

Tarheel News

Message from Communications

Your NCHFMA Communications Team is here to keep you connected, engaged, and informed! We're always here to highlight your achievements and share important updates—let us know what you'd like to see featured in future newsletters.

- Charity Brown, Director of Communications



715

Members with Certifications

3

Upcoming in-person events



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1797

New members since January

184,571

Impressions on LinkedIn since January

3,006

followers on LinkedIn

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Message from Board

**Phil Rooney, Secretary/Treasurer, NCHFMA
Director - Denial Prevention, Johns Hopkins Health System**



I am currently serving as the Secretary/Treasurer on the NC HFMA board and am excited for my upcoming journey through the executive board track. My journey started at the end of COVID and offered an in-person connection, which wasn't always available in our day-to-day remote work lives any longer. For many of us, gone are the days of stopping by an office to chat, gathering in the hallway after a meeting, or having a lunch crew to go out with each week and talk about anything other than work. The HFMA board, volunteers, and folks involved have turned into a second work family for me and are some of the closest personal and professional acquaintances in my life today.

Whether you're new to HFMA or are a tenured member, we would like to invite you to attend, participate, and/or get involved with our NC HFMA chapter if you are able to. No need to jump straight into a leadership role or full council chair, as it takes a village to keep everything running in the HFMA world, and there are always opportunities to fit everyone's availability. If you are interested, please reach out on the volunteer link below, and we would love to hear from you.

[NC HFMA Volunteer Link](#)

I hope to see everyone at some of our upcoming networking events, conferences, or just to grab lunch over the next year!

Phil

2025-2026 NC HFMA Chapter Leadership

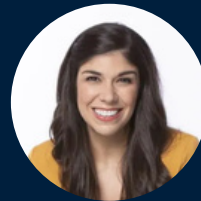
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HFMA Event Highlights



HFMA Event Highlights



HFMA Event Highlights



Member Spotlight

Tara Schwab, Contract Manager, Healthrise



Who is Tara?

Dedicated volunteer supporting student outreach, membership, events, and philanthropy. At Healthrise for the past year and a half, she thrives in a culture that empowers leadership, innovation, and meaningful impact in healthcare. Known for her authenticity and service-driven leadership, Tara is passionate about mentoring others, giving back, and driving future innovation, including AI-enabled front-end transformation.

How long have you been a member?

2 Years

Tackling Industry Challenges?

It often feels like payers hold all the power, creating rules that prioritize profit over people, while patients and providers bear the consequences. It's a challenge today, yes, but I truly believe that with all the industry leaders working together, one day this will be a win for patients and for healthcare as a whole.

Mentorship Advice?

Absolutely, my previous boss, Mindy Grubbs, who is now a best friend, taught me one of the most valuable lessons: "Did you document it? Did you send a follow-up email?" This advice has saved me countless times. Covering your bases and creating a clear paper trail.

Wisdom for Future Leaders?

Have the courage to fail—and to own it. Be honest, be human, and be authentic. Leadership isn't about perfection; it's about connection. When you admit mistakes and stand up for your team, you build trust. Find common ground, share a laugh, show appreciation, and never underestimate the power of a smile. Small gestures build trust, and trust builds teams.

Member Spotlight

Tara Schwab, Contract Manager, Healthrise



What does Tara do for fun?

I've been sober for 7 years and am incredibly proud of that journey. I'm also a proud mom to an 18-year-old senior heading to Cape Fear in Wilmington to play college volleyball. Outside of work, I'm a certified wedding planner who loves event planning, Saints and LSU football, cooking Cajun dishes learned from my dad, and a little friendly competition. I enjoy country life, fishing, getting muddy, and adventure, and I'm even planning to build my own home by hand.

Tara's Inspiration?

My daily work is inspired by my sobriety and the reminder that anything is possible with effort and faith. My belief in God grounds me in doing what's right—not just for myself, but for others. Helping people brings me the greatest joy, and today I strive to be the helping hand I once needed.

Tara's NCHFMA Impact?

