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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 . . .

Lisa Schaaf

Dear NJ HFMA Members,

A new chapter year is a chance to set the tone for what comes next, and I want to set ours with a clear message: We are ready for what this year brings.

The 2026-27 HFMA theme that fits our chapter well: Dare to Solve. Our field is facing real challenges, tighter margins, more complex payer relationships, new technologies to master and a workforce stretched thin. Those challenges are also where opportunity lives. Every one of them is a chance to sharpen our skills, strengthen our organizations and grow as leaders.

Dare to Solve is a call to act, not just adapt. It means bringing solutions to the table instead of waiting for someone else to find them. It means using this chapter as a resource, not just a network, to sharpen your thinking, expand your skill set, and land on solid answers faster than you would on your own.

Here's how to make the most of this year: Show up to chapter events, even the ones that aren't convenient. Volunteer for a committee and put your expertise to work. Pursue the certification you've been putting off. Reach out to a colleague who's solved the problem you're facing. Every one of these moves you, your organization, and our chapter forward.

I'm confident about this year because I know the caliber of people in this chapter. We have the skills, the drive, and the collective experience to meet this moment head-on. Let's get to work.

Thank you for being part of NJ HFMA. I look forward to what we accomplish together.

Warm Regards,

Lisa

DARE to SOLVE hfma '26-'27

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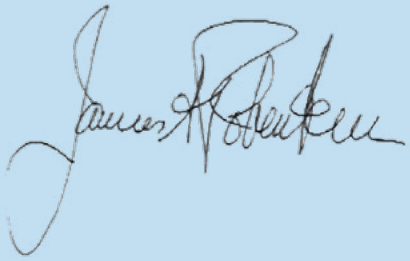
From the Editor . . .

Jim Robertson

As the World Cup captivates our attention and imagination, I give you this riddle. Go Team USA!

I dance with a ball but rarely with my hands,
Creating magic before packed stands.
Though not the tallest, I rise above all,
Leaving defenders chasing shadows as they fall.
As a child, a challenge threatened my dream,
Yet I pushed ahead and joined football's elite team.
In blue and red I built a legendary name,
Winning countless trophies and mastering the game.
I crossed an ocean, yet my fame only grew,
Leading my homeland to a triumph long overdue.
With golden awards stacked high on my shelf,
Many call me the greatest to ever be myself.
Who am I?

Answer: Lionel Messi



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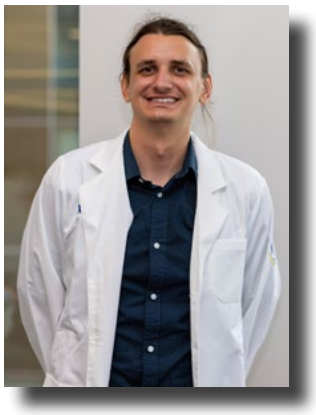
Beyond "Noncompliance": A Medical Student's Perspective on the Cost of Unaffordable Care



Cooper Bahr

By Cooper Bahr

As a medical student preparing to enter residency, healthcare finance has become an increasingly important area of focus. This topic has been a source of interest for many years, including my undergraduate honors thesis on pharmaceutical pricing and healthcare affordability.

As clinicians, our main goal is healing. However, our clinical activities can sometimes unintentionally cause financial harm. This is a significant responsibility we carry, and we must use it thoughtfully to help our patients. Physicians, in many ways, have an unofficial fiduciary responsibility that encourages cost consciousness and shared decision-making as part of patient care.

During my clinical rotations, I have observed a pattern I had previously understood in theory: many hospital admissions and readmissions are caused by patients not taking their medications. This issue is complex and multifactorial.
What is often documented as "noncompliance" is, in reality, unaffordable or impractical care. When written in the chart, it can subconsciously suggest a moral character flaw in the patient. This label is then passed along to other providers who read the chart but do not see the full story.

I recall a patient with urinary incontinence whose daughter served as her primary caregiver. She explained that oxybutynin, prescribed for symptom management, was prohibitively expensive through their insurance. By discussing alternatives, I was able to suggest an over-the-counter patch that was significantly more affordable. A small change in approach made the treatment plan more accessible, and therefore more likely to be followed.

There are many similar opportunities in everyday practice. In some cases, medications prescribed through traditional channels can be obtained at lower cost through over-the-counter options, alternative formulations, or cash-pay pharmacies. Simply asking patients directly, "Were you able to pick up your medication?" or "How much did it cost you?" can reveal barriers that would otherwise remain hidden.

The way these questions are asked also matters. Patients may feel uncomfortable admitting that they could not afford a medication or chose not to fill a prescription. Framing the conversation in a nonjudgmental way, such as, "Many patients have trouble affording medications. Has cost ever been a barrier for you?" can create space for more honest and productive discussions.

For healthcare finance professionals, these individual interactions reflect a broader system-level issue. Medication nonadherence is associated with increased hospitalizations, disease progression, and higher long-term costs. When nonadherence is driven by affordability, it represents a missed opportunity for early, low-cost intervention. Relying on individual clinicians to consistently identify these barriers is inherently variable.

There is an opportunity to incorporate affordability more systematically into clinical workflows. Standardized intake questions, such as whether a patient has skipped or not filled a prescription due to cost, can help surface these issues early. Integrating cost awareness into prescribing practices and improving access to lower-cost alternatives can further reduce barriers to adherence.

Encouragingly, medical education is beginning to incorporate these concepts. During my third year, students are required to complete coursework on the business of healthcare, alongside specialty-specific exposure to financial considerations in clinical practice. However, residency training remains demanding, and many physicians still enter practice feeling underprepared to navigate the complexities of the healthcare system.

Physicians who better understand the financial aspects of care are in a stronger position to deliver high-quality, patient-

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centered treatment. As healthcare costs continue to rise and the population ages, integrating cost awareness into clinical decision-making will only become more essential.

I firmly believe physicians who better understand our current healthcare landscape can provide higher quality care to their patients. With an aging population and healthcare costs continuing to increase, these skill sets are becoming increasingly important. I am encouraged by what I have learned so far and look forward to helping my future patients in meaningful ways that extend beyond the clinic.

About the author: *Cooper Bahr is a third-year medical student at Drexel University College of Medicine in Philadelphia, Pennsylvania. He can be reached at cooperbahr@gmail.com.*

Mark Your Calendar

2026 New Jersey HFMA Annual Regulatory and Reimbursement Committee Fall Meeting

September 10, 2026 — Webinar

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 hfmanj.org

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NJ HFMA Annual Conference 2026 Preview

Tara Bogart

By: Tara Bogart

The NJ HFMA Annual Conference returns to the Borgata Hotel Casino & Spa Atlantic City this October, bringing together healthcare finance leaders, revenue cycle executives, and industry innovators for three days of education, networking, and collaboration.

This year's program is built around many of the issues currently shaping healthcare finance, including artificial intelligence, revenue cycle transformation, patient financial experience, regulatory changes, value-based care, and data-driven decision-making. Attendees will hear from provider executives, industry experts, consultants, and technology leaders who are navigating these challenges in real time.

The event kicks off with a welcome lunch on Wednesday, October 21st at 11:30am and continues through Friday, October 23rd. The conference opens with a discussion on scaling AI in healthcare finance, exploring practical applications of artificial intelligence across revenue cycle operations, cybersecurity, and governance.

Following break out sessions, Family Feud: Vendor vs. Provider promises to bring entertainment as healthcare vendors and providers square off in a lighthearted competition that highlights the realities—and occasional misconceptions—of their working relationships. The fun continues afterward with the annual Charity Event, providing attendees another opportunity to network while supporting a worthy cause.

Thursday's keynote presentation features Jack Hoban, who will deliver Leadership Under Stress: Timeless Ethics for Healthcare Finance Leaders. Drawing on his extensive experience in leadership development and martial arts philosophy, Hoban will share practical strategies for making ethical decisions, maintaining perspective, and leading effectively during times of uncertainty and pressure. His session promises to provide valuable lessons that extend well beyond healthcare finance and will resonate with leaders at every level of an organization.

One of the conference's most anticipated interactive sessions is the Innovation Gauntlet, a session led by Nio Quiero, where emerging ideas and solutions will compete for audience support in a fast-paced, engaging format designed to spark new thinking and challenge conventional approaches.

In addition to the featured general sessions on Thursday, attendees can choose from a broad range of breakout sessions with four options for each of the three breakout sessions. Special lunchtime sessions, including HFMA 101 and Enterprise 101, will introduce attendees to the benefits of HFMA membership and provide valuable information for organizations who have or are considering enterprise participation. After a full day of education, the networking events begin with a President's Reception from 4:00–6:00 PM. For those who can thrive on a little less sleep, the fun picks back up at 10:00 PM and continues until 1:00 AM.

Friday morning includes two general sessions, with the event ending after the CFO Panel. With an estimated 15.5 CPE credits available and a program packed with timely content, the 2026 NJ HFMA Annual Conference is shaping up to be a valuable event for healthcare finance professionals across the region.

A special thanks is owed to the members of the Annual Institute Committee and the Chapter President, Lisa Schaaf. We also thank our sponsors, whose continual support allows us to bring you such an exciting event at such a reasonable cost. I hope this article gives you a peek into what we have planned, and that you'll be able to join us at the Borgata on October 23rd.

About the author

Tara Bogart, Vice President at PMMC, is a healthcare finance professional with extensive experience in revenue cycle management, managed care contract optimization, reimbursement analytics, pricing transparency, and strategic charge master rate setting. She partners with hospitals and health systems to improve financial performance, enhance payer accountability, and navigate the complexities of an evolving reimbursement landscape.

A dedicated member of the Healthcare Financial Management Association (HFMA), Tara actively serves on committees across four HFMA chapters. She believes involvement in this organization is pivotal to staying at the forefront of industry trends, fostering collaboration, and contributing to the advancement of healthcare financial management practices.

Tara can be reached at tara.bogart@pmmconline.com.

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Medicare Managed Care: Are Traditional Clinical Decision-Making and Automated Utilization Management Systems on a Collision Course?

James A. Robertson

Paul L. Croce

By: James A. Robertson and Paul L. Croce

Hospitals and managed care organizations (MCOs) have long existed in a state of uneasy coexistence, but the rapid expansion of Medicare Advantage has intensified the conflict into one of the most consequential legal and policy battles in American healthcare. What was once viewed primarily as a reimbursement dispute has evolved into a broader debate over who controls medical decision-making: physicians and hospitals, or insurers using increasingly sophisticated, and often automated, utilization management systems.

Today, more than half of Medicare beneficiaries are enrolled in Medicare Advantage plans administered by private insurers rather than the traditional fee-for-service Medicare system. Supporters argue that managed care promotes efficiency, reduces waste, and coordinates treatment more effectively. Hospitals and physician groups, however, contend that many insurers have gone beyond legitimate cost management and have created administrative systems that delay care, deny medically necessary treatment, and burden providers with extraordinary operational costs.

At the center of the controversy is prior authorization. Under Medicare Advantage, insurers often require approval before patients can receive certain procedures, imaging studies, rehabilitation services, or transfers to post-acute facilities such as skilled nursing facilities. Hospitals argue that these requirements frequently delay treatment and prolong inpatient stays while clinicians wait for insurer approval. In many cases, providers assert that denials are later overturned on appeal, suggesting the initial denials may have lacked sufficient medical justification.

The financial implications are enormous. Hospital systems across the country now maintain large administrative departments dedicated solely to utilization management, claims appeals, and insurer negotiations. Many providers argue that the administrative complexity of Medicare Advantage increasingly rivals -- or exceeds -- the clinical work itself. Rural hospitals and safety-net institutions are particularly vulnerable because they often lack the negotiating leverage and staffing resources available to larger health systems.

The conflict has become even more contentious with the growing use of artificial intelligence and predictive algorithms in coverage determinations. Insurers maintain that algorithmic tools can help standardize decision-making and identify unnecessary utilization. Critics, however, argue that these systems may effectively substitute automated predictions for individualized physician judgment.

One of the most closely watched legal disputes involves allegations against UnitedHealth Group subsidiary NaviHealth, where plaintiffs claim that an algorithm known as "nH Predict" was used to prematurely terminate rehabilitation coverage for elderly Medicare Advantage patients. According to the lawsuit, patients were allegedly discharged from skilled nursing facilities based on predictive models rather than individualized clinical assessments. While the court has not ruled on the merits of those allegations, recent judicial decisions allowing broad discovery into the insurer's internal practices signal increasing judicial willingness to scrutinize how insurers use AI-driven decision-making.

