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DEADLINE FOR SUBMISSION OF MATERIAL

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OBJECTIVE

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

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The President's View . . .

Jonathan Besler

Dear New Jersey HFMA Chapter Members,

Happy October to everyone! In a few short weeks, the New Jersey HFMA Chapter will be welcoming over 400 attendees to our Annual Institute at the Hard Rock Hotel and Casino! It's a wonderful to opportunity to gather together after months of preparation and anticipation. A special thank you to our Annual Institute committee and volunteers for putting together a tremendous agenda of timely and relevant content brought to you by remarkable industry experts. We look forward to seeing so many leaders, colleagues, and friends in Atlantic City and the growing attendance is a true reflection of the strength and dedication of our chapter community. This Chapter runs on the energy and commitment of you, volunteers and our participants.

As Chapter President, I'm excited for what promises to be an inspiring and information-packed 3 days. Our agenda tackles some of the most important topics in our field — from managed care and accounting guidance updates, to payer-provider collaboration, Medicaid redeterminations, the 340B program, and charge integrity. We will welcome Kiran Batheja, National HFMA Chair, to inspire us to Lead Now! A message we can all implement across our personal and professional lives.

We'll gain valuable insights from expert panels exploring revenue cycle, reimbursement, and financial leadership, including our much-anticipated CFO panel. And as our industry evolves, we'll look ahead to innovation, AI, and professional development — areas that are shaping the future of how we work. Our Institute Committee reviewed countless abstracts and cultivated a wonderful agenda for you, touching on current and future focused topics; get engaged and attend!

I encourage each of you to make the most of this experience: engage with your peers, exchange ideas, and walk away with new perspectives that can make a lasting impact in your organization.

Our Charity Sponsor this year is the Philadelphia Eagles Autism Foundation. We have an ambitious Chapter goal to raise $10,000 on their behalf and we are almost half way there, thank you to the generosity of those who have contributed already. There will be many opportunities (at registration, QR codes, raffle prizes, etc.) to contribute to this charity doing great work in our communities. Please learn more at Eagles Autism Foundation and don't forget to attend their presentation on Wednesday evening.

Thank you for joining us, for your commitment to excellence, and for being part of this amazing event. Let's make this year's conference our best one yet!

Sincerely,
Jonathan Besler, CPA
President, NJ HFMA

Eagles Autism Foundation Donation

From the Editor . . .

Jim Robertson

We are thrilled to provide you with this edition of Garden State FOCUS, commemorating the 49th Anniversary of the New Jersey & Metro Philadelphia HFMA Annual Institute, the hallmark event of the year for the healthcare finance community. This year, the Annual Institute brings us back to The Hard Rock Hotel & Casino in Atlantic City and promises, once again, to be an exceptional gathering of industry leaders, innovators, and experts who are shaping the future of healthcare finance.

The Annual Institute is not just a conference. It's a celebration of colleague collaboration and the earnest pursuit of excellence. As we gather from October 29-31 to exchange ideas and insights, we're reminded of the critical role each one of you plays in advancing our industry. Your dedication and expertise are the driving force behind the transformative changes we are currently living through.

A distinguished lineup of speakers will share their knowledge and experiences with us over the next three days. I am honored to kick off Day 1 of the Annual Institute with a keynote summarizing the crucial takeaways from the One Big Beautiful Bill Act. I'm followed by our esteemed Managed Care Panel, featuring Patrick Young of Hackensack Meridian Health, Kevin Joyce from Atlantic Health, Nisha Sikder of Valley Health, Jon Hollenweger from Inspira Health, and moderated by Eric Fishbein of Virtua Health.

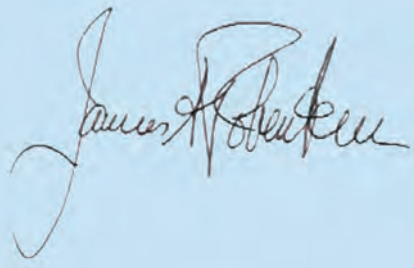
Some of our breakout sessions on Day 1 will include James Trubenbach-Byrne from Withum who will give the 2025 A&A and Uniform Guidance Update. Luke Parrish of Penn Medicine, and Kyle Pennington and Jesse Vo of Baker Tilley will enlighten us on navigating Medicaid redeterminations and 340B program retention strategies. Additionally, Melonie O'Connell from Milliman will tell us why providers, payers, and employers are "taking the plunge into price transparency data." And, Michael DiFranco of Temple University Health System and Adrianne Boylen of Grant Thornton Advisors will demonstrate how automation can transform your financial operations.

Day 2 brings us Marcia Leighton from MC3 Consulting who will argue that we embrace AI in our workplaces to stay competitive. Christine Gordon of Virtua Health and Michael Rossi of Penn Medicine will join in a discussion of regulatory and reimbursement issues with our very own Jonathan Besler as moderator. Kiran Batheja, our HFMA National Chair, will deliver the Day 2 keynote address on leadership. The Day 2 breakout sessions will include an update from Paul Croce of Greenbaum, Rowe, Smith & Davis on several New Jersey hospitals' challenge to charity care underfunding under the 5th Amendment Takings Clause of the United States Constitution, as well as an informative program on leveraging payer analytics to improve hospital revenue cycle presented by Jonathan Davis of Yale New Haven Health and Tara Bogart of PMMC.

Finally, Day 3 brings us Mike Coppa and Michael Haas from RSM who will discuss emerging trends in healthcare finance diversification strategies. Ben Tweel from Bank of America will provide a crucial update on healthcare cybersecurity, a topic of rapidly growing importance in our digital age. Finally, the Annual Institute will close with the star-studded CFO roundtable moderated by Garrick Stoldt of Saint Peter's Healthcare System, and featuring Stella Visaggio of Atlantic Health, Gene Gofman of Penn Presbyterian Medical Center, and Frank Pipas of RWJ Barnabas Health, and who will share their insights, wisdom and experiences at the financial helm of some of the largest New Jersey and Pennsylvania health systems.

As you engage with these thought leaders and your peers, we encourage you to explore new ideas, forge meaningful connections, and take full advantage of the opportunities the Annual Institute offers. We hope you enjoy the Annual Institute and this Edition of FOCUS.

Warm rega



Welcome to the 49th Annual New Jersey and Metro Philadelphia HFMA Annual Institute!

Tara Bogart

By Tara Bogart

We are excited to welcome you to the 49th Annual New Jersey and Metro Philadelphia Annual Institute, taking place from October 29-31 at the Hard Rock Hotel & Casino in Atlantic City, New Jersey. This year's event promises a dynamic blend of insightful education, meaningful networking, and high-energy entertainment.

With four panels—Managed Care, Regulatory & Reimbursement, Revenue Cycle, and CFO—attendees will gain timely insights from distinguished healthcare leaders representing some of the region's most respected organizations.

What to Expect

The Institute kicks off with a Welcome Lunch on Wednesday, October 29 at 11:30 AM, followed by the first round of educational sessions beginning at 12:00 PM. Programming concludes on Friday, October 31 at 12:05 PM, following three packed days of learning, collaboration, and innovation.

Education and Credits

Attendees have the opportunity to earn up to 15.5 CPE credits through 29 sessions over the three days. The conference features five series of breakout sessions on Wednesday and Thursday, offering a choice of three to four different topics per session. Areas of focus include compliance, data analytics, financial reporting/tax, revenue cycle, and managed care/payer updates.

New This Year: "HFMA 101 – Things You Didn't Know to Ask"

We're excited to introduce a brand-new session this year: "HFMA 101 – Things You Didn't Know to Ask." This 30-minute session will take place during lunch on Thursday, October 30th at 12:15 PM, and is open to both new and existing members.

Whether you're just joining or have been a member for years, there's always something new to learn. For our existing members, this is a great opportunity to refresh your knowledge about the organization and explore offerings you may not have taken advantage of—including professional certifications. For our new members, we highly encourage you to attend. This session will serve as both your official welcome and chapter orientation, providing a comprehensive overview of our chapter's history, structure, events, and committees—all designed to help you get the most out of your membership. Don't miss this valuable opportunity to connect, learn, and grow within HFMA!

Featured Sessions

We have an exciting lineup of sessions featuring leaders from top regional health systems, including **Atlantic Health, Emerson Health, Hackensack Meridian Health, Inspira Health, Jefferson Healthcare, Penn Medicine, RWJ Barnabas Health, Saint Peter's University Hospital, Temple Health, Valley Health, Virtua Health, and Yale New Haven Health.** Here are a few session highlights:

- **Wednesday, 12:00 PM** – Federal Update - Big Beautiful Bill presented by James Robertson from Greenbaum Rowe Smith & Davis LLP
- **Wednesday, 1:00 PM** – Managed Care Panel moderated by Eric Fishbein from Virtua Health. This discussion will feature insights from industry leaders including Patrick Young, Hackensack Meridian Health; Kevin Joyce, Atlantic Health; Nisha Sikder, Valley Health and Jon Hollenweger, Inspira Health.
- **Wednesday, 3:20 PM** – Tackling DRG Downgrades: The Silent Revenue Killer presented by Meghan Mackenzie & Tracey Flowers from Hackensack Meridian Health and Charlotte Hadland from Aspirion.
- **Thursday, 9:00 AM** – Adopt or Fall Behind: Why AI Belongs in Your Professional Toolbox with Marcia Leighton, MC3 Consulting.
- **Thursday, 9:50 AM** – Regulatory & Reimbursement Panel: Join Jonathan Besler from BESLER as he leads a discussion with Christine Gordon, Virtua Health and Michael Rossi, Penn Medicine.

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- **Thursday, 11:00 AM** – Lead Now! Hear from NJ's very own Kiran Batheja, HFMA National Chair.
- **Thursday, 1:00 PM** – A Discussion of the New Jersey Supreme Court's Decision in Englewood Hospital & Medical Center v. State of New Jersey: Is NJ's Mandate that Hospitals Provide Care to Any Patient Regardless of Ability to Pay an Unconstitutional Taking of Hospital Property Without Just Compensation? with Paul Croce and James Robertson, Greenbaum Rowe Smith & Davis LLP.
- **Thursday, 3:10 PM** – Topical FY2026 IPPS Updates and Provider Implementation with Richard Toner, Mayo Clinic and Christina Brown, BESLER.
- **Thursday, 4:10 PM** – Revenue Cycle Panel - Patients as Payors – Addressing the Patient Affordability Gap While Changing Patient Behavior. It's Easier Than You Think! This panel includes Jason Kane, Inspira Health; Steven Honeywell, Penn Medicine; Jeff Hinkle, Temple Health and will be moderated by John Fistner, AblePay.
- **Friday, 9:5 0 AM** – Healthcare Cybersecurity Update with Ben Tweel, Bank of America.
- **Friday, 10:50 AM** – CFO Suite Panel: Garrick Stoldt, CFO, Saint Peter's Healthcare System will moderate a panel including Stella Visaggio, CFO, Atlantic Health; Gene Gofman, CFO, Penn Medicine; Frank Pipas, CFO, RWJ Barnabas Health.

Networking Events

- **Wednesday Night – Charity Event:** Join us for the annual charity event on October 29 from 5:30 to 7:30 PM. Enjoy heavy hors d'oeuvres, cocktails, wine, and beer while supporting Eagles Autism Foundation. Their mission is to advance and fund the highest quality, most impactful autism research and programs to improve the lives of individuals and families affected by autism.
- **Thursday Night – President's Reception:** Attend the President's Reception on October 30 from 6:00 to 8:00 PM, featuring light hors d'oeuvres, cocktails, wine, and beer.
- **Thursday Night – Late Night Event:** The celebration doesn't stop after dark! Join us October 30 from 10:00 PM to 1:00 AM for an unforgettable night filled with cocktails, beer, wine, dancing, and live music that'll keep you on your feet. We're bringing in local legends, The Nerds — New Jersey's ultimate cover band — known for their high-energy performances and genre-spanning setlists. From R&B and blues to funk, classic rock, and everything in between, The Nerds will have you singing along and dancing all night long.

Acknowledgments

We extend our sincere thanks to our sponsors and volunteers, whose support makes this event possible. A special thank you to the HFMA officers, committee chairs, and members for their dedication to organizing this engaging and educational conference. We hope you enjoy this year's 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.***

Mark Your Calendar

NJ HFMA Holiday Pizza Networking Event
November 18, 2026 — Wood Stack Pizza & Kitchen, Metuchen, NJ

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

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

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

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

This Year's Charity: The Eagles Autism Foundation

By: Jonathan Besler

Jonathan Besler

Each year HFMA 's NJ and Metro Philadelphia Annual Institute Committee chooses a worthy charity to sponsor. This year we have chosen the Eagles Autism Foundation.

The Eagles Autism Foundation is dedicated to raising funds for innovative autism research and care programs. By providing the necessary resources to doctors and scientists at leading institutions, we will be able to assist those currently affected by autism as well as future generations. The Eagles Autism Challenge aims to inspire and engage the community, so together, we can provide much-needed support to make a lasting impact in the field of autism.

Championed by Eagles Chairman and CEO Jeffrey Lurie, the Eagles Autism Foundation sets out to fund innovative research, drive scientific breakthroughs, and provide critical resources to create a major shift from awareness to action through the signature fundraising event, the Eagles Autism Challenge. One hundred percent of participant-raised funds from the team's signature charity event are invested into the autism research and care community, with more than $40 million raised in eight years.

Today, millions of people around the world are connected to autism. The Center for Disease Control estimates that 1 in 31 people under 21 living in the United States are on the autism spectrum, making it the fastest-growing developmental disorder. For Eagles Chairman and CEO Jeffrey Lurie, it is personal.

At the Eagles, they take their responsibility to the community very seriously and look for how to best leverage their brand and ability to bring people together in order to drive critical resources and funding to autism. They want to give a voice to families who live with autism – the ones who are out there every day advocating, promoting, supporting, and seeking out opportunities for their loved ones.

One organization can't do it alone, so Eagles Autism Foundation is partnering with thought leaders to advance scientific breakthroughs. Together all of us can shift from autism awareness to action for transformational impact, not only in Philadelphia but throughout the world.

HFMA is dedicated to raising awareness and advocating for Autism research. Join us in donating to our fundraiser by scanning the QR code. Please help us help Eagles Autism Foundation!

One Big Beautiful Bill Act: Key Healthcare Provisions & Effects

James A. Robertson

By: James A. Robertson, Sukrti Thonse and Jake Newcomb

Sukrti Thonse

Jake Newcomb

Congress recently passed the One Big Beautiful Bill Act (OBBBA), a sweeping piece of legislation that reshapes healthcare financing and delivery across Medicaid, Medicare, and the insurance Marketplaces. Much of the public commentary has focused on dire predictions that millions will lose coverage. While those headlines capture the scale of disruption, healthcare leaders should also pay close attention to the regulatory details of the bill. The law makes technical but highly consequential changes to eligibility, provider funding, and state financing mechanisms. For hospitals, particularly safety-net and rural facilities, these provisions could significantly alter reimbursement flows, increase compliance obligations, and intensify the pressure to manage uncompensated care.

Medicaid Changes: Coverage Churn and New Barriers

The bill's most immediate impact will be felt in Medicaid expansion populations. Starting with renewals scheduled on or after December 31, 2026, states must conduct semi-annual eligibility redeterminations for expansion adults (ages 19–64). For hospitals, this means greater churn among low-income patients, with individuals cycling in and out of coverage more frequently. The legislation also introduces community engagement requirements, obligating able-bodied adults (ages 19 and 64) to work or participate in qualifying activities for at least 80 hours per month. Importantly, individuals who lose Medicaid due to non-compliance are also barred from receiving subsidized Marketplace coverage. Experience from prior state experiments with work requirements suggests that these rules, even with exemptions, often lead to disenrollment and higher emergency department utilization.

At the same time, the bill places a moratorium on certain CMS rules until September 30, 3034, including the 2024 Medicaid/Children's Health Insurance Program (CHIP) eligibility and enrollment streamlining rule, the Medicare Savings Program final rule, and the long-term care nursing home staffing standards. While this may temporarily reduce compliance costs for long-term care providers, it also postpones long-awaited quality and oversight improvements.

Financing Pressures: Provider Taxes and Directed Payments

Perhaps most concerning for state governments and large hospital systems are changes to Medicaid financing mechanisms. OBBBA gradually reduces the cap on provider taxes from roughly 6% to 3.5% by 2032 (via a five-year step-down beginning in 2028). These taxes are a critical tool states use to draw down federal matching funds. Reducing the threshold will leave states with fewer dollars to support hospitals, compounding financial stress at a time of projected coverage losses.