Being a member of NCHFMA has benefited me both professionally and personally in countless ways. It has connected me with an incredible network of professionals, many of whom I now call friends. I've had the privilege of serving as a mentor to two amazing women in our field, and watching their growth and accomplishments has been one of the most rewarding experiences of my career. There's something truly special about cheering someone on and helping them see the light they've had all along. Through NCHFMA, I've gained valuable knowledge, earned my CRCR certification, attended networking events, and contributed to giving back to our communities. These opportunities have not only strengthened my professional skills but also enriched my personal sense of purpose and fulfillment.

Member Spotlight

Emily Baxter, Senior Account Executive,
TREND Health Partners



Who is Emily?

Emily is a Senior Account Executive at TREND Health Partners who's deeply involved in NCHFMA and passionate about strengthening payer-provider collaboration. She values connection, continuous learning, and working smarter rather than harder, as reflected in her mentorship experiences and professional goals.

Role and Passion?

TREND's mission of transparency and collaboration is something I'm proud to represent. We're proving that payers and providers can work together, and the impact is real. The team is passionate, leadership is deeply involved, and the culture makes the work genuinely inspiring.

Tackling Industry Challenges?

Revenue cycle teams are stretched thin, juggling constant fires and uneven resources. Everyone wants better margins, but without a shared focus on accurate, fair payment, the system stays stuck in wasted time, higher costs, and poorer patient experiences.

Mentorship Advice?

A mentor once told me to work smarter, not harder — and it stuck. I tend to avoid discomfort by doing things the same old way, but I'm learning to ask myself: am I choosing the hard way just to dodge something new? That's the habit I'm actively trying to break.

Wisdom for Future Leaders?

It's easy to freeze up when you worry about how you're perceived, but life rarely goes as planned anyway. When you replay your awkward moments, remember this is your first time living life — and everyone else's too. Don't let fear or imposter syndrome keep you silent or sidelined. You've earned your place, so use it.

Member Spotlight

Emily Baxter, Senior Account Executive,
TREND Health Partners



Emily's Fun Fact

I was the Spelling Bee runner-up in 2nd grade. I don't tell many people because it's probably intimidating to meet the former silver medalist of the Jackson-Via Elementary Spelling Bee. If you see me around, ask me what word cost me the gold – you'll be shocked anyone could misspell it, even a 7-year-old.

Emily's Personal Life?

I majored in French in college, studied abroad in Marseille, and still have a pen pal from Besançon. I love to travel and read – 63 books last year and 69 in 2024. Work took me to several states in 2025, and I also visited NOLA and Croatia. I'm planning trips to Colombia (Cartagena, Santa Marta) and Basque Country in 2026.

Emily's NCHFMA Impact?

Being part of NCHFMA and HFMA has been incredibly rewarding. The connections alone open doors to relationships and insights you'd never get in day-to-day work. The education – certifications, webinars, conferences – is timely, practical, and delivered by a passionate, welcoming community. Getting involved this past year has made me far more confident in my role thanks to the knowledge and network HFMA provides

Upcoming NCHFMA Events

In-person Events



NCHFMA Reimbursement Event

August 7, 2026
8 AM -5 PM
WakeMed, Cary



Carolinas HFMA Fall Symposium

September 16 - 18 2026
Wilmington, NC



NCHFMA Healthcare Finance Bootcamp

October 13, 2026
8 AM - 4:30 PM
The Pearl @ Advocate Health

The Next Big Thing on Your 2027 Checklist: Unique NPIs for Every Off-Campus HOPD

Educational Article

by Olivia Britt, VP of Client Success



If there's one thing hospitals love more than new technology, it's a new federal mandate. Grab your coffee and your process maps because we're officially in that phase now.

In early 2026, Congress passed, and the President signed, a requirement that could have jumped straight out of a healthcare RFP: all hospitals must obtain a unique National Provider Identifier (NPI) for each off-campus outpatient department as a condition of receiving Medicare payment under the Outpatient Prospective Payment System (OPPS). In other words, if it's an off-campus HOPD and you want Medicare to pay you for its services on or after January 1, 2028, it needs its own NPI and a provider-based status attestation to boot.

