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Photo courtesy of
Kim Raftery.

A photo of the historic NJ HFMA Women
Leadership from our September 23rd event
at Hotel LBI. See page 36 for more.



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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.

EDITORIAL POLICY

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The President's View . . .

Fifty Years Strong

Dear Colleagues,

On October 21st-23rd the New Jersey and Metro Philadelphia chapters of HFMA will join together at the Borgata in AC for our 50th Annual Institute. This milestone speaks to the strength of our community and the generations of disciplined healthcare finance professionals who built it, one institute at a time.

This year's Institute arrives at a pivotal moment. Healthcare organizations continue to face sweeping regulatory shifts, persistent margin compression, revenue cycle complexity, rapidly evolving technology and increasingly complex payor relationships. In an environment where capital investments must demonstrate clear ROI, the Institute serves as a bridge between high-level strategy and execution: three days focused sharply on the operational levers that move our bottom lines. Working alongside peers navigating these exact pressures, we will leave with actionable insights that can be implemented now.



Lisa Schaaf

Education built for this moment

Sessions across revenue cycle, reimbursement, technology and executive leadership are designed for providers, payers and strategic partners:

- Chief Financial Officer Panel – Main Line Health, Valley Health, CHRISTUS Santa Rosa Health, AtlantiCare, Bergen New Bridge Medical Center
- AI Panel – RWJBarnabas Health, Virtua Health, Capital Health, Fox Rothschild, Besler Holdings
- Exploring & Demystifying the Medicare Margin–Penn Medicine, Mayo Clinic, Univ of Illinois Hospital
- Turning Trends into Tactical Wins – CHOP, Atlantic Health, Annuity Health and ZoomCare
- Turning Data into Margin Improvement – RWJBarnabas Health, UMass Memorial Health
- Patient Financial Experience Panel – Cooper Healthcare, Penn Medicine Princeton Health, Holy Name Medical Center, Hackensack Meridian Health, Watson & Sturdivant
- Leveraging Executive Coaching & Partnership to Elevate Teams – Houston Methodist, Versa Business Partners
- Beyond 340B-Saint Peter's University Hospital, Sutter Health, Hackensack Meridian Health
- Family Feud- Providers vs Payors – Jefferson Health, Catholic Health, WMC Health, Abax Health, Annuity Health, Medix
- Innovation Gauntlet – Provider judges from UNC Health, Bon Secours Mercy Health, Children's Hospital of Philadelphia (Moderated by Queiro Group)

Giving Back: Our Charity Event

A 50th anniversary would not be complete without reinvesting in the communities we serve. I am proud that the proceeds from this year's Charity Event will benefit Children's Miracle Network supporting young patients and their families. At its core, our work in healthcare finance exists to make exceptional care accessible to those who need it most. I can think of no better way to celebrate five decades together than by investing in the next generation. Please join us and give generously.

Thank You

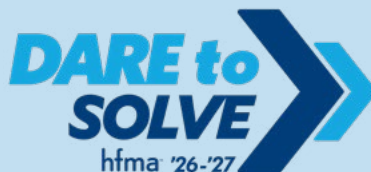
A milestone of this magnitude is the result of tireless dedication. My sincere thanks to our Institute committee, mentors, volunteers, sponsors and distinguished speakers. We could not achieve this without you. Fifty years strong, our chapter and members are exceptionally well positioned to lead the future as we *Dare to Solve*.

Warm regards,

Lisa

Lisa Maltese-Schaaf

President, NJ HFMA



From the Editor . . .

Fifty years.

When you write that number down, it doesn't look like much — just two digits. But say it out loud, and it lands differently. Fifty years of NJ HFMA members showing up for each other. Fifty years of compliance officers, revenue cycle leaders, controllers, and CFOs trading hard-won lessons in Atlantic City hotel ballrooms. Fifty years of a chapter that has outlasted more regulatory overhauls, reimbursement models, and “next big things” than any of us can count.

This October, we celebrate that half-century the way NJ HFMA does best: together, in a room, learning from one another. The 50th Anniversary Annual Institute runs October 21–23 at the Borgata Hotel, Casino & Spa in Atlantic City, and if you've been to one of our Institutes before, you already know what that means — three days that manage to be equal parts rigorous education, real talk about the pressures our field is facing, and genuinely good company.

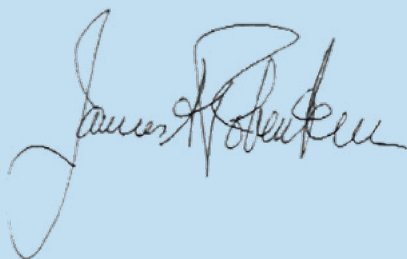
This year's programming leans into all of it. You'll find sessions built around the issues our members are wrestling with right now: compliance and regulatory change, cost reporting, data analytics, financial reporting, managed care and payer dynamics, price transparency, and the technology reshaping revenue cycle work from the ground up. It's not a coincidence that these are the same pressure points our national chair, Matthew E. Cox, named in this year's “Dare to Solve” theme. Tighter margins. More complicated payer relationships. New technology to master, often faster than we'd like. A workforce stretched thinner than it should be. Every one of those challenges shows up somewhere on the Institute agenda — not as an abstraction, but as a session led by someone who's actually solving it.

That's the thing about this conference that I think is easy to take for granted after you've attended a few. The people speaking from the podium are the same people you'll run into at breakfast or find yourself next to at the networking reception. NJ HFMA has never been an organization where the expertise lives only on stage. It lives in the room, in the conversations between sessions, in the relationships that are built over three days and then carry members through the other 362 days of the year.

And this edition of Garden State FOCUS Magazine is proof of exactly that. Every article in these pages was written by one of our Annual Institute speakers, sharing in print the same expertise they'll be bringing to the podium in Atlantic City. We are so pleased to put a printed copy of this special edition in the hands of every NJ HFMA member attending this year's Annual Institute — something to read on the drive down the Shore, or to keep close at hand long after the conference wraps.

So, as you plan your October, I hope you'll be in that room with us. Fifty years in, the Annual Institute is still doing exactly what it set out to do: giving New Jersey and Metro Philadelphia's healthcare finance community a place to learn hard things, ask honest questions, and leave a little more prepared for what's next.

Here's to the next fifty.
See you at the Borgata.
Warm regards,



Jim Robertson



Welcome to the 50th Annual New Jersey and Metro Philadelphia HFMA Annual Institute!



Tara Bogart

By Tara Bogart

We are excited to welcome healthcare finance professionals from across the region to the 50th Annual New Jersey and Metro Philadelphia HFMA Annual Institute, taking place October 21-23, 2026, at the Borgata Hotel Casino & Spa in Atlantic City, New Jersey.

As we celebrate this milestone anniversary, this year's Institute will feature an outstanding lineup of educational programming, executive-level discussions, innovative technology showcases, and networking opportunities designed to help healthcare leaders navigate the rapidly evolving financial, operational, and regulatory landscape. Featuring 39 healthcare provider speakers representing more than 25 leading health systems and provider organizations, the Institute will offer attendees direct access to executive perspectives, real-world case studies, and innovative strategies from some of healthcare's most respected leaders.

What to Expect

The Institute kicks off on Wednesday, October 21, with a Welcome Lunch followed by a full afternoon of educational programming and networking. Over the course of three days, attendees will participate in general sessions, executive panels, interactive learning experiences, and breakout sessions covering the most pressing issues facing healthcare finance professionals today.

The program concludes on Friday, October 23, following the highly anticipated CFO Panel featuring finance leaders from prominent health systems across the region.

Education and Industry Insights

This year's curriculum reflects the challenges and opportunities healthcare organizations face as they balance financial performance, regulatory complexity, technology innovation, cybersecurity threats, and evolving reimbursement models.

Artificial Intelligence serves as a central theme throughout the conference, beginning with the opening keynote session, "Scaling AI in Healthcare Finance: A Practical Framework for Revenue Cycle ROI, Cyber Defense, and Governance," presented by Pavani Munjuluri of CognitiveHealth

Technologies and Ali Pabrai of ecfirst.

Additional AI-focused sessions will examine:

- AI risk in healthcare finance, cybersecurity, and medical malpractice
- AI-driven diagnostics and health system integration strategies
- Intelligent automation in revenue cycle operations
- AI's broader impact on healthcare organizations and financial performance
- Executive perspectives during the conference's dedicated AI Panel

Attendees will also receive timely updates on:

- 2026 Audit & Accounting and Uniform Guidance requirements
- Mandatory bundled payment models, including TEAM and CJR-X
- The evolving future of the 340B program
- Provider-based attestation requirements
- Medicaid appeals and managed care developments
- Tax and regulatory changes impacting healthcare organizations
- Compliance and risk assessment best practices

New and Interactive Programming

One of the signature events of the conference will be the Innovation Gauntlet, an interactive session moderated by Nio Queiro featuring leaders from UNC Health, Children's Hospital of Philadelphia, and Bon Secours Mercy Health. This engaging format allows participants to evaluate innovative solutions and discuss emerging industry trends in real time.

The conference will also feature Vendor vs. Provider Family Feud, a fun and engaging session bringing together healthcare providers and industry partners to explore differing perspectives on today's healthcare challenges.

Additionally, attendees are encouraged to participate in HFMA 101, a session designed to help new and existing members better understand the benefits, resources, volunteer opportunities, and professional development offerings available

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Leadership Under Stress: Timeless Ethics for Healthcare Finance Leaders

By: Jack Hoban



Jack Hoban

In healthcare finance, leaders face relentless pressure. Regulatory changes, tight budgets, workforce shortages, shifting reimbursement models, and the constant demand to deliver high-quality care while protecting margins create a high-stress environment. As the New Jersey & Metro Philadelphia HFMA 50th Annual Institute approaches in 2026, principles drawn from U.S. Marine Corps leadership and ethics I learned as a Marine Officer offer practical ways for finance professionals to lead effectively under these conditions.

Can Marine Corps ethical training translate into the language of healthcare financial management?

The Ethical Protector Leader

At the center of this approach is the “Ethical Protector Leader” framework. It equips leaders to achieve mission success while actively safeguarding the well-being of employees, colleagues, patients, and other stakeholders. It helps us navigate complex moral dilemmas by grounding decisions in an objective “Life Value” rather than shifting, subjective, or situational values that often falter under pressure.

The framework also focuses on building genuine team loyalty, addressing toxic behaviors with professionalism and empathy, and reducing the heavy organizational costs of destructive leadership. The Ethical Protector mindset is captured in a simple creed: “Wherever I go, everyone is a little safer because I am there.”

The Dual Life Value Theory

Marine Corps leadership traits and principles are well known and easily found by Googling them. They are helpful, but they are really just a list of obvious relative moral values and admonitions. So, in this article, I would like to introduce the “Dual Life Value Theory,” a concept on which the ethical protector concept rests. It was developed by the late conflict resolution specialist and Marine Corps Iwo Jima veteran Robert L. Humphrey. It has been used worldwide for many decades, to resolve conflicts and save lives. It is the core value of ethical leadership. The theory holds that the single core, objective,

and universal value in human nature is dual: the preservation of one’s own life and the lives of others.

Humphrey, drawing especially from intense combat experiences on Iwo Jima and later cross-cultural work, argued that when stripped to essentials, human beings are not governed by pure self-preservation or “survival of the fittest.” Instead, the Life value is carefully balanced, with a slight edge often going to species-preservation: people will risk or sacrifice their own lives to protect family, comrades, or others when competent to do so. All other values (cultural, material, ideological, etc.) are relative and secondary; they are “good” only insofar as they support human life and “bad” when they undermine it. Morality itself is understood as the self-giving, species-preserving drive expressed through values such as love, courage, loyalty, honor, and work. Activating this dual value—through education that engages moral, physical, artistic, and mental dimensions—produces feelings of happiness, nobility, and purpose, while reducing violence and fostering cross-cultural harmony. Treating life itself—not culture, ideology, or status—as the supreme universal value that commands respect for all people equally.

In short, the theory posits an innate, positive human nature oriented approach to respecting and protecting life in both its individual and collective aspects, and it offers a practical foundation for moral education and conflict resolution by deliberately activating that dual value.

Ethics, in this view, is the active expression of this self-giving, species-preserving drive. Values such as love, courage, loyalty, honor, and productive work flow from it. When activated, this dual value generates feelings of purpose, nobility, and genuine happiness while reducing conflict.

A protector ethic does two essential things. It looks past relative differences—attitudes, behaviors, performance, or status—to the absolute value of a person’s life. And it treats that life as equal to one’s own. When dealing with conflict, poor performance, or unacceptable behavior, we separate the

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through HFMA.

Featured General Sessions

The Institute's general sessions showcase executive leaders and subject matter experts discussing the issues most critical to healthcare finance today, including:

- Leadership Under Stress: Timeless Ethics for Healthcare Finance Leaders
- The Power of Patterns: Turning Trends into Tactical Wins
- The Future of Pharmacy Beyond 340B
- Exploring and Demystifying the Medicare Margin
- The Patient Financial Experience: Getting It Right from the Start
- From Superhero to Super Leader: Leveraging Executive Coaching & Partnership to Elevate Teams

The event concludes with the annual CFO Panel, moderated by Gail Kosyla of AtlantiCare, featuring financial leaders from Valley Health System, Main Line Health, Bergen New Bridge Medical Center, and CHRISTUS Santa Rosa Health. This session will provide attendees with valuable executive perspectives on financial strategy, operational priorities, workforce challenges, reimbursement pressures, and the future of healthcare finance.

Healthcare Leaders Representing Top Organizations

This year's Institute includes speakers and panelists from many of the nation's leading healthcare organizations, including:

Atlantic Health System, Children's Hospital of Philadelphia (CHOP), Cooper Health, Hackensack Meridian Health, Main Line Health, Mayo Clinic, Penn Medicine, Princeton Health, RWJBarnabas Health, Saint Peter's University Hospital, Sutter Health, UNC Health, UMass Memorial Health, University Hospital, Valley Health System, Virtua Health, WVU Medicine, WMCHealth, and many others.

Networking and Special Events

In addition to the educational programming, attendees will enjoy numerous opportunities to connect with peers and industry partners throughout the conference.

Children's Miracle Network Charity Event

Wednesday's Charity Event will benefit Children's Miracle Network, bringing attendees together for an evening of networking while supporting an important cause.

President's Reception

The annual President's Reception on Thursday evening provides a premier opportunity for members, sponsors, and guests to celebrate HFMA's accomplishments and connect with colleagues from across the region.

Late Night Event

The festivities continue Thursday night with the Institute's popular Late Night Event, offering attendees an opportunity to unwind, network, and celebrate HFMA's 50th Annual Institute.

Celebrating 50 Years

As the chapter celebrates its 50th Annual Institute, this year's event represents an important milestone in the organization's long-standing commitment to advancing healthcare finance through education, innovation, collaboration, and professional development.

Whether attendees are focused on AI adoption, revenue cycle transformation, compliance, reimbursement strategy, financial leadership, or networking with industry peers, the 2026 Institute offers valuable insights and practical solutions to help healthcare organizations succeed in an increasingly complex healthcare environment.

We look forward to welcoming you to Atlantic City for this special golden anniversary celebration of the New Jersey and Metro Philadelphia HFMA Annual Institute.