The bill also restricts state-directed payments, limiting them to 100% of Medicare rates in expansion states and 110% of Medicare in non-expansion states, with any above-cap arrangements phased down by 10 percentage points per year starting Jan 1, 2028. Safety-net hospitals, many of which rely on these enhanced payments to cover uncompensated care, face a phased reduction in supplemental support.

Marketplaces and Medicare: Narrowing Eligibility

Beyond Medicaid, OBBBA tightens eligibility for both private coverage and Medicare. Statutorily, Marketplaces must now conduct stricter pre-enrollment verification of income, lawful status, and residency (effective for tax years after 2027). In addition, premium subsidies are no longer available for individuals enrolling through income-based Special Enrollment Periods (SEPs) rather than qualifying life events (effective for plan years after 2025). For hospitals, these restrictions translate into fewer insured patients and increased

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bad debt.

Separately, in June 2025, CMS issued a regulatory rule eliminating the federal year-round SEP for individuals under 150% of the Federal Poverty Line (FPL). Taken together, these changes will reduce the number of insured patients hospitals can expect, with resulting increases in bad debt and uncompensated care.

Medicare eligibility is also narrowed, excluding many immigrants who previously qualified. OBBBA narrows eligibility to U.S. citizens, lawful permanent residents, COFA migrants,[1] and Cuban–Haitian entrants. Immigrants outside those categories will no longer qualify, though there is an 18-month transition period for current enrollees. Hospitals in states with larger immigrant populations may experience growing volumes of unreimbursed care, especially for older patients.

Rural Healthcare: Limited Relief

To offset some of these reductions, the bill creates a $50 billion Rural Healthcare Transformation Program to be distributed from 2026 to 2030. $10 billion will be distributed each fiscal year. While this investment is welcome, it is unlikely to fully counterbalance the projected $793 billion in Medicaid federal spending cuts and over $1 trillion in combined Medicaid and Marketplace spending reductions over the same period. For many rural hospitals already operating on thin margins, the fund may provide temporary relief but will not address the underlying structural losses.

Key Provisions at a Glance

The chart below consolidates the major healthcare provisions of OBBBA, their statutory or regulatory basis, and the likely impact on hospital systems.

Practical Considerations for Hospitals and Regulators

For hospital systems, the OBBBA presents both immediate operational challenges and long-term strategic risks. Compliance teams should begin preparing for semi-annual eligibility redeterminations and new reporting requirements, while finance departments model the impact of reduced Medicaid reimbursements and supplemental payments. Rural systems, in particular, should position themselves to compete for grants under the Rural Healthcare Transformation Program,

Provision	Statutory/ Regulatory Citation	Summary of Change	Anticipated Effect on Hospitals/Access
Medicaid Redeterminations	OBBBA § §71107(amending 42 U.S.C. § 1396a)	Semi-annual eligibility checks for expansion adults starting scheduled on or after December 31, 2026.	Increased administrative burden; coverage churn; more uncompensated care.
Community Engagement Requirements	OBBBA § 71119 (new subsection to 42 U.S.C. §1396a)	Able-bodied adults (19–64) must complete 80 hrs/month work or engagement; non-compliance leads to Medicaid loss and bar from Marketplace subsidies.	Coverage loss for vulnerable populations; ED utilization spikes.
Moratorium on Certain Medicaid/CHIP Rules	OBBBA §§71101, 71102, 71111	Freezes enforcement of (i) CMS 2024 Medicaid/CHIP eligibility/enrollment final rule, (ii) Medicare Savings Program final rule, and (iii) nursing home staffing rule until 9/30/2034.	Relief from costly staffing rules but delays in quality improvements.
Provider Tax Reductions	OBBBA § 71115 (amending 42 U.S.C. § 1396b(w))	Provider tax threshold caps phased down for expansion states from ~ 6% → 3.5% by 2032; via 5.5% (2028) → 5.0% (2029) → 4.5% (2030) → 4.0% (2031) → 3.5% (2032+).	Billions in lost state/federal match; revenue pressure on hospitals.
Limits on State-Directed Payments	OBBBA § 71116 (modifying 42 C.F.R. § 438.6(c))	Capped at 100% (expansion states) / 110% (non-expansion states), phased down 10 percentage points per year starting 1/1/2028	Safety-net hospitals lose supplemental funding streams.

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Medicaid Coverage for Immigrants	OBBBA § 71109 (amending 42 U.S.C. § 1396b)	Starting 10/1/2026, Narrows eligibility to citizens, Lawful Permanent Resident (LPRs), and narrow immigrant groups	Hospitals face unreimbursed costs for older immigrant populations.
Marketplace Eligibility Restrictions	OBBBA § 71303–71304 (ACA amendments); plus CMS 6/25/2025 rule	Statutory: stricter pre-enrollment verification (2027 tax years); bans income-only SEPs (2026 plan years). Regulatory: eliminated federal "<150% FPL" SEP	Fewer insured; higher uncompensated care and bad debt.
Medicare Immigrant Restrictions	OBBBA § 71201 (modifying 42 U.S.C. § 426)	Medicaid/CHIP limited to citizens, LPRs, COFA migrants, and Cuban-Haitian entrants (with limited CHIP/legal Immigrant Children's Health Improvement Act (ICHIA) carve-outs) starting Oct 1, 2026. Medicare eligibility likewise limited to citizens, LPRs, COFA, and Cuban-Haitian entrants, with	Loss of Medicare coverage for older immigrants → unreimbursed care burden.
Provision	**Statutory/ Regulatory Citation**	**Summary of Change**	**Anticipated Effect on Hospitals/Access**
		an 18-month transition for those currently enrolled.	
Rural Healthcare Transformation Fund	OBBBA §71401 (new CMS-administered grant program)	$50B ($10B/yr, FY 2026–2030) split between states & CMS discretion	Limited relief; competitive grants unlikely to offset Medicaid cuts fully.

while also engaging state policymakers to mitigate funding losses.

At the same time, system leaders should anticipate greater uncompensated care burdens and consider strategies to expand telehealth, direct primary care models, and patient financial assistance programs. For regulators, close coordination with CMS on waiver approvals and eligibility verification standards will be critical.

Conclusion

The One Big Beautiful Bill Act represents the most significant restructuring of healthcare financing in over a decade. While public debate has centered on coverage losses, the real story for hospitals lies in the regulatory details: new eligibility rules, reduced financing flexibility, and restricted supplemental payments. The result will likely be increased financial stress on hospitals—especially those serving low-income, rural, and immigrant communities. Hospital systems should act now to prepare for these changes, engage with policymakers, and adapt care models to safeguard access in a more constrained funding environment.

About the Authors:

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

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Jake Newcomb is a third-year law student at Rutgers Law School and a 2025 summer associate at Greenbaum, Rowe, Smith & Davis, LLP, whose time and effort in drafting this article are greatly appreciated.

[1] COFA migrants refer to individuals from the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau who have the right to live and work in the United States under the Compact of Free Association (COFA).

From Open Mics to Executive Leadership: Mike Allen's Journey of Courage Over Comfort

How music, authenticity, and the willingness to get uncomfortable have shaped one CFO's approach to leading in healthcare's most challenging era

By: Denny Henderson & Michael Mckeever

When Mike Allen steps onto a stage with his guitar, hands shaking slightly as he adjusts the microphone, he's deliberately putting himself in one of the most vulnerable positions imaginable. No backup band, no safety net—just him, his music, and an audience of strangers. It's terrifying. And that's exactly the point.

As CFO and President of Financial Services Division at Hackensack Meridian Health (HMH), Allen has built a leadership philosophy around what he calls "courage over comfort"—a concept borrowed from researcher Brené Brown but lived out in his own unique way. Whether he's stepping onto an open mic stage or stepping into his role leading financial operations for New Jersey's largest health system, Allen believes growth only happens when you're willing to get a little uncomfortable.

"I'm a believer you've got to make yourself uncomfortable to grow," Allen explains. "You've got to get out of your comfort zone. Now, that's different for everybody, but if you have aspirations to be in bigger and more impactful roles than whatever role you might have today, this courage over comfort idea is essential."

Mike Allen Performing at the Laundromat Networking Event

The Soundtrack of Leadership

Allen's journey to healthcare finance leadership began not in a boardroom, but in a house filled with music. Growing up, his mother played piano and organ, his grandfather played organ, and his parents always had music on. When they built a house in the mid-1960s, they installed something almost unheard of at the time: a closet with a turntable and receiver connected to speakers embedded in three different rooms throughout the house.

"Music was just around all the time," Allen recalls. While he learned guitar in high school, it wasn't until adulthood that music became central to his leadership development. "As I became an adult, music became more and more part of my life. With our work pressures and all the things in our everyday lives, it becomes a release. It's how I wind down or distract myself from all the things that feel like pressures in the world." But music serves a dual purpose in Allen's life. While it provides therapeutic release from the demands of leading financial operations for a $9 billion health system, it also became his training ground for discomfort. "I use music to make myself uncomfortable," he says, acknowledging the irony. "When you go play an open mic somewhere you've never done it before, you're just up on a stage with a microphone, trying to figure out how the speakers work, trying to get your hands to move right on the guitar and your voice to come out. There's no backup—you're just exposed."

This willingness to be vulnerable in public translated directly to his professional approach. Allen even brought his guitar to the HFMA national conference during his tenure as board chair, performing on stage despite his nervousness. His theme during that leadership role? "Dare You to Move"—borrowed from a Switchfoot song that embodies his philosophy of taking risks and getting up out of your comfort zone.

The Art of Difficult Conversations

Allen's courage-over-comfort philosophy becomes most crucial in one of leadership's hardest challenges: having honest conversations with team members about their performance. Throughout his 35-year career in healthcare finance, including

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Tackling DRG Downgrades: A Strategic Defense Against Healthcare's Silent Revenue Killer

Meghan Mackenzie

By: Meghan Mackenzie, MBA, BSN, RN, CCM, Tracey Flowers, CCS, & Charlotte Hadland, JD

Tracey Flowers

Charlotte Hadland

The Hidden Revenue Crisis

Hackensack Meridian Health (HMH), like many healthcare providers across the country, is facing a substantial rise in diagnosis-related group (DRG) downgrades[1]. This growing challenge presents considerable financial and operational pressures for providers who are already managing narrow profit margins.

A DRG downgrade occurs when a DRG classification—initially assigned by the provider based on the diagnosis—is subsequently reduced by the payer, resulting in lower reimbursement than originally anticipated. DRG systems categorize patients with similar clinical conditions to determine appropriate payment levels, with more complex cases associated with higher reimbursement rates.

The Paradox of "Appropriate Care, Denied Payment"

Retrospective clinical validation audits have become a tactic increasingly employed by payers to reduce or deny provider payments. These audits allow payers to retroactively question physician diagnoses based solely on documentation review, with Medicare Advantage plans being particularly aggressive compared to traditional Medicare[2].

Consider this scenario: A physician diagnoses sepsis based on clinical expertise and direct patient evaluation. The patient receives appropriate treatment, and coders assign the corresponding diagnosis code. However, weeks later, a payer reviewer who never examined the patient determines the sepsis diagnosis wasn't "clinically valid" and downgrades the DRG.

One healthcare leader noted that a major Florida payer's medical director agreed the provider's sepsis treatment was absolutely correct, but the payer still refused to pay for that diagnosis[3].

This creates legal and ethical dilemmas. Per the American Hospital Association, American Medical Association and federal guidelines, physicians and hospitals follow different coding rules than payors. Provider coding guidelines require billing all diagnoses that affect or could affect the patient during their stay, while payors focus on cutting costs associated with perceived overbilling.

Strategic Partnership Delivers Actionable Results

HMH's partnership with Aspirion addresses the administrative challenges of claims appeals through access to national claims data and specialized expertise. The collaboration utilizes Aspirion's database of frequently disputed diagnosis codes across major payers, including conditions like sepsis, acute respiratory failure, metabolic encephalopathy, and acute kidney failure (See Tables 1 & 2). Through this arrangement, HMH transfers complex appeals cases to Aspirion's team of attorneys and clinicians supported by proprietary artificial intelligence. The partnership provides HMH with insights into payer-specific denial patterns and industry trends, helping identify potentially problematic claims and understand evolving payer behaviors across different diagnosis codes and insurance companies.

Understanding the Financial Impact

The financial impact extends beyond immediate revenue reduction. For many health systems, the cumulative impact can reach millions of dollars annually. Staff must dedicate significant time to preparing appeals—often spending hours on a single

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case—while administrative costs increase and payment delays affect cash flow.

One of the hardest elements is capturing downgrades quickly. Downgraded claims rarely contain clear indicators that an audit has taken place, making it difficult to ascertain the code at issue without detailed audit letters.

Building Your Defense Strategy

At HMH, we have experienced firsthand the growing challenge of DRG downgrades. Through our partnership with Aspirion and others, we now have a comprehensive approach to combat this revenue threat. To combat rising denials, HMH has collaborated with medical executives as well as clinical documentation improvement (CDI) and coding teams in standardizing clinical definitions. We developed clear, internal clinical guidelines for frequently denied diagnoses and created targeted education for our physicians and clinical staff, improving both coding accuracy and the clarity of patient records. Our focus is implementing several proactive strategies to address DRG downgrades through data-driven approaches, such as:

Enhanced Contract Negotiations: Historical downgrade data is analyzed before contract renewals. We establish protective language with clear terminology regarding DRG classifications, negotiate penalties for unjustified downgrades and set procedural boundaries for chart requests and review quantities. In fact, one of the most useful contract policies is not allowing medical record requests on all claims, instead limiting them to a smaller percentage for retroactive review.

Process Optimization: We've implemented integrated audit workflows and electronic submission systems for medical documentation. Our teams proactively attach supporting documentation for diagnoses known to trigger downgrades, taking a careful look at heavily scrutinized diagnosis codes and tagging accounts for review before billing. Aspirion provides feedback on DXs or DRGs, such as a recent project on D62 for Horizon NJ Blue Cross Blue Shield, which our coding team found helpful.

Legal and Regulatory Developments

We closely monitor regulatory developments that may impact DRG downgrade practices. California's "Physicians Make Decisions Act," effective January 1, 2025, limits AI use by health insurers and requires review by healthcare providers, potentially decreasing retrospective reviews. Additionally, the pending lawsuit against Cigna regarding their AI-powered algorithm argues it violates ERISA fiduciary duties, with implications that could affect industry practices.

Implementation Lessons Learned

Through our experience, we have learned that each organization must assess how much time and effort is worthwhile for these denials based on expected returns. This depends on organizational size and requires evaluating case strength and likelihood of success. Tracking and measuring at the single account level becomes crucial.

While some organizations pursue external appeals with limited success, we have found that our strategic partnership with Aspirion has improved outcomes. It's particularly worthwhile with strong cases, especially when peers see similar denial types.

Future Outlook

As DRG downgrades continue to increase across the healthcare landscape, HMH remains committed to protecting our revenue and ensuring fair reimbursement for the care we provide. Our multifaceted approach, combining data intelligence, strengthened contracts, optimized processes, and strategic technology partnerships, has proven effective in combating this challenge.

Historically, providers may have accepted these denials because they were rare and complicated. With increasing numbers, healthcare organizations are realizing they need to take a stand, educate themselves on best practices, and find protection against DRG downgrades. Our partnership with Aspirion exemplifies how strategic vendor relationships can amplify internal capabilities and improve outcomes.

The era of simply accepting complex denials as inevitable is over. Healthcare organizations must take a stand, educate themselves on best practices, and implement comprehensive strategies to protect against DRG downgrades. Both Hackensack Meridian Health and Aspirion are committed to leading this effort and sharing our experiences to help other providers succeed in this challenging environment.

References:

[1] *"Healthcare providers seeing more diagnosis-related group downgrades and ghost denials," Healthcare*

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How Hospitals Can Safeguard 340B Program Eligibility

Karl Rebay

Jesse Vo

By: Karl Rebay and Jesse Vo

Hospitals and health systems across the country are grappling with changes in Medicaid eligibility brought on by recent industry shifts, including regulatory changes, the end of the public health emergency (PHE), Medicaid redetermination, and the halt of continuous enrollment.

These seismic shifts have created a significant financial crisis for many health organizations: the loss of 340B Drug Pricing Program (340B) eligibility and access to beneficial drug pricing under the 340B program.

