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- Articles can cover a range of topics from educational pieces, member spotlights, social event news, and event recaps
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UP NEXT!



8:30 - 8:45	**Welcome from HFMA MA RI Chapter President & Co-Chairs** Julie Hall Co-Founder and Principal, Integrated Revenue Integrity
8:45 – 9:30	**Intro to Rev Cycle** Keisha Downes, VP Mid-Revenue Cycle, BILH
9:45 – 10:35	**Skill Enhancement & Certifications** Mike Tracy, Emerson Health
Break	**Networking Break**
11:00 – 12:30	**Resume Reviews/Building, Social Media Use, AI Integration** **Moderator:** Caitlin Yergeau Director Revenue Cycle Optimization, BILH **Panelists:** Doreen Howard, PSC Manager, MGB Rachel Correia, VP Patient Financial Services, BILH Chris Kelly, Medix Team
Lunch	
1:40 – 2:30	**Dashboards to Decisions** Chris Hutchins, former Chief Data & Analytics Officer, Norwell Health; Founder & CEO, Hutchins Data Strategy Consultants
Break	**Networking Break**
2:45 – 3:45	**Career Spotlight – Career Navigation, Interdisciplinary Collaboration, Networking** **Moderator:** Jordan Malinoski, Practice Manager, Emerson Health **Panelists:** Brendan Hames, Emerson Health Kelly McCue, BILH Diane Torres, Physician Billing Director, BCH
3:50 – 4:00	**Closing Remarks & Prize Raffle** Caitlin Yergeau Director Revenue Cycle Optimization, BILH Jordan Malinoski, Practice Manager, Emerson Health
4:00 – 6:00	**Offsite Networking/Social Event** MGB- Trivia!

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Intro to Revenue Cycle

The Life of a Claim

Dr. Keisha Downes DMSc, MBA, RN, CCDS, CCS
Vice President Mid-Revenue Cycle, Beth Israel Lahey Health
HFMA Emerging Healthcare Leaders Summit

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Agenda

1

The Big Picture

Definition, journey and the Downhill Effect

2

Front-End

Patient access and intake

3

Mid-Cycle

Clinical and charge integrity

4

Back-End

The business office

5

The Tech Stack

Automation across the cycle

6

KPIs

HFMA MAP Keys and measuring success

7

Wrap-Up

Collaboration, future of RCM, Q&A

3 pillars

One cycle, from first call to final payment

SECTION 1 · THE BIG PICTURE

RCM: The Financial Nervous System

THE DEFINITION

Every administrative and clinical function that captures, manages and collects patient service revenue.

Far beyond billing: it starts before the patient arrives and ends after the last dollar is posted.

A signal network

Registration data, clinical documentation, codes and payments all travel the same pathway.

A vital sign

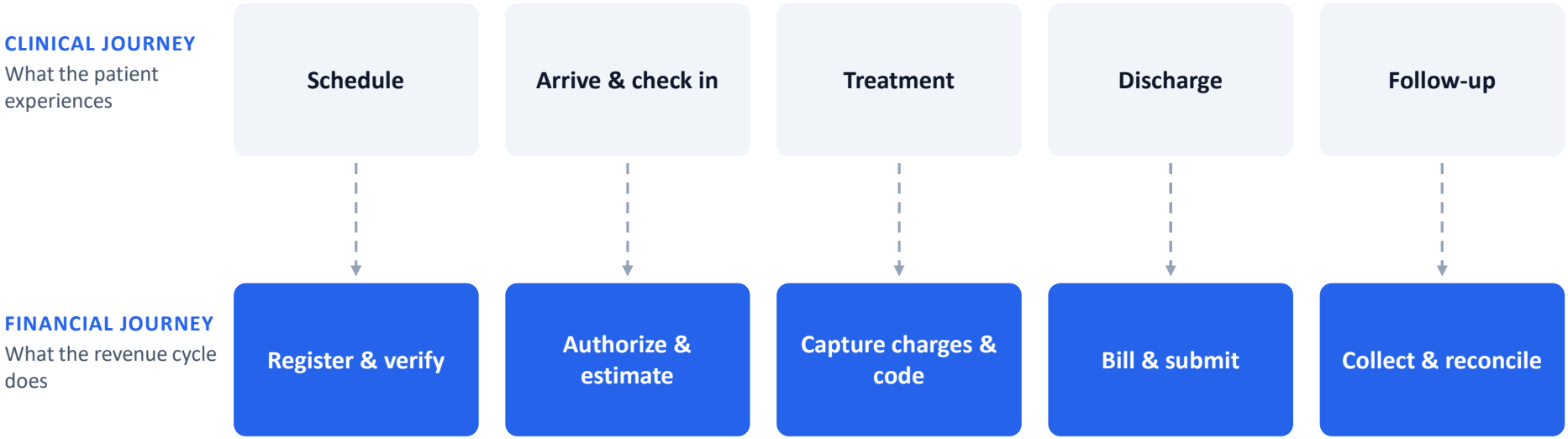
Cash flow, denial rates and days in A/R show how healthy the organization really is.

A funding engine

Margin pays for staff, equipment and new services, so the mission depends on it.

SECTION 1 · THE BIG PICTURE

Two Journeys, One Patient



Every clinical event triggers a financial event, and every financial event depends on data created upstream.

SECTION 1 · THE BIG PICTURE

The Golden Rule: The Downhill Effect

FRONT-END ERROR

$10

to prevent at patient access

10×

BACK-END FIX

$100

to find, rework and recover in the business office

Why the cost compounds

Rework

Staff time spent investigating, correcting and resubmitting.

Delay

Cash slips from days to weeks while accounts wait in queues.

Leakage

Missed filing deadlines and write-offs turn into lost revenue.

SECTION 1 · THE BIG PICTURE

Three Pillars, One Cycle

FRONT-END

Patient Access

Can we get paid for this visit?

- Scheduling & registration
- Eligibility & authorization
- Estimates & POS collections

MID-CYCLE

Clinical & Charge Integrity

Did we accurately capture and describe the care?

- Charge capture
- Clinical documentation (CDI)
- Medical coding

BACK-END

The Business Office

Did we collect everything we are owed?

- Claim scrubbing & submission
- Denials & appeals
- A/R follow-up & patient collections

WHY EMERGING LEADERS MUST CARE

Margin Equals Mission

Financial health dictates clinical capability.



Capital

Margin funds the equipment, facilities and technology that make new care possible.



People

Sustainable finances let organizations recruit, retain and support clinicians and staff.



Access

A healthy margin underwrites community programs, charity care and new service lines.

You don't have to run the business office to move the numbers. You have to know where the handoffs break.

First Skill: The Front-End

PATIENT ACCESS

Core Functions

- Patient registration.
- Insurance eligibility verification.
- Securing prior authorizations.

Key Roles

- Patient Access Representatives.
- Financial Counselors.
- Authorization Specialists.

The Golden Rule

$10 mistake on the front end.

$100 to fix on the back end.

SECTION 2 · FRONT-END

Scheduling & Registration

Patient identity

Legal name, birth date, address, contact

Coverage

Payer, plan, member and group IDs

Guarantor

Who is financially responsible

Orders & referrals

Ordering provider, diagnosis, service

Encounter details

Visit type, location, date and time

Documents

Consents, ID and card images

WHY IT MATTERS

Registration is the claim's DNA.

Every downstream step inherits what is entered here: eligibility checks, authorizations, codes and the claim itself.

BEST PRACTICE

- Match ID and insurance card exactly
- Confirm identity at every touchpoint
- Fix it at the source, not at billing

SECTION 2 · FRONT-END

Eligibility & Verification

Real-Time Check

ON DEMAND

- Instant payer response (EDI 270/271) at scheduling, check-in or portal
- Best for same-day, add-on and walk-in visits
- Confirms coverage as it stands today

Batch Check

SCHEDULED

- Overnight file for the upcoming schedule, typically days ahead
- Surfaces inactive coverage while there is time to fix it
- Reduces front-desk firefighting on the day of service

What gets verified

Active coverage | Plan & benefits | Copay & deductible | Other coverage | Auth required?

SECTION 2 · FRONT-END

Prior Authorization

1

Order placed

A clinician orders a service that may need approval.

2

Check rules

Confirm if this payer and code require approval.

3

Submit clinicals

Send documentation that supports medical necessity.

4

Track & record

Capture approval number, dates, units and site.

WHY IT MATTERS

A clean, well-coded claim can still be denied for a missing or mismatched authorization, and it is hard to repair after the service is delivered.

WHERE IT BREAKS

- Authorization never requested before service
- Approved code, dates or location changed
- Approved units or visits exceeded

SECTION 2 · FRONT-END

Financial Counseling

1 Estimate

Calculate expected out-of-pocket cost from benefits and the expected allowed amount.

2 Screen for help

Check eligibility for Medicaid, charity care or financial assistance.

3 Arrange payment

Explain options and set up payment plans before service, not after.

HOW AN ESTIMATE IS BUILT

Expected allowed amount
the payer's contracted rate

−

Plan payment
after benefits are applied

=

Patient responsibility
deductible, coinsurance, copay

SECTION 2 · FRONT-END

Point-of-Service Collections

1

Pre-service

Estimate and collect during scheduling or reminder calls.

2

Check-in

Copays and deductibles at arrival.

3

Checkout

Remaining balance before the patient leaves.