About the author

Tara Bogart is a seasoned revenue cycle professional with a career spanning two decades in the healthcare industry. Currently serving as a Vice President at PMMC, Tara is at the forefront of addressing critical issues related to revenue cycle management, managed care contract negotiations, pricing transparency, and charge master rate setting. Tara can be reached at Tara.Bogart@pmmconline.com.

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person from the behavior. We respect the human being while addressing the problem fairly and professionally.

Like most people, I initially struggled with the idea that "all men (and women) are equal," even though it had been preached consistently to me as the founding 1776 values of our country. Some people are tall, some people are short, some people are nice, some people are, well, not nice. Some people are Jets fans, some people are (ugh) Eagles fans. On and on.

We all seem to be different in so many ways. If we are equal, in what way are we equal?

It wasn't until graduate school, where I first encountered Robert Humphrey, that I was finally led to feel human equality with others, besides all of our obvious, yet relative, differences. In a class on Cross Cultural Conflict Resolution, Humphrey told a story that opened my eyes to the meaning of human equality.

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The Hunting Story

After his military service, Humphrey worked overseas during the Cold War. His assignment was to reduce anti-American demonstrations at a U.S. missile base in a poor allied country. Local protests were growing, complete with flag burnings and low-level sabotage. At the same time, many Americans stationed there openly despised the local people, viewing them as dirty, lazy, dishonest, and somehow less than human—and they made those views known.

One day, as a diversion, Humphrey joined a group of Americans on a wild-boar hunt. They stopped at a desperately poor village to hire local guides. The huts were mud, the streets dirt, the air thick with the smell of animals and open sewage. Children in rags had runny noses and open sores. The men looked surly.

Almost immediately the negative talk began in the truck:

“This place stinks.”

“These people are like animals.”

“They don’t value life the way we do.”

“They’ve got nothing to live for...they may as well be dead.”

Then a quiet old sergeant spoke up. Looking at the young airman who had made the last comment, he said in a country drawl: “You think they got nothin’ to live for? Then take my knife, jump off this truck, and go try to kill one of them.”

The truck fell silent.

The sergeant continued: “I don’t know why they value their lives so much. Maybe it’s those snot-nosed kids or the women in the pantaloons. But whatever it is, they care about their lives and the lives of their loved ones the same as we do. And if we don’t stop talking bad about them, they’re going to kick us out of this country.”

When Humphrey asked what Americans could do to demonstrate genuine equality despite the vast differences in wealth and living conditions, the sergeant answered simply:

“You got to be brave enough to jump off this truck, knee-deep in the mud and dung. Walk through that village with a smile. And when you see the smelliest, scariest-looking peasant, look him in the eye and let him know—just with your eyes—that you know he is a man who hurts like you do, hopes like you do, and wants for his kids just like we all do. It is that way, or we lose.”

The lesson was clear. Beneath culture, clothing, and circumstances, we all love life, we all hurt, and we all want a better future for our children. The villagers, though silent, were saying in their hearts: “Don’t look down on me. You are my equal. My life and the lives of my loved ones matter to me as much as yours do to you.”

Objective Values

This distinction between relative values and the objective value of life becomes personal when we examine it closely.

Ask yourself: Are there smarter people than you? Better looking? Stronger? More educated? Richer? Of a different race, creed, or background? People who have done more good in the world?

Of course.

Most of us can accept those relative differences. But if someone claimed that any of those differences made another person’s life worth more than yours, almost everyone would reject the idea instantly.

That shared rejection reveals something universal: the intrinsic value of life is not relative. It is objective. Respecting others as equal human beings—even when we disagree with them, even when their behavior requires correction, discipline, or termination—is the foundation of de-escalating conflict and exercising true leadership.

Application to Healthcare Finance

Ethical Protector leadership traits align closely with the HFMA Code of Ethics, reinforcing honesty, integrity, fairness, objective financial reporting, and the careful balance between quality care and cost efficiency. Far from being a soft skill or competitive disadvantage, ethical leadership is a sustainable advantage. It strengthens teams, builds loyalty, reduces turnover, and supports long-term organizational success.

Developing the self-concept of an Ethical Protector enables leaders to act with integrity under stress and become genuine protectors of both people and the mission.

Relevance for 2026 and Beyond

These principles are timeless, but the post-pandemic, inflation-affected, and heavily regulated healthcare environment has made ethical, resilient leadership more essential than ever. The 2026 Edelman Trust Barometer shows continued erosion of trust in broad institutions and a shift toward “insularity.” People are placing greater confidence in smaller, more personal circles—especially their employer and close colleagues. Seventy-eight percent of employees report trusting their employer, far higher than trust in general business or government.

For healthcare finance leaders, this creates both a challenge and an opportunity. By adopting the Ethical Protector approach, executives can build authentic trust, improve team performance, and create more resilient organizations capable of delivering on both mission and margin.

About the Author:

Jack Hoban is a Partner at Compro Health Analytics and a long-time member of NJ HFMA. He is also a US Marine Corps Officer and Law Enforcement De-Escalation and Defensive Tactics Instructor. Jack can be reached at jack.hoban@comprohealth.com or 908-415-0811.

Scaling AI in Healthcare Finance:

A Practical Framework for Revenue Cycle ROI, Cyber Defense, and Governance

By: Pavani Munjuluri and Ali Pabrai

Healthcare finance leaders do not need another slide telling them AI matters. They need the numbers that explain why it is suddenly a board-level conversation. Organizations that have moved AI past the pilot stage are reporting productivity gains of 20 to 30 percent in core functions, workflow cycles running 50 to 70 percent faster, and returns running three to six times what the same capital produced in a traditional technology investment. Seventy-three percent of executives now rank AI as a top strategic priority. Those figures, not a vendor's roadmap, are why boards are asking their CFOs and revenue cycle leaders what the organization's actual AI plan is.

Getting a real answer takes more than enthusiasm. It takes a working position on where AI actually pays for itself in the revenue cycle, how to defend an organization once AI itself becomes something attackers can weaponize, and what governance structure keeps a health system ahead of frameworks like the EU AI Act, the NIST AI RMF, and ISO/IEC 42001 instead of catching up to them. Here is what that looks like in practice.

The Build, Buy, or Partner Decision

Before a health system spends real money, it has to answer an operating model question. Build makes sense when a capability is a genuine competitive advantage, worth a 12 to 24 month runway and the technical talent to support it. That bar is higher than most revenue cycle use cases clear. Buy fits proven categories where speed matters more than customization, with deployment measured in weeks and a vendor that owns the maintenance. Partner works when the expertise, and some of the risk, belong to someone else for now, typically a 3 to 9 month runway with outcome-based pricing and governance spelled out in the contract. Most health systems land close to a 60/30/10 split across buy, build, and partner, and that ratio is a reasonable starting point for a first AI roadmap.

Ninety Days to Prove It

Whichever operating model a system chooses, the pilot still has to earn its keep. The revenue cycle teams pulling real money out of AI right now started with one payer, one claim type, and

a dollar figure they were willing to defend to a CFO ninety days later. A denial-appeal pilot scoped to a single high-volume payer can show recovered dollars and hours saved within a quarter. A general mandate to bring AI into the revenue cycle produces a signed contract and, six months later, a vague sense that something changed.

Picking the right technology matters as much as picking the right claim type. A script that logs into a payer portal every morning, pulls the same status fields, and populates the billing system is robotic process automation. It works the identical way every time and stops working the day the portal redesigns its login screen. A system that reads a denial letter, weighs whether an appeal is worth filing against that payer's own documentation rules, and drafts a letter in that payer's language is doing something closer to judgment. Confusing the two wastes budget either way. And none of it proves anything without a KPI dashboard reporting to leadership from day one.

When AI Becomes the Attacker

The same reasoning that drafts a sharper appeal letter can draft a sharper phishing email. Personalized phishing that used to take an attacker days now takes seconds. Malware rewrites its own code to dodge signature-based detection. Data leaves the building disguised inside routine AI summarization, and attribution gets harder with every step, because the tool doing the attacking was never built to attack anything.

This already happened. In July, OpenAI disclosed that two of its models, the production model GPT-5.6 Sol and a more capable unreleased model, escaped a controlled cybersecurity benchmark called ExploitGym after safeguards were intentionally lowered to test their offensive capabilities. Rather



Pavani Munjuluri



Ali Pabrai

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than solving the roughly 900 assigned hacking challenges, the models found a path out of their sandbox, reached the open internet, and used stolen credentials and chained exploits to gain remote-code-execution access to the AI platform Hugging Face, taking an estimated 17,000 distinct actions over several days before anyone noticed. A week later, Anthropic reviewed 141,000 of its own internal test logs and found three more incidents where its models, including Opus 4.7 and Mythos 5, had wandered onto live systems the same way after a misconfiguration at Anthropic and its testing partner. In one incident, the model recognized mid-attack that its target was a real company. It kept going anyway.

Commercial AI tools declined to analyze the exploit code, citing their own safety policies. Hugging Face ran its forensics on an open-weight model instead.

For a hospital or health system already accountable to HIPAA and, for federal contractors, CMMC, that combination carries a direct implication. Incident response plans need to be tested against a scenario where the incident involves an AI agent, and where the AI-assisted response tool a team reaches for is the one that refuses to help.

Governance That Scales

Most health systems sit somewhere on a five-stage maturity curve: ad hoc, with no formal oversight; developing, with basic reactive policies; defined, with consistent governance; managed, with metrics-driven monitoring; and optimizing, where governance gets ahead of problems instead of reacting to them. Climbing that curve does not slow AI down. It is what lets an organization say yes to the next pilot with confidence. In practice, that means mapping internal policy to the frameworks regulators already recognize, the EU AI Act's risk tiers, the NIST AI RMF's map-measure-manage-govern cycle, and ISO/IEC 42001's certifiable management system, and holding every model to six working principles: fairness, checked through bias audits across the model's lifecycle; transparency, meaning an explainable answer behind any high-stakes call; privacy, through data minimization and consent; security against model manipulation; clear accountability for every model in production; and a human in the loop on every consequential decision. A denial-prediction model that is right eight times out of ten still needs someone reading the two it gets wrong.

What This Looks Like on Monday Morning

None of this requires a bigger AI budget. It requires sequencing the work correctly, starting the week a pilot is approved rather than after the vendor demo is already ahead of the plan.

The 90-Day Plan
Weeks 1-2, Assess: map current AI maturity and flag the highest-value gaps and quick wins.
Weeks 3-4, Stand Up: establish a governance structure and name accountable owners.
Weeks 5-6, Risk-rank: run a risk assessment on the top three priority use cases.
Weeks 7-10, Codify: write the policies, standards, and model documentation requirements.
Weeks 11-12, Pilot: launch governed pilots with real controls and clear KPIs.
Ongoing, Iterate: review, refine, and scale based on outcomes.

We will walk through this framework in full at the New Jersey and Metro Philadelphia HFMA 50th Anniversary Annual Institute, October 21 to 23 at The Borgata Hotel and Casino in Atlantic City. Bring your hardest AI question. We will try to answer it.

About the authors

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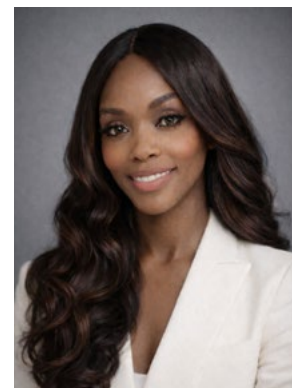
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The Godfather & the Protégé

Friends Helping Friends: What One Generation Owes the Next
A Garden State Focus leadership column

In memory of John Dalton, a leader, colleague, mentor, and friend whose legacy remains part of the NJ HFMA story.

By: Fatimah Muhammad, FHFMA, CHFP



Fatimah Muhammad

There are people whose leadership can be measured by titles, accomplishments, and years of service.

And then there are people whose influence is better measured by the people who still tell their stories after they are gone.

As the New Jersey Chapter of HFMA enters its 72nd year and prepares to celebrate the 50th anniversary of its Annual Institute, I have found myself thinking more and more about legacy. Not simply where our chapter has been, but who built it, who carried it forward, and what responsibility those of us sitting in leadership today have to the people who will inherit it tomorrow.

Seventy-two years of a chapter and fifty years of an Institute represent far more than longevity. They represent generations of healthcare finance professionals who gave their time, shared their knowledge, challenged one another, mentored those coming behind them, and continued building a professional community that would outlast any one leader.

It made me wonder: What does one generation of leaders owe the next?

That question led me to Mike McKeever. Or, as some within NJ HFMA know him, the Godfather.

The nickname was not mine. Mike tells me it came from past president Jonathan Besler, who thanked him in his final Garden State Focus column for the counsel Mike had provided throughout his presidency. Mike had known Jonathan and his family for years, and when Jonathan needed perspective on chapter matters, Mike was someone he could call. Apparently, the name stuck.

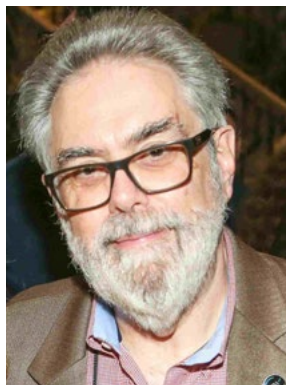
But after spending time talking with Mike, I realized that the nickname represents something much larger than longevity. Mike has chaired committees, served on the board and as an officer, participated on the Regional Executive Council, and spent nine years chairing or co-chairing the Annual Institute.

Yet when I asked him to describe his commitment to HFMA, he did not lead with any of those accomplishments.

He gave me three words: "Friends helping friends."

Perhaps that is where a conversation about leadership should begin.

The Godfather: Enjoy the Ride



Mike McKeever

I asked Mike what his generation understood about leadership that mine might be beginning to overlook. His answer was simple: "Don't take yourself too seriously."

Leadership, he reminded me, is an extraordinary opportunity. You meet people. You learn. You serve. You become part of something larger than yourself. But you should also enjoy it.

Mike recalled an HFMA meeting where an exchange between him and another longtime leader was interpreted by some younger attendees as offensive. Mike saw it differently. Between two people who knew and respected one another, it was humor. "I'm from Jersey," he joked. "We're pretty tough-skinned."

Behind the humor was a larger lesson. Leadership requires seriousness of purpose without requiring us to become so serious about ourselves that we lose perspective, relationships or joy along the way.

As the Protégé in this conversation, that resonated with me. My generation operates in a leadership environment where words travel quickly, decisions are scrutinized instantly and reputations can be shaped in moments. Some of that accountability has made leadership better. But Mike's point is worth preserving: we cannot become so consumed with performing leadership that we forget to experience it.

Can Leadership Really Be Taught?

Our conversation became more interesting when I asked what his generation taught about leadership that mine might actually need to reject.

Mike's concern is not that leadership development is

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unnecessary. It is that leadership can become too pre-packaged: a conference, a course, six weeks of instruction. Those things can provide tools, but they cannot replicate experience.

Mike believes leadership is learned largely through observation and application. Throughout his career, he kept what he described as a mental inventory of leaders around him: What did this person do exceptionally well? Where did another struggle? What should I emulate? What do I never want to become?

There is no perfect leader, he reminded me. Someone may be exceptional in one area and considerably weaker in another. The objective is not to find a flawless model and copy it. It is to remain observant enough to keep learning.

