the prevailing model of reimbursement in America

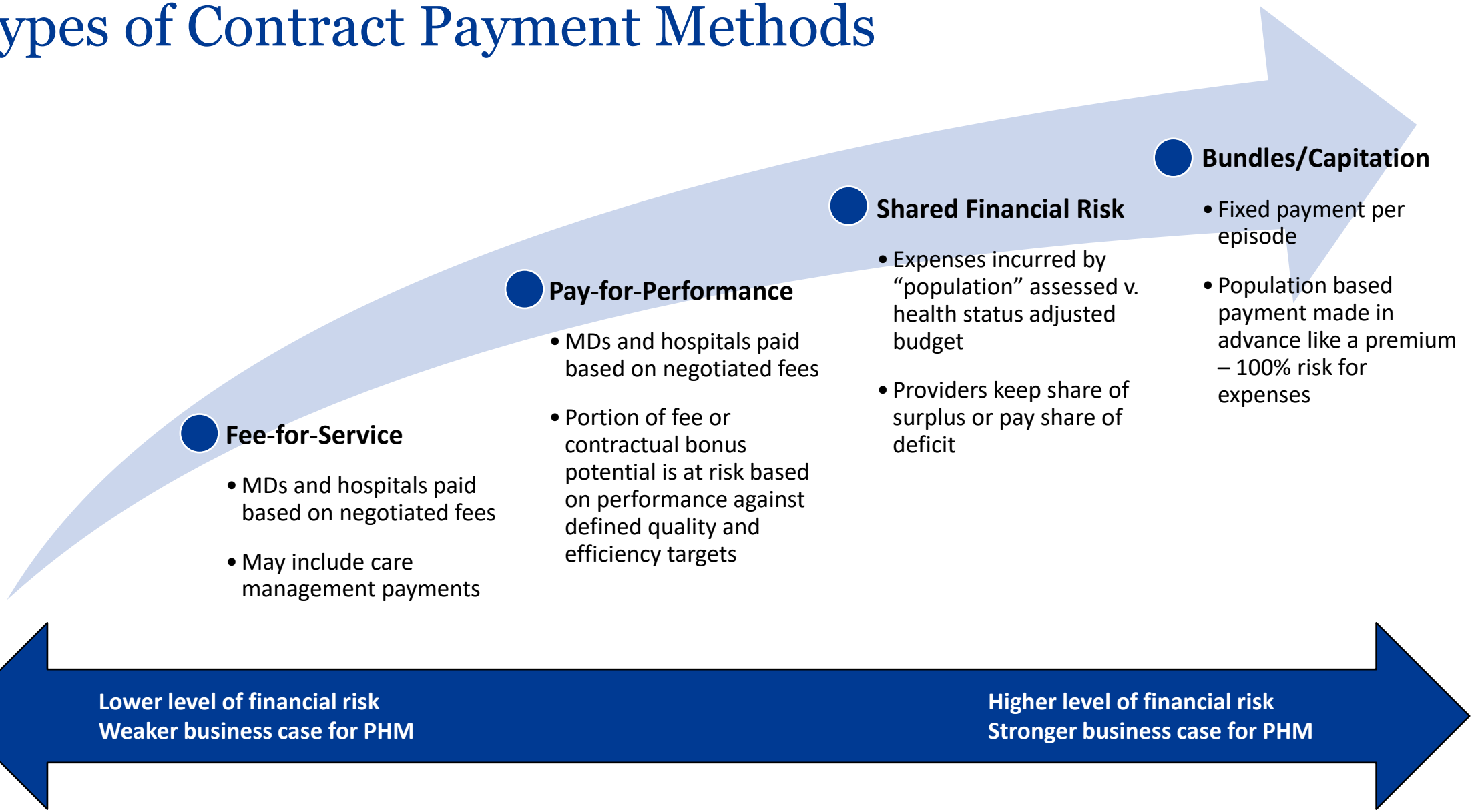
Most simple method – Percent of Charges (Hospital and Physician Group Chargemaster)

More Common – Reimbursement Schedules

- CPT Codes (Professional) and HCPCS (Facility)
- Groupers
  - DRGs, MS-DRGs, APR DRGs

Payer and Providers must agree on methodology and level of reimbursement (typically a base factor that is multiplied by relative weight for each procedure, inpatient stay, or doctor visit)

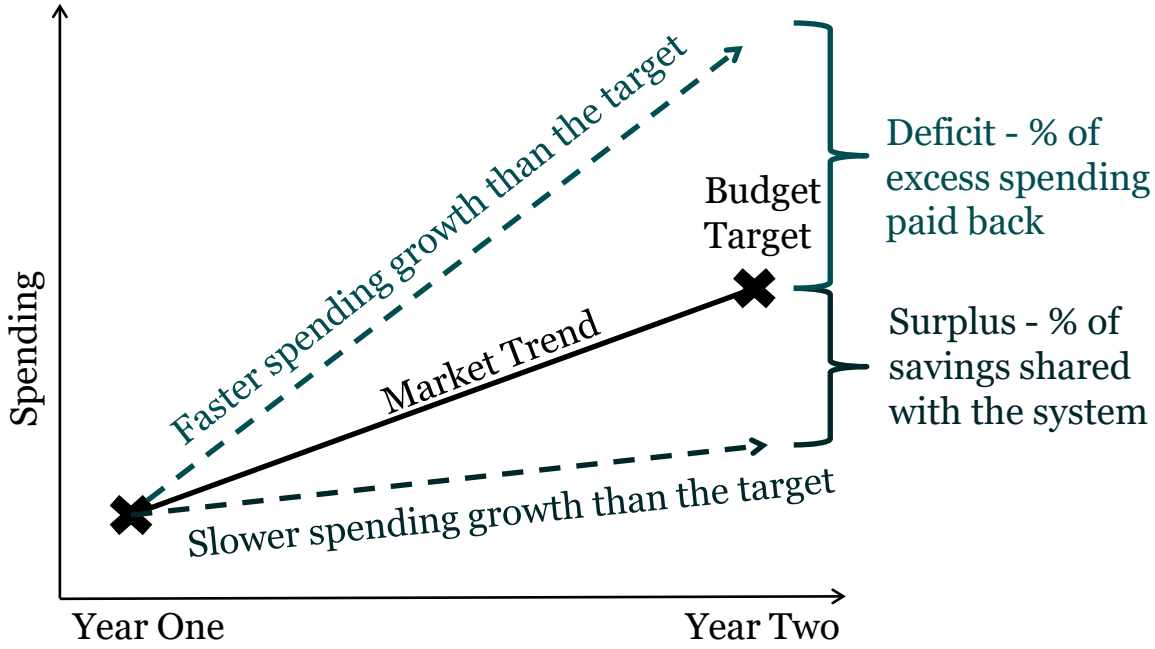
Types of Contract Payment Methods



Trend-Based Risk Arrangements

- **Limited risk**
- **Start from baseline of actual expenses at MGB price & health status**
- **Baseline includes expenses for services incurred at MGB and non-MGB providers for PCP-attributed population**
- **Mostly performance based – manage to a health status adjusted trend target equal to rest of market excluding MGB**
- **Fee-for-service payment continues**

Accounts for market-wide changes in demographics, medical progress, economic trends



Context Setting – why focus on pricing?

PRELIMINARY

Unprecedented medical cost inflation is challenging providers

THE WALL STREET JOURNAL.

Nov 22, 2021 – Nurse salaries rise as demand for their services soars during COVID-19 pandemic: Average annual salary for registered nurses, not including bonus pay such as overtime, increased about 4% this year to $81,376

Modern Healthcare

Oct 6, 2021 – Hospitals spending $24B more per year on clinical labor

…and while providers have been seeking higher rates, there is limited data to date on whether payers are accepting

THE WALL STREET JOURNAL.

May 8, 2022 – Hospitals look to raise treatment costs as nurses' salaries increase

"People familiar with negotiations say some hospitals are asking to increase their prices by 7.5% to 15%."

CNN

Feb 3, 2022 – Health insurance companies make record profits as costs soar in US:

"The price of an employer-sponsored family policy is up 47% since 2011, outpacing wages and inflation… [but this is] part of a bigger debate about healthcare spending, which has soared in recent years."

Providers, and MGB in particular, are facing increased pressures from regulatory efforts

THE WALL STREET JOURNAL.

Dec 15, 2021 – Three Miles and $400 Apart: Hospital Prices Vary Wildly Even in the Same City:

"U.S. hospitals for the first time this year had to divulge all their prices under a new federal rule… The data reveals the wide variety of prices charged by different hospitals"

"It's not clear that patients or employers are getting what they pay for"

The Boston Globe

April 5, 2022 – 'A new reality': State's decision against Mass General Brigham's suburban expansion could mean tighter regulation of costs and hospital growth:

"According to experts, the rejection appears to be the first time in decades that DPH has stood in the way of hospital expansion"

"Everybody is watching, everybody is paying attention"

Source: Press search

Pricing Transparency is not new in Massachusetts .....but transparency data opens up new possibilities

Mass.gov

> Office of the State Auditor > Evaluation of the Health Care Cost Containment L

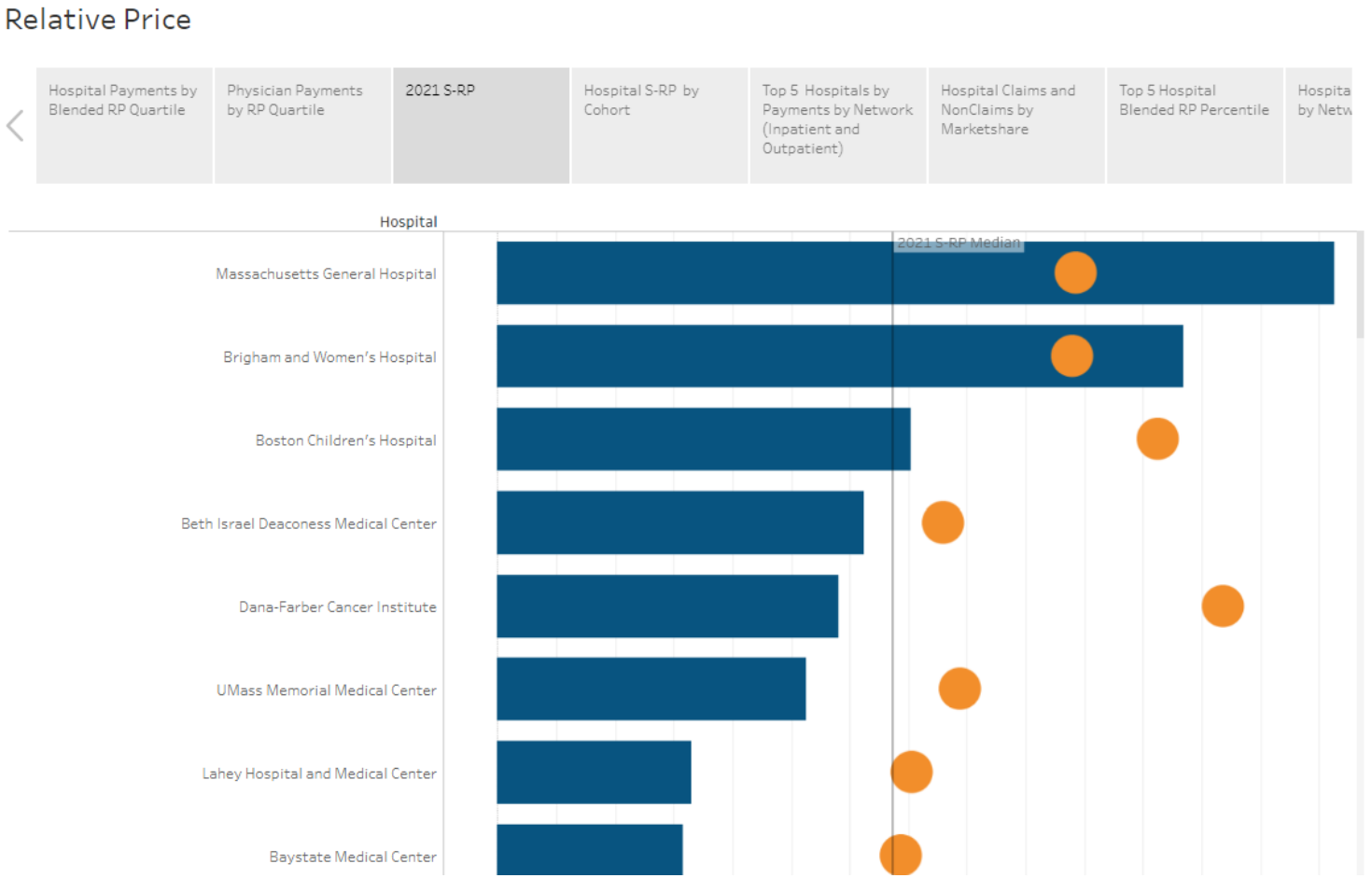
OFFERED BY Office of the State Auditor

Chapter 224 overview

Learn more about the health care cost containment

Chapter 224 was signed into law in 2012. With its passage, the Patrick set in motion a number of initiatives and administrative several health care goals, primarily to control the growth of hea health care access and quality, and promote public health.

CHIA. HEALTH INFORMATION AND ANALYSIS



Knowledge Check

Which of the following is not a valid reimbursement method?

1) Percent of Charges
2) DRGs
3) ETFs
4) Case Rates

Knowledge Check

What of these *is not* a responsibility of payer contracting?

a) System Pricing Strategy
b) Alternative Payment Models
c) Tracking Accounts Receivable by Payer
d) Quality Performance, Incentives, and measurement

How’s it going?
Challenges & Opportunities

Challenges in the current environment

Systemic and intense conflict between providers and payors

148%

Increase in the number of public disputes this year through September 1st compared to last year. More than one-third of the publicly reported disputes in 2024 have failed to reach a timely agreement.

Market share is concentrated with the largest & most aggressive payors

91%

Of markets have a single payor with more than 30% market share and 46% have a payor with more than 50% of market share. Pricing pressures have increased, making it harder for provider organizations to negotiate reasonable and sustainable rates for their services.

