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OBJECTIVE

Our objective is to provide members with information regarding Chapter and national activities, with current and useful news of both national and local significance to healthcare financial professionals and as to serve as a forum for the exchange of ideas and information.

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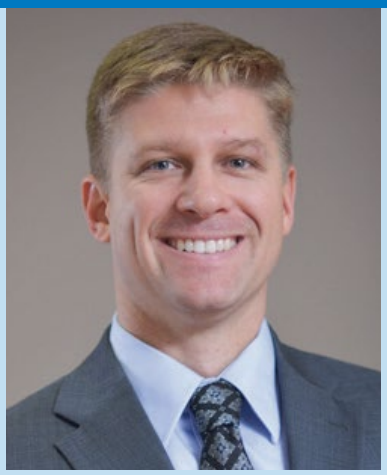
The President's View . . .



Jonathan Besler

It is remarkable to consider that Spring has arrived and, with it, my final column for Garden State Focus as Chapter President. I am grateful for having had the opportunity to lead the organization this past year and look forward to Lisa Schaaf, President-elect, building to even greater heights. Although this past year has passed quickly, I find myself reflecting on the many exceptional programs hosted by the NJ Chapter, as well as the privilege of working alongside such dedicated colleagues throughout our Chapter, Region, and the Association. It has been a truly rewarding experience to collaborate with so many individuals committed to advancing our shared mission. Our Officers and Board set goals this year, and we worked consistently to achieve them.

Looking ahead, there is much to anticipate. I am pleased to share that Lisa Schaaf, Amina Razanica, Lisa Weinstein, Christine Gordon, and Tara Bogart are already preparing for the upcoming Annual Institute, which will be held October 21–23 at The Borgata Hotel Casino and Spa in Atlantic City. …Borgata 2023, Hard Rock 2024, Hard Rock 2025, Borgata 2026, if you can't remember where we are this year, just remember that it promises to be another "can't miss" event.

This year, we set a goal to improve engagement across the Chapter. Whether it be an increase to registration at the Annual Institute (accomplished), more sponsorship opportunities at our golf outing (accomplished) or engaging membership in new ways (accomplished), your Officers and Board delivered this past year. We successfully launched and continued engaging the Chapter membership throughout the year by hosting the HFMA 101 session and Enterprise Membership education sessions. Thank you to Danny Demetrops and Peter Pollio for their consistency in those initiatives.

Several important events remain on this year's education and events calendar. Our Women's Leadership and Development Session will take place on April 22 at the DoubleTree by Hilton in Tinton Falls. Come engage with the Chapter and Ignite Your Potential!". On May 6, we will host our 3rd AI series to build upon your knowledge in this growing area. Finally, our Annual Golf Outing at Mercer Oaks Golf Course in West Windsor will be held on May 7th. We are pleased to continue the Golf Clinic, which provides an opportunity for participants of all skill levels to enhance their abilities. Those unable to participate in the outing itself are warmly invited to attend the cocktail reception and dinner. Thanks to Chris Czvornyek and Mia Morse's steady hands, this annual event has steadily increased participation and has a variety of sponsorship and participation options. Meet me there, in the woods, or at the 19th hole.

As I conclude my term, I wish to express my sincere appreciation to our Officers, Board Members, Committee Chairs and Co-Chairs, and, most importantly, to our members, for their continued support and engagement throughout the year. Serving as President of the NJ Chapter has been both an honor and a privilege. I would also like to extend my gratitude to our Chapter Administrator, Laura Hess, for her exceptional dedication and contributions. Without her, the Chapter year would not have been a success. And a personal thank you to Mike McKeever, the Chapter Godfather. Mike personally mentored me, even before I entered the Officer track and helped make my year and the Annual Institute a tremendous success. Thank you for your support, Mike.

Finally, I offer my best wishes to Lisa as she assumes leadership in the coming year. She has already assembled a great team of people to help support her goals and initiatives and I look forward to her efforts yielding positive results for the Chapter. The Chapter is ready for the future!

Best wishes,
Jonathan H. Besler
President

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From the Editor . . .

Jim Robertson

I've been thinking a lot lately about how different life can be depending on where you live, especially when comparing smaller states to very large ones. Living in a smaller geographic state like New Jersey offers some unique advantages that people often overlook. Even though it's not very big on the map, New Jersey manages to pack a lot of opportunity, convenience, and variety into a compact space.

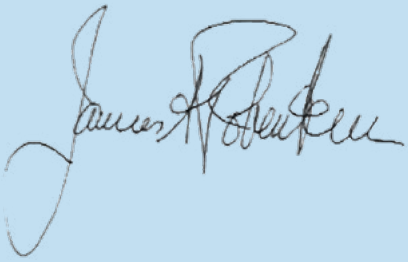
This is especially true as it relates to how geography impacts an organization. Take New York, for example. In three hours, you could drive only from Montauk, Long Island to the border of Queens without ever entering a New York City Borough. This same three-hour drive would take you from the northernmost tip of Idaho down the Idaho Panhandle, leaving 400-500 more driving miles to reach the Nevada border. How does anyone in other states get their members to come together physically? The bigger the geography, the harder it is to connect.

But not in New Jersey. In less than three hours (without traffic, of course), you can drive the entire length of our state from the Cliffs of the Palisades to the Cape May Lighthouse. This, no doubt, has a positive impact on the culture of our beloved New Jersey HFMA Chapter. We have a special bond. Being near each other allows us to connect and network with our colleagues and friends more freely and frequently. Whether it's the Joint Happy Hour with NJ ACHE in Morristown or the Women's Leadership & Development Event in Tinton Falls, no problem … I can get there! Or if you're interested in the Golf Outing at Mercer Oaks in Princeton or the Summer Networking Event at Watermark in Asbury Park, fuhgeddaboudit … Count me in! Let's face it – in New Jersey everything feels more connected.

So, as we enter the spring and summer months (I'm very excited about summer by the way), let's stay connected. There are many events that you can attend to network with your NJHFMA colleagues. Visit our website for the full list at: https://www.cvent.com/c/calendar/3eb78678-40ac-4618-99ec-8f76ef4aaa30

Oh, and enjoy this month's Edition of Garden State FOCUS!

Warm regards,



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From the Big Beautiful Bill to the Great Healthcare Plan: President Trump and Congressional Republicans Unveil Their Healthcare Proposal to Reform the American Healthcare System

Jim Robertson

Sukrti Thonse

By James A. Robertson and Sukrti Thonse

Since the enactment of the One Big Beautiful Bill Act (OBBBA) in mid-2025, the healthcare industry has been navigating a period of accelerated policy change affecting coverage, reimbursement, and care delivery. As implementation continues into 2026, early enrollment data and newly distributed federal funds are offering clearer insight into how the law is reshaping the healthcare landscape at both the national and state levels.

Against this backdrop, President Trump recently unveiled the Great Healthcare Plan, a new policy framework aimed at addressing rising premiums, declining coverage, and structural inefficiencies across the healthcare system. In addition, Congress recently passed the fiscal year 2026 appropriations bill (FY26 Bill) which was signed by President Trump on February 5, 2026. This FY26 Bill introduces significant operational and reimbursement implications for hospitals that will interact directly with both OBBBA implementation and future reform efforts. For hospitals and providers, these developments arrive at a moment of heightened financial and operational sensitivity, particularly as payer mix volatility and underinsurance concerns continue to grow.

This article builds on our earlier analysis of the One Big Beautiful Bill Act, "One Big Beautiful Bill Act: Key Healthcare Provisions & Effects,"[1] which examined the legislation's structure and early healthcare implications following its enactment.

I. Ongoing Implementation of the One Big Beautiful Bill Act

Passed in July 2025, the OBBBA represents the most significant federal healthcare legislation enacted through budget reconciliation this cycle. While many provisions phase in over time, the law's early effects are already being felt across Medicaid administration, marketplace coverage, and state-level healthcare financing.

The OBBBA introduced new work and community engagement requirements for certain Medicaid populations and imposed new limits on states' use of provider taxes to generate federal matching funds. CMS has now operationalized these statutory limits through its January 29, 2026 "Provider Tax Waiver" Final Rule, effective April 3, 2026. The rule narrows the circumstances under which states may rely on non-uniform or non-broad-based provider taxes to generate federal Medicaid matching funds and establishes phased compliance deadlines for existing arrangements. By restricting certain financing structures that previously qualified under waivers, the rule may require affected states to restructure Medicaid funding mechanisms or identify alternative revenue sources. The extent of the impact will vary by state, as jurisdictions already operating within broad-based and uniform tax parameters may see minimal disruption, while those relying on waiver-dependent financing structures are more likely to require substantive program or revenue adjustments. For hospitals, particularly Medicaid-heavy providers, this introduces additional fiscal uncertainty, as provider tax structures are often closely tied to supplemental payments and Medicaid Disproportionate Share Hospital (DSH) financing strategies.

CMS also issued February 2, 2026 guidance implementing Section 71116 governing Medicaid managed care State Directed Payments (SDPs). The guidance caps payment rates

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for certain hospital, nursing facility, and academic medical center services at a percentage of Medicare payment levels and requires states to revise payment arrangements that exceed those limits beginning with rating periods on or after July 4, 2025, subject to limited grandfathering through 2028. Because SDPs have become a major source of supplemental reimbursement for hospitals, particularly in Medicaid managed care environments, these new limits may materially reduce available supplemental funding and require states and providers to reevaluate financing structures.

At the same time, the FY26 Bill adjusts several Medicaid financing mechanisms that will materially affect hospitals. Most notably, the legislation reduces and delays previously scheduled DSH cuts, scaling a planned three-year, $24 billion reduction down to an $8 billion cut in fiscal year 2028. While this postponement provides short-term relief, the bill also revises the methodology for calculating hospital-specific DSH limits by requiring Medicare, Medicare Advantage, and other primary payments to be deducted when determining uncompensated care. This change may significantly impact hospitals serving large dual-eligible populations.

These Medicaid adjustments underscore the broader theme emerging under OBBBA implementation: while Congress has softened certain reductions, it has simultaneously tightened fiscal guardrails, reinforcing pressure on hospitals to manage uncompensated care and reimbursement exposure carefully.

II. Early Evidence of ACA Marketplace Enrollment Declines

In parallel with Medicaid changes, early federal data show a meaningful decline in Affordable Care Act (ACA) marketplace enrollment for the 2026 plan year, following the expiration of enhanced premium tax credits that had substantially lowered coverage costs in recent years.[2]

As of early January, approximately 22.8 million individuals had enrolled in ACA plans, compared with 24.2 million enrollees at the close of the prior year's enrollment period. This represents 1.4 million fewer enrollees overall, or a 5.8 percent drop in enrollment, and roughly 800,000 fewer enrollees when compared to the same point in last year's enrollment cycle. While enrollment remains open in certain states, these figures provide the first official indication of how subsidy expiration is affecting coverage.

Importantly, the FY26 Bill did not extend the enhanced ACA premium subsidies. As a result, many enrollees are now facing premium obligations projected to more than double relative to 2025 out-of-pocket costs, on average. Although a bipartisan group of senators continues to explore potential compromise legislation, no extension has been enacted to date.

A. State-Level Trends and Coverage Shifts

State-reported data, published by CMS as of January 28, 2026, illustrate uneven but concerning trends: [3]

- Large federally facilitated states such as Florida, North Carolina, and Ohio experienced significant year-over-year enrollment drops, reflecting affordability pressures following the expiration of enhanced premium tax credits.
- California, Colorado, Minnesota, New Mexico, Idaho, Virginia, and Pennsylvania recorded substantial enrollment totals in the 2026 Open Enrollment (OE) snapshot, but state-level public reporting on year-over-year shifts varies and hasn't uniformly confirmed earlier interim termination trends.
- New Jersey, operating its own state-based exchange, reported approximately 486,231 plan selections for 2026, reflecting continued robust engagement despite subsidy expiration and higher net premiums.
- These updated figures suggest broad downward pressure on coverage uptake across multiple markets rather than isolated spikes or flat enrollment in specific states.

