

Tarheel News

Message from Communications

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



240+

Attendees at the Annual Conference

4

Upcoming in-person events



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1,654

New members since January

98,922+

Impressions on LinkedIn since January

2,774+

followers on LinkedIn

Interested in Volunteering with NCHFMA?

Grow professionally, expand your network, and make a positive impact in shaping the future of healthcare.

[Fill out our form](#)

Message from The President

Elaine Peeler, President, NCHFMA
Manager, Revenue Cycle Quality Assurance, Novant Health



Welcome to the 2025-2026 Chapter Year!

Your new board is thrilled to kick off this new chapter with fresh energy and ideas! We're eager to explore new ways to deliver the education you and your teams have asked for – and to find better ways to gather your feedback. Why? Because at the heart of it all, our chapter exists to support you, our healthcare finance professional, with the educational content you need.

And the best part? We get to have fun along the way – through networking, building lasting friendships, and collaborating with peers from across different organizations and areas of finance.

As I shared in my incoming address back in February, HFMA is what you make of it. For me, that's meant 22 years of treasured friendships. These are the people I turn to when I need to talk through a challenge or toss around a new idea. And now, in this season of life, many of them are the ones who check in on me regularly. I encourage you to build a network like that—it's truly one of a kind.

You might be wondering, How do I get started? The answer is simple: get involved—at any level. Whether it's moderating a one-hour webinar, introducing a speaker, or going all in as a committee co-chair, there's a role that fits your availability and interests. This year, I invite you to ask, "What can I do to help?" and take that first step toward getting involved. I can't wait to see what we'll accomplish together!

Elaine Peeler
President NCHFMA 2025-2026

2025-2026 NC HFMA Chapter Leadership

Officers



Elaine Peeler - President



Wendi Cardwell - President Elect



Ashley Sanders - Vice President



Phil Rooney - Secretary/Treasurer

Board of Directors



Allison White - Chapter Services



Kyle Fredette - Education



Olivia Britt - Programs



John Lloyd - Compliance & Certification



Charity Brown - Communications

Committee/Council Co-Chairs



Matt Mitchell - Partnership



Jennifer Struble - Education
Co-Chair



Diana Stoyova - Certification
Co-Chair



Nicole Hester - Membership
Co-Chair



Gabrielle Wierling - Membership
Co-Chair

Other



Jason Nelms - Immediate Past President



Kim Coker - Chapter Bookkeeper



Kevin Leder - NASBA



Jaclyn Goldsmith Snow - NCHA Liaison

HFMA Event Highlights



Member Spotlight

Lance Grainer, Revenue Cycle IT
Applications Manager, WakeMed 
WakeMed Health & Hospitals



Who is Lance Granier?

Lance Granier is the Revenue Cycle IT Applications Manager at WakeMed, leading cross-functional teams that support EPIC and other clinical technologies.

Role and Passion?

With an MBA in Healthcare Administration and experience across IT, revenue cycle, and consulting, he's passionate about connecting innovation with real-world operations to improve patient care and financial sustainability.

Tackling Industry Challenges?

Lance focuses on navigating reimbursement shifts, clinical workflow changes, and value-based care, seeing each as an opportunity to align IT and operations for long-term success.

Mentorship Advice?

A mentor once taught him that leadership is about influence, not authority.

Wisdom for Future Leaders?

His advice for future leaders: "Stay curious, stay grounded, and learn the business of healthcare—not just your function."

Member Spotlight

Lance Grainer, Revenue Cycle IT
Applications Manager, **WakeMed**
WakeMed Health & Hospitals



What does Lance do for fun?

Outside of work, he's passionate about fitness, hip-hop culture, and mentoring young men and admits to sneaking in push-ups most mornings.

Lance's Inspiration?

Proud of his rural North Carolina roots, Lance is inspired daily by his late mother's strength and dedication to service.

Lance's NCHFMA Impact?

Rejoining NCHFMA this year, Lance values the network, collaboration, and insight into payer trends the organization provides. He looks forward to deepening his involvement and helping shape the future of healthcare finance.



Member Spotlight

Margarita Khosh, AVP Sr. Strategic Partnerships, **Commerce Healthcare**



Who is Margarita?

A new face to NCHFMA, Margarita is eager to gain deeper insight into revenue cycle management while building meaningful connections across North Carolina.

Role and Passion?