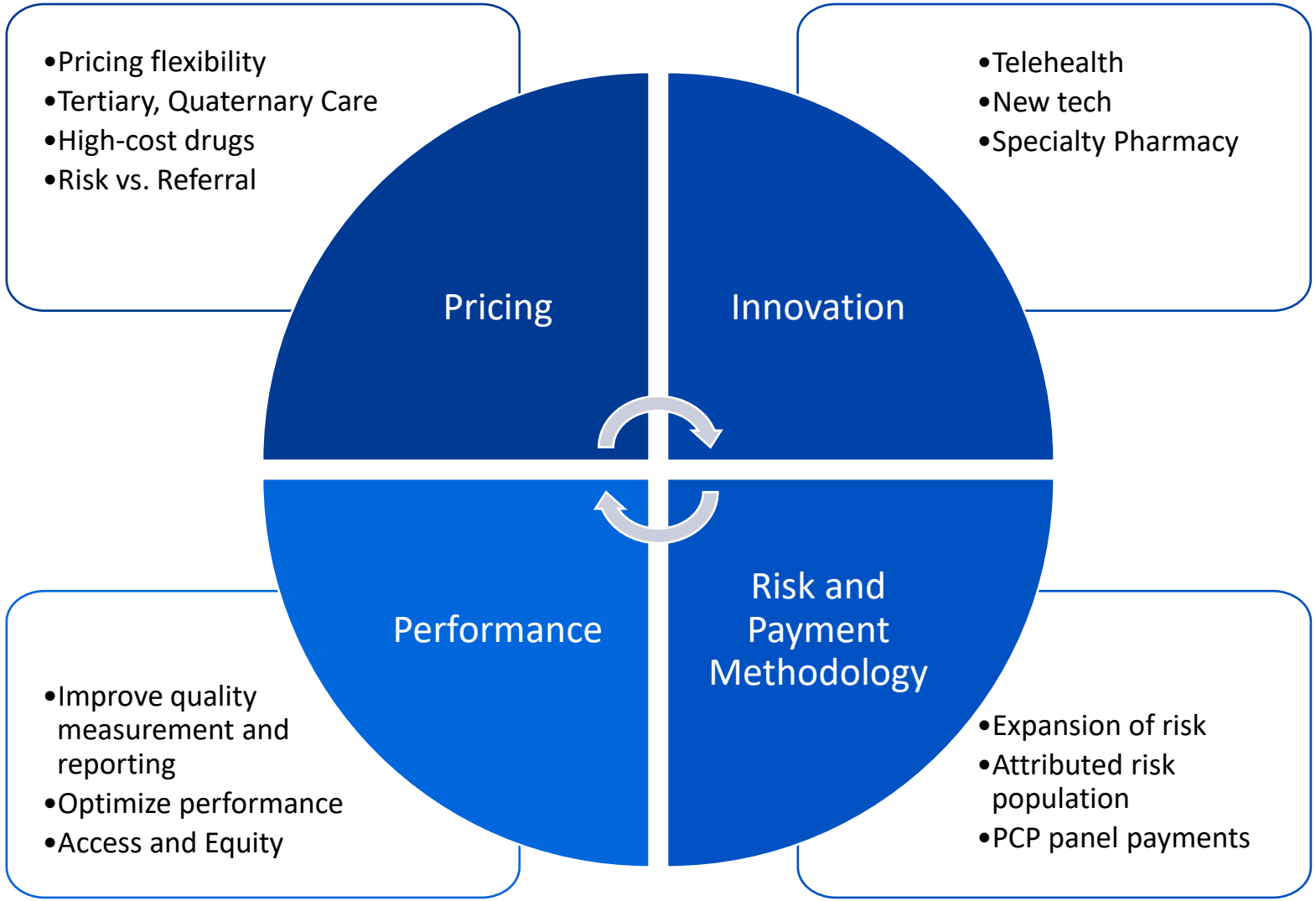
The most significant period of inflation in over 50 years

21% & 28%

Increase in total expenses per patient from 2019 to 2021 including a 37% increase in drug costs and an overall staffing increase of 19% (139% increase in contracted labor). The 2022 medical CPI was a surreal28.2% - an additional $98B increase between 2022 and 2023.

Source: Unlock Health

Issues for the Future



Knowledge Check

What does CPT in “CPT code” stands for?
a. Combustion Patent Timer
b. Current Procedural Terminology
c. Caribou Patient Triage
d. Certified Public Trainer

Knowledge Check

When was Chapter 224 made law in MA?
a. 2000
b. 1985
c. 2020
d. 2012

Financial statement presentation – NFP healthcare entities

Polling Question #1

How much knowledge do you have of healthcare financial reporting?

A. I don’t know much about healthcare financial reporting.

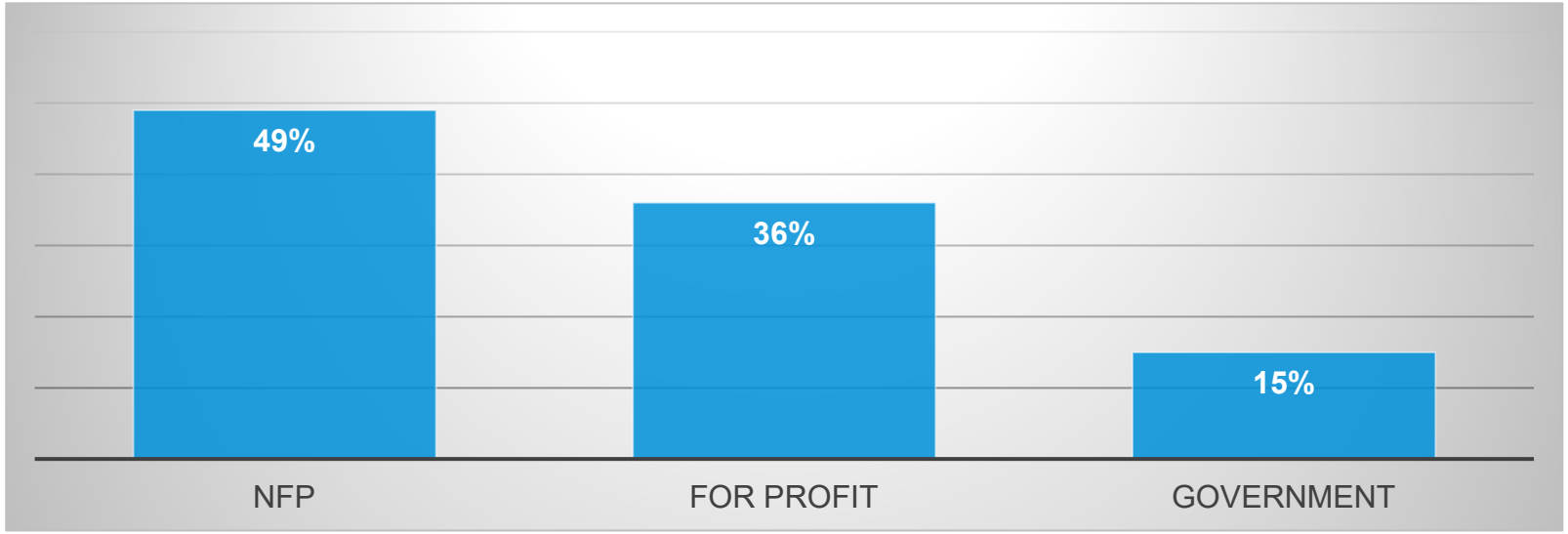
B. I think I might be in the wrong session.

C. I know the basics and have a bit of experience with financial reporting in the workplace.

D. I actively work in healthcare financial reporting and have a lot of experience.

Not for profit vs. for profit vs. government sponsored

US hospital ownership by type



ASC 954, Healthcare Entities

U.S. GAAP accounting for healthcare entities is covered in FASB Accounting Standards Codification (ASC) 954, Healthcare Entitles SC 954

Key aspects of ASC 954 are:

- Tailored presentation of financial statements for healthcare operations.
- Revenue recognition, particularly for patient service revenue.
- Accounting for charity care and contractual adjustments.
- "Performance indicator" for not-for-profit entities, like excess of revenues over expenses.
- Specific disclosures for healthcare entities, including patient accounts receivable and third-party payor arrangements.
- Nonprofit Healthcare Organizations: Focus on contributions and net asset classifications.

Healthcare Financial Reporting

Internal Financial Reporting

- Not a one size fits all approach
  - Monthly Financial Reporting
  - Annual Financial Statements
  - Other Reporting

Basics of internal and external

- Statement of Financial Position (the Balance Sheet)
- Statement of Operations (the Income Statement or Profit & Loss)
- Statement of Changes in Net Assets
- Statement of Cash Flows

Best Practices

- Key financial and operating indicators
- Statistics by department reflecting the levels of activity
  - (Actual vs. Budget / PY)
- Additional reporting
  - 12 month rolling trend (BS, SOO & SCF)
  - Narrative (the story behind the numbers)

Typical contents of external financial statements

Balance Sheet

Health System, Inc.
Consolidated Balance Sheet

September 30,		202X
Assets		
Current Assets:		
Cash and cash equivalents	$	7,106,045
Investments, at fair value		2,257,437
Patient accounts receivable, net		16,203,313
Grants receivable, net		564,170
Prepaid expenses and other current assets		2,674,368
Total Current Assets		28,805,333
Other Assets:		
Long-term investments		30,271,539
Property and equipment, net		77,381,894
Right-of-use operating lease assets		2,502,354
Other assets		11,439,300
Total Non-Current Assets		121,595,087
Total Assets	$	150,400,420

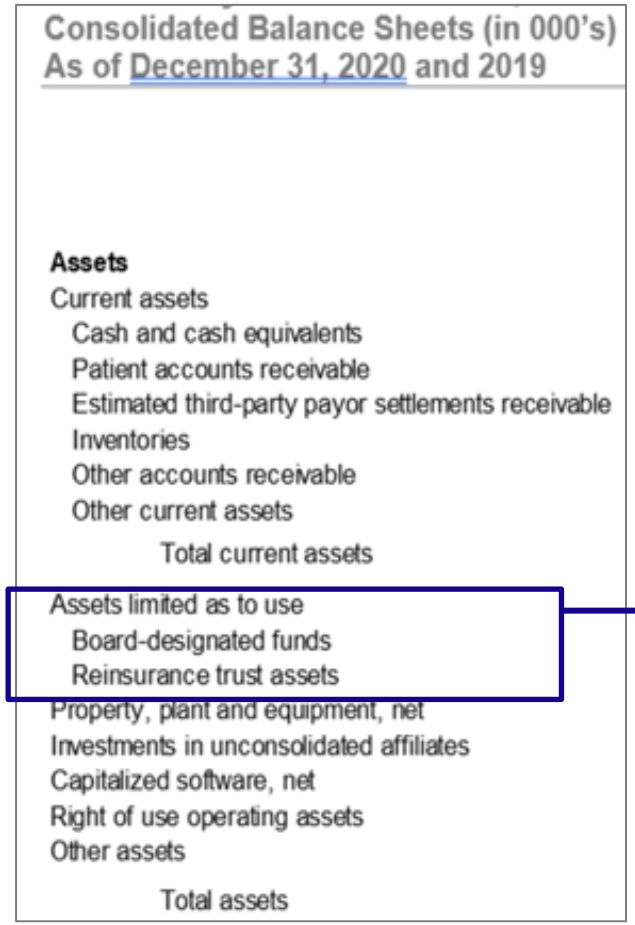
Balance Sheet Key Items

- Total Cash/Investments Position
- Working Capital/Current Ratio
- Debt to Equity
- Net Assets Without Restrictions

Health System, Inc.
Consolidated Balance Sheet

September 30,		202X
Liabilities and Net Assets		
Current Liabilities:		
Accounts payable and accrued expenses	$	11,143,264
Accrued employee compensation and benefits		9,429,226
Current portion of long-term debt		817,232
Current portion of operating lease liabilities		368,682
Unexpended funds on research grants		540,476
Estimated settlements with third-party payors		4,382,528
Total Current Liabilities		26,681,408
Other Liabilities:		
Long-term debt		39,758,386
Operating lease liabilities, net of current portion		3,054,327
Accrued malpractice liabilities		2,058,756
Accrued pension liabilities		2,453,521
Estimated settlements with third-party payors		1,238,374
Accrued other		4,583,290
Total Non-Current Liabilities		53,146,654
Net Assets:		
Without donor restrictions		63,972,456
With donor restrictions		6,599,902
Total Net Assets		70,572,358
Total Liabilities and Net Assets	$	150,400,420

Financial statement presentation


Consolidated Balance Sheets (in 000's)
As of December 31, 2020 and 2019

Assets
Current assets
Cash and cash equivalents
Patient accounts receivable
Estimated third-party payor settlements receivable
Inventories
Other accounts receivable
Other current assets
Total current assets

Assets limited as to use
Board-designated funds
Reinsurance trust assets
Property, plant and equipment, net
Investments in unconsolidated affiliates
Capitalized software, net
Right of use operating assets
Other assets

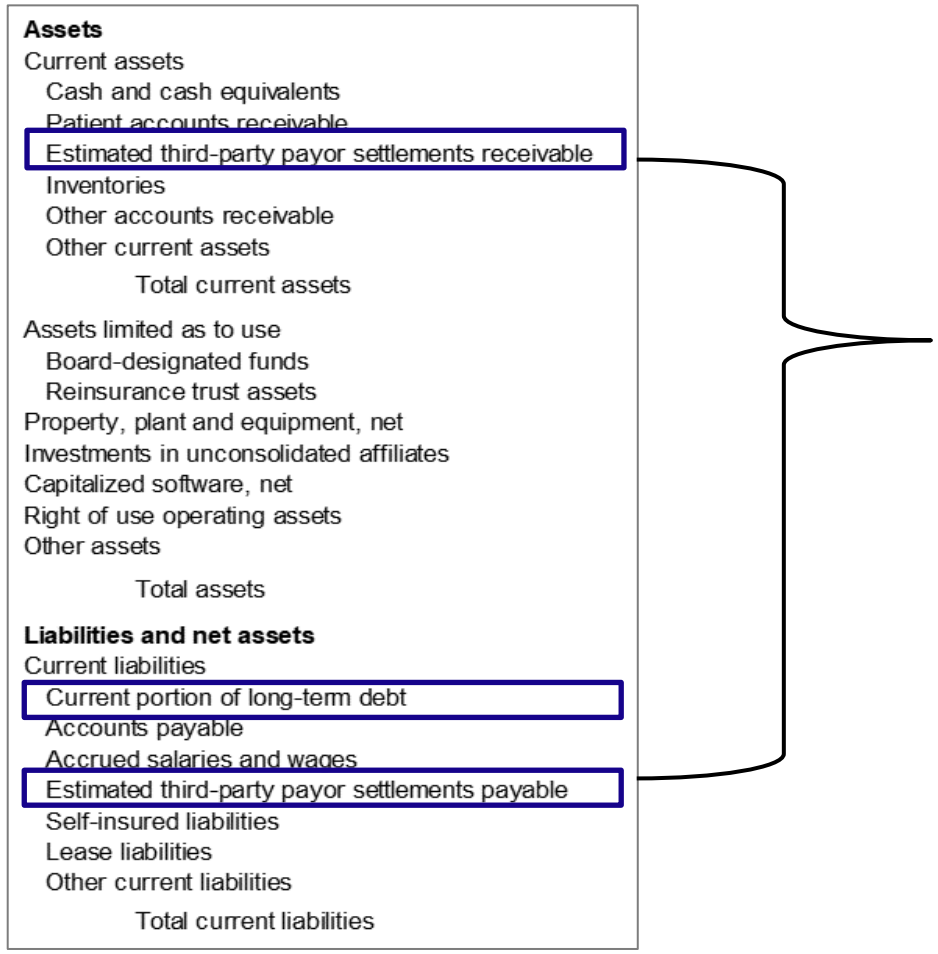
Total assets

Balance sheet

Classification

- NFP healthcare entities are required to classify assets and liabilities as current and noncurrent.
- Normally, an operating cycle of 12 months is used to distinguish current and noncurrent.
- NFP healthcare entities often sequence assets and liabilities within each balance sheet section in order of liquidity (i.e., within current assets, cash precedes accounts receivable); .
- Liquid assets that are subject to limitations on use that override their natural liquidity should be reported as noncurrent assets. For example, funds designated by the governing board to acquire noncurrent assets must be classified as noncurrent.
- NFP healthcare entities are required to present internally designated funds separately from externally restricted funds either on the face of the balance sheet or in the notes. These funds are typically referred to as assets limited as to use.