These cases illustrate a significant shift in how courts

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are approaching managed care disputes. Historically, judges were often reluctant to interfere with insurer utilization management practices, viewing such matters as highly technical administrative issues governed by federal Medicare regulations. Increasingly, however, courts appear more willing to examine whether insurers are complying with Medicare standards requiring individualized review and medically necessary coverage determinations.

A central legal issue emerging from recent litigation is the distinction between AI-assisted decision support and automated denial systems. Courts and regulators generally appear comfortable with technology serving as a clinical aid. However, when plaintiffs allege that clinicians merely "rubber stamp" algorithmic recommendations without meaningful independent evaluation, judges are showing heightened concern about opaque "black-box" systems where patients and providers cannot fully understand the basis for denials.

At the same time, courts are also grappling with the structural complexity of Medicare Advantage itself. Many insurers argue that disputes over denials or payment must first proceed through Medicare's administrative appeals process rather than through direct lawsuits in state or federal court. This doctrine – sometime referred to as "administrative exhaustion" -- has become a major battleground in managed care litigation. Some courts have required providers and patients to exhaust federal administrative remedies before filing suit, while others have allowed breach of contract, fraud, and unfair business practice claims to proceed independently.

These procedural disputes carry enormous practical significance. If insurers succeed in forcing most disputes into lengthy administrative processes, litigation becomes far more difficult and expensive for hospitals and beneficiaries, particularly where the claim relates to the treatment of one particular patient. Conversely, if courts increasingly permit direct lawsuits, insurers may face broader discovery obligations and greater exposure to class action litigation.

Government enforcement actions are also reshaping the landscape. Federal regulators and the Department of Justice have intensified scrutiny of Medicare Advantage organizations, particularly regarding risk-adjustment practices and billing methodologies that allegedly inflate government payments. At the same time, regulators have signaled growing concern about prior authorization practices that may improperly restrict access to medically necessary care.

Notably, courts have not uniformly sided with either providers or regulators. In one significant recent decision, a federal court invalidated portions of CMS's RADV audit rule affecting Medicare Advantage insurers, which would have allowed CMS to extrapolate audit results over the universe of claims submitted under a particular contract. The court concluded that the agency violated administrative law requirements during rulemaking. The decision represented a substantial victory for insurers and demonstrated that courts remain willing to police regulatory overreach as well.

What emerges from these cases is not a wholesale judicial rejection of managed care, but rather a growing insistence on transparency, procedural fairness, and individualized medical review. Courts appear increasingly skeptical of systems that prioritize cost containment at the expense of demonstrable clinical judgment. Judges are particularly sensitive to allegations involving delayed post-acute care, retroactive denials, and the use of algorithms that may obscure how coverage decisions are made.

The stakes extend far beyond hospitals and insurers. As Medicare Advantage enrollment continues to grow, the legal standards now being developed will shape how millions of elderly Americans access healthcare. The fundamental question is no longer simply whether insurers may manage care costs -- they clearly can -- but how far they may go before utilization management interferes with the core medical judgment traditionally exercised by treating physicians.

Over the next several years, litigation is likely to focus increasingly on algorithmic transparency, human oversight requirements, and the extent to which federal Medicare standards constrain insurer discretion. Courts will continue to play a pivotal role in defining the balance between efficiency and patient protection in a healthcare system that is becoming ever more dependent on managed care.

In many respects, these disputes represent the next major phase of healthcare regulation: the collision between traditional clinical decision-making and increasingly automated systems designed to control cost, standardize treatment, and manage risk at scale. How courts resolve that tension may ultimately determine the future structure of Medicare Advantage itself.

About the Authors: *James A. Robertson is a Partner and Chair of the Healthcare Department at Greenbaum, Rowe, Smith & Davis LLP, 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.*

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Igniting Potential: Women in Healthcare Finance Chart a New Course

Lisheon Thompson

By: Lisheon Thompson, MBA, CRCR

TINTON FALLS, NJ – A palpable energy of ambition, collaboration, and empowerment filled the DoubleTree by Hilton on April 22, 2026, as the New Jersey Chapter of the Healthcare Financial Management Association (HFMA) hosted its Annual Women's Leadership & Development Event. With the theme "Ignite Your Potential: Strength in Leadership, Compassion in Action, and Graceful Impact," the event brought together women from across the healthcare finance sector for a day of inspiration, learning, and connection.

The conference was meticulously designed to provide a dedicated space for women in a field often dominated by numbers and bottom lines to focus on the human side of leadership. It served as a powerful reminder that true leadership is a blend of strength, empathy, and grace. The day's agenda was packed with insightful keynote speakers, dynamic panel discussions, and invaluable networking opportunities, all aimed at uplifting and empowering women to navigate their careers and the evolving healthcare landscape with confidence. Esteemed keynote speakers and panelists, all leaders in their respective fields, shared their personal and professional journeys, offering candid insights into the challenges and triumphs of leadership. The sessions were curated to address the multifaceted nature of leadership in today's complex healthcare environment. Topics ranged from strategic leadership and compassionate decision-making to maintaining grace under pressure during times of organizational change. Attendees were encouraged to reflect on their own leadership styles and identify areas for personal and professional growth.

A central focus of the event was the power of community. The organizers fostered an environment where attendees could engage in meaningful conversations about their shared experiences. Discussions on navigating career transitions, the importance of building supportive professional networks, and the critical role of mentorship and sponsorship for women were prevalent throughout the day. The event underscored the belief that by lifting each other up, women in healthcare finance can collectively rise to new heights.

The resounding takeaway from the day was a renewed sense of purpose and a powerful toolkit of practical leadership insights. Participants left with a deeper understanding of how to lead with both strength and empathy, and a stronger connection to a community of women dedicated to making a graceful yet powerful impact on the healthcare finance landscape. The NJ HFMA Women's Leadership & Development Event once again proved to be a vital platform for fostering the next generation of women leaders, ensuring a brighter, more compassionate future for healthcare.

Thank you to everyone who attended and contributed to making this event such a memorable and impactful success. We look forward to seeing you next year.

About the author

Lisheon Thompson, MBA, CRCR is a seasoned healthcare revenue cycle leader with more than a decade of experience optimizing end to end revenue cycle operations across Hackensack Meridian Health. As Network Manager of Hospital Billing, she drives system wide improvements in billing accuracy, claim acceptance and operational efficiency. An EPIC credentialed trainer and active HFMA member, Lisheon is recognized for her patient-centered approach, data-driven leadership, and a core belief that a healthy revenue cycle is essential for quality patient care.

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Honoring John Dalton

John Dalton

It was with a great deal of sorrow that we recently heard of the passing of John J. Dalton, who had been an integral part of the Chapter for so many years. John was the President of the New Jersey HFMA for the Chapter year 1989 – 1990. He served on the HFMA Board from 1994 through 1996 and in 2001 won the Association's prestigious Frederick C. Morgan Individual Achievement Award for his outstanding contributions to HFMA over the course of his long and distinguished career. More recently, John was well recognized by the membership from his role as the Emcee of the Annual Institute, and also as the editor of the "Three Minute Read", a newsletter enjoyed by so many Healthcare leaders.

The NJ healthcare industry lost a giant with the passing of John Dalton this past April. Over 40 years I watched with amazement as he progressed thru the industry in various roles always with good cheer and energy. Given the length of John's career, he became the unofficial historian of the NJ HFMA reporting on monthly meetings and especially the annual institute. John was a prolific writer and may hold the record for articles published in the Garden State FOCUS.

While John and I spent allot of time together while we were working it is the time I spent with him in retirement that I will cherish and remember the most. Starting in 2021 I began playing golf with John more or less on a weekly basis. John was still a bundle of energy and would literally run around the course like a teenager. Though he hit from the forward tees as he claimed was his right being he was in his 80's he could occasionally out drive us all. John and I would also attend Phil Besler's annual clamming trip in Barnegat Bay. Again, John's energy and positive attitude were always present

I will miss John greatly as I know his wife Ann and family do as well. John was a force in the NJ healthcare industry and a true leader but most of all he was gentleman and a good friend

Joe Lemaire

I met John over 40 years ago when I joined the "HealthCare Financial Management Association." John and I were on the Focus newsletter committee. John always had a penchant for writing. John immersed himself into everything that he did. He was loyal and passionate. He provided an insightful prospective. His ability to guide and provide meaningful consul is why organizations sought him out placing him in leadership positions. Over the years I got to know John very well as he moved into leadership positions in the association both the New Jersey Chapter and the National board and in other organizations.

I had the privilege to know John as he wore his many hats. Early in his career we worked for different accounting firms…… John was more a mentor than competitor. Over the years, he was also a consultant / vendor that I relied on at the Hospitals I worked for. We were colleagues on boards.

When I retired 9 years ago, John reached out and added me to his coveted golfing email. Since then, I have had the opportunity to play golf with John, meet his many friends and relax on the golf course. He was our captain, the glue that kept us all going, he never gave up even when plagued with back problems and other maladies ……he was John ……. our energizer bunny……I thank John for his patience, putting up with my errant shots and lost balls on the course. He was there commiserating with me when I couldn't break 120 and celebrating with me when I reached milestones breaking 100 and the elusive 90.

There are many ways to remember John….as a Colleague, Associate, Consultant, Advisor, Mentor, Fellow Board Member, Golf Buddy……I will remember John as a very dear friend that I will greatly miss.

Cheers, John.

John Calandriello

John and I first met back in 1977, when he was with Haskins & Sells and I was with Blue Cross of Greater New York. He and I were asked to team together on an important project that served to support testimony before Congress by his boss and Partner at Haskins & Sells and my then boss Sister Cathleen Maloney. From our first luncheon with our bosses at 2 Broadway and up until his recent passing we enjoyed our mutual friendship and discussing the many twists and turns in our chosen Healthcare field. John will surely be missed by all that knew him.

Jeff Blumengold

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When I think back on my career in Healthcare, it seems that John was always there, a constant at Chapter events who had the unique ability to make everyone feel welcome. Professionally, I became aware of John through an engagement that Healthcare Business Specialists had with St. Lawrence Rehab, where my Healthcare career began. And I still have my HBS STRESS-LESS Biofeedback Relaxation Ruler, although the sensor pad stopped working years ago. Or perhaps I'm more stressed now.

For years John was the Emcee at the Annual Institute. It was impressive how easy he made it look, managing the flow for the general sessions and panel discussions. And of course, he never missed a networking event, where he was equally popular with seasoned members as well as the early careerists attending their first major conference. I was both honored and a little apprehensive when John recommended me as his replacement a few years back, when he decided to step away from the role he had performed so well over the years. I say apprehensive, since I knew the amount of time he spent every year preparing for the Institute. I can only hope that I'm living up to the high standard he set.

Mike McKeever

I met John at the very beginning of my healthcare career. John was the president of a small consulting company called HBS. The company included himself, Dick King, Cathy Bush, Becky Weber, Judy Hebble, Steve Nowicki, and his son and daughter, Chris and Susan. He treated his team like family. He taught me that personal friendships and work friendships don't have to be mutually exclusive.

John was our leader, and my mentor. Above all, he was knowledgeable and professional. He seemed to know everyone in the industry and was respected by all. He taught us the Dalton Consulting Rules – #1 Clearly define issues, #2 Concisely describe the corrective steps that are required, and #3 Offer to help.

John was a fixture at every industry gathering. He never missed an event. Yet, true to his character, he never wanted to be the center of attention. He was often the organizer or moderator, while he let others shine. He didn't need the spotlight to make his presence felt.

Although John was a classic stubborn Irishman but could also adapt. For years, he loved playing tennis. Back in the day, NJHFMA scheduled an annual Golf & Tennis Outing. Every year John had us on the phones, recruiting enough tennis players to fill out a round-robin tournament. But as the time passed, and our knees got collectively older, John made the executive decision to trade the tennis court for the golf course. He applied his signature work ethic to golf and picked up the game quickly. The happiest that I ever saw him was one time at the Cranbury Golf Club, when it looked like his chip shot was going to fly over the green, it hit the flag stick and fell into the hole. "Just like I planned it", he said with a huge smile.

John also left us with some very practical, foolproof life advice. John firmly believed that a home-baked loaf of Irish Soda Bread was an entirely appropriate gift for every single occasion. St. Patrick's Day? Irish Soda Bread. Birthday? Irish Soda Bread. New job? Irish Soda Bread. And he was right. Unlike some gifts, every Soda Bread was warmly received and quickly consumed.