The 340B loss is costing organizations tens-of-millions of dollars in savings—for larger systems it can be in the hundreds of millions of dollars, annually. Health systems already suffering negative or thin margins can face bankruptcy.

Safeguard access to 340B pricing—as well as solve other challenges—with the following insights into actionable strategies.

Background

Many safety-net health care organizations rely on savings generated from participation in the 340B program to stretch federal funding and other resources, reach more eligible patients, and provide more comprehensive services to their communities.

For hospitals, the ability to access the beneficial 340B drug pricing is based on the Medicare DSH calculation comprised of the ratio of inpatient services provided to Medicaid patients as compared to all patients, and the latest available Social Security Income (SSI) ratio comparing the patients at the hospital who are Medicare Part A or C and SSI eligible compared to all Medicare Part A and C eligible patients treated in the hospital. To be eligible for the 340B Drug Pricing Program, a hospital must meet a certain DSH patient percentage threshold. The specific threshold for eligibility is to be greater than 11.75% with the exception of hospitals classified as sole community or a rural referral center. Sole community or rural referral center hospital classes have a DSH percentage threshold of 8.00% to qualify for 340B with the incentive to have DSH percentage greater than 11.75% for orphan drug discounts.

This means that a hospital must have a minimum of 8.00% or above 11.75% of its patient population coming from low-income or Medicaid-eligible individuals—which is reflected in the DSH calculation—to participate in the 340B program based on the hospital classification.

Some hospitals, such as children's hospitals and freestanding cancer hospitals, may have different requirements or may be exempt from this threshold if they meet other eligibility criteria.

Reimbursement Strategy

340B qualification is determined by the latest filed CMS 2552 Medicare cost report, which is a summary of the hospital's yearly financial activity. The hospital has five months after the close of the fiscal year to submit the cost report and alert the Health Resources and Services Administration (HRSA) of its 340B eligibility status. By the time the hospital submits this cost report, it can be too late to initiate actions that result in a qualifying DSH percentage.

The savings afforded by qualifying for the 340B program have such a large impact that any uncertainty year to year can create a tremendous financial burden. Understanding in real time the multiple factors that contribute to the qualifying Medicare DSH percentage allows management to anticipate how current calculations and decisions can affect the hospital for years to come.

The following are short- and long-term initiatives that can help hospitals increase their DSH percentage.

- Use real time Medicaid eligibility matching on an interim basis to get a sense of your DSH percentage before the fiscal year ends
- Research and understanding Medicaid programs and

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insurances in your state and bordering states to leverage the population included in the numerator of the DSH calculation
- Isolate and review individual portions of the Medicare DSH calculation, such as Medicaid days, total acute inpatient days, and SSI fraction
- Work with a vendor or create external outreach and community programs at the hospital to help patients who may qualify for Medicaid complete the application process.
- Perform analysis of high Medicaid utilization exempt units to determine if 340B savings outweigh the current reimbursement mechanisms
- Perform mileage analysis as a health system to determine potential relicensing of units to other health system providers to maximize reporting for the Medicare DSH calculation
- Analyze the population of Medicare eligible patients and Medicare eligible SSI entitled patients as a predictor for SSI fraction used in the Medicare DSH calculation in future years; the SSI fraction is on a two-year delay from the latest published year to the calendar year

Service Line Strategy

In addition to reimbursement-focused tactics, hospitals should evaluate broader operational levers—particularly through service line strategy—to safeguard 340B eligibility. Service lines are specialty-specific subdivisions of health care that are organized around types of clinical service, such as cardiovascular, orthopedics, and labor and delivery. Service line strategy involves the development or refinement of specialty care delivery within the acute setting, coordinated with ambulatory care in a way that's organized, efficient, and drives high quality and physician and patient satisfaction, thereby increasing marketability and attracting more patients. Increasing effectiveness involves developing processes and structures that foster high-quality, efficient care supported by dedicated administrative capabilities. From a conceptual standpoint it's quite simple. From a practical standpoint, success can be extremely elusive.

Proven tactics that can have a positive impact include:
- Analysis to identify and study the root causes of challenges and the impact of levers that can improve operations that impact qualification
- Organization of modalities in a logical manner that harnesses specialty knowledge and experience
- Coordination with pre- and post-acute providers, such as physicians, physician groups, ancillary service providers, social service agencies, to develop an organized and thoughtful approach to care and effectuate care transitions
- In-house clinical processes that move patients through their care episode as effectively and efficiently as possible starting with intake including the emergency room, and hyper-effective discharge planning (throughput)
- Business processes that facilitate functions, such as care coordination, administrative components of care episodes
- Connectivity between the inpatient and ambulatory ecosystems that prioritizes effective treatment of patients, organized around service lines
- Structural and licensing considerations to logically leverage opportunity
- Strategy that drives growth and market share

The chassis design must incorporate all the above to have meaningful and lasting impact.

Once the basic framework is developed, an approach can be customized to prioritize whatever is most important. If financial losses are significant enough, a complete system overhaul might be the answer. If the loss or potential loss of 340B pricing is going to be a big problem, focusing on those areas that drive Medicaid volumes may be the priority.

Again, this isn't a simple challenge to overcome, but the environmental reality is giving leaders minimal options. It's either to adopt strategies that support 340B participation, barely muddle along, or experience severe financial hardship.

Organizations who are struggling with 340B or have declining ratios approaching the qualification thresholds need to act now as operational mitigation strategies take time to implement and generate results.

About the author

Karl Rebay has over 25 years of experience in the health care industry and is a leader with the Baker Tilly health care consulting team. He's focused on providing high-impact health care advisory services to help the firm's industry clients navigate and succeed in the rapidly evolving national health care landscape. His clients include health systems, hospitals, health plans, long-term care organizations, and IPAs, among others. Karl can be reached at ***karl.rebay@bakertilly.com****.*

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. Jesse can be reached at ***jesse.vo@bakertilly.com.***

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28 years as a CFO, he's encountered countless situations where previous leaders had avoided difficult but necessary conversations with staff.

"I've inherited someone who had been in an organization for 27, 28 years, and no one had ever leveled with him," Allen shares. "Everyone around the organization was somewhat critical of his approach and work ethic, but no one had really been honest with him. I couldn't let that go on—it wasn't right for the organization, and it wasn't good for him."

These conversations require tremendous courage, but Allen has found they succeed about eight out of ten times. "Usually, far more often than not, the person ends up picking themselves up and making positive progress after that," he explains. "Alternately, they're stuck where they are, and they end up having to move into another role. But not having that conversation isn't okay."

The key, according to Allen, is authenticity and genuine care for both the individual and the organization. "I try to think about what's best for the individual and the organization. In most cases, when you have these hard conversations, it's more about how they just haven't been positioned well, or that no one's leveled with them. Once they know, most people respond well to that."

Building Environments Where People Thrive

Allen's leadership approach extends far beyond difficult conversations to creating environments where talented people can flourish. His philosophy is refreshingly straightforward: hire people smarter than yourself, give them meaningful work, and get out of their way.

"I've never, ever in my career subscribed to the idea that I didn't want somebody more talented than myself working for me," Allen states. "I'm not the smartest person in the room, and I can't be expert at everything. I want really talented people on my teams, and I want them to do well."

This abundance mindset—believing the pie is big enough for everyone—has served him well throughout his career. When identifying talent, Allen looks for a balance of IQ and EQ, with emotional intelligence often taking precedence. "In our complex matrix of work nowadays, you've got to understand what motivates people, how to get people on board, how to bring people along. You have to understand the politics of how things happen in any organization."

Critical thinking ranks high on Allen's list of essential skills, something he defines through the lens of lean methodology's "five whys." Rather than accepting surface-level explanations, he pushes his team to dig deeper. "It's easy to have a quick pat answer for everything," he explains. "In healthcare, we might say 'we missed budget because it's flu season.' But was the flu actually up? Did we look at the CDC data? Today, with the tools and data we have, we can actually find what's closer to the real answer."

Leading in Today's Complex Healthcare Environment

As CFO of HMH, Allen oversees financial operations for an integrated health system with more than $9 billion in annual revenue and $12 billion in assets, including academic medical centers, a school of medicine, and research divisions. His focus extends beyond traditional CFO responsibilities to include actively leading the integration of financial and strategic planning, modernizing analytics platforms, and participating in partnership and M&A activities.

Allen sees his role as helping mature the financial systems and processes so the organization can focus on strategic work rather than fighting daily fires. "We want the daily things of the organization to run well and on time so we can pay attention to the strategic work that leads to the next generation of what this organization could become."

This perspective reflects his broader view of healthcare finance's mission. "We don't deliver care," Allen tells his finance team. "Supporting our physicians, nurses, and other healthcare professionals is the most important thing we're doing—they take care of patients. But without what we do, they couldn't do their job either. Our roles are critical and important."

The Courage to Keep Moving

Allen's career has been marked by strategic moves that required leaving comfortable situations for new challenges. After nine years at OSF Healthcare, where he had built a strong team and successful finance function, he recognized the signs that it was time for change.

"I can start to feel when I'm getting a little bored or complacent," Allen admits. "I felt like my team was ready to go on their own without me, and I had done most of what I could have done. I also felt like they weren't going to get an opportunity to step up if I didn't step out."

His move to New Jersey—from the Midwest where he'd spent his entire career—embodied his courage-over-comfort philosophy. "Moving to the East Coast meant a different culture, a new health system, new people to work with, a new board, a new level of traffic, a new level of anxious drivers," he laughs. "I've been here six months, and there have been times it's been really uncomfortable and uneasy. But that's where your potential growth lies."

For healthcare finance professionals considering their own career moves, Allen offers this perspective: "After somewhere past the five to seven-year mark, you should be getting mature in your role. That's different for every situation and organization, but at some point, it's healthy to let somebody

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else put fresh eyes on it."

A Legacy of Making a Difference

Throughout his career, Allen has remained connected to his deeper purpose in healthcare finance. Whether ensuring payroll runs smoothly so caregivers can focus on patients, or creating environments where team members can reach their potential, he sees his work as fundamentally about making a difference.

"In the end, we all want to make a difference in what we do," Allen reflects. "We spend most of our lives at work, and we all want to feel we've done something positive for the organization, for ourselves, for our families, for the people who depend on our care. When you walk away thinking you've made an impact and feel good about that—that's a career well-served."

His advice for emerging leaders centers on the willingness to push beyond perceived boundaries. "Often, particularly early in careers, people think smaller about what they could do and accomplish than they actually can. Once people start believing, everything becomes possible."

As Allen continues to lead HMH's financial operations through healthcare's evolving landscape, he carries forward the same philosophy that took him from nervous open mic performances to executive leadership: the courage to move, to be uncomfortable, and to dare others to do the same. In a profession that demands both technical expertise and human connection, perhaps that's exactly the kind of leadership healthcare needs.

Sidebar: Mike Allen's Leadership Principles

Courage Over Comfort

- Growth happens outside your comfort zone
- Take calculated risks and expect some failures
- Use discomfort as a signal for potential growth

Authenticity in Action

- Be open, vulnerable, and real with your team
- Address performance issues directly but with care
- Assume best intentions while holding people accountable

Building Talent

- Hire people smarter than yourself
- Focus on EQ as much as IQ
- Give meaningful work and get out of the way

Critical Thinking

- Use the "five whys" to dig deeper than surface answers
- Leverage data and analytics to find real solutions
- Question easy explanations and pat answers

Making a Difference

- Remember that finance enables patient care
- Create environments where people can thrive
- Leave organizations better than you found them

About the authors

Mike Allen was interviewed by Denny Henderson, FHFMA, from FairCode and Mike McKeever, FHFMA, CPA, retired, and was written with assistance from Claude, an AI assistant built by Anthropic.

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Financial Management Association, May 30, 2023

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About the authors

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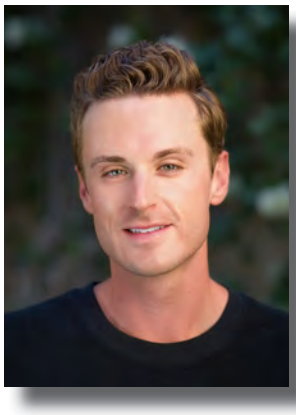
Charlotte Hadland serves as Director and Managing Attorney of Denials at Aspirion. With over a decade at Aspirion, she has successfully appealed thousands of claims nationwide, collaborating closely with provider partners to ensure the overturn of wrongful denials. Charlotte holds a B.S. in Biological Science and a Juris Doctorate from Florida State University. She can be reached at: ***charlotte.hadland@aspirion.com****.*

Expected Reimbursement: Maslow's Hierarchy of Revenue Cycle Needs



Matthew Thomas

By: Matthew Thomas

Maslow's 'Hierarchy of Needs' outlines a pyramid of requirements that are essential to meet self-actualization – or to put it simply, the ability to be one's best self. At the base of the pyramid are the *physiological essentials* for living – food, water, shelter. The second layer, physical and social security. Third, social acceptance. Fourth, *internal and external respect*. Only once each is achieved may one ascend to the next tier – ending with full potential realization.

While healthcare in Maslow's time certainly looked different than healthcare in our world, the same principles can be applied to the modern revenue cycle. We are often dazzled by business intelligence dashboards, RPA, artificial intelligence, and the latest patient accounting system bolt-on, but what many fail to do is to evaluate whether the foundational elements are in place for revenue cycle self-actualization to be achieved.

At the base of the revenue cycle pyramid is an often-overlooked and underappreciated core competency – expected reimbursement. While executives recognize its importance, expected reimbursement is often not prioritized or leveraged to its full potential – leaving what Maslow may have called an "unstable foundation".

OUR PERSPECTIVE

Accurate Expected Reimbursement is challenging to establish and even more challenging to maintain. Never-ending changes to agreements, amendments, fee schedules, payer policies, and new plans entering the marketplace make for an incredibly demanding environment ripe for error. However, investment in this base level of the pyramid is essential to a streamlined revenue cycle.

BENEFITS

When utilized effectively, Expected Reimbursement will drive an efficient revenue cycle through encouraging productive touches, reducing vendor spend, and fostering process improvement. Furthermore, it can serve as a unifying metric for revenue cycle, finance, and contracting for AR valuation, vendor management, and contract negotiation.

Drive Productive Workflow

The most apparent benefit to trustworthy Expected Reimbursement is a productive workflow. When revenue cycle teams are faced with inaccurate Expected Reimbursement, unproductive account touches are at an all-time high – working accounts that don't warrant additional revenue, pursuing payors for incorrect rates, and being burdened by posting manual contractuals on false underpayments and credit balances can be detrimental to a team's effectiveness. Resolving false variances through correcting contract management logic will immediately impact cash acceleration as work queue volumes decrease and teams can value/prioritize accounts effectively.

Leverage Automation

In many modern patient accounting systems, Expected Reimbursement can unlock powerful automation capabilities that reduce manual intervention and streamline operations. For example, late charge billing can be automated to trigger only when reimbursement increases exceed a defined threshold – eliminating unnecessary touches and focusing staff efforts where they matter most. Additionally, in some systems, Expected Reimbursement directly feeds front-end patient estimates. The more reliable the reimbursement logic, the more trustworthy the patient estimates will be to ultimately drive improved point-of-service collections and patient financial transparency.

Increase Accountability

Expected Reimbursement isn't just a financial tool – it's a powerful mechanism for driving accountability across the revenue cycle ecosystem. When leveraged effectively, it becomes the shared source of truth for Finance, Contracting, and Revenue Cycle teams, aligning internal operations around a unified view of anticipated revenue. It also empowers health systems to hold external vendors accountable by measuring performance against accurate reimbursement expectations, ensuring that outsourced efforts are both efficient and

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justified. Additionally, Expected Reimbursement can feed real-time payer performance dashboards, providing visibility into whether negotiated rates are being realized and highlighting discrepancies that warrant attention. With all stakeholders operating from the same data foundation, transparency and accountability are no longer aspirational – they're operational.

Decrease Vendor Spend

Inaccurate Expected Reimbursement can have unexpected impacts to vendor spend. Investing in Expected Reimbursement can reduce vendor spend by eliminating common scenarios of revenue leakage. For example, zero-balance vendors collecting on underpayments internal revenue cycle teams did not see or understand– either because the rate wasn't programmed or because there was an error in the contract pricing logic. For those with outsourced AR vendors, contracts may include fees to manually adjust incorrect balances which could be automated through system actions or valuable vendor hours may be wasted working accounts that don't warrant additional reimbursement.