Financial statement presentation



Balance sheet

Classification, continued

- Classification considerations of debt.

Offsetting

- Balance sheet offsetting is permitted when a right of setoff exists.
- GAAP specifically prohibits offsetting for certain activities and transactions (e.g., insurance recoveries may not be netted with insurance liabilities).

Financial statement presentation

Net assets
Net assets without donor restrictions
Network net assets without donor restrictions
Noncontrolling interest
Total net assets without donor restrictions
Net assets with donor restrictions
Total net assets

Balance sheet

Net asset presentation

- NFPs must distinguish between net assets without donor restrictions and with donor restrictions.
- NFPs must present the total of each net asset class and total net assets on the face of the balance sheet.
- GAAP requires NFPs to provide further detail about each net asset classification, either on the face of the balance sheet or in the notes.
  - For example, if net assets without donor restrictions contain board-designated funds, the nature of those board designations must be presented on the face or in the notes.
  - NFP healthcare entities normally present this information in the notes.

Common errors or diversity in practice

Balance sheet

Improper aggregation of accounts within balance sheet captions

Improper display of current or noncurrent assets and liabilities

Improper presentation of Medical Malpractice accounts

Property held for investment purposes not presented as part of investments

Improper netting of assets and liabilities

Inappropriate recognition and/or classification of donor-restricted assets and expiration of restrictions

Failure to capitalize leasehold improvements

Misclassification of assets limited or restricted as to use

Failure to correctly and/or timely adopt new accounting standards

Statement of Operations

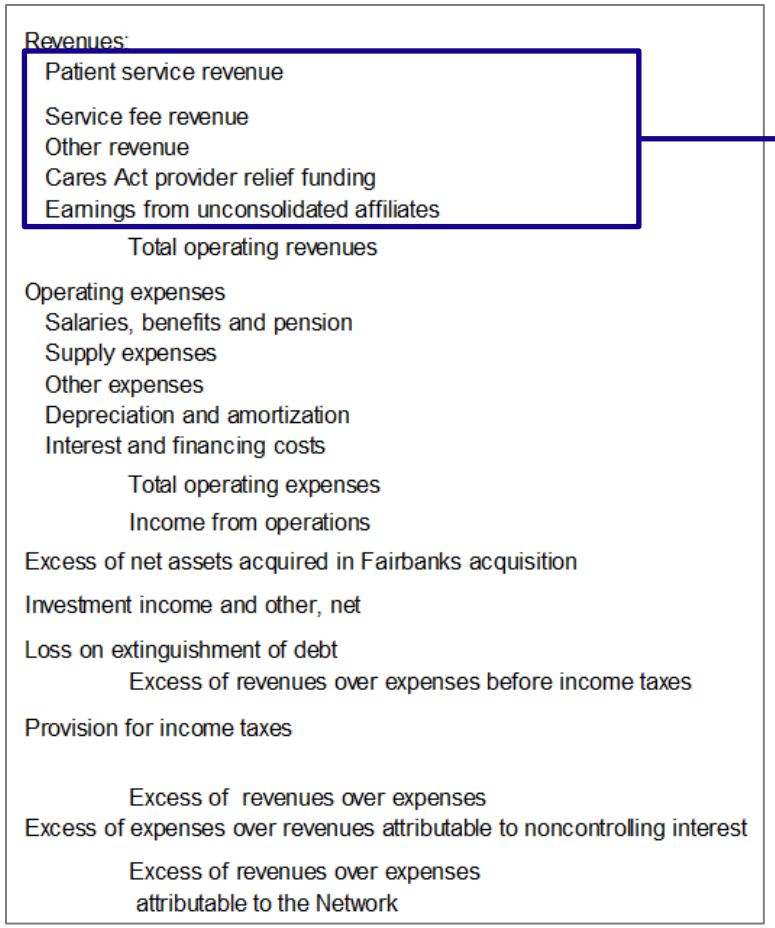
Statement of Operations Key Items

- Comparison to budget and understanding differences
- Annual budgetary process
- Cost report consideration

Health System, Inc.
Consolidated Statements of Operations

Years ended September 30,	202X
Revenue and Other Support:	
Net patient service revenue	165,568,558
Research revenue	11,822,910
Other revenue	709,459
Total operating revenues	178,100,927
Expenses:	
Salaries and wages	100,984,801
Supplies and other expenses	51,277,970
Research expenses	11,822,910
Depreciation and amortization expense	9,672,737
Interest expense	2,840,293
Total operating expenses	176,598,711
Income from operations	1,502,216
Non-operating Income, Gains and (Losses)	
Unrealized gains and losses on investments	517,226
Interest and dividends	17,618
Contribution revenue	50,016
Other nonoperating income	168,942
Total nonoperating gains, net	753,802
Excess of revenues over expenses	2,256,018
Net assets released from restriction used for purchases of Property and Equipment	680,285
Cumulative effect of accounting change	(542,808)
Increase in Net Assets without Donor Restrictions	2,393,495

Financial statement presentation

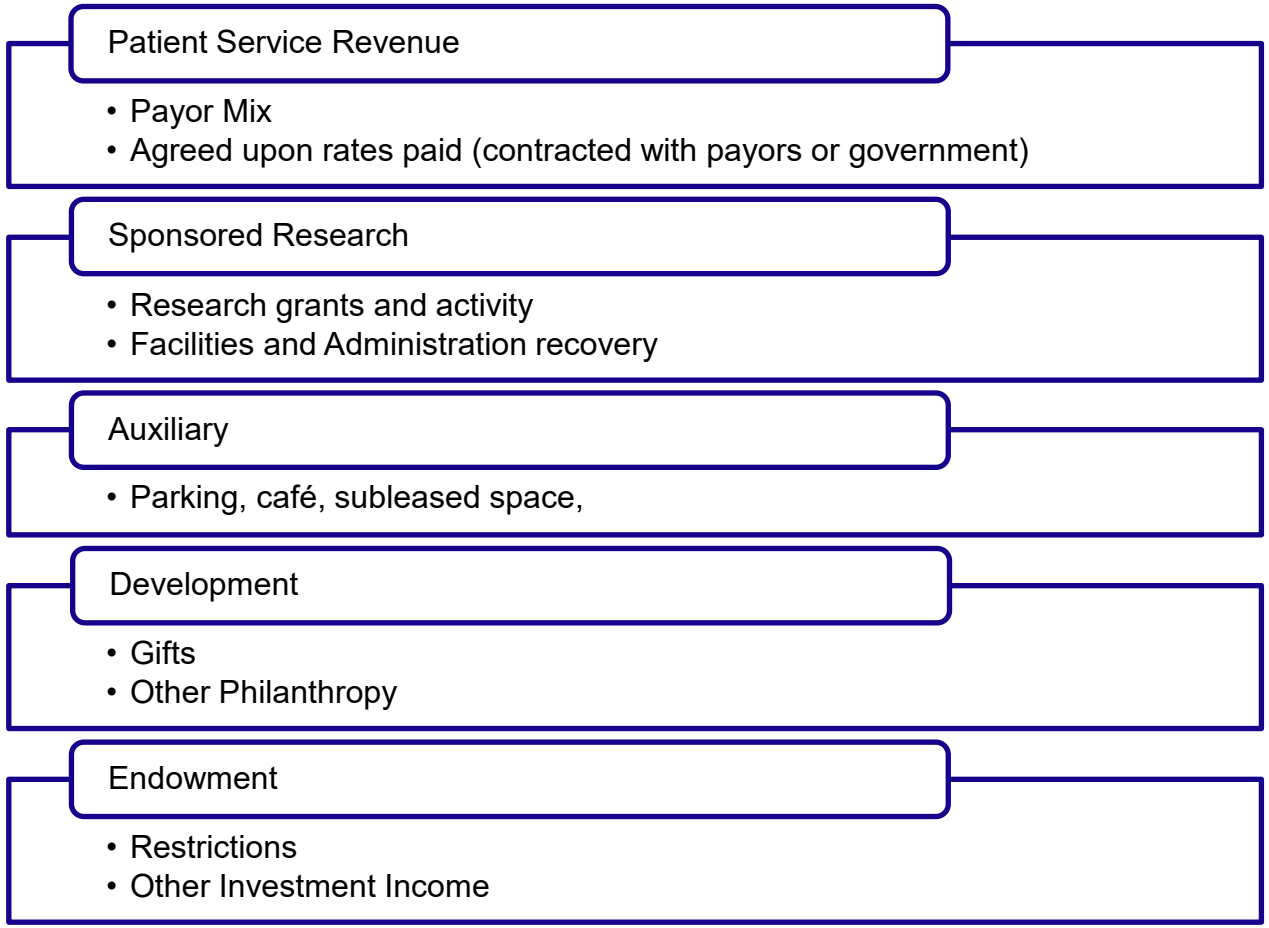


Statement of operations

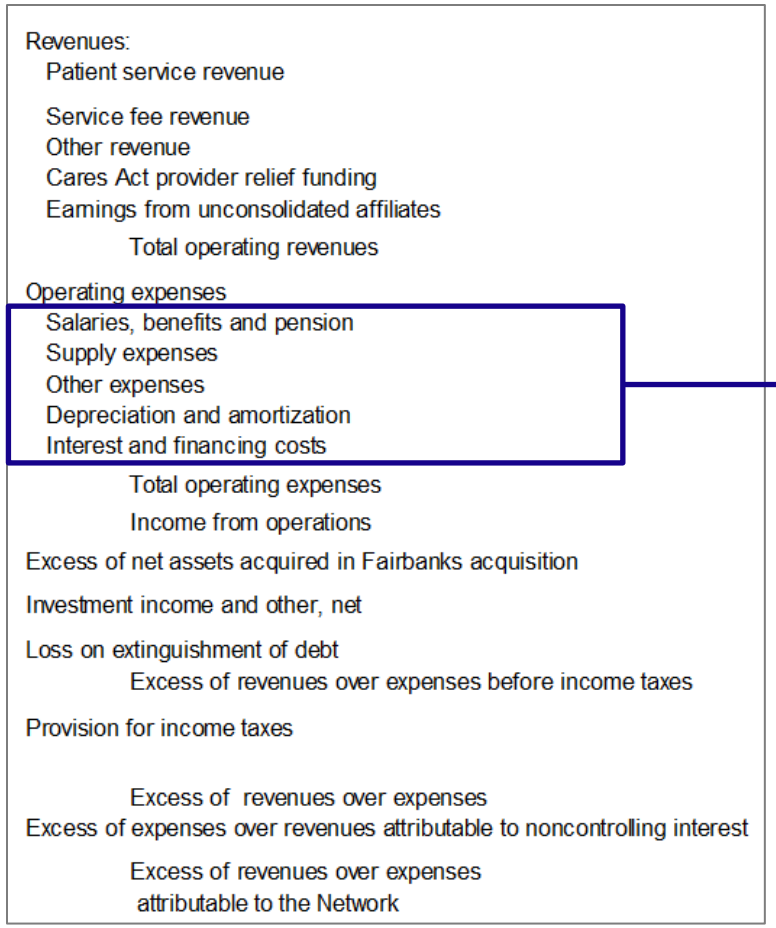
Revenue

- Major revenue streams with dissimilar characteristics may be presented in separate line items

Traditional Operating Model/Revenue Drivers



Financial statement presentation

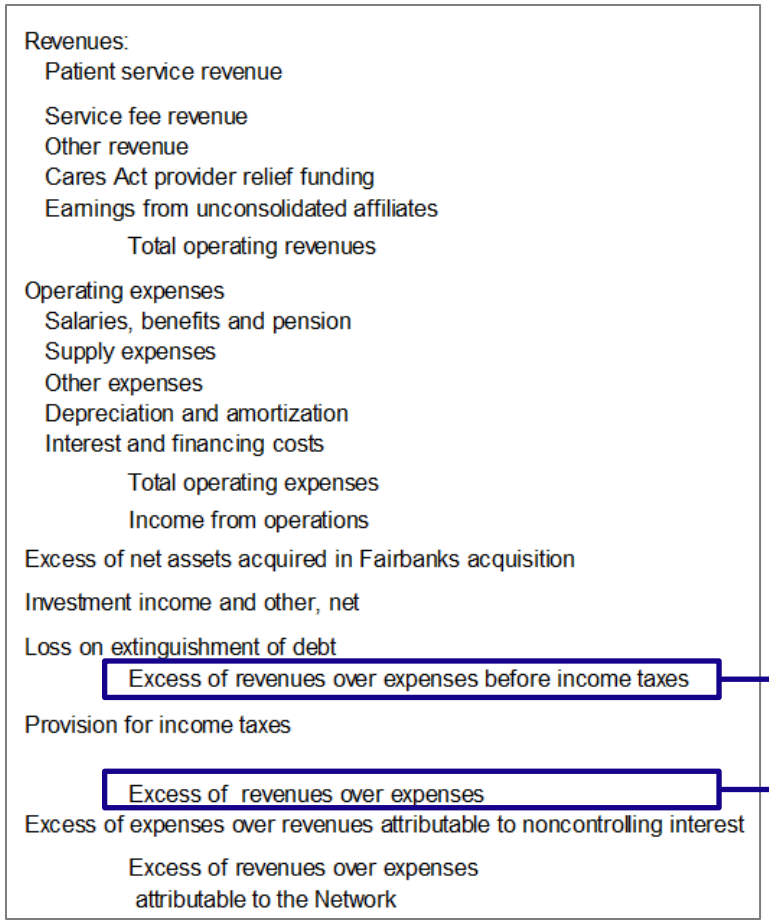


Statement of operations

Expense

- NFP healthcare entities may present expenses using natural, functional, or other classifications.
  - Most NFP healthcare entities use natural classifications.
- Regardless of presentation on the face, GAAP requires NFP healthcare entities to present an analysis of expenses by natural and functional classification.
  - This analysis could be provided on the face, but most NFP healthcare entities present it in the notes.

Financial statement presentation



Statement of operations

Intermediate subtotals

- NFP healthcare entities may present intermediate subtotals to highlight certain activities or provide information deemed useful to financial statement users.

Performance indicator

- NFP healthcare entities are required to present a performance indicator. The measure is similar to income from continuing operations of a business entity.
  - The term ‘net income’ cannot be used because NFP healthcare entities present certain activities outside of the performance indicator that business entities would include in net income.
- Certain activities must be excluded from the performance indicator (i.e., presented after the performance indicator).
  - Contributions and net assets released from donor restrictions for long-lived assets
  - Unrealized gains and losses on ‘other than trading’ debt securities
  - Actuarial changes of pension and OPEB plans
  - Gains and losses on derivatives designated as cash flow hedging instruments
- GAAP requires note disclosure of the nature and composition of the performance indicator.

Common errors or diversity in practice

Statement of operations

1. Improper netting of transactions.
2. Total balances included in consolidated/combined statements of operations do not reconcile to notes or to supplemental consolidating schedules.
3. Improper classification of items included in other changes in net assets without donor restrictions (e.g. capital grants and contributions should be included in other changes in net assets).
4. Change in net assets does not reconcile to statement of cash flows and/or statement of changes in net assets.
5. Consistency of reporting items (such as initial recognition and subsequent measurement of a business combination) within and outside of a reported intermediate measure of operations.