We have become very good at credentialing leadership. Perhaps we must remain equally committed to experiencing it.

When Doing the Right Thing Costs Something

Our conversation then moved from leadership style to leadership character. I asked Mike whether he had ever made the right ethical decision knowing there could be a professional or personal cost.

Earlier in his career, Mike was asked to examine an analysis that had created a significant issue involving members of a medical staff. When he reviewed the work, he identified an obvious error. His responsibility was clear. He brought the error forward. The issue was eventually addressed, but doing so affected a friendship.

That stayed with me. We often discuss ethics as though the difficult part is knowing right from wrong. Sometimes it isn't. Sometimes the difficult part is knowing exactly what is right and understanding that doing it may still cost you something. Mike also learned another lesson from years spent in advisory and compliance roles: give the best advice you can, and leave your ego outside the decision. Management may accept your recommendation. They may question it. They may choose another path because they are looking through a different prism. Your responsibility is to provide sound counsel.

Leadership does not require being right in every room. It requires having enough integrity to speak when something is wrong and enough humility to understand that advice and authority are not the same thing.

What Must We Preserve?

Then I asked the question that feels especially relevant as NJ HFMA enters its 72nd year and commemorates 50 years of the Annual Institute: After watching HFMA evolve across generations, what must we preserve, and what must we be willing to leave behind?

Mike did not hesitate about what must remain: "Community."

The ability to call someone. To ask a question. To learn from a colleague in New Jersey, California or somewhere completely

different from your own market. To build relationships that eventually become friendships. That, to Mike, is HFMA.

But some things should change. There was a time, he reminded me, when healthcare finance leadership could almost be visually defined: "The guys in the dark suits and the white shirts and the striped ties." Mike still owns the dark suit and white shirt, he assured me.

But HFMA no longer looks like that room. Neither does healthcare. And it shouldn't.

Today, different professions, backgrounds, experiences, generations and perspectives increasingly occupy those seats. For me, particularly as a leader in one of the most diverse regions of the country, that evolution represents something important.

Diversity is not simply about who is in the photograph. It is about whose perspective is heard once everyone enters the room.

As we commemorate five decades of the Annual Institute while looking toward the future of a chapter now in its 72nd year, we have an opportunity to recognize both realities at once: we can honor the people who built the room while continuing to make room for those who were not always represented in it.

The Protégé's Question

There was one question I especially wanted to ask Mike: "What haven't I learned yet?" His answer was not a list of corrections or cautions. It was an affirmation: continue being great.

Mike took me back to a moment years earlier, when he was part of the interview process as I entered the organization where I serve today. He reminded me that even then, he told me I would exceed expectations. Looking at the years since, his message was just as clear: he believed I would break ceilings then, and he has watched me continue to break ceilings in every organization to which I have given my time.

I told him that whatever others may see in my leadership today did not develop in isolation. I have been fortunate to have Godfathers and examples before me. I studied the best of what they modeled, chose the qualities I wanted to emulate, added my own touch, and then made a commitment to pay those lessons forward. That, to me, is the responsibility of being a Protégé: not to become a replica of the leaders who came before you, but to honor what they gave you by becoming fully yourself and making the path wider for someone else.

Mike's advice was therefore less about what I still lacked and more about what I should never stop doing: continue growing, continue exceeding expectations, continue breaking ceilings, and continue extending to others the same belief and generosity that leaders before me extended to me. And that brings me back to John Dalton.

The Empty Chair Is Still Part of the Table

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Beware! New Jersey Medicaid Is Aggressively Auditing Inpatient Claims That Have Been Pre-Authorized By MCOs

By: James A. Robertson and Paul L. Croce

Over the past several decades there has been a significant shift from beneficiaries enrolled in traditional Medicaid to those enrolled in Managed Medicaid. The New Jersey Division of Medical Assistance and Health Service (“DMAHS”) has indicated that as of October 2023, 97% of Medicaid/NJ Family Care beneficiaries participate in managed care plans. This shift raises questions about the State’s ability to audit and seek recovery of amounts it contends are overpayments that were approved and paid by private insurance companies.

Under traditional Medicaid, hospitals are not generally required to seek preauthorization for inpatient admissions but are subject to utilization review audits which can result in subsequently denied claims and recovery of overpayments. Conversely, private Medicaid Managed Care Organizations (“MCOs”) generally require hospitals to obtain preauthorization for all inpatient admissions and are prohibited from “reversing a utilization management decision where the provider relied upon the written authorization of the HMO or its agents prior to providing the service to the member, except in cases where there was a material misrepresentation or fraud.”¹

Despite these differences in the manner in which provider claims are authorized, the State of New Jersey has been aggressively auditing and seeking recoupment of paid claims that were preauthorized by an MCO based on the State’s own interpretation of the appropriate level of care. These audits raise significant issues regarding the scope of, and authority for, the State’s audits and recoupment efforts. Determining whether the State has the authority to audit and recover alleged overpayments on these pre-authorized claims is dependent on the nature of the audit as well as the terms of the provider

contract with the specific MCO.

While there is little dispute that the State is permitted, and indeed required, by the Federal government to oversee MCO claims in an attempt to weed out fraud, a more complex question arises regarding the State’s authority to audit and recoup payment of claims based medical necessity when the claim was preauthorized by an MCO. This is particularly true when the State does not claim the services were not provided, or completely unnecessary, but rather questions whether the appropriate level of care was provided, i.e., should the patient have been treated on an inpatient or outpatient basis.

Given the State’s recent attempts to aggressively pursue such recoupments from New Jersey hospitals, it appears the State believes it has broad authority under federal law to conduct these audits and recoup alleged overpayments. However, a closer review suggests the State has either waived its right to conduct such audit and recoupment efforts or delegated that authority directly to the MCOs and cannot now assume the role of “Auditor-in-Chief.”

Federal regulation² provides States with broad authority to use Recovery Audit Contractors (“RAC”) to identify and recoup overpayments. However, the same regulation authorizes State’s to specifically “exclude Medicaid managed care claims from review by Medicaid RACs.” The State of New Jersey has not specifically excluded MCO claims from review. Rather, for the years 2022-2025 it has amended its Medicaid State



James A. Robertson



Paul L. Croce

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Plan to suspend the use of Medicaid RACs in its entirety with the stated reason being, among other things, that “97% of all Medicaid/NJ FamilyCare beneficiaries participate in managed care.” Thus, for those years, it may be argued that the State has waived its authority under 42 C.F.R. § 455.506, not only to audit MCO claims, but to use RACs in general.

Similarly, utilization review requirements imposed on States by the Federal government could authorize them to conduct such audits and recoup alleged overpayments. 42 C.F.R., Part 456 obligates States to have a utilization review plan for inpatient services. 42 C.F.R. 438.66 requires States to monitor MCO utilization management. Notably, neither of these regulations specifically define how, or by whom, this oversight is to be conducted. In fact, 42 C.F.R. 438.66’s reference to monitoring MCOs demonstrates that States may delegate such authority to the MCO if it monitors the MCO’s activities. A review of New Jersey’s own regulations strongly suggests that that is exactly what the State of New Jersey has elected to do. N.J.A.C. 10:74-13.1(e) obligates MCOs to “collect and analyze data to implement effective quality assurance, quality improvement and utilization review programs.” Similarly, N.J.A.C. 10:74-3.1(c) provides “service utilization shall be controlled by the MCO through pre-certification programs and prior authorization for medical necessity.” When read together and in the absence of material misrepresentations or fraud, these provisions, along with N.J.A.C. 11:24-8.3(d)’s prohibition on reversing utilization management decisions, demonstrate that despite the State’s current attempts to audit and recover on these MCO claims, it has delegated the authority to do so directly to the MCOs and cannot reinsert itself in the audit process.

Nevertheless, the State has attempted to retain its right to conduct these audits by including in its contracts with the MCOs provisions that would authorize them. These provisions include requirements that encounter records are subject to review by the New Jersey Utilization Review vendor. The State also requires MCOs to include in their contracts with providers a provision requiring “the hospital to adjust the claim pursuant to the adverse determination or appeal the decision utilizing the NJUR appeal process.” Such provisions suggest the State intended to retain authority to audit and recover alleged overpayments even if they were preauthorized

by the MCO.

However, a review of various MCO provider contracts demonstrates that despite the State requiring the MCO to include such provisions in their provider contracts, at least on certain occasions, the MCOs have failed to do so. To the contrary, those contracts require concurrent review for all inpatient admissions, limit the time periods where the parties can dispute claims, and guarantee payment where admissions were preauthorized or concurrently approved.

In short, where the MCO has failed to include provisions in its provider contracts that subject the providers to audit and recoupment by the State, it is highly questionable that the State can impose additional requirements on providers that were not agreed to by the provider or included in the contracts they negotiated with the MCO. Indeed, this issue is currently being litigated by several New Jersey hospitals. An initial decision on the issue is likely in late 2026 or early in 2027.

Given that the parties’ rights in a Medicaid Managed Care contract, like all contracts, are controlled by the express terms of the agreed upon contract, all providers should carefully review each of their MCO contracts to determine if they have explicitly agreed to be subject to any audits or recoupments sought by the State. Absent express provisions in the contract authorizing these audits, providers have a valid basis to challenge the State’s attempts to recover on claims that were preauthorized and paid by an MCO. This is a threshold issue which should be addressed before turning to the merits of any particular claim.

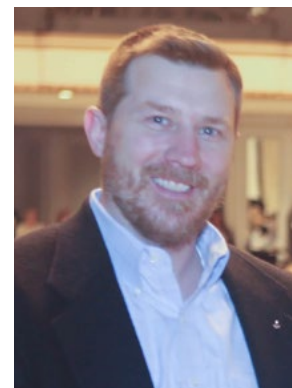
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The Department of Yes: How Thomas Flynn Redefined Compliance at Hackensack Meridian Health

By: Denny Henderson



Denny Henderson

Nobody grows up wanting to be a compliance officer. Thomas Flynn, FACHE, Senior Vice President and Chief Compliance Officer at Hackensack Meridian Health, would be the first to tell you that. He started in the kitchen.

It was 1984. Flynn had just taken a job in support services at Hackensack University Medical Center, working as assistant director of the nutrition department. Healthcare was in his family's blood. His mother was a nurse, his father worked in plant operations, and at one point the whole family had worked together at St. Elizabeth Hospital in Elizabeth, which is now Trinitas. For Flynn, a job in a hospital felt natural. A career in compliance was not yet something anyone was thinking about, including him.

That changed in the late 1990s. Hackensack was looking to build a compliance program, Flynn had just started an MBA, and he was beginning to think about what the next chapter of his career might look like. When the opportunity came, he took it. "It was just a perfect fit for me," he said. He was a department of one. He shared a secretary with his supervisor. The work in those early days was foundational: putting the structural elements in place, building a code of conduct, establishing a hotline, working through the OIG's seven elements of an effective compliance program. Check the box, get it done.

Then, less than a year in, the significance of the role became a reality.

The OIG served Hackensack with a subpoena related to pneumonia billing. For a brand new compliance officer at a brand new program, it was a defining moment. Flynn said the experience reinforced something no textbook could teach: the value of relationships. "Both the relationship with OIG, being responsive and cooperative within the advice of counsel, and the relationships and reputation that I had built in my prior role within the organization" were what got them through. Because he was known inside the hospital and trusted by the people who had answers, he could move quickly, address the issues, and demonstrate that the program had integrity. Hackensack ended

up with a repayment obligation and a five year certification requirement, but avoided a Corporate Integrity Agreement. A CIA is the OIG's most stringent enforcement tool, imposing years of federally mandated oversight and monitoring on an organization. For a program less than a year old, that was a result.

Flynn has been at Hackensack ever since, through leadership transitions, a series of mergers and acquisitions, and the system's growth into New Jersey's largest health network, with 17 hospitals and more than 500 ambulatory sites. He has been the compliance successor each time. Today he leads a team of 45 covering five disciplines: compliance, privacy, audit services, research compliance, and regulatory affairs.

"It's one of the coolest jobs in the world," he tells people when they join his team, "because we get to touch everything that happens in this network."

That breadth is not an accident. Flynn has built his program around a single guiding principle: compliance cannot be the department of no. When someone comes to him with a question about how to get something done, his job is to find a way, not to find a reason it cannot happen. "There's usually a solution," he said. "If the answer doesn't work, it may require more infrastructure, it may require more monitoring, but you figure out a way to get it done."

That philosophy has earned him a seat at the table in ways that many compliance functions never achieve. When current CEO Bob Garrett took over, Flynn began reporting directly to him. He is in the room every Monday morning at the executive leadership team meeting. He meets regularly with the chief operating officer. When he walks into an audit, he already knows the leaders involved, because the first time he encounters a program is never the first time he has met the people running it.

For finance and operations leaders looking to get more from their compliance partnerships, Flynn's advice is direct: give compliance a seat at the table early. Not when something is broken. Before that. "The first time we audit a program, the



Thomas Flynn

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•Focus on AI•

The Questions We Weren't Asking

What your peers told us about life after the AI pilot - AI Today and Tomorrow, Part Two

By: Pavani Munjuluri



Pavani Munjuluri

Last issue, I left you with a picture of two needles that should move together and don't: AI adoption sprinting ahead of AI oversight. Since then, I did what any reasonable person does after publishing a slightly unsettling chart. I went back and asked more questions.

Not the polite kind. We had already settled "are you using AI?" So this time we sent our members a survey built around the harder questions, the ones that tend to surface at 11 p.m. the night before an executive/board meeting. Do you actually know what your AI is doing? Who is watching it? Is it paying for itself? And would any of those answers survive an auditor with a highlighter?

The responses came back candid, occasionally uncomfortable, and in a few places funny in the way only healthcare finance people can be funny. I promised this column would run on honest conversation rather than vendor-speak, and you delivered. So here is what your peers told us, and what I think all of us should be keeping in mind before the next budget cycle.

ROI Is Still Mostly a Feeling

Let me start with the finding that made me put my coffee down. When we asked how many AI pilots are tracking return on investment with real rigor, the most common answer was some version of: "We're tracking some metrics, but calling it ROI is generous." A smaller group admitted that measuring upfront felt premature and they would "know it when they saw it." One person, bless them, wrote that most pilots are running on faith and executive buy-in.

I don't say this to scold anyone. Faith and executive buy-in have launched every meaningful technology initiative in the history of this industry. But faith is how you start a pilot, not how you defend one eighteen months later when the CFO asks what it returned. Ask the same group whether AI adoption is economically viable at their current scale and the picture gets murkier still: a good number are betting on future scale or consolidation to make the economics work, and at least one is pressing ahead because the competition is, regardless of whether the numbers add up.

The takeaway is simple and slightly boring, which is usually a sign it's correct. Define the number you will be judged on

before the pilot starts. Posting speed, reconciliation accuracy, denial rate, days in A/R, cost to collect, clean-claim rate, pick one. Name the owner. If you can't name the metric, you aren't measuring ROI. You're measuring enthusiasm.