Margarita leads Strategic Partnerships for Commerce Healthcare and enjoys the strong company culture, collaborative teams and the impactful work they're doing together.

Tackling Industry Challenges?

Like many in healthcare, she is focused on understanding and navigating the evolving challenges of RCM and financial management, while continuing to grow her knowledge and expertise.

Mentorship Advice?

A mentor once taught her to always pay it forward and add value.

Wisdom for Future Leaders?

Lead with empathy and keep an open mind to build lasting relationships.

Member Spotlight

Margarita Khosh, AVP Sr. Strategic Partnerships, **Commerce Healthcare**



What does Name do for fun?

Outside of work, Margarita is an avid reader, cook, and late-in-life yogi who also enjoys painting, hiking, and hosting epic Friday night dinner parties.

Name's Personal Life?

Balancing it all means scheduling time each day for at least one activity that feeds her creativity and well-being.

Her NCHFMA Impact?

Margaria is early in her journey with HFMA, but is excited to discover the professional and personal benefits of membership. She aims to pursue certifications to strengthen her expertise.



Upcoming NCHFMA Events

In-person Events



SC & NC HFMA 1st Annual Fall Symposium

October 29th - 31st

📍 Hyatt Regency: 220 North Main Street, Greenville, SC

[Register Here](#)



Healthcare Finance & Technology Summit

December 9th - 10th

📍 Northeastern University - Charlotte Campus

[Register Here](#)



NCHFMA Healthcare Finance Bootcamp

November 12th

8:00 am - 4:30 pm

Networking Event to Follow

📍 ECU Health

[Register Here](#)



North Carolina HFMA Annual Conference

February 4th - 6th, 2026

📍 Pinehurst Resort

[Registration Comming Soon](#)

Good Faith Appeals to Unlock Denied Revenue

Educational Article

by Elizabeth Purdy, JD, Associate Attorney at



In revenue cycle management, there are moments when the claim lifecycle seems to close—timely filing deadlines pass, appeal levels are exhausted, and payer portals show “final.” For experienced recovery teams, however, final doesn’t always mean the end. It can actually mean a new beginning.

One of the most underutilized strategies in these cases is the “good faith appeal.” While not part of a formal regulatory process like Medicare Administrative Law Judge hearings or state-level fair hearings, good-faith appeals provide a path to reopen dialogue with payers when all other options appear exhausted. For example, according to the Centers for Medicare and Medicaid Services, plans may accept a request for a standard or expedited level 1 appeal after the 65-day timeframe if a filing party shows good cause.

When to Consider Good Faith Appeals

When executed strategically with documentation, clinical narratives, and escalation support, good-faith appeals can result in surprising payment recoveries on claims that would otherwise be written off.

A good-faith appeal is not a legal entitlement; it’s a strategic request made outside standard payer timelines or appeal windows. So, what is its purpose? To prompt reconsideration when a denial was procedurally or clinically unjustified, but no longer eligible for formal review.

This strategy is often used when:

- Timely filing deadlines were missed due to system errors or delayed eligibility
- A strong medical-necessity argument exists, but appeal rights have expired
- Coverage was retroactively assigned after services were rendered
- The payer failed to follow its own policy during the initial denial
- A new or corrected claim would still be rejected as a duplicate

Unlike typical appeals, good faith appeals rely on narrative leverage. They must humanize the denial, highlight documentation gaps that have been corrected, and demonstrate why reconsideration is warranted, even if policy doesn’t require it.

Good Faith Appeals to Unlock Denied Revenue

Educational Article

by Elizabeth Purdy, JD, Associate Attorney at 



The Executive Reality

Good faith appeals take precision. They require careful case selection, detailed storytelling, and elevating the request through the proper channels. They also demand more than form letters—they must tell a compelling story of error, resolution, and equity. When used wisely, they can unlock revenue that's otherwise lost to write-offs.

Many payers, especially in high-dollar, medically necessary care, are more willing to reconsider claims when the right context and documentation are in place—especially if escalation shows the denial conflicts with federal standards, clinical guidelines, or continuity of care requirements. Consider the following examples:

Example 1: A 2024 case involving a Medicare Advantage claim. The facility submitted two appeals, both of which were denied. We submitted a good-faith appeal, and the denial was overturned, resulting in a recovery of over \$15K.

Example 2: Another 2024 case involving a Medicare Advantage claim. The facility submitted two appeals, both of which were denied. We submitted a good-faith appeal, and the denial was overturned, resulting in a recovery of over \$14K.