From a provider perspective, these trends raise concerns not only about increases in the uninsured population, but also about growth in underinsured patients whose high deductibles and cost-sharing obligations may delay care and increase bad debt.

B. New Jersey Marketplace Context

These national trends are particularly relevant in New Jersey, which operates its own state-based exchange, GetCoveredNJ. In recent years, New Jersey experienced record marketplace enrollment, with more than 500,000 residents enrolled for 2025 coverage, driven in part by enhanced federal subsidies and state outreach efforts. However, since those enhanced federal subsidies expired entering the 2026 plan year, New Jersey residents are facing higher net premiums, raising affordability concerns that mirror national enrollment declines.

New Jersey has taken steps to mitigate these effects by extending its open enrollment period through January 31, 2026, providing residents additional time to evaluate coverage options. Nevertheless, insurers in the New Jersey marketplace implemented premium increases for 2026, and early indicators suggest that some enrollees are responding by downgrading to lower-tier plans or foregoing coverage altogether.4 Recent data from Get Covered NJ confirms a measurable migration toward lower-cost coverage options for 2026.[5] Among consumers who actively shopped for plans, Silver plan selections declined from approximately 83% in plan year 2025 to 69% in plan year 2026, while

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Bronze plan selections increased from 16% to 30% during the first nine weeks of Open Enrollment. At the same time, the share of consumers receiving financial assistance that reduced premiums to $10 per month or less dropped sharply from 48% in 2025 to just 10% in 2026, underscoring the affordability pressures driving enrollment shifts.

For New Jersey providers, these developments may translate into greater payer mix volatility, increased patient financial responsibility, and heightened pressure on revenue cycle operations.

III. CMS Distributes Rural Health Transformation Funding, Including $147.25 Million to New Jersey

One of the most consequential provisions of the OBBBA has already moved from authorization to implementation. Under the Rural Health Transformation (RHT) Program, CMS has distributed the first $10 billion in federal funding to states for fiscal year 2026, marking the first installment of a $50 billion, five-year initiative to strengthen rural healthcare delivery nationwide.

States received first-year awards averaging approximately $200 million, with allocations determined by a combination of base funding and weighting based on rural population, healthcare access needs, and proposed transformation strategies.

New Jersey received a fiscal year 2026 award of $147,250,806, reflecting the state's smaller rural footprint relative to more heavily rural states. Despite being at the lower end of the national funding range, this award represents a significant infusion of federal resources aimed at strengthening rural health capacity within the state.

Separately, the FY26 Bill maintains stand-alone funding for agencies such as the Health Resources and Services Administration (HRSA), bypassing a previously proposed restructuring that would have consolidated several HHS agencies. HHS is funded through September 30, 2026, at $116.8 billion. This is a decrease from the previous fiscal year but higher than earlier House proposals and the Administration's initial budget request. Continued HRSA funding is particularly relevant for rural providers and safety-net institutions reliant on federal grants.

The funds may be used for a broad range of initiatives, including:

- Workforce recruitment, training, and retention in underserved areas;
- Expansion of primary, preventive, and behavioral health services;
- Investments in telehealth and health information technology; and
- Regional collaborations and innovative care delivery models tailored to rural populations.

Importantly, RHT funds flow through state agencies rather than directly to providers, making provider engagement with state implementation plans critical. For rural hospitals and clinics in New Jersey, participation in state-led planning efforts will be essential to accessing sub-awards and shaping how funds are deployed.

IV. The Great Healthcare Plan and Emerging Federal Reform Themes

On January 15, 2026, President Trump unveiled the Great Healthcare Plan, outlining a policy framework intended to address rising healthcare costs, declining marketplace enrollment, and perceived inefficiencies in the current system. While the proposal has not yet been introduced as legislation, it signals the Administration's priorities and may influence future regulatory or congressional action.

Key elements of the proposal include:

- Prescription drug pricing reforms, including international benchmarking and expanded over-the-counter access;
- Redirecting certain federal subsidies directly to individuals to increase consumer choice and price sensitivity;
- Enhanced transparency and accountability requirements for insurers and healthcare entities; and
- Reforms targeting pharmacy benefit manager practices and insurer competition.

The FY26 Bill reflects early bipartisan momentum around cost containment and payment reform themes that parallel aspects of the Great Healthcare Plan. Notably, the legislation requires hospitals to obtain a unique National Provider Identifier (NPI) for each off-campus outpatient department (OPD) beginning January 1, 2028. Hospitals must also attest that each off-campus OPD meets Medicare's provider-based requirements. Noncompliance would render the OPD ineligible for Medicare payment.

This statutory change builds on Section 6225 of the Consolidated Appropriations Act, 2026, which significantly tightens Medicare reimbursement rules for off-campus hospital outpatient departments. Historically, hospitals were able to bill certain off-campus facilities as provider-based departments (PBDs) under the Outpatient Prospective Payment System (OPPS), resulting in higher reimbursement than freestanding physician offices. While prior site-neutral payment reforms applied primarily to "non-excepted" off-campus departments established after November 2, 2015, Section 6225 expands CMS oversight by strengthening documentation, attestation, and compliance requirements for all off-campus PBDs, including those previously grandfathered. The provision is designed to ensure that facilities billing under OPPS truly meet provider-based criteria related to clinical integration, financial control, and public awareness.

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The 340B Rebate Pilot: Revenue Cycle Implications of a Near-Miss Crisis

Fatimah Muhammad

By: Fatimah Muhammad, FHFMA, CSBI, CHFP, CSPR, CRCR

On December 29, 2025, the healthcare revenue cycle narrowly avoided what could have been a financial catastrophe for safety-net providers. U.S. District Judge Lance E. Walker temporarily blocked the Health Resources and Services Administration (HRSA) from implementing its controversial 340B Rebate Pilot Program, which was scheduled to take effect just days later, January 1, 2026. In a significant development on January 17, 2026, the federal government officially dismissed its appeal, voluntarily ending its effort to overturn the lower court order that temporarily blocked the rebate model. While this represents a meaningful victory for 340B covered entities, revenue cycle leaders must understand this reprieve may be temporary. The government indicated it is in discussions with hospital plaintiffs about returning the manufacturer approvals to HRSA for reconsideration. The potential return of this program, even in modified form, represents one of the most significant operational and financial challenges 340B entities could face in the program's 34-year history.

Understanding the Revenue Cycle Impact

For more than three decades, the 340B Drug Pricing Program has operated on a straightforward premise: eligible safety-net hospitals and health centers purchase discounted medications upfront, allowing them to stretch scarce resources and serve vulnerable patient populations. This model has provided predictability, immediate cash flow benefits, and minimal administrative burden. The proposed rebate pilot would have fundamentally upended this framework, with profound consequences for the revenue cycle.

Under the pilot program, covered entities would have been required to purchase ten specific medications. The first drugs selected for Medicare's drug price negotiation program under the Inflation Reduction Act, at Wholesale Acquisition Cost (WAC), are often hundreds of percentage points higher than 340B pricing. Entities would then need to submit claims data to manufacturers, wait for approval, and receive rebates within ten days. This seemingly simple administrative change masked a revenue cycle disaster in the making.

The $700 Million Working Capital Crisis

Analysis of real-world provider data revealed the magnitude of the financial burden: covered entities would have needed to advance approximately $700 million in upfront costs to manufacturers in year one alone, based on a representative sample. For comparison, many 340B hospitals operate on razor-thin margins, with days cash on hand often measured in weeks, not months. Small rural hospitals and federally qualified health centers are the backbone of the 340B program and would have faced impossible choices: delay purchasing life-saving medications, draw down already depleted cash reserves, or seek costly lines of credit to bridge the gap.

This working capital shock would have cascaded through revenue cycles already strained by rising bad debt, declining reimbursements, and workforce shortages. Unlike commercial enterprises that can absorb temporary cash flow disruptions, safety-net providers serve populations with limited ability to pay and depend on 340B margin to fund essential services like charity care, medication assistance programs, and specialty clinics that would otherwise be financially unviable.

The Rebate Denial Risk: A Revenue Cycle Nightmare

Perhaps more concerning than the upfront cost was the specter of rebate denials and delays. Revenue cycle leaders are painfully familiar with payor denial management, the endless appeals, documentation requests, and payment delays that plague medical billing. The rebate model threatened to import this dysfunction into pharmaceutical purchasing, except with a critical difference: manufacturers would hold all the leverage. Under the pilot, manufacturers would review claims data and determine whether to approve rebates. What recourse would a covered entity have if a manufacturer delayed payment beyond the ten-day window? What if manufacturers imposed new documentation requirements not contemplated by the program? What if disputes arose over contract pharmacy arrangements or split-billing methodologies? Unlike payor denials, where regulatory frameworks and appeals processes exist, the rebate model offered covered entities virtually no protection or escalation mechanisms.

For revenue cycle teams already struggling with prior authorization burdens and medical necessity denials, the prospect of adding pharmaceutical rebate denials to their workload was untenable. Healthcare CFOs testified they feared systematic delays or denials could permanently erode their 340B margin, turning what should have been a 20-50% discount into a break-even proposition or worse.

The Hidden Costs: Administrative Burden and Compliance Gaps

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Beyond the direct financial impact, covered entities would have faced substantial administrative costs to implement rebate tracking infrastructure. Most 340B programs operate with lean teams focused on program compliance and auditing. The rebate model would have required new systems to track WAC purchases, submit claims data to multiple manufacturers, reconcile rebate payments, follow up on delays, manage disputes, and maintain audit trails proving compliance with program requirements.

Small and rural entities, precisely those that the 340B program was designed to support, would have struggled most. While large academic medical centers might absorb these costs by adding FTEs or purchasing specialized software, a critical access hospital in rural America could not. The administrative burden would have created a two-tiered 340B program: well-resourced entities that could navigate the complexity, and under-resourced entities that would be forced to forgo 340B discounts entirely.

Furthermore, the rebate model exposed covered entities to new compliance risks. What if documentation standards evolved after implementation? What if manufacturers cited good-faith errors as reasons to deny rebates? What if the inevitable technical glitches in new systems resulted in missed submissions or incomplete data? These weren't hypothetical concerns; they were predictable outcomes given the compressed implementation timeline and lack of testing.

The Court's Revenue Cycle Perspective

In his decision blocking the pilot, Judge Walker recognized these realities of the revenue cycle. He noted that HRSA's administrative record was "threadbare" and failed to adequately consider "the impact of a rebate model on 340B hospitals, who rely on upfront price concessions to stretch few resources as far as possible to serve rural and poor communities." The judge understood what revenue cycle professionals know instinctively: cash flow is oxygen for healthcare organizations, and disrupting it can be fatal.

The court's decision emphasized the principle of reliance interest: that when the government establishes a program that entities depend upon for more than three decades; it cannot radically alter it without carefully considering the consequences. For 340B covered entities, the upfront discount model wasn't just a convenience; it was fundamental to their financial viability and their ability to serve their communities. The First Circuit Court of Appeals agreed, describing Judge Walker's opinion as "careful and thorough" and finding that HRSA's administrative record was indeed "threadbare." When the government dropped its appeal on January 12, 2026, and indicated plans to return the manufacturer approvals to HRSA for reconsideration, it effectively acknowledged the program's flaws.

The Appeal Dismissal: A Significant but Temporary Victory

On January 17, 2026, the federal government took the significant step of voluntarily dismissing its appeal of Judge Walker's preliminary injunction. According to the court filing, the government and hospital plaintiffs consented to the dismissal, effectively ending the government's effort to overturn the lower court order. This development provides covered entities with greater near-term certainty that the preliminary injunction remains in place, and HRSA cannot implement the rebate pilot program unless a future court order or new agency action changes that posture.