4

Post-service

Statements, calls and payment plans.

Easier and cheaper to collect → harder and costlier

Levers that move POS performance

Estimates

Patients pay when they trust the number.

Training

Make the ask confident and routine.

Payment channels

Kiosk, text-to-pay, portal and front desk.

Goals & feedback

Track by location and by staff member.

SECTION 2 · FRONT-END

Roles & Personas



Patient Access Representatives

Customer service meets data-entry precision.

- Schedule and register patients
- Capture and verify coverage
- Collect copays at check-in

Key skill: **precision**



Financial Counselors

The bridge between patient anxiety and financial clarity.

- Explain estimates plainly
- Screen for financial assistance
- Set up payment plans

Key skill: **communication**



Authorization Specialists

The clinical and administrative liaison with payers.

- Identify services needing approval
- Submit clinical documentation
- Track and record approvals

Key skill: **payer rules**

SECTION 2 · FRONT-END

The Cost of Bad Data

ERROR	WHAT HAPPENS	RESULT
Misspelled last name	The payer's system cannot match the name to the member record.	**Eligibility fails or the claim is rejected on submission.**
Wrong birth date	The date of birth does not match the subscriber file at the payer.	**Coverage not found: claim held, denied or billed to the patient.**
Transposed member ID	The check returns no active coverage, or the wrong person's.	**Back-end rework, delayed cash and timely-filing risk.**

Illustrative scenarios

Registration accuracy is the first edit in every claim.

SECTION 2 · FRONT-END

The No Surprises Act

Billing protections

Limits patient cost-sharing and bans balance billing for emergency care and certain out-of-network care at in-network facilities.

Good Faith Estimates

Uninsured and self-pay patients must receive a written estimate of expected charges before scheduled care (since Jan 2022).

Dispute resolution

Independent dispute resolution settles provider-payer payment disputes. Patients can dispute a bill $400 or more over their estimate.

WHAT THIS MEANS AT THE FRONT END

Ask at scheduling: insured, uninsured, or self-pay for this service?

Deliver on time: 1 business day if scheduled 3+ days out; 3 business days if 10+ days out or on request.

Keep every estimate on file for 6 years. Insured-patient Advanced EOB rules are still pending.

Source: CMS, No Surprises Act resources (cms.gov/nosurprises)



CLINICAL INTEGRATION

Second Skill: The Mid-Cycle

Translating clinical care into standardized, billable data.

1. **Clinical Documentation Integrity**
   Real-time physician note reviews.
2. **Medical Coding**
   Assigning accurate ICD-10 and CPT codes.
3. **Health Information Management**
   Overseeing legal records and compliance.

SECTION 3 · MID-CYCLE

Charge Capture & the Chargemaster

- A medication dose
- A procedure
- A room-and-board day

THE CHARGEMASTER (CDM)

The master list of every billable item

Description, price, revenue code and link to CPT or HCPCS.

WHAT LANDS ON THE CLAIM

- Description
- Revenue code
- CPT / HCPCS code
- Units
- Charge amount

Missed charges mean lost revenue

A wrong CDM entry means a wrong claim

Late charges mean delayed billing

SECTION 3 · MID-CYCLE

Clinical Documentation Integrity

1. **Review concurrently**
   CDI specialists read charts while the patient is still in-house.

2. **Query the physician**
   Compliant, non-leading questions prompt clearer documentation.

3. **Record and code accurately**
   The updated record drives accurate codes and severity.

WHAT CDI PROTECTS

Severity of illness
The record shows how sick the patient really was.

Quality and risk scores
Risk-adjusted metrics depend on documented diagnoses.

Accurate payment
DRG assignment follows what the chart supports.

SECTION 3 · MID-CYCLE

Medical Coding: Three Code Sets

ICD-10

Diagnoses

Describes why the patient was treated, plus inpatient procedures (ICD-10-PCS).

Answers: why?

CPT

Procedures & services

Describes what clinicians did. Maintained by the American Medical Association.

Answers: what was done?

HCPCS

Supplies & more

Level II codes cover drugs, supplies, equipment and services outside CPT.

Answers: what was supplied?

Documentation → **Codes** → **Claim** → **Payment**

If the note is vague, the code is vague, and the payment is wrong.

SECTION 3 · MID-CYCLE

Roles & Personas

CDI Specialists

Often RNs who review charts concurrently and prompt clearer documentation.

- Review charts while in-house
- Issue compliant physician queries
- Track documentation trends

Key skill: **judgment**

Medical Coders

Certified professionals (e.g., CPC, CCS) who assign alphanumeric codes.

- Turn notes into ICD-10, CPT, HCPCS
- Apply guidelines and payer edits
- Resolve questions with clinicians

Key skill: **guidelines**

HIM Directors

Guardians of the legal medical record.

- Protect record integrity
- Manage release of information
- Lead audits and privacy compliance

Key skill: **compliance**

SECTION 3 · MID-CYCLE · DOCUMENTATION

“If it isn't documented, it didn't happen.”

Legal

The record is the primary evidence in audits, disputes and malpractice reviews.

Financial

Payers pay for what the record supports, no more and no less.

Clinical

The next caregiver relies on the note to deliver safe, continuous care.

SECTION 3 · MID-CYCLE

How a CDI Query Changes the Record

PHYSICIAN NOTE

Patient admitted with heart failure.

→

CDI QUERY

Clinical indicators suggest worsening shortness of breath and reduced ejection fraction. Can the type and acuity of heart failure be clarified?

→

UPDATED RECORD

Acute on chronic systolic heart failure.

More specific ICD-10 code, more accurate severity

Compliance guardrail: queries must be non-leading and clinically supported. They never suggest a diagnosis to raise payment.

SECTION 3 · MID-CYCLE

Upcoding vs. Downcoding

Upcoding

Reporting a higher-paying code than the documentation supports.

- Audit and repayment exposure
- False Claims Act risk
- Penalties and reputational damage

Downcoding

Reporting less than the care delivered or the record could support.

- Revenue leakage on every encounter
- Understated severity and risk scores
- Distorted quality and cost data

The goal is accuracy, not maximization: code what is documented, and document what was done.

Third Skill: The Back-End

THE BUSINESS OFFICE



Claim Scrubbing

Ensuring claims meet specific payer rules before submission.



Denials Management

Investigating rejections and writing clinical or financial appeals.

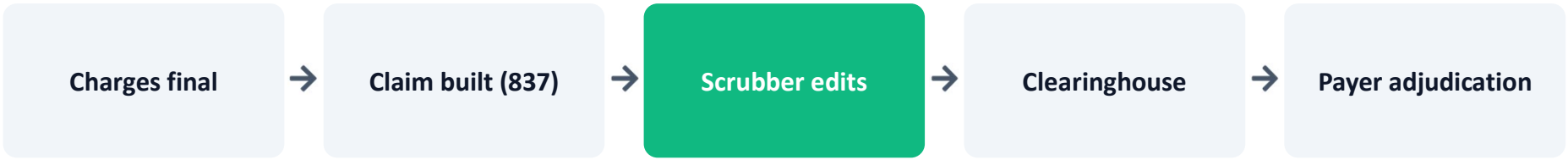


Accounts Receivable

Relentless follow-up to turn pending charges into collected cash.

SECTION 4 · BACK-END

Claim Scrubbing & Submission



WHAT SCRUBBERS CATCH

Front-end errors

Missing or invalid demographics, member IDs and authorization numbers.

Coding conflicts

Invalid code combinations, missing modifiers, diagnosis-procedure mismatches.

Payer-specific rules

Edits that reflect each payer's own billing requirements.

Timeliness

Claims approaching filing limits are flagged for priority.

Rejected ≠ denied. Rejections stop at the scrubber or clearinghouse. Denials come from the payer after adjudication.

SECTION 4 · BACK-END

Payment Posting & Remittance Advice

Expected

What the payer contract says it should pay

vs

Remittance (ERA)

The electronic 835 explaining each payment

vs

Actual deposit

Cash that really arrives in the bank

What posting does

- Applies payments and adjustments to the right account
- Moves remaining balances to patient responsibility
- Triggers denial and underpayment work queues

Variances to catch

- Underpayments against the contracted rate
- Denials and adjustments coded with CARC / RARC
- Misapplied or unposted deposits

SECTION 4 · BACK-END

Denials Management & Appeals

1. **Receive**
   Denial arrives on the remittance or payer portal.
2. **Diagnose**
   Categorize the root cause and decide if it is fixable.
3. **Fix or appeal**
   Correct and resubmit, or write the appeal.
4. **Prevent**
   Share what you learned with upstream teams.

Root causes feed back to registration, authorization and coding

Clinical appeals

Medical necessity and level-of-care disputes, argued with clinical evidence from the record.

Financial appeals

Coverage, authorization, timely-filing and coding disputes, argued with payer policy.

SECTION 4 · BACK-END

The Anatomy of a Denial

Soft denial

Temporary and often fixable

EXAMPLES

- Missing or incorrect information
- Documentation not yet received
- Coding or edit error

Action: Fix, resubmit or send documents

Hard denial

Final unless overturned

EXAMPLES

- Non-covered service
- Timely-filing limit passed
- Authorization not obtained

Action: Formal appeal, or write off

Work soft denials fast. They become hard denials when the clock runs out.