May the road rise to meet you, John. May the wind be always at your back. May the sun shine warm upon your face, and may you find the perfect golf course in heaven—ideally with a fresh loaf of soda bread waiting at the clubhouse.

Dennis Jones

I first met John in the 1980s, before he left Deloitte to found Healthcare Business Specialists (HBS). We were both active in the New Jersey chapter of HFMA and frequently participated in educational presentations together. I particularly remember one early program that John organized - I believe the topic was New Jersey Charity Care - where four of us were each responsible for presenting a different segment.

On the evening of the presentation, we discovered that one of the other presenters had mistakenly prepared the same segment as John. Rather than becoming flustered, John simply took the attitude that "the show must go on" and, with his typical professionalism, seamlessly presented the segment for which he had not prepared. That calmness under pressure and willingness to step up was quintessential John.

Over the years, our paths crossed often through mutual clients, and we had the opportunity to work together on several projects. Later in his career, John joined our firm, Besler Consulting, as a Senior Advisor and contributed in countless ways to the firm's growth and success. His counsel to me as President of the firm was always valued and welcomed.

John was truly a fixture in the New Jersey healthcare industry. I would venture to say that throughout the 1980s, 1990s, and 2000s, there was hardly anyone working in New Jersey healthcare who did not know John. He had a well-earned reputation as the consummate professional and gentleman. Not only was he wonderful to work with, but he was also a good friend.

I used to joke with John that he was the "Dick Clark of New Jersey healthcare" because, like Dick Clark of American Bandstand fame, he never seemed to age. He will be deeply missed by many, but he leaves behind countless great memories for all of us fortunate enough to have known him.

Brian Sherin

Other Info:

John was honored by Stevens Institute of Technology: https://www.stevens.edu/news/the-2024-stevens-awards-gala-honors-six-extraordinary-alumni

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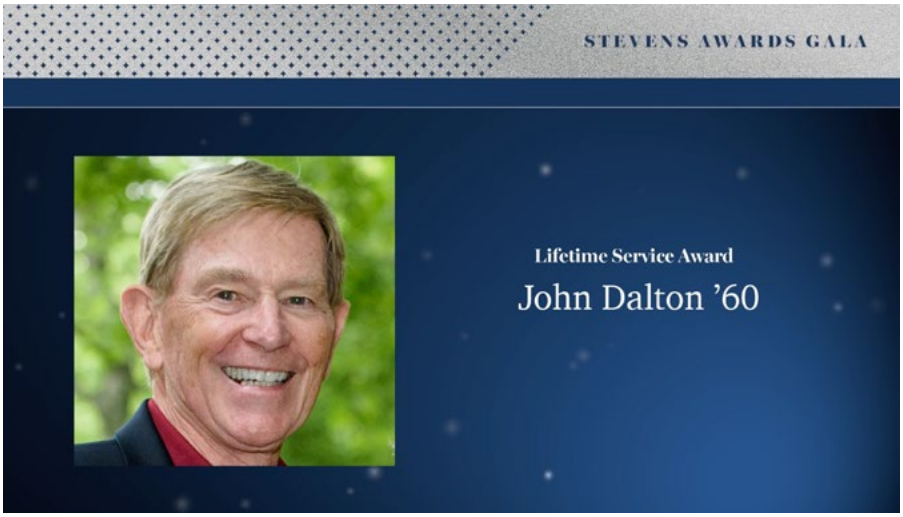

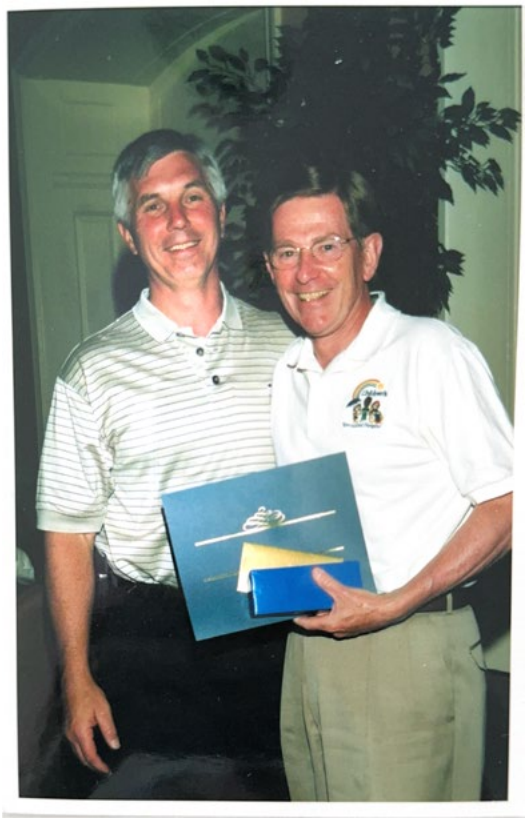

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Remembering Dotti Lindstrom

Dotti Lindstrom

It is with deep sadness that we share the passing of Dotti Lindstrom. Dott was the President of the New Jersey Chapter from 2006-2007 which was the first of the five years leading to the Chapter winning the prestigious Robert M Shelton Award for Sustained Excellence.
Dotti was highly regarded in the industry and will be remembered for her intelligence, strong work ethic and attention to detail.

Dotti was someone you simply never forgot once you met her. She was equal parts talented professional, trusted mentor, and loyal friend.

I first met Dotti while doing work at one of the hospitals where she worked although, at this point, I cannot remember which hospital it was. She certainly had a presence and, at first, could be a bit intimidating. I quickly came to realize, however, that while Dotti ran a very tight ship, she was also an incredibly caring and wonderful person. She could project a tough façade, but it was never very long before her warmth and genuine kindness shone through.

We both served on the Board of the New Jersey chapter of HFMA, including serving as Chapter President, Dotti in 2006–07 and me in 2009–10. I can honestly say we had an absolute blast working together during those years. There was certainly serious work to be done, but there were just as many laughs along the way.

Dotti's term as President marked the beginning of a remarkable five-year stretch that ultimately culminated in the Chapter receiving the coveted Shelton Award, the highest honor bestowed by the national HFMA organization. The award recognizes "chapters that have demonstrated exemplary, continuous service to their members across all operational areas over the immediate past five years." Dotti set the tone during her presidency and encouraged succeeding presidents to continue striving toward that achievement. That says a great deal about the respect she commanded and the influence she had.
Even after her presidency, Dotti continued dedicating enormous amounts of time and energy to HFMA. If you ever arrived at the New Jersey HFMA golf outing and Dotti was not sitting at the registration table with a bright smile on her face, you would think you had somehow come to the wrong place. She was truly an icon in the industry, and people loved being around her - not only for her wisdom and leadership, but also for her tremendous sense of humor.

During our years together on the Board, Dotti often entrusted me with the task of taking the final pass at polishing written materials. Because of my tendency to mark-up documents with red strikethroughs and edits, she began calling me "The Professor." From that point forward, the nickname stuck. I will always treasure that moniker because it came from Dotti.
Brian Sherin

"The Professor" captured Dotti perfectly, and his words brought back so many great memories.
I met Dotti when I was a Kelly summer temp at Muhlenberg Hospital in Plainfield, filling in while her secretary was on maternity leave. And yes, she was very intimidating—I think she was a little proud of that. ☺ (I think I hear her chuckling right now – lol)

At the end of the summer, I returned to school and soon received a call from Dotti: "Sharon isn't coming back—I'll take whatever you can give me." From then on, I worked every day I didn't have class and during every break. She taught me everything—and I mean everything—about patient accounting, along with some general finance. Over the next few years, she mentored me into the billing manager role.

Over the years, Dotti and I became very close, and like many close friends, we sometimes fought like cats and dogs. One of my proudest moments came during one of those disagreements, when she realized I was right about the work issue we were debating and said, "You know, you're the only one who makes me think." I remember thinking, Wow— I guess I had finally passed her test.

Beneath that tough exterior though, Dotti was a truly wonderful person. Years later, I learned that she had anonymously sent Christmas gifts to the family of one of our employees—a single mother who was struggling. Dotti had always been hard on her too, but I think it was because she saw her potential. That was the kind of heart Dotti had. She is gone way too soon.
Laura Hess

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From Collection Calls to the C-Suite: How Jason Kane Built a Revenue Cycle Career on Trust

Jason Kane

By: Denny Henderson

Revenue cycle leadership does not follow a single path. Some leaders come up through coding or patient access. Others through finance or consulting. Jason Kane came up through collections, and the lessons he learned there still shape how he leads a 400-person revenue cycle operation today.

I have had the pleasure of spending time with Jason at multiple HFMA events, listening to him share from across the dinner table and from up on the stage. He has a magnetism that draws people in, and what he offers is always worth the listen.

Jason Kane is Vice President of Revenue Cycle Operations and Managed Care Contracting at Inspira Health, a nonprofit health system in South Jersey with six hospitals, 1400 physicians and advanced practice providers, and more than 8,000 employees. He oversees patient access, HIM, billing, collections, CDI, and managed care contracting, with 12 direct reports. Before Inspira, he spent nearly a decade at Jefferson Health, rising from manager to VP within six years. His trajectory is the kind of story that resonates with HFMA members at every stage of their careers, not because it was easy, but because it was intentional.

A Start Nobody Plans For

Jason grew up in inner-city Philadelphia, raised by a single mother. By his junior year of high school, he was working nights at a collections agency to help pay bills. He had planned to become a high school history teacher. But the commission checks kept growing, and by his third year of college, he left school to work collections full time.

He does not romanticize it. The money was good for a young person without many options, and the work taught him the mechanics of healthcare finance from the ground up: CPT codes, HCPCS, payer remittance, the language of claims and denials. When he eventually hit a ceiling in the collections industry, he went back to finish his degree in business with a concentration in finance. He kept collecting.

The pivot came through a personal connection. A family friend with ties to Jefferson Health's CFO passed along Jason's resume. The opportunity meant a pay cut and a step back in title, from running his own office to a manager role on the provider side. People close to him questioned the move. From a purely financial standpoint, it did not make sense on paper. But his mother pushed him toward it, and Jason saw what a salary could not measure: exposure, scale, and complexity. He took the step back.

"I identified that the long-term opportunity and the growth in my career would be worth it," Jason said. "I took the jump and moved over to Jefferson, and I fell in love with it right away."

Attitude Over Aptitude

At Jefferson, Jason found something he had not encountered in the collections world: mentors who invested in his development. Shiny George, the VP who hired him, told him early on that she evaluated people on attitude over aptitude. That philosophy stuck.

"She told me that as long as I have a good attitude and I'm willing to go in and work hard, it's going to work," Jason recalled. "That was the jumping-off point that really freed me from anything that was holding me back mentally."

Later, Senior Vice President Cindy Fry connected him with Jefferson's CFO and other executives, and arranged for him to work with a career coach for a full year. Cindy told Jason she saw two things in him: the ability to hold both operational detail and the bigger picture at the same time, and a natural way of connecting with people across different levels of the organization. "Technical knowledge can get you into the room," Jason reflected, "but leadership in revenue cycle is really about influence. It's about aligning clinical, operational, and financial stakeholders who often have very different priorities." Jason credits a succession of leaders at Jefferson, including Donna Wright and Robin Brown-Stovall, with shaping his leadership style. The common thread among all of them was trust. They trusted him before he had fully proven himself, and he responded by doing the work to justify that trust.

Building Leaders, Not Managing Staff

Jason draws a hard line between leaders and managers. Managers, in his view, are afraid to develop people beyond their own capability. Leaders see it differently.

"If I build you up to be capable of taking my job, that

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means I've done a good enough job in my role that I'm now capable of moving into another position," Jason said.

He points to Tisha Peterkin as proof. Tisha was a manager at Abington Health System when Jefferson acquired it. She came to Jason with a candid admission: she was unhappy and felt she did not have a path forward despite strong performance and education. Jason made her a commitment. Give him time, work as a team, and he would help her build a clear career path.

Over roughly five years, Tisha moved from manager to director, director to senior director, and now serves as AVP of Access and Business Office Operations at Inspira. Jason brought her with him because he trusted her, and she trusted him. That relationship, he said, made both better.

The Two-Year Turnaround

Not every relationship starts well. Jason shared the story of a previous direct report who resisted his leadership from the beginning. The person disagreed with his approach, was guarded in meetings, and quietly considered leaving. Jason could see it in the mannerisms, the way the person reacted to conversations and directives, even before anyone said it directly.