The dismissal means litigation over HRSA's initial rebate approvals remains with the district court in Maine, which has not yet indicated when it will hold hearings on the full merits of the case. However, the government provided an important caveat: it indicated it is in discussions with hospital plaintiffs about returning the manufacturer approvals to HRSA for reconsideration. This language is crucial, and it signals that while this particular version of the rebate pilot is effectively dead, HRSA may attempt to develop a revised program that addresses the procedural deficiencies identified by the court.

What Covered Entities Have Avoided for Now

The dismissal of the appeal allows revenue cycle leaders to fully appreciate what their organizations have avoided, at least temporarily. Had the rebate pilot taken effect on January 1, 2026, covered entities would have immediately faced a cascade of financial and operational challenges most were unprepared to handle.

The Cash Flow Crisis That Didn't Happen: Covered entities were days away from needing to purchase high-cost medications at WAC prices that can be 300-500% higher than 340B pricing. For many safety-net hospitals already operating with minimal cash reserves, this would have required immediate draws on credit lines, delayed payments to other vendors, or even temporary suspension of medication purchases. Small rural hospitals might have faced impossible choices: take on debt to maintain pharmacy operations or limit formularies to only the most essential medications.

The Compliance Nightmare Averted: The rebate model would have created entirely new compliance obligations with unclear standards and severe financial consequences for errors. Covered entities would have needed to submit claims data to multiple manufacturers, each potentially with different data requirements, submission portals, and validation criteria. A single technical error, missed deadline, or documentation gap could result in the denial of rebates worth thousands or even millions of dollars. Unlike traditional 340B audits, where entities have established procedures and vendor support, the rebate model would have been uncharted territory with no clear roadmap for compliance.

The Technology Investment Deferred: Most 340B entities were ill-prepared for the technology requirements of rebate tracking and submission. The compressed timeline meant many organizations wouldn't have had functioning systems in place by January 1, forcing them to rely on manual processes prone to errors and inefficiencies. The dismissal provides time to properly evaluate technology solutions, conduct vendor demonstrations, and implement systems thoughtfully rather

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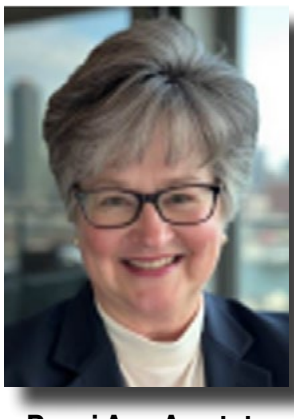
What's Changed in NCCI since December 17, 2025?

By: Peggi Ann Amstutz, MBA, CCS, CCS-P, CPC-I, CRCR



Peggi Ann Amstutz

During the December 17th webinar, it was mentioned that we were patiently waiting for CMS to publish the National Correct Coding Initiative (NCCI) Manuals for 2026. Good news, the Medicare manual was published one week later, on Christmas Eve. Here is the link https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-policy-manual . The Medicaid manual was published on New Years Eve, at this location https://www.cms.gov/files/document/2026-ncci-medicaid-policy-manual.pdf. The Medicare manual is slightly longer with 287 pages of reading pleasure whereas the Medicaid manual has only 283 pages to review.

Both manuals had their usual minor edits, a few new edits (less than previous years). As to be expected, there are several new sections related to new CPTs/HCPCSs codes for 2026. Thankfully, CMS does indicate new or changed information in red font throughout the document.

Here is a summary of some of the Medicare & Medicaid NCCI Manual changes for 2026.

- Chapter 5, Pages V-13 and V-15 of the Medicare manual and pages V13 and V-14 in the Medicaid manual have the following additions related to Cardiovascular System (see items #19 and #24)
  - #19-Vascular obstruction may be caused by thrombosis, embolism, atherosclerosis, or other conditions. Treatment may include thrombectomy, embolectomy, and/or endarterectomy. CPT codes describe embolectomy/thrombectomy (e.g., CPT codes 34001-34490), atherectomy (e.g., CPT codes 0234T-0238T, 37271-37278, 37288-37295), and thromboendarterectomy (e.g., CPT codes 35301-35390). Only the most comprehensive code(s) describing the services performed at a given site/vessel may be reported. Therefore, for a given site/vessel, codes from more than one of the above code ranges shall not be reported together. If a percutaneous interventional procedure fails (e.g., balloon thrombectomy) and the same physician performs an open procedure (e.g., thromboendarterectomy) at the same patient encounter, only the completed procedure, generally the more extensive open procedure, may be reported. (CPT codes 37225, 37227, 37229, 37231, 37233, and 37235 were deleted January 1, 2026.)"
  - #24- "24. CPT codes 37211-37214 (Transcatheter therapy with infusion for thrombolysis of noncoronary vessel) may be reported when a blood vessel is catheterized for the purpose of transcatheter infusion for thrombolysis of a non-coronary vessel. With the exception of lower extremity endovascular revascularization procedures (CPT codes 37254-37299), CPT codes 37211-37214 should not be reported for infusion of a thrombolytic agent into a blood vessel in the catheterization pathway of a blood vessel undergoing a percutaneous or open diagnostic or interventional intravascular procedure since a catheter is already in the blood vessel. Thrombolysis in a lower extremity vessel may be reported separately with an endovascular revascularization procedure (CPT codes 37254-37299). (CPT codes 37220-37235 were deleted January 1, 2026.)
- Chapter 11, Section V, Medically Unlikely Edits (MUEs) (both Medicare and Medicaid) on page XI-36, 22:
  - CPT code 92941 describes percutaneous transluminal revascularization of an acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel major coronary artery and/or its branches or single bypass graft and/or its subtended branches of a coronary artery or coronary artery bypass graft during an acute myocardial infarction. This code may be reported with one unit of service. If additional revascularization procedures of coronary arteries or coronary artery bypass grafts are performed at the same patient encounter, these procedures shall not be

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reported with CPT code 92941, but with other CPT codes such as 92920, 92924, and/or 92943. 92941 is intended for emergent situations and should not be used for non-emergent PCI.

- Medicare Chapter 13, Category III Codes on page XIII-5, Medicaid page X11-9, CCI Procedure-to-Procedure (PTP) Edit Specific Issues

1. Since HCPCS code V2790 (Amniotic membrane for surgical reconstruction, per procedure) includes amniotic membrane, it shall not be reported separately with CPT codes 65778 (Placement of amniotic membrane on the ocular surface; without sutures) or 65779 (Placement of amniotic membrane on the ocular surface; single layer, sutured) since payment for these 2 CPT codes also include the amniotic membrane."

Finally, CMS often publishes transmittals related to NCCI updates throughout the year, remember to periodically check the CMS transmittal website located here https://www.cms.gov/medicare/regulations-guidance/transmittals/2026-transmittals for updated information throughout the year.

Author, Peggi Ann Amstutz, MBA, CCS, CCS-P, CPC-I, CRCR, paamstutz@panaceainc.com

About the author

Peggi Ann has over 35 years of experience in the healthcare revenue cycle industry, providing leadership to consulting projects from both the provider and consulting sides. Her credentials include an MBA, CCS, CCS-P, CPC-I, AHIMA-Approved ICD-10-CM/PCS Trainer, CPC Approved-Instructor, and a Certified Revenue Cycle Representative. She has created an industry reputation for her Revenue Cycle and CDM project management skills, and is adept at compliance, coding, and revenue integrity-focused engagements. Her educational skills include coaching hospital teams, developing educational content, and presenting seminars from basic coding to revenue integrity to compliance. Currently working full-time at Panacea, Peggi Ann serves as a Revenue Integrity Advisor, providing support for software, customer training, education, and consulting. Peggi Ann also presents at her local AAPC and AHIMA Chapter events and serves as an Instructor in the Medical Insurance Billing Program at California State University Dominguez Hills, College of Continuing and Professional Education. Peggi Ann can be reached at paamstutz@panaceainc.com.

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AI & Cybersecurity at the NJ HFMA January Meeting

Gerry Blass

By: Gerry Blass

The NJ HFMA event held on January 22, 2026, at the APA Hotel in Woodbridge, New Jersey was an exceptional forum for collaboration, education, and peer engagement among healthcare finance and revenue cycle leaders across the state. As a long-standing supporter of NJ HFMA and its mission to advance the healthcare finance profession, I had the privilege of moderating a panel discussion focused on AI and Cybersecurity in Healthcare, a topic of growing importance across both clinical and non-clinical environments, including patient access and patient financial services. The strong attendance and active participation from NJ HFMA members highlighted the organization's continued commitment to delivering timely, relevant, and practical programming.

Our panel brought together an outstanding group of industry leaders — Jack Hueter, Martin von Grossman, and Rick Kerr — who shared real-world insights on how healthcare organizations are navigating AI adoption while addressing cybersecurity, regulatory, and governance challenges. The discussion emphasized the need for thoughtful oversight, strong vendor vetting, and alignment with established governance, risk and compliance frameworks as AI becomes more deeply embedded in healthcare operations. The dialogue and engagement reinforced NJ HFMA's role as a trusted community for education and leadership development, and ComplyAssistant was proud to support an event that delivered meaningful value to its members and advanced important conversations shaping the future of healthcare finance.

About the author

Gerry Blass is the President and CEO of Comply Assist. He can be reached at gerry@complyassistant.com.

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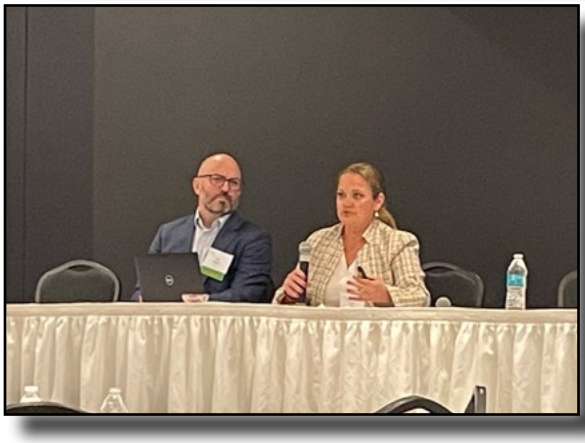

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•Focus on Finance•

New IRS Guidance and Increased Scrutiny: What Tax-Exempt Hospitals Need to Know

Nick Perkins

John Smith

By: Nick Perkins & John Smith

Tax-exempt organizations have new guidance to follow as they fall under increased scrutiny by lawmakers. On September 30, 2025, the Internal Revenue Service ("IRS") and U.S. Treasury Department released the 2025–2026 Priority Guidance Plan, outlining projects aimed at clarifying regulations and tightening compliance in areas such as executive compensation, donor-advised funds, digital assets and retirement plan updates under the SECURE 2.0 Act. At the same time, a recent House Ways and Means Oversight Subcommittee hearing focused on concerns over whether tax-exempt hospitals are delivering sufficient community benefits central to their tax advantages, signaling potential audits, enforcement actions and even revisions to Form 990. Together, these developments underscore a clear message: transparency and proactive compliance are essential for maintaining tax-exempt status and public trust.

IRS 2025-2026 Priority Guidance Plan

The IRS Priority Guidance Plan is released annually to prioritize and identify tax issues addressed via regulations, revenue rulings, revenue procedures, notices and other guidance.

The 2025-2026 Priority Guidance Plan outlines 105 tax guidance projects the IRS and Treasury Department aim to address from July 1, 2025, to June 30, 2026. Of the 105 tax guidance projects, 11 have been released or published as of August 31, 2025. The Priority Guidance Plan reflects the Treasury Department's and the IRS's focus on 5 key areas: implementation of the One Big Beautiful Bill Act, commonly referred to as the OBBBA or OB3, deregulation and burden reduction along with guidance addressing tribal tax issues, digital assets and the SECURE 2.0 Act.

Outlined below are tax guidance projects for tax-exempt organizations.