Improve Processes & Maximize Reimbursement

Retrospective reviews of Expected Reimbursement through standard variance reports can bring light to systemic issues such as inaccurate registration, faulty registration/coverage logic, billing edit errors, coding issues, denial/remark programming, contract interpretation and even payor behavior for contracting negotiations.

CHALLENGES

While the benefits of accurate Expected Reimbursement are substantial, achieving and sustaining it is no small feat. Health systems face a trifecta of challenges that must be addressed to unlock its full potential. Without addressing foundational challenges, the pyramid remains unstable and cannot support higher-level functions like automation, accountability, and strategic insight.

Subject Matter Expertise

Programming Expected Reimbursement requires a unique blend of skills that spans both technical, legal, and operational domains. It's not a task that can be owned solely by IT or Managed Care – instead, it demands professionals who understand contract language, reimbursement methodologies, system logic, and how decisions will impact revenue cycle workflows. These experts serve as the bridge between negotiated agreements, system configuration, and operational efficiency to ensure that reimbursement expectations are accurately translated into actionable logic. Without the right resources in place, even the most advanced systems will fall short of delivering reliable results.

Technology Limitations

Even industry-leading contract management systems have limitations. To counteract Expected Reimbursement system pricing limitations, workflows should be developed to provide education and safety-net processes to ensure revenue is accurately identified and quantified. Common technical limitations include coordination of benefits, interim claims, cost-based reimbursement, and unclassified drugs and biologicals. Creating stop-gaps for these shortcomings can help ensure underpaid revenue is captured before it goes to downstream vendors or is closed out in error.

Establishing Robust Controls

To ensure the integrity of Expected Reimbursement, health systems must implement both proactive and retrospective controls. Standardized variance reports should be reviewed regularly by cross-functional experts who understand contract logic, revenue cycle workflows, and payer agreements—feeding insights back into system updates and upstream process corrections. Additionally, a rigorous testing protocol must be in place before any new contract build or amendment goes live, with checks and balances designed to catch errors early. These controls not only safeguard accuracy but also reduce rework, accelerate productivity, and foster continuous improvement across the revenue cycle

OUR SUMMARY

We are often drawn to the latest innovations – business intelligence dashboards, RPA, and artificial intelligence. While there are incredible benefits to these tools, we urge you to first consider investing in your revenue cycle's hierarchy of needs.

Establishing and maintaining accurate Expected Reimbursement is at the base of the revenue cycle pyramid. It drives the second layer of workflow, informs the third layer of subject matter experts within finance, contracting, and revenue cycle, and lastly establishes a means of delivering the fourth layer – consistent feedback and process improvement.

With these pyramid layers in place, your revenue cycle can achieve self-actualization, too. Just as individuals cannot reach self-actualization without meeting basic needs, health systems cannot achieve peak revenue cycle performance without a solid foundation of Expected Reimbursement.

About the Author

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A Collaborative Approach to CDM Management and Revenue Integrity

By: Sarah L. Goodman, MBA, CHCAF, COC, CHRI, CCP, FCS

Sarah L. Goodman

This session, "A Collaborative Approach to CDM Management and Revenue Integrity," offers insight into best-practice strategies for maintaining an up-to-date and accurate charge description master (CDM) and promoting collaboration among CDM professionals, financial leadership, and external experts. In the ever-evolving healthcare landscape, and with numerous entities striving to do more with less, cooperation and alliance among key stakeholders is imperative to success.

Such efforts may include staying abreast of regulations, facilitating lines of communication, becoming familiar with system nuances, and developing a strategy for ongoing auditing and monitoring—engaging internal resources as well as contracting when necessary for additional expertise. Employing a team approach is highly recommended, where possible, not only to garner buy-in, but also to leverage the knowledge base of the team members and to remain proactive in the dynamic world of CDM maintenance and charge capture. Moreover, a CDM team can be invaluable to the institution's overall compliance plan.

Utilizing tools and resources that are available to facilitate the process should be encouraged, and if training is needed to maximize their use, that this be established as a priority. Time and time again, such tools are purchased and contracts renewed, but due to staff turnover, licensure and access constraints, or other logistics, they are not utilized to their fullest potential. A CDM team can prove useful here, as well, in drafting revenue integrity policies and procedures and for identifying gaps in the process.

Furthermore, understanding the relationship between cost reporting and UB-04 revenue coding for CDM services, in particular, is crucial. Cost-to-charge ratios (CCRs) are a critical metric that can define a hospital's financial viability. A CDM team can ensure markup policies make sense, minimize charge compression, and are reviewed in a timely fashion.

A collaborative approach has many advantages and relatively few, if any, disadvantages. At the very least, collaboration fosters a sense of community among CDM coordinators, ancillary managers, IT staff, coders, physicians, finance, reimbursement, cost reporting, compliance, outside vendors and consultants, and other key players. In this age of price transparency and budgetary restrictions, teamwork and sharing tips for addressing CDM challenges, utilizing resources, and promoting revenue integrity in the facility setting becomes the norm—integrated into every step along the way—with a brighter future on the horizon for all!

About the author

Sarah L. Goodman, MBA, CHCAF, COC, CHRI, CCP, FCS, President/CEO, SLG, Inc., Raleigh, NC, is a nationally known speaker and author on the charge description master, outpatient facility coding, and billing compliance, and has more than 35 years' experience in the healthcare industry. Ms. Goodman has been actively involved and held leadership roles in several professional organizations, including the AHCAE, AHIMA, APUS, NAHRI, and NCHFMA, to which she was recently appointed Awards Committee Member-At-Large. In March 2019, Ms. Goodman was awarded the HFMA Founders Medal of Honor, the highest honor bestowed by the HFMA for volunteer activities at the national, regional and/or chapter levels, and in early 2021, was selected as a new mentor/mentorship partner for the VA-DC HFMA Mentorship Program. Ms. Goodman can be reached at ***slgincconsulting@aol.com.***

CDM Shape-Up: Strengthening Charge Integrity, Avoiding Supply Denials, and Strategic Pricing for Supplies and Pharmacy

BreAnn Meadows

Govind Goyal

By: BreAnn Meadows & Govind Goyal

In today's healthcare environment, hospitals and health systems face increasing pressure to balance financial stability, compliance, and transparency. At the center of this effort is the Charge Description Master (CDM)—a foundational element of revenue integrity that drives billing accuracy, regulatory compliance, and defensible pricing.

A clean, accurate, and strategically managed CDM is essential. Errors or outdated codes can create vulnerabilities, leading to compliance risks, misaligned pricing, or unnecessary claim denials. With federal mandates requiring full price transparency, the state of an organization's CDM is now publicly visible, making accuracy not only a financial issue but also a matter of reputation and patient trust.

The CDM directly links clinical services and supplies to hospital revenue. Every entry must align with regulatory requirements and payer expectations while accurately reflecting the cost and value of the care provided. When the CDM is well maintained, it supports smooth charge capture, reduces compliance risk, and strengthens financial performance.

One of the most pressing challenges hospitals face involves supply and implant billing. Payers are increasingly requiring precise HCPCS code assignments to validate charges. Missing or misapplied codes often result in denials, delayed payments, and lost revenue. To mitigate this, healthcare organizations must adopt proactive strategies to maintain compliant supply CDMs, ensuring they can prevent denials and prevent costly revenue leakage.

Medical supply charges are a growing source of friction between providers and payers. In the past, our practices were to bill for supplies provided. Now, many insurers are denying claims where a 27X revenue code is billed without a corresponding HCPCS code. The result is a significant financial burden for providers, who must devote time and resources to appeal processes, major CDM clean-up of their supplies which can be voluminous or absorb revenue losses altogether.

Analyzing denial patterns can reveal underlying issues such as missing HCPCS codes, lack of supporting documentation, or misalignment between the CDM and payer policy. By pinpointing these root causes and updating your supply charging policy, providers can implement corrective action, reduce denials, and streamline reimbursement processes.

Strategic Pricing: Optimizing Revenue While Avoiding Denials

While maintaining a clean and compliant CDM is critical, hospitals must also adopt a strategic pricing approach to ensure they are not leaving revenue on the table. This is particularly important for supply and pharmacy items that may not have an associated HCPCS code but still generate significant revenue.

The first step in this process is to evaluate whether a HCPCS code can be feasibly assigned to the supply or pharmacy item. If a code exists and can be appropriately applied, this should be done to avoid denials and ensure proper reimbursement. However, if no HCPCS code is available or appropriate, hospitals must take a deeper look at the financial impact of these items.

By quantifying the net revenue impact of supply and pharmacy items without HCPCS codes, hospitals can make informed decisions about whether to deactivate these line items and shift the associated revenue into chargeable surgeries and procedures. This approach allows hospitals to avoid denials while still capturing the revenue they are entitled to for services rendered.

To maintain a defensible and standardized pricing strategy, hospitals should also focus on best practices in supply and pharmacy pricing. This includes:

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Workforce Strategies 2030+ Building with Stewardship and Legacy in Mind

Sandra Pinette

By: Sandra Pinette

What makes great organizations stand the test of time? Their teams! What does building bench strength have to do with healthcare organizational stewardship and legacy? What is the impact on building appropriate teams in critical areas for the long run?

Let's explore what workforce stewardship and legacy mean. Stewardship is by definition, "a practice committed to ethical value that embodies the responsible planning and management of resources." Legacy encompasses "the long-lasting impact of past events and actions." Healthcare, by its nature, is an industry built upon community, stewardship and legacy, going as far back as the foundational roots in the Hippocratic oath and has used by healthcare clinicians globally for centuries. At a high level, it emphasizes beneficence (doing good), non-maleficence (avoiding harm), confidentiality, and respect for life, colleagues and teachers. This does not simply apply to clinicians, but to all those in healthcare organizations and by extension, the communities they serve. So how do we connect this with stewardship, legacy and leaving our workforce in a better place than we found it?

Queue recent and current events impacting healthcare teams. We are dealing with shortages within certain markets and specialties due to an aging population (workforce and patients), increased acuity/demand for services, financial constraints, dwindling numbers of younger professionals entering the workforce, and the seismic consequences of COVID. This is evidenced in the most recent **US Labor Department Report which states the average age of healthcare workers is approximately 42 years old.** The pandemic compounded these issues and put a spotlight on mental health challenges of those in healthcare, such as burnout. "Quiet quitting" hit all industries and became the norm for several industries. Alternative staffing models (i.e. gig workers), remote solutions and increased flexibility were deployed to address pre and immediate post pandemic shortages.

Fast forward to today's environment and the lingering repercussions of COVID. According to a **Microsoft Work Index Report** in June 2025, "**the 9-5 workday is dead, and the infinite workday has replaced it.**" It states that, "**while the pandemic didn't create an out of hours culture, it made it more normal.**" Lines were blurred as employees worked remotely, juggling caregiving and other necessary activities. It does not appear that there will be a reset. The report showed that **US employees receive 50 work-related messages outside of standard business hours, 40 percent who are online at 6am review emails,** nearly **30 percent check emails after 10pm,** and **1 in 5 review work correspondence on weekends.** This has resulted in the trends such as "quiet cracking" and "revenge quitting."

While hard-to-fill open positions in healthcare continue, various industries are shedding jobs-technology, banking, retail, and manufacturing. A recent report in July 2025, from global outplacement and executive coaching firm Challenger, Gray & Christmas shows that the technology sector (the most effected from the list above) saw 89,251 layoffs so far in 2025, a 36% increase from the same period in 2024.

New technologies and financial constraints are creating a mercurial job market. Both have contributed to diminishing job opportunities for all career levels in multiple industries. Advanced technology and innovation have been double-edged swords for millennia in how work is performed and completed. Groundbreaking advancements have created drastic changes locally, nationally, and globally, revolutionizing how we live and work. Recall historical events like the industrial revolution, computing over the last 75 years, transportation, and now the various ideations of AI (generative, adaptive, ambient). Many in healthcare are being charged with leveraging evolving technologies like AI to see if it can strike a balance between creating efficiencies while ensuring that optimal levels of staff are maintained.

How then, with all the external factors of a diverse workforce demographic and urgency to utilize breakthrough technologies, do healthcare providers-attract, hire, and retain appropriate team members for the short- and long-term stewardship of their organizations and communities?

Other industries, along with healthcare, have been tackling the same concerns. I mentioned above the technology sector is taking big hits with layoffs and worker displacement this year. Several sources are pointing to AI as the culprit specifically, with early careerists/Gen Z. Additionally, industries like banking/financial services and retail are increasingly shifting due to emerging automation and digital platforms for their consumers.

Is there a path for those who have been in other industries (early, mid, senior) careerists to migrate into certain healthcare

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How Claim Denials Reveal Deeper Systemic Flaws: Turn Denials into Diagnostic Tools Not Just KPIs

Will Richter

Denials are more than just a financial nuisance — they're a red flag waving from deep within your operations.

By: Will Richter

According to AHA's 2025 Environmental Scan, nearly 15% of all claims submitted to private payers for reimbursement initially are denied — a staggering figure that highlights a persistent and costly challenge in the healthcare revenue cycle. The "why" in how this happens varies greatly among healthcare organizations. While it's easy to chalk this up to payers being difficult or overly bureaucratic (and sometimes, that can be true), that assumption often masks deeper issues. In reality, every denial is a data point signaling a process breakdown in your revenue cycle operation.

Instead of treating denials as isolated incidents to work and appeal, frame them as symptoms of underlying operational inefficiencies. By shifting to this perspective, healthcare leaders can transform denials management into a strategic opportunity for uncovering and resolving the root causes eroding revenue, performance, and the patient experience.

Diagnose Your Financial Health

Think of denials as an x-ray of your revenue cycle's health—they reveal the underlying issues that may be impacting your financial performance. Just like an x-ray provides a diagnostic snapshot to guide clinical decisions, denial data offers valuable insight into operational inefficiencies, compliance gaps, and process breakdowns. With this clarity, healthcare organizations can make informed, targeted decisions to correct course, develop an action plan, and strengthen their revenue integrity. However, identifying the issue is only the first step; unlike a simple diagnostic scan, resolving denials often requires a deeper dive into workflows, payer policies, and documentation practices. In our experience, four denial reasons consistently rise to the top as the most common culprits:

1. **Eligibility/verification:** Failure to accurately verify a patient's information, insurance coverage, and benefits before services are rendered can lead to claim denials, delayed payments, or patient billing disputes.
2. **Authorization hurdles:** When required prior authorizations are not obtained or have administrative issues surrounding them before services are provided, claims are often denied outright.
3. **Coding errors:** When incorrect or incomplete diagnosis or procedure codes are assigned to a claim, even if due to a change in payer policies, it can lead to denials, delayed payments, or potential compliance risks.
4. **Timely filing:** Front-end obstacles causing late claim submission risk automatic denials.

How can you identify these bottlenecks for your own healthcare organization? Let's start with these three steps:

1. **Track:** Identify your top five denial reasons by payer.
2. **Map:** Work inter-departmentally to trace those reasons to specific touchpoints in your organization's workflow. This will help you identify the true root cause(s). As you work through it may help to think of your labels as one of the following: people, process, or technology.
3. **Act:** Prioritize treating each "diagnosis" based on the financial impact and effort to resolve.

Strategies to Reduce Denied Claims

As we've identified, claim denials are as much a financial risk as an operational headache. Frequent denials can lead to cash flow issues and hinder net patient revenue, resulting in lost opportunities for growth.

The key, then, is not just fighting denials—but preventing them. To ensure your revenue cycle remains uninterrupted, it is essential to reduce the time and resources spent on appealing denials.

Here are several actionable strategies you can implement into your operation to combat the four most common types of denials we identified earlier:

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Preparing for the Impact of the One Big Beautiful Bill Act

Chad Mulvany

Koy Dever

By: Chad Mulvany & Koy Dever

On July 4, H.R. 1, commonly known as the One Big Beautiful Bill Act (OBBBA), was signed into law. The bill extends provisions of the Tax Cuts and Jobs Act of 2017 (TCJA) and enacts additional tax cuts, border security measures, and defense spending. It also includes significant cuts to Medicaid and health insurance exchange marketplaces as part of the offsets needed to pass the legislation via the reconciliation process.

The Congressional Budget Office (CBO) projects that the OBBBA will reduce Medicaid spending by more than $1 trillion over 10 years and exchange funding by an additional $200 billion. CBO also projects the bill will increase the uninsured rate by 17 million individuals by 2034. These projections are based on the impact of provisions that revise eligibility and enrollment requirements and limit funding mechanisms states use to support safety net providers.