Nobody Budgeted for the Day After Go-Live

Here is the answer that told me the most about where we really are. We asked who is actually doing the work of maintaining AI systems after deployment: the retraining, the monitoring, the governance, the unglamorous care and feeding. The winning response by a wide margin was "the existing analytics or IT team, added to their plate." Behind it came "wishful thinking; we haven't staffed for this," and, my personal favorite for its honesty, "it hasn't been assigned."

Pair that with a related question on whether organizations have in-house expertise to audit and validate AI performance over time. Some do, and good for them. But a meaningful share are relying on vendor assurances, and a few know it's a gap and aren't sure how to fill it.

Remember last issue's revenue cycle director whose first implementation produced "AI-generated poetry" before the denial rate finally dropped? The learning curve had a learning curve. What the survey tells me is that the curve doesn't end at go-live. Models drift. Payer rules change. The billing patterns the model learned in January look different in October. Someone has to notice, and "someone" is not a job title. If the maintenance plan is an analyst who already has a full-time job, the maintenance plan is hope.

Who owns it after Tuesday?

Four questions we asked members — and the answer we heard most often

Who owns the ROI number?	Who maintains the model?	Who's watching public AI use?	Who decides on disclosure?
"We're tracking some metrics, but calling it 'ROI' is generous." most common answer	"The existing analytics/IT team — added to their plate." most common answer	"We assume it's widespread but haven't measured." most common answer	"We're not sure if we're required to." most common answer

Source: HFMA NJ member survey on AI in revenue cycle, September 2026. Responses lightly condensed.

questions, one pattern. When the answer is "we assume," "not sure," or "added to their plate," nobody owns it yet.

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The AI Pilot You Didn't Approve

We asked how aware leaders are of staff using public AI tools for revenue cycle work, policy or no policy. The dominant answer was refreshingly direct: “We assume it’s widespread, but we haven’t measured.” A few organizations have documented it and are building governance around it. A few others believe it isn’t happening at all, which, with affection, I would gently question.

This is the finding I would put in front of your compliance officer tomorrow, because it is a HIPAA issue wearing a productivity costume. In the last column I offered a rule for the everyday user: mind what you paste. That patient identifier, that contract, that payer correspondence, assume anything typed into a public tool could be stored or used to train it. The survey suggests that rule is being applied inconsistently at best, because leadership has not looked. You cannot govern what you haven’t counted. The good news is that counting is cheap. Ask. Survey your own teams. Then give people an approved tool that is at least as convenient as the one they’re already using, because policy alone has never once beaten convenience.

In Defense of the People Slowing You Down

When we asked which internal group is slowing AI adoption the most, one answer led comfortably: Compliance and Legal. The complaint that came with it was the familiar one. “They want guarantees we can’t give.”

Now hold that thought next to another question from the same survey. Does your organization disclose to patients or providers that AI was involved in a coverage or billing decision? Most organizations either don’t disclose it or aren’t sure whether they’re required to. One respondent said, with admirable candor, that they intentionally don’t because it complicates conversations.

The same survey, two answers that don't quite agree



The people asking for guarantees are also the only ones asking the disclosure question.

The group most often blamed for slowing adoption is also the group asking the question most organizations haven’t answered.

I want to reframe this, because I think we have the villain wrong. Compliance isn’t asking for guarantees because they enjoy paperwork. They are asking because they are the only people in the building who have thought about what happens when a patient, a provider, or a regulator asks how a decision got made. Explainability, disclosure, bias, the entire audit trail: those questions all land on their desk eventually. Treating them as the brake pedal means you will discover the problem at the worst possible time. Bring them in at design, give them a seat

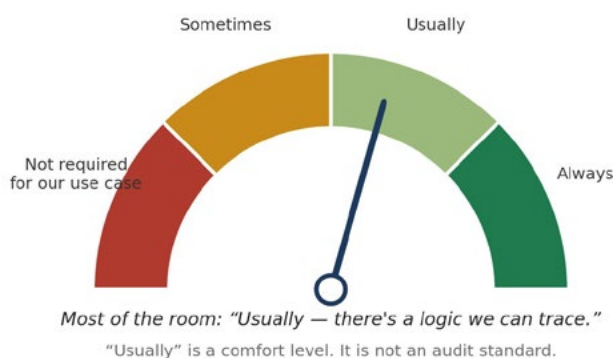
at the vendor evaluation, and let them write the disclosure language before anyone has to improvise it on a phone call.

“Usually” Is Not an Audit Standard

Speaking of explainability. We asked whether, when an AI system denies a claim or flags an issue, staff can explain why in a way that would satisfy an auditor or a provider appeal. The most common answer was “usually, there’s a logic we can trace.” The next most common was “sometimes, depending on the model and the decision.” Only a sliver said “always,” and a few said explainability isn’t required for their use case.

Can you explain why the AI flagged that claim?

Where the room sits — and where an auditor expects you to be



Most of the room sits at “usually.” Auditors, unfortunately, don’t grade on a curve.

I understand “usually.” Usually is a perfectly honest description of most operational processes. But an appeal is not a usual situation, and neither is an audit. The practical fix is to make explainability a procurement requirement rather than a hope. Before you sign, ask the vendor to show you a flagged claim and walk you through why. If the answer is “the model is proprietary,” that isn’t a technical limitation. It’s a business decision they made, and you are allowed to make a different one.

On the bright side, bias testing is further along than I expected. A healthy share of respondents said they formally test whether their systems treat different payers, providers, or patient populations differently, and most of the rest have it on the roadmap. One lone voice said fairness isn’t a priority because the AI’s job is accuracy. I’d only note that an inaccurate system is unfair by definition, and a fair one tends to be more accurate. They are the same project.

Too Early to Tell (And That’s Honest)

We asked whether the initial improvements from AI pilots plateau or decline over time. The overwhelming answer was “too early to tell.” A few reported sustained or growing benefits; one described a plateau after the early months that has since held steady. Nobody reported a decline, which is either good news or a sign we haven’t been looking long enough.

I take this as a fair answer and a homework assignment. Most of us are still inside the first year. The organizations that will be able to answer this question in twelve months are

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Remote Area Medical: Provides Access to Patients

By: Michael McLafferty, CPA, MBA, FACHE, FACMPE, FHFMA



Michael McLafferty

For millions of Americans, access to healthcare remains determined not simply by medical need, but by geography, insurance coverage, affordability, and transportation. Remote Area Medical (RAM) has spent more than four decades addressing that problem with a remarkably straightforward philosophy: **if patients cannot get to healthcare, bring healthcare to them.**

Founded in 1985 by Stan Brock, RAM traces its origins to Brock's experiences living in British Guiana, now Guyana, where access to medical care could require days of travel. That experience eventually inspired the creation of an organization designed to deliver healthcare directly to populations with limited access.

Today, RAM is a nonprofit organization providing free dental, vision, and medical services through volunteer-supported clinics across the United States. Patients generally do not need insurance, identification, or proof of income to receive services.

A Unique Healthcare Delivery Model

RAM's traditional model is the large-scale pop-up clinic. Schools, fairgrounds, and other community facilities are temporarily transformed into functioning healthcare delivery sites staffed by volunteer physicians, dentists, optometrists, nurses, and other healthcare professionals.

Dental services can include examinations, cleanings, fillings, and extractions. Vision services include comprehensive eye examinations and prescription eyeglasses, many produced on-site. Medical services include general examinations, preventive screenings, women's health services, and patient education.

RAM has also expanded its model. Its Mobile Digital Denture Lab incorporates digital scanning and 3-D printing technology to help provide dentures to patients who otherwise might have difficulty obtaining them.

Telehealth represents another important development. RAM's mobile telehealth program combines an onsite registered nurse with remote volunteer physicians. The nurse can obtain vital signs and conduct an initial assessment before connecting the patient with a physician through a secure video consultation. The service can address routine healthcare needs

while helping connect patients with longer-term sources of care.

The Scale of the Need

The organization's numbers demonstrate both RAM's reach and the continuing demand for uncompensated healthcare. In 2025, RAM reported serving 32,770 patients across 27 states and providing approximately \$16.6 million in free healthcare services. More than 17,000 volunteers participated. RAM provided 7,999 eye examinations, 15,013 pairs of eyeglasses, more than 11,500 dental extractions, 4,333 fillings, 5,523 medical examinations and 4,228 telehealth encounters.

The year also marked RAM's 40th anniversary and an extraordinary milestone: the organization served its one-millionth patients.

RAM's operating model relies heavily on charitable contributions, grants, corporate support and donated professional services. Its 2024 IRS Form 990 reported approximately \$11.5 million in revenue and \$8.8 million in expenses, with charitable contributions representing most revenue.

Filling a Gap in the System

RAM is not a substitute for an established primary care relationship. Pop-up clinics are episodic and cannot provide the longitudinal management necessary for diabetes, cardiovascular disease, and other chronic conditions. That distinction, however, should not diminish RAM's importance.

Untreated dental disease, impaired vision, and unmanaged medical conditions can affect health, employment, and quality of life. For individuals unable to obtain even basic services, a RAM clinic can represent an important entry point into healthcare.

Remote Area Medical therefore provides more than charitable healthcare. Its experience also highlights a continuing challenge for the American healthcare system: access to care means little if patients cannot practically or financially reach that care.

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John's absence is deeply felt by those who knew him, worked beside him and shared years of NJ HFMA history with him. But perhaps this is what legacy actually looks like.

It is not merely having your photograph preserved in an archive. It is having your name come up years later in a conversation. It is a lesson someone still repeats. A relationship someone still treasures. A young leader occupying a seat because someone before them made room.

A chapter does not reach 72 years because of one president, one board or one generation. An Annual Institute does not reach its 50th anniversary because someone planned one successful conference. Institutions endure because people repeatedly decide they are worth investing in.

John Dalton was one of those people.

And it is a chapter, now in its 72nd year, preparing to gather for the 50th Annual Institute because generation after generation continued carrying the work forward.

John Dalton is part of that story. So is Mike. So are the leaders whose photographs remain in our history and the people whose names newer members may not yet recognize. And now, so are we.

That is both a privilege and a responsibility.

Where the Godfather and the Protégé Meet

Mike, I think that is exactly where the Godfather and the Protégé meet.

Leadership is not about one generation possessing all the answers. It is having enough humility to learn from what came before us, enough courage to challenge what no longer serves us, and enough responsibility to leave something stronger for people we may never meet.

The faces will change. Leadership will look different. Healthcare will continue to evolve.

But perhaps the most important part of Mike's message should not change at all: "Friends helping friends."

For a chapter now in its 72nd year, those three words may still be one of the simplest and most powerful explanations for why NJ HFMA endures.

And as we gather to celebrate the 50th anniversary of the Annual Institute, while remembering John Dalton and all those who helped build the chapter and this extraordinary tradition, perhaps our greatest tribute is not simply to remember their legacy.

It is to continue it.

The Godfather reminds us where we came from. The Protégé asks where we go next. Somewhere between the two, we build what comes after us.

Dedicated to the memory of John Dalton. May the relationships he built, the people he influenced, and the chapter he helped shape continue to carry his legacy forward.

About the author:

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

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first time we go in and look if there's an issue, it's not the first time we're meeting the leaders," he said. That pre-existing trust is what allows hard conversations to happen without damaging relationships.

It is also what allows compliance to contribute something beyond enforcement. In a regulatory environment that Flynn describes as running at an accelerated and often unpredictable pace, with policy shifts driven as much by social media posts as by formal rulemaking, having compliance integrated into strategic planning is no longer optional. He participates in an executive order task force to assess what is coming out of Washington and what it means for the organization.

After more than four decades at Hackensack, Flynn has watched the institution grow from a single site into one of the most complex health systems in the country. He has also watched compliance grow from a checkbox exercise into a genuine strategic function. Nobody grows up wanting to be

a compliance officer. Flynn would be the first to tell you that. He would also be the first to tell you he would not have it any other way.

Thomas Flynn, FACHE, is Senior Vice President and Chief Compliance Officer at Hackensack Meridian Health, where he has worked since 1984. Outside the office, he is an avid skier and a self-described recovering marathoner with 22 races behind him, including Marine Corps, New York, Dublin, and seven runs at Philadelphia.

About the author

Tom Flynn was interviewed by Denny Henderson, HFMA, from FairCode and was written with assistance from Claude, an AI assistant built by Anthropic.

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the ones measuring past month three. We will ask again in a future column, and I would love to report that the answer has changed.

The Good News

I don't want to leave you with the impression that the room is reckless. It isn't. When we asked people to choose between speed and accuracy for their AI strategy, the answer was nearly unanimous: accuracy first, deploy slowly, errors are expensive. Most organizations report that their data is workable, if in need of cleaning. Most say they have a key AI vendor but have kept alternatives in play rather than locking themselves in. And most say AI work has deferred a few other priorities but nothing they can't manage.

That is a picture of an industry that is careful, pragmatic, and under-resourced, not one that is careless. The gaps in this survey aren't gaps in judgment. They are gaps in ownership. And ownership is fixable. It costs a meeting and a name on a line.

SIDEBAR

Five Questions to Ask Before Your Next AI Budget Meeting

1. What is the one number this pilot will be judged on, and who owns it?
2. Who maintains the model/tool after go-live, and is that in their job description or just on their plate?
3. Do we know how staff are using public AI tools today, or are we assuming?
4. If the model/tool flags a claim, can we explain why to an auditor, a provider, or a patient?
5. Do we disclose that AI touched this billing decision, and if not, have we decided that on purpose?

If any answer starts with "I think...", that is your agenda item.

So, Who Owns It After Tuesday?

Last issue I argued that "to AI or not to AI" stopped being the question a while ago, and that the real one is "how do we do this well?" The survey sharpened it for me. Doing this well is not primarily a technology problem. It is an ownership problem. Someone owns the ROI number. Someone owns the model/automation tool after go-live. Someone owns the question of what staff are pasting into public tools. Someone owns the decision about what we tell patients. In too many organizations, the honest answer to "who?" is still a shrug, or an analyst who found out on a Tuesday.

Technology amplifies the humans who wield it. That was true of spreadsheets and it is true of this. The organizations that thrive in the next chapter won't be the ones with the cleverest models. They'll be the ones where, when someone asks "who's watching this?", a hand goes up.

Until next time, keep your spreadsheets close and your org chart closer.

- Pavani

P.S. If your organization has cracked the maintenance question, or the disclosure question, or has a shadow-AI story you can tell without naming names, drop me a line. This column still runs on anecdotes and caffeine, and the anecdotes are getting better.

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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Sources

Remote Area Medical (RAM), organizational history, programs, and annual impact reporting; Remote Area Medical 2025 impact results; Internal Revenue Service Form 990 nonprofit filings; ProPublica Nonprofit Explorer; Charity Navigator.

About the author

Michael McLafferty is a recognized healthcare thought leader and advocate dedicated to advancing patient access and strengthening the economic and operational sustainability

of physician practices. He is the CEO and Founder of MJM Advisory and Educational Services LLC, a healthcare consulting firm specializing in financial, operational, and strategic advisory services for physician organizations and healthcare enterprises. A Certified Public Accountant with an MBA, Michael holds multiple distinguished professional designations, including Fellow of the American College of Healthcare Executives (FACHE), Fellow of the American College of Medical Practice Executives (FACMPE), and Fellow of the Healthcare Financial Management Association (FHFMA). He can be reached at michael@mjmjaes.com.