1. One Big Beautiful Bill Act

   The new guidance outlines priorities for regulations under section 4968 regarding excise tax based on investment income of certain private colleges and universities. It also broadened guidance under Section 4960 regarding excess compensation paid by applicable tax-exempt organizations, notably expanding the definition of a "covered employee". The OBBBA expands the 21% excise tax on compensation over $1M to all employees of a tax-exempt organization who provide administrative services.

2. Deregulation and Burden Reduction

   The new guidance also addresses deregulation and burden reduction, with updates to regulations under Section 4945. These regulations have to do with proposed updates to expenditure responsibility requirements. Tax-exempt organizations that pay grants to other tax-exempt organizations or public charities will need to be aware of these updates.

   There is continued work towards final regulations under section 4966 regarding donor-advised funds, including excise taxes on sponsoring organizations and fund management. Proposed regulations were published in November 2023.

3. Tribal Tax Issues

   The new priority guidance includes final regulations under Section 7701 regarding the federal tax treatment of an entity wholly owned by one or more Indian Tribal governments.

4. Digital Assets

   Guidance is also included addressing the tax treatment of transactions involving digital assets. Tax-exempt organizations must report receipt of digital assets on their annual Form 990.

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5. SECURE 2.0 Act

The IRS and Treasury Department published final regulations implementing changes made by the SECURE 2.0 Act, specifically when it comes to updates on catch-up contributions to retirement plans.

In addition, the Priority Guidance Plan includes recommendations on the application and interpretation of the fundamental public policy against racial discrimination, with the consideration of recent caselaw, when determining the eligibility of private schools for tax-exempt status under Section 501(c)(3).

Finally, the implementation plan proposes guidance on the "Johnson Amendment," which is the statutory prohibition in Section 501(c)(3) barring the participation or intervention in political campaigns.

House Ways and Means Oversight Subcommittee Hearing

On September 16, 2025, at a House Ways and Means Oversight Subcommittee hearing, several witnesses warned that tax-exempt hospitals are failing to provide their necessary healthcare benefits to their communities on which their tax-exempt status rests. The hearing referenced the following key focus areas:

Key findings from recent studies: The hearing covered multiple studies that indicate tax-exempt hospitals provide less charity care and community investment than the estimated value of their tax breaks.

- One study cited during the hearing found that between 2020 and 2022, the gap averaged $11.5 billion per year and fewer than half of tax-exempt hospitals gave back to their communities in excess of their tax breaks.

Issues with current reporting: Tax-exempt hospitals utilize Form 990, Schedule H to report community benefit. The studies found that this reporting is often vague and ambiguous.

- The studies referenced broad categories in this reporting, like money spent on "community health improvement services" and "education," without specifying what services or education were provided.

Use of funds: While tax-exempt hospitals received $37.4 billion in tax benefits in 2021, the studies found that instead of prioritizing healthcare benefits to their communities, some hospitals spent funds on:

- Stadium naming rights
- Real estate investments
- Green energy initiatives
- Political activism

Structural concerns: The hearing also addressed the current structure of Schedule H, which benefits large hospital chains because they are not required to disaggregate benefits provided by individual facilities.

Regulatory outlook: Tax-exempt hospitals reporting on Schedule H can expect increased audits and enforcement. This comes in the wake of studies suggesting tax-exempt hospitals count activities that are unrelated to healthcare toward meeting the community benefit standard. This is due to vague legal requirements in reporting.

Future changes: The IRS is expected to release a completely revised Form 990 within the next 12-36 months. This updated form would incorporate greater transparency on Schedule H reporting for tax-exempt hospitals.

Conclusion

The landscape for tax-exempt organizations is shifting rapidly, with the IRS and Treasury Department prioritizing new guidance alongside increased scrutiny of community benefits reporting by tax-exempt hospitals. Tax-exempt entities should take proactive measures to safeguard their status and reinforce public trust in their mission-driven work. Withum's Healthcare Tax Team can help walk you through these updates and answer questions about how to remain compliant amidst evolving expectations.

About the author

John Smith is a Senior Manager with Withum. He can be reached at JSmith@Withum.com.

Nick Perkins is a Supervisor with Withum. He can be reached at NPerkins@Withum.com.

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The Case for Radical Honesty in Revenue Cycle Leadership

Steven Honeywell, Associate Vice President of Patient Accounting at Penn Medicine, on an unconventional start and the philosophy that followed.

By: Denny Henderson

Steven Honeywell got his start in revenue cycle through a strike of lightning. Literally.

Fresh out of Rutgers with a degree in healthcare administration, Honeywell struggled to land his first job. The classic catch-22: everyone wanted experience, but nobody would give it. Then he was out in the field with friends and family when someone in the group was struck by lightning. Honeywell performed CPR and brought the man back, though he ultimately didn't survive.

In the aftermath, Honeywell connected with the man's sibling, who worked at Cornell Medical Center. That conversation led to an entry-level position as a checkout clerk in a cardiology practice.

"I'm saying 'that's $50 for today's visit, and the doctor wants to see you in 10 days. How's February 5th? We accept cash, check, or charge.' That's what I was doing with my college degree," Honeywell recalls. "At first I hated it. But I wouldn't trade that experience for the world, because it gave me a foundation for everything that came after."

Steven Honeywell

Forty years later, 28 of them at Penn Medicine, Honeywell serves as Associate Vice President of Patient Accounting, overseeing a physician billing operation that collects nearly $2 billion annually. His path from checkout clerk to senior leadership wasn't built on credentials or connections. It was built on work ethic, relationships, and a leadership philosophy rooted in something uncommon: telling people exactly where they stand.

Relationships as Foundation

That lightning strike taught Honeywell something he's carried throughout his career: relationships open doors that resumes cannot.

"In our world, so much of what we do is based on relationships," he says. "Comfort level. Looking people in the eye. Having conversations about their family, their goals, or the work itself. It's all about building relationships with employees, with vendor partners, with everyone."

This conviction shapes how he approaches every aspect of his role. His team includes managers who have worked with him for 20 and 30 years. He treats vendor relationships as partnerships, not transactions, outsourcing a portion of accounts receivable to partners he holds to the same standards as his internal team. And he invests heavily in industry involvement through HFMA, AAHAM, and the East Coast CORE user group for Epic. These are voluntary commitments he views as obligations to help develop the next generation.

"Nobody wakes up in the morning saying 'I'm going to be a revenue cycle person,"' Honeywell notes. "Most of us got here through weird or circuitous routes. It's our obligation to help the people coming up behind us."

Directness as Respect

For Honeywell, honesty is how relationships get built and maintained. You can't have a real relationship with someone if you're not telling them the truth.

"You always know where you stand on something when you're talking to me," he says. "I say what I mean, and I do what I say. Nothing supports that better than having a track record of doing it."

That directness isn't about being tough for its own sake. It's about believing people deserve the truth because they're capable of handling it and growing from it.

Honeywell sits down with his high-potential team members regularly for frank career conversations. Not performance reviews. Career conversations. Where do you want to go? What do you want exposure to? What are your strengths?

Sometimes those conversations end with a path forward at

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Penn Medicine. Sometimes they don't.

"I look people in the eye and tell them squared up. I don't see you in that role. But I see you in this role," he explains. "Or if you want this opportunity, that's not going to happen here, so you might want to look elsewhere."

When team members have been recruited away to other health systems, he doesn't view it as a loss. He waves it as a banner of success.

"That means we're hiring good people who know what they want."

The Acquisition Test

Honeywell's approach gets tested every time Penn Medicine acquires a new facility. He's been through it with Lancaster General, Princeton, and most recently Doylestown. Each time, he faces people who have every reason to distrust the corporate team walking in.

His response: don't ask them to trust you. Give them permission to verify.

"I tell them, 'You don't know me from a can of paint. I know you may not believe me. So I encourage you to go talk to the people we brought on from previous acquisitions. Get their honest feeling. I don't need to be on that call."'

The willingness to let his reputation speak, and to let skeptical employees investigate for themselves, reflects the same philosophy. People can handle the truth. Give it to them and let them decide.

Creating Space to Fail Forward

Honeywell's directness extends to how he develops emerging leaders. Rather than promoting people into new roles and hoping it works, he creates structured trials by pairing rising talent with experienced leaders for months before any transition.

One team member wanted to move into a different function. Instead of forcing a binary decision, Honeywell worked out an arrangement: three days a week on the new work, two days continuing the existing role. After a few months, the employee realized the new path wasn't the right fit. Because they hadn't fully vacated their previous position, they could pivot without derailing their career.

"Give them the opportunity to fail. Give them the opportunity to succeed. Or to surprise us," Honeywell says. "Pairing them up first to see if it's going to work is almost like an internship before you make the leap."

The Interpersonal Gap

Honeywell worries that the type of foundation he's built his career on is eroding. Remote work and digital communication have created distance that goes beyond geography.

He tells a story about an intern working on-site who needed information from a manager five doors down. The intern emailed two or three times with no response, then complained that the manager wasn't getting back to him.

"Did you go knock on the door?" Honeywell asked. "The person's five doors down from you."

It hadn't occurred to the intern to just walk over.

"Teaching them that sometimes you have to be more than an email or a text is one of the biggest barriers I see," Honeywell says. "The interpersonal piece. How do you actually work with people?"

He recognizes the trade-offs that come with remote work. No one misses the 45-minute commute. But a recent holiday party reminded him how much gets lost when people don't share physical space. The informal conversations, the relationships built over time, the ability to read a room. Remote work offers flexibility, but it comes at a cost that's hard to quantify until you feel it.

"I can only imagine growing up in this generation and not having those kinds of relationships," he reflects.
"Because in our world, relationships are everything."

Loyalty Earned, Not Assumed

Honeywell describes himself as a hard charger with high expectations. He also claims to be the most loyal boss you'll ever have. The two go together.

"My management team knows if they messed something up, we're going to have words behind closed doors. But that's between me and them," he says. "When it comes to our clients or senior leadership, it's 'what do we do to fix the problem?' I have their back."

That loyalty runs deep. Honeywell uses brand allegiances as shorthand for how he operates: Coke, not Pepsi. Heinz, not Hunts, Hellmann's, not Miracle Whip. Once he's committed, he's committed.

But loyalty for Honeywell isn't blind protection. It's rooted in believing his people can grow, can handle feedback, and can make good decisions when given real information.

Nobody plans their way into revenue cycle. Honeywell certainly didn't. But his unconventional start shaped a philosophy that has defined his career: relationships are the foundation, honesty is how you maintain them, and trusting people with the truth is the highest form of respect.

Steven Honeywell is Associate Vice President of Patient Accounting at Penn Medicine and has been active in HFMA and AAHAM throughout his career. He serves as President of East Coast CORE for Epic users and volunteers with the AAHAM education committee.

About the author

Steven Honeywell was interviewed by Denny Henderson, FHFMA, from FairCode and was written with assistance from Claude, an AI assistant built by Anthropic.

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The Operational Leader as Financial Steward: How Clinical Research Administration Safeguards Institutional Resources in an Era of Policy Uncertainty

Fatimah Muhammad

By: Fatimah Muhammad, FHFMA, CSBI, CHFP, CSPR, CRCR

Let me tell you about a conversation that changed how I think about healthcare finance.

I was talking with Staci N. Love, PRMS Administrator at a Health System in New York, about her work managing protocol reviews and research governance. On the surface, it sounded like classic administrative coordination, the kind of behind-the-scenes operational work that keeps academic medical centers running but rarely shows up in strategic planning meetings.

Then she said something that stopped me cold: "Every day a study sits in review is a day it's not enrolling patients. Every compliance issue that could have been caught early becomes exponentially more expensive to remediate later."

And suddenly I understood. We were talking about money. Real money. Institutional financial health. Revenue protection. Risk mitigation.

We just weren't calling it that.