Yes, that's right: the voluntary world of attestations is officially over. CMS will no longer pay a dime for services furnished at an off-campus outpatient department unless the hospital has (1) obtained a separate NPI for that site and (2) submitted an attestation confirming compliance with provider-based requirements.

Why This Matters (Beyond One More Inbox Alert)

Don't let the acronym soup distract you. Here's the core of what's coming:

- **Administrative Impact:** Hospitals will need to inventory every off-campus outpatient department and establish a distinct identity for each in both Medicare and payor systems. Think claims, EHRs, enrollment records, and downstream integrations across payors. National Provider Identifiers are not just numbers; they're claim-processing triggers.

The Next Big Thing on Your 2027 Checklist: Unique NPIs for Every Off-Campus HOPD

Continued

- Operational Complexity: Beyond obtaining NPIs, hospitals will need to file attestations for provider-based compliance, often new, often institution-wide, and potentially recurring. The initial attestation window opens January 1, 2026, and closes December 31, 2027. Fail to submit, and you won't get paid.
- Claims Dependencies: EHR systems, clearinghouses, and payors must recognize the new NPIs correctly. How will this all sync, and rogue NPIs with mismatched taxonomies or enrollment records will lead to denials or delayed payments.

LEAN Planning Starts Now

This isn't a "sprint last quarter of 2027" project. This is LEAN work: eliminate waste, standardize processes upfront, engage stakeholders early, and reuse and build where possible.

1. Build a Comprehensive Inventory: Start with a process mapping of all off-campus provider-based outpatient departments. Treat this step like Value Stream Mapping for waste elimination: know what you have, where it bills, and how it currently shows up in your systems.
2. Create a Single Version of Truth: A master file that aligns location, tax ID, taxonomy codes, and desired NPIs isn't a luxury; it's a control point. Standardize taxonomy codes (e.g., 28 for hospital units) and validate with your billing systems before you request NPIs.
3. Engage Your IT and Revenue Cycle Partners: Don't let claims and EHR teams get pulled in late. Incorporate them into planning so NPIs are recognized across credentialing, enrollment, claims edits, provider directories, and payer systems.

The Next Big Thing on Your 2027 Checklist: Unique NPIs for Every Off-Campus HOPD

Continued

4. Plan Your Attestation Strategy: Treat attestations like regulatory submissions, not clerical tasks. Build checklists, assign owners, and schedule reviews. Remember, this isn't a one-time checkbox. Expect CMS to require periodic updates, think continuous improvement cadence.
5. Validate with Payers Early and Often: Interpretations vary. What gets accepted by Medicare might get misread by commercial payers. Early test claims and reconciliation runs will surface issues when you can still change course.

A Leader's Lens on This Burden

Yes, this adds burden. Yes, it will strain hospitals' administrative capacity. But it also presents an opportunity to LEAN up provider enrollment and billing operations, reduce denied claims from location mismatches, and harmonize provider identities across payors. Think of it as "forced housekeeping" for your provider data.

When Medicare first required NPIs nearly three decades ago, it was about simplifying electronic transactions. What's emerging now feels like the next phase of that simplification on steroids: ensuring every service location is transparent, traceable, and cleanly identified across the healthcare ecosystem.

For those of us who see problems as opportunities, this mandate isn't a boogeyman; it's a catalyst for stronger operational discipline, better data hygiene, and a tighter connection between provider identity and care delivery.

Let's get ahead of it. If you would like to receive a copy of a Lean Workflow Template, please email me at Olivia.Britt@savistarcm.com

Length of Stay & How Caregivers Make a Difference

Educational Article

by Jeremy Szydelko
Manager, Provider Solutions



Hospital leaders are increasingly focused on length of stay (LOS) and not just from a clinical standpoint. LOS has become a key financial and operational priority for many organizations. A 2025 improvement initiative at an urban safety net hospital found that targeted LOS strategies reduced the Length of Stay Index from 1.15 to 1.02, meaning patients are being discharged 13% quicker without increasing readmissions or mortality, demonstrating that LOS optimization can improve efficiency without compromising safety. Around the same time, a broad review of LOS research reinforced that extended hospital stays increase the risk of complications, drive up resource use, and place additional pressure on both care teams and hospital budgets. Together, these findings have reshaped how hospitals view LOS, elevating it from a standard clinical measure to a core driver of financial performance.