Example 3: A 2023 case involving a commercial insurance claim. The facility submitted one appeal. The account was referred to us after a timely had passed. We submitted a good-faith appeal, and the denial was overturned, resulting in a recovery of over \$31K.

Leveraging AI Technology

One of the biggest challenges in good-faith appeals is crafting a narrative that bridges clinical facts with payer expectations. That's where artificial intelligence (AI) enhanced technology can be helpful, offering a strategic edge to appeal writing.

Good Faith Appeals to Unlock Denied Revenue

Educational Article

by Elizabeth Purdy, JD, Associate Attorney at 



For instance, our AI-powered program DocIQ can analyze medical records and auto-generate a clinical summary that aligns patient-specific data with established guidelines like MCG and InterQual. This saves time, but more importantly, it translates complex clinical information into language payers understand.

AI technology can accelerate and enhance good faith appeals because it:

- Reduces manual hours spent combing through records
- Strengthens the appeal by connecting patient care directly to MCG or InterQual criteria
- Delivers a more credible and cohesive case—especially for high-dollar or past-timely denials
- Helps highlight discrepancies between denial rationale and clinical evidence, making appeals stronger and more objective
- Ensures consistency in how cases are presented, reducing variation that can hurt outcomes

In good faith appeals, especially where the traditional appeal windows are closed or exhausted, the ability to synthesize clinical and coding context into a single, cohesive narrative is essential. AI can't replace human expertise—it amplifies it by streamlining the technical work and sharpening the story that's told.

What Makes a Good Faith Appeal Work?

To be effective, a good faith appeal should include:

- Clear documentation of medical necessity, corrected error, or payer error
- Explanation of extenuating circumstances (e.g., eligibility issues or systemic delays, etc.)
- Supportive literature or internal-policy excerpts when applicable (e.g., InterQual/MCG guidelines or medical journals, etc.)
- A strong narrative that demonstrates equity, continuity, or clinical impact

Final Thought

In healthcare reimbursement, the line between policy and payment isn't always clear. While good faith appeals aren't guaranteed, they reflect the provider's right and responsibility to advocate when denials don't reflect the clinical or administrative reality.

Sometimes, the strongest argument is simply: This was the right care. And it deserves to be paid.

When S-10 Reporting Fails, Reimbursement Falls Short

Educational Article

by Tiffani Frank, VP Operations, Government
Reimbursement at 



You delivered the care. But mismatched reports could cost you the reimbursement. That's what happens when S-10 and Medicare Bad Debt logs don't align.

Why S-10 Matters

Worksheet S-10 is part of the annual Medicare Cost Report. It captures the cost of caring for Medicare patients who can't or don't pay their bills and helps determine how much Uncompensated Care reimbursement a hospital receives.

S-10 and Medicare Bad Debt logs use the same data, but they're often prepared separately, sometimes by different departments or vendors. That split can lead to misalignment, which can then trigger audits, delayed payments, or lost reimbursement. The financial consequences can cost hospitals hundreds of thousands or more.

Why S-10 is Relatively Easy to Get Wrong

S-10 is fairly new, becoming a key part of the reimbursement formula only about five years ago. It's also relatively complicated, reported as a separate line item with multiple fields that must be filled out precisely.

S-10 logs are also audited faster than Medicare Bad Debt logs, leaving little time to fix errors after submission.

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What Hospitals Can Do

To avoid misalignment and missed revenue, hospitals should treat S-10 and Medicare Bad Debt as complementary services, not separate tasks. That means compiling the two reports together, and if using a vendor, getting written confirmation that all data has been placed in the appropriate fields.

When S-10 and Medicare Bad Debt numbers don't align, CMS pays attention. And hospitals often pay the price. Now's the time to examine your process and make sure your reports are in sync and successful. Your revenue cycle results depend on it.

The Big Beautiful Bind: How will NC Hospitals Survive the Shift?

Educational Article

by Olivia Britt, VP of Client Success at SAVISTA



As North Carolina hospitals, especially rural ones, brace for the ripple effects of the newly enacted One Big Beautiful Bill Act (OBBBA), many are questioning whether “beautiful” was meant sadly or sarcastically. Signed into law on July 4, 2025, this sweeping federal legislation carries dramatic cuts to Medicaid and safety-net programs while offering only modest rural health funding. Effective October 1, 2025, Medicaid reimbursement in North Carolina will also be reduced by at least three percent due to a \$319 million shortfall in the state budget and changes to Medicaid policy. Together, these factors create an increasingly fragile financial landscape for hospitals across the state.