The Financial Blind Spot

In healthcare finance, we've become fluent in revenue cycle optimization, payer contract negotiations, 340B program management, and regulatory compliance. I spend my days navigating those waters. But there's a dimension of institutional financial health that rarely makes it into budget meetings or C-suite strategy sessions: the operational infrastructure that determines whether clinical research programs generate revenue or drain resources.

A delayed study activation costs real money in lost enrollment windows, in investigator time, and in opportunity costs. A compliance failure can trigger an FDA or OHRP investigation that diverts institutional resources for months, sometimes years. An inefficient protocol review process doesn't just frustrate investigators; it impacts an institution's competitive positioning in an increasingly brutal research funding landscape.

The institutions that get this right have people like Love managing the machinery. The ones that don't? They're hemorrhaging resources and don't always know it.

What This Actually Looks Like

Love's role sits at what she calls "the intersection of policy, people, and process." She serves as primary advisor and liaison between investigators, study teams, and faculty leadership, guiding them through the intricate governance structures that govern oncology research at a major academic medical center, including Disease Management Teams, Feasibility Review Committees, Protocol Review and Monitoring Committees.

She advises thirteen medical oncology divisions. Thirteen. Each has distinct therapeutic focuses, patient populations, and operational needs.

"A core part of my work involves translating institutional policies, SOPs, and regulatory requirements into clear, executable workflows," Love told me. "Bridging the gap between written policy and real-world practice so studies can activate efficiently without compromising compliance."

That translational work? It's financial protection. Because here's what happens without it:

A study was approved that was never actually feasible, given the institution's patient population. Activation costs get spent. Staff time gets invested. The study failed to enroll. That's wasted money, wasted opportunity, and potentially a damaged relationship with a sponsor who won't bring trials back to that institution.

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Or: A protocol moves through review with a compliance gap nobody caught. It activates. Six months later, an audit finds the problem. Now you're looking at corrective action plans, potential study suspension, investigator sanctions, and institutional reputation damage that affects future funding.
Love prevents those scenarios. Daily.

Why This Matters Now

The current policy environment has made operational excellence in clinical research not just desirable but financially imperative. And I'm watching this play out across multiple dimensions:

The regulatory landscape keeps shifting. FDA continues issuing evolving guidance on decentralized trials, real-world evidence, and adaptive designs. Each new policy requires institutional interpretation, workflow adaptation, and staff training. All of which costs money. Organizations that lack a strong operational infrastructure spend more time achieving compliance and face a greater risk of error.

Federal research funding is constrained in ways we haven't seen before. NIH paylines are brutal. Competition for grants is intense. Institutions that can demonstrate efficient study activation, strong enrollment, and exemplary regulatory compliance have a competitive advantage in securing and retaining federal funding. The ones that can't? They're facing mounting opportunity costs while watching research dollars go elsewhere.

We cannot staff these programs the way we used to. Clinical research coordinators, regulatory specialists, and research nurses are increasingly difficult to recruit and retain. I see this in my own institution. In this environment, operational leaders who can create systems that reduce burden and support staff effectiveness become force multipliers for institutional capacity. That has direct financial value.

And here's one we don't talk about enough: Payer scrutiny of research costs is growing. As healthcare costs continue to rise, payers increasingly question what they're being billed for in clinical trials. Clear delineation between standard-of-care costs and research-specific costs, a distinction that requires meticulous operational management, is essential to avoiding billing compliance issues that can trigger expensive audits and recoupments.

Love sees these pressures from her vantage point, working across multiple divisions. "We're being asked to do more with less, activate more studies, enroll faster, maintain higher compliance standards, all while managing resource constraints. The only way that works is if the underlying systems are sound."

She paused, then added: "That's where operational leadership becomes a financial strategy."
I hadn't thought of it that way before, but she's right.

The ROI Nobody Calculates

Love independently leads Disease Management Team and Feasibility Review Committee meetings in collaboration with faculty chairs. These aren't ceremonial gatherings. They're high-stakes discussions that determine which studies move forward and how they're executed.

Feasibility reviews assess whether an institution has the patient population, staffing capacity, and infrastructure to successfully execute a proposed study. Getting this assessment wrong, approving a study that fails to enroll or overwhelms existing resources, has direct financial consequences.

"That translation work prevents expensive mistakes," Love said. "It keeps studies on a timeline. It protects the institution from regulatory risk. All of those things have a bottom-line impact."

The quality assurance reviews she conducts serve a similar function. By ensuring submissions meet PRMS, DMT, PRMC, and regulatory standards before they advance through formal governance channels, she prevents the costly cycle of repeated submissions, extended review timelines, and delayed activations.

She also tracks operational metrics to support continuous process improvement, data that enables leadership to make strategic decisions about resource allocation and therapeutic area prioritization.

This is infrastructure work. The kind that's invisible when it's working and catastrophically expensive when it's not.

The Equity Angle

Here's where Love's approach gets interesting from a financial perspective, and it's something I've been thinking about a lot in my own work around access and health equity.
"Equity shows up in how processes are built, how voices are included in decision-making, and how knowledge is shared rather than gatekept," she said. "I have seen firsthand how systems, when thoughtfully designed, can either create barriers or open doors."

At first blush, this sounds like values talk. And it is. But it's also operational efficiency, which means its financial efficiency. Inequitable systems are inefficient systems. When critical information is siloed, when processes are opaque, when only certain people have access to the knowledge needed to navigate institutional requirements, you get waste. Investigators spend months pursuing studies that were never feasible. New faculty face unnecessary delays because no one walks them through the process. Research teams burn time navigating bureaucratic obstacles that shouldn't exist.

"When someone comes to me uncertain about how to move a protocol forward, I don't just point them to a policy document. I walk them through it," Love explained. "That investment in education and clarity pays off in faster activations, fewer errors, and better resource utilization."

It also addresses workforce retention, a significant financial concern. Research staff who feel supported, who have access to clear guidance and systems that work, are more likely to stay. The cost of turnover in specialized research positions can exceed $100,000 per position when you factor in recruitment, training, and lost productivity.

We talk about equity like it's separate from financial sustainability. It's not.

What Healthcare Finance Leaders Need to Understand

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•Certification Corner•

A New Learning Experience Is Coming – Spring 2026

Big things are on the way! In March 2026, HFMA will launch its new Learning Center — a modern, engaging, and mobile-friendly platform designed to make professional development easier, more flexible, and more impactful for healthcare finance professionals.

Why the change?

HFMA is upgrading to a more contemporary learning management system to deliver a smoother, more intuitive experience. The new platform will feature a refreshed design, enhanced navigation, expanded interactive content (including video instruction and avatars), and a growing library of bite-size courses that fit into your busy schedule.

What's in it for you?

The new Learning Center is built around how members learn best:

- Mobile-friendly access so you can learn anytime, anywhere
- Interactive courses with videos, discussions, and quick knowledge checks
- Personalized learning pathways aligned with your professional goals
- Short, focused microlearning courses to build essential skills quickly
- Secure, reliable exams with accurate results tracking

This upgrade is about more than new technology — it's about delivering a learning experience that supports real-world skill building and career growth.

What about the transition?

HFMA anticipates brief, intermittent service interruptions of approximately two weeks in March 2026 (specific dates will be shared in advance).

If members are currently enrolled in a program, they are encouraged to complete courses that are near finishing or document the progress before the transition. The good news? Members' course history, certificates, and login credentials will transfer seamlessly to the new system.

HFMA will also provide quick-start guides and short video tutorials to help hit the ground running.

The future of HFMA learning is almost here — and it's designed with members in mind.

Stay tuned for more details as we approach launch! For questions or assistance, please contact inquiry@hfma.org and Amina Razanica at arazanica@njha.com

Mark Your Calendar

Annual Women's Leadership & Development Session
April 22, 2026 — DoubleTree Hotel, Tinton Falls, NJ

New Jersey HFMA Webinar 3 Part AI Series
May 6th, 13th & 20th, 2026 — Lunch & Learn webinarAnnual Golf Outing

Annual Golf Outing
May 7, 2026 — Mercer Oaks, West Windsor Township, NJ

New Jersey HFMA 2026 Summer Networking Happy Hour at the Watermark
June 17, 2026 — Watermark, Asbury Park

New Jersey & Metro Philadelphia HFMA 50th Anniversary Annual Institute
October 21 – 23, 2026 — The Borgata Hotel & Casino, Atlantic City, NJ

Watch for updates on all of these events, or visit the Chapter website at https://www.hfma.org/chapters/region-3/new-jersey/

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Finding Equilibrium: How Healthcare Leaders Can Manage Demands Without Burning Out

Lisa Hammett

By: Lisa Hammett

Healthcare leadership often feels like balancing on a tightrope — between patient care, organizational pressures, and personal responsibilities. The pace is relentless, the stakes are high, and the emotional load is heavy. But sustainable leadership doesn't come from endurance alone; it emerges from designing balance with the same precision used to design care systems.

Quick Highlights

- Energy management beats time management for long-term resilience.
- Micro-boundaries protect focus and sanity during high-demand periods.
- Delegation isn't weakness — it's operational intelligence.
- Reflection, structure, and recovery should be built into your calendar.
- Simple systems (like digital document workflows) can reduce mental clutter dramatically.

Reframing the Core Challenge

Burnout in healthcare leadership is not simply overwork, it's chronic misalignment. Leaders spend disproportionate energy on reactive management, leaving little for strategic or restorative thinking. The fix begins with acknowledging that the leader's state of mind directly shapes the culture, efficiency, and care quality of their teams.

When Time Isn't the Problem, Focus Is

Too many leaders chase "time freedom" while ignoring attention leaks. It's not the hours that exhausts you; it's the fragmentation. Interruptions, redundant approvals, and decision fatigue drain your bandwidth.

One effective approach is energy zoning — assigning different times of day to distinct cognitive modes:

Zone	Primary Focus	Ideal Duration	Examples
Deep Focus	Strategic planning, data review	90-120 mins	Quality metrics, project visioning
Operational	Quick meetings, coordination	60-90 mins	Shift alignment, reporting
Relational	Mentoring, empathy-based dialogue	45-60 mins	Staff check-ins, coaching
Recovery	No-screen reflection time	Variable	Walking meetings, journaling

Shifting your calendar from "meetings" to "zones" creates structure that resists chaos.

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Evaluating RPA and Agentic AI: Choosing the Right Automation for a Better Revenue Cycle

Adityaa Shukla

By: Adityaa Shukla, BS, CRCR

The automation conversation in the healthcare revenue cycle has reached a critical inflection point. Leaders are being pitched RPA (Robotic Process Automation), AI-powered intelligent automation, and now Agentic AI – often with vendors positioning these solutions as interchangeable. They're not. These technologies change problems in fundamentally different ways, and the consequences of choosing the wrong tool for the wrong workflow extend far beyond wasted budget. Misaligned automation frustrates staff, fragments processes, and can even setback your automation strategy.

RPA and Agentic AI each solve problems using different approaches. Most revenue cycles need both but determining where each technology fits requires moving past vendor marketing and into the operational realities of your workflows. The essential question isn't "In which technology should we invest?" It's "What specific work are we actually trying to automate and what capabilities does that work require?"

Understanding Core Differences

Before evaluating where each tool fits in your revenue cycle, it helps to understand the fundamental differences between RPA and Agentic AI.

RPA is automation designed for predictable, rules-based work. It can log into systems, move data, and follow predefined steps with remarkable speed and accuracy. However, the moment it encounters UI changes or workflow variations, RPA cannot adapt on its own. It excels at pre-determined, consistent, structured tasks but lacks the flexibility to handle exceptions or make contextual decisions. Revenue Cycle processes are constantly evolving and require adaptability.

Agentic AI operates from an entirely different foundation. It combines large language models with decision-making and workflow capabilities, allowing it to reason, plan, and adapt to changing circumstances. Agentic AI can handle complex, multi-step tasks that vary significantly from account to account. It is great at navigating ambiguity, learning from experience, and filling gaps where traditional automation typically fails.