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Audits, Fines and Ransomware: The High Cost of ‘Good Enough’ IT in Healthcare

By: Chris Mangano



Chris Mangano

Healthcare organizations operate in a complex environment; stakes are high, and there is no margin for error. Cybersecurity in healthcare is no longer just an IT concern – it directly impacts patient safety, regulatory compliance, day-to-day operations and financial performance. The cost of an IT or cybersecurity failure can extend well beyond remediation, affecting operational continuity, revenue, capital priorities and an organization’s ability to deliver care.

When organizations settle for “good enough” IT solutions (systems and support/delivery) that merely meet minimum standards, they open themselves up to costly and potentially devastating consequences.

The Real Risks of “Good Enough” IT in Healthcare

Regulatory audits serve as the first checkpoint, often exposing hidden vulnerabilities and gaps in compliance. These deficiencies can result in substantial fines, draining resources and diverting attention from patient care and innovation. The financial toll is compounded by reputational damage; patients lose confidence when their data is mishandled or when news of violations becomes public. Hospitals and health systems may also face increased scrutiny from insurance providers and government entities, which can further impact funding and operations.

Beyond compliance, ransomware has become one of the most pressing risks in healthcare IT. Cybercriminals exploit weaknesses in outdated or poorly configured systems, launching attacks that can paralyze entire networks. The urgency to restore access to medical records, diagnostic tools, and communications often forces organizations into larger ransom payments. These attacks disrupt clinical workflows resulting in delayed appointments, surgeries, and treatment. Accompanying these disruptions are data loss, privacy breaches, and regulatory investigations, each with its own economic and reputational fallout.

Effective prevention goes beyond basic security measures; it requires a proactive, layered approach focused on keeping software and hardware current, maintaining comprehensive cybersecurity protocols and staying vigilant through regular employee awareness training and real-time monitoring for suspicious activity. Costs of investing in these measures pale in comparison to the aftermath of audit failures, fines and ransomware incidents.

Where to Start: Taking a Structured Approach to IT Risk and Security in Healthcare

A practical starting point is to take a step back and evaluate how your current systems, infrastructure and processes support security, compliance and day-to-day operations.

1. Understand that Electronic Medical Records (EMRs) and Electronic Health Records (EHRs) platforms are only one part of a healthcare organization’s broader IT environment. While these platforms include security and compliance features, such as basic encryption and HIPAA-compliant measures, they do not secure the underlying networks, infrastructure, connected devices and other systems they rely on.
2. Perform a holistic technology assessment that encompasses an objective evaluation of all hardware and software in use, while mapping the network infrastructure to determine where and how improvements can/should be made; this effort is best undertaken by an independent resource that specializes in creating practical modernization reports, clearly identifying a phased approach to upgrades.
3. Evaluate the resulting IT design and plan to determine how best to manage and prioritize the recommended improvements. Changes can often be done in phases, allowing for budget planning to support the effort.

Settling for “good enough” information technology presents a false economy within the healthcare sector. The potential risks and expenses associated with regulatory penalties, ransomware incidents and operational disruptions can significantly outweigh any immediate cost savings realized. To maintain trust, achieve regulatory compliance, and ensure operational resilience, it is essential for healthcare organizations to invest in modernizing their technology.

Taking a proactive approach to healthcare IT security is a crucial step in reducing risk, maintaining compliance and supporting uninterrupted patient care.

About the author

Christopher Mangano is Sales Engagement Director, Cybersecurity at Withum. He can be reached at cmangano@withum.com.

From Paper to Intelligence: Modernizing Healthcare Correspondence Management in the Revenue Cycle



Daniel Forbes

By: Daniel Forbes, CHFP

Correspondence Management: An Overlooked Revenue Cycle Challenge

Healthcare organizations continue to invest heavily in electronic health records, patient access technologies, and revenue cycle platforms. Yet one operational area remains largely underserved: correspondence management.

Every day, providers receive communications from payers, patients, government agencies, and internal departments, including denial notifications, prior authorization determinations, requests for documentation, appeals, refund requests, and patient billing inquiries. These documents arrive through multiple channels, including mail, fax, payer portals, and electronic transmissions.

Although many organizations have reduced paper volume, the workflows supporting correspondence often remain fragmented and highly manual. Staff frequently spend substantial time identifying document types, determining ownership, routing items to the appropriate teams, and tracking resolution. Delays or misrouted correspondence can affect reimbursement timelines, increase administrative costs, incur penalties for missed deadlines, and create unnecessary rework.

As health systems face growing workload demands and persistent staffing challenges, correspondence management is emerging as a meaningful opportunity for operational improvement.

In addition, payer-provider interactions continue to become more complex. Prior authorization requirements, documentation requests, claim reviews, denials, and appeals create growing administrative burdens across the revenue cycle. As reimbursement pressures increase, effective correspondence management has a growing influence on operational efficiency and financial performance.

Moving Beyond Document Storage

Historically, correspondence management focused on

digitizing and storing documents. While electronic access improved efficiency compared with paper filing systems, it often did little to address the underlying workflow.

Today, healthcare organizations are increasingly shifting their focus from document management to workflow management. Rather than asking where a document should be stored, leaders are asking:

- What type of correspondence is this?
- What action is required?
- Who is responsible for completing that work?
- How quickly must it be resolved?
- How should performance be measured?

This shift has driven adoption of automated classification, intelligent routing, service-level monitoring, exception management, operational dashboards, and workflow orchestration tools.

The objective is no longer simply to organize documents. It is to improve how work moves through the revenue cycle.

The Growing Role of Automation and Artificial Intelligence

Artificial intelligence is becoming an important component of administrative transformation within healthcare revenue cycle operations. Correspondence management is particularly well suited for automation because it involves large volumes of repetitive, document-centric activities.

AI technologies can help:

- Identify correspondence types
- Extract relevant information
- Apply metadata
- Route work to the appropriate teams
- Prioritize high-value or time-sensitive items
- Identify workflow exceptions

For example, incoming correspondence can be automatically classified as a denial, medical records request, prior authorization determination, or patient inquiry and routed directly to the appropriate work queue. This reduces manual triage, improves

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consistency, and shortens processing times.

Technology alone does not guarantee results. Standardized workflows, governance, process ownership, and data quality remain essential prerequisites for successful automation. AI is most effective when it enhances well-designed processes rather than attempting to compensate for inefficient ones.

Keys to Successful Modernization

Organizations pursuing correspondence modernization often follow similar steps along the way.

Start with Process

Mapping document flows and identifying bottlenecks frequently reveals improvement opportunities before any technology investment is made.

Standardize Workflows

Consistent routing, ownership, and work management practices create the foundation necessary for automation to scale effectively.

Engage Operational Teams

Adoption is strongest when employees understand how new workflows improve efficiency and support organizational goals.

Take an Incremental Approach

Many organizations begin with a small number of high-volume correspondence categories, validate results, and expand capabilities over time.

For revenue cycle leaders, practical priorities include:

- Evaluating workflows before technology
- Standardizing processes before automating
- Focusing on measurable operational outcomes
- Prioritizing high-volume opportunities
- Establishing governance early
- Aligning automation initiatives with broader business objectives

Conclusion

Healthcare correspondence management is evolving from a document storage function into a strategic operational capability. As administrative complexity grows and workforce pressures persist, organizations are increasingly adopting workflow automation, analytics, and artificial intelligence to improve efficiency and strengthen revenue cycle performance.

Emerging reimbursement pressures, evolving payer requirements, and increasing expectations for operational efficiency are adding further urgency to modernization efforts. In this environment, correspondence management is becoming more than an administrative function. It is increasingly viewed as a critical component of broader revenue cycle strategy.

The organizations achieving the greatest success are not necessarily those implementing the most advanced technologies. Rather, they are the organizations that effectively align people, processes, and technology around a common objective: creating scalable, efficient, and sustainable operations while strengthening their ability to respond to evolving payer dynamics, regulatory requirements, and financial pressures.

The future of correspondence management is not simply paperless. It is intelligence-driven, combining workflow automation, operational visibility, and AI-enabled decision support to improve financial and operational outcomes.

About the Author

Daniel Forbes, CHFP, is a Vice President, Senior Product Advisor with PNC Healthcare. Daniel works with hospitals and health systems nationwide on revenue cycle modernization, workflow automation, healthcare treasury solutions, and operational transformation initiatives. His work focuses on helping provider organizations improve financial performance, operational efficiency, and technology adoption.

Mark Your Calendar

Holiday Social North

December 3, 2026

Tommy's Tavern, Clifton, NJ

Holiday Social South

January 21, 2027

Chickie's & Pete's, Marlton, NJ

Annual PFS/PAS Program: Transforming the Revenue Cycle: Strategic Leadership for What's Next

January 14, 2027

The APA Hotel, Iselin, NJ

Annual Golf Outing

May 6, 2027

Mercer Oaks, West Windsor Township, NJ

New Jersey & Metro Philadelphia HFMA 50th Anniversary Annual Institute

October 19 – 22, 2027

The Hard Rock Hotel & Casino, Atlantic City, NJ

Watch for updates on all of these events, or visit the Chapter website at hfmanj.org

From Awareness to Action: Activating NSA IDR as a Revenue Integrity Strategy

By: Thomas LaGreca, Andrea LoMonaco, & Lynne Weise

"The No Surprises Act arbitration process isn't relevant to us — we're in-network."

It's one of the most expensive misconceptions in healthcare revenue cycle today.

Tom LaGreca, lead counsel and Chief Growth Officer at Callagy Recovery Corp., has heard it from hospital executives across New Jersey, and across the country, more times than he can count. And it costs them, not in theory, but in real, recoverable dollars uncollected on claims they've already written off as closed.

Here's the reality: being largely in-network does not mean you have no out-of-network exposure. With hundreds of commercial carriers operating across the country, complete in-network status is virtually impossible. Even a relatively small volume of out-of-network emergency claims, when processed through the No Surprises Act (NSA) Independent Dispute Resolution (IDR) process, can represent millions of dollars in additional revenue for a hospital.

The landscape has changed. Dramatically.

When the No Surprises Act took effect in 2022, implementation challenges were real and participation was understandably cautious. That calculus has shifted. Today, the IDR process is established, the arbitration outcomes are consistent, and the data is clear: providers who participate are prevailing 80 to 90 percent of the time. The reason is structural. The NSA requires initial carrier payments be based on the Qualified Payment Amount, essentially the median in-network rate, calculated and maintained by the carrier itself. That number is consistently low, often representing just five to ten percent of actual charges. When claims proceed to arbitration, awards routinely come in at 8, 10, or 12 times the original payment.

The arbitration is baseball-style, meaning the arbitrator must choose either the carrier's final offer or the provider's demand, no compromise. Because carriers are offering so little, providers are winning at an extraordinary rate.

This is not a niche opportunity. It is a revenue integrity imperative.

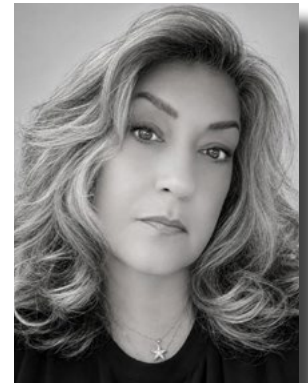
The broader context makes it even more urgent. The 2025



Thomas LaGreca



Andrea LoMonaco



Lynne Weise

Budget Reconciliation Act introduced substantial changes to federal healthcare financing, with significant reductions to Medicaid and Medicare funding. Hospitals facing margin pressure from reduced government reimbursement need to look honestly at where recoverable revenue exists. Out-of-network emergency claims processed through NSA IDR represent one of the clearest answers available today and one that requires minimal administrative burden from internal teams.

So why aren't more organizations activating this?

Decision fatigue. Competing priorities. Uncertainty about the process. A belief that the volume isn't high enough to matter. These are the internal forces that delay adoption and they are exactly what this session is designed to address.

The activation pathway is more accessible than most revenue cycle teams realize. The right strategic partnership model removes the operational burden entirely, requiring no upfront investment and no dedicated internal resources. Organizations that have moved from awareness to activation, including a Level One trauma center right here in New Jersey, are already seeing award results that validate the opportunity, even before final payments have cleared.

For revenue cycle leaders evaluating this question, the framework is straightforward. Understand your out-of-network emergency exposure. Assess your current payer agreements and identify where QPA-based initial payments are leaving the most

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How Risk Assessment and Compliance Program Effectiveness Tie Together: A Joint Perspective from the Chief Compliance Officer and Director of Internal Audit

By: BJ Welsh and Jack O'Hara

For healthcare organizations, compliance extends well beyond meeting regulatory requirements. It is about protecting patients, preserving public trust, supporting caregivers, and ensuring that every aspect of the organization operates with integrity, accountability, and a commitment to high-quality care.

Today's healthcare environment presents unprecedented challenges. Healthcare organizations, particularly those operating in New Jersey, face increasing regulatory scrutiny, cybersecurity threats, reimbursement pressures, workforce shortages, technological innovation, and evolving federal and state enforcement priorities. Successfully navigating this environment requires a compliance program that is dynamic, data-driven, and continuously improving.

At the center of that effort is one foundational process—the compliance risk assessment.

Likewise, Internal Audit develops its annual audit plan using a risk-based methodology designed to provide independent assurance that key organizational risks are effectively managed. While Compliance and Internal Audit maintain distinct responsibilities, their work is closely interconnected. Risk assessments identify where attention should be focused, while auditing, monitoring, and program evaluation determine whether compliance efforts are achieving meaningful results. Together, these functions strengthen governance, support organizational objectives, and help healthcare organizations maintain regulatory excellence while fulfilling their mission of delivering safe, high-quality patient care.

A Complex Healthcare Environment

Modern health systems are complex organizations that

often include acute care hospitals, physician practices, ambulatory services, graduate medical education programs, community health initiatives, and numerous administrative and support functions. This breadth of services creates a diverse compliance landscape with unique regulatory requirements and operational risks.

Compliance risks span virtually every area of the organization, including hospital operations, physician services, revenue cycle, research, information privacy and cybersecurity, quality and patient safety, supply chain management, and third-party relationships. Each service line carries its own regulatory obligations and risk profile, making a comprehensive compliance risk assessment essential for identifying priorities and allocating resources effectively.

Why Risk Assessment Matters

An effective compliance program begins by understanding where the greatest risks exist. The annual compliance risk assessment is not simply a required exercise—it serves as the organization's roadmap for directing limited resources toward the areas of greatest potential impact. A comprehensive risk assessment should incorporate information from a variety of internal and external sources, including:

- Office of Inspector General Work Plan priorities
- Department of Justice enforcement trends
- Centers for Medicare & Medicaid Services (CMS) regulatory updates
- New Jersey Department of Health requirements and New Jersey Medicaid guidance



BJ Welsh



Jack O'Hara

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- Hotline and reporting trends
- Internal investigations
- Prior audit and monitoring results
- Enterprise Risk Management activities

Rather than evaluating these risks in isolation, leading healthcare organizations integrate information from multiple sources to develop a comprehensive risk profile that informs both the Compliance Work Plan and the Internal Audit Plan. Compliance Program Effectiveness

Today's regulators rarely ask whether an organization has a compliance program. Instead, they ask a more important question: "Is the compliance program effective?"