The Good (If You’re a Budget Hawk)

- Rural Hospital Fund increases from 25 billion to 50 billion to partially offset Medicaid cuts.
- Proponents celebrate fiscal restraint with tax cuts for high earners, tightened Medicaid rules, and new work requirements.
- Supporters argue that stricter requirements and reduced funding for perceived inefficiencies may encourage greater self-sufficiency.

The Bad

- The Congressional Budget Office projects Medicaid spending will decline by roughly \$1 trillion over the next decade, potentially leaving up to 10.9 million Americans without coverage. Some estimates climb to 17 million when new Marketplace rules and subsidy changes are included.
- In North Carolina, about 523,000 residents could lose Medicaid or Marketplace coverage as a direct result.
- The UNC Sheps Center warns that more than 300 rural hospitals nationwide, including five in North Carolina, are at risk of closure. Facilities potentially impacted include Person Memorial in Roxboro and UNC Health Chatham in Siler City.

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The Ugly

- Realignment of Medicaid rules introduces 80-hour per month work requirements for able-bodied adults, shorter eligibility redeterminations, and caps on provider taxes. This is particularly harmful for North Carolina, which relies heavily on a six percent hospital provider assessment to fund its share of Medicaid expansion.
 - The legislation includes a “trigger” provision that automatically ends Medicaid expansion if provider revenue falls below required levels. This could strip coverage from more than 673,000 North Carolinians currently enrolled through expansion.
 - Additional budget neutrality requirements are expected to impose new administrative burdens and system costs on NCDHHS, further straining hospitals.

What It Means for NC Hospitals and HASP

Hospitals in North Carolina face a treacherous fiscal landscape. Medicaid reimbursement will be cut by at least three percent beginning October 1, 2025. Combined with OBBBA’s reductions, hospitals could lose tens if not hundreds of millions over the coming decade through decreased Medicaid payments, valuation reductions, and growing uncompensated care burdens.

NCDHHS and NCHA estimate a \$32 billion impact on hospital finances and the state’s Medicaid budget over ten years. The Hospital Access Stabilization Program (HASP), which was designed to steady hospital finances, may also see its funding model weakened. This leaves hospitals to confront a triple threat of reduced Medicaid match dollars, higher administrative costs from new eligibility rules, and unpredictable HASP revenue streams, all while patient safety nets continue to fray.

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by Olivia Britt, VP of Client Success at SAVISTA



Final Take: A Balancing Act

The good: some effort to restrain entitlement spending, increase rural support, and enforce work requirements.

The bad: major coverage losses in North Carolina, declining hospital revenues, and the risk of Medicaid rollback.

The ugly: potential hospital closures, loss of Medicaid expansion, and adverse health outcomes for thousands of residents.

Hospitals and policymakers must now navigate fiscal uncertainty, legal ambiguity, and political fallout. Leaders will be challenged to protect both financial stability and healthcare access. Irony aside, this “beautiful” bill may be the storm warning that North Carolina was not prepared to face.

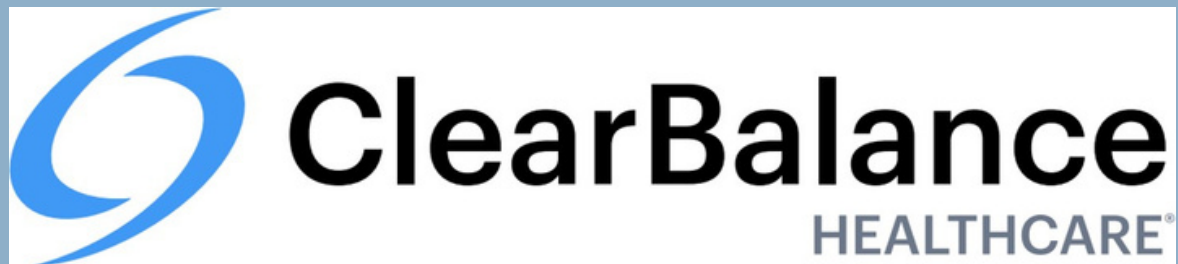
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North Carolina Health News
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