Polling Question #2

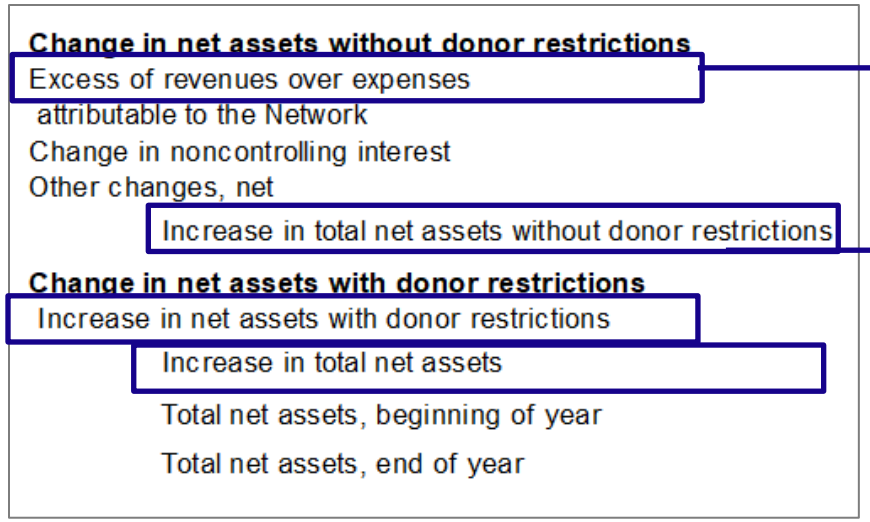
Which is an example of the name used for the “performance indicator” included on the Statement of Operations?

A. Net profit

B. Excess revenues over expenses

C. Net income

Financial statement presentation



Statement of changes in net assets

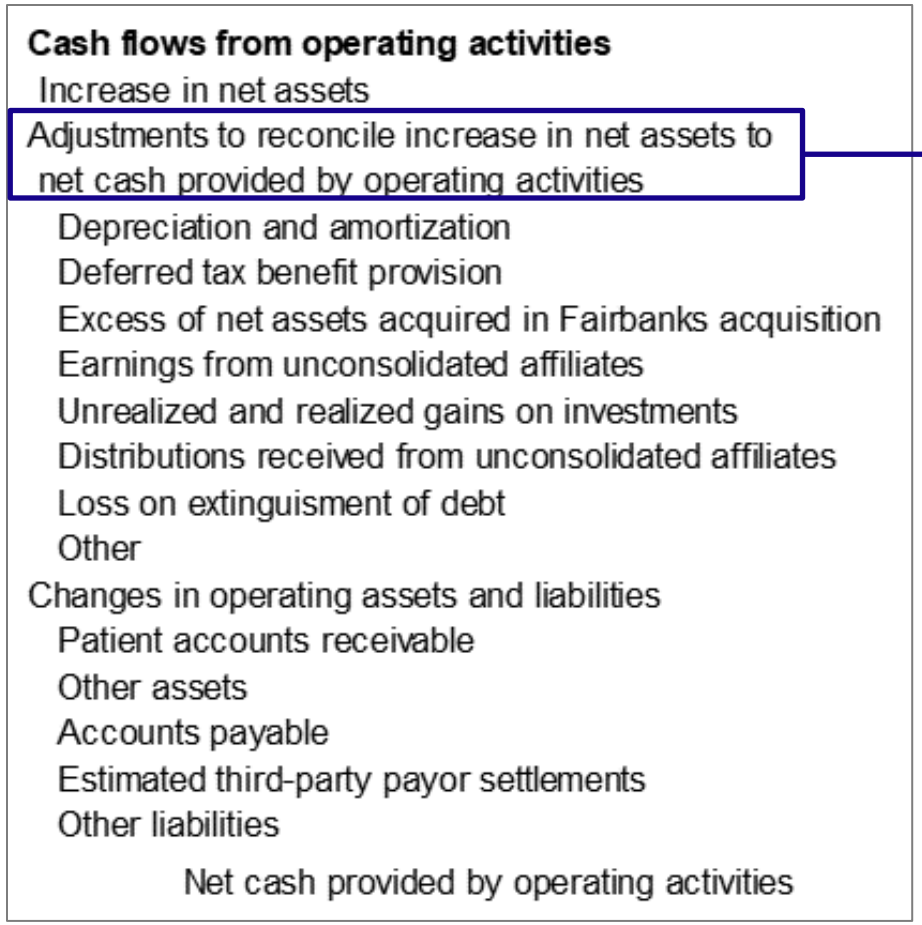
Presentation

- The statement of changes in net assets normally begins with the performance indicator.
- When presented as a separate statement, the first section of the statement of changes in net assets (i.e., changes in net assets without donor restrictions) repeats the activity presented at the end of the statement of operations.

Required subtotals

- The statement of changes in net assets must present the following three subtotals:
  - Change in net assets without donor restrictions
  - Change in net assets with donor restriction
  - Total change in net assets

Financial statement presentation



Statement of cash flows

- Need to understand where cash comes from and where it is going
- Should explain everything you spent cash on during the year

Presentation

- NFPs present the statement of cash flows similar to business entities.
- The statement of cash flows is separated into three sections:
  - Operating
  - Investing
  - Financing
- GAAP allows both the direct and indirect method of presenting operating activities.
  - Most NFPs use the indirect method.
  - Unlike business entities, if an NFP uses the direct method, the NFP does not have to also present the indirect method.
- Noncash investing and financing activity must be presented either on the face or in the notes.
- NFPs generally follow the same guidance on classification and presentation of cash flows as business entities.

Common errors or diversity in practice

Statement of cash flows

- Improper netting of items (e.g. purchases and sales of certain types of investments)
- Cash flow line items do not agree to specific line items on the statements of operations and changes in net assets
- Restricted cash contributions for long term purposes (e.g. capital purposes or donor-restricted endowment) should be excluded from cash flows from operating activities and be classified as financing activities
- Reporting cash, restricted cash and amounts generally described as restricted cash and restricted cash equivalents
- Missing supplemental disclosure of interest paid, income tax paid, and non-cash investing and financing activities such as accrued fixed asset additions
- Adjusting operating activities for gains/losses on fixed asset disposals

Common errors or diversity in practice

Statement of cash flows

- Improper classification of cash flows (or classification as cash and cash equivalents) where a subsidiary shares a common treasury function (stand alone subsidiary financial statements)
- Rollforward of accounts from the footnotes do not agree to the activity within the cash flow statement
- Positive cash flow totals should be presented as “provided by” where as negative cash flows should be presented as “used in”
- Missing presentation of cash flows attributable to noncontrolling interest (financing activities) and discontinued operations

More common errors - Disclosures

Redundant disclosures

Incomplete disclosures

Failure to include the appropriate disclosures for business combinations

“Combined” versus “consolidated” financial statements

Dollars in 000’s consistency

Missing “public entity” required disclosures for health care entities that are conduit bond obligors

Disclosure amounts do not reconcile to the financial statements

Missing or inappropriate disclosure of functional expense classification

Key Operating & Financial Metrics - Non Financial

Profitability Indicators

- Charity Care %
- Bad Debt %
- Collection Ratio
- Revenue per Patient Days, Discharges, and Units
- Cost per Patient Days, Discharges, and Units
- Ratio of Cost to Charges

Cost Indicators

- Number of full-time employees
- Full-time employees per occupied beds/visits
- Salary per full-time employee
- Benefits as a percentage of salary

Volume Indicators

- Discharges/admissions
- Patient Days
- Observation Days
- Average Length of Stay
- Average Daily Occupancy
- Outpatient Visits

Key Operating and Financial Metrics

Monitor Trends, Benchmark Against Peers, Assess Budget vs. Actual Results

Balance Sheet Metrics

Liquidity

- Days cash on hand (Measurers how long an organization can cover operating expenses from liquid assets)
- Working Capital: Current Assets less Current Liabilities
- Days in Patient AR: Net Patient AR / (Net Patient Rev/365) (Indicates the number of days in average collection period)

Leverage & Capital Structure

- Debt to Equity
- Equity Financing: Net Assets / Total Assets (Measurers the % of total assets that has been financed with sources other than debt)
- Debt Service Coverage
- Debt Covenant Compliance

Endowment Spending Policy/Distribution Rate

- Best Practice: Spending Rate plus Inflation Allowance to preserve purchasing power should not exceed expected Total Long-Term Return

Profitability Indicators

Operating Margin

- Net Operating Income / Total Operating Revenue
- Measurers the operating profit retained per dollar of sales

Total Margin

- Net Income / Total Operating Revenue
- Measurers the net profit retained per dollar of sales inclusive of operating and non operating sources

Bad Debt Percentage

- Provision for Bad Debt/ Total Net Patient Service Revenue
- Measurers bad debts for trending and comparative purposes

Payer Mix

- Visits / Providers

Non-Recurring Items – Asset sales, extraordinary gifts/grants

Polling Question #3

What is an example of a balance sheet metric to monitor and benchmark against peers?

A. Operating margin

B. Working capital

C. Number of employees

D. Payor mix

Other Reporting Requirements

IRS Reporting

- IRS Form 990, Form 990-EZ, Form 990-T, Form 990-PF (due 4.5 months after fiscal year-end)
  - Validating exempt status of NFP
- Massachusetts Form PC (due 4.5 months after year-end)
- Massachusetts Annual Report (due by November 1st)

Cost Reporting

- Support for reimbursable claims submitted
- Detail cost and allocation of cost to specific service centers
- Information of types of services provided

Uniform Guidance

- States, local governments and non-profit organizations with $1,000,000+ of Federal awards during the fiscal year
- Preparation of the Schedule of Expenditures of Federal Assistance “SEFA” by government sponsor and contract

Other

- MA Uniform Financial Report (entities receiving $100,000+ in state contracts)
- Department of Education filing requirements for all healthcare entities that have a higher education component

Thank you!

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HFMA MA-RI Chapter Emerging Healthcare Leaders Summit

AI in Healthcare: A Multi-Stakeholder Perspective

October 17, 2025

Life Sciences & Healthcare Consulting

Today's Objectives:

During this presentation, we will cover:

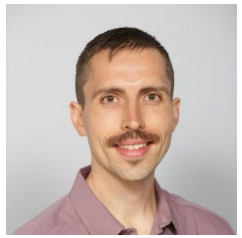
1. Overview of AI in the Healthcare Industry with a focus on clinical and non-clinical opportunities and challenges

2. Discuss hot topics / current trends within the complex realm of AI and how AI is viewed from a Compliance, Privacy, Legal, Clinical, and Technology perspective

3. Understand the best practices and key considerations for the now and future

Panel Members

Dhara Satija, CHC, CFE, CRCR
Healthcare Consulting Leader
Paul Hastings LLP



Paulius Mui, MD
Founder
X = Primary Care

Donna Lewis, RN, BSN, MBA, CHC
Executive Director
Cape Cod Healthcare

Amanda Centi
Senior Manager, Emerging Technologies
Mass General Brigham

Robert Martin
Associate General Counsel
Mass General Brigham

Garrett Gillespie
Chief Compliance Officer
Tufts Medicine

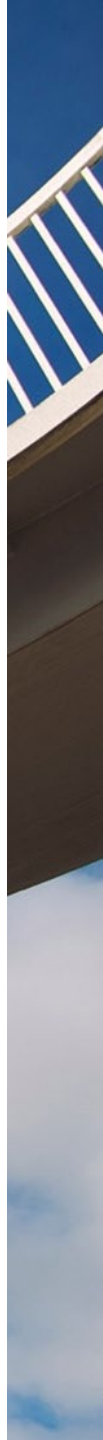
Polling Question #1

Have you used ChatGPT or another AI tool at work?

A. **Yes**

B. **No**

C. **May be (What is AI?)**



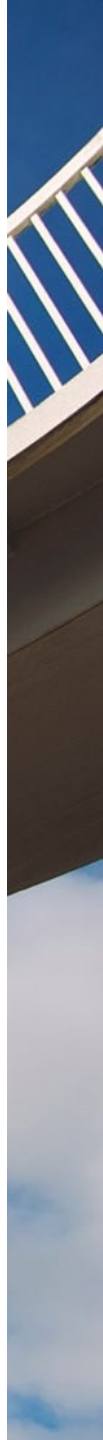
Polling Question #2

How would you rate your current understanding of AI?

A. **Beginner—I know very little, but I'm eager to learn.**

B. **Intermediate—I've heard the terms and maybe used some AI tools.**

C. **Advanced—I'm very familiar with AI concepts and applications**



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OVERVIEW OF AI IN THE HEALTHCARE INDUSTRY

Mass General Brigham

The ABCs of AI in Healthcare

October 2025

What Is Artificial Intelligence?

Artificial Intelligence (AI) refers to computer systems that can perform tasks that, up until now, required human intelligence – such as learning, problem-solving, and pattern recognition.

AI Is a Spectrum

Rules-based systems	Machine learning	Generative AI
Systems that follow a set of rules written by people to make decisions. These rules can be simple or complex, but they are created ahead of time. Example: "If a patient has a fever and a cough, test for Covid-19."	**Systems that learn from data by finding patterns on their own,** without being directly programmed. These patterns are often too complex for people to easily understand. Example: A system that predicts hospital readmissions based on 100,000 past patients' data.	**Systems that can make new content.** In language tasks, it can understand and produce human-like text. Example: A clinical documentation tool that drafts notes based on a recorded patient visit.

AI Glossary

Agentic AI
A type of AI that can make its own decisions and take action without needing human help. Examples include self-driving cars, virtual assistants, and AI copilots that complete specific tasks.

Artificial Intelligence (AI)
Technology that allows machines to perform tasks that usually require human thinking, like learning, problem-solving, and decision-making.

AI Bias
When an AI system makes unfair or unequal decisions because of biased data, flawed programming, or human influence during its creation.

AI Hallucination
When an AI gives incorrect or made-up information. This can happen if the AI didn't learn enough, misunderstood the data, or was trained with biased information.

Conversational AI
AI that can understand and respond to human language, allowing it to have conversations with people. This is made possible through natural language processing (NLP).

ChatGPT
A well-known AI chatbot that can hold conversations and help with many different tasks using advanced language technology.

Generative AI
AI that uses deep learning to create text, images, audio, or video based on user input. In language tasks, it can understand and produce human-like text.

Large Language Models (LLMs)
Powerful AI models trained on huge amounts of data that can understand and generate natural language and other content.

Machine Learning (ML)
A part of AI that teaches computers to learn from data and improve their performance over time, similar to how humans learn from experience.

Natural Language Processing (NLP)
A field of AI that helps computers understand and work with human language by combining language rules, statistics, and machine learning.

Predictive Analytics
The use of data and AI tools to predict future outcomes. It analyzes past data to help make better decisions.

Why AI Matters for Healthcare and its Transformative Impact

Use of generative AI (Gen AI) in healthcare is becoming mainstream

Gen AI can help lower healthcare costs and optimize resource allocation

Implementing AI solutions can augment employee experience

Physicians are growing more comfortable using generative AI

Healthcare employees are already using public Gen AI platforms

Utilize AI for task automation, enhance knowledge sharing and decision making

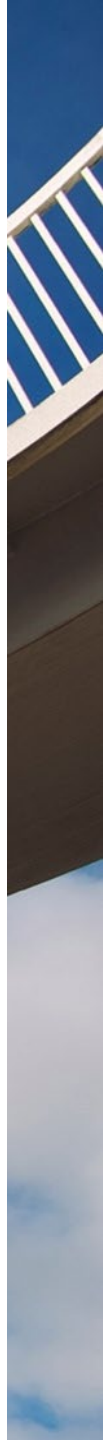
Accenture. (2025). Gen AI amplified Scaling productivity for healthcare providers. https://www.accenture.com/content/dam/accenture/final/accenture-com/document-3/AI-Amplified-Scaling-Productivity-Final.pdf

Polling Question #3

Are you actively helping identify, assess, or deploy AI solution at work?