Jason did not force the issue. He slowed down, shifted the focus of their meetings away from day-to-day operations and toward building the relationship. It was a slow process. There were stretches where he questioned whether it was worth the investment. But he held a conviction that carried him through: the hardest relationships are usually the most important ones to get right. Walking away would have sent a message to the rest of the team that connection was optional when it got difficult.

About two years in, this person came to him with an honest admission: they had been leery of his leadership style from the start, but the operational results were proving out, and they had come to appreciate his approach. The person thanked him not just for the results, but for not giving up on them.

"That person finally came to me and said, 'I have to tell you how much I appreciate you.' And for me, at the end of the day, that was so personal," Jason said. "To this day, I still talk to that person. We don't work together anymore, but we still have a relationship."

How Jason Builds Trust

When asked what trust means to him, Jason is direct: "Without trust, there's nothing. Everything else really has no meaning to it."

His approach starts with leading by example and being willing to admit when he needs help. He has never been afraid to admit when he is struggling, and he expects the same openness from his team. Every Monday morning, he sends a Teams message to all 12 direct reports: how was your weekend, here is something from mine, looking forward to our huddle this week. The team holds a mandatory huddle every single week, regardless of what else is going on, because face time builds camaraderie and trust in ways that email and reports cannot.

Jason also pays close attention to follow-through as a diagnostic tool. When someone does not complete a task, he resists the instinct to ask why. Instead, he asks where the disconnect happened. Was it a misunderstanding? A disagreement with the strategy? A lack of belief in the direction? That one shift in language, he said, often reveals whether the real issue is competence, communication, or trust. And once you know which one it is, you can address it.

He is candid that this work is not one-size-fits-all. With 12 direct reports, each person needs something different. Some need more check-ins. Some need space. The only way to know is to spend the time learning who they are, not just what they do.

The Business Case for Trust

Jason's leadership philosophy is not abstract. The numbers from his first year at Inspira make the case in terms a CFO would recognize.

When he arrived, the consistent message from Inspira's executive leadership was that revenue cycle lacked teamwork, collaboration, and accountability. Jason recognized it as a trust problem, not a technical one, and made relationships the first priority. Instead of dictating change, he made strategy and decision-making a team effort, explaining the who, what, and why behind every initiative. He built governance models, a clear accountability structure, and followed up consistently so that expectations did not live only on paper.

By the end of that first year, the results were significant: approximately $30 million in revenue over prior year, a 6% reduction in A/R days, 15% reduction in AR age, a 30% increase in clean claim rate, and a 34% reduction in CFB/DNFB. The team also launched a formal coding audit and provider education program and restructured the revenue cycle to better align with industry best practices.

"Trust isn't separate from performance, it drives it," Jason said. "When people understand the vision, feel included in the process, and know they're being held accountable in a fair and consistent way, they perform at a much higher level."

Leading Through Change in South Jersey

Jason is currently guiding Inspira through a $120 million Epic implementation, with a go-live targeted for July 2026. He was at Jefferson for its Epic rollout, but Inspira presents a different challenge entirely.

Inspira serves two of the poorest counties in New Jersey, Salem and Cumberland. It is the largest employer in both. Many employees have worked there for decades, and the pace of change has historically been slower than what he experienced at a large academic medical center. He has had to recalibrate.

"Working at a large health system, everything was go, go, go," Jason said. "Here, it's: hold on, let's think about it. Go a little

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Paid Isn't the Same as Accurate A Process Blind Spot in Healthcare Finance

Jennifer Harrington

By: Jennifer Harrington | HFMA NJ Focus

Healthcare finance leaders are under relentless pressure to do more with less, yet one of the most persistent sources of financial leakage remains largely unexamined.

Early in my career, I served as an examiner for a state-level Malcolm Baldrige Quality Award. The experience introduced a principle that has shaped how I approach operational performance. The process is designed to produce exactly the results we are getting. If we want different outcomes, we have to change the process.

In one widely reported case, a fraud scheme resulted in Google and Facebook paying more than $100 million in invoices later determined to be fraudulent. The issue was not a lack of capability. The process functioned as designed. Invoices were received, approved, and paid.

But the process was designed for payment, not independent verification.

Healthcare finance leaders are navigating sustained margin pressure driven by reimbursement constraints, rising operating costs, and ongoing organizational change.

Within most healthcare organizations, accounts payable processes are built for efficiency and control. Yet embedded within that process is an assumption that approved and paid invoices are accurate.

The Assumption Problem

Accounts payable systems are designed to answer a specific question.

Should this invoice be paid?

They are not designed to answer a different question. Is this invoice accurate in every detail?

That distinction is fundamental.

In practice, most approval workflows validate that a charge appears reasonable, aligns generally with expectations, and is supported by documentation. They do not typically involve a detailed reconciliation of billing elements against contract terms, service inventories, or jurisdiction-specific tax rules, particularly in categories where invoices are dense, technical, and distributed across multiple locations.

As a result, invoices can move through the system exactly as designed, reviewed, approved, and paid, while still containing discrepancies that go undetected.

Over time, even small discrepancies can accumulate across a large organization.

Even a one to three percent discrepancy across complex vendor categories can translate into millions in avoidable spend for large health systems.

Paid does not mean accurate.

The Vendor Economy of Healthcare

Healthcare organizations operate within a vast and increasingly complex vendor ecosystem.

As organizations grow, this environment becomes more difficult to manage with precision.

Contracts are amended, services are added or retired, locations change, and responsibility for oversight is often distributed across multiple departments.

In this context, financial processes are asked to translate a dynamic operational environment into accurate, static billing.

Maintaining that level of alignment is inherently difficult when operational changes occur in one system, contract terms are updated in another, and billing is generated in a third.

At a summary level, the process succeeds. At a detailed level, the margin for misalignment is significant.

The result is a gradual divergence between what an organization believes it is being billed for and what it is actually paying.

Telecommunications and Billing Drift

Telecommunications illustrates how billing inaccuracies develop over time.

A service may be disconnected in practice but remain active in billing. A negotiated rate may not be fully reflected in the invoice. A tax jurisdiction may no longer align with the service location.

Individually, these discrepancies may appear immaterial. Across multiple locations, services, and billing cycles, they accumulate.

This creates billing drift, a gradual misalignment between what an organization believes it is purchasing and what it is actually being billed.

Billing drift is rarely the result of a single failure. It is the predictable outcome of systems that are not designed to stay

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The Telehealth Cliff We Didn't Fall Off, and the One Still Coming

What New Jersey's Return to Pre-COVID Prescribing Rules Means for Healthcare Finance, 340B, and Patient Access

Fatimah Muhammad

By: Fatimah Muhammad, FHFMA, CHFP

For the past five years, telehealth has stopped being a temporary emergency solution and became operational infrastructure. Health systems built access strategies around it. Behavioral health programs expanded through it. Revenue cycle teams built workflows around it. Specialty pharmacy growth increasingly depended on it. Patients structured their care around it.

Now New Jersey is rapidly pulling portions of that infrastructure back.

What many leaders still view as a clinical or regulatory issue is becoming something much larger. This is a healthcare finance issue. It is a compliance issue. It is a patient access issue. And for safety-net organizations already operating under extraordinary financial pressure, it is increasingly becoming a sustainability issue.

The healthcare industry spent years operationalizing temporary flexibilities without fully knowing when, or how, those flexibilities would end. That moment is no longer theoretical in New Jersey. It is already happening.

Where Federal Policy Stands

At the federal level, telehealth prescribing flexibilities for controlled substances remain temporarily extended through December 31, 2026. Under the current federal framework, providers may continue prescribing Schedule II through V controlled substances through telehealth without a prior in-person visit.

But the operative word remains temporary.

Neither administration has finalized a permanent, long-term regulatory structure for controlled substance prescribing through telehealth. Multiple proposed frameworks stalled under provider and public opposition. Meanwhile, healthcare organizations continue building operational strategies around policies that remain unresolved at the federal level.

Where New Jersey Stands

New Jersey has already moved more aggressively than the federal government.

With the expiration of the COVID-era emergency framework under Executive Order 415, New Jersey providers reverted back to the state's pre-pandemic prescribing requirements under N.J.S.A. 45:1-62(e). Effective February 16, 2026, providers prescribing Schedule II controlled dangerous substances through telehealth once again became subject to New Jersey's in-person examination requirements. Existing adult telehealth patients were granted a transition period requiring completion of an in-person visit by May 16, 2026, to maintain prescribing continuity. That deadline has now passed.

Adult patients receiving Schedule II controlled substances, including stimulants such as Adderall and Vyvanse, are now required to complete an initial in-person evaluation before prescribing may occur through telehealth. Continued prescribing thereafter requires recurring face-to-face visits at least once every three months.

One exception remains in place for minors under age 18. New Jersey permits telehealth prescribing of Schedule II stimulants for pediatric patients without an initial in-person visit, provided the provider utilizes real-time audio-video technology and obtains documented parental or guardian consent.

Key compliance point: Federal flexibility does not override stricter state law. Organizations that assume continued federal allowances fully protect telehealth prescribing operations may expose themselves to payer scrutiny, documentation vulnerabilities, compliance findings, and downstream audit risk.

The Financial Implications

For healthcare finance leaders, this changes the conversation entirely.

Telehealth is no longer simply a discussion about access strategies. It is now directly connected to revenue integrity,

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bit. Think about it some more. Go a little bit. And that's what works for this organization."

His team is investing in readiness plans, tip sheets, training seminars, and consulting partnerships that go beyond a standard Epic implementation. The goal is not just technical adoption but cultural confidence. Jason knows that forcing the pace would erode the trust he has spent years building.

The Value of the HFMA Network

Jason credits HFMA with much of his professional growth beyond what any single employer could provide. He calls colleagues across the country whom he met through HFMA events. He uses HFMA's training course catalogs to build annual education goals for his team. And he volunteers his time to help plan conferences, including an upcoming regional event where Inspira's CEO will deliver the keynote.

"Without those types of professional organizations, our industry would not be as good as it is," Jason said. "I make time for it, even with the busy schedule, because it's been tremendous for my growth as a leader."

Advice for the Next Generation

When asked what he would tell someone early in their career, Jason kept it simple: find a mentor, trust them, and do not be afraid to ask for help.

"People think asking for help is a sign of weakness, but it's really a strength," he said. "You're not going to be able to get anywhere on your own. You really have to rely on other people."

He also offered a challenge. When he looks at the revenue cycle leaders coming up behind him, the skill he sees missing most often is the ability to connect operational decisions to enterprise-level impact. Many emerging leaders are strong technically, but struggle to translate details into financial and strategic outcomes that resonate with executive leadership. "It's one thing to say you improved clean claim rate by 3%. It's another to say that 3% improvement equates to a specific dollar amount in accelerated cash and reduces A/R days by a measurable number. That second language is what helps you stay in the room."

Jason Kane is Vice President of Revenue Cycle Operations and Managed Care Contracting at Inspira Health.

About the author

Jason Kane 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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aligned over time.

Redefining Billing Verification as a Financial Control

Billing verification is not an administrative task. It is a financial control.

Controls are not designed to process activity. They are designed to ensure that outcomes align with expectations.

If the objective is not only to approve payment, but to ensure accuracy, then the process must be designed accordingly.

The starting point is not a new system. It is a different set of questions.

When was the last time billing in this category was systematically reconciled against both contract terms and actual service inventories?

Who is responsible for validating billing accuracy across this category?

How are negotiated rates tested to ensure they are consistently reflected in invoices over time?

Are tax treatments periodically reviewed to confirm alignment with service locations and regulatory requirements?

How are inactive or disconnected services identified and removed from billing?

The answers to these questions reflect design, not effort.

The process has been doing exactly what it was designed to do.

The question for finance leaders is whether verification belongs inside that design.

About the author

Jennifer Harrington is a healthcare operations executive and founder of CorecTel, where she advises organizations on vendor invoice accuracy and financial controls within complex carrier environments in tax-exempt healthcare systems.

Over a 20-year leadership career, Jennifer has served as COO at MarinHealth Medical Center and as Executive Director/CEO of the San Francisco Public Health Foundation. In those roles, she directed multi-site operations, public funding stewardship, and financial compliance through the COVID-19 crisis. Earlier in her career, she held progressive leadership roles at Kaiser Permanente and HCA.