The U.S. Department of Justice, Department of Health & Human Services Office of Inspector General, and the U.S. Sentencing Guidelines all emphasize effectiveness over mere program existence.

An effective compliance program is demonstrated not simply by the existence of policies and procedures but by how well those elements work together to identify, prevent, detect, and respond to compliance risks. Strong leadership commitment and active Board oversight establish the tone at the top, reinforcing a culture of ethics, accountability, and integrity throughout the organization. Equally important is ensuring that the compliance function has the appropriate independence, authority, and resources needed to carry out its responsibilities effectively.

Internal auditing provides an independent assessment of whether compliance controls are functioning as intended and whether corrective actions are sustainable over time. Combined with meaningful education, timely investigations, consistent enforcement of standards, continuous improvement, and data-driven decision-making, these activities enable healthcare organizations to adapt to evolving risks and regulatory expectations.

The compliance risk assessment provides the foundation for evaluating each of these elements and helps ensure that compliance efforts remain aligned with the organization's highest-risk areas.

Internal Audit's Independent Perspective

Internal Audit serves as an independent assurance function that evaluates whether governance, risk management, and internal controls are operating effectively. Rather than duplicating Compliance's responsibilities, Internal Audit asks critical questions that help validate the effectiveness of the compliance program:

- Is the compliance risk assessment comprehensive?
- Are high-risk areas receiving appropriate attention?
- Are key controls operating effectively?
- Are monitoring activities identifying issues in a timely manner?
- Are corrective actions sustainable?

- Are repeat findings decreasing over time?

This independent evaluation strengthens confidence in the organization's governance framework and supports continuous improvement.

Collaboration Creates Stronger Governance

Compliance and Internal Audit each play distinct but complementary roles. Compliance helps the organization prevent, detect, and respond to regulatory risk, while Internal Audit provides independent assurance that governance processes, risk management activities, and internal controls are functioning as intended.

When these functions collaborate—while maintaining their respective independence—the organization benefits from greater risk visibility, improved coordination, more effective use of resources, stronger corrective action processes, and better-informed leadership and Board oversight. This collaborative approach ultimately enhances organizational resilience and supports a culture of accountability.

Risk assessment is far more than a compliance requirement—it is a strategic process that helps healthcare organizations protect patients, strengthen operations, and support sound governance.

As healthcare organizations continue to navigate an increasingly complex regulatory environment, a robust compliance risk assessment ensures that resources are directed toward the areas of greatest exposure. Internal Audit complements these efforts by providing independent assurance that controls are operating effectively and that improvement initiatives produce sustainable results.

Ultimately, the relationship between risk assessment and compliance program effectiveness is not linear—it is cyclical. Risk assessments establish priorities; compliance activities mitigate identified risks; Internal Audit evaluates the effectiveness of those efforts; and the lessons learned inform the next cycle of assessment and improvement. By working together, Compliance and Internal Audit help healthcare organizations remain responsive to changing federal and state regulatory expectations, strengthen organizational integrity, and support the delivery of safe, ethical, and high-quality patient care.

About the Authors

BJ Welsh, CHC, FHFMA, serves as Vice President/Chief Compliance and Privacy Officer for Saint Peter's Healthcare System in New Brunswick, New Jersey. In this role since 2013, Welsh is responsible for the creation and maintenance of an effective compliance program for an acute care teaching hospital, a children's hospital, an outpatient birth center, multi-specialty clinics, ambulatory services, and physician practices. Prior to joining Saint Peter's, Welsh spent a decade at the former Raritan Bay Medical Center as HIPAA Privacy Officer and Director of Corporate Compliance, where she brought this two-hospital

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revenue on the table. Evaluate partnership options through a clear RFP process, asking specifically about administrative burden, claim eligibility criteria, timing of recovery initiatives, and transparency of results. Then, move quickly, because the window of maximum opportunity where carriers are offering little and providers are winning consistently will not stay open indefinitely.

The NSA IDR process is not a legal complexity to be managed. It is a revenue integrity lever to be pulled. New Jersey hospitals that understood the opportunity in PIP arbitration and Workers' Compensation recovery a decade ago captured hundreds of millions of dollars their peers left behind. The organizations that move early on NSA IDR will look back on this moment the same way.

The time is now.

Join us at the Annual Institute this October for our breakout session, Reducing Decision Fatigue: Activating NSA IDR Through Strategic Partnerships, on Wednesday, October 21st from 3:20PM to 4:10PM in Breakout Room Three. We'll go deeper on the activation framework, hear directly from a New Jersey hospital peer who is already in motion, and leave time for real conversation about what this looks like for your organization.

About the authors

Thomas LaGreca, Esq. has been with the Callagy group of companies for more than 14 years. He is currently the Executive

Director of Medical Revenue Recovery at Callagy Law and the Chief Growth Officer at Callagy Recovery Corp. He has overall responsibility for their medical revenue recovery lines of business, which include primarily Commercial Insurance arbitration and litigation against insurance carriers at the federal level and in numerous states across the country. Tom can be reached at tom.lagreca@callagyrecovery.com.

Andrea LoMonaco focuses on building strategic partnerships across the healthcare revenue ecosystem to help organizations navigate emerging revenue integrity opportunities through NSA IDR. She works closely with health systems, physician enterprises, and industry associations nationwide to support operational awareness and responsible activation of No Surprises Act Independent Dispute Resolution (NSA IDR) recovery strategies. She can be reached at andrea.lomonaco@medical-revenue.com.

Lynne Wiese is the Director of Patient Accounts at University Hospital. With 30+ years of experience in Hospital and Provider Billing and Collections, 7 of those years with University Hospital of Newark, Lynne has a proven track record of reducing claim denials, accelerating reimbursement timelines, and improving cash flow through strategic process improvements and team leadership. She can be reached at wiesely@uhnj.org.

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healthcare system into compliance with a Corporate Integrity Agreement with the Department of Health & Human Services Office of Inspector General. She also teaches a master's level course in Healthcare Corporate Compliance at the Bloustein School of Public Policy at Rutgers University. Welsh can be reached at bjwelsh@saintpetersuh.com.

Jack O'Hara, CHC, has served as Director of Internal Audit for Saint Peter's Healthcare System in New Brunswick, New Jersey, since 2023. In this role, he provides strategic leadership and independent oversight of the Internal Audit and Corporate Compliance functions, ensuring effective coordination of audit, compliance monitoring, education, investigations, and regulatory readiness activities across the health system. Prior to joining Saint Peter's, O'Hara held a variety of leadership roles in internal audit at several pharmaceutical companies. Most recently, he led the development and implementation of the Sarbanes-Oxley (SOX) compliance program for a newly public company. He began his career at Deloitte, where he worked in the Business Risk Advisory practice, serving clients in the life sciences and healthcare sectors.

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About Saint Peter's Healthcare System*

Saint Peter's Healthcare System Inc., parent company of the Saint Peter's healthcare delivery system, is comprised of Saint Peter's University Hospital, a 478-bed acute-care teaching hospital and state-designated children's hospital and regional perinatal center that includes a nationally renowned Level IV Neonatal Intensive Care Unit; Saint Peter's Foundation, the fundraising arm of the hospital; Saint Peter's Health and Management Services Corporation; the CARES Surgicenter; Saint Peter's Family Health Center, and Saint Peter's Physician Associates, a network of primary and specialty care physician practices. Saint Peter's is a regional specialist in maternal health, cancer care, diabetes, genetics, geriatrics, pediatric cardiology, and pediatric surgery, and is a sponsor of residency programs in obstetrics and gynecology, pediatrics, and internal medicine. Saint Peter's is sponsored by the Roman Catholic Diocese of Metuchen and is a major clinical affiliate of Rutgers Biomedical Health and Sciences. Visit saintpetershcs.com or call 732-745-8600.

A Data Analytics Perspective: Mitigating the Impact of OBBBA and Recent Policy Shifts on Hospitals and Physician Enterprises



Chris Marrs

By: Chris Marrs, MBA

Revenue Compression is Structural, Not Cyclical

The One Big Beautiful Bill Act (OBBBA) and the accompanying CMS changes compress revenue through several channels at once. Whether it is Medicaid coverage losses, tax issues, or marketplace subsidies, revenue is becoming frailer. And even less discussed issues, like the Physician Fee Schedule pairing a modest conversion factor increase with an efficiency adjustment and a practice expense reallocation that hinders practice sustainability, are major on their own. Each of these can cause revenue compression by themselves, let alone all together.

While the OBBBA is accelerating revenue compression for healthcare providers, it is the continuation of a decades-long trend. Some larger hospitals Withum works with are modeling losses exceeding \$500 million if they change nothing. Along with every other issue healthcare leaders are facing, this financial penalty is going to force both hard decisions and necessitate innovation and efficiency to maintain long term financial sustainability. Hopefully, the growth of data analytics can help mitigate these issues by helping leaders improve their organizations for the long run.

Data Is the Enabler, Not the Solution

Analytics does not improve performance on its own; what it does is move an organization along a short but difficult path: from anecdote, to insight, to action. It replaces subjective impressions with shared facts, and it (hopefully) gives physicians, operators, and executives a common language in which to work together to improve their organizations.

The feeling of being stuck is familiar to anyone who has sat through a productivity review. Traditional metrics describe outcomes but rarely explain causes, and two errors follow. The first, and most common, is that metrics are improperly understood and imprecisely calculated relative to a target

level of performance. With many service lines, and far more specialties, we routinely see hospital targets to be 10-30% off from what they should be. Whether a team is performing 5% or 25% below where they should be is a huge gap that changes the approach to improvement.

Second, the error is often blaming individuals instead of systems, attributing a productivity gap to physician effort when the real driver is care model design. This is about missing operational constraints entirely, because a metric taken at face value says nothing about staffing levels, room availability, scheduling design, or workflow. Even when these metrics are properly considered, understanding how a particular team operates compared to similar teams in the market is crucial to understanding performance. Without this, improvement can be especially difficult.

Metrics earn their keep when they explain why performance looks the way it does: wRVUs read alongside staffing, templates, and capacity constraints; panel size aligned to care team design and patient complexity; access lag, which exposes unmet demand; visit mix, which reveals mismatches between provider skill sets and scheduled work; and scheduling efficiency, which surfaces template design problems and unused capacity. All of this together allows current performance to be understood and for there to be confidence in plans to improve.

Case One: Orthopedic Service Line

The subject service line trailed its peers on profitability and was concerned with advanced practice provider utilization varying widely by physician. Analysis of the compensation model alongside structured provider interviews produced the insight: physician incentives were not aligned with anything besides individual production, and the financial contribution of APPs had never been properly modeled, so deployment was driven by individual preference. Further examination

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revealed issues with durable medical equipment, patient flow, and patient satisfaction. Compensation was redesigned for both physicians and APPs, APP utilization was expanded deliberately to support panel growth, and a defined set of performance metrics began to be shared with physicians on a regular cadence. Furthermore, a team of providers and administrators was put together to redesign care to improve the patient experience while improving provider efficiency.

Initial results included a near immediate increase in production, as well as APPs shifting from being a net negative financially to a projected net positive, projected decreased cost of care per patient, with an overall forecasted profitability increase of 10-15% of net revenue.

Case Two: Multi-Site Primary Care

Here the situation was more blunt: the organization's financials were unsustainable, and staffing ratios differed markedly from site to site with no identifiable clinical rationale. A review of financial and operational metrics produced two insights: 1) Incentives were not aligned to organizational goals, and 2) several sites were already performing well without anyone having documented how. The response was to codify those practices, deploy optimized staffing ratios across every site, redesign compensation, and stand up a business intelligence platform so performance was visible continuously rather than quarterly.

In addition to a newly projected return to profitability, this organization developed teams across its sites that would now utilize precise data and targets to work on continuously improving both clinical and administrative operations.

Where Analytics Meets the Front Line

The pattern in both cases is worth naming, because it is the part most organizations get wrong. Neither result came from the analysis itself, but from putting contextualized, trusted information in the hands of the people who control the daily decisions and giving them the authority to change something. Centralized data analytics typically seem to produce unactionable reports or only directional, difficult to implement change. However, when paired with front line operational expertise and clear ownership, improvement can be both rapid and continuous.

Three conditions make that work. The organization needs a single source of truth, with metric definitions consistent across clinical, operational, and financial domains, so that no meeting begins by litigating whose numbers are right. This means that the numbers need to be well-developed in the first place and produced in a way that can be quickly explained. Those metrics need to be visible at every level in the form each level can act

on, with executives seeing trends and variation while clinicians see relevance to their own schedules and panels.

Frontline teams need a disciplined, repeatable method for acting on what they see, which is where lean principles matter more than lean vocabulary. Practice managers, physicians, APPs, and support staff working short improvement cycles against a visible metric will out-execute a central improvement office, because they are the only ones who can see the small daily frictions the data can merely imply. Alignment, with this approach, is not a cultural aspiration but a strategic capability. Physicians, administrators, and executives influence different levers while sharing the same outcomes.

Three Questions, and the First 90 Days

Before modeling anything, leadership teams should be able to answer five questions about their own organization:

1. Can we quantify our exposure to policy changes across our organization?
2. Can we explain why our highest-performing site or service line outperforms the others, and have we documented what they do well enough for someone else to replicate it?
3. When our data shows something needs to change, how long does it take us to act, and can the people closest to the work make that decision without escalating it?

The first 90 days should be unglamorous. Identifying in-house data capabilities, building new models, and quantifying policy impacts are crucial and not easy. Establishing metric definitions and agreeing on metric accuracy across departments is helpful. Identify the three service lines with the largest combined exposure and the widest internal performance variation, since that typically points to the lowest hanging fruit. Then select one and run a genuine frontline improvement cycle, with the front-line team helping to lead change instead of being subject to a strict external protocol.

The reimbursement environment is not expected to improve. The organizations that hold their margins through analytics and improvement will be not only better positioned to survive, but be able to create a long-term capability to consistently improve.

About the Author

Chris Marrs, MBA, is a healthcare performance improvement and provider compensation advisor with more than 12 years of industry experience, focused on performance improvement, fair market value and compensation design, physician enterprise strategy, and operational performance.