A. Yes

B. No



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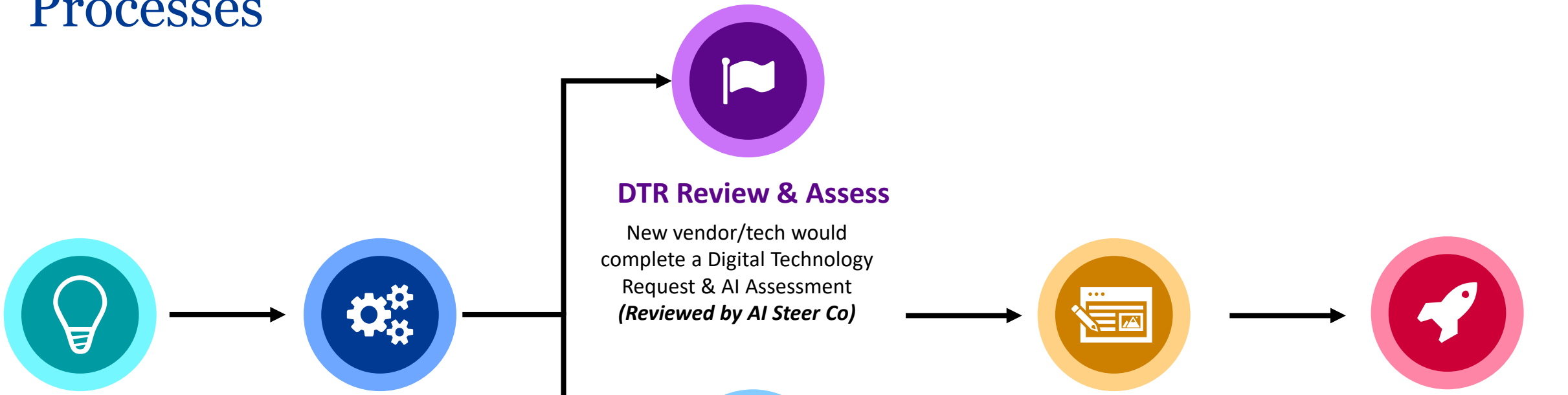
PANEL DISCUSSION

Governing AI within Healthcare

An Example: Fitting AI into current Intake & Review Processes



Use Case Request Intake

Documents the ask and/or request

Consultation

Identify need and provide guidance on best platform/environment/vendor

DTR Review & Assess

New vendor/tech would complete a Digital Technology Request & AI Assessment ***(Reviewed by AI Steer Co)***

Access

Provision access for self-service type requests; if model creation or validation, may need to repeat process for full operationalization

Complete Digital Review

Standard Digital Risk Deconditioning and Contract Execution

Implementation & Ongoing Support

Monitor technology & features; If initial implementation is pilot, may need to repeat process for full operationalization

Example: AI Triage Risk Categorization

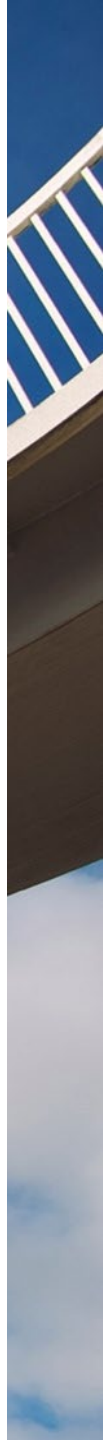
	Low	Medium	High
Use Case Consideration (examples)	Administrative/ operational, No/low clinical impact	May impact clinical care and/or significant impact to operations, (human review required)	Significant impact to patient care
Course of Action	*Quick wins*- scale if aligns with Strategic Priorities	*May need some fine tuning*- test & validate workflow before scaling	*Higher risk to clinical care*- ensure guardrails before moving through full scale of test & validate workflow
Timeline	Do now (turn on no need to test)	1-6 months (test with our 'alpha group')	6-12 months (partner with vendor to establish evidence first)

When considering the risk of an AI usecase, MGB is taking into account our relationship with the vendor/developer in addition to the general use case being tested.

AI Issue Spotting for Healthcare Entities

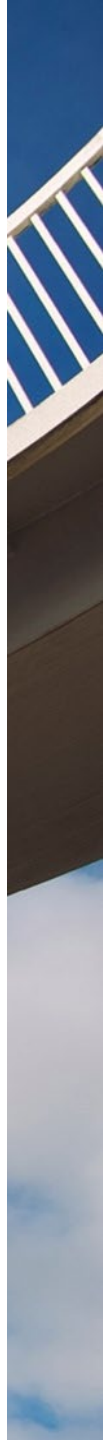
AI-specific laws, regulation & guidance:

- **Legislation/regulation:** states and federal agencies have taken the lead so far on legislation and regulatory guidance.
- **Focus so far:** medical device requirements, consumer protection, accuracy of product claims, bias & discrimination, transparency, utilization management (CMS), use in employment.
- **Billing and coding:** if the product could impact billing, need to validate accuracy.
- **Contracts:** address who bears what risks, study the warranties and reps re: product.
- **Data rights/privacy:** consider who owns the data, how will it be used.
- **FDA device requirements:** understand what the intended uses of the product are, and whether the product might evolve.



AI Issue Spotting for Healthcare Entities

- **Governance & decision-making:** need structure and process.
- **Healthcare regulations and AI:** issues include corporate practice, medical board licensure and discipline, telehealth + AI (both have state-by-state regulation)
- **IP:** consider who owns the product, product improvements, and the outputs. Be mindful of user agreements (and how they can change).
- **Liability & insurance:** consider both the organization and practitioners.
- **Quality processes:** For manufacturers, but customers should consider:
    - Protocols, controls, documentation,
    - Human-in-the-loop,
    - Auditing and monitoring (pre-launch, pilots, post-launch),
    - Reporting & quality feedback loops
- **Security:** Cybersecurity controls



Considerations for AI Use in Healthcare: Responsible Use, Governance and Education

An Example: Responsible AI Use Framework at Mass General Brigham

Characteristics of Responsible Use of AI	Sub-areas
Fairness	• Patient-centered • Equitable
Transparent and Explainable	• Documentation of data and development • Performance metrics / confidence intervals • Patient education
Responsible and Accountable	• Responsibility across model lifecycle • AI governance structure, controls, and policies • ROI
Robust and Reliable	• Model performance across shifts in data • Performance monitoring and thresholds
Privacy	• De-identified data used for model training • Access to output • Role of Informed consent and IRB
Safety and Security	• User interaction • Education • Feedback loops / AE reporting • Cybersecurity
Benefit	• Patient outcomes and satisfaction • Clinician and staff wellness • Financial ROI

Saenz AD; Mass General Brigham AI Governance Committee; et al. Establishing responsible use of AI guidelines: a comprehensive case study for healthcare institutions. NPJ Digit Med. 2024 Nov 30;7(1):348.

Artificial Intelligence Strategy needs to align with entity strategy

MGB's holistic approach to AI is ***ethical, equitable, and productivity- and quality-driven***

AI for Patient Care

AI for Care Team

AI for Research

AI for Employees

Equitable, Ethical and Responsible AI

With Human Oversight

Boosting Productivity and Quality

Enabling AI and Data Commercialization

An Example of MGB AI Use Cases and Programs

Clinical Care Delivery

Virtual Sitting for Safer, Smarter Monitoring
Artificial Intelligence-powered alerts to prevent falls and reduce sitter staffing needs

Clinical Messaging with Artificial Intelligence
Triaging, routing EMR InBasket, reducing manual review

AI-Powered Pre-Visit Insight
Artificial Intelligence-generated chart summaries to improve pre-visit planning

Scaling AI-Powered Clinical Documentation
Expanding automated draft note generation to 4,000+ ambient users

AI-Guided Triage for Primary Care Gaps
Piloting digital symptom checking and care routing to expand access

Proactive Care Through Predictive Insights
Models to anticipate admission, readmission, deterioration, and more

Optimizing Clinical Operations with Artificial Intelligence
Smarter workflows through cloud-enabled and predictive tools

Employee

Artificial Intelligence to Automate the Everyday
Reducing manual effort through Artificial Intelligence-powered task support

Knowledge On-Demand with Artificial Intelligence Assistants
Artificial Intelligence tools surface answers across documents, data, and systems

Driving Decisions with Real-Time Artificial Intelligence Insights
Leveraging Artificial Intelligence and real-time data to inform and accelerate outcomes

Researcher

Accelerating Heart Failure Trial Enrollment with Artificial Intelligence
AI-enabled tools outperform manual screening for eligibility

Artificial Intelligence Infrastructure for Clinical Trial Inclusion
Using Retrieval-Augmented Generation and electronic health record data to improve eligibility detection

AI-Powered Innovation in Cancer Research
Artificial Intelligence tools for early detection, patient communication, and imaging breakthroughs

Upskilling Employees

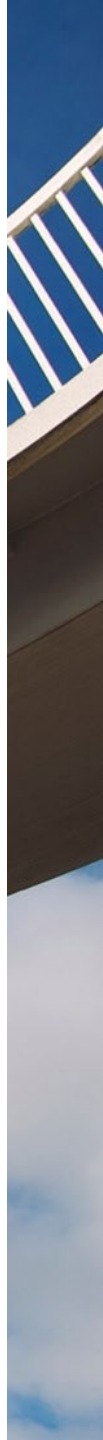
- Communication around approved tools
- Best practices education
- Prompt-a-thons
- Teams channel support for support crowdsourcing
- Educational Series hosted by Leadership

As healthcare organizations, however, ***we must ensure the privacy and security of protected health information (PHI) and ensure the safe and effective use of these technologies.***

Polling Question #4

In your opinion, is it likely that AI will eventually surpass human-level intelligence?

A. Yes, definitely
B. Possibly, in the distant future
C. Unlikely
D. Never



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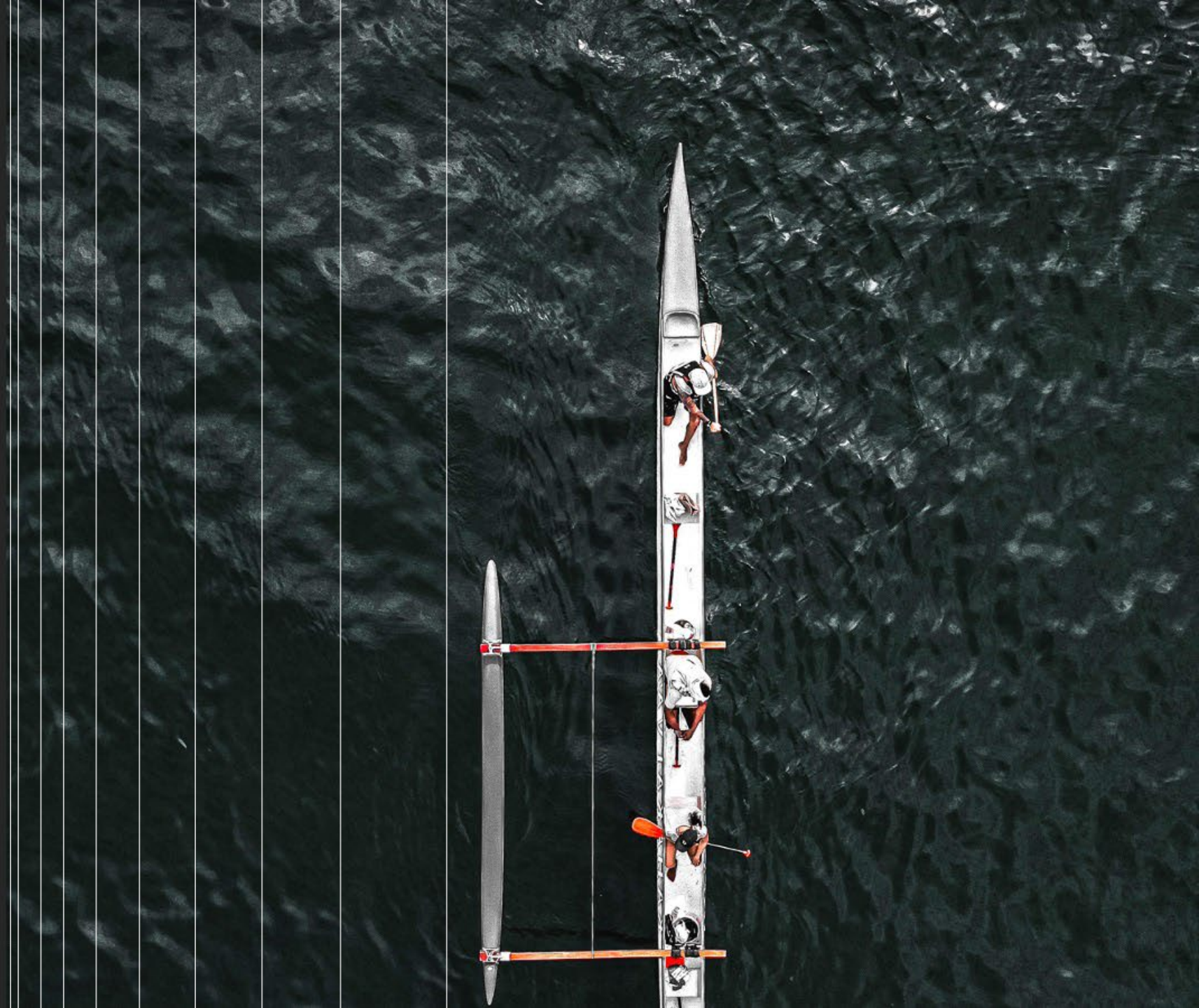
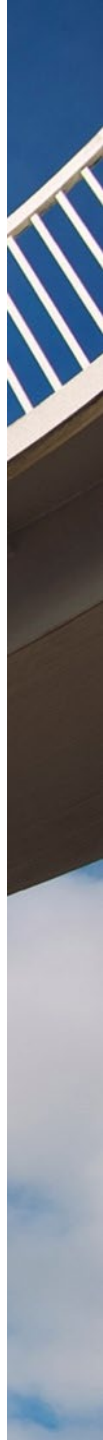
Q&A



Polling Question #5

Have you taken an AI course or obtained AI-related certification?

A. Yes
B. No
C. Planning to in the future



HFMA AI Governance Micro-Credential

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Elevate Your Career with the AI Governance Micro-Credential

Program Highlights – Access the training on ALIGNMT AI's user-friendly platform, where you'll explore seven in-depth courses:

- Introduction to AI in Healthcare: Uncover the potential of AI to transform healthcare finance and understand the risks involved.
- AI Governance Committee Operations: Learn how to establish and lead an AI governance committee focusing on ethical decision-making and accountability.
- Enterprise AI Risk Mitigation: Develop strategies to minimize AI-related risks and maintain compliance across your organization.
- Incident Response for AI Applications: Equip yourself with the skills to manage and respond to AI-related incidents effectively.
- Conflict of Interest Standards: Understand how to recognize and manage conflicts of interest within AI operations to maintain transparency.
- Whistleblower Protection for AI Compliance: Gain knowledge on fostering a culture that encourages reporting of AI misconduct while ensuring confidentiality.
- AI Governance Policies: Learn to design and implement robust governance policies tailored to your organization's needs.