Her transition to entrepreneurship began with a simple governance question: why was a recurring, high-volume vendor category being paid without line-item verification? That inquiry became the foundation for her work today, helping healthcare finance leaders evaluate ownership gaps, strengthen oversight, and protect margins without adding operational burden.

Jennifer brings an audit-committee perspective to cost stewardship, informed by her experience managing complex P&Ls and building practical financial controls in fast-moving healthcare environments. She currently serves on the Board of AFP Silicon Valley as Treasurer-Elect and lectures in public health systems.

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reimbursement stability, operational compliance, behavioral health continuity, specialty pharmacy performance, and 340B program sustainability.

The financial implications are already beginning to surface across New Jersey. Healthcare organizations built telehealth into provider productivity assumptions, behavioral health expansion models, specialty pharmacy growth planning, and patient retention strategies. As regulatory requirements tighten, those operational assumptions must be reassessed immediately. One of the first pressure points is billing exposure. Telehealth encounters tied to controlled substance management have historically followed different billing workflows than in-person care models. As organizations transition patients back into physical encounters, documentation integrity and coding accuracy become increasingly important. Improper billing tied to noncompliant telehealth prescribing creates exposure not only from payers, but potentially during HRSA review activity as well.

The larger concern may ultimately be volume compression. Research consistently demonstrates that reducing telehealth access reduces utilization, particularly among vulnerable populations. Many patients who relied on telehealth during the pandemic did so because traditional care access was genuinely difficult. Transportation barriers, childcare limitations, work schedules, disability, and financial instability all contributed to telehealth adoption. When those barriers return, many patients disengage from care entirely. The financial consequences of that disengagement are measurable. Reduced visit volume affects provider productivity, behavioral health utilization, specialty pharmacy prescription capture, and downstream revenue generation. In Bergen, Passaic, and Essex counties, psychiatric provider wait times of four to eight weeks are already emerging as a direct operational consequence of the stricter requirements. For a patient who needs an in-person visit to maintain a prescription and faces a two-month wait, that is not an inconvenience. That is a care gap. And care gaps show up on the balance sheet.

A second financial deadline deserves immediate attention. New Jersey's telehealth payment parity law, which requires health benefits plans to reimburse telehealth services at the same rate as in-person visits, expires July 1, 2026. When that requirement sunsets, payers may move to lower reimbursement rates for telehealth encounters. Finance teams should be in conversations with payer relations now, before the next contracting cycle, to understand the exposure and negotiate ahead of the change.

As state requirements tighten around prescribing eligibility and visit modality, expect increased scrutiny on telehealth claims for controlled substances. Denials tied to the absence of a required in-person examination prior to prescribing are foreseeable and defensible from the payer side. Revenue cycle teams should establish documentation review protocols to confirm in-person visit requirements were satisfied before claims go out the door.

What This Means for 340B

For 340B covered entities, the implications extend even further.

Telehealth became part of the operational scaffolding that supports prescription continuity, specialty pharmacy growth, and patient access across many safety-net organizations. As telehealth access contracts, 340B program performance may contract alongside it.

This is not a downstream issue. It is immediate.

If patients disengage from care because access becomes more difficult, organizations lose prescription volume and corresponding 340B savings opportunities. For many hospitals and FQHCs, those savings directly support uncompensated care programs, patient assistance initiatives, and broader community health investments.

The operational, financial, and compliance implications are now deeply interconnected. Qualifying encounter documentation for telehealth visits must be airtight, particularly for 340B-eligible prescriptions. If a telehealth encounter does not meet New Jersey's in-person prescribing requirement and a prescription is written anyway, the lawfulness of that prescription is in question. So is the defensibility of the associated 340B transaction in an audit.

For organizations using contract pharmacy arrangements, the chain of custody between a telehealth-initiated prescription, a covered entity qualifying encounter, and a contract pharmacy dispense deserves fresh scrutiny under the new regulatory framework. Any gap in that documentation is an audit exposure point.

The Patient Access and Safety-Net Risk

This is why finance leaders can no longer afford to remain adjacent to telehealth strategy discussions.

The populations most reliant on telehealth for controlled substance access overlap substantially with the populations served by New Jersey's safety-net hospitals, community health centers, and Medicaid-heavy provider networks. Patients managing ADHD, behavioral health conditions, addiction medicine regimens, and chronic pain are the same patients who often lack reliable transportation, flexible work schedules, or the resources to absorb the cost and logistics of quarterly in-person visits.

When access is restricted and care is disrupted, the costs do

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not disappear. They shift. Undertreated psychiatric conditions, disrupted addiction medicine regimens, and unmanaged chronic conditions generate measurable downstream consequences. Emergency department utilization goes up. Behavioral health crisis interventions increase. Uncompensated care rises. The downstream consequences eventually reach the balance sheet, the compliance program, and the sustainability of the patient access model itself.

What Finance and Compliance Leaders Should Be Doing Now

The regulatory environment will continue to evolve. The federal extension through December 31, 2026 creates a window at the national level. New Jersey has already moved through its own. Here is what the NJHFMA community should have on its active agenda.

1. **Audit your telehealth billing practices.** Review claims submitted for controlled substance prescribing since February 17, 2026. Confirm that new patient encounters included a preceding in-person visit. Identify documentation gaps before a payer or HRSA auditor finds them first.
2. **Revisit your 340B compliance documentation.** Ensure qualifying encounter documentation for telehealth visits is solid, particularly for 340B-eligible prescriptions. If your organization is in a mock audit or HRSA audit cycle right now, this needs to be an explicit focus area in your corrective action work.
3. **Model the revenue impact.** Run scenario analyses on what declining telehealth access does to projected visit volume, specialty pharmacy dispense volume, and 340B savings through the end of fiscal year 2026. Build conservative and moderate scenarios and bring those projections to your CFO with clear assumptions.
4. **Get ahead of the July 1 payment parity expiration.** Engage your payer relations team now. Identify which payers have maintained telehealth payment parity and under what conditions that could change. Flag any exposure before the next contracting cycle, not after.
5. **Assess patient access risk proactively.** Model the populations most likely to disengage from care under the new requirements. In counties where provider wait times are already running four to eight weeks, the care gap is quantifiable. Quantify it before it drives uncompensated care increases.
6. **Monitor federal rulemaking.** The federal extension expires December 31, 2026 and the DEA has not released a final rule. Whatever permanent framework emerges will layer on top of New Jersey's existing requirements. This requires active monitoring, not periodic review.

The telehealth revolution was not supposed to remain permanently in its pandemic form. But the infrastructure built around it became real. The workflows became real. The patient reliance became real. And now the operational and financial consequences of unwinding that infrastructure are becoming very real as well.

Too often, healthcare finance leaders are brought into telehealth conversations after operational decisions have already been made and financial exposure has already materialized. That approach no longer works.

This is the moment for healthcare finance and compliance leaders to be at the table early, with data, operational insights, modeled projections, and a clear understanding of how regulatory shifts translate into financial and patient-care consequences.

Because in today's healthcare environment, access strategy is financial strategy.

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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•Focus on AI•

To AI or Not to AI – Is That Still a Question?

The Launch of our new AI quarterly series – AI Today and Tomorrow

Pavani Munjuluri

By: Pavani Munjuluri

Here's a fun game to play at your next healthcare finance happy hour: ask the room whether AI is going to save healthcare or destroy it. Within approximately four minutes, you'll witness a full spectrum of opinions ranging from "it's the future of everything" to "it's just pattern matching on steroids" to "my EHR vendor is already trying to sell me the same thing with a chatbot attached."

I should know. I've been in that room. Often as the one asking the question, occasionally as the one making the argument, always as the one nursing the drink in the corner when it gets heated.

But here's what I've noticed: the debate itself has become a bit... exhausting. We're past "should we?" We're deep in "how do we actually do this without burning the budget, losing our jobs, or accidentally billing a patient for being a foreign object in their own digestive tract."

Which brings me to this column. Every quarter, we're going to talk about the real stuff, the war stories, the lessons learned, the occasional enterprise software that clearly had a personality disorder, and maybe a guest quote or two from people brave enough to admit what actually happened in their organizations. No vendor-speak. No consultant platitudes. Just honest conversation about a technology that is, let's be honest, simultaneously overhyped and genuinely transformative. Because both of those things can be true at once.

A Quick Trip Down Memory Lane

I want to tell you about spreadsheets. Not in the nostalgic, "remember when we used to do things manually?" way. I mean really remember what it felt like when spreadsheets showed up in finance departments and people genuinely believed accountants were about to become extinct.

Spoiler: they didn't.

What happened instead was more interesting. The technology changed the nature of the work. Fewer people doing data entry, more people doing analysis. Fewer people calculating, more people questioning what the calculation meant. The humans evolved or they transitioned and honestly, some of both was probably healthy for the industry.

AI feels exactly like that. Except instead of a ten-year adoption curve, we seem to be running it at warp speed while everyone watches and nobody agrees on the rules. The stakes feel higher. The proclamations are louder. And yes, there's more dramatic hand-wringing on LinkedIn.

But the fundamental lesson? The same one it always is: technology amplifies the humans who wield it. Good humans with clear intentions make good use of tools. Confused humans with unclear intentions make very creative mistakes. Which leads us to...

The Learning Curve Is Real

Here's what nobody tells you about AI adoption: the first six months are humbling. I spoke with a revenue cycle director recently who shared her team's "AI journey" - which sounded less like a journey and more like an extreme sport. Their first implementation produced billing codes so creative that the compliance team coined a new phrase: "AI-generated poetry."

"It's not wrong, exactly," she told me, "just... optimistic about what the procedure actually was."

But here's the thing , nine months later? Their denial rates dropped 13%. They figured it out. The learning curve had a learning curve, but they climbed it.

What the Room Actually Told Us

I don't have to guess where you all are on this, because we asked. Across our three-part AI webinar series this spring, we ran live polls in every session, and roughly 250 of you answered. The results were the most honest focus group I've ever sat in on, mostly because nobody could see anyone else's hand go up.

Here's the headline that stuck with me. By the final session, 73% of you said your organization is already piloting or scaling AI, only a sliver are still "just exploring." And yet, in the same breath, 71% rated your own AI governance at the two lowest maturity levels: ad-hoc or merely "developing." Read that twice. We are driving the car faster than we're building the brakes. That gap, adoption sprinting ahead of oversight, is the single most important thing this column is going to keep poking at.

A few other things you told us, while we're being candid. In session one, the #1 worry about AI wasn't cost or accuracy, it was job security (40% of you). By session two, 9 in 10 of you agreed that strong leadership during an AI pilot means setting clear goals, metrics, and ownership, not buying the shiniest tool. And the top barrier to governance? Regulatory uncertainty (51%), narrowly ahead of the ever-present

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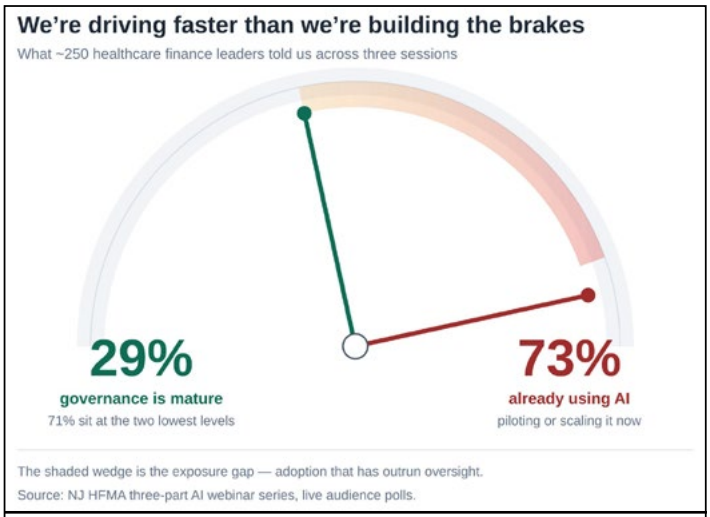
"budget." Translation: you're not afraid of the technology. You're afraid of doing it without a map.

The two needles that should move together — and don't. Adoption has outrun oversight.



The two needles that should move together — and don't. Adoption has outrun oversight.

One last number, because it made me a little sentimental: 73 of you showed up for all three sessions, and by the finale 90% of the room were returning faces. You didn't come for a sales pitch, there wasn't one. You came back because the questions are real and the answers are still being written. That's exactly the crowd this column is for.