Consider these operational examples:

RPA in practice: A bot logs into a payer portal each morning, systematically pulls claim status updates, and populates the billing system. Note, there would need to be a bot for every workflow and payer. The process is identical every time, following the same login sequences and data extraction steps.

Agentic AI in practice: The agent can log into any portal, review an unpaid claim, analyze the denial reason within the context of payer-specific requirements. Using reasoning logic, it determines whether an appeal is clinically and financially warranted, and then will hand off to another AI Agent which will identify the necessary supporting documentation, and draft an appeal letter tailored to that payer's language and submission guidelines.

The distinction matters because organizations often deploy these technologies incorrectly forcing RPA into workflows that require judgment or underutilize Agentic AI solutions for simple, structured tasks that don't warrant the investment. This is similar to a person using ChatGPT as a search engine. While effective, that person would be grossly underutilizing the capability.

Addressing Common Misconceptions

Despite widespread interest in AI and automation, there are still misconceptions that may derail strategic decision-making:

Misconception 1: "RPA is a form of AI." RPA automates tasks through programmed scripts, but it doesn't learn, reason, or adapt. Calling it "AI" simply because it automates work misrepresents its capabilities. [Note, there are solutions that pair RPA with AI].

Misconception 2: "Agentic AI can replace every manual step in the revenue cycle." Agentic AI is powerful, but these systems still require clean data inputs, clearly defined objectives and appropriate guardrails. Without these foundations, Agentic AI can create rework for humans through "AI slop" rather than resolving it. Note, these Agentic systems often require thoughtful prompting and intensive testing before they achieve the desired result.

Misconception 3: "Organizations must choose between RPA and Agentic AI." The reality is that the most effective automation strategies leverage both technologies strategically. RPA handles the structured, repetitive foundation. Agentic AI addresses the judgment-based, variable work. Framing this as an either/or decision misses the opportunity to build a truly

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optimized revenue cycle.

Clearing up these misconceptions is essential before engaging vendors or allocating capital to automation initiatives.

Mapping Technology to Revenue Cycle Workflows

Rather than starting with the technology, effective evaluation begins by asking operational questions: What specific tasks are overwhelming your teams? Where are staff spending disproportionate time relative to the value they're creating? Are they bogged down in structured, repetitive work that drains capacity for higher-value activities? Or are they struggling with decision-heavy workflows like denial resolution, complex prior authorizations, or nuanced coding determinations?

Deploy RPA when workflows are:

- Highly structured and predictable with minimal variation
- Repetitive across high volumes
- Rule-based with clear if/then logic
- Dependent on speed and accuracy rather than contextual judgment
- **Revenue cycle examples:** Claim status inquiries, remittance posting, routine eligibility verification, batch claim submission, standard patient statement generation (IBM, n.d.; TechTarget, 2021)

Deploy Agentic AI when workflows require:

- Interpretation of unstructured information
- Contextual decision-making that varies by scenario
- Adaptation to payer-specific rules, clinical nuances, or account complexities
- Navigation of exceptions that don't fit predefined scripts
- **Revenue cycle examples:** Denial analysis and appeal generation, complex prior authorization determination, charge capture validation, underpayment detection, identifying payer specific behaviors, contractual compliance, patient financial counseling for high-cost services, and coordination of benefits. (McKinsey & Company, 2026)

In most organizations, the optimal automation strategy blends both approaches … at least, for now. Use RPA where structure and predictability exist. Deploy Agentic AI where professional judgment, variability, and adaptability are required. This hybrid approach moves revenue cycle operations toward meaningful touchless processing without the false starts that come from mismatched technology deployment.

Case Study: The Denial Management Workflow

Denial management provides a clear illustration of where the choice between RPA and Agentic AI becomes operationally significant.

Certain components of denial workflows are highly structured: pulling remittance files, identifying denial (CARC/RARC) codes, routing based on payer from table references. These tasks are ideal candidates for RPA. They're predictable, rules-based, and benefit from speed and consistency.

But once the workflow moves into the analytical and decision-making phases, the requirements shift dramatically. Revenue cycle staff must interpret payer-specific language, determine root causes, assess whether an appeal is financially justified, gather clinical and administrative documentation, craft persuasive appeal narratives, and adapt when denial scenarios don't align with standard templates. No two denials are identical. Payer policies evolve constantly. Clinical contexts vary. This is precisely where Agentic AI delivers measurable value: analyzing denial specifics, recommending prioritized next actions, drafting customized appeal content, and adapting when new scenarios emerge that don't match historical patterns.

By decomposing the workflow into structured versus judgment-based components, leaders can identify where RPA provides sufficient automation and where Agentic AI becomes necessary to genuinely reduce manual intervention. This granular analysis is particularly important given that Agentic AI typically carries higher costs for licensing, implementation, and initial validation.

Critical Vendor Questions

Vendors frequently use similar terminology to describe very different technological capabilities. Cutting through marketing language requires discipline and specificity. The following questions help differentiate substantive solutions from overstated claims:

What happens when workflows or system interfaces change?

RPA breaks when processes shift or UI elements are modified. Agentic AI should demonstrate adaptability. How vendors answer this question reveals whether their solution is truly intelligent or simply scripted automation repackaged as AI.

How does your solution handle payer-specific variability?

If the response centers on building custom rules for each payer, you're evaluating RPA capabilities, not Agentic AI. True Agentic AI should navigate variability through reasoning and contextual understanding, not hardcoded logic trees.

What level of IT and operational support is required to maintain this solution over time?

RPA often demands ongoing scripting updates, bot maintenance, and technical intervention when workflows change. Agentic AI requires different but equally important operational overhead: governance frameworks, monitoring protocols, performance evaluation, and guardrail management. Both carry costs, but the resource profiles differ significantly.

What are the failure modes and limitations of this technology?

Every automation system has boundaries. Understanding where a solution breaks, whether from data quality issues, volume thresholds, edge cases, or specific workflow scenarios, is essential before deployment and continually, not after operational disruptions occur. There should be an early warning system present.

How does the system improve and learn over time?

Genuine Agentic AI should demonstrate improvement through exposure to new scenarios, feedback loops, and pattern

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In practical terms, hospitals should anticipate heightened scrutiny of off-campus operations, including audits focused on whether departments satisfy Medicare's provider-based regulations at 42 C.F.R. § 413.65. Failure to meet these standards may result not only in prospective payment denials but also in recoupment of prior reimbursements if CMS determines that a department was improperly billing under OPPS. These changes, combined with the new NPI requirement, signal a clear federal policy direction toward increased transparency in off-campus billing and may serve as a foundation for broader site-neutral payment expansion in future rulemaking cycles.

This new administrative requirement is widely viewed as a precursor to expanded site-neutral payment policies, an area where CMS has already taken action for 2026 by expanding site-neutral payments to certain drug administration services and beginning a phased elimination of the inpatient-only list. Increased transparency into off-campus billing patterns may accelerate broader reimbursement reforms in both Medicare and commercial markets.

At the same time, the appropriations package extends several provider-favorable programs, including pandemic-era Medicare telehealth waivers through 2027, the acute-care hospital-at-home program through fiscal year 2030, supplemental payments for low-volume and Medicare-dependent hospitals, and add-on payments for ambulance services. These extensions provide temporary stability amid broader structural shifts.

V. Implications for Hospitals and Providers

Taken together, these developments point to a healthcare environment characterized by coverage instability, financial pressure, and increased reliance on state-level implementation.

As a result, hospitals and other providers should prepare for:

- Continued payer mix shifts and potential increases in uninsured and underinsured populations;
- Greater exposure to uncompensated care and bad debt, particularly as high-deductible coverage becomes more prevalent;
- New compliance obligations, including unique NPI requirements and provider-based attestations for off-campus OPD;
- New opportunities tied to state-administered rural healthcare funding, including in New Jersey;
- Evolving Medicaid DSH calculations affecting dual-eligible populations; and
- Potential future structural reforms if elements of the Great Healthcare Plan advance through reconciliation or regulatory action

VI. Bottom Line

The months following enactment of the One Big Beautiful Bill Act have clarified both its opportunities and its challenges. Early ACA enrollment data suggest meaningful coverage declines following the expiration of enhanced subsidies, while the distribution of rural health transformation funding marks a historic federal investment in access and infrastructure. The proposed Great Healthcare Plan and FY26 Bill adds an additional layer of policy direction, underscoring ongoing debates about affordability, transparency, and system reform.

What's the bottom line? For hospitals, health systems, and providers, particularly those operating in New Jersey, the year ahead will require careful monitoring of federal and state developments, strategic engagement with policymakers, and proactive financial planning to navigate an increasingly dynamic healthcare policy landscape.

About the Authors:

James A. Robertson is a Partner and Chair of the Healthcare Department at Greenbaum Law, where he concentrates his practice in the areas of healthcare transactional, regulatory and reimbursement matters. He can be reached by email at jrobertson@greenbaumlaw.com.

Sukrti Thonse is an Associate in the Healthcare and Corporate Departments at Greenbaum Law where she concentrates her legal practice on complex healthcare transactions, HIPAA compliance, corporate governance, and healthcare regulatory matters. She can be reached by email at sthonse@greenbaumlaw.com.

[1] *See Garden State FOCUS, vol. 72, num. 1 at pp. 8-10 (Fall 2025).*

[2] *Marketplace 2026 Open Enrollment Period Report: National Snapshot," Centers for Medicare & Medicaid Services (Jan.12,2026). https://www.cms.gov/newsroom/fact-sheets/marketplace-2026-open-enrollment-period-report-national-snapshot-0.*

[3] *Marketplace 2026 Open Enrollment Period Report: National Snapshot," Centers for Medicare & Medicaid Services (Jan. 28, 2026). https://www.cms.gov/newsroom/fact-sheets/marketplace-2026-open-enrollment-period-report-national-snapshot-2.*

[4] *Featured Updates," Get Covered New Jersey (State of New Jersey). https://www.nj.gov/getcoverednj/findanswers/updates/.*

[5] *2026 Open Enrollment Update Week #9 Snapshot, New Jersey Department of Banking and Insurance (Jan. 2, 2026). https://www.nj.gov/getcoverednj/help/about/2026openenrollmentupdate/Week9Snapshot.pdf.*

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than in crisis mode. This alone could save covered entities millions in rushed implementations and vendor change-order fees.

The Staffing Crisis Postponed: Revenue cycle and pharmacy teams were already stretched thin managing existing 340B compliance requirements, manufacturer restrictions, and operational demands. The rebate model would have required additional full-time equivalents to manage submissions, reconciliations, follow-ups on delayed rebates, and dispute resolution, all without time to budget for these positions or recruit qualified staff. For small rural entities, finding individuals with the necessary expertise in both 340B program requirements and pharmaceutical rebate processing would have been nearly impossible.

The Manufacturer Control Avoided: Perhaps most significantly, covered entities have avoided ceding control over their 340B discounts to pharmaceutical manufacturers. Under the rebate model, manufacturers would have held all the leverage; they could delay rebate processing, request additional documentation, dispute eligible claims, or simply fail to meet the ten-day payment window, with limited recourse for covered entities. The asymmetric power dynamic would have fundamentally altered the 340B program's operation, shifting from a statutory discount guaranteed by law to a manufacturer-controlled reimbursement process. The appeal dismissal preserves, at least for now, the existing framework where covered entities receive guaranteed upfront discounts.

What This Means for Revenue Cycle Leaders

The appeal dismissal is undoubtedly positive news, but revenue cycle leaders must avoid complacency. Judge Walker explicitly noted that HRSA "is empowered by statute to achieve the de-duplication objective through a rebate model." His ruling focused on the procedural failures, the inadequate administrative record, and insufficient consideration of impacts, not the substantive authority. The government's indication that it is considering returning the approvals to HRSA for reconsideration confirms that a revised rebate program remains a realistic possibility.