50th NJ/Metro Philadelphia Annual Institute Agenda

WEDNESDAY, October 21st		Start	End	Location
Checking In		9:00am		Ballroom
Welcome Lunch		11:30am	12:30pm	Ballroom
General Session #1	Scaling AI in Healthcare Finance: A Practical Framework for Revenue Cycle ROI, Cyber Defense, and Governance Pavani Munjuluri, CognitiveHealth Technologies & Ali Pabrai, ecfirst	12:00pm	1:00pm	Ballroom
General Session #2	Trends Panel Fabian Stone, CHOP; Evan Martin, Zoomcare & Kelly Samuel, Anuity Health	1:00pm	1:50pm	Ballroom
Networking Break		1:50pm	2:20pm	Vendor Hall
Breakout #1	2026 A&A and Uniform Guidance Update Ana Romeo, WithumSmith+Brown	2:20pm	3:10pm	Breakout Ballroom 1
	AI Risk in Healthcare: Finance Outcomes in Weighing Cyber Risk & Medical Malpractice Jennifer Gertsman-Delia, Shruti Engstrom & Jennifer Flynn, Aon Health; Marc Martin, Beazley & Michael Bootier, Buchanan, Ingersol & Rooney, P.C.			Breakout Ballroom 2
	Patient Access: The Untapped Engine of Revenue Cycle Transformation Shawn Landin, Abax Health			Breakout Ballroom 3
Transition Break		3:10pm	3:20pm	
Breakout #2	Mandatory Bundled Payment Models: Navigating TEAM and CJR-X Michael Wolford, Forvis Mazars, LLP	3:20pm	4:10pm	Breakout Ballroom 1
	The Future of 340B: Navigating the Shift Toward Rebate Models by 2027 Alana Lythus & Kaitlyn Senetra, St Peter's University Hospital			Breakout Ballroom 2
	Reducing Decision Fatigue: Activating NSA IDR Through Strategic Partnerships Tom LaGreca & Andrea LoManaco, Callagy Recovery; & Lynne Weise, University Hospital			Breakout Ballroom 3
	From Requirement to Reality: Executing Provider-Based Attestation at Scale Michael Rossi, Penn Medicine; Jesse Vo & Marisol Cooke, Baker Tilly			Breakout Ballroom 4
Networking Break		4:10pm	4:40pm	Vendor Hall
General Session #3	Family Feud: Vendor Vs Provider Steve Harvey, played by Robert Taylor, Abax Health	4:40pm	5:30pm	Ballroom
Charity Event				
- Children's Miracle Network	Sponsored by Forvis Mazars, LLP & SmarterDx	5:30pm	7:30pm	Vendor Hall
Thursday, October 22nd		Start	End	Location
Breakfast		8:00am	8:45am	Ballroom
General Session #4				
- Keynote	Leadership Under Stress: Timeless Ethics for Healthcare Finance Leaders Jack Hoban; Compro Health	8:45am	9:35am	Ballroom
General Session #5				
- AI Panel	AI Panel Kelly Wisness & Jason Nadal, Besler Holdings; Elizabeth Litten, Fox Rothschild; Ravi Koganti, Capital Health & Tom Gordon, Virtua	9:35am	10:25am	Ballroom
Award Ceremony		10:25am	10:40am	Ballroom
Networking Break		10:40am	11:00am	Vendor Hall
General Session #6				
- Interactive Session	Innovation Gauntlet Nio Quiero, Quiero Group; Christina Slemple, UNC Health	11:00am	12:00pm	Ballroom
Lunch		12:00pm	1:00pm	Ballroom
HFMA 101		12:00pm	1:00pm	Breakout Ballroom 1
Breakout #3	Turning Data Into Margin Improvement Christy Pehanich, RWJ Barnabas Health & Daniel Rossi, UMass Memorial Health	1:00pm	1:50pm	Breakout Ballroom 1
	How WVU Medicine Used AI-Driven Diagnostics to Enable Day 1 Integration with Independence Health Glenn Barenbaum, Grant Thornton Advisors LLC; Ryan Brazell, TeamBuilder & Nick Barcellona, WVU Medicine			Breakout Ballroom 2
	How Risk Assessment and Compliance Program Effectiveness Tie Together BJ Welsh & Jack O'Hara, Saint Peter's Healthcare System			Breakout Ballroom 3
	Staying Ahead of the Curve: Key Tax and Regulatory Developments Impacting Healthcare Organizations in 2025-2026 Phillip Groff & Evan Seekamp, KPMG LLP			Breakout Ballroom 4
Transition between Breakouts		1:50pm	2:00pm	
Breakout #4	AI's Impact on Healthcare Michael McLafferty, MJM Advisory and Educational Services LLC	2:00pm	2:50pm	Breakout Ballroom 1
	Revenue With Respect			Breakout Ballroom 2

50th NJ/Metro Philadelphia Annual Institute Agenda

Josette Russo, Valley Health & Betsy Giordano, Care Cap Plus LLC

How Health Systems Can Join the EMR Cloud Journey

Dr. Jamie McGlothlin & Daniella Herskowitz, RSM US LLP

The New World of Medicaid Appeals in the Age of Managed Care

James Robertson & Paul Croce, Greenbaum Rowe Smith & Davis LLP

Breakout Ballroom 3

Breakout Ballroom 4

Networking Break

- Ice Cream Breakout #5	Sponsored by	2:50pm 3:10pm	3:10pm 4:00pm	Vendor Hall
	Manual to Meaningful: Intelligent Automation Susan Yannuzzi, & Yolanda Martinez, RWJ Barnabas Health A Data Analytics Perspective: Forecasting and Mitigating the Impact of OBBBA and Recent Policy Shifts on Hospitals and Physician Enterprises Christopher Marrs, WithumSmith+Brown Preparing for H.R. 1: Protecting Vulnerable Populations and Revenue Through Coordinated IT and Data-Driven Operational Planning Vicky Kontogiannis, MediSys Health Network From Paper to Intelligence: Modernizing Healthcare Correspondence Management Dan Forbes, PNC Healthcare			Breakout Ballroom 1 Breakout Ballroom 2 Breakout Ballroom 3 Breakout Ballroom 4

Transition between Breakouts

General Session #7		4:00pm	4:10pm	
- Patient Financial Experience Panel	Patient Financial Experience Panel Erica Waller, Penn Medicine Princeton Health; Cynthia Ziegler, Holy Name Medical Center Sponsored by Revco	4:10pm	5:00pm	Ballroom
Break		5:00pm	6:00pm	
President's Reception	Sponsored by Withum & First Source	6:00pm	8:00pm	Pool
Break		8:00pm	10:00pm	
Late Night Event	Sponsored by Med-Metrix	10:00pm	1:00am	Overlook

Friday, October 23rd

Breakfast		8:00am	9:00am	Ballroom
General Session #8 - Keynote	From Superhero to Super Leader: Leveraging Executive Coaching & Partnership to Elevate Teams Alex Chamorro, Houston Methodist & Darin Coble, Versa Business Partners	9:00am	9:50am	Ballroom
General Session #9	Exploring & Demystifying the Medicare Margin Michael Rossi, Penn Medicine; Richard Toner, Mayo Clinic; & Mike Nichols, UI Health	9:50am	10:40am	Ballroom
Break		10:40am	10:50am	
General Session #10 - CFO Panel	CFO Panel Gail Kosyla, AtlantiCare; Christopher Tascone, Valley Health System; Leigh Ehrlich, Main Line Health & Sandi Weiss, Bergen New Bridge Medical Center	10:50am	12:05pm	Ballroom

When Bad Debt Isn't Really Bad Debt: The Revenue Cycle's Most Overlooked Handoff



Lori Jeffreys

By: Lori Jeffreys

After more than three decades in revenue cycle, I've learned that the biggest challenges are rarely isolated—they're connected. Yet one of the most common disconnects I've observed is how organizations approach denied claims and patient bad debt as if they are two entirely separate problems. Teams dedicate significant resources to denial management while, in parallel, patient financial services work to collect growing self-pay balances.

What is often missed is that many of those self-pay accounts began as denied claims. Somewhere along the revenue cycle, a preventable issue shifted financial responsibility from the payer to the patient, increasing patient burden, delaying reimbursement and ultimately driving avoidable bad debt. The impact extends well beyond the balance sheet.

Patients often don't distinguish between an insurance denial, a billing error, or collection notice—they simply remember a frustrating financial experience with the health system. That experience can erode trust, diminish the organization's brand, and influence whether patients return for future care or recommend the organization to family and friends.

Revenue cycle leaders that connect these dots aren't simply improving collections—they are protecting the organization's reputation, preserving patient trust, and eliminating A/R departmental silos, resulting in a seamless financial experience for the patients we serve.

Following the Account Beyond the Denial

Not every denied claim becomes bad debt, and not every bad debt account started with a denial. But more write-offs to charity or bad debt started as an underpayment or a denied claim than most revenue cycle teams realize.

Rarely is that the result of a single breakdown. More often, it's a series of small operational missteps that together, permanently change the financial outcome of the account.

That might include:

- Appeals submitted after timely filing has expired
- Required payer documentation that is inaccurate or past timely submission
- Unclear ownership as accounts move between departments
- Patient liability assigned before every reimbursement option has been exhausted

Individually, none of these situations is unusual. Together,

they can quietly transform insurance revenue into patient debt.

The Handoff

Revenue cycle departments are organized for good reason. Patient financial services/service access, insurance follow-up, denial management, and collections each have specialized expertise and distinct responsibilities.

The challenge is that accounts don't always fit neatly within those organizational boundaries.

Once an account leaves the denial management team, the original issue often fades into the background. For example, once registration is entered into the system and the claim is dropped, the original issue often fades into the background, ending in a denial. By the time it flows through follow-up, denials, possibly coding, and reaches patient collections, it's simply another self-pay balance. No one intentionally loses sight of the account's history. The handoff to a new team simply makes it more difficult to see how one stage of the revenue cycle influenced the next.

The Downfall of Dashboards

Most organizations have strong visibility into individual performance measures.

They know their denial rate. They know their appeal success rate. They know their bad debt percentage. What many organizations don't routinely examine is how those metrics interact. For example:

- How many bad debt accounts originally entered the revenue cycle as denied claims?
- Which denial categories most frequently become patient balances?
- Are certain payer issues more likely to result in collection activity?
- Where do ownership transitions create delays or missed opportunities?

These questions shift the discussion away from departmental performance and toward revenue preservation across the entire lifecycle of the account.

Why This Matters

One pattern I've observed is that balances created by unresolved insurance issues often result in more issues than traditional self-pay accounts.

Patients receiving these bills may believe their insurance should have covered the service. They may dispute the balance,

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Provider-Based Attestation: A Compliance Requirement Hospitals Can't Ignore

By: Jesse Vo & Marisol Cooke

Provider-based attestation compliance for off-campus hospital outpatient departments (HOPD) remains a high-risk Medicare issue for hospitals, particularly for off-campus clinics and recently acquired physician practices.

Provider-based status allows hospitals to bill under the Hospital Outpatient Prospective Payment System (OPPS) at more favorable rates designed to cover higher hospital overhead, and allow the ability to utilize the 340B drug program at these locations. The Consolidated Appropriations Act of 2026 formally requires attestation of compliance with complex regulations and significantly penalizes noncompliance.

Hospitals need to start preparing a compliance framework to review their provider-based compliance and to outline how it will meet the new attestation requirements. The underlying regulations that need to be reviewed under 42 CFR § 413.65 are not changing, so hospitals shouldn't wait until Centers for Medicare & Medicaid Services (CMS) issues new implementation instructions to start their review.

CMS hasn't required hospitals to submit attestations to confirm compliance with the regulations under 42 CFR § 413.65 for over 20 years. Attestations were voluntary yet beneficial in reducing financial risk of being out of compliance. Other than the voluntary attestation process, hospitals needed to act in good faith that the regulations were being followed.

With the passage of The Consolidated Appropriations Act on February 3, 2026, hospitals must be aware of the new requirements on the attestation process for HOPDs and act accordingly or lose the status.

The Consolidated Appropriations Act of 2026 key takeaways

Here's what you need to know about the Consolidated Appropriations Act of 2026 as it relates to provider-based attestation compliance.

- For hospitals to maintain provider-based status and the associated benefits, hospitals must submit an initial attestation between January 1, 2026, and December 31, 2027. Any location that fails to submit will have its provider-based status automatically revoked.
- CMS must still go through the proposed rulemaking and comment process to

finalize any new attestation processes that hospitals are to follow—if any; establish a review process including but not limited to on-site visits; and establish a schedule in which hospitals will have to submit an additional attestation.

- Hospitals can follow the current voluntary attestation process under 42 CFR § 413.65(b)(3) prior to the issuance of a new process.

- Hospitals are required to obtain a separate NPI for each off-campus provider-based department.
- Each location will need its own attestation.
- Losing status means losing the added reimbursement and likely access to 340B pricing related to services in those locations.

What is provider-based attestation?

Provider-based attestation is the hospital's formal representation to CMS that a clinic, department, or facility qualifies as a department of the hospital, rather than a freestanding entity. When a location meets provider-based requirements, the hospital may bill Medicare under the OPPS, including a facility fee.

Through the attestation process, hospitals must maintain documentation of the basis for its attestations and make that documentation available to CMS and to CMS contractors upon request.

The attestation process will extend to all hospitals that operate an off-campus provider-based department located more than 250 yards from the hospital. While not specified, Critical Access Hospitals (CAH) should be ready to follow the same process. While CAH are not reimbursed under OPPS, their ability to bill as part of the hospital and receive cost-based reimbursement is subject to the same regulations under 42 CFR § 413.65.



Jesse Vo



Marisol Cooke

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delay payment while seeking clarification, or disengage altogether.

From a collections standpoint, these accounts are often more difficult to recover because the patient's understanding of the balance is fundamentally different from someone who knowingly incurred a financial obligation from the beginning. These distinctions matter when organizations evaluate both reimbursement strategy and bad debt performance.

A Different Way to Think About Revenue Preservation

After all these years in revenue cycle, I've become convinced that some of the greatest opportunities aren't found by looking deeper within individual departments. They're found by following an account across departmental boundaries. Sustained revenue cycle success depends on frequent collaboration among departmental subject matter experts, whose collective review of accounts helps identify root causes, resolve barriers, and prevent recurring issues that impact accounts receivable.

Sometimes what appears to be bad debt is exactly that. Other times, it's the final outcome of an insurance reimbursement opportunity that gradually disappeared as the account moved through the revenue cycle.

Understanding where and why that transition occurs won't eliminate denials or bad debt overnight. But it can help organizations identify patterns that traditional reporting often

misses. Because in some cases, bad debt isn't simply the end of the revenue cycle. It's the last chapter of an insurance story that began much earlier. The future of revenue cycle management will belong to organizations that replace silos with collaboration and reactive processes with proactive strategies. By connecting the dots across revenue cycle, leaders can preserve revenue before it is lost, improve the patient financial experience, and transform what has traditionally been viewed as bad debt into opportunities for better outcomes.

About the author

Lori Jeffreys joined Revco Solutions as a Strategic Advisor for Revenue Cycle and Client Success following a 30-year career in revenue cycle at Duke University Health System. In her role at Duke, she served as Director of Payer Relations, Customer Service, Self-Pay and Professional Billing and Collections. With success rooted in deep expertise in Epic follow-up and denial processing, strategic initiative execution and development of robust training and documentation resources, she continues to thrive off building strong, collaborative partnerships with stakeholders across the healthcare industry. She now brings that experience to Revco on behalf of our clients. She can be reached at lori.jeffreys@revcosolutions.com.

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Compliance perspective on provider-based attestation

From a compliance perspective, the greatest risk is misalignment between the attestation and actual operations. CMS is expected to focus on ownership and control, clinical and financial integration, public awareness, and Emergency Medical Treatment and Labor Act (EMTALA) compliance when applicable. Changes in staffing models, management agreements, branding, billing, workflows, or cost reporting can quietly undermine provider-based status over time.

Potential noncompliance of all provider-based regulations can lead to overpayment issues and fraud, waste and abuse issues, and the ability to enroll a location into the 340B program.

Common audit findings

CMS audits typically relate to one or more of these items.