SECTION 4 · BACK-END

Accounts Receivable Follow-Up

0–30 days

Monitor

Claim is in normal adjudication. Confirm the payer received it.

31–60 days

Check status

Call, use the portal or a bot to confirm the claim is on file and moving.

61–90 days

Escalate

Find the barrier: denial, missing records or payer error. Appeal or correct.

90+ days

High risk

Management review. Weigh appeal effort against write-off risk.

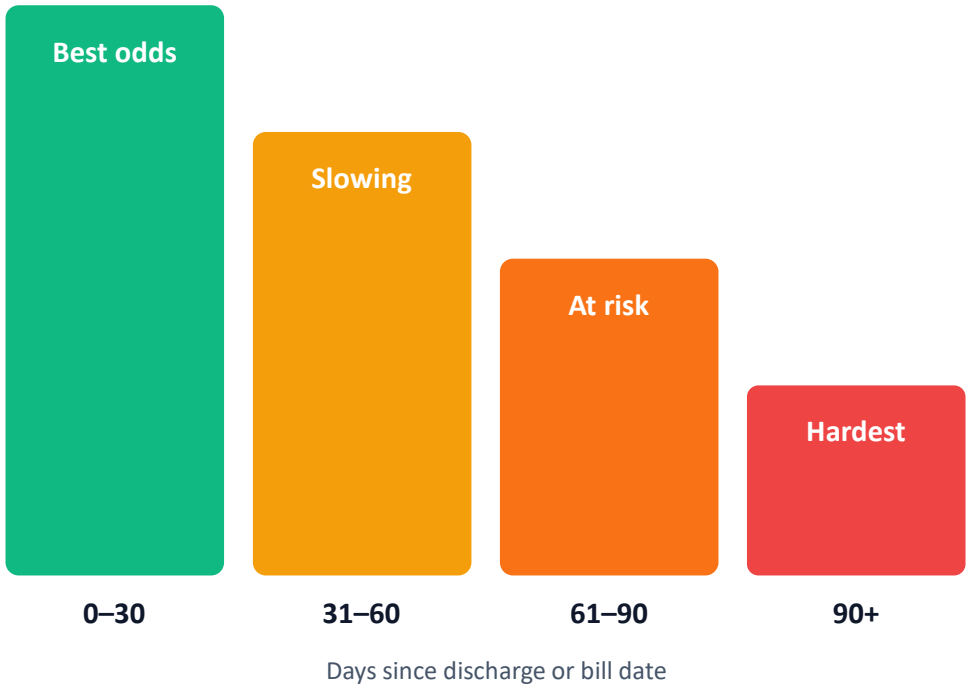
How teams prioritize the work

- **Highest dollars and oldest accounts first**
- **Segment by payer and denial reason**
- **Measure touches per claim and productivity**

SECTION 4 · BACK-END

The Aging Report: Time Is the Enemy

Collectability falls as claims age



HOW TO READ THE REPORT

- Buckets show how many dollars sit at each age.
- Slice by payer, facility and financial class to find the pattern.
- Watch the share of billed A/R over 90 days. HFMA tracks it as a MAP Key.
- Old balances rarely age because of one cause. Look upstream.

SECTION 4 · BACK-END

Patient Collections

1. **Statement** — Clear bill after insurance pays.
2. **Reminder** — Text, email or call before it ages.
3. **Payment plan** — Offer plans and financial aid.
4. **Final notice** — Last step before an agency.

Why it matters more every year: higher deductibles shift more of the bill to patients.

Patient-friendly billing

- Plain-language, itemized statements
- Multiple ways to pay: online, phone, text
- Offer assistance before collections

Track separately

- Self-pay A/R and its aging
- Bad debt and charity care
- Patient billing satisfaction

SECTION 4 · BACK-END

Roles & Personas

Billing Specialists

Navigating clearinghouse portals and payer-specific submission rules.

- Work scrubber and portal edits
- Submit and track claims
- Correct and resubmit rejections

Key skill: **accuracy**

Denials Management Analysts

Writing clinical and financial appeals to overturn payer rejections.

- Categorize denials by root cause
- Draft and submit appeals
- Report trends upstream

Key skill: **investigation**

Patient Financial Services Reps

Handling patient billing inquiries.

- Explain statements and balances
- Set up plans and refer for aid
- Resolve disputes with empathy

Key skill: **de-escalation**

SECTION 5 · THE TECH STACK

The Revenue Cycle Tech Stack

FRONT-END **Patient Access**	Digital check-in kiosks	OCR for insurance cards	Automated eligibility APIs
MID-CYCLE **Clinical & Charge Integrity**	Computer-assisted coding (CAC)	Natural language processing for CDI	
BACK-END **The Business Office**	RPA for claim status checks	Predictive AI for denial prevention	

Technology removes repetitive work. People handle exceptions, judgment and relationships.

SECTION 5 · THE TECH STACK

Front-End Technology

Digital check-in kiosks

Patients self-check-in, update demographics, scan ID and pay copays.

Lifts: **POS collections, data quality**

OCR for insurance cards

Reads cards and IDs into structured fields and removes manual keying errors.

Lifts: **clean registration data**

Eligibility APIs

Automated real-time checks against payers at scheduling and check-in.

Lifts: **fewer eligibility denials**

WATCH-OUTS

Keep assisted check-in for patients who need it

Verify OCR output before it reaches the claim

SECTION 5 · THE TECH STACK

Mid-Cycle Technology

Computer-assisted coding (CAC)

Software reads clinical documentation and suggests codes. Coders review and validate.

Lifts: **coder productivity, DNFB days**

NLP for CDI

Natural language processing scans notes at scale and flags gaps for CDI specialists.

Lifts: **documentation specificity, query speed**

WATCH-OUTS

- Suggested codes are a starting point, not a final answer
- Garbage-in, garbage-out: documentation quality still rules
- Audit outputs for upcoding drift

SECTION 5 · THE TECH STACK

Back-End Technology

Robotic process automation (RPA)

Bots check claim status, post payments and work repetitive payer-portal tasks.

Lifts: **cost to collect, A/R touches**

Predictive AI for denial prevention

Models score claims before submission and route likely denials for a fix first.

Lifts: **clean claim rate, denial rate**

WATCH-OUTS

- Fix broken processes before automating them
- Keep humans on exceptions and appeals
- Monitor models as payer rules change

SECTION 6 · MEASURING SUCCESS

Measuring Success: HFMA MAP Keys

Standard definitions turn opinions into numbers you can compare.

FRONT-END

POS Cash Collections

Are we collecting what patients owe at the time of service?

MID-CYCLE

Discharged Not Final Billed

How long do finished stays wait to be billed?

BACK-END

Net Days in A/R

How fast does billed revenue turn into cash?

WHOLE CYCLE

Clean Claim Rate

How many claims pass the first time?

EFFICIENCY

Cost to Collect

What does it cost to collect each dollar?

Front-end and mid-cycle accuracy drive clean claims. Back-end speed drives days in A/R.

SECTION 6 · KPI · FRONT-END

POS Cash Collections

THE FORMULA

$$\frac{\text{Patient point-of-service payments}}{\text{Total self-pay cash collected}}$$

= share of patient cash captured at or before the visit

BENCHMARKING

Trend vs. peers

No single universal target. Use HFMA MAP peer data.

What it tells you

- Counts pre-service, time-of-service and, for current encounters, payments up to seven days after discharge
- A leading indicator of bad debt and statement volume
- Reflects estimate accuracy and front-desk skill

How to move it

- Give accurate estimates before arrival
- Script, train and give daily feedback
- Offer kiosk, text-to-pay and portal options

SECTION 6 · KPI · MID-CYCLE

Discharged Not Final Billed

THE FORMULA

$$\frac{\text{Gross dollars in DNFB}}{\text{Average daily gross patient service revenue}}$$

= days of revenue waiting to be billed

COMMONLY CITED RANGE

About 3–5 days

Sources vary by case mix and organization.

What it tells you

- Shows the coding and billing backlog between discharge and final bill
- Causes include missing documentation, uncoded charts, charge errors and billing edits
- Many hospitals review it daily

How to move it

- Run concurrent CDI and coding
- Reconcile charges every day
- Work holds by reason, not by account number

SECTION 6 · KPI · BACK-END

Net Days in A/R

THE FORMULA

$$\frac{\text{Net patient accounts receivable}}{\text{Average daily net patient service revenue}}$$

= days of revenue sitting in receivables

COMMONLY CITED TARGET

About 35–40 days

Hospital payer mix and complexity push results higher or lower.

What it tells you

- How quickly billed revenue becomes cash
- Blends front-end, mid-cycle and back-end performance
- HFMA uses a three-month average for daily revenue

How to move it

- Cut DNFB days and charge lag
- Prevent and rework denials quickly
- Work aged accounts by dollars and age

SECTION 6 · KPI · WHOLE CYCLE

Clean Claim Rate

THE FORMULA

$$\frac{\text{Claims accepted first time with no edits or rework}}{\text{Total claims submitted}}$$

= percent of claims that pass on the first attempt

COMMONLY CITED TARGET

95% or higher

Widely used industry target, not an HFMA mandate.