Pharmaceutical manufacturers remain committed to the rebate approach. Multiple manufacturers filed amicus briefs supporting the pilot, and third-party platforms like Truzo have already launched to facilitate rebate processing. PhRMA described the rebate model as "common sense" and expressed disappointment at the delay. Make no mistake: manufacturers want this change and have the resources to see it through.

Revenue cycle leaders should therefore treat this reprieve as an opportunity, not a conclusion. While we don't know if or when HRSA will attempt to revive the rebate program, the prudent course is preparation.

Preparing for Potential Implementation

Revenue cycle leaders at 340B covered entities should consider several proactive steps during this pause:

Cash Flow Modeling: Conduct worst-case scenario planning for how a rebate model would impact your organization's cash position. Model the timing gap between WAC purchases and rebate receipts and identify whether existing credit facilities could cover the shortfall. For multi-site systems, understand that different entities may face different impacts based on patient mix and medication utilization.

Technology Assessment: Evaluate your current 340B technology platforms and determine whether they can handle rebate tracking and submission. If not, begin conversations with vendors about potential solutions. The compressed timeline of the original pilot caught many entities flatfooted; don't let that happen again.

Staffing Review: Assess whether your current 340B team has the capacity to manage rebate submissions, reconciliations, and dispute resolution. If not, begin building the business case for additional resources. Remember that smaller rural entities will struggle most and may need creative solutions like shared services or regional collaboratives.

Board Education: Ensure your board and senior leadership understand the 340B program's importance to your revenue cycle and the potential impact of a rebate model. Many board members focus on clinical quality and patient experience; they may not appreciate how foundational 340B margin is to your mission. Use this pause to build that awareness.

Advocacy Engagement: Stay connected with state and national hospital associations, 340B Health, and other advocacy groups monitoring this issue. The more voices HRSA hears about the revenue cycle impact, the more likely any future iteration will include meaningful protections for covered entities.

Documentation Readiness: Review your existing 340B compliance documentation and claims data systems. If a rebate model returns, robust data will be essential. Ensure you can quickly produce the utilization data manufacturers will require and that your split-billing methodologies are well-documented and defensible.

The Broader Policy Context

The rebate pilot didn't emerge in a vacuum. For years, pharmaceutical manufacturers have sought to limit the scope of the 340B program through various means, including contract pharmacy restrictions, duplicate discount claims, and aggressive audits. The rebate model represents their most ambitious effort yet, an attempt to fundamentally restructure how the program operates while gaining unprecedented visibility into covered entity operations.

Manufacturers frame this as a matter of program integrity and preventing duplicate discounts under the Inflation Reduction Act. Covered entities view it as a solution in search of a problem, creating massive disruption and risk to address speculative concerns about duplicate Medicaid rebates that existing safeguards already prevent. Revenue cycle leaders recognize it as a threat to the financial viability of safety-net providers that serve the nation's most vulnerable populations.

What makes this particularly challenging is the power imbalance. Pharmaceutical manufacturers collectively spend hundreds of millions of dollars on lobbying and advocacy, far

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exceeding the resources of safety-net providers. Manufacturers have funded advertising campaigns questioning the 340B program's integrity, despite the lack of evidence supporting widespread abuse. This narrative has gained traction in some policy circles, creating political pressure for program changes that may not be justified by the facts.

Conclusion: Vigilance and Preparation

The government's voluntary dismissal of its appeal represents a significant victory for safety-net providers and the communities they serve. Judge Walker's decision, now firmly in place, validated what revenue cycle leaders knew instinctively: upfront discounts aren't just a convenience, they're essential to the financial model that allows covered entities to serve vulnerable populations. The appeal dismissal means covered entities can operate under existing 340B purchasing frameworks without the immediate threat of a disruptive transition to rebate processing.

However, this is not the end of the story. The government's indication that it is considering returning manufacturer approvals to HRSA for reconsideration signals that a revised rebate program may emerge. HRSA retains the statutory authority to pursue a rebate model if it builds a more robust administrative record and meaningfully addresses the concerns raised by the court. Pharmaceutical manufacturers remain committed to this approach and will continue pushing for changes that give them greater control over the program.

For revenue cycle leaders, the imperative is clear: use this breathing room wisely. The appeal dismissal provides something the original compressed timeline did not, a time to prepare thoughtfully rather than react frantically. Model the financial impact, assess your operational readiness, evaluate technology solutions, engage your leadership and boards, and connect with advocacy efforts. If the rebate pilot returns in a different form, it may include longer implementation timelines or additional guardrails for covered entities. Your preparation now will determine whether your organization can navigate that challenge when it arrives.

The 340B program has weathered many challenges over its 34-year history. It has survived manufacturer restrictions, regulatory uncertainty, and persistent attacks on its legitimacy. It survives because safety-net providers recognize that the 340B margin isn't "extra" revenue, it's the difference between keeping the doors open and closing them. As revenue cycle leaders, we must ensure that policymakers, manufacturers, and courts continue to understand this fundamental truth.

The court bought us time, and the appeal dismissal confirmed it. Let's use it wisely.

The True North of 340B

Amid the legal battles, policy debates, and revenue cycle implications, we must never lose sight of why the 340B program exists. Congress created this program with a singular, unambiguous purpose: to enable covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services. The statute doesn't mention manufacturer profits, administrative convenience, or data transparency. It focuses entirely on one thing, ensuring that safety-net providers can afford to serve the vulnerable populations that no one else will.

Every dollar of 340B margin funds cancer screenings for uninsured patients, provides HIV medications to those who cannot afford them, keeps rural emergency departments open 24/7, supports prenatal care for high-risk mothers, and delivers mental health services in underserved communities. When we talk about revenue cycle impact, we're not discussing abstract financial metrics; we're talking about a grandmother who gets her diabetes medication, a young mother who receives substance abuse treatment, or a rural community that still has a hospital because 340B made it financially viable.

The current challenges facing the 340B program, manufacturer restrictions, rebate proposals, compliance burdens, and ongoing attacks on program integrity all threaten this fundamental mission. As healthcare leaders, policymakers, manufacturers, and advocates, we share a collective responsibility to ensure the program's success. This means:

For covered entities: Demonstrating transparent stewardship of 340B savings, investing margin directly into patient care and community benefit, and rigorously maintaining program compliance to preserve the program's integrity and public trust.

For manufacturers: Recognizing that 340B is not a loophole to be closed but a statutory obligation designed to help the most vulnerable and working collaboratively rather than antagonistically to address legitimate program concerns without undermining its core mission.

For policymakers: Understanding that program changes must be evaluated not by their administrative elegance or manufacturer preferences, but by their impact on patient access to care and covered entities' ability to serve their communities.

For revenue cycle leaders: Advocating loudly and clearly for policies that preserve 340B's mission, educating boards and senior leadership about what's at stake, and ensuring every stakeholder understands that this isn't about hospital revenue, it's about patient care.

Healthcare in America faces unprecedented challenges: rising costs, workforce shortages, payment pressures, and growing health inequities. The patients served by 340B covered entities, the uninsured, the underinsured, the rural, and the marginalized face these challenges most acutely. They cannot absorb higher medication costs. They cannot travel hundreds of miles for specialty care. They cannot wait for market forces to make serving them profitable.

The 340B program exists because Congress recognized this reality 34 years ago, and that reality has only intensified. As we navigate the current legal and policy landscape, we must remain united in our commitment to the program's true purpose. The rebate pilot may have been temporarily blocked, but the broader battle for 340B's future continues. Success will require all stakeholders, providers, manufacturers, policymakers, and

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advocates to align around a simple truth: when 340B succeeds, vulnerable patients and underserved communities succeed. When 340B is undermined, it is not hospitals that suffer most; it is the single mother working two jobs without insurance, the elderly farmer in rural America, the person living with HIV in an urban safety-net clinic, and countless others who depend on these providers for care.

That is what we're fighting for. That is what we must protect. And that is why this matters.

About the author

Fatimah Muhammad is a writer for HFMANJ Focus Magazine and Director of 340B Pharmaceutical Services, Saint Peter's University Specialty Pharmacy, Drug Replacement, and ADM Pharmaceutical Services at Saint Peter's University Hospital in New Jersey. he holds HFMA fellowship status and serves on the NJHFMA Board of Directors and on multiple healthcare leadership boards focused on operational excellence and health equity.She can be reached at fmuhammad@saintpetersuh.com.

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Industry-sponsored clinical trials can bring millions of dollars in research funding to academic medical centers. But only if those trials activate efficiently and enroll successfully. Investigator-initiated studies supported by federal grants require meticulous compliance to maintain institutional eligibility for future funding.

And in an era where Medicare reimbursement increasingly links to quality metrics and outcomes data, the research that informs clinical practice guidelines has direct financial implications for how institutions get paid.

Love's work directly impacts these financial outcomes. She designs end-to-end submission workflows, conducts quality reviews, and provides real-time guidance to study teams. She prevents costly delays and compliance failures before they occur.

"At its core, my role is about building clarity where complexity exists," she told me. "I am known for translating policy into practice, creating systems that allow research teams to focus on what matters most, advancing meaningful, ethical research that ultimately benefits patients."

But in 2025, that work also matters to CFOs, revenue cycle leaders, and institutional strategists who understand that research programs can't generate financial returns if the operational infrastructure isn't sound.

Looking Forward

Love is motivated to continue expanding her impact within clinical research operations and health services administration, deepening her leadership, broadening her strategic influence, and remaining a trusted partner to investigators and institutions.

"Growth, for me, is not only about advancement, but it is also about alignment," she said. "Alignment between my values, my skills, and the environments I help shape."

That alignment between values and systems is precisely what healthcare organizations need as we navigate policy uncertainty, funding constraints, and mounting operational pressures.

The institutions that will thrive are those that invest in operational infrastructure not as an afterthought, but as a strategic priority with clear financial implications.

Love's career reminds me that some of healthcare's most important financial safeguards exist not in revenue cycle departments or finance offices, but in the meticulous operational work that happens behind the scenes. "This journey has taught me that meaningful progress happens behind the scenes, through structure, collaboration, and care." Her work may not appear on balance sheets, but its financial impact is undeniable. And in today's policy environment, it's more essential than ever.

I left that conversation thinking differently about operational leadership. About what counts as financial stewardship. About where institutional value actually gets protected or lost.

The next time someone tells you they work in research administration, ask them what they do. Really ask. You might discover they're safeguarding your institution's financial future in ways you never realized.

About the author

Fatimah Muhammad is a writer for HFMANJ Focus Magazine and Director of 340B Pharmaceutical Services, Saint Peter's University Specialty Pharmacy, Drug Replacement, and ADM Pharmaceutical Services at Saint Peter's University Hospital in New Jersey. She holds HFMA fellowship status and serves on the NJHFMA Board of Directors and on multiple healthcare leadership boards focused on operational excellence and health equity.She can be reached at fmuhammad@saintpetersuh.com.

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A System That Simplifies Workload

Effective document management can radically streamline operations. When policies, protocols, and reports are scattered across drives and inboxes, every small task adds friction. Centralizing digital files, labeling consistently, and automating version control cuts through clutter — freeing up cognitive space and reducing stress.

Saving key files as PDFs ensures formatting integrity and easy sharing across teams. And if you need to change a Word doc to a PDF, tools like an online converter make it effortless. Small technical shifts like this compound into significant mental relief for leaders managing constant documentation.

How to Reclaim a Sense of Control

It's not the number of responsibilities but the absence of structure that overwhelms. The The following checklist offers a practical way to reset.

Leadership Balance Checklist

Use this to identify what's off balance and what needs recalibration.