AI Literacy for the Rest of Us (No Computer Science Degree Required)

Most of us aren't building these tools, we're the ones who get handed them on a Tuesday with a cheerful "this'll save you time!" So before we spend the next year swapping war stories, let me offer a short field guide for the everyday user, the analyst, the biller, the manager, the person who just typed a question into a chatbot and isn't sure whether to trust the answer.

It's confident, not correct. Today's AI is a very articulate guesser. It predicts the most plausible next words, which is not the same as knowing the right answer. When it's wrong, it's wrong in complete sentences and a calm tone. Treat every output as a sharp first draft from a brilliant intern, useful, but you sign off, not it.

Verify anything that matters. If a number, a code, or a claim would embarrass you in front of an auditor or a patient, check it against the source before it leaves your desk. "The AI said so" has never once held up in a compliance review.

Mind what you paste. That patient identifier, that contract, that payroll file, assume anything you type into a public AI tool could be stored or used to train it. Use the tools your organization has actually approved, and when in doubt, leave the protected information out. Good AI habits and good HIPAA habits are the same habits.

Better question in, better answer out. The single fastest way to improve your results isn't a fancier tool, it's a clearer ask. Give it context, tell it the format you want, and say who the answer is for. "Summarize this denial trend for a CFO in three bullets" beats "tell me about denials" every time.

You're still the expert. The judgment, the context, the gut feel that something's off, that's the part the machine doesn't have. AI is a power tool, not a replacement for the carpenter. The people who thrive in this next chapter won't be the ones who fear it or blindly trust it. They'll be the ones who learned to ask it good questions and double-check its homework.

Guest Quote (Yes, We Went There)

"Implementing AI in healthcare is like teaching a very eager intern who has read every book but never actually seen a patient. The knowledge is there. The judgment? That's still on us."

-Anonymous CFO, who shall remain nameless but who absolutely has a name badge that says "Human."

What's Coming

In future columns, we'll bring you:

- **Real stories from the trenches –** the good, the bad, and the "we're still trying to explain that one to IT"
- **Guest perspectives –** leaders willing to share what actually worked (and what didn't)
- **History lessons –** because those of us who've been around remember when "the cloud" was something you saw from an airplane
- **Practical takeaways –** not theoretical, not vendor-sponsored, just honest "here's what we learned"

I'm not here to sell you on AI or scare you away from it. I'm here to help you navigate the middle ground, the messy, sometimes hilarious, occasionally frustrating reality of bringing artificial intelligence into an industry that runs on human judgment, compassion, and the occasional miracle.

So, to answer the question: "To AI or not to AI?" that stopped being the question a while ago. The real question is: *How do we do this well?*

And that, dear readers, is exactly what we'll explore together.

Until next time, keep your spreadsheets close and your skepticism close-er.

- Pavani

P.S. If you have a story to share, a lesson learned, or a prediction to debate, drop me a line. This column runs on anecdotes and caffeine, in that order.

About the author

Pavani Munjuluri is CEO and Co-founder of CognitiveHealth, an AI-driven healthcare technology company transforming administrative and revenue cycle workflows through intelligent automation. With more than 20 years of healthcare experience across payer and provider environments, she has led large-scale businesses in analytics, BPM, IT services, product development, and client success. Since co-founding CognitiveHealth, Pavani has helped shape iCAN, the company's purpose-built AI platform for healthcare revenue cycle management. An engineer and MBA with global experience across the UK, Asia Pacific, and India, she is passionate about advancing women in leadership and using technology to improve both patient and financial outcomes in healthcare. Pavani can be reached at pavani@cognitivehealthit.com.

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•Certification Corner•

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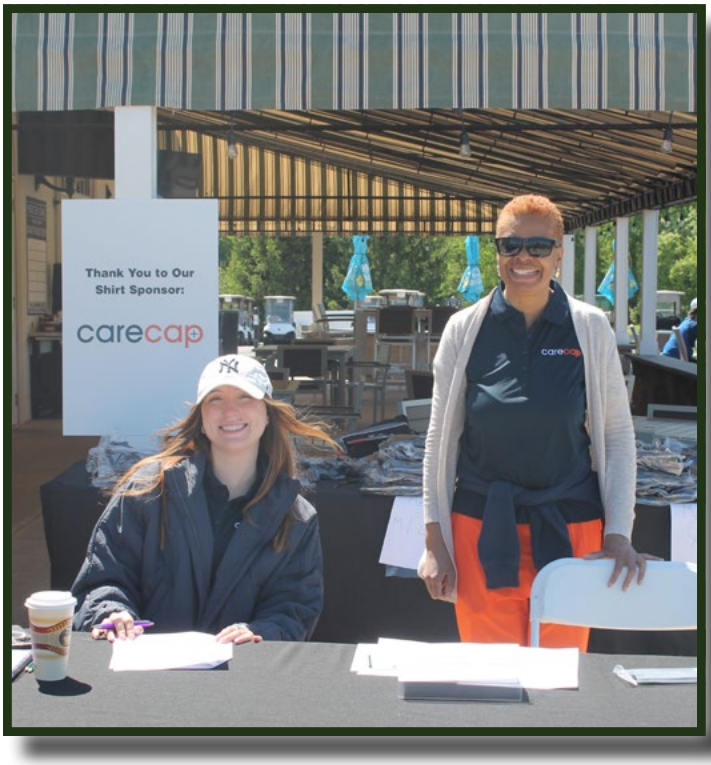

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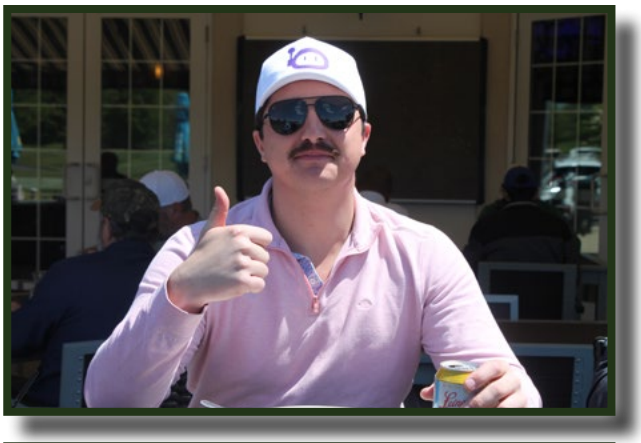

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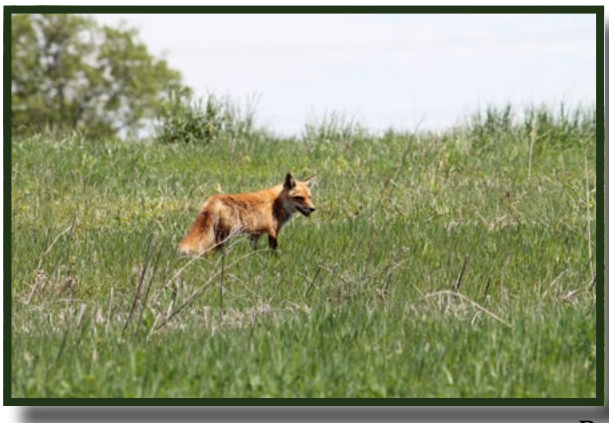

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Golf Recap

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The Price of Transparency

A new House proposal claims to want clarity on 340B. What it actually wants is a number.

By: Fatimah Muhammad, FHFMA, CHFP

Fatimah Muhammad

There is a version of transparency that serves patients. And there is a version that serves a political argument. The discussion draft released by the House Ways and Means Committee ahead of its planned May 20 markup is, without question, the latter.

The proposal would impose sweeping new reporting mandates on all nonprofit hospitals, requiring disclosure of community benefits, charity care, advertising expenditures, quality improvement spending, subsidized service lines, financial assistance applications, and more, all filed through the annual tax return, at both the system level and for each individual hospital in the organization. The draft would also compel hospitals to estimate the taxes they would have owed absent their tax-exempt status. That last requirement is not a transparency measure. It is a pressure point.

For 340B-participating hospitals, the draft goes further still. It would require reporting of the total number of individuals dispensed or administered 340B drugs and a calculated figure it calls aggregate net 340B revenue, defined as payer payments received, reduced by the 340B ceiling price and participation costs. This is where the proposal reveals its real intent, and where those of us who work in this space have an obligation to speak clearly.

> "When you measure against the wrong baseline, you will always arrive at a figure that looks like a windfall. That is precisely the point."

That methodology presents a fundamentally flawed interpretation of program value, and stakeholders across the field have raised that concern consistently for years. Comparing payer reimbursement to the 340B ceiling price does not measure program value. It overstates it, dramatically, because it ignores the actual counterfactual. The relevant comparison is not what a hospital receives versus the ceiling price. It is what a hospital pays under 340B versus what it would have paid without the program, typically a negotiated GPO contract price. That distinction is not a footnote. It is the entire argument. When you measure against the wrong baseline, you will always arrive at a figure that looks like a windfall, and that is precisely the point.

What makes this draft particularly telling is what it does not ask. There is no request for a hospital narrative on how 340B savings are used. No space to document the specialty pharmacy services a covered entity sustains, the patient assistance programs it funds, or the maternal health initiatives it supports in communities where those services would otherwise not exist. Charity care is a legitimate measure of program impact, but it has never been the only measure. Any framework that treats it as the whole picture is not designed to understand 340B. It is designed to discredit it.

For many safety-net hospitals across New Jersey and beyond, these programs support access strategies that extend far beyond pharmacy, including behavioral health access, maternal health services, specialty medication coordination, and care continuity initiatives that would otherwise face significant financial strain. At a time when hospitals are already managing workforce pressures, reimbursement instability, and growing uncompensated care demands, additional reporting frameworks built on flawed assumptions create financial and operational consequences that extend well beyond compliance.

The compliance burden compounds the concern. A significant portion of the data this draft demands is not currently tracked or reported in the format required. For the disproportionate share hospitals, federally qualified health centers, critical access hospitals, and children's hospitals that form the backbone of the 340B program, building those reporting systems is not a minor administrative undertaking. The cost falls hardest on the institutions least positioned to absorb it, which is itself a form of policy pressure.

The language is still a discussion draft and could be amended before or during the May 20 markup. But the direction is unmistakable, and the time to engage is now. 340B Health is analyzing the full proposal and will be providing member

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From Safety Net to Centerpiece: The Rise of the 340B Drug Pricing Program

By: Anirudh Shukla

Anirudh Shukla

When Congress created the 340B Drug Pricing Program in 1992 through the Veterans Health Care Act, it was not designed to become one of the largest drug purchasing programs in the country.[1] Its original purpose was fairly straightforward: help safety-net providers stretch limited federal dollars so they could continue serving patients who could not afford care. For many patients in underserved communities, the program can directly influence whether affordable medications remain accessible locally. Looking at where the program stands today, though, it is clear that a lot has changed.

Under 340B, drug manufacturers participating in Medicaid are required to offer discounted outpatient medications to eligible providers, which the program calls "covered entities." These include federally qualified health centers, disproportionate share hospitals (DSH), rural referral centers, and other facilities focused on underserved populations.[1] According to the Congressional Research Service, the program is run by the Health Resources and Services Administration (HRSA), and covered entities are not allowed to receive duplicate discounts, meaning they cannot claim both a 340B discount and a Medicaid rebate on the same drug.[1]

At the program's start, fewer than 100 hospitals were enrolled.[2] Eligibility expanded in the 2000's, and then more significantly in 2010 when the Affordable Care Act added four new hospital types: children's hospitals, cancer treatment facilities, critical access hospitals, and sole community hospitals.[2] That same year, HRSA issued guidance letting covered entities contract with an unlimited number of outside pharmacies, a major shift from the single contract pharmacy limit that had been in place since 1996.[2] The number of registered 340B sites has since grown to more than 53,000, nearly double what it was in 2014.[1]

These structural changes set the stage for a period of rapid financial expansion that few could have anticipated.

By 2023, drug purchases under 340B had reached $66.3 billion, up 23% from the previous year.[3] By 2024, that figure climbed to $81.4 billion, another 23% increase.[4] According to Drug Channels, 340B purchases now exceed Medicaid's net prescription drug spending by more than 50%, and hospitals account for roughly 87% of all 340B purchases each year.[4] The American Hospital Association has argued that this broader reach reflects the program doing exactly what it was designed to do: expanding access to medications for communities that need it most.[5] While the financial expansion of the program has been significant, researchers have questioned whether that scaling has benefited all covered entities equally.