From a financial perspective, every extra day in the hospital carries cost implications. While reimbursement under DRG-based models remains largely fixed, daily operating expenses continue to accumulate through additional nursing hours, medications, meals, and supplies. Longer stays also restrict capacity, which can create bottlenecks in the emergency department, delay elective surgeries, and limit access for higher-acuity patients who often bring more favorable reimbursement. Furthermore, prolonged LOS increases exposure to falls, infections, and medication errors. These clinical events also have financial consequences and can influence payer performance measures and value-based purchasing outcomes.

Length of Stay & How Caregivers Make a Difference

Continued

An overlooked contributor to LOS is the role of caregivers in helping patients with their Activities of Daily Living (ADLs). While this element does not stem from the cited research, it is widely recognized across hospitals that basic supports, such as assisting with walking, bathing, and toileting, help patients regain strength faster. Early mobility and routine ADL engagement improve recovery, reduce complications, and accelerate discharge readiness. Caregivers also play a key role in identifying functional barriers early, giving therapy and case management teams the time they need to intervene before a discharge delay occurs. These simple, hands-on interactions often prevent the last-minute setbacks that extend LOS by a day or more.

For hospital finance and operations leaders, LOS has become a truly multidimensional metric. Shortening LOS lowers cost per case, increases bed availability, reduces complication-related expenses, and strengthens reimbursement performance. And with evidence showing that LOS can be reduced safely and sustainably, LOS improvement has become a strategic priority that supports both financial stability and patient care.

Whether you sit in finance, operations, nursing, or case management, LOS is everyone's business now. And while advanced tools and workflows play an important role, the day-to-day work of caregivers helping patients move, regain strength, and rebuild confidence may be one of the most effective LOS strategies of all.

The “Second Look” Problem: Why Post-Payment Reviews are Changing Revenue Cycle Strategy

Educational Article

by Elizabeth Purdy, Esq.



For years revenue cycle strategy has focused on getting claims right the first time. Clean claims, accurate coding, proper authorization, and complete documentation have long been viewed as the foundation of successful reimbursement.

In 2026, that foundation is shifting. Providers are increasingly encountering a new challenge: claims are paid correctly at the outset, only to be revisited, reinterpreted, and recouped months later. These “second look” reviews, whether framed as audits, clinical validation, or policy-based adjustments, are changing the way organizations should think about revenue integrity.

What was once considered final payment, the final stage of the claim lifecycle, is now, in many cases, conditional, subject to retrospective review and validation.

The Rise of the “Second Look” Environment

Post-payment review is not a new concept. However, its frequency, scope, and complexity have expanded significantly in recent years.

Payers are implementing several tactics, including retrospective clinical review, data-driven audit selection, policy reinterpretation after adjudication, and vendor-supported audit programs. These processes allow payers to revisit claims after payment without disrupting front-end workflows. The result is a reimbursement environment in which initial adjudication no longer represents finality, and revenue remains exposed long after services are rendered.

The “Second Look” Problem: Why Post-Payment Reviews are Changing Revenue Cycle Strategy

Continued

What’s Driving the Shift?

Financial Pressure on Payers

As reimbursement pressures increase, payer focus on cost containment has intensified. Post payment review allows payers to identify and recover payments without delaying initial claims processing. As a result, recovery strategies have become a more prominent component of payer operations.

Data and Technology Advancements

Advancements in analytics have fundamentally changed how payers identify claims for review. Payers are able to identify patterns across large volumes of claims. Claims are no longer evaluated in isolation; instead they are increasingly assessed among broader datasets.

Payers are increasingly using analytics to flag claims based on:

- provider-specific utilization patterns
- diagnosis-procedure mismatches
- historical billing and denial trends
- deviations from “expected” clinical pathways

This shift enables pattern-based recovery strategies, where claims may be selected not because they are clearly incorrect, but because they appear statistically inconsistent. As a result, providers may face recoupments tied not to discrete errors, but to alleged statistical inconsistencies, creating new challenges in both prevention and appeal.