What it tells you

- The ultimate check on front-end and mid-cycle accuracy
- Every unclean claim adds rework and delays cash
- Segment by payer and error type to find root causes

How to move it

- Verify eligibility and authorization before service
- Improve documentation, coding and charge accuracy
- Tune scrubber edits to each payer's rules

SECTION 6 · KPI · EFFICIENCY

Cost to Collect

THE FORMULA

$$\frac{\text{Total revenue cycle cost}}{\text{Total patient service cash collected}}$$

= what it costs to collect each dollar

BENCHMARKING

Trend vs. peers

Use one consistent cost definition when comparing.

What it tells you

- Measures the efficiency of the whole RCM operation
- Counts staff, vendor, outsourcing and software-subscription costs
- HFMA treats it as a trending indicator of productivity

How to move it

- Automate repetitive work
- Reduce rework and touches per claim
- Right-size staffing and vendor mix

SECTION 7 · WRAP-UP

RCM Is a Team Sport



Shared KPIs

Give every department a stake in the same numbers, like clean claim rate and net days in A/R.

Denial huddles

Bring registration, coding and billing together to trace root causes.

Feedback loops

Send corrections back to the person who made the error, with context.

SECTION 7 · WRAP-UP

The Future of RCM

	Fee-for-service	→	Value-based care
Revenue driver	Volume of services delivered		**Outcomes, quality and total cost of care**
RCM focus	Charge capture and clean claims		**Risk adjustment, quality capture and care coordination**
Key metrics	Clean claim rate, days in A/R		**Quality scores, cost per member, shared savings**
Financial risk	Mostly carried by the payer		**Increasingly shared with the provider**

Most organizations run both models at once. The discipline carries over; the scorecard changes.

SECTION 7 · WRAP-UP

Takeaways for Emerging Leaders



Know the cycle

NEXT STEP

- Spend an hour with a registrar, a coder and a denials analyst
- Map where one claim can go wrong



Measure what matters

NEXT STEP

- Pick two MAP Keys and find their owners
- Trend them monthly and compare to peers



Break the silos

NEXT STEP

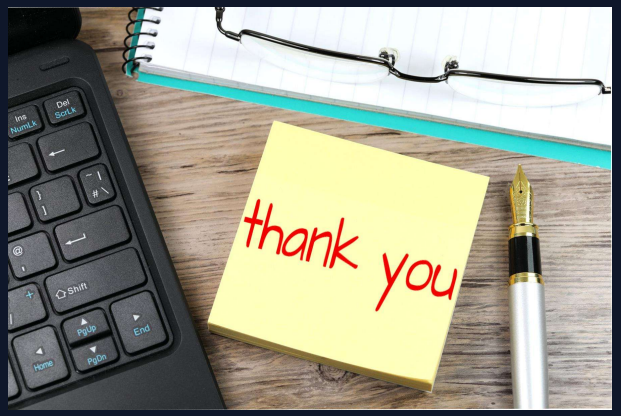
- Ask where your denials originate
- Start a monthly cross-department huddle

FINAL Q&A

Questions?

The floor is yours, emerging leaders.

Follow up questions may be sent to kdownes2@bilh.org



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UP NEXT!



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HFMA Certification Programs

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Mike Tracy
Administrative Director
Emerson Health

Agenda

- HFMA Overview
- Where Are You in Your Career?
- How Can You Be Nimble and Adapt?
- Certifications Deep Dive
- Advanced Certification Opportunities
- HFMA Micro-Credential Highlight
- Is This Applicable to Me?

HFMA Overview

WE ARE HFMA

We're the Healthcare Financial Management Association representing 140,000 + leaders in healthcare finance, clinical medicine, health plans, and business partners.

We bring together professionals across the healthcare continuum to collaborate and deliver value.

Our mission is to lead the financial management of health care.

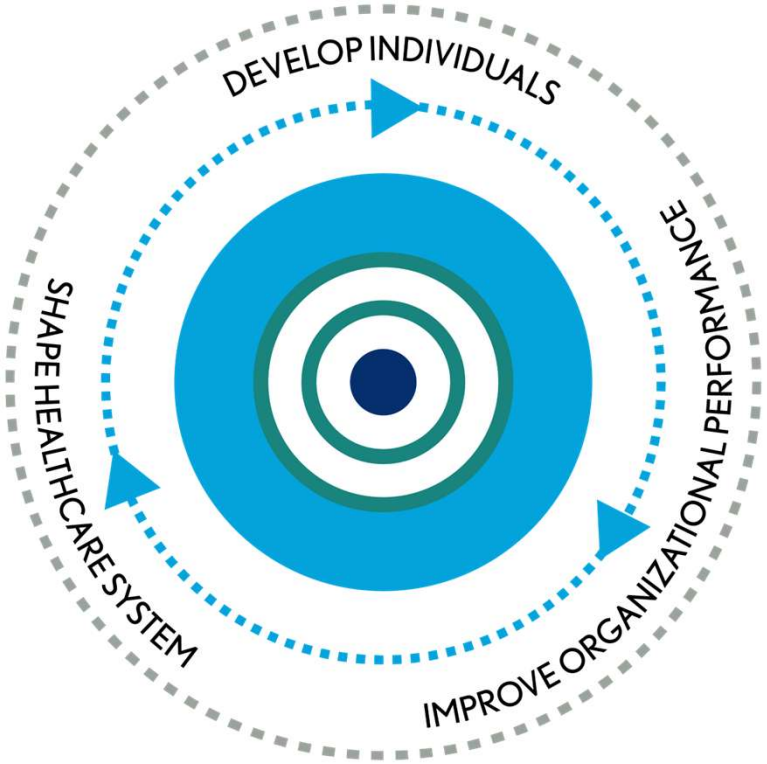


hfma | Enterprise Solutions

We Help Stakeholders Achieve Optimal Results

OUR MISSION

Leading the financial management of health care



OUR VISION

HFMA will bring value to the industry as the leading organization for healthcare finance

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Member Benefits

Members receive:

- *hfm* magazine
- Newsletters
- Podcasts
- Community
- Talent management + development tools
- Exclusive access to HFMA Education!









https://www.hfma.org/membership/summary-of-benefits/

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Member Benefits – Education

Members Receive Unlimited Access to:

- Webinars*
- Online Learning including:
  - Online Education Courses
  - HFMA Business of Health Care® Online Program**
  - Patient Financial Communications Program
  - Patient Access Essentials Program
  - Leadership Courses
  - And more



learn.hfma.org/catalog

**CPE eligible for LIVE webinars only.*
***CPE, CE, and CME eligible.*

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Where Are You in Your Career?

Audience Question
What Phase of Your Career Are You In?

a) **Exploring:** I'm figuring out what I like

b) **Building:** I know what interests me and I'm developing skills

c) **Advancing:** I'm ready for more responsibility

d) **Leading:** I'm developing others and creating impact

Normalizing Career Uncertainty

- Raise your hand if you have your entire healthcare career mapped out
- Now keep your hand up if you're 100% confident that plan won't change

Key message: Career paths change, sometimes outside of our control. How can we adapt?

How Can You Be Nimble and Adapt?

Audience Question
Do You Have an HFMA Certification?

a) Yes

b) Not yet

c) I am in the process of achieving a certification

HFMA Certification Programs

Why get HFMA certified?

Establishing and maintaining a clear competitive edge is a prerequisite for today's changing economy – for individuals and organizational leaders. You can gain and demonstrate your edge by enhancing your knowledge and proving proficiency with HFMA's certification programs. Explore and choose your area of focus from the wide-range of certification options available to you.

HFMA Certification Programs

- **Value for individuals:** Increase your earning potential and stand out among your peers. The job market is highly competitive. Maintain the skills, confidence, and proficiencies you need to give yourself an edge in healthcare finance.
- **Value for organizational leaders:** Build a culture of learning and position your organization for success. Increasing your team's knowledge of industry terminology helps them meet the demands of department leadership and provides the tools they need to exceed the expectations of your clients, patients, and partners.

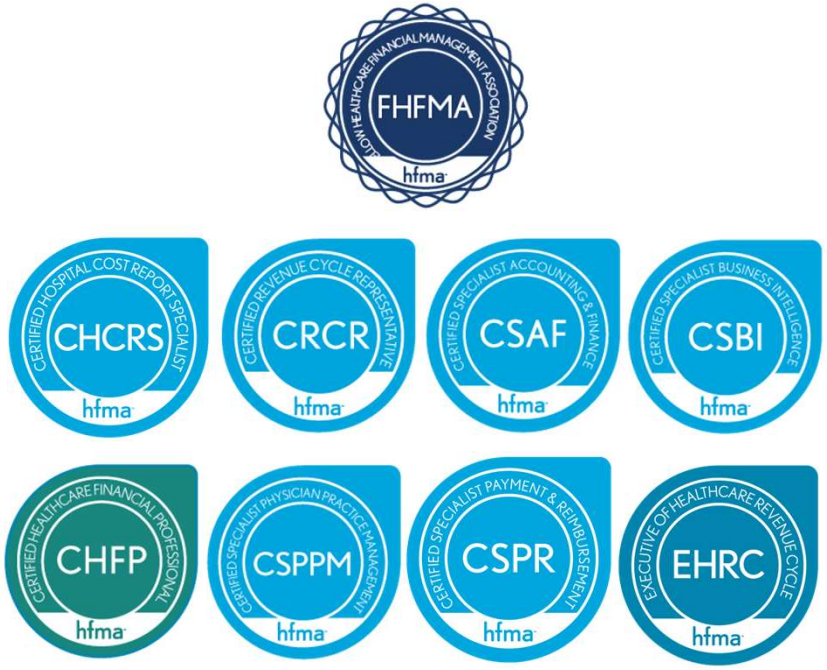
HFMA Certification Paths

Path	Examples	Best Fit
Finance	CHFP, CSAF	Healthcare finance, accounting, strategy, risk
Revenue Cycle	CRCR, EHRC	Patient financial journey, billing, access, collections
Data	CSBI	Analytics, business intelligence, data-informed decisions
Practice Management	CSPPM, CSAPM	Physician practice and ambulatory operations
Reimbursement	CSPR	Payment systems, managed care, reimbursement
Cost Reporting	CHCRS	Hospital cost reporting
Advanced	FHFMA, EHRC	Professional expertise, leadership, and service