A 2026 analysis from Johnson & Johnson's Center for U.S. Healthcare Policy Research found that hospitals in the top quartile by bed size made up only 33% of 340B participants but drove 81% of child site, the off-site facilities of a parent hospital, growth and 60% of contract pharmacy expansion between 2017 and 2023.[6] Major teaching hospitals were especially active, averaging nearly twice as many child sites and contract pharmacy relationships as similarly sized non-teaching hospitals.[6] The researchers raised a straightforward question: is the program's increasing footprint being driven by patient need, or by the resources and market position of larger institutions?[6]

A 2025 white paper from the USC Schaeffer Center looked at the issue from a different angle. The researchers found that the program's core revenue mechanism, called the "spread," tends to benefit hospitals with higher rates of commercially insured patients more than those actually serving lower-income communities.[2] Their analysis also showed that utilization, not rising drug prices, drove about 80% of the program's total growth between 2018 and 2024.[2] A 2021 study in the American Journal of Managed Care added another layer to the debate, finding that hospital entry into 340B was not consistently linked to higher levels of uncompensated care for low-income patients.[7]

These research findings have added fuel to a broader policy debate that is playing out in courts and legislatures across the country.

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Simon's Run Recap and Photos

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The Hidden Cost of Misalignment: Why Alignment is a Strategic Financial Lever in Healthcare

By: Dr. Sophia Brown

Dr. Sophia Brown

In U.S. hospitals and health systems, misaligned workflows, technology, and leadership priorities can quietly drain millions each year. This is not fraud or accounting error — it is preventable inefficiency, miscommunication, and underutilized tools. For healthcare finance leaders, the consequences are clear: revenue leakage, delayed reimbursements, compliance risks, and staff burnout. Alignment is more than a management buzzword — it is a strategic lever that directly impacts an organization's financial health.

Understanding Misalignment in Healthcare

Misalignment in healthcare occurs in three primary areas: operations, leadership, and technology. Each contributes to wasted resources and financial loss.

Operations: Redundant or poorly designed workflows can slow patient throughput, duplicate staff effort, or delay revenue capture. For example, inconsistent documentation practices across departments can result in delayed billing, rejected claims, and extended accounts receivable cycles.

Leadership: When leaders operate in silos or pursue conflicting priorities, teams lack clear direction. This misalignment often results in duplicated initiatives, conflicting instructions to frontline staff, or investments in technologies that do not support operational goals.

Informatics and Technology: Underutilized or fragmented systems reduce efficiency and increase costs. Without integration between electronic health records, revenue cycle software, and reporting tools, organizations risk delayed claims, missed opportunities for optimization, and data inconsistencies that impact decision-making.

Each of these misalignments carries a tangible financial cost — wasted labor hours, delayed revenue, and penalties for noncompliance with regulatory or payer requirements.

Quantifying the Cost

The financial impact of misalignment can be substantial. Consider a mid-sized hospital: a 10% inefficiency in revenue cycle workflows can translate into hundreds of thousands of dollars in lost revenue per quarter. A table illustrating "Type of Misalignment → Impact → Estimated Annual Cost" can make these numbers concrete for finance teams.

Type of Misalignment	Impact Estimated	Annual Cost
Operational misalignment	duplicated processes, workflow bottlenecks	$250,000–$500,000/year
Leadership misalignment	conflicting priorities, siloed initiatives	$100,000–$300,000/year
Technology misalignment	underutilized systems, poor integration	$150,000–$400,000/year

These figures underscore the real, measurable consequences of misalignment — consequences that HFMA readers are responsible for managing every day.

How Alignment Solves the Problem

Alignment is a powerful tool to reduce waste and improve financial performance. By connecting leadership priorities, operational workflows, and technology tools, hospitals can create a cohesive system that minimizes inefficiency and maximizes revenue capture.

The approach begins with a systematic alignment review. This process maps leadership goals against departmental workflows and technology utilization to identify friction points. For instance, one hospital identified that mismatched scheduling protocols between nursing and revenue cycle staff led to delayed claim submission. By realigning workflows and integrating scheduling software, the hospital reduced days in accounts receivable by 20% — translating into over $1.2 million in recovered revenue annually.

The benefits extend beyond finances. Aligned systems improve staff satisfaction, reduce burnout, enhance patient experience, and strengthen compliance with regulatory standards. Leaders can clearly see where resources are most needed and deploy them strategically, rather than reactively.

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Good Faith Estimates Under the No Surprises Act: Navigating Compliance and Implementation Challenges

Govind Goyal

By: Govind Goyal

Background and Overview

The No Surprises Act (NSA), which took effect in January 2022, represents a significant shift in healthcare transparency and patient protection. Among its most complex requirements is the mandate for Good Faith Estimates (GFEs), a provision that requires healthcare providers and facilities to furnish comprehensive, itemized cost estimates for schedulable services before they are rendered. While the intent is to empower patients with pricing information to make informed healthcare decisions, the implementation has proven far more challenging than anticipated.

To understand the scope of this requirement, it's essential to distinguish between the different patient populations affected. The GFE requirement applies to two distinct groups: uninsured patients (those without any health insurance coverage) and self-pay patients (those who have insurance but elect not to use it, often because provider self-pay discounts may result in lower out-of-pocket costs than their insurance plan's cost-sharing requirements). This distinction is crucial because it expands the requirement beyond the traditionally uninsured population to include insured individuals making strategic financial decisions about their care.

The NSA also establishes important roles in the GFE process. The convening facility or provider is responsible for scheduling the primary procedure or service and must coordinate the entire GFE process. In contrast, co-providers are all other healthcare professionals and facilities involved in the patient's care episode. This distinction creates a complex web of coordination challenges. For example, a patient scheduled for a colonoscopy at a hospital might receive separate bills from the hospital facility, the gastroenterologist performing the procedure, and an anesthesiologist. However, the NSA requires that all these anticipated charges be consolidated into a single, comprehensive GFE provided by the convening entity.

Under current regulations, GFEs must be provided to qualifying patients for all scheduled services occurring at least three business days in advance, both orally and in writing. This represents a significant operational burden for healthcare organizations, particularly given the requirement's broad scope and the $400 accuracy threshold that triggers patient dispute rights.

The Challenge of Itemized, All-Inclusive Estimates

Perhaps the most technically challenging aspect of GFE compliance lies in producing truly "itemized" estimates that capture all anticipated ancillary charges associated with the primary procedure. The complexity varies dramatically based on the service being provided. A simple laboratory test like a Complete Blood Count (CBC) might require only a single line item on the GFE. However, a complex procedure such as knee arthroscopy demands a sophisticated analysis to identify all reasonably expected ancillary services.

Developing compliant GFEs for complex procedures requires robust statistical analysis of historical claims data. Healthcare organizations must examine their claims history to identify patterns of ancillary services typically associated with specific primary procedures. This process involves removing statistical outliers (such as cases involving unexpected complications) and performing frequency distribution analysis to determine which ancillary charges should reasonably be included in the estimate.

For instance, in knee arthroscopy cases, the analysis might reveal that a specific antibiotic like cefazolin is administered in 85% of historical cases, making it appropriate for inclusion in the GFE. Conversely, if a specialized pain medication like liposomal bupivacaine is only used in 20% of cases – perhaps reserved for patients with specific risk factors or preferences – it would likely be inappropriate to include this charge, as doing so would overstate the estimate for most patients.

This analytical approach serves dual purposes: ensuring estimate accuracy and providing a defensible audit trail. When patients question specific charges included in their GFE, providers can reference the statistical analysis supporting each line item's inclusion. This evidence-based approach to GFE development represents a best practice that many organizations are still working to implement effectively.

The stakes for accuracy are significant. If a patient's final bill exceeds the GFE by more than $400, the patient has the right to dispute the charges and seek resolution through the

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NSA's dispute resolution process. This threshold underscores the importance of sophisticated estimation methodologies and comprehensive data analysis.

Distinguishing GFEs from Price Transparency Requirements Healthcare organizations must navigate multiple, sometimes overlapping transparency requirements, making it crucial to understand the distinctions between GFEs and hospital price transparency mandates. Under the Hospital Price Transparency Rule, hospitals must provide Consumer Displays or Patient Estimation Systems (PES) that allow patients to "shop" for services independently. However, GFEs operate under a fundamentally different framework.

GFEs cannot be accessed through self-service shopping tools; they must be actively provided by the convening facility or provider through direct patient interaction, both orally and in writing. The scope requirements also differ significantly. While current price transparency regulations require Consumer Displays for approximately 300 "shoppable" services, GFEs apply to all scheduled services meeting the timing criteria, regardless of whether they are considered shoppable. This creates a much broader compliance obligation for healthcare organizations.

Content requirements represent another key distinction. GFEs must include specific patient information such as date of birth and diagnosis codes, as well as detailed provider information including Tax Identification Numbers (TINs) and National Provider Identifiers (NPIs) for all involved facilities and providers. Price transparency tools, while comprehensive in their own right, do not require this level of patient-specific detail or multi-provider coordination.

Perhaps most importantly, GFEs represent a more interactive, relationship-based approach to price transparency, requiring active engagement between providers and patients rather than passive information display. This fundamental difference in approach reflects the NSA's focus on ensuring patients receive personalized, comprehensive cost information for their specific care episodes.

Implementation Delays and Coordination Challenges

Recognizing the complexity of multi-provider coordination, the Department of Health and Human Services (HHS) has delayed enforcement of certain co-provider requirements. This delay acknowledges the practical challenges that convening facilities face in gathering expected charge information from all providers involved in a patient's care episode.

The coordination challenges extend beyond simple logistics to include significant Health Insurance Portability and Accountability Act (HIPAA) considerations. Sharing patient information among multiple providers for GFE development requires careful attention to privacy regulations and appropriate data sharing agreements. Currently, standardized data exchange protocols specifically designed for GFE information sharing do not exist, leaving providers to develop ad hoc solutions or rely on manual processes.

HHS has indicated that standard data exchanges will be necessary for secure and effective information gathering, but these standards remain under development. The healthcare industry finds itself in a waiting game, with clear policy requirements but insufficient procedural guidance and technical infrastructure to support full compliance. This gap between policy intent and implementation reality has created uncertainty for healthcare organizations attempting to build compliant GFE processes.

The Future: Advanced Explanation of Benefits (AEOB) While current GFE requirements apply only to uninsured and self-pay patients, the NSA envisions an expanded future where insured patients also receive advance cost information through a process called Advanced Explanation of Benefits (AEOB). Under this future framework, the convening hospital or provider would create comprehensive, itemized GFEs that function as "pre-claims" and submit them to insurance payers for advance adjudication.

The insurance payer would then process this GFE and generate an AEOB for the patient, providing crucial information including network status verification, covered benefit amounts, estimated payer responsibility, and the patient's anticipated out-of-pocket costs. For out-of-network providers, the AEOB would include information about in-network alternatives, enabling true price shopping and informed decision-making.

However, this vision raises both practical and philosophical concerns within the industry. While "claims adjudication" has become standard terminology in healthcare revenue cycle management, "GFE adjudication" sounds awkward and potentially problematic. The prospect of insurance payers "denying" GFEs introduces concerning possibilities: healthcare organizations might find themselves managing denial work queues for estimates, dealing with Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) for services not yet provided, and developing appeals processes for disputed estimates.

The administrative burden of managing GFE denials could prove as complex and resource intensive as current claims denial management, effectively doubling the administrative work associated with each service episode. While this scenario might seem far-fetched, the historical expansion of payer administrative requirements suggests it's not beyond the realm of possibility.

Moving Forward: Industry Preparedness

The healthcare industry currently awaits additional guidance and technical standards from HHS to support full NSA implementation. Critical needs include standardized Application Programming Interfaces (APIs) or HL7 messaging standards for secure GFE information exchange among

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The HFMA Member Engagement Award Program

Member Engagement Award Point Categories, Values, and Definitions

(Achieve 25 points for Bronze, 50 points for Silver, and 75 points for Gold)

As an HFMA member one way to get involved is through engaging in volunteer activities and other such contributions. HFMA values these contributions and has developed the Member Engagement Program to honor these engagement achievements by members. There are many different ways to earn points as part of the Member Engagement Program – both at a local chapter level and at a national level. Below you'll find a list of various activities in five different categories – Literary Contributions, Chapter Committees, National Committees, Event Contributions and Miscellaneous. Later in this document you can learn more about the award levels, verifying your points are correct, and background on the Award Program.