The “Second Look” Problem: Why Post-Payment Reviews are Changing Revenue Cycle Strategy

Continued

Policy Complexity and Interpretation

Many payer reimbursement policies, particularly those addressing medical necessity, level of care, and clinical validation, allow for interpretation. This creates opportunities for retrospective review, even when services were initially approved or paid.

Operational Impact on Providers:

Revenue Instability: Payments that were once considered finalized are now subject to recoupment, complicating financial projection and planning. Organizations need to account not only for denials but also for unpredictable delayed revenue reversals.

Timing Mismatch Between Payment and Risk : A critical issue is the timing gap between payment and recoupment.

In many cases:

- Claims are paid within standard timelines
- Revenue is recognized and reported
- Months later, the same claims are selected for review

This lag creates a risk environment in which revenue previously considered secure becomes vulnerable. Additionally, appeal timelines and the retrieval of documentation may be affected by the passage of time, making it more difficult to defend claims.

The “Second Look” Problem: Why Post-Payment Reviews are Changing Revenue Cycle Strategy

Continued

Increased Administrative Burden: Post-payment reviews require organizations to maintain readiness beyond the initial billing lifecycle

This includes:

- Retrieval of historical documentation
- Coordination across clinical, coding, and compliance teams
- Development of complex appeal responses

These activities increase workload and extend the revenue cycle beyond traditional boundaries.

Documentation Gaps Become Financial Risk

Documentation that was sufficient for initial billing may fail to withstand retrospective scrutiny.

Reviews conducted months after the fact often apply different expectations, particularly when clinical decision-making is evaluated without the context available at the time of care. As a result, documentation gaps are no longer simply compliance concerns; they are direct financial risks.

Rethinking Revenue Cycle Strategy

To adapt, providers must shift from a transactional mindset to a defensive, lifecycle-based approach to reimbursement.

The “Second Look” Problem: Why Post-Payment Reviews are Changing Revenue Cycle Strategy

Continued

1. Build for the Audit, Not Just the Claim

Documentation should be developed with the understanding that it may be reviewed long after the service is rendered by individuals who were not involved in the initial care decision. This requires:

- Clear articulation of clinical rationale
- Consistency across the medical record
- Alignment with payer policy language and criteria

Organizations must move beyond documenting what occurred and also document why it was clinically appropriate at the time.

2. Integrate Clinical, Compliance, and Revenue Cycle Functions: Post-payment reviews often turn on clinical interpretation. As a result, collaboration between clinical teams, utilization review, coding, and/or legal/compliance is increasingly critical to ensure defensible documentation and consistent positioning. This integration of teams ensures that documentation, coding, and appeal strategies are aligned and defensible.

3. Track and Analyze Recoupment Trends: Recoupments should be treated as a distinct category of revenue risk. Organization should be tracking:

- Payer-specific audit behavior
- Common rationales for recoupment
- Timeframes between payment and review

The “Second Look” Problem: Why Post-Payment Reviews are Changing Revenue Cycle Strategy

Continued

This data can be used to identify patterns, inform prevention efforts, and prioritize high-risk areas for intervention.

4. Strengthen Appeal Infrastructure

Appeals related to post-payment reviews often require a different approach than traditional denials. These cases require providers to respond to retrospective reinterpretation of previously accepted claims.

As these disputes become more complex, organizations may need to incorporate legal and regulatory analysis into their appeal workflows, specifically when addressing issues related to procedural consistency and policy application.

Conclusion

The increase in post-payment review signifies a fundamental shift in how reimbursement is determined and managed. In this ever-changing environment, payment is no longer the end of the revenue lifecycle; it is simply another stage in an ongoing process of validation.

For revenue cycle leaders, success will depend on anticipating not only how claims are adjudicated initially, but also how they may be reassessed over time, and on defending that initial payment.

In 2026, it is no longer enough to get paid. Organizations must be prepared to defend what they have earned in order to keep what they have earned.

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