- Reserve at least two uninterrupted 90-minute deep work blocks per week.
- Schedule "decision days" for approvals; reduce micro-decisions during other times.
- Implement one no-meeting day monthly for reflective planning.
- Delegate all low-leverage tasks that don't require your unique expertise.
- Audit your calendar quarterly for activities that drain vs. energize.
- Prioritize one professional development or peer learning touchpoint each month.

Consistency in these micro-decisions compounds into sustained balance.

The Recovery Mindset

It's easy to glorify "servant leadership," but even service must be sustainable. The nervous system requires cycles of rest to sustain empathy, innovation, and judgment. Sleep,movement, and micro-breaks are not indulgences, they're biochemical maintenance for cognitive clarity.

Here's one way to think about what fuels recovery:

- Emotional restoration: meaningful conversations outside of work.
- Physical restoration: sleep, nutrition, and movement.
- Cognitive restoration: focus on one task at a time, without screens.
- Existential restoration: reconnecting with purpose, faith, or community.

Even five minutes of deep breathing before meetings can anchor you in the present, resetting stress physiology.

Common Questions from Healthcare Leaders

Below are answers to questions leaders often ask when trying to find balance.

Q: How can I maintain boundaries without seeming unavailable?

A: Communicate them early and link them to performance. "I reserve this block for focused patient-safety strategy, it helps me support the team better."

Q: I can't delegate clinical oversight. How do I avoid overload?

A: Keep oversight, not ownership. Set up transparent reporting systems where others can escalate only exceptions, not everything.

Q: How do I keep purpose alive when work feels transactional?

A: Revisit impact stories regularly. Integrate patient outcomes or staff success stories into team huddles to reconnect daily work with human meaning.

Rebalancing Through Intentional Design

Before burnout becomes visible, imbalance whispers. By replacing reactive busyness with intentional systems, both personal and operational, healthcare leaders can sustain not just their careers, but their humanity. The strongest leaders are not those who do the most, but those who build environments where excellence and rest coexist.

In summary: sustainable leadership comes from designing the same kind of care for yourself that you give to your teams: structured, intentional, and deeply human.

About the author

Lisa Hammett is an accomplished motivational and TEDx speaker, an international best-selling author, a Certified Positive Intelligence PQ Coach, and a wellness expert, helping stressed and burned out Executives and Leaders in Healthcare and HR develop mental fitness to manage stress, improve productivity and communication, and regain their health and wellbeing. She reached burnout, after 26 years in the corporate retail sector. After a transformative health and wellness journey, where she lost 65 pounds, Lisa decided to dedicate her life to helping others achieve their health and wellness objectives. She has empowered thousands of individuals to make sustainable, healthy lifestyle changes. Lisa can be reached at info@lisahammett.com.

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recognition. If learning is absent or requires extensive manual retraining for each variation, the underlying technology may be less sophisticated than marketed.

What is the total cost of ownership beyond initial licensing?

Initial licensing represents only a fraction of true costs. Probe deeply on implementation timelines, integration complexity, ongoing maintenance requirements, staff training needs, monitoring infrastructure, version upgrades, and vendor support models. These operational costs frequently exceed initial estimates, often only contemplating implementation, and can undermine ROI projections.

These questions separate marketing narratives from operational realities and help ensure technology investments align with actual workflow requirements.

The Hidden Costs of Misaligned Automation Strategy

The financial and operational consequences of choosing the wrong automation approach include costs that often surface only after implementation:

Maintenance burden escalation. RPA systems require continuous updates as payer portals evolve, regulatory requirements shift, and internal workflows change. What appears cost-effective during initial deployment can become a significant IT resource drain that persists indefinitely.

Workflow fragmentation rather than streamlining. When RPA handles only the structured components of a process, staff continue to intervene manually for exceptions, judgment calls, and non-standard scenarios. Instead of reducing handoffs and touches, poorly designed automation can actually increase process fragmentation.

Rework and error remediation. When bots fail silently, process outdated logic, or misinterpret changed business rules, teams can invest substantial time identifying and correcting errors—often discovering problems only after they've compounded across multiple accounts or reporting periods.

Underestimating Agentic AI governance requirements. Agentic AI delivers significant value, but not without appropriate oversight. Deploying these systems without clear governance, defined success metrics, quality monitoring, and operational boundaries can create more operational complexity than the technology resolves.

Opportunity cost accumulation. Every quarter spent maintaining misaligned automation tools represents a lost opportunity to address the workflows that would genuinely benefit from technological intervention. Perhaps more importantly, failed automation initiatives erode staff confidence in future technology adoption. Another consideration is that point solutions can quickly become sunk costs.

Recognizing these hidden costs during the evaluation phase—rather than discovering them through operational experience—enables more informed investment decisions.

Additional Considerations – AI Governance

New Jersey is moving quickly on AI. That matters for any AI product that touches consumers, payers, or employment decisions within the state.

Executive action and statewide strategy. In October 2023, Governor Phil Murphy created the New Jersey Artificial Intelligence Task Force through Executive Order No. 346. The Task Force was charged with studying AI's impacts and recommending government actions to encourage ethical use across the state. (State of New Jersey, Office of the Governor, 2023; State of New Jersey, Office of the Governor, 2024).

In January 2025, the New Jersey Attorney General and the Division on Civil Rights issued guidance clarifying that the New Jersey Law Against Discrimination applies fully to algorithmic discrimination. The guidance covers employers, housing providers, places of public accommodation, credit, and contracting, and it makes clear that entities can be held liable even if a biased tool was developed by a third party. For revenue cycle vendors and providers, this elevates expectations for testing models, monitoring outputs, and remediating disparate impacts in New Jersey. (New Jersey Office of the Attorney General & New Jersey Division on Civil Rights, 2025).

Insurance specific guardrails. In February 2025, the Department of Banking and Insurance issued a bulletin that sets expectations for AI use in insurance. It aligns with NAIC principles and calls for a written AI systems program, governance and internal controls, lifecycle coverage, consumer notifications where applicable, and documentation to show how risks of unfair or discriminatory outcomes are mitigated. Revenue cycle tools that influence claims, pricing, or fraud detection in New Jersey's insurance ecosystem will feel these controls in practice.

Legislative momentum to watch. A bill introduced in November 2025, the New Jersey Responsible AI Advancement and Workforce Protection Act, would require impact assessments for high-risk AI systems used in areas such as healthcare, housing, and employment. It also emphasizes workforce transparency and training. If enacted, vendors that deploy decisioning agents in New Jersey could face formal risk management, documentation, and assessment obligations that directly affect product design and go to market timelines. (New Jersey Legislature, 2025).

What this means for AI product and compliance in New Jersey:

- **Model risk management by design.** Build and maintain documented risk management and monitoring for any agent that scores, recommends, or drafts decisions that affect consumers or workers in New Jersey. Expect to show training data lineage, testing protocols, fairness checks, and remediation plans. The state's civil rights guidance treats algorithmic discrimination like any other discriminatory conduct. (State of New Jersey, Office of the Governor).
- **Insurance integrations with controls.** If your product interacts with payers or influences insurance decisions,

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align to DOBI's expectations. Maintain an AI systems program that covers vendor diligence, lifecycle governance, audit trails, and consumer disclosures when decisions materially affect individuals.

- **Be ready for impact assessments.** Track NJ legislation so you can stand up algorithmic impact assessments promptly if required. A lightweight template now is better than a scramble later.
- **Regional trend awareness.** Colorado's AI Act takes effect in 2026 and requires risk management programs, impact assessments, consumer disclosure, and human appeal options for high-risk systems. California has adopted multiple AI transparency and safety statutes, including training data disclosure requirements for generative AI and a law on frontier model transparency. New Jersey's direction is consistent with these trends, which means a common policy baseline will help reduce state-by-state rework. (Colorado General Assembly, 2024; Kourinian, 2024).

Agentic AI can improve denial resolution and financial outcomes, but deployment in New Jersey must include robust governance, fairness testing, and documented oversight. These requirements will influence product roadmaps, operating models, and vendor selection.

Building an Intentional, Sustainable Automation Strategy

The most successful automation initiatives don't begin with technology selection. They begin with rigorous operational analysis.

Leaders who systematically map current-state workflows, identify where variability and exceptions occur, quantify where staff time is disproportionately consumed, and understand the actual decision-making requirements within processes are positioned to make technology choices that align with operational reality rather than vendor promises.

When workflows are decomposed into structured, predictable steps versus judgment-intensive, variable tasks, the appropriate automation path becomes substantially clearer. This analytical foundation also creates the basis for realistic ROI projections, thoughtful change management, and measurable performance evaluation post-implementation.

As automation technologies continue to mature, the healthcare organizations that will achieve sustainable competitive advantage won't be those that adopt the most sophisticated tools first. They'll be the organizations that match the right technology to the right type of work, implement with operational discipline, and design automation strategies that genuinely strengthen—rather than complicate—revenue cycle performance.

Both RPA and Agentic AI have legitimate, valuable roles in modern revenue cycle operations. But they excel in fundamentally different contexts. By investing the time to understand your specific workflows, clarifying where structured automation is sufficient and where intelligent decision-making becomes necessary, and asking vendors the questions that reveal true capability rather than marketing positioning, finance leaders can build automation strategies that measurably reduce manual intervention, strengthen staff capacity, improve days in A/R, and enhance overall financial performance.

The path to a more touchless revenue cycle isn't about selecting the most advanced technology or the vendor with the most impressive demonstrations. It's about choosing wisely, implementing intentionally, measuring rigorously, and designing for adaptability from the beginning. (McKinsey & Company, 2026).

About the author

Adityaa Shukla, BS, CRCR (she/her), is a healthcare strategist who loves untangling complex problems across care and finance. She started as a 340B analyst at a local hospital, advanced through roles at UnitedHealthcare and Optum, and now works in healthcare consulting at R1RCM in the R37 lab, focusing on modern AI-driven revenue cycle solutions.

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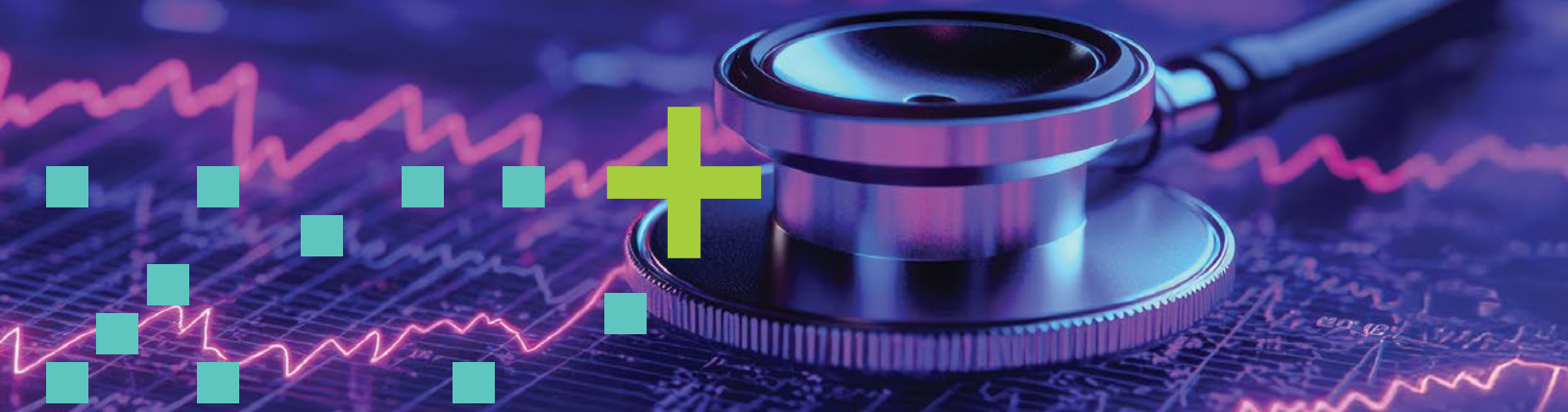

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