Registration is NOW OPEN. Please reach out to admin@ma-ri-hfma.org for more details.

Register Now

The HFMA MA-RI Chapter and the New England Healthcare Internal Auditors (NEHIA) are proud to once again host a three-day educational conference featuring leading experts in healthcare compliance, privacy, security, and internal auditing. This event offers attendees at all levels the chance to learn directly from industry leaders, gain practical insights, and explore best practices shaping today's healthcare environment. Along with delivering affordable, high-quality sessions that qualify for CPE credits, NEHIA and HFMA MA-RI are committed to fostering connections among participants—building a collaborative and supportive community of healthcare professionals across New England.

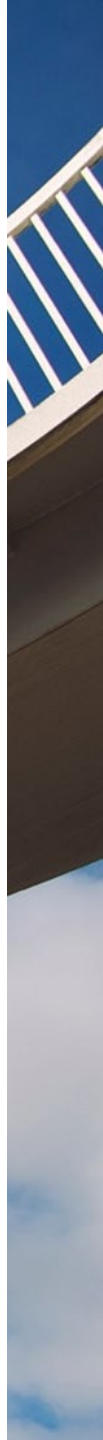
Polling Question #6

Are you planning to attend our December Compliance & Internal Audit Conference?

A. **Yes**

B. **No**

C. **May be**



Presenter bios

Dhara Satija
Healthcare Consulting Leader
Paul Hastings LLP

Dhara Satija is a Director in the Paul Hastings Life Sciences Consulting Group where she leads the group's healthcare consulting practice. She has nearly 15 years of consulting experience serving healthcare and life sciences clients across an array of issues, including projects ranging from strategy and operations to regulatory and corporate compliance, risk management, and investigation and litigation support. In particular, Ms. Satija has led projects related to: development and implementation of compliance programs (i.e., written standards, training, and monitoring/auditing); design and delivery of internal compliance audits, investigations, and corrective action plans; compliance and revenue cycle due diligence; support for provider self-disclosures/voluntary refunds; government-initiated audits; litigation support services; and Corporate Integrity Agreement (CIA) requirements.

Dhara is currently serving as President of the Massachusetts-Rhode Island Chapter of Healthcare Financial Management Association (HFMA) for the 2025-2026 term.

M: +1 (978) 604.9939
dharasatija@paulhastings.com

Amanda Centi
Senior Manager
Emerging Technologies
Mass General Brigham

As Senior Manager with Mass General Brigham Digital's Emerging Technologies Team, Amanda works with digital, clinical and operational leaders across Mass General Brigham to facilitate proof of concept and pilot projects focused on meeting the strategic needs of our patients, providers, researchers and employees. Our team focuses on identifying and expediting steps to project implementation and removing barriers to allow for quicker testing and validation of technological solutions in real world settings with buy-in from operational and clinical leadership to facilitate expansion of successful projects. We work with businesses ranging from startups to Fortune 100 companies as well as internal innovators to evaluate how their products and new technology may benefit the Mass General Brigham community in terms of usability, acceptability, and ROI. Amanda applies her strong background in evaluating emerging digital technologies and all aspects of project management to identify potential scalable products that can have an impact across our healthcare system. She is always looking for innovative processes to utilize her additional skills in facilitating brainstorming and design thinking sessions. Amanda holds a BS and MS in Exercise Physiology from Ithaca College and PhD in Biochemical and Molecular Nutrition with a focus on Nutritional Pathophysiology from Tufts University. She previously worked for the US Army to conduct clinical research on physiological impacts of military training and deployment as well as innovative technologies leveraged for rehabilitation.

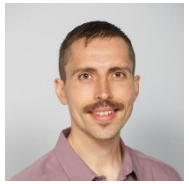
Robert Martin
Associate General Counsel
Mass General Brigham

Robert G. Martin is an Associate General Counsel in the Office of the General Counsel at Mass General Brigham Incorporated (formerly Partners HealthCare System, Inc.). Rob's responsibilities at Mass General Brigham include support for the Mass General Brigham Digital team, privacy and information security issues (including day to day support and incident response activities), and other general corporate matters. Recent projects have included legal support for artificial intelligence governance and implementation; Mass General Brigham's enterprise-wide clinical system projects; enterprise wide information security initiatives; and other large scale clinical and administrative digital projects. Prior to joining Mass General Brigham, Rob served as Director of Legal Affairs at a privately held, venture backed software company. Rob received his J.D. from Georgetown University Law Center where he was a member of the Georgetown Law Journal, and his B.A from the University of Pennsylvania.

PAUL HASTINGS

Presenter bios

Paulius Mui, MD
Founder
X = Primary Care



Dr. Paulius Mui is a board-certified family medicine physician with 10+ years of experience in entrepreneurship, operations, education, and primary care leadership across state and national organizations. He is the founder of XPC, a platform for measuring and developing healthcare workforce skills. His work spans virtual care, medical education, and building technology that support frontline clinicians.

Donna Lewis,
RN, BSN, MBA, CHC
Executive Director
Cape Cod Healthcare

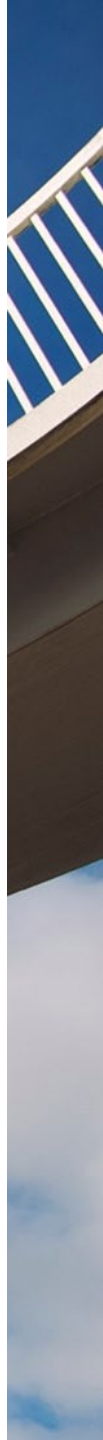
Donna Lewis is the Executive Director Compliance at Cape Cod Healthcare in Massachusetts. She has over 20 years of healthcare compliance, privacy and clinical risk management. Donna has held the Chief Compliance/Privacy Officer role in various settings including payor and provider for profit, not for profit, public health care systems as well as startup physician practices in collaboration with MSOs. In her current role, her primary focus is medical necessity compliance and Clinical Research Administration. She has led projects and initiatives related to 340 B litigation support, Corporate Integrity Agreements and streamlining compliance program operations. Donna has provided support for provider self-disclosures, high profile HIPAA privacy matters and has worked to build compliance programs as well a mature existing programs in highly stressful environments. She is a member of the Health Care Compliance Association (HCCA), Project Management Institute (PMI), and HIMSS to name a few. She holds a Bachelor of Science in Nursing from Florida International University and a Master's in Business Administration (MBA) from the University of Miami with certificates in Health Policy, Health Administration and Six Sigma. Additionally, she has experience in AI Governance. In her spare time, she serves as an Advocacy Ambassador for the Susan G Komen Center for Public Policy where she works with elected officials at the state and federal level to support breast cancer initiatives.

Garrett Gillespie
Chief Compliance Officer
Tufts Medicine

Garrett is the Chief Compliance Officer of Tufts Medicine. Previously, he was a Strategic Compliance Lead and Regulatory Counsel for Verily Life Sciences, a Google company. In these roles, he has provided guidance, created training materials, and developed policies and procedures regarding artificial intelligence. Before that, he was the Vice President, Deputy General Counsel & Corporate Compliance Officer at Boston Medical Center HealthNet Plan (now WellSense Health Plan), which is part of the integrated BMC Health System. Prior to that, he worked at CVS Health as the lead lawyer and an Executive Team member for MinuteClinic, and he was Of Counsel in Mintz Levin's Health Law Section. Garrett is a former President of the Massachusetts-Rhode Island Chapter of the Healthcare Financial Management Association and is a graduate of Yale University and the University of Virginia School of Law.

Resources

- Joint Commission and Coalition for Health AI (CHAI) Release Initial Guidance to Support Responsible AI Adoption Across U.S. Health Systems [Link]; The guidance is publicly available here.
- FDA Request For Public Comment: Measuring and Evaluating Artificial Intelligence-enabled Medical Device Performance in the Real-World Issued on 9/30/2025
- 7 ways AI is transforming healthcare by World Economic Forum
- Saenz AD; Mass General Brigham AI Governance Committee; et al. Establishing responsible use of AI guidelines: a comprehensive case study for healthcare institutions. NPJ Digit Med. 2024 Nov 30;7(1):348 [Link]
- DOJ Evaluation of Corporate Compliance Programs (Updated September 2024) [Link]
- Building a Comprehensive AI Governance Framework [Link] - Client Alert by Paul Hastings LLP



PAUL HASTINGS

Mass General Brigham

TuftsMedicine

Cape Cod Healthcare

XPC CLINIC

Thank You

HFMA Emerging Healthcare Leaders Summit

Revenue Cycle Overview

Mary Beth Remorenko MHA, SVP Revenue Cycle Operations BILH
Keisha Downes MBA-HM, RN, VP Mid-Revenue Cycle, BILH

hfma
massachusetts-rhode island chapter

Agenda and Learning Objectives

Agenda:

Intro and Patient Access	Mary Beth Remorenko
Middle Revenue Cycle	Keisha Downes
Patient Financial Services	Mary Beth Remorenko

Learning Objectives:

Understand definitions and functional components of the revenue cycle

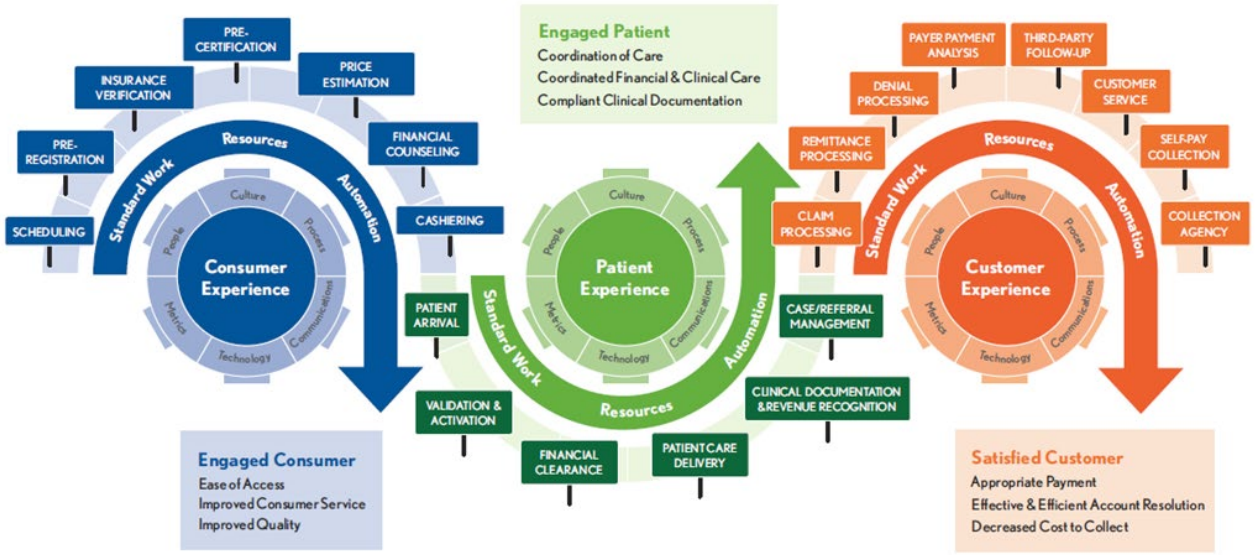
Introduction of key revenue concepts and financial impacts to health care providers

Overview of enabling capabilities, strategy and innovation in the revenue cycle

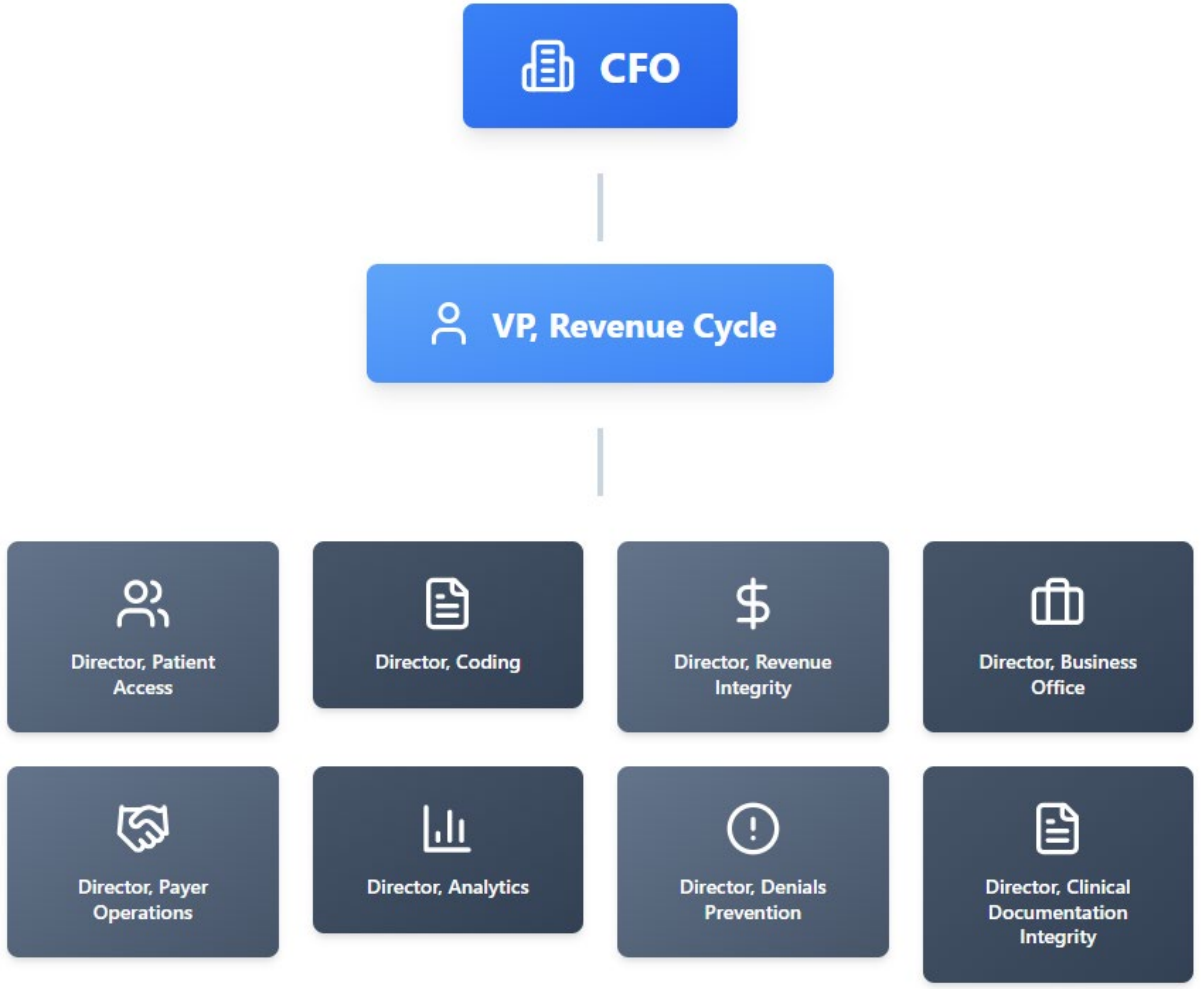
Revenue Cycle Management

Revenue Cycle Management is the process used by healthcare systems to track the revenue obtained from the initial appointment or encounter patients have with the healthcare system to their final payment of balance.