Member Benefits – Education

Members Receive Unlimited Access to:

- Certifications:
  - Certified Revenue Cycle Representative (CRCR)
  - Certified Healthcare Financial Professional (CHFP)
  - Certified Hospital Cost Report Specialist (CHCRS)
  - Certified Specialist Business Intelligence (CSBI)
  - Certified Specialist Physician Practice Management (CSPPM)
  - Certified Specialist Ambulatory Practice Management (CSAPM)
  - Certified Specialist Payment & Reimbursement (CSPR)
  - Certified Specialist Accounting & Finance (CSAF)
  - Executive of Healthcare Revenue Cycle (EHRC)
  - Fellow Healthcare Financial Management Association (FHFMA)



hfma.org/certification

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HFMA Digital Credentials

All HFMA Certification programs offer a digital badge.

Digital badges:

- Increase an earner's credibility - An HFMA credential validates that you have the education needed to succeed in your field
- Position a person for advancement - Show your manager you are committed to staying up to date in your profession
- Differentiate an earner in the job market - Maintain the proficiencies leaders in the field are seeking to meet their organizational goals



Certifications Deep Dive

Certified Specialist Accounting and Finance (CSAF)

What the certification helps candidates do:

- Compare various types of budgets
- Identify types of cost behaviors
- Recognize the types of risk-sharing arrangements in managed care contracts
- Identify capital investment evaluation techniques

Certified Specialist Business Intelligence (CSBI)

What the Certification helps candidates do:

- Identify the concepts and tools of business intelligence
- Recognize how information for better decisions is derived from large clinical, financial, and other databases
- Recognize the decision types and analytic tools that are part of decision management
- Identify how data warehousing, reporting and analysis tools, and data systems architecture are used
- Apply the basics of analytical and quantitative skills of BI in healthcare



Certified Specialist Payment and Reimbursement (CSPR)

What the certification helps Candidates do:

- Identify key factors that influenced the development of managed care
- Explain coordination of benefits, managed Medicare organizations, and TRICARE
  Describe the role of Medicare and Medicaid Managed Care
- Identify the clinical integration components of case management
  Describe basic hospital service reimbursement methodologies and cost control incentives
- Describe the impact of the ACA on reimbursement, and list emerging payment trends under healthcare reform
- List key case and utilization (care) management and clinical integration components
- Identify major trends in healthcare policy, including consumerism, outcomes-based reimbursement, and other elements of reform

Certified Specialist Physician Practice Management (CSPPM)

What the certification helps candidates do:

- Implement the key elements of patient registration, accounts receivable and collection processing
- Identify the key contributory elements of evaluation and management services
- Define ratios valuable in monitoring financial performance of a practice
- Identify processes related to physician compensation, compliance and contract evaluation
- Identify elements of strategic planning, information technology and the role of marketing

Certified Specialist Ambulatory Practice Management (CSAPM)

What the certification helps candidates do (specific to Ambulatory Practices):

- Implement the key elements of patient registration, accounts receivable and collection processing
- Identify the key contributory elements of evaluation and management services
- Define ratios valuable in monitoring financial performance of a practice
- Identify processes for evaluating a contract, legal and regulatory compliance
- Identify elements of strategic planning, information technology and the role of marketing

Certified Hospital Cost Report Specialist (CHCRS)

Overview:

- A specialty certification recommended for: CFOs, controllers, reimbursement managers, directors and staff, accounting and finance staff, cost and budget staff, and consultants
- The CHCRS certification designation demonstrates an in-depth
- understanding of key components of hospital cost reporting
- Digital Badge and CPE awarded



Certified Hospital Cost Report Specialist (CHCRS)

Earning the CHCRS:

- Step 1: Enroll/complete required Cost Report Prerequisite Courses
  - Medicare Inpatient Prospective Payment System Fundamentals
  - Medicare Outpatient Prospective Payment System Fundamentals

- Step 2: Enroll in the online HFMA Cost Report certification program OR complete FORVIS led cost report training – Fees apply
- Step 3: Successfully pass the certification program assessment

HFMA's Certified Revenue Cycle Representative Program

- Here's where to gain the insight and knowledge to succeed in today's contemporary revenue cycle environment
- HFMA's CRCR is the only content available today that provides a national-level certification for addressing the contemporary patient-centric revenue cycle
- With HFMA's CRCR certification, you will be better prepared to increase receivables, reduce denials, and work more efficiently – all while earning your organization high patient satisfaction scores

HFMA's Certified Revenue Cycle Representative Program

- After this program, you'll be able to:
  - Enhance the patient experience
  - Reduce denials and simplify collections
  - Improve financial performance
  - Comply with new regulations
  - Increase interdepartmental cooperation
  - Heighten staff confidence and work satisfaction
  - Measure revenue cycle staff proficiency
  - Recognize staff knowledge and expertise
  - Decrease turnover

CRCR Program Format

Modular

- The CRCR is an online, self-directed, interactive program made up of short, searchable courses with knowledge checkpoints.
- Each course takes 15-20 minutes to complete

Interactive

- Enrollees can validate what they learn through periodic course interactions. There is one final, comprehensive assessment for the entire program

Stop-and-Start Convenience

- Courses can be completed independently from each other. Current progress is bookmarked when logging out of the program.

Certified Revenue Cycle Representative (CRCR) and Specialty Certification Programs

HFMA CRCR and those holding specialty certifications must maintain their certification every two years. The recertification process is straightforward:

- To re-certify as a CRCR or a specialty holder, you must take a 50-question online exam. To help you prepare for the exam, you will have access to an updated eLearning course.
- With all-access membership there is no cost for the study materials and exams.
- The maintenance fee for non-members is $100 per certification. No fee for HFMA members.

CHFP Overview

- Course material provides powerful guidance about the Business of Health Care
- Great Content Overall
- Module II Use of case studies to validate the content learned in Module II
- Very well organized and informative
- Digital Credential
- CHFP is Required for Fellowship
- CHFP Membership Requirement

CHFP Program Modules

The Business of Health Care	Operational Excellence: Pursuing Strategy
1. The Big Picture 2. Accounting Principles 3. Cost Accounting Principles 4. Managing Financial Resources 5. Strategic Financial Planning 6. Looking to the Future: Trends	Working with the Stakeholders: • Payers • Physicians and others • Providers • Patients

All CHFP materials are available through HFMA's website and accessed via the member eLearning account

Earning the CHFP

- **Step 1:**

  Enroll in CHFP Module I - HFMA Business of Health Care

  - ✓ 75 multiple choices questions to be completed in 90 minutes. Successfully complete the end-of-course assessment prior to taking ‘Step 2' below.
- **Step 2:**

  Enroll in Module II - Operational Excellence assessment

  - ✓ 8 case studies, each with 7 multiple choice questions. Total of 56 questions to be completed in 3 hours

Advanced Certifications Opportunities

Fellow of HFMA

- Earning the HFMA Fellowship attests to one's financial expertise and leadership.
- As recognized industry leaders, HFMA Fellows act as ambassadors to the profession by raising the standard of practice through consistent participation in professional development activities and service to the healthcare finance industry.
- HFMA Fellows recognize and accept the responsibility of utilizing healthcare finance professional skills for community benefit.



Fellow of HFMA

- Hold the Certified Healthcare Financial Professional (CHFP) designation
- Minimum five (5) years professional membership in HFMA (student membership does not count toward this total)
- Evidence of bachelor's or master’s degree
- Letter of recommendation from an FHFMA (active HFMA Fellow) or chapter leader
- Volunteer activity — demonstrate one of the listed contributions to HFMA or the industry within the three years prior to applying

Executive of Healthcare Revenue Cycle (EHRC)

Overview:

- An executive level designation for revenue cycle professionals in the industry and HFMA
- The EHRC certification designation demonstrates revenue cycle excellence
- Digital Badge awarded
- Link: www.hfma.org/ehrc

EHRC Application Requirements:

- Hold the CRCR designation
- HFMA Membership (minimum 5 years)
- Letter of Recommendation
- Professional Activity (select one of several options)

HFMA Micro-Credential Highlight

HFMA AI Governance Micro-Credential

Why Choose This Micro-Credential?