Background

The Healthcare Financial Management Association (HFMA) recognizes that its strength lies in volunteers who contribute their time, ideas, and energy to serve the healthcare industry, their profession, and one another. Active participation in HFMA at the national, regional and/or chapter levels provides members with numerous opportunities for professional development, information, networking, and advocacy. Established in 1960, the Founders Merit Award Series (now Member Engagement Award Program) acknowledges the contributions made by HFMA members. These awards are part of a merit-rating plan in which specific activities are assigned a range of point values.

The Founders Merit Award Series was revised in April 2004, returning to its core purpose of "Recognizing the Volunteer in You". Point categories were adjusted to reflect volunteer activity only. In 2024 the Founders Merit Award Series program was refreshed to reflect current opportunities for volunteerism and was renamed the Member Engagement Award Program to focus on the opportunities at all levels of membership for engagement.

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HFMA encourages continuous active participation at the local and national levels. Therefore, the point system and award levels have been established to promote continuous active engagement in HFMA.

How to Verify if Your Points are Accurate

Please sign in and review your record under the My Engagement Points section of the HFMA website, www.hfma.org. You will find this on left had side of the screen.
Founders Contacts enter points for the following categories (all other points are awarded by HFMA National automatically):

- Mentor
- Committee Chair or Member (must have attended 50% of meetings) - these will be automatically entered.
- Chapter Article
- Event Volunteer
- Speaker (4 hours or less)
- Speaker (4 hours or more)

Should you have something to add to your record, please fill out the following form: https://cvent.me/Z0oy1r.

The Awards

The Bronze Award is awarded after a member has earned 25 engagement points.

The Silver Award is awarded to a member who has earned 50 total engagement points.

The Gold Award is presented to a member who has earned a total of 75 engagement points.

The Medal of Honor is conferred by nomination of the Chapter Board of Directors. This prestigious award recognizes an individual who has been actively involved in HFMA for at least three years after earning the Gold Award, has provided significant service at the chapter, regional and/or national level in

at least two of those years, and remains a member in good standing. A chapter may nominate members for this award at any time during the year.

Reminders:

- ✔ Although HFMA National and the chapters track chapter and national committee engagement points, it is ultimately the responsibility of the individual member to report points earned using the Awards input screen in their member profile. To add a missing chapter or national committee position, reach out to the Chapter's Award Chairperson, who serves as a liaison to HFMA National. Member points are automatically transferred from one chapter to another.
- ✔ Retroactive scoring of points for all categories is permissible if appropriate documentation is provided.
- ✔ No points are earned for serving terms of office of less than one-half of a chapter's fiscal year for any category, services a member is paid to perform, or for chapter participation prior to HFMA membership.
- ✔ Chapter members can view their Engagement points on the HFMA website under Manage My Account in their personal profiles. Any discrepancies between points awarded and points earned should be reported to the Chapter's Award Chairperson.
- ✔ No points are awarded when an honorarium is provided.

Should you have any questions on the program or your record, please reach out to Laura Hess at NJHFMA@aol.com. Thanks for your conttibutions!

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When Physician Pay Becomes a Compliance Problem

By: Marisol Cooke

Marisol Cooke

On March 25th as part of the Nothing but the FACTs on Finance, Accounting, Capital & Taxes in Healthcare virtual event, I had the opportunity to co-present a webinar with Lawrence ("Larry") Vernaglia from Foley & Lardner on physician compensation, team-based models, and enforcement risk to a group of hospital CFOs and healthcare finance leaders. As our session moved along, what stood out to me was not just the complexity of the physician compensation topic — it was how much the conversation has shifted over the last several years. Compensation structure is no longer just a legal or compliance discussion. It is now also a finance and governance issue because of how it directly impacts revenue integrity.

What I took away from the experience presenting alongside Larry was how important it is to bridge regulatory interpretation with operational reality. While legal frameworks like Stark Law and the Anti-Kickback Statute set the rules, the real risk often comes from how compensation models are designed, implemented, and monitored over time.

In nearly every example we discussed — whether it was medical directorships, Fair Market Value (FMV) determinations, or team-based incentives — the root issue was not intent. They lacked visibility and governance. This is where finance leaders play a critical role.

Key themes that resonated with CFOs

1. **FMV is not a number** — it is a conclusion and many organizations still rely too heavily on percentiles (like the 75th). Regulators are asking deeper questions:
   - What services are being performed?
   - Is the arrangement commercially reasonable?
   - Would it exist without referrals?
2. **Total compensation matters more than individual components.** Compensation stacking — base salary + stipends + call + incentives — can quickly push total pay beyond defensible levels if not reviewed holistically.
3. **Medical directorships remain a high-risk area.** Lack of time tracking, vague duties, and automatic renewals are still common — and still heavily scrutinized.
4. **Downstream revenue is being looked at differently.** It is not about whether referrals occur — it is about whether compensation appears tied to their value.
5. **Advanced Practice Provider (APP) integration is changing productivity models.** As APPs become more embedded in care delivery, organizations need to ensure compensation reflects appropriate supervision and actual services performed.

The biggest takeaway

The most important message for me — and one that clearly resonated with attendees — is this:

1. Most of this risk is manageable.
2. Hospitals already have the data:
   - Compensation
   - Productivity
   - Referral patterns
   - FMV documentation

The difference comes down to whether that data is being used for active oversightand where finance leaders can add value immediately. Some of the most practical steps we discussed included:

- Building a compensation risk dashboard
- Reviewing total compensation, not just components
- Ensuring FMV opinions are current and aligned with duties
- Monitoring APP-driven productivity trends
- Reassessing medical directorship structures annually

Presenting this session reinforced something I have seen across organizations:

- Strong compensation governance is not about compliance — it is about protecting revenue, strategy, and long-term financial stability.

I appreciate the opportunity to share insights with such an engaged group of finance leaders. If others are seeing similar challenges or approaching this differently, I would be interested in hearing your perspective.

About the Author

Marisol has worked in the health care industry since 2007. She provides regulatory compliance in the health care and life sciences industries. She's a trusted compliance advisor with experience developing and implementing regulatory and privacy programs for high-profile organizations. For more information or to discuss the topic further, she can be reached at marisol.cooke@bakertilly.com

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hospitals with advocacy templates in the coming days. I urge every NJHFMA member with a stake in this issue to use those templates, to contact their Ways and Means representatives directly, and to make clear that a reporting framework built on a flawed methodology and designed to omit context does not serve transparency. It serves a conclusion that was reached before the data was ever collected.

We know this program. We know what it does and how it works. This is the moment to say so.

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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Manufacturers have started placing restrictions on contract pharmacy arrangements, arguing that the program's wider reach has increased the risk of fraud and duplicate discounts. HRSA pushed back by issuing violation letters, and the dispute has since led to lawsuits in multiple federal courts.[1] The Congressional Research Service noted that the 340B statute says very little about the role contract pharmacies should play, which has left a lot of room for legal disagreement.[1] Individual states have also stepped in with their own legislation, further complicating the picture.

The future of the program remains unsettled. What does seem clear is that 340B has grown into something much larger than its founders likely intended. Whether that broader reach is still serving the patients the program was built around, those in underserved communities who need affordable medications, is a question that researchers, policymakers, and healthcare leaders are still working through.

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Anirudh (Ani) Shukla is a student at Rutgers University, majoring in Finance and Data Science with a minor in Quantitative Economics. He is currently an intern at Saint Peter's University Hospital, where he is gaining exposure to healthcare operations and finance. After graduation, he hopes to pursue a career in banking or financial services, where he can combine his finance experience with emerging applications of artificial intelligence and data science. In his free time, Ani enjoys biking, especially through nature trails and outdoor areas. He can be reached at as4794@scarletmail.rutgers.edu.

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Practical Takeaways for Healthcare Finance Leaders

For HFMA readers, the question becomes: How can your organization achieve alignment and reduce waste?

1. **Conduct regular alignment audits** across operations, leadership initiatives, and technology use.
2. **Map leadership objectives to operational KPIs** to ensure priorities translate into daily practice.
3. **Integrate technology** to reinforce efficient workflows and reduce duplication.
4. **Review outcomes quarterly** to maintain alignment and continuously improve processes.

These steps create a culture where efficiency, accountability, and financial performance reinforce each other — and where misalignment is promptly addressed before it drains revenue or compromises care.

Closing: Alignment is a Strategic Imperative

Every misaligned process or priority leak revenue. For healthcare finance leaders, the stakes are high. Alignment is not optional — it is a strategic imperative that drives operational efficiency, financial stability, and better patient outcomes. By prioritizing alignment, leaders can turn preventable waste into measurable financial and operational gains. Start mapping your organization's alignment today — your bottom line depends on it.

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About the author

Dr. Sophia Brown RN, PHD, DBA, is a healthcare leadership strategist, informatics expert, and founder of Strategic Informatics Solutions. With more than 35 years of experience in nursing, operations, and change management, she helps healthcare organizations improve alignment, strengthen leadership, and drive measurable financial and operational performance through data-informed transformation strategies. She can be reached at drsophia@stratinformatics.com.

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providers and between providers and payers. Without these technical foundations, the vision of seamless, comprehensive advance cost transparency remains elusive.

Healthcare organizations should focus on building robust data analytics capabilities to support accurate GFE development while preparing for eventual AEOB implementation. This includes investing in historical claims analysis tools, developing statistical modeling capabilities for ancillary service prediction, and creating workflows that can accommodate both current GFE requirements and future AEOB processes.

Healthcare organizations that proactively develop sophisticated GFE capabilities will be better positioned to compete in an increasingly price-conscious marketplace. The ability to provide accurate, comprehensive cost estimates represents not just regulatory compliance but a competitive advantage in patient acquisition and satisfaction.

As the industry navigates these evolving requirements, success will depend on balancing regulatory compliance with operational efficiency while maintaining focus on the ultimate goal: empowering patients with the information they need to make informed healthcare decisions. The journey toward true price transparency is complex, but the No Surprises Act's Good Faith Estimate requirements represent a significant step forward in creating a more consumer-friendly healthcare marketplace.

About the Author

Govi leads Panacea's financial consulting team, partnering with hospitals, health systems, and healthcare providers to improve financial performance and operational outcomes. He brings deep industry expertise and a strong commitment to client service, guiding organizations to implement defensible pricing strategies, improve payer performance, and maintain compliance with evolving CMS regulations.

A recognized thought leader, Govi frequently speaks for HFMA, AAHAM, AHIMA, and other industry organizations, with a focus on hospital price transparency and the No Surprises Act. His perspective is shaped by leadership roles in high-tech and Big Four consulting, as well as earlier provider-side finance roles within large academic and not-for-profit health systems.

Govi holds a Bachelor of Science from the University of Illinois at Urbana-Champaign and a Master of Science in Health Systems Management from Rush University Medical Center. He is Epic CDM and HFMA CRCR certified and served as President of the Florida HFMA Chapter during the 2021–2022 membership year.

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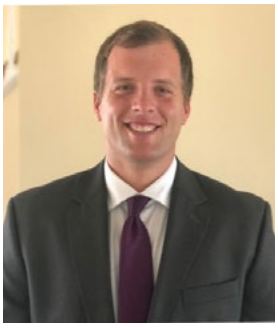

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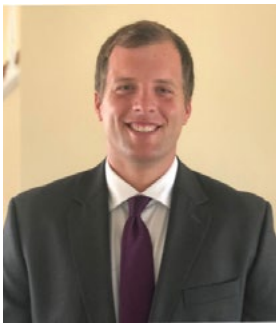

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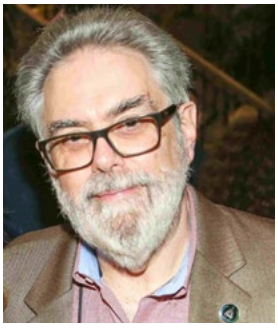

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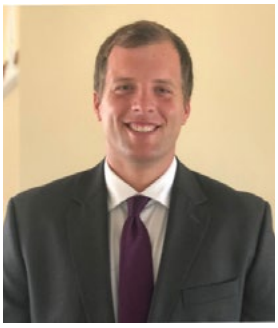

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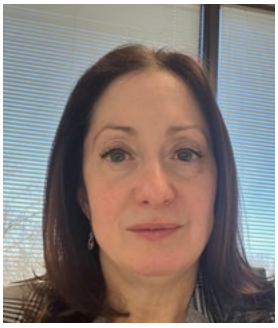

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