The revenue cycle is comprised of all administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue.



RCM Organizational Chart



Polling Question 1

Revenue Cycle is typically characterized by how many groups of functions:

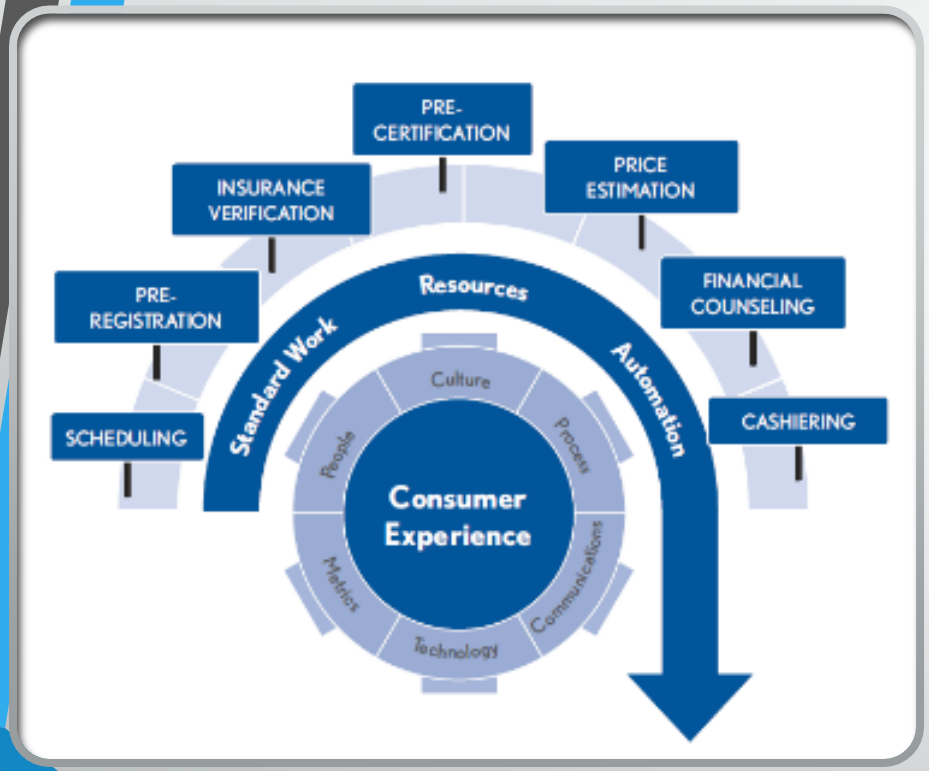
a. 3- front, middle, back

b. 4- left, right, top, bottom

c. 2- front, back

Patient Access

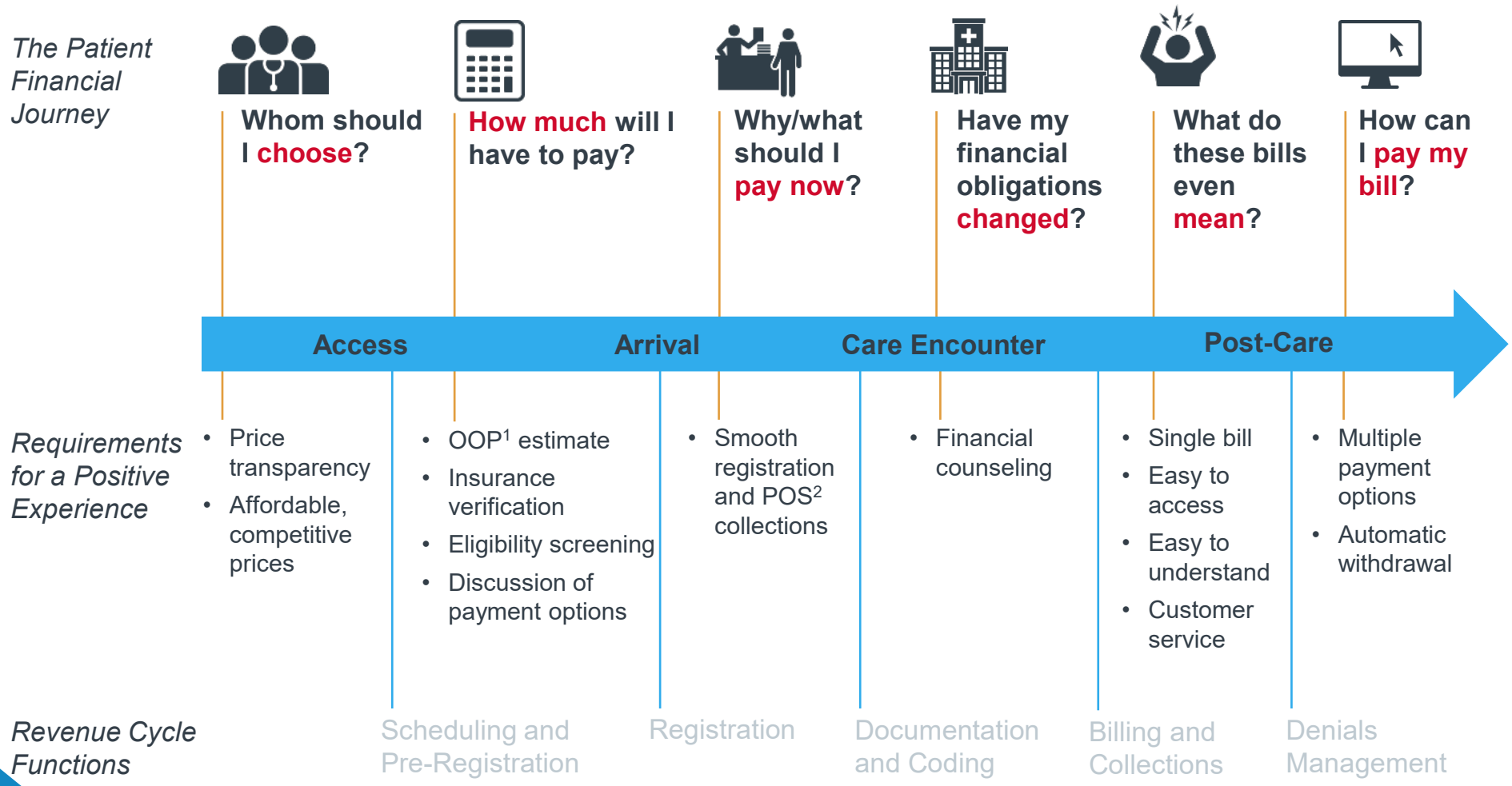
Patient Access & Experience- 'Front end"



- Ambulatory Contact Center
- PSC Registration
- PSC Referrals
- Patient Financial Experience
- Patient Billing Solutions

The Patient Financial Journey

Meeting Patients' Expectations Requires a New Approach to Revenue Cycle



Source: Optum/Advisory Board- Patient Financial

Compliance with the No Surprises Act Provisions

No Surprises Act: Federal

Federal Law effective January 1, 2022 to protect patients from surprise medical bills, especially from out-of-network providers or in emergencies.

In-Network Convening Providers/ Out-of-Network Co-Providers

Full Compliance required with emergent and non-emergent services (ERAP)

Each individual provider responsible for their own cost estimate

Patients only responsible for in-network cost sharing

Uninsured/Self-Pay Good Faith Estimates

One all-inclusive estimate is provided to the patient including ALL professional and technical costs… however, each provider held responsible for their own GFE and $400.00 threshold variance

Dispute Resolution Process

Independent dispute resolution (IDR) process for escalating and resolving payment disagreements between providers and insurers

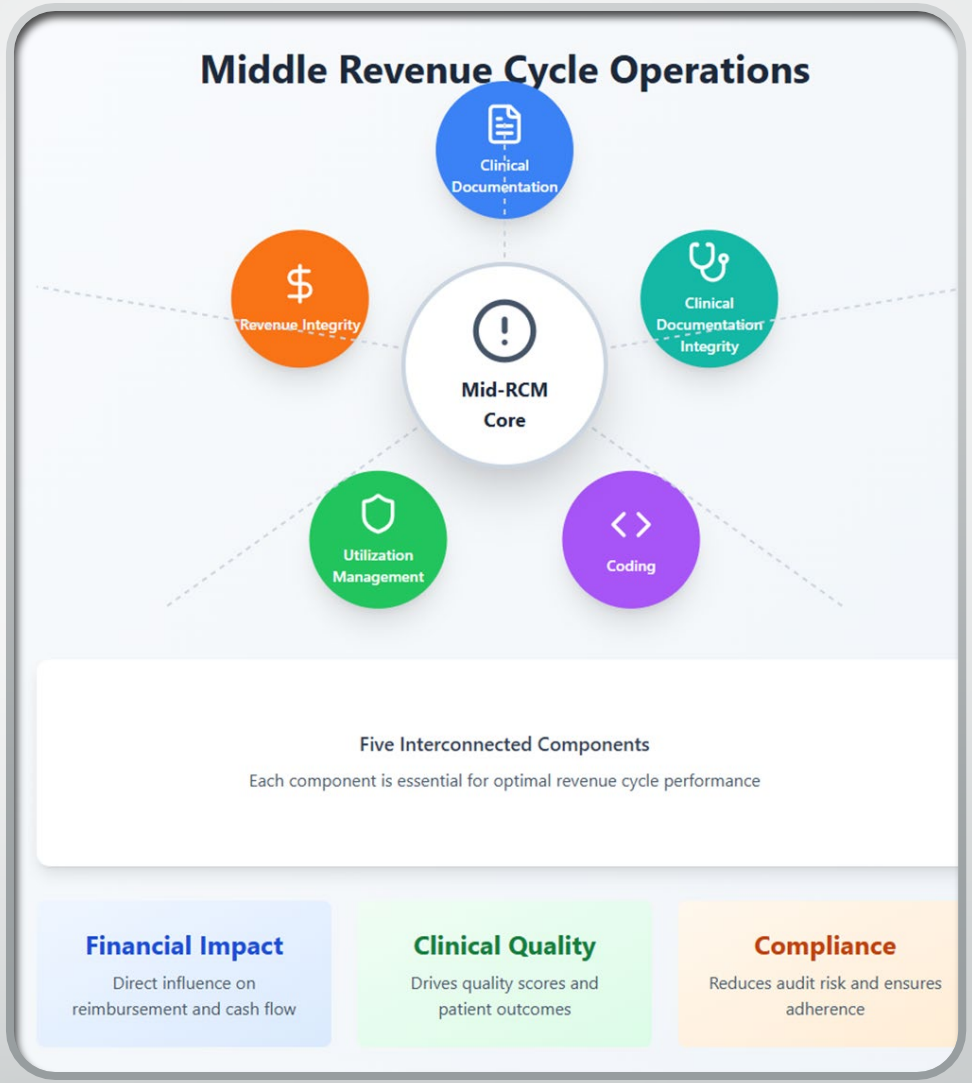
Source: HMFA Rev Cycle Training Deck 092724

Middle Revenue Cycle

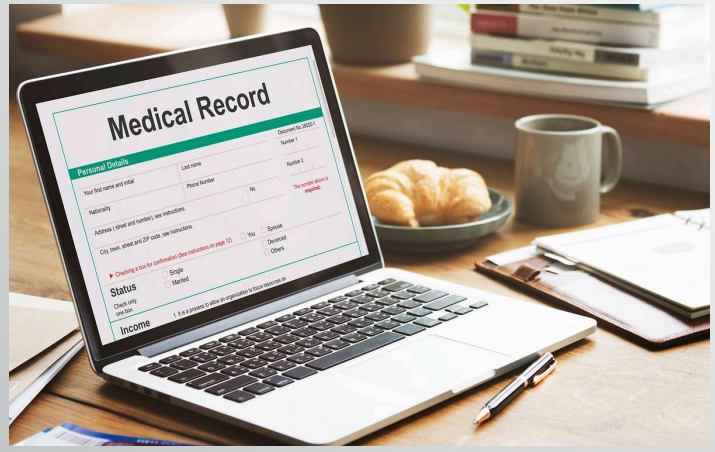
Middle Revenue Cycle (Mid-RCM)

Why is Mid-Revenue Cycle Important?

- **Financial Impact**: The middle revenue cycle directly influences reimbursement, denials, and cash flow.
- **Clinical Quality & Outcomes:** Documentation and coding drive quality scores, risk adjustment, and population health metrics.
- **Compliance & Risk**: Accurate coding and documentation reduce audit risk and ensure regulatory adherence.
- **Strategic Decision-Making:** Leaders who understand Mid-RCM can make better decisions around staffing, technology investments, physician engagement, and payer negotiations



Clinical Documentation



Clinical Documentation

"If it's not documented, it didn't happen."

Purpose

Ensure the medical record accurately and completely reflects the patient's story, care provided, diagnoses, and clinical decision-making.

Foundation

For coding, quality metrics, reimbursement, and legal compliance

Documentation Standards

Must be clear, complete, specific, and timely

Clinical Impact

Affects SOI, ROM, DRG assignment, and quality reporting

Collaboration

Between providers, CDI, coding, and revenue cycle teams

⚠ **Quality Documentation Reduces Denials and Audit Risk Downstream**

Clinical Documentation Integrity

Clinical Documentation Integrity (CDI)

"Translating clinical reality into coded language."

Purpose

Bridge the gap between clinical language and coding requirements to ensure documentation accurately supports coding, billing, and reporting.

CDI Specialists

Nurses or coders review records to identify documentation gaps and clarification needs

Provider Queries

Capture clinical specificity and completeness (sepsis severity, type of heart failure)

Performance Impact

Improves CMI, reimbursement accuracy, quality scores, risk adjustment, and reduces denials

Expanding Role

Increasingly involved in outpatient CDI and value-based care documentation

Strong Provider Engagement and Education are Key to CDI Success

Coding

Coding

"Turning care into data."

Purpose

Assign standardized codes (ICD-10, CPT, HCPCS) to diagnoses, procedures, and services based on clinical documentation. Accurate coding ensures appropriate reimbursement, compliance, and reliable data.

Core Function

Ensures proper reimbursement, compliance, and analytics through accurate coding

Coder Expertise

Interpret clinical language, follow official guidelines, and stay current with regulatory changes

Broad Impact

Affects MS-DRG/APC assignment, HCCs, quality reporting, and public health data

Technology Integration

Computer-assisted coding, NLP, and AI transform workflows, but human oversight remains critical

Collaboration with CDI and Providers Strengthens Documentation and Reduces Queries

Utilization Management

Utilization Management (UM)

"Right care, right time, right setting."

Purpose

Ensure patients receive medically necessary care in the appropriate setting, aligning clinical decisions with payer requirements and clinical standards to support reimbursement and compliance.

Utilization Review

Appropriateness of admission, level of care, continued stay, and case management

Medical Necessity

Ensures clinical documentation supports medical necessity and payer authorization criteria

Revenue Protection

Prevents denials, protects revenue, and optimizes patient flow

Value-Based Care

Plays a critical role in value-based care models and population health strategies

Collaboration with Providers, Payers, and Revenue Cycle Teams is Essential

Revenue Integrity

Revenue Integrity

"Protecting revenue by getting it right the first time."