- Specialized Expertise: Dive deep into AI applications within healthcare finance, learning how to enhance operational efficiency and decision-making while managing associated risks.
- Regulatory Readiness: Align your knowledge with key regulations like ONC HTI1 (b)(11), DOJ's updated corporate compliance standards, and emerging state AI laws, ensuring you're prepared for current and future compliance demands.
- Practical Skills: Engage with interactive courses featuring case studies and exercises that you can apply immediately in your role.
- Career Advancement: Earn a micro-credential and digital badge upon completion to showcase your expertise

HFMA AI Governance Micro-Credential

Program Topics

- Introduction to AI in Healthcare
- AI Governance Committee Operations
- Enterprise AI Risk Mitigation
- Incident Response for AI Applications
- Conflict of Interest Standards
- Whistleblower Protection for AI Compliance
- AI Governance Policies

Is This Applicable to Me?

Audience Question
Why is HFMA Certification an Accessible Option?

a) Certifications are fully online

b) Certifications are self-paced

c) Certification courses are modular

d) All of the above!

Where Am I in My Career?

Early Careerists

or New to the Field

- Many certifications can provide foundational knowledge
- Becoming certified demonstrates to employers baseline competency and eagerness to develop

Career Advancement

- CHFP (and FHFMA) programs combine experience with leadership level finance and revenue cycle knowledge

Next Steps



Think about your goals and what you need to reach them

Hint- HFMA can help!



Sign up for a Certification and join our Committee!

Questions?

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Break Time
10:35-11:00





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Caitlin Yergeau
Dir. Revenue Optimization, BILH
Moderator



Chris Kelly
Regional Director, Medix
Panelist



Rachel Correia, CRCR
VP Patient Financial Services, BILH
Panelist



Kristen Woods
Dir. Patient Access, MGB
Panelist

HFMA Emerging Leaders: Resume Review, Social Media & AI Integration

Resume Review | Interviewing | Social Media | AI | Career Growth

Agenda

- Introduction to Topic
- Panel Introductions
- Career Development Topics
- Audience Participation
  - Ask Questions! We will answer them throughout as time allows

Resume Building & Reviews



What makes a good resume?

Interview Process




REMOTE WORKING



When to go? How Often to go?

Social Media

Business Professional



Artificial Intelligence (AI)

1. Canva
2. Claude
3. Chat CPT
4. Co-Pilot
5. Resume.io
6. Jobscan
7. Enhancy
8. Novoresume





Caitlin Yergeau
Dir. Revenue Optimization, BILH
Moderator



Chris Kelly
Regional Director, Medix
Panelist



Rachel Correia, CRCR
VP Patient Financial Services, BILH
Panelist



Kristen Woods
Dir. Patient Access, MGB
Panelist

LIGHTNING ROUND

Thank you

Questions?

Now presenting….. Your Lunch!

Station #1 Tex Mex
Chicken Tinga & Carne Asada, Veggies, Rice, & all the fixings!

Dessert: Churros

Station #2 Southern Buffett
Buttermilk fried chicken thigh, southern spoonbread, Thyme/Kale/Sweet Potato Salad, Tomato Salad

Dessert: Whipped Yogurt Honey Mouse with Berries

Boxes
Chicken Ceasar Salad

Drinks
Orange Infused Water and Tractor Sweet Tea





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Dashboards to Decisions



Chris Hutchins

HFMA MA-RI Emerging Healthcare Leaders Summit

October 23, 2026

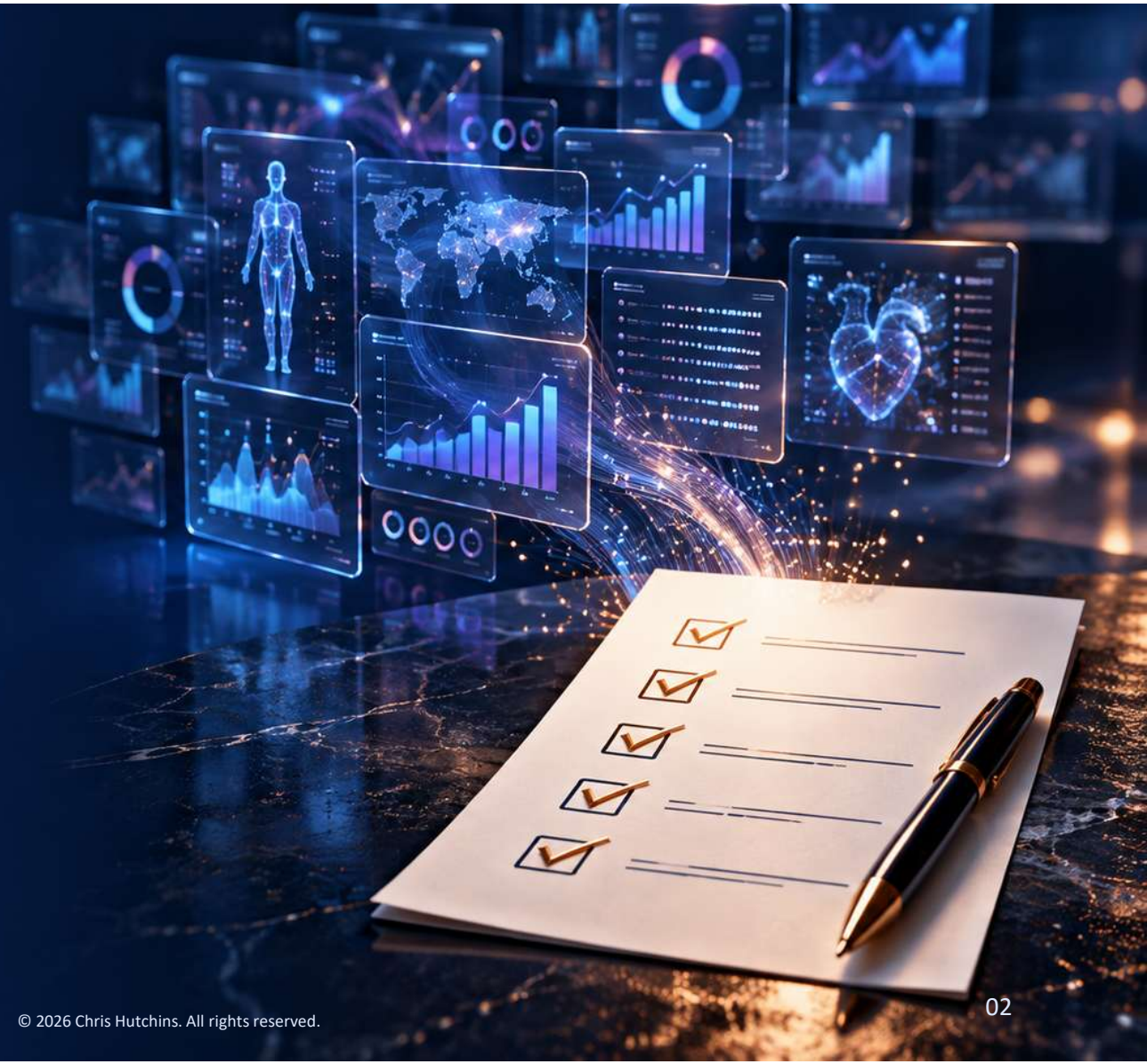
Chris Hutchins

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Hutchins Data Strategy
HUMANIZING AI FOR CARE

Dashboard envy

Sometimes a list is enough.



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Does this change any decision you can make?

The test for every dashboard

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What makes a bed available?

Built. Staffed. Ready.



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21 hospitals
A shared definition

A glossary. Named owners.



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The number can hide the question