How Should Healthcare Organizations Respond?

The financial impact of the OBBBA will be significant for organizations across the continuum of care. As organizations plan their response to the bill's changes, they should focus on five core capabilities necessary to thrive in the current environment. Below, we explore important considerations related to each capability.

Financial Discipline: Generating the margins necessary to thrive by securing and maintaining market relevance. Key considerations include:

- **Cost Structure Efficiency:** Continue to seek performance improvement opportunities in labor and non-labor cost areas. Important focus areas include workforce productivity and supply chain.
- **Negotiated Managed Care Rates:** Utilize publicly available price transparency data to benchmark negotiated rates relative to competitors to understand and pursue rate improvement opportunities.
- **Revenue Cycle Excellence:** In addition to reducing denials and leakage to realize contracted rates, organizations should evaluate patient collections strategies and help connect individuals who lose Medicaid eligibility with other sources of coverage or financial assistance for those who qualify.

Strategic Agility: Calibrating strategic direction as conditions demand and opportunities present. Key considerations include:

- **Increased Focus on Strategic Planning:** Given increased uncertainty and risk of payment cuts, executives should dedicate more time to strategic planning and execution. This will support the continued alignment of activities and investments with the organization's goals and objectives. For example, organizations may consider creating a process for reviewing proposed expense reduction efforts, so they don't detract from investments necessary to achieve strategic goals.

Aligned Growth: Pursuing strategic investments, integration activity, and partnerships across the healthcare value chain. Key considerations include:

- **Integration Opportunities:** Particularly for organizations with strong balance sheets, passage of the OBBBA will create opportunities to integrate with other organizations seeking the scale necessary to continue serving their communities. Organizations should consider proactively creating a framework to evaluate potential integration opportunities to determine if they support aligned growth strategies.

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1. **Eligibility/verification:** Use automated tools to verify insurance coverage and benefits before the patient arrives, reducing the risk of coverage-related denials.
2. **Missing authorization:** Create a centralized, current payer-specific authorization guide to help staff understand which services require authorization based on payer rules, preventing missed requirements.
3. **Coding errors:** Invest in coder training and continuing education. Additionally, use coding software with built-in compliance checks to catch common errors or inconsistencies before claims are submitted.
4. **Timely filing:** Standardize internal workflows with defined timeframes for claim processing. Establish clear timelines from date of service to claim submission to prevent delays and missed filing windows.

By diagnosing the root cause of your most common claim denials and delays and implementing effective prevention strategies, your organization can reduce denials, recover more insurance revenue and enhance long-term financial stability. A revenue cycle partner can help you go beyond basic denials management – helping you prevent avoidable denials, accelerate appeals, and recover reimbursement that might otherwise be written off.

About the Author:

Will Richter is the EVP of Client Experience at Revco Solutions. His career history includes complex claims work at an attorney-based RCM firm and strategic roles at Regence BCBS, giving him a unique perspective on both payer and provider dynamics. Will can be reached ***will.richter@wakeassoc.com.***

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Regulatory Excellence: Understanding the rapidly evolving regulatory environment and acting strategically within it. Key considerations include:

- **Traditional Medicare:** Given the anticipated loss of Medicaid coverage and increase in the uninsured, hospitals need to capture all Medicaid days for DSH and 340B eligibility (if applicable). Hospitals with access to the 340B program may need to consider additional strategies to remain eligible. Hospitals should also explore strategies to help capture additional allowable Medicare bad debt, optimize their wage index, and expand access to IME/GME funding.
- **Medicare Advantage (MA):** Given the revenue cycle challenges providers are experiencing, organizations should review their portfolio of MA contracts to determine if the relationships continue to meet their strategic objectives.

Talent Optimization: Building exceptional teams and equipping them to succeed in executing mission-aligned business and care delivery models. Key considerations include:

- **Workforce Alignment:** Organizations should focus on aligning their workforce with their care delivery models. This is particularly true of the physician enterprise. Many organizations have opportunities to better align compensation and staffing with their overarching strategic objectives to improve care delivery and outcomes. Developing and strengthening clinically integrated networks (CINs) can help improve coordination and efficiency.

These core capabilities will help providers not only respond to the impact of the OBBBA but also navigate change and ambiguity amid evolving federal policies and congressional legislation in the months and years to come. Ultimately, this will allow them to more effectively deliver on their mission of achieving health for the communities they serve.

Note: A version of this article originally appeared on forvismazars.us.

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Koy Dever is a managing director at Forvis Mazars and industry leader of the Healthcare Practice for the firm's New York office. She has more than 20 years of experience assisting clients with Medicaid, Medicare, Medicare Advantage, and Medicaid managed long-term care reimbursement and regulatory issues. She also assists with strategic planning considerations and finance department education and support. Koy can be reached at ***Koy.Dever@us.forvismazars.com.***

The IPPS Final Rule and the Importance of Provider Implementation

Christina Brown

By: Christina Brown

The Medicare FY2026 IPPS Final Rule, released July 31, 2025, introduces several critical updates for hospitals, making proactive provider engagement essential to safeguarding financial health and compliance.

Key Financial and Operational Impacts

The FY2026 IPPS Final Rule spans more than 2,000 pages, detailing changes with potentially significant financial repercussions for providers. Hospitals must carefully evaluate these annual modifications to determine how they affect reimbursement rates, operational processes, and compliance requirements.

- **Rate Adjustments:** This year's rule increases the base payment rate by 2.6% over FFY2025. Providers should assess the impact on annual budgets and revenue analyses.
- **Wage Index Revision:** CMS will terminate the Low Wage Index Hospital Policy, a change that could affect hospitals previously benefiting from this adjustment. Finance teams should review wage index transitions and budget implications.
- **Disproportionate Share/Uncompensated Care:** With a $2 billion increase to overall DSH payments and Factor 3 calculation updates, eligible hospitals should closely examine changes to ensure accurate cost reporting and maximize reimbursement.
- **Program Enhancements:** Updates affect the Readmission Reduction Program, Value-Based Incentive Payments, and HAC Reduction Program. Of note, the Transforming Episode Accountability Model introduces bundled payments for surgical procedures beginning January 1, 2026, requiring operational preparation.

Provider Strategy and Implementation

Hospitals vary in type, location, and program eligibility, so tailored analysis of the IPPS Final Rule is vital. Key stakeholder teams must promptly evaluate rule details to identify areas requiring strategic response. Some examples would include:

- DSH-qualified hospitals should closely track the cost report years relevant to calculations for Factor 3 and review the applicable portion of the pool amount.
- Hospitals affected by the discontinued Low Wage Index Policy need to plan for operational and financial transition.

Summary for Financial Leadership

Timely, detailed examination of the IPPS Final Rule positions hospitals to pursue operational optimization and financial performance. Finance leaders should coordinate cross-functional reviews, prepare for program updates, and ensure compliance with new CMS requirements. Every annual release challenges providers to adapt rapidly: whether responding to new reimbursement structures or evolving program rules, comprehensive analysis is essential for fiscal stability and compliance. Hospitals that prioritize understanding and implementing regulatory updates will better withstand financial pressures and continue achieving mission-critical goals.

About the Author

Christina Brown is the Vice President of Reimbursement Services at BESLER, where she leads the Reimbursement Services team and plays an active role in BESLER's reimbursement software development. Prior to BESLER she worked for multiple large hospital chain organizations on the east coast where she gained valuable provider insight working through all aspects of the cost report, as well as budgeting and net revenue analysis. Christina can be reached at ***cbrown@besler.com.***

Intentional and Strategic Outsourcing and Automation: A New Era of Revenue Cycle Management

Renee Mary Stephens

Pavani Munjuluri

By: Renee Mary Stephens & Pavani Munjuluri

Healthcare organizations across the country — from small regional hospitals to large physician groups — are facing a difficult truth. Denial rates are climbing, payer rules are changing faster than staff can keep up, and administrative costs continue to rise. At the same time, staffing shortages are stretching teams thin. Many organizations are realizing that the traditional playbook — hiring more billers or plugging in one-off automation tools — no longer works.

What's needed now is a more intentional, strategic approach: outsourcing and automation working hand in hand, guided by clear goals and measurable outcomes.

When Outsourcing Becomes Strategic

For years, outsourcing in revenue cycle management (RCM) was treated as a stopgap — a way to handle overflow work, cover staff shortages, or reduce costs. But when done with intent, outsourcing can transform an organization's financial health.

Consider the case of a large physician group with over 80 providers. Their front-desk staff were spending hours every day calling payers and navigating online portals to verify insurance eligibility. Despite their effort, mistakes slipped through, leading to denied claims and frustrated patients. Instead of hiring additional staff, the group chose to outsource eligibility verification to a partner that used both skilled staff and automation. Within six months, eligibility-related denials dropped by 22%, front-office staff reclaimed 15 hours a week, and patient scheduling ran more smoothly.

Industry-wide, the need for these strategies is clear. Studies show that hospitals and physician groups lose between $262 billion and $420 billion annually due to inefficiencies in the revenue cycle. Meanwhile, staffing shortages remain persistent, with revenue cycle teams reporting turnover rates exceeding 25% in some regions. For many organizations, outsourcing is no longer about cost savings — it's about survival.

Beyond Bots: The Role of Automation - Multi-Agent AI: A Smarter Model for Automation

While hospitals and physician groups have struggled with staffing shortages, rising denial rates, and growing administrative complexity, automation itself has matured far beyond simple bots. Through the ongoing collaboration of AI and automation start-ups with forward-thinking hospital executives, physician group leaders, and revenue cycle professionals, these technologies are delivering real results.

What makes today's solutions different is that AI is no longer just rule based. By leveraging various aspects of Artificial intelligence (AI), robotic process automation (RPA), and machine learning, it is learning the nuances of payer behavior, coding variations, and clinical documentation patterns. It has become more nimble, able to adapt to shifting policies and payer requirements in ways that static automation never could. In doing so, AI isn't just filling gaps; it is actively helping the healthcare industry evolve, offering organizations a smarter, more resilient way to manage complexity at scale.

At CognitiveHealth, we advocate for multi-agent AI platforms that orchestrate the entire RCM workflow — not just pieces of it.

- Cash Posting: Automated posting improves speed and accuracy.
- Denials Management: AI identifies root causes, proposes remediation, and accelerates appeals.
- Correspondence Handling: Payer communications are intelligently routed and resolved.

This integrated approach delivers measurable results:

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1. Regularly Updating Charge Capture Policies: Ensure that charge capture policies are reviewed and updated regularly to reflect changes in payer requirements and industry standards. This includes updating HCPCS code assignments, revenue codes, and charge descriptions.
2. Standardizing Cost Markups: Implement a standardized approach to cost markup that is defensible and aligned with industry benchmarks. This helps ensure that pricing is consistent across the organization and reduces the risk of payer pushback.
3. Conducting Regular CDM Audits: Perform regular audits of the CDM to identify and address issues such as missing HCPCS codes, outdated pricing, or misaligned charge capture policies. This proactive approach can help prevent denials and ensure compliance.
4. Collaborating with Clinical Teams: Work closely with clinical teams to understand the cost and value of supplies and pharmacy items. This collaboration can help ensure that pricing accurately reflects the cost of care while also supporting clinical decision-making.

By adopting these best practices and taking a strategic approach to pricing, hospitals can strengthen their revenue integrity, reduce denials, and ensure they are capturing the full value of the care they provide.

About the authors

BreAnn Meadows, FHFMA, is President of Panacea's Revenue Integrity Services Division, where she leads nationwide initiatives in chargemaster optimization, patient advocacy, and compliance solutions for hospitals and health systems. With over 25 years of executive experience spanning hospital leadership and consulting, she brings deep expertise in healthcare finance and revenue cycle strategy. A Fellow of HFMA and past president of the Northeast PA Chapter, Bre is widely recognized as a thought leader and frequent speaker on revenue integrity and compliance at regional and national conferences. BreAnn can be reached at ***bmeadows@panaceainc.com.***

Govi Goyal leads Panacea's team of financial and revenue integrity experts who strategically partner with hospitals, health systems and other providers to grow their financial and revenue integrity performance, and to comply with recent CMS Price Transparency and other regulations through the use of technology. He has held several leadership roles within the high-tech and big 4 consulting space and served on the provider side working for large academic and not-for-profit community-based health care systems. Govi can be reached at ***ggoyal@panaceainc.com.***

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roles? How is healthcare courting these resources to create teams that can drive business continuity for today and the future? How can technologies be folded into processes to optimize productivity, revenue and team satisfaction? Recently, LinkedIn spotlighted the top 25 metropolitan areas as Cities on the Rise US due to the opportunities for job hunters. Healthcare and hospitals were consistently listed as top hiring sources. The article points to a variety of methods being used to attract early, mid and senior level candidates. One southeast system focuses on early careerists for initial recruitment, but also offers pathways for growth through career coaching, working with community organizations and offering training programs which can also benefit those bringing experience from outside healthcare. Several hospitals are working on attracting job seekers with external industry skills that can augment areas with outside experiences. A multiple state academic medical system in the Northeast is actively recognizing the viability of those with transferable skills. Technology and financial services backgrounds have been identified as areas which could have symmetry within the healthcare scope. Many of these industries have been pioneers with developing and deploying new technologies concurrently with process improvements.

Regardless of the makeup of the teams built, use of these evolving technologies has been met with mixed results and changing viewpoints on how best to deploy them. "Flipping the switch" and hoping for the best, or trusting that solutions will perform as designed, is no longer an option. It is up to organizations to understand that human-centric use and measurement of these solutions is mission critical for overall stewardship and legacy of the industry and the patients we serve. Let's look forward together to ensure enduring support for our teams and our communities.

About the author

Sandra is a seasoned client development executive and recognized thought leader with 15+ years of experience in revenue cycle solutions, partnerships, and process optimization. Currently Vice President of Client Development at Professional Credit, she's held key roles at Kode Health, ITx, and Financial Health Strategies, specializing in negotiations, client management, and team building to help optimize revenue cycle processes.
She's an active member of ACHE, AAHAM, and HFMA, she served as President of the Northern New England HFMA chapter and received multiple honors, including Yerger Awards, the Follmer Bronze, Reeves Silver, and Muncie Gold Merit Awards. She's authored several articles on ACA, 501R, best practices for eligibility, and personal branding, and has presented at numerous industry events, including HFMA Women in Healthcare Symposiums across the country. Sandra can be reached at spinette@professionalcredit.com.

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reduced denial rates, faster collections, and healthier margins — all without increasing administrative overhead.

An urgent care organization recently discovered this first-hand. Struggling with a backlog of payer correspondence and mounting denials, they partnered with an AI-enabled outsourcing provider. Instead of relying solely on human staff, the partner deployed multi-agent AI that could read, classify, and route payer letters instantly while flagging high-risk denials for immediate review. Within a year, the organization reduced its denial resolution time from 45 days to 18 and recovered revenue that had previously been written off.

This aligns with industry benchmarks. Best-in-class organizations aim for denial rates below 5%, a clean claim rate above 98%, and days in A/R under 40. Yet, according to HFMA data, the average hospital denial rate is now closer to 10–12%, double the industry target. Without automation and analytics, most organizations fall behind.

Measuring What Matters

Of course, no outsourcing or automation initiative is complete without a clear plan for measurement. Leaders need to see the return on investment, not just in financial terms, but also in operational efficiency.

A small regional hospital in the South partnered with an outsourcing provider to handle cash posting. With thousands of payments flowing in from payers and patients each month, the hospital's staff often struggled to keep up, leading to reconciliation delays. By outsourcing the function to a partner that combined staff expertise with automation, the hospital cut reconciliation times in half. Days in A/R dropped, staff stress decreased, and finance leaders had a clearer, real-time picture of cash flow.

Nationally, outsourcing and automation initiatives often deliver a 30–40% improvement in productivity, and in some cases, hospitals have reported recovering hundreds of thousands of dollars annually in revenue that would otherwise have been written off.

Compliance and Trust as Cornerstones

Every healthcare leader knows the risks that come with outsourcing and automation: HIPAA compliance, CMS rules, payer policies, and cybersecurity concerns. That's why trust and transparency are essential in building the right partnerships.