Purpose

Ensure that clinical services provided are accurately documented, appropriately charged, compliantly billed, and fully reimbursed — safeguarding the organization from revenue leakage, denials, and compliance risk.

Charge Capture Accuracy

Verifies all services are documented and charged correctly, preventing missed or duplicate charges

CDM Oversight

Maintains charge description master to ensure codes, pricing, and descriptions align with regulations

Proactive Auditing

Identifies patterns, errors, and opportunities before claims submission, reducing denials and rework

Cross-Functional Collaboration

Works across clinical, coding, billing, compliance, and finance teams to resolve revenue leakage

Safeguarding the Organization from Revenue Leakage, Denials, and Compliance Risk

Polling Question 2

Which Mid-Revenue Cycle function has the MOST direct impact on Case Mix Index (CMI)?

a. Clinical Documentation Integrity (CDI)
b. Utilization Management (UM)
c. Revenue Integrity
d. Coding

Patient Financial Services

Patient Financial Services "Back End"

Responses from payers are posted to Epic through an electronic remittance advice (ERA), HIPAA 835.
The file contains the following information:

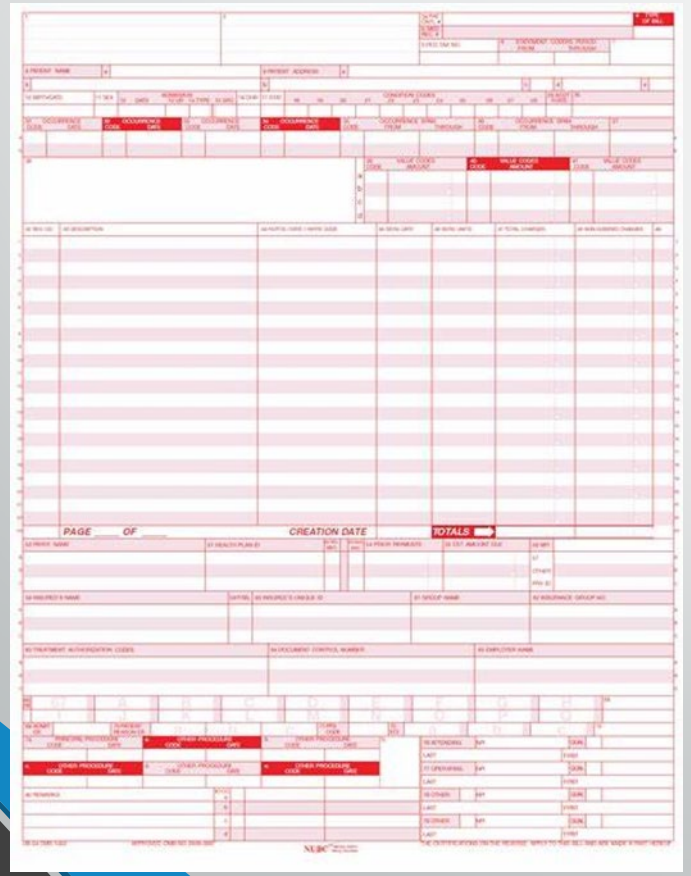
- Payment
- Allowed amount
- Rejection codes
- CARC- Claim Adjustment Reason Codes
- RARC- Remittance Advice Remark Codes
- Patient Liability

Top rejections:
Auth/Referral
Coordination of Benefits
Patient not covered
Not Medically Necessary
Filing Limit

Once the detail is posted to patient financial system, logic determines what the next actions are:
Patient Liability→bill patient
Partial Pay (80%) Co-insurance due → bill secondary
Claim Rejects → file to a work queue for third party reviewer processing

Patient Financial Services – Hospital Billing UB-04/837i

UB04/Hospital Claim



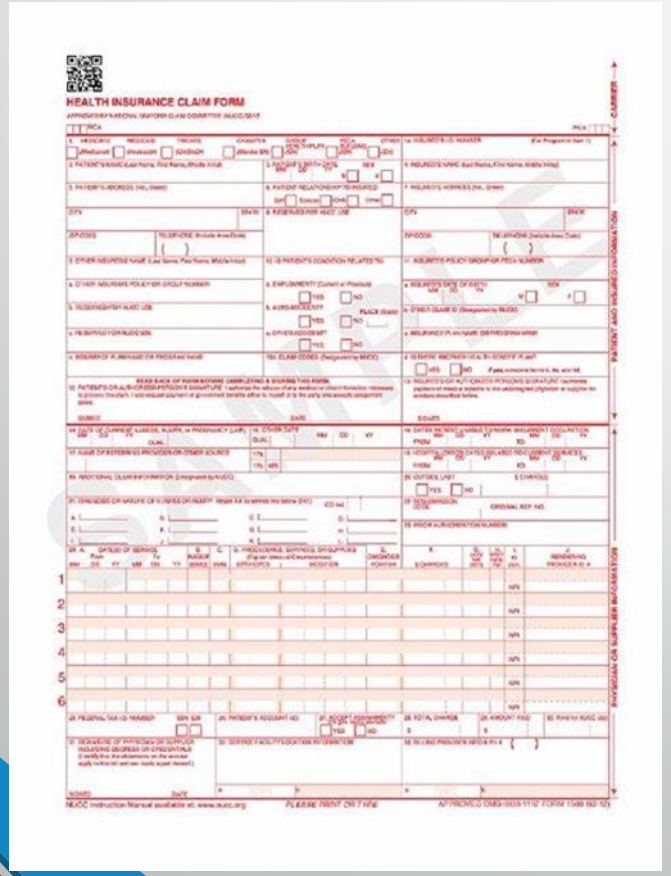
UB04 Data Sources

81 field locators

Patient Access – 40%
Service Departments – 11%
Clinical Coding – 20%
Billing/System – 20%
Reserved for future use – 9%
Acute Care @ Home
Z-codes

Patient Financial Services – Professional Billing
CMS 1500/837p

1500/Professional Claim


HEALTH INSURANCE CLAIM FORM

1500 Data Sources

33 Fields

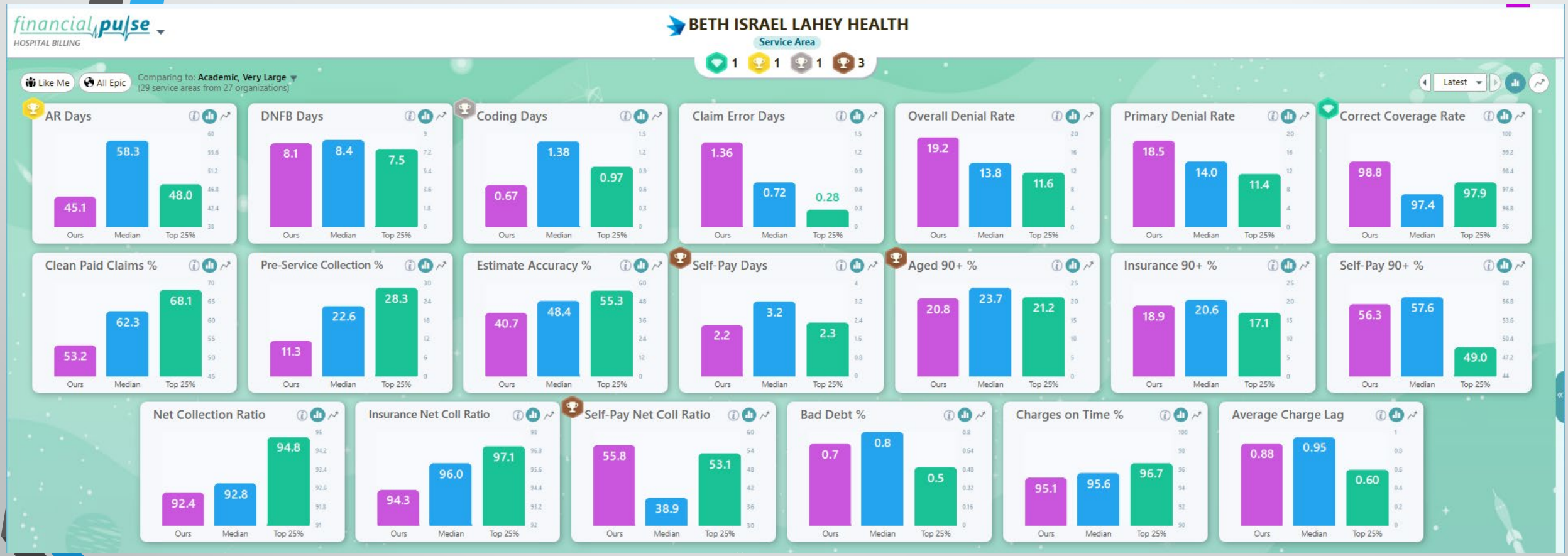
Patient Access – 90%
Service Departments – 2.5%
Clinical Coding – 1%
Billing/System – 4.5%
Reserved for future use – 2%
Telehealth codes

Polling Question 3

True or False

Hospital claims are billed on a UB92 and Professional claims are billed on a CMS1500.

Key Performance Metrics



Source: BILH Epic Pulse 101325

Revenue Cycle Strategy

Objective and Desired Outcomes

Design a future state structure that enables efficiency, enhances collaboration, and ensures system-wide Revenue Cycle best practices

Enhanced Core Capabilities

Enhanced core capabilities and new strategic capabilities to create a leading, future focused organization

Improved Experience

Improved patient and provider experience by aligning customer facing capabilities

Employee Engagement

Increased employee engagement by cultivating opportunities for innovation and advancement

Strategic Alignment

Increased alignment with system strategic priorities and objectives through enterprise level integration

Enterprise-Site Collaboration

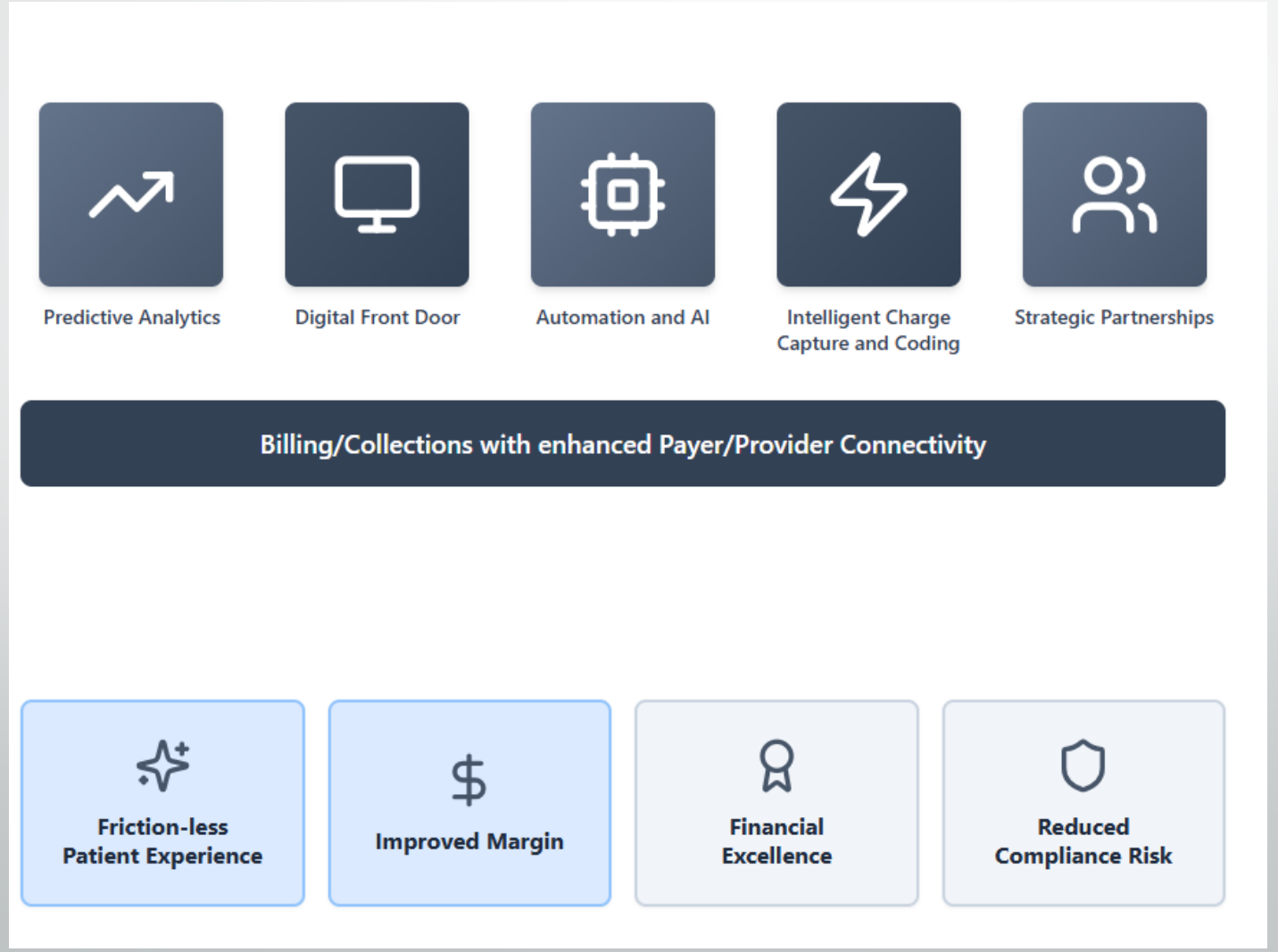
Enhanced alignment and collaboration of Enterprise Revenue Cycle and Site Revenue Cycle capabilities

Operations Partnership

Enhanced collaboration between Operations and Revenue Cycle via data and feedback loops

Revenue Cycle Innovation

Sometimes the old way of thinking needs to be shifted…



Rev Cycle Technology and Vendors

Technology in the revenue cycle is a key capability and enabler. Robotic Process Automation (RPA) and AI have emerged in this space over the last 5-10 years.

Resources

Advisory Board. (2018, August). *The patient financial journey*. https://www.advisory.com/topics/revenue-cycle/2018/08/the-patient-financial-journey

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Career Spotlight

Emerging Healthcare Leaders Summit

October 17, 2025

Emerging Healthcare Leaders Summit Career Spotlight

Objectives

Listen to a panel of healthcare finance experts discuss their professional journeys and provide personal insights on career experiences

Learn about potential opportunities in the diverse healthcare finance field

Emerging Healthcare Leaders Summit Career Spotlight – Polling Question #1

How many years have you worked in healthcare?

A. Fewer than five years
B. More than five and fewer than ten years
C. More than ten years
D. Not Applicable

Emerging Healthcare Leaders Summit
Career Spotlight – Polling Question #2

As an early careerist, which of the below do you feel will be most helpful in your continued career growth?

A. Further education
B. Professional society certification
C. Networking
D. All of the above

Emerging Healthcare Leaders Summit Career Spotlight – Polling Question #3

Do you have someone you would call a mentor?

A. Yes

B. No

HFMA Emerging Healthcare Leaders Summit

October 17, 2025

8:30 am – 4:00 pm

@ Mass General Brigham Assembly Row

4:00 pm – 6:00 pm

@ Lucky Strike Assembly Row

hfma

massachusetts-rhode island chapter

Emerging Healthcare Leaders Summit
Offsite Networking Event

Please join us for post-conference networking/social event from 4:00 pm – 6:00 pm @ Lucky Strike Assembly Row