Revenue



Staffing



Access

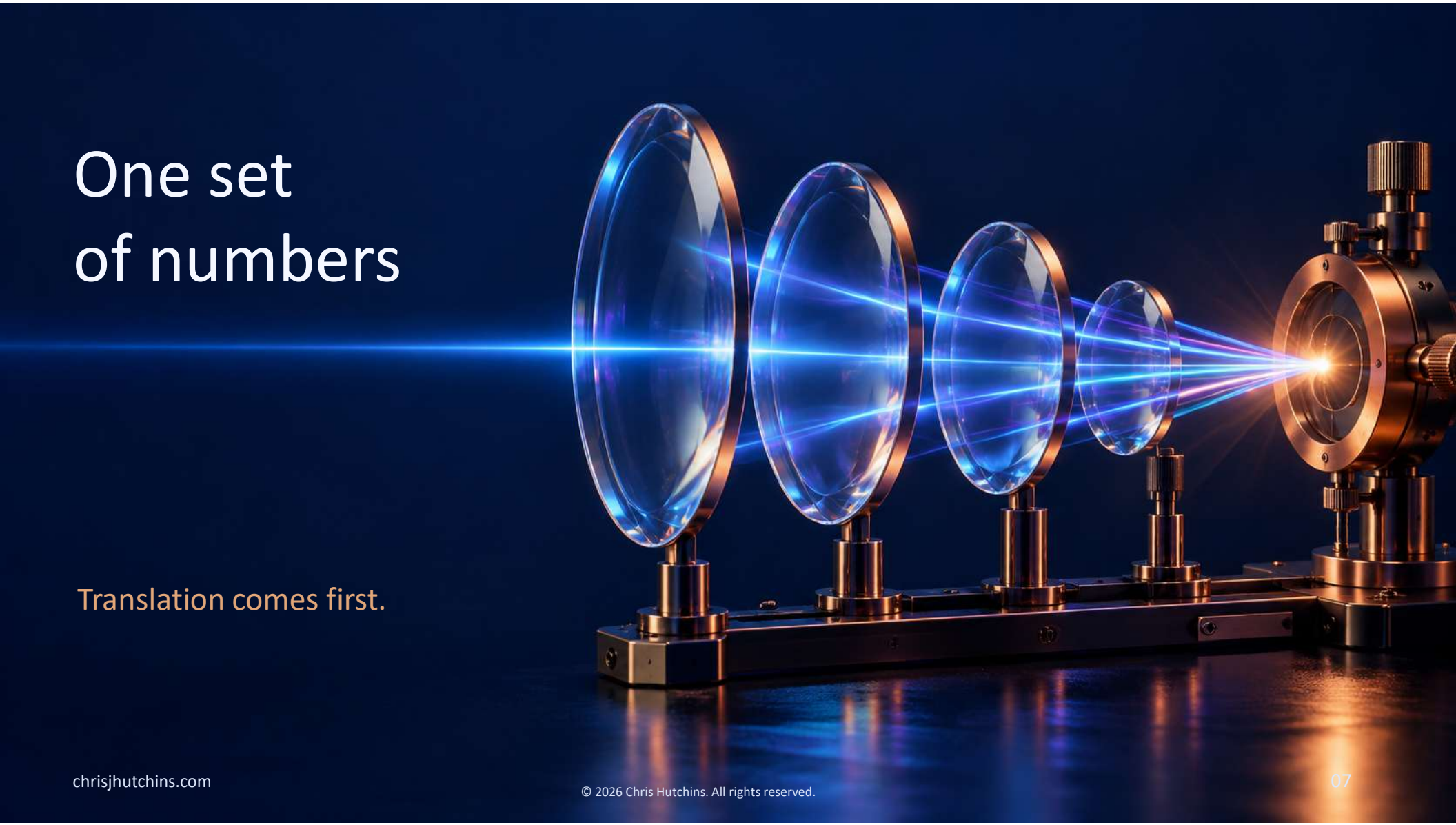


Quality

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One set of numbers

Translation comes first.



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A common number needs a purpose



Finance. Revenue cycle.

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20+ directors
One system

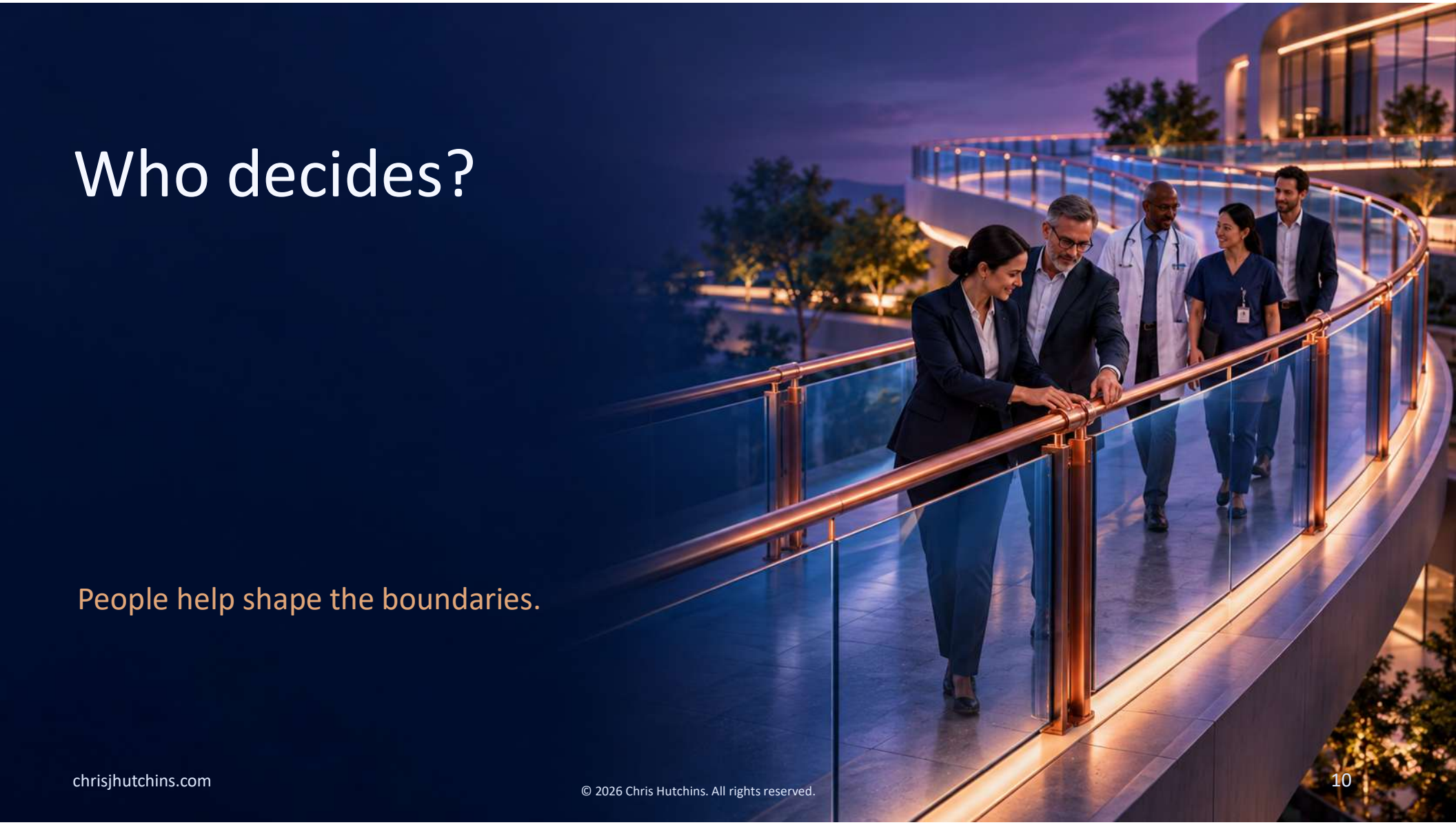


Local expertise. Shared decisions.

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Who decides?

People help shape the boundaries.



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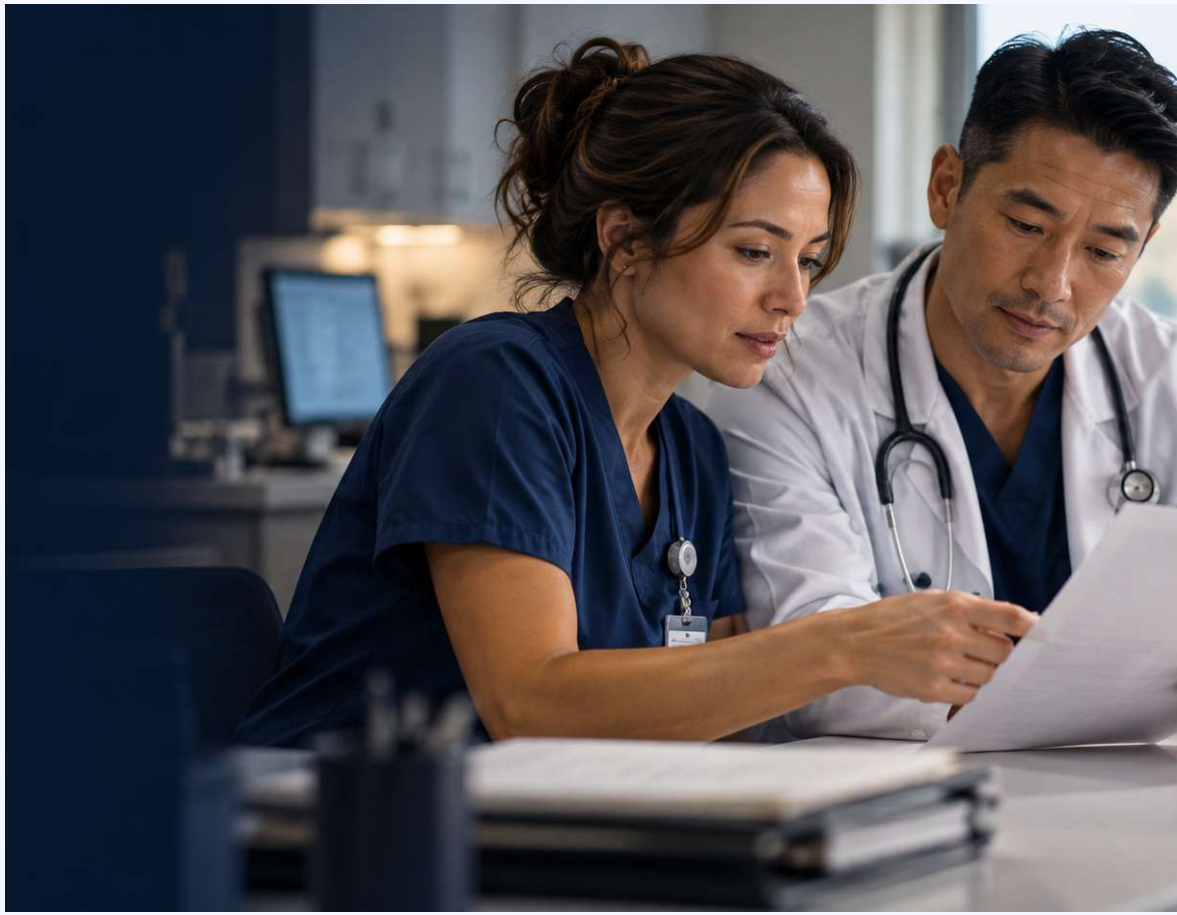
What are they afraid of losing?