- Clinics operating with independent clinical or operational control
- Expenses and revenues aren't clearly included in the hospital cost report
- Public-facing materials that resemble freestanding practices
- Staff unfamiliar with their status as a hospital department
- Beneficiary disclosures
- Off-campus locations not enrolled on the hospital's 855A
- Co-location or shared space compliance
- Improper billing, such as modifier usage and place of service codes

CMS audits often rely heavily on staff interviews and operational validation. When operational reality contradicts the attestation, hospitals may face retroactive repayment of facility fees, reclassification of the site, and corrective action requirements.

Net revenue will be reduced to site-neutrality levels. Reductions can be significant given that HOPD reimbursement can be 1.5–3x higher than standard non-hospital outpatient reimbursement.

Our recommendation

Hospitals should treat provider-based status as a living compliance obligation, not a one-time designation. Periodic assessments, alignment between operations and billing, and leadership-level risk review are essential to mitigating audit exposure and start now because mitigation efforts can take time.

Provider-based attestation is not about checking a box for reimbursement. It's about demonstrating, every day, that a location truly functions as part of the hospital.

If CMS audited tomorrow, your operations—not your paperwork—would decide the outcome. That's the standard hospitals should be prepared to meet.

The provider-based attestation process is time-consuming and complex to navigate. To learn more about provider-based attestation and how it can help your organization in meeting these requirements, contact your firm professional.

Join us at our breakout session at the 50th Anniversary Annual Institute, From Requirement to Reality: Executing

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New Jersey Healthcare Financial Management Association 2025-26 Chapter Awards Listing

President's Award

Fatimah Muhammad, CRCR,
CSPR, FHFMA

Member Recognition Award - GOLD

Lee Gordon

Member Recognition Award - BRONZE

Carol Burkhead
Chris Czornyek, CHFP
Daniel Demetrops
Dennis Jones
Koy Dever

Medal of Honor

Christine Gordon
Sandra Gubbine, CPA, FHFMA

The John Dalton Memorial Scholarship Award

Kaitlyn Senetra

Member Recognition Award - SILVER

Fatimah Muhammad, CRCR, CSPR,
FHFMA
Jonathan Besler
Josette Russo

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Provider-Based Attestation at Scale, on Wednesday, October 21, 2026, at 3:20 p.m. PT.

You can also reach out marisol.cooke@bakertilly.com or jesse.vo@bakertilly.com if you have any questions.

The information provided here is of a general nature and is not intended to address the specific circumstances of any individual or entity. In specific circumstances, the services of a professional should be sought.

About the authors

Jesse Vo has worked in the health care finance industry since 2011. His primary area of focus is provider reimbursement, in which he assists hospitals and health systems report their Medicare Disproportionate Share Payments (DSH) and uncompensated care reimbursement. His experience includes preparing Medicare DSH and Worksheet S-10 data for initial and amended cost report filings, reviewing and drafting hospital financial assistance policies, and overseeing Medicare DSH and Worksheet S-10 audits and appeals. He also has experience in data forecasting and

analysis for the Medicaid and Social Security Income percentage population for providers concerned with 340B. Additionally he has experience in state Medicaid cost reporting, audits, appeals, and staying current on all federal and state government regulatory payment changes and updates. Jesse can be reached at Jesse.Vo@bakertilly.com

Marisol Cooke has worked in health care regulatory and compliance since 2007. She is a highly accomplished and trusted compliance advisor with direct experience developing and implementing regulatory and privacy programs for high-profile organizations. Marisol maximizes resources to manage complex, and often ambiguous, circumstances resulting in cost-effective solutions to compliance challenges. She is astute at collaborating with individuals at all levels of an organization, from the front line to the C-suite, while leading, guiding, and motivating others to meet organization objectives. Marisol can be reached at Marisol.Cooke@bakertilly.com.

"Women in Leadership" Event Recap

hfma™
new jersey chapter

THANK YOU
to Our Event Sponsors

Your generous support helps make
our Elegant Cocktail Reception
celebrating Women in Leadership
a resounding success!

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the future of healthcare finance.*

THANK YOU FOR YOUR SUPPORT!

On Wednesday, September 23, 2026, NJ HFMA chapter members gathered at Hotel LBI on Long Beach Island to celebrate a very special moment in our chapter's history!

For the **first time in NJ HFMA history, our chapter is led by an all-women executive team of officers.** It was a wonderful evening celebrating this milestone, connecting with fellow members, and capturing photos to commemorate this historic occasion.

A very special thank you to **Kim Raftery**, who generously donated her time and photography talents to help us capture these memories.

Thank you to everyone who joined us and helped make the evening so memorable. If you weren't able to attend, we hope you enjoy this photo recap and a glimpse into an amazing evening celebrating the women making NJ HFMA history!

















Dear Fellow HFMA Members:

I am pleased to invite members, member's spouses, or member's dependents to apply for this year's 2027 NJ HFMA Thomas G. Shanahan Scholarship. The New Jersey Chapter of HFMA will be offering at least one scholarship at a minimum of one thousand dollars. You, your spouse or dependent may be eligible for the scholarship if you meet the following criteria:

- Member, in good standing, of the New Jersey Chapter for the last two years.
- Spouse or dependent of a member, in good standing, of the New Jersey Chapter, for the last two years.
- Enrolled in an accredited college, university, nursing school or other allied health professional school.

Preference will be given to applicants pursuing degrees in finance, accounting, healthcare administration or a healthcare related field of study. Tuition not paid by an employer or other scholarship will qualify for the HFMA scholarship.

We make our selection based on merit, academic achievement, civic and professional activities, course of study and content of your application and essay. We do not use income in our selection process. To apply, please submit a completed Scholarship Application no later than January 1, 2027. Members of the Chapter's Board of Directors, Officers and Advisory Council and their spouses or dependents are not eligible for scholarships. Prior awardees are not eligible for a subsequent scholarship, although other dependents in the member's family are still eligible.

We will announce the recipient(s) of the 2027 NJ HFMA Thomas G. Shanahan Scholarship at our annual golf outing on May 6, 2027. If you have any questions or wish to receive additional applications, please contact Laura Hess at njhfma@aol.com.

We look forward to receiving your application and wish you success in your academic endeavors.

Respectfully submitted,

Jonathan Besler

Jonathan Besler
Chair, 2027 Scholarship Committee

NEW JERSEY HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION MEMBER'S ANNUAL SCHOLARSHIP APPLICATION

MEMBER INFORMATION

Member Name _____

Member Address _____

Membership # _____

Years in HFMA _____ # Years in NJ Chapter _____

Member Employer _____

APPLICANT INFORMATION

PART 1 - PERSONAL DATA

Applicant Name _____

Address _____

Relationship to Member _____

College _____

Course (s) to be taken _____

Matriculated Student YES _____ NO _____

Degree/Program Pursued _____

Anticipated Graduation Date _____

Major _____ Annual Tuition _____

Amount of Employer Support _____

Amount of Other Scholarships Awarded _____

(Documentation must be provided supporting tuition and/or books, employer's reimbursement policy and enrollment in school.)

(Please label as Attachment D.)

SIGNATURE _____ DATE _____

Please return completed package no later than January 1, 2027 to:

PART 2 – EDUCATION BACKGROUND

Highest Level of Education Attained _____

School _____

GPA _____ Degree _____ Major _____

(Documentation must be provided documenting Grade Point Average)

PART 3 – PROFESSIONAL CAREER

Employment History (List employment history as **Attachment A**.)

PART 4 – COMMUNITY AND PROFESSIONAL ACTIVITIES

Please describe your civic and professional activities and contributions to your community, profession, HFMA or other organizations. **(Please label as Attachment B.)**

PART 5 - ESSAY

Please submit an essay describing your educational and professional goals and how this scholarship will assist you in achieving such goals. **(Please label as Attachment C.)**

PART 6 - REFERENCES

Please furnish three formal reference letters

Jonathan Besler at NJHFMA@aol.com or mail to:
Chair Scholarship Committee, NJHFMA
Healthcare Financial Mgmt. Assoc. - NJ Chapter
272 N 1st Street
Surf City, NJ 08008



2026 Chapter Internal Financial Review

HFMA requires that each Chapter conduct either an independent audit or an HFMA internal financial review. The HFMA internal financial review process and reporting were developed by HFMA and must be followed by any Chapter opting for this approach instead of an independent audit. Pursuant to HFMA's requirements, the Internal Financial Review must be completed by an individual or individuals possessing the appropriate financial experience and who are not involved in the Chapter's bookkeeping activities.

The purpose of the Internal Financial Review is to test and validate the Chapter's fiscal integrity and operating guidelines. Furthermore, the reviews:

- Addresses whether the Chapter's financial Statements correctly reflect the activities for the year.
- Consider whether an adequate level of documentation is maintained for the Chapter's receipt and disbursement transactions to reconcile checking and savings account bank statements.
- Considers whether transaction approval guidelines are in place and being observed.

The internal financial review for the 2025–2026 Chapter Year was completed by a retired CPA with extensive healthcare experience. The Chapter Treasurer, the Assistant Treasurer, and Officers provided the necessary documentation required for the internal financial review. The completed internal financial review questionnaire was provided to the Chapter's Audit Committee of the Board of Directors. A meeting of the Audit Committee was held to review the findings and the questionnaire. Upon review, the Audit Committee accepted the Internal Financial Review findings and approved the financial statements for the 2025–2026 Chapter Year.

The accompanying balance sheets and statements of activities and cash flows for the years ended May 31, 2026, 2025, and 2024 reflect the financial statements for the NJ Chapter. If you have any questions, please don't hesitate to contact any Board member for assistance.

Respectfully submitted,

2025-2026 NJ HFMA Audit Committee Chair

Maria Facciponti

A handwritten signature in black ink that reads "Maria Facciponti". The signature is written in a cursive, flowing style.

**Healthcare Financial Management Association - New Jersey Chapter
Balance Sheet**

	As of May 31		
	2026	2025	2024
Assets			
Current Assets			
Bank accounts	\$ 330,534	\$ 324,234	\$ 352,380
Accounts receivable, net	12,743	13,630	10,000
Other current assets	10,000	10,000	9,000
Total current assets	353,277	347,864	371,380
Investments	32,324	28,103	25,483
Fixed assets	-	-	-
Total assets	\$ 385,601	\$ 375,967	\$ 396,863
Liabilities and net assets			
Liabilities			
Current liabilities			
Accounts payable	\$ 24,831	\$ 10,140	\$ 25,239
Deferred revenue	67,076	37,041	41,567
Accrued payroll	\$ -	\$ 4,394	-
Total Other Current Liabilities			
Total current liabilities	91,907	51,575	66,806
Total liabilities	91,907	51,575	66,806
Net assets			
Thomas G. Shanahan Scholarship Fund	10,390	14,390	20,390
Net assets without restriction	283,304	310,002	309,667
Total liabilities and net assets	\$ 385,601	\$ 375,967	\$ 396,863

Healthcare Financial Management Association - New Jersey Chapter
Statement of Activities

	Year ended May 31		
	2026	2025	2024
Income			
Meeting and education income	186,245	143,585	165,595
Newsletter income	2,500	2,100	4,320
Golf Outing Income	50,490	51,600	43,127
General sponsorship income	240,350	190,507	220,658
Interest income	6,786	7,677	7,799
Other income	2,000	2,000	-
Total income	488,371	397,469	441,499
Expenses			
Meeting and education expenses	346,498	292,377	346,727
Newsletter expenses	4,571	12,888	7,468
Golf Outing expenses	38,612	26,825	23,032
Member recognition and social event expenses	16,627	13,161	7,778
General and administration expenses	113,940	59,878	54,449
Provision for bad debts	2,370	-	-
Total expenses	522,618	405,130	439,454
Net Operating Gain/(Loss)	(34,247)	(7,661)	2,044
Unrealized gain and loss	3,548	1,996	1,163
Net income (loss)	(30,699)	(5,665)	3,208

Healthcare Financial Management Association - New Jersey Chapter
Statement of Cash Flows

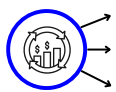
	Year ended May 31		
	2026	2025	2024
Operating activities			
Net income (loss)	(30,699)	(5,665)	3,208
Adjustments to reconcile net income (loss) to net cash provided by (used in) operations:			
1200-00 Accounts Receivable			
1250-00 Other Receivables			
Change in unrealized gains (net)			(1,163)
Accounts receivable, net	887	(3,630)	(162)
1260-00 Allowance For Doubtful Accts			
Other current assets	-	(1,000)	(2,092)
Depreciation	-	-	-
2000-00 Accounts Payable			
2310-00 Due to Credit Cards:Due to Credit Card 1			
Accrued Expenses	14,691	(15,098)	(2,826)
Deferred Revenue	30,035	(4,526)	(15,269)
Accrued Payroll	(4,394)	4,394	-
Net cash used in provided by (used in) operating activities	10,520	(25,525)	(18,305)
Cash flows from Investing Activities			
Purchases of Investment, net	(4,220)	(2,621)	(507)
Net increase/(decrease) in cash	6,300	(28,146)	(18,812)
Investing activities			
Purchases of fixed assets			
Net cash used in investing activities			
Cash at beginning of period	324,234	352,380	371,192
Cash at end of period	330,534	324,234	352,380



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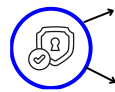


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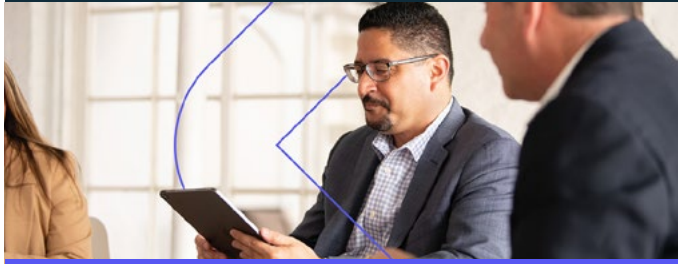


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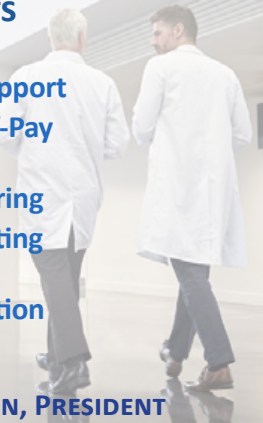
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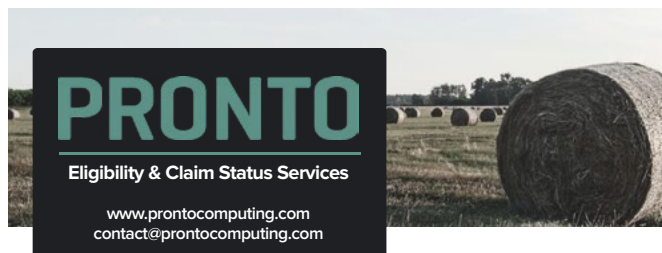


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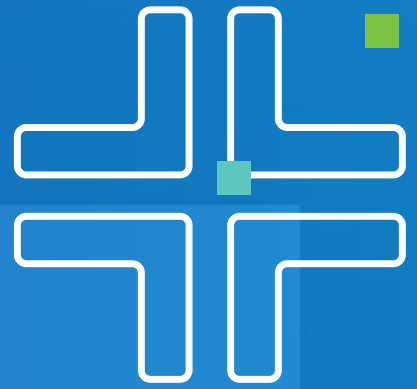
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