The best outsourcing and automation providers don't operate as black boxes. They provide dashboards, audit trails, and regular reporting so organizations can see exactly how claims are being processed, how denials are being resolved, and where improvements are happening. Some even tie their fees to performance metrics, ensuring that they share the same risks and rewards as their clients.

When outsourcing and automation are intentional, compliance and security aren't afterthoughts — they are embedded into every workflow.

A Call for Intentionality

Healthcare organizations today don't have the luxury of trial and error. Margins are too thin, and the stakes are too high. The future belongs to hospitals and physician groups that treat outsourcing and automation not as quick fixes, but as strategic pillars of their revenue cycle strategy.

- Outsource with intent, focusing on functions where outside expertise and technology add the most value.
- Automate strategically, deploying integrated AI solutions that manage entire workflows instead of piecemeal tasks.
- Measure relentlessly, holding partners accountable for financial and operational results.
- Build partnerships, not transactions, where trust, transparency, and shared goals define success.

Healthcare reimbursement may be getting more complex, but with intentional and strategic outsourcing and automation, organizations can build resilience, improve financial stability, and create space for what truly matters: delivering exceptional patient care.

About the authors

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Pavani Munjuluri – Pavani has 25+ years of experience across healthcare technology, outsourcing and consulting. She is currently the Co-founder and CEO of CognitiveHealth Technologies, an AI-driven healthcare company revolutionizing revenue cycle operations and financial outcomes through automating administrative workflows. She created significant business impact in her various senior leadership positions at large tech companies and healthcare start-ups, driving the development of groundbreaking digital healthcare products. Pavani can be reached at ***pavani@cognitivehealthit.com.***

AP Automation inHealthcare: From Back-Office Fix to Enterprise Advantage

Mike DiFranco

By: Mike DiFranco and Adrianne Boylen

Hospitals and health systems continue to operate on thin margins while absorbing persistent cost pressures across labor, supplies, and administrative burden. In 2023, U.S. health spending jumped 7.5% to $4.9 trillion (17.6% of GDP), with hospital expenditures up 10.4%, the fastest pace since 2003, forcing finance leaders to wring more value from every nonclinical dollar. Administrative expenses alone account for roughly 15%-25% of national health expenditures; underscoring why administrative simplification remains a material margin lever.

Against this backdrop, accounts payable (AP) automation has matured from a tactical project into a strategic capability that improves cash, controls, and resilience. Automation within healthcare finance is continuing to expand, and AP is ripe with opportunity given its straightforward processes.

Why AP automation, why now?

Healthcare finance is under sustained pressure. Even five years after COVID, current economic realities have amplified the need to reduce non-clinical overhead and protect margins. At the same time, technology adoption is accelerating. Grant Thornton's CFO survey from late last year shows how much digital transformation and AI are board-level priorities, with more than 60% of finance leaders already deploying automation to improve efficiency and resilience. AP automation is a natural starting point: it addresses high volume, rules-based processes that are still heavily manual in many organizations

For most healthcare systems, AP remains a bottleneck–characterized by paper invoices, manual data entry, and fragmented workflows. These inefficiencies drive late payments, missed discounts, and compliance risk. Automating AP delivers measurable benefits:

- Lower operating costs through reduced manual effort
- Faster processing and improved accuracy, minimizing rework
- Enhanced compliance and audit readiness with digital trails
- Better supplier relationships and working capital optimization

In short, AP automation is no longer a "nice to have." It is a lever for cost containment and operational sustainability, freeing up resources to reinvest in patient care and growth.

Adrianne Boylen

Case in Point: Temple University Health System

Temple University Health System (TUHS) undertook a comprehensive AP transformation to stabilize operations and build readiness for scalable automation. With ~$2.6B in revenue, 13 dedicated AP FTEs, and ~290,000 invoices annually, Temple began with a hard look at its data, policies, and process variation across the procure-to-pay continuum.

Key steps included:

- **Eliminating backlogs and redesigning workflows:** Aligned policy with leading practice, and clarified roles across supply chain, IT, and finance.
- **ERP "health check" and roadmap:** Assessed its ERP capabilities and decided that it will be pursuing a cloud-based platform for planning and analytics for future automation rests on modern, scalable infrastructure.
- **Establishing Key Performance Indicators:** Designed dashboards for standard AP KPIs and entity-specific metrics. Determined and set KPI goals based on industry standards.
- **Governance and change management:** Hosting semi-annual Procure-to-Pay Excellence Summit with AP, supply chain, accounting, IT, and treasury, to align cross-functional solutions, standardize exception handling, and institutionalize KPIs.

The result is a disciplined foundation: standardized processes, measurable KPIs, and a technology roadmap to transition from "baseline" digitization to stable and then optimized operations—unlocking touchless processing and

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Finance Diversification Strategies for Health Systems

Michael Haas

By: Michael Haas

In the evolving landscape of US health care, financial diversification has become a pivotal strategy for health systems striving to overcome economic and operational challenges. The industry continues to see significant blows to hospital operating margins, driven by labor shortages, increased supply expenses, and reimbursement shifts. To adapt, health care providers are moving beyond traditional acute care services by expanding into emerging high-growth sectors. Diversification not only helps mitigate financial risks but also supports value creation, cash flow generation, and competitive positioning against well-funded disruptors such as payers, private equity-backed firms, and technology companies constructing expansive healthcare ecosystems.

Key Growth Strategies

While there are multiple ways for health systems to diversify financially, three common strategies are monetizing existing capabilities, expanding into high growth segments and building innovation capacities. Over 70% of health system executives surveyed intend to increase spending on diversification initiatives, recognizing their vital role in generating sustainable financial returns and enhancing organizational capabilities.

Mechanisms Supporting Diversification

Health systems employ various models for diversification. These include external investments and acquisitions of mature companies for near-term cash flow, venture funding in early-stage innovators for cutting-edge solutions, and internal innovation efforts that reconfigure existing operations. Strategic partnerships provide access to new markets, technologies, and expertise, simultaneously expanding financial upside and offsetting operational losses.

Diversification in Health Insurance

Complementing provider efforts, research on product diversification within US health insurance reveals a strong positive correlation between diverse product portfolios and financial performance. Insurers that offer a variety of coverage options while sharing networks and managed care expertise achieve economies of scope and reduced risk exposure. This approach stabilizes profitability across different market cycles, including economic downturns and regulatory reform periods, by balancing payer and insured population mixes and mitigating volatility.

Looking Ahead

Financial diversification in US health care represents a comprehensive response to unprecedented challenges and industry transformation. By broadening revenue sources, investing in burgeoning segments, and fostering innovation, health systems and insurers alike enhance their economic sustainability and competitive edge. This multi-pronged strategy addresses declining hospital margins, intensifying competition, and the imperative to improve care accessibility, quality, and affordability.

About the author

Michael Haas is a technology management consulting director at RSM with over 15 years of experience in health care revenue cycle optimization and system implementations. He specializes in process improvement, coding compliance, and EHR adoption, helping clients enhance efficiency and financial performance. Michael co-leads our Microsoft Azure AI practice navigating clients through developing AI use cases and implementing these processes to improve revenue streams and workflow optimization. In 2022, he was selected for RSM's Industry Eminence Program, where he analyzes trends shaping the health care and nonprofit industries. Michael can be reached at ***Michael.Haas@rsmus.com.***

Leveraging Payer Analytics to Improve the Hospital Revenue Cycle

Jonathan Davis

By: Jonathan Davis

The financial health of hospitals depends on a strong revenue cycle. Between rising labor costs, shrinking reimbursement margins, and increasingly complex payer policies, healthcare organizations face mounting pressure to secure timely and accurate payments. Revenue cycle leaders are tasked not only with resolving claims but also with managing payer relationships in a way that improves long-term performance.

Analytics has emerged as a powerful tool to meet these challenges. By transforming large volumes of payer and claims data into actionable insights, hospitals can move beyond anecdotal disputes and instead address systemic inefficiencies with evidence. Leveraging payer analytics provides a foundation for accountability, collaboration, and improved cash flow, ensuring that health systems remain financially sustainable while continuing to deliver high-quality patient care.

The Role of Payer Scorecards

At Yale New Haven Health, payer analytics has become central to revenue cycle strategy. Jonathan Davis, Executive Director of Revenue Cycle Analytics, leads a team that collaborates closely with Managed Care to prepare payer scorecards—comprehensive benchmarking tools that compare each payer's performance against peers in both commercial managed care and Medicare Advantage.

These scorecards track payer behavior across several critical dimensions:

- **Accounts Receivable Aging** – Measuring the percentage of accounts receivable (AR) over 90 days compared to peer averages, providing a clear view of payment timeliness.
- **Administrative Burden** – Tracking the number and average value of claims requiring additional itemized bills or medical record requests, which can delay reimbursement and add operational costs.
- **Escalations and Appeals** – Highlighting the frequency of claims that require escalation or formal appeal compared to peers, illustrating the friction involved in securing payment.

By presenting this data in a standardized, comparative format, Yale New Haven Health creates a fact-based foundation for dialogue with payers. Instead of debating isolated examples, both sides can focus on measurable performance and work toward targeted solutions.

Measuring Collections Against Expectations

While scorecards are powerful for negotiations and accountability, analytics must also extend to the ongoing monitoring of payment accuracy. One key question every health system must ask is whether actual reimbursement aligns with expected fee schedules.

By backing out patient responsibility and secondary payer adjustments, hospitals can determine whether they are consistently receiving the contracted payment rate that is appropriate to a payer. By isolating the payer's performance separately from patient and secondary responsibilities, Yale New Haven Health is able to directly trace the impact payer actions such as denials and underpayments are having on payer performance. Further analysis examines how much this percentage declines once patient share is factored in. Tracking these metrics over time highlights whether overall collections on closed accounts are stable or trending downward—a critical signal of changes in payer behavior or patient payment performance.

This level of analysis provides insight beyond individual disputes. It allows health systems to recognize broader shifts in payer policy or adjudication that may erode revenue across entire service lines.

Monitoring Trends Beyond Negotiations

Even outside of contract negotiations, continuous monitoring of payer behavior is essential. Payer policies can change unexpectedly, creating downstream effects on reimbursement, denials, and cash flow. Yale New Haven Health addresses this by partnering its revenue cycle team with finance to monitor AR and payer activity trends that directly impact revenue recognition and AR valuation.

A core component of this monitoring is the analysis of 12-month AR liquidation rates, tracked period-to-period. By observing how quickly AR is converted to cash, the team can detect unanticipated shifts in managed care collection performance early. For example, a decline in liquidation rates may indicate emerging payer delays, an increase in denials, or policy changes affecting reimbursement. Identifying

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electronic payments at scale.

Risk, Controls, and Compliance (Yes, AP Is a Control Hub)

There is opportunity through AP modernization to tighten controls while increasing speed:

- **Data integrity and vendor risk:** Centralize vendor master data; require EIN/TIN validation and bank account verification; enforce "no PO, no pay" for targeted categories.
- **Regulatory and payer friction:** Administrative requirements drive back-office workload. Reducing rework through standardization frees scarce staff capacity.
- **Audit readiness:** Digital invoice trails, automated 2/3-way match, and role-based approvals compress audit cycles and reduce findings.

From Efficiency to Intelligence: The Automation Continuum

Automation in healthcare finance delivers benefits that extend beyond cost savings. At its core, AP automation reduces paper waste, accelerates invoice processing, and strengthens compliance. These efficiencies translate into measurable financial gains, while also improving staff experience and patient satisfaction by freeing resources for higher value work.

However, automation is not static. It exists on a continuum:

- **Rules-Based Automation:** Early stages focus on digitizing workflows and applying structured business rules to eliminate manual tasks.
- **Intelligent Automation:** As organizations mature, it integrates AI and machine learning to handle exceptions, predict risks, and enable real-time decision-making.
- **Transformative AI:** The future lies in adaptive systems that learn from unstructured data, enabling predictive insights and autonomous processing.

Understanding this progression helps finance leaders set realistic expectations and build a roadmap that aligns with organizational readiness. AP automation is the foundational step toward a more intelligent, data-driven finance function.

About the authors

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these trends in real time allows the organization to intervene promptly, mitigating revenue risk and avoiding surprises during financial reporting.

Broader Implications for Hospitals

The experience at Yale New Haven Health underscores a broader lesson for hospitals nationwide: payer analytics is not just a negotiation tool, but a strategic capability. When applied consistently, analytics enables health systems to:

- **Enhance Cash Flow Predictability** – By anticipating payer behavior and tracking payment timelines.
- **Reduce Administrative Waste** – By identifying and addressing unnecessary requests for records and itemized bills.
- **Support Accurate Valuation** – By providing finance teams with reliable AR and liquidation rate insights.
- **Strengthen Payer Partnerships** – By shifting conversations from anecdotal disputes to data-driven collaboration.

In a healthcare environment where margins are tight and labor costs are rising, these capabilities are no longer optional—they are essential.

Conclusion

Hospitals today face unprecedented financial pressure, and the revenue cycle has become a critical determinant of organizational sustainability. Payer analytics offers a way forward, enabling health systems to hold payers accountable, track collection performance against expectations, and adapt quickly to changes in policy and reimbursement trends.

At Yale New Haven Health, the integration of payer scorecards, ongoing collection analysis, and close collaboration with finance has created a model for data-driven revenue cycle management. The result is not only stronger financial performance, but also a more transparent and productive relationship with payers.

Analytics is about turning data into action. By measuring the right things, we can anticipate challenges, address them early, and ensure our hospitals remain focused on caring for patients.

About the author

Jonathan Davis is Executive Director Revenue Cycle Strategy and Analytics at Yale New Haven Health. He can be reached at jonathan.davis@ynhh.org.

49th NJ/Metro Philadelphia Annual Institute Agenda

Wednesday, October 29th		Start	End	CPE	Location
Checking In		9:00am			Seminole Ballroom
Welcome Lunch		11:30am	12:30pm		Seminole Ballroom
General Session #1- Keynote	**Federal Update - Big Beautiful Bill** James Robertson, Greenbaum Rowe Smith & Davis LLP	12:00pm	1:00pm	1	Seminole Ballroom
General Session #2 - Panel	**Managed Care Panel** Patrick Young, Hackensack Meridian Health; Kevin Joyce, Atlantic Health; Nisha Sikder, Valley Health; Jon Hollenweger, Inspira Health; Moderated by Eric Fishbein, Virtua Health	1:00pm	1:50pm	1	Seminole Ballroom
Networking Break		1:50pm	2:20pm		Vendor Hall
Breakout #1		2:20pm	3:10pm	1	
	2025 A&A and Uniform Guidance Update James Trubenbach-Byrne, Withum				Brighton Ballroom 1
	Navigating Medicaid Redeterminations & 340B program Retention: Challenges, Strategies, and Real-World Solutions Luke Parrish, Penn Medicine; Kyle Pennington & Jesse Vo, Baker Tilley				Brighton Ballroom 2
	Exploring Strategic Opportunities: Why Providers, Payers, and Employers are Taking the Plunge into Price Transparency Data Melonie O'Connell, Milliman				Brighton Ballroom 3
Transition Break		3:10pm	3:20pm		
Breakout #2		3:20pm	4:10pm	1	
	Tackling DRG Downgrades: The Silent Revenue Killer Meghan Mackenzie & Tracey Flowers, Hackensack Meridian Health & Charlotte Hadland, Aspirion				Brighton Ballroom 1
	Transforming Financial Operations: Automation in Action Michael DiFranco, Temple University Health System & Adrianne Boylen, Grant Thornton Advisors LLC				Brighton Ballroom 2
	CDM Shape-Up: Strengthening Charge Integrity, Avoiding Supply Denials and Strategic Pricing for Supplies and Pharmacy Govi Goyal & BreAnn Meadows, Panacea				Brighton Ballroom 3
	Federal Legislative and Regulatory Update: Outlook 2025 - 2026 Chad Mulvany, Forvis Mazars				Brighton Ballroom 4
Networking Break		4:10pm	4:40pm		Vendor Hall
General Session #3	**Charity Presentation**	4:40pm	5:30pm	1	Seminole Ballroom
Charity Event	**Sponsored by Forvis Mazars & Hollis Cobb**	5:30pm	7:30pm		Vendor Hall