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Supporting a leader

The decision
The draft
The limits



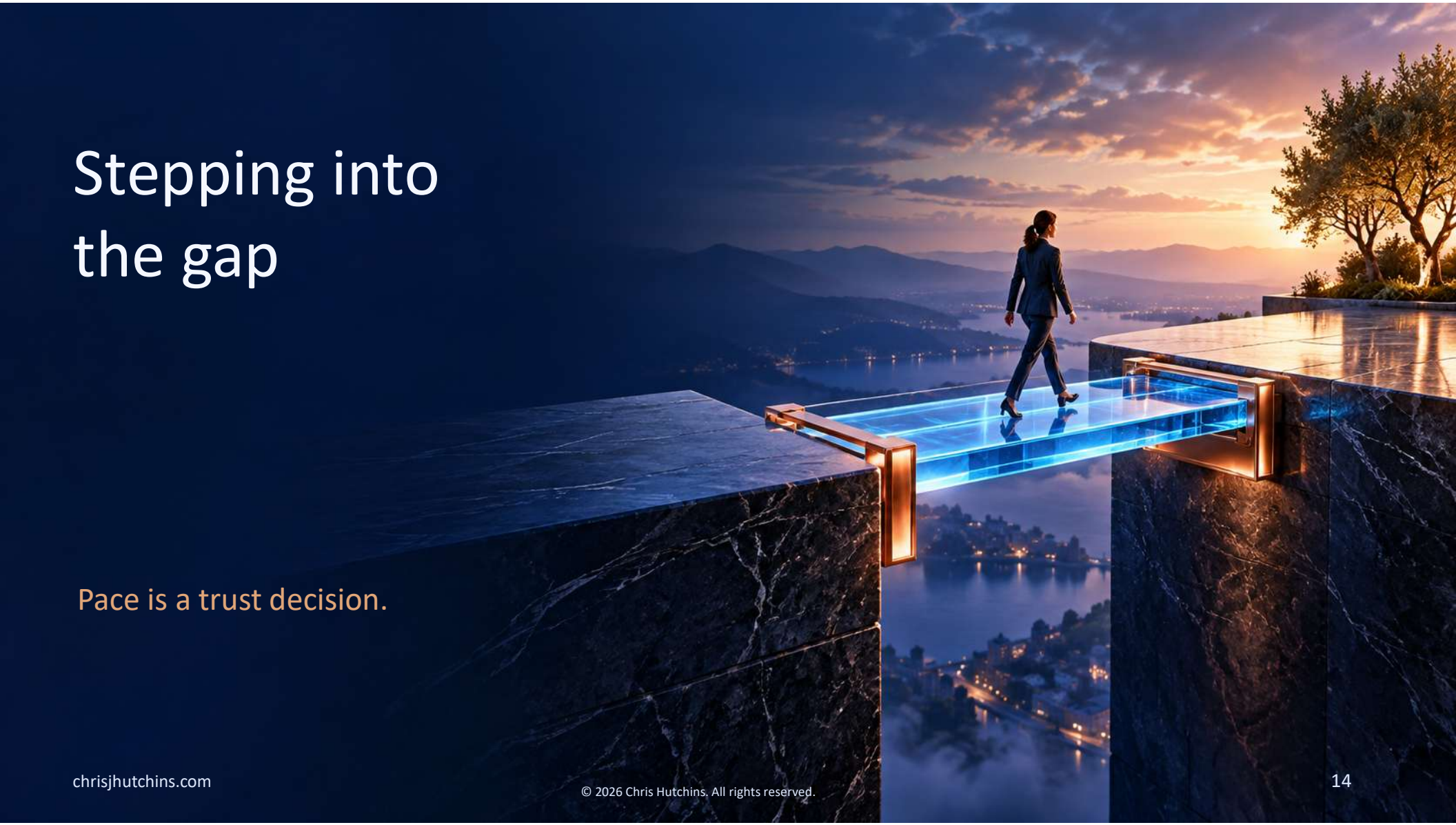
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“Don’t let us discover it. You tell us.”

Bring problems early. Follow through. Give credit by name.

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Stepping into the gap



Pace is a trust decision.

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“I need you to help the room understand itself.”

A senior executive’s charge

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The hard 1%

The conversations we avoid.



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Preparation for the hard conversations

Competition for a role

Say names out loud. Make contributions visible.

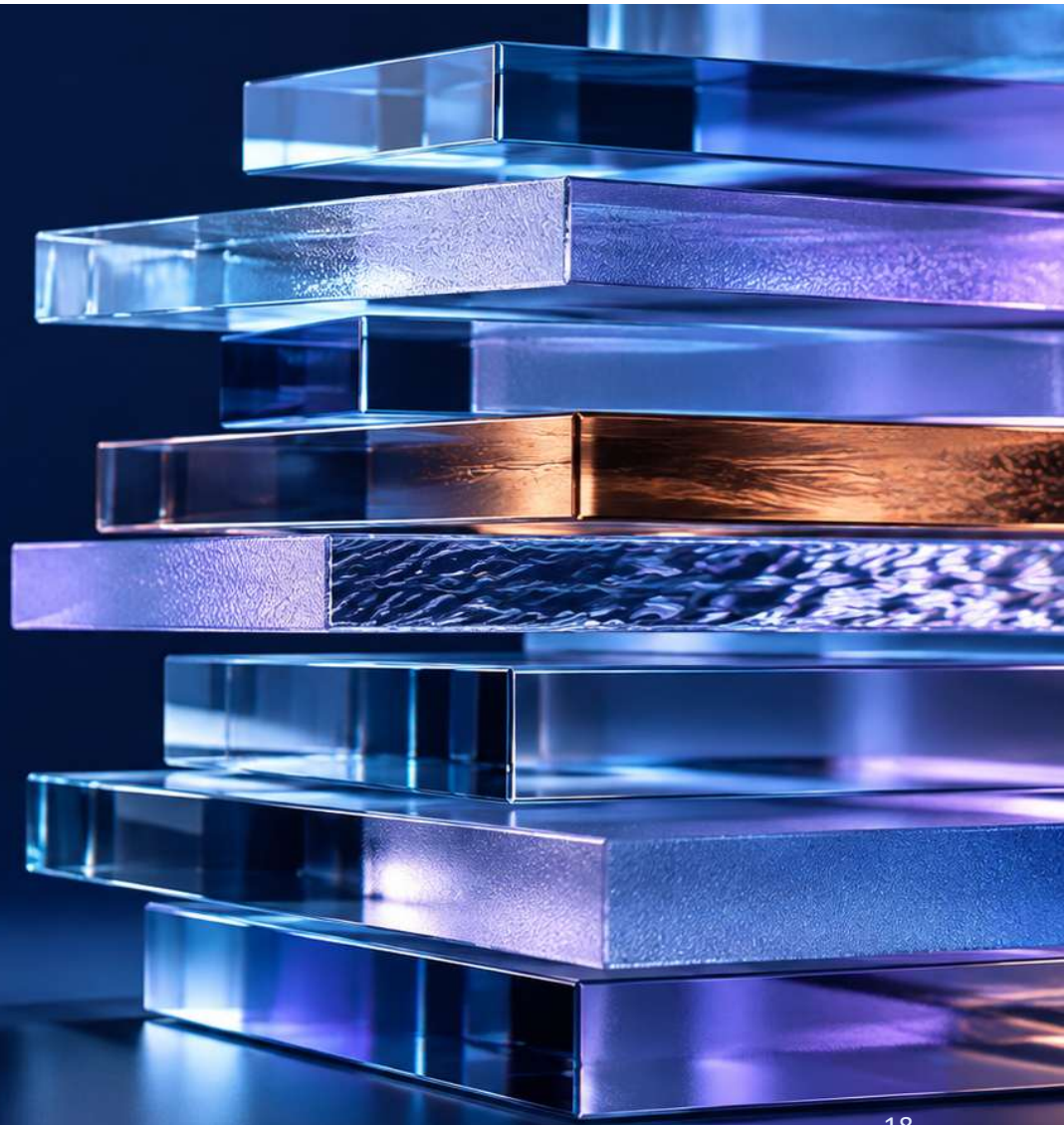
Training

Ask before you need it.

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AI and responsibility

A broader picture.
Human accountability.



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At the time, it looked like Tuesday



Titles change.
The experience stays.

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Monday



Trace one number.
Find its owner.
Write the definitions.

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Chris Hutchins

Hutchins Data Strategy
HUMANIZING AI FOR CARE

Questions

Which number does your team need to understand differently?

The Signal Room / Season 2

Healthcare AI and the decisions leaders own

Begins November 4 • signalroompodcast.com

chrisjhutchins.com

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Break Time
2:30-2:45





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Practice Manager
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Moderator



Brendan Hames
Practice Manager
Emerson Health



Diane Torres
Physician Billing Director
Boston Children's Hospital



Kelley McCue
Compliance and Privacy Officer
Lahey Clinic and BILH Medical Group

HFMA Emerging Leaders Career Spotlight

Career Navigation| Interdisciplinary Collaboration | Networking


Thank you!

hfma™

Lead. Solve. Grow.

admin@ma-ri-hfma.org

hfma.org