Thursday, October 30th		Start	End	CPE	Location
Breakfast		8:00am	8:45am		Seminole Ballroom
Award Ceremony		8:45am	9:00am		Seminole Ballroom
General Session #4	**Adopt or Fall Behind: Why AI Belongs in Your Professional Toolbox** Marcia Leighton, MC3 Consulting	9:00am	9:50am	1	Seminole Ballroom
General Session #5 - Panel	**Regulatory & Reimbursement Panel** Christine Gordon, Virtua Health; Michael Rossi, Penn Medicine; Moderated by Jonathan Besler, BESLER	9:50am	10:40am	1	Seminole Ballroom
Networking Break		10:40am	11:00am		Vendor Hall
General Session #6 - Keynote	**Lead Now!** Kiran Batheja, HFMA National Chair	11:00am	12:00pm	1	Seminole Ballroom
Lunch		12:00pm	1:00pm		Seminole Ballroom
HFMA 101		12:15pm	12:45pm		Brighton Ballroom 1
Vendor Demos		12:15pm	12:45pm		Brighton Ballroom 2
Vendor Demos		12:15pm	12:45pm		Brighton Ballroom 3
Breakout #3		1:00pm	1:50pm	1	
	Healthcare Revenue Cycle Workforce 2030+ Building for today, tomorrow and beyond Sandra Pinette, Professional Credit				Brighton Ballroom 1
					Brighton Ballroom 2

49th NJ/Metro Philadelphia Annual Institute Agenda

	A Discussion of the New Jersey Supreme Court's Decision in Englewood Hospital & Medical Center v. State of New Jersey: Is NJ's Mandate that Hospitals Provide Care to Any Patient Regardless of Ability to Pay an Unconstitutional Taking of Hospital Property Without Just Compensation? Paul Croce & James Robertson, Greenbaum Rowe Smith & Davis LLP				
	From Data to Dollars: Leveraging Payer Analytics to Improve Hospital Revenue Cycle Jonathan Davis, Yale New Haven Health & Tara Bogart, PMMC				**Brighton Ballroom 3**
	Healthcare Industry Tax Update 2025 John Smith & Akshita Supawala, Withum				**Brighton Ballroom 4**
Transition between Breakouts		**1:50pm**	**2:00pm**		
Breakout #4		**2:00pm**	**2:50pm**	**1**	
					Brighton Ballroom 1
	When Tech Underdelivers: How to Stay Ahead of Contract Management System Limitations Matthew Thomas & Samantha Isch, RemedyIQ				
	A Collaborative Approach to CDM Management and Revenue Integrity Sarah Goodman, SLG Inc.				**Brighton Ballroom 2**
	Inpatient vs. Outpatient Surgery and Procedures: What Status? Ronald Hirsh, R1 RCM				**Brighton Ballroom 3**
	Behind the Denial: Patients, Providers, and the Price We All Pay Craig Nesta, Emerson Health & Will Richter, Revco Solutions				**Brighton Ballroom 4**
Networking Break - Ice Cream	**Sponsored by CorroHealth**	**2:50pm**	**3:10pm**		**Vendor Hall**
Breakout #5		**3:10pm**	**4:00pm**	**1**	
	Topical FY2026 IPPS Updates and Provider Implementation Richard Toner, Mayo Clinic & Christina Brown, BESLER Consulting				**Brighton Ballroom 1**
	Insurance Claims Complexity and Cybersecurity Risk Management Alois Rottkamp, Renovo Secure & Margaux Weinraub, Marsh McLennan Agency				**Brighton Ballroom 2**
	Use Accurate Data to Negotiate Better Contracts with Payors Byron Glasgow, Temple University Health System & Bob Alexander, Health Catalyst				**Brighton Ballroom 3**
	Intentional and Strategic Outsourcing and Automation Pavani Munjuluri, Cognitive Health & Mary Renee Stephens, MindPath Health				**Brighton Ballroom 4**
Transition between Breakouts		**4:00pm**	**4:10pm**		
General Session #7 - Panel	**Revenue Cycle Panel** Jason Kane, Inspira Health; Steven Honeywell, Penn Medicine; Jeff Hinkle, Temple Health; Moderated by John Fistner, AblePay	**4:10pm**	**5:00pm**	**1**	**Seminole Ballroom**
Break		**5:00pm**	**6:00pm**		
President's Reception	**Sponsored by BESLER & Withum**	**6:00pm**	**8:00pm**		**Plum Lounge**
Break		**8:00pm**	**10:00pm**		
Late Night Event	**Sponsored by & Med-Metrix**	**10:00pm**	**1:00am**		**The Balcony**

Friday, October 31th		**Start**	**End**	**CPE**	**Location**
Breakfast		**8:00am**	**9:00am**		**Seminole Ballroom**
General Session #8	**Emerging Trends in Health Care: Finance Diversification Strategies** Mike Coppa & Michael Haas, RSM US LLP	**9:00am**	**9:50am**	**1**	**Seminole Ballroom**
General Session #9	**Healthcare Cybersecurity Update** Ben Tweel, Bank Of America	**9:50am**	**10:40am**	**1**	**Seminole Ballroom**
Break		**10:40am**	**10:50am**		
General Session #10 - Panel	**CFO Panel** Stella Visaggio, Atlantic Health; Gene Gofman, Penn Medicine; Frank Pipas, RWJ Barnabas Health; Moderated by Garrick Stoldt, Saint Peter's Healthcare System	**10:50am**	**12:05pm**	**1.5**	**Seminole Ballroom**
TOTAL CPEs:				**15.5**	

Protecting Your Days Cash On Hand With Cybersecurity Insurance

Margaux Weinraub

Al Rottkamp

By: Margaux Weinraub and Al Rottkamp

Every healthcare entity, from private practices to large hospital systems, relies on internet connectivity. Whether it is a cloud-based EHR, PACS or a simple email system, data flows across networks, clouds, and states and countries. With connectivity comes risk.

The volume and sensitivity of healthcare data make the industry a prime target for cyberattacks. On the dark net, the value of credit card information varies from $5 to $100 dollars per record (Experian). Unlike credit card data which can be quickly locked and easily canceled, medical records have long-term value, selling for $250 to $1,000 per record on the dark web (HIPAAVault). This persistence elevates both the risk profile and the fiscal impact of breaches.

Cyber Risk and Financial Exposure

Managing cyber risk involves balancing acceptance, avoidance, reduction, and transfer. Breach costs can escalate rapidly: ransomware, forensics, and litigation alone may exceed $2 million. When lost revenue, restoration expenses, and HIPAA penalties are added, the average healthcare breach can surpass $5 million in unbudgeted expenses.

For healthcare finance leaders, the stakes are clear: understanding cybersecurity as a financial risk is as critical as managing supply costs, payer mix, or labor expenses.

Cybersecurity Insurance in Context

Transferring cyber risk to an insurance policy is one method to protect cash and financial investments.

Professional Liability (PL), Errors & Omissions (E&O), Directors & Officers (D&O), and Business Interruption coverage policies may overlap, but cyber insurance is unique and tailored to your risk environment.

Cyber insurance applications vary from self-reporting forms to comprehensive third-party audits. Advanced policies in a complex business may require cyber-attack simulation reporting as well as financial stress test analysis.

There are federal and state laws that require compliance. At the federal level are HIPAA and the CFAA, Computer Fraud and Abuse Act.

The HIPAA Security rule requires entities and associates to ensure the confidentiality, integrity, and availability (CIA) of protected health information (ePHI) and to take steps to protect the CIA against anticipated threats. The rule is enforced with breach requirements and financial penalties.

The Computer Fraud and Abuse Act (CFAA) is a federal law prohibiting certain computer-related crimes, including unauthorized access, and computer-related crimes. Over time, the CFAA has been applied to certain criminal and civil penalties for offenses such as hacking, identity theft, etc.

State data, computer use, and fraud laws vary. One stands out. In 2018 California (CA) became the first state to define and impose cybersecurity requirements for IoT (Internet of Things devices, which includes IoMT medical devices). The law requires manufacturers of connected devices sold in CA to implement "reasonable security features." The law defines connected devices, authentication, and access. (California Code, Civil Code - CIV § 1798.91.05, https://law.justia.com/codes/california/2018/code-civ/division-3/part-4/title-1.81.26.a/section-1798.91.04/). In 2019, Oregon passed a similar but limited IoT law.

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Although there is no federal data privacy rule, twenty states have enacted comprehensive data privacy laws: California, Colorado, Connecticut, Delaware, Florida, Indiana, Iowa, Kentucky, Maryland, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, Oregon, Rhode Island, Tennessee, Texas, Utah, and Virginia. These laws grant consumers various rights over their personal data, though the specific provisions and effective dates differ by state (iapp.org).

IoT, computer use, and data privacy laws are complicated. Questions concerning coverage or payout are often challenged in a court of appeals.

Policy language, premiums, exclusions, and coverage limits vary widely. Partnering with a dedicated cyber insurance broker ensures the right balance of risk transfer, coverage, and cost control.

The Real World

In healthcare, breaches impact more than finances. In 2023, a Pennsylvania hospital network attack exposed sensitive personal data, including medical images of 600 cancer patients (Alder, 2023). Beyond the $65 million class-action lawsuit, the reputational damage was severe. In 2023 a total of 400 U.S. healthcare institutions were victims of ransomware attacks (Lagasse, 2024). One insurer's breach topped $2 billion in costs (Japsen, 2024).

There are several methods hackers utilize to gain access into your system, from electronic network attacks and laptop theft, to just plain scamming you out of important information. The most common types of cyber-attacks are Business Email Compromise, Escalation of Privilege, Network Attacks, Web Site Attacks and Social Engineering. (OCR.gov, Verizon Data Breach Report, CrowdStrike).

Social Engineering attacks are the most common type as they attack the human element in the cyber security chain. The most effective social engineering attacks have an emotional element with a sense of urgency. Email phishing scams are misleading, with a deceptive sense of trust and need for action.

Artificial Intelligence does not comprise a new class of risk, but rather an extension and amplification of existing classes of risk. Its rapid and widespread adoption has created new challenges in terms of data privacy, litigation, and coverage. Artificial Intelligence (AI) presents its own new threats: AI Poisoning, AI Hallucinations and Audio/Visual Deep Fakes.

Common Cyber Expenses

- **Ransomware:** Data and systems locked until ransom is paid, often with leaks even if payment occurs.
- **Wire Transfer Fraud:** Impersonation of executives requesting fraudulent payments.
- **Network Rebuild:** Restoring servers, patching systems, and reconfiguring firewalls.
- **Litigation, Fines, & Uncovered Costs:** Many expenses may fall outside insurance coverage.

Typical Cyber Insurance Coverage

Coverage Type	Definition	Healthcare Example
First-party	Costs incurred directly by your organization	Forensics, ransom payments, data restoration
Third-party	Claims from customers, partners, or regulators	HIPAA fines, lawsuits, regulatory actions
Business Interruption	Lost income from operational downtime	Ransomware halts admissions
Contingent BI (CBI)	Loss from vendor downtime	EHR vendor outage
Regulatory Defense	Legal/compliance support	OCR/HIPAA investigation
Data Breach Response	Legal counsel, patient notification	Required after SQL injection
Extortion Coverage	Covers ransom/negotiations	Paid ransom to unlock EMR

Financial Statement Implications

Payouts and restructuring are expensive. Common sources of financial information are Fitch, Definitive and KaufmanHall: CrowdStrike, Verizon and Vulncheck provide cyber information. The Office of Civil Rights (OCR) tracks HIPAA breaches as reported. Both OCR and the HIPAA Journal report results.

To appreciate the financial impact of a cyber incident at a fictitious hospital, we will look at several key indicators:

- **Current Ratio** – ability to cover short-term liabilities with current assets.
- **Quick Ratio (Acid Test)** – ability to cover liabilities with liquid assets.
- **Days Cash on Hand (DCO)** – operating days funded by cash reserves.
- **Operating Margin** – profitability from core operations.

Case Example: "Anywhere Hospital"

- 600 Med/Surg beds, 3,500 employees
- Pre-incident DCO: 50 days
- Ransomware downtime: 5 days
- Expenses: $3.45M immediate + $2.55M longer-term = $6M total
- Cyber insurance coverage: $5M

Impact Analysis

Metric	Pre-Incident	With Insurance	Without Insurance
Quick Ratio	0.9	0.85	0.80
Current Ratio	1.0	0.95	0.91
DCO	50 days	49 days	46 days
Operating Margin	-0.6%	-0.7%	-1.1%

Without insurance, the hospital essentially self-insures $6M, with sharp deterioration in ratios. Cyber insurance helps

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Discover Cost Clarity: Unlock Deeper Insights for Smarter Healthcare Finance

Denials are more than just a financial nuisance — they're a red flag waving from deep within your operations.

By: Byron Glasgow and Bob Alexander

Byron Glasgow

Bob Alexander

In the healthcare sector, the ability to access and analyze accurate cost data plays a crucial role in negotiating better payments from payors. Organizations that utilize robust cost data are better equipped to demonstrate the true cost of providing services, which can lead to more favorable reimbursement rates. By leveraging detailed cost breakdowns, including direct and indirect costs, healthcare providers can present a clearer picture of their financial needs, fostering transparency and trust during negotiations. Additionally, understanding cost structures allows organizations to identify areas of inefficiency or overutilization, which can be used to adjust pricing models or improve service delivery. Improved cost data empowers healthcare organizations to engage in data-driven negotiations, aligning payment structures more closely with the actual value provided, and ultimately improving financial sustainability and operational efficiency.

Outdated costing systems, such as ones built primarily based on cost-to-charge ratios and relative value units, have not gained traction within healthcare organizations. Costing data has long been thought of as imprecise or muddled with averages that make it unactionable and difficult to convey to non-finance audiences. Over the past several years, Temple Health has used Health Catalyst's data and analytics technology to gain insights into operational costs.

Temple Health uses the cost accounting output for routine purposes such as budgeting, operational improvements, margin analysis, and business planning. Additionally, the cost output and analytics have enabled optimized purchasing of costly drugs like Sugammadex where the system helped detect waste in the dosage of the drug allowing the purchasing team to standardize around a lower dose option that reduced waste. This resulted in over $100K in savings at one location.

Having a solid foundation of cost data enables the organization to be smart about understanding the implications of switching biologics from a cost and outcomes perspective, quantifying the additional costs associated with opioid use disorder patients, and identifying lost revenue. By switching away from outdated costing methodologies, Temple Health was able to more precisely quantify the costs of treating burn patients and found anomalies in how the underlying billing system was configured leading to the discovery of lost revenue for certain ICU patient days.

Regarding contract negotiations, accurate cost and margin data has helped show a drop in margin from certain cases moving from inpatient to outpatient settings. By analyzing margin across services and focusing on Medicare populations where margins were consistent from one specialty to the next, they justified moving commercial contracts to a percentage of Medicare, allowing for more consistent margins across hospitals. A takeaway is the intersection of cost and quality becomes easier as you drive consistency and predictability. Another great example of leveraging better data for payer negotiations was around delays in getting patients discharged to a skilled nursing or long-term care facility. Temple Health was able to quantify the additional costs incurred for this subset of patients and is on track to collect over $1.5M on disposition days. The Chief Clinical Officer now also meets with the payer physician team regularly to review and improve the overall process.

These are just some of the ways that one health system used better cost data to expose waste, find lost revenue, and improve confidence in their decision-making. Having an objective source of truth that many audiences can agree upon is invaluable. With uncertainty in future reimbursement

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Surgery Admission Status in 2026 – A New Paradigm

Ronald Hirsch

By: Ronald Hirsch, MD, FACP, ACPA-C, CHRI, CHCQM-PHYADV

As this issue of Garden State Focus is published, we will soon know if the Centers for Medicare & Medicaid Services (CMS) has adopted their proposal in the 2026 Outpatient Prospective Payment Rule to eliminate the Inpatient Only List, also known as Addendum E, over the next three years. This is a significant revenue cycle issue, as for many hospitals the revenue from inpatient surgical care is crucial to fund much of the operation of the operations of the facility, provide revenue for the medical education programs, and allow the hospital to provide care for all the residents of their community as both outpatient and inpatient.

Hospitals have already started to feel the pinch of CMS' move to allowing more procedures in the non-inpatient setting with the continued growth of procedures that can be done at Ambulatory Surgery Centers (ASCs), as indicated on the ASC-Covered Procedure List (ASC-CPL) which already includes many orthopedic and cardiac procedures that were once limited to the hospital setting.

CMS' plan is to eliminate the list over three years. For 2026, almost all orthopedic procedures will be removed from the list. But perhaps even more financially daunting is that at the same time, CMS is proposing that these procedures will be added to the ASC-CPL. For those hospitals in areas with a heavy penetration of physician-owned ASCs, the financial consequences could be significant as "healthy" Medicare patients have their surgery at the ASC and those patients who have comorbid conditions that could make their care most costly with extended stays will be routed to the hospital for surgery either as outpatient or inpatient.

As CMS removes surgeries from the inpatient only list, they note that they will be assigning the surgeries to the Ambulatory Payment Classification (APC) that most closely matches the cost of the procedure as paid under the Diagnosis Related Grouping (DRG) system. That is reassuring but it must be noted that the DRG system is structured to not only pay for the procedure but also includes payments for Indirect Medical Education (IME), Disproportionate Share Hospital (DSH) payment, uncompensated care, and value-based payment programs. On the other hand, the outpatient APC is only adjusted for the hospital's wage index. While some of those do "balance out" at year end with cost reporting, others only occur with inpatient admissions and represent true lost revenue. For some surgeries at academic medical centers, the loss of revenue can exceed $10,000 per admission.

But all is not lost. The removal of a procedure from the inpatient only list does not mean it must be performed as outpatient. For every surgery that is no longer on the inpatient only list, the two-midnight rule, in place since 2013, will apply. That means there is still an ability to get the inpatient DRG payment if the provisions of the rule are met. For finance professionals, the details of the rule are less important, but what is important are the actions that can be taken to ensure patients who warrant inpatient admission are admitted as inpatient.

To start, it is important to know that the vast majority of surgical procedures in a hospital are scheduled rather than urgent or emergent. That means there is plenty of opportunity to not only ensure the payer has approved the surgery, if required, but also to have a process in place to assess for the correct admission status and obtain the correct documentation to support that.

This assessment can also greatly assist your case management staff who can use that information and determine what, if any, post-hospital services will be necessary and start arrangements prior to the patient's arrival. Most case managers can tell stories about being called late in the afternoon on a Friday to arrange post-acute care that should have been anticipated prior to surgery, when the insurer was in the office to answer the phone and help make such arrangements. Instead that patient may remain hospitalized over the weekend, waiting for the offices to open again.

For Medicare, the two-midnight rule allows inpatient admission if the physician expects the patient will require over two midnights of hospital care for necessary hospital care and their documentation supports that expectation. For some surgeries, such as complex, multi-level spine surgeries, the standard of care is to keep the patient in the hospital for over two midnights to monitor for excess swelling, drainage, bleeding or other complications. In that case, the description of the planned surgery and expected stay speaks for itself. But for surgeries where the stay can be simply overnight, the need for a longer hospital stay will need to be supported, such as the presence of medications that increase the risk of bleeding or potentially unstable medical conditions that will require extended in-hospital care, such as heart failure or poorly controlled diabetes.

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New Jersey Supreme Court Finds the Take All Comers Statute is Not an Unconstitutional Taking of Hospital Private Property: Next Stop . . . SCOTUS

James A. Robertson

Paul L. Croce

By: James A. Robertson and Paul L. Croce

N.J.S.A. 26:2H-18.64 (the "Take All Comers Statute") ***requires*** all New Jersey hospitals to provide admission and appropriate services to ***any patient*** who presents to the hospital ***regardless of their ability to pay.*** N.J.A.C. 10:52-11.14 prohibits hospitals from billing or seeking to collect for the services provided to any patient who qualifies for charity care. The combination of these two New Jersey laws effectively requires hospitals to provide a potentially unlimited amount of care to a potentially unlimited number of patients without any obligation by the State to pay for such care. The 5th Amendment of the United States Constitution prohibits the government from "taking" private property for a public purpose unless it pays the property owner "just" compensation.

For nearly two decades, New Jersey hospitals have sought to obtain "just" compensation for the uncompensated care they've provided to the State's most vulnerable patient populations. New Jersey hospitals have fought this fight in the state agencies, administrative courts, New Jersey trial and appellate courts, and, most recently, in the New Jersey Supreme Court.

The hospitals have been told by the agencies and the courts that they don't have the authority to hear constitutional takings challenges, that the agencies lacked jurisdiction to decide the constitutional issue, that the hospitals' claims were not ripe for adjudication, that the duty to provide free care does not arise until the hospital makes someone a "patient" which is the hospital's voluntary decision, and that the hospitals don't have a legitimate expectation that they will be able to realize a profit from their operations in the heavily regulated healthcare industry.

But the hospitals keep fighting the good fight . . .

This past July, the New Jersey Supreme Court found that no taking of the hospitals' property had occurred under two important Supreme Court of the United States ("SCOTUS") cases entitled Horne v. Department of Agriculture, 576 U.S. 350 (2015) (Horne), and Cedar Point Nursery v. Hassid, 594 U.S. 139 (2021) (Cedar Point). Both Horne and Cedar Point held that unconstitutional takings had occurred under the facts of those cases.

Horne held that a regulation requiring California raisin growers to reserve a percentage of their crop for use by the Department of Agriculture was a per se physical taking. However, the New Jersey Supreme Court distinguished the facts in Horne from the hospitals' case on the grounds that the Take All Comers Statute did not require hospitals to "physically set aside" any portion of the hospitals' property for use by the government or indigent patients, nor was there a transfer of title to the property from the hospital to the government or indigent patients. The court suggested, however, that if the hospitals "were required to hand over boxes of bandages or to surrender medical devices to the government or a third party, which could then sell or dispose of those bandages or devices at will, this case would fall neatly into Horne's analysis."

Cedar Point held that a regulation requiring farm owners to permit access to their property by union organizers for up to 3 hours per day/120 days per year likewise constituted a per se physical taking of the farm's private property. However, the New Jersey Supreme Court distinguished the facts in Cedar Point on the basis that a hospital, unlike the farm, is "open to the public," which made the case more analogous to the shopping center which was found to be akin to the modern "town square" in SCOTUS's earlier case of PruneYard Shopping Center v. Robins, 447 U.S. 74 (1980), and therefore, there can be no taking.

Despite finding no taking of the hospital property, the New Jersey Supreme Court acknowledged the charity care program's unfair requirement "for medical professionals and hospitals to

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protect your operating margins and liquidity, preserving capital during post incident recovery.

Risk Reduction Steps & Policy Implications

Cyber insurance premiums are determined by how an underwriter views your organization's risk profile. The stronger your cybersecurity posture, the lower your risk rating—and often the more favorable your premiums. A well-documented, actively managed cybersecurity program directly protects not only your systems and data, but also your Days Cash On Hand (DCO) by preventing costly incidents and keeping insurance costs under control.

Best Practice Controls

- **Multifactor Authentication (MFA):** Strengthens identity security and prevents unauthorized access.
- **Password Complexity Standards:** Enforces strong, unique credentials across the enterprise.
- **Role-Based Access (RBAC):** Ensures employees only have access to the data and systems needed for their role.
- **Patch and Upgrade Management:** Keeps systems current and reduces known vulnerabilities.
- **Penetration and Stress Testing:** Validates resilience and identifies weaknesses before attackers do.

Best Practices for Risk Reduction

A. Training & Awareness

- Conduct regular phishing awareness programs to reduce social engineering risk.
- Introduce staff to emerging threats such as deep fakes and AI-driven impersonation attempts.

B. Continuous Monitoring

Use electronic monitoring tools (IoT/medical device monitoring, incident & event monitoring).

Reinforce with human oversight & common sense—encourage staff to question unusual requests or behaviors.

C. Incident Response & Resilience

- Maintain a clear, tested Incident Response Plan (IRP).
- Conduct tabletop and walk through exercises with executives, IT, clinical staff, and finance teams to ensure readiness.

D. Independent Validation

- Schedule third-party audits and assessments, as well as Pen Tests, to verify compliance, uncover blind spots, and provide assurance to insurers.
- Schedule third-party physical access tests to visitor access, verify card access, and loading dock access.

Closing Note

In this article, we have touched on the methods hackers utilize to compromise your system, types of insurance, law, and financial impacts. You have worked hard, with multiple health insurance carriers, to collect your revenue and maintain a low aged accounts receivable. To properly tailor your cyber coverage contracts, it is imperative your CIO and internal counsel work with a cyber security insurance broker to protect your capital and hard work.

In August 2025, Becker's Hospital Review reported 19 hospital closures. While closures often reflect multiple pressures, financial losses from cyber incidents can accelerate insolvency. Protect your Days Cash on Hand with strong cyber hygiene and the right insurance coverage.

Author Bio's

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Provider Pricing Strategies: A holistic approach for physicians, hospitals and health systems to drive new revenue and margins

Melonie O'Connell

By: Melonie O'Connell

Comprehensive and effective pricing strategies are essential in the current healthcare environment of margin compression and reimbursement pressures. Physicians, hospitals and health systems (providers) who define and execute a holistic strategy can chart a course to drive new net revenue and protect existing margins by aligning all aspects of pricing.

Over the past five years, ongoing fiscal pressures have led some providers to negotiate short-term infusions of new revenue to maintain services while sacrificing careful development and execution of a holistic pricing strategy. To keep pace with inflation and rising costs, providers may have traded hard-won contract elements for rate increases and/or administrative relief, turning previous non-negotiables into bargaining chips. While these short-term decisions may have been necessary, long-term stability depends on a more deliberate approach. A proactive pricing strategy not only aligns with market value but also secures the new net revenue needed to advance an organization's mission. And when done well, it provides a framework for evaluating new opportunities, preparing for negotiations, and navigating market dynamics. With the right analyses, health systems and physician groups can strategically align the levers that drive the most value and propel their organizations toward a more strategic approach.

This article explores the key components and benefits of a comprehensive pricing strategy.

An effective pricing strategy answers key questions tied to rates, risk, and revenue volatility.

Pricing strategy helps providers define their brand, set rates, optimize networks, and make operational decisions that directly influence net revenue. The strategy sets goals that are three-to-five years beyond current market dynamics, with each move carefully planned on the chess board of healthcare economics. Defining a pricing strategy begins with questions such as:

1. How will we position each payer in our portfolio?
2. How should we position our services in the market?
3. Which networks and products optimize our presence in the market?
4. How do we minimize revenue volatility?
5. How do we set targets for upcoming negotiations to achieve our organization's goals?
6. How prepared is our organization to deliver value as defined by purchasers? Is our risk profile aligned with the operational capabilities to manage that risk?
7. How do we align other operational decisions and levers to support the pricing strategy?

Providers should revisit their three- to five-year goals annually to ensure the pricing strategy charts a clear course for the year ahead. An effective strategy establishes guardrails and themes that empower pricing leaders to respond quickly to market shifts and evaluate new proposals, negotiations, and opportunities in context, rather than in isolation.

What are the key components of an effective pricing strategy?

True pricing strategy encompasses far more than contract negotiations. The seven components outlined below are essential to optimizing net revenue potential. While not exhaustive, they can serve as a checklist for providers to evaluate the strength of their annual strategies and progress toward long-term goals.

1. Payer relationships and negotiations

- Our team ensures the value from each payer is optimized to encourage a diverse portfolio, new net revenue, and

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access.

- We are participating in the right networks to optimize access and revenue.
- We view each payer relationship holistically. We incorporate fee-for-service metrics, including disciplined revenue cycle analytics, and value-based care incentives across all products to fully evaluate each relationship.
- We are considered a partner by most major payers. We are the first call for any new collaboration opportunity in our market.

2. New facility and services pricing

- Our prices for new facilities or services align with market, value, brand, and financial projections.

3. Chargemaster optimization

- We optimize the chargemaster for rational, defensible, market-driven decisions aligned with overall brand positioning and revenue goals.

4. New product evaluation or development

- We have a clear understanding of the price/volume tradeoffs, in-migration opportunities, and the margin tradeoffs required to participate in new products or networks. We are aware of the risks of not participating and potentially losing current volume and margin.
- We are nimble and take calculated risks to prepare for new products.
- We understand options available to self-insured employers in our market and are intentionally positioned among those offerings.

5. Market and policy trends awareness

- We regularly assess the ways consumer, payer, and policy trends impact our pricing strategy, operational decisions, and revenue projections.
- We align our decisions with our brand and an awareness of reputational and consumer impact.
- We account for market and policy trends when determining our payer strategy, targets, and negotiations.
- We model the financial impact of major new policies and legislation and adjust our operations and contracts accordingly.

6. Site-of-care transition planning

- We optimize margins in current sites of care while planning for future shifts by protecting at-risk revenue with strategic price decisions, meeting market demand, and diversifying the portfolio.

7. Value-based payment risk planning

- Our team has clarity on the level of risk the organization is comfortable assuming and has a roadmap for ongoing innovation.

A few critical, targeted analyses can inform these key components of an effective pricing strategy. For example, rate benchmarks, like those available from payer-posted Transparency in Coverage (TiC) or the hospital price transparency (HPT) data, can inform all seven key components. Marrying the analyses with other major market, policy, or payer trends will provide insights to inform an annual review of an organization's evolving pricing strategy.

The annual review of the pricing strategy will provide guardrails to guide decisions throughout the year and clear objectives to share with executives. Many organizations have mastered specific components of an effective pricing strategy, but the power is in aligning all components to work in harmony toward a common vision.

About the author

Melonie O'Connell is a senior healthcare management consultant with Milliman where she is responsible for developing and marketing Milliman's price transparency tool, Milliman Transparent, and assisting organizations with price strategy and rate benchmarking studies. Melonie's areas of expertise include provider pricing strategies designed to position health systems at the forefront of market driven price decisions, and innovative product strategy to drive new net revenue, differentiation, attributed lives, and network integrity. Melonie can be reached at ***melonie.oconnell@milliman.com.***

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new jersey chapter

2025 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 2024–2025 Chapter Year was completed by a retired CPA with 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 2024–2025 Chapter Year.

The accompanying balance sheets and statements of activities and cash flows for the years ended May 31, 2025, 2024, and 2023 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,

Heather Stanisci

2024-2025 NJ HFMA Audit Committee Chair

Healthcare Financial Management Association - New Jersey Chapter
Balance Sheets

	As of May 31		
	2025	2024	2023
Assets			
Current Assets			
Bank accounts	$ 324,234	$ 352,380	$ 371,192
Accounts receivable, net	13,630	10,000	9,839
Other current assets	10,000	9,000	6,908
Total current assets	347,864	371,380	387,939
Investments	28,103	25,483	23,812
Fixed assets	-	-	-
Total assets	$ 375,967	$ 396,863	$ 411,751
Liabilities and net assets			
Liabilities			
Current liabilities			
Accounts payable	$ 10,140	$ 25,239	$ 28,066
Deferred revenue	37,041	41,567	56,836
Accrued payroll	$ 4,394	-	-
Total current liabilities	51,575	66,806	84,902
Total liabilities	51,575	66,806	84,902
Net assets			
Thomas G. Shanahan Scholarship Fund	14,390	20,390	20,390
Net assets without restriction	310,002	309,667	306,459
Total liabilities and net assets	$ 375,967	$ 396,863	$ 411,751

Healthcare Financial Management Association - New Jersey Chapter
Statements of Activities

	Year ended May 31		
	2025	2024	2023
Income			
Meeting and education income	143,585	165,595	177,820
Newsletter income	2,100	4,320	5,240
Golf Outing Income	51,600	43,127	45,300
General sponsorship income	190,507	220,658	157,450
Interest income	7,677	7,799	4,087
Other income	2,000	-	23,390
Total income	397,469	441,499	413,286
Expenses			
Meeting and education expenses	292,377	346,727	286,932
Newsletter expenses	12,888	7,468	4,537
Golf Outing expenses	26,825	23,032	28,854
Member recognition and social event expenses	13,161	7,778	7,553
General and administration expenses	59,878	54,449	37,127
Provision for bad debts	-	-	-
Total expenses	405,130	439,454	365,002
Net Operating Gain/(Loss)	(7,661)	2,044	48,284
Unrealized gain and loss	1,996	1,163	(542)
Net income (loss)	(5,665)	3,208	47,742

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

	Year ended May 31 2025	2024	2023
Operating activities			
Net income (loss)	(5,665)	3,208	47,742
1250-00 Other Receivables			
Change in unrealized gains (net)		(1,163)	542
Accounts receivable, net	(3,630)	(162)	4,542
1260-00 Allowance For Doubtful Accts			
Other current assets	(1,000)	(2,092)	(4,928)
Accrued Expenses	(15,098)	(2,827)	27,898
Deferred Revenue	(4,526)	(15,269)	54,335
Accrued Payroll	4,394	-	(5,684)
Net cash used in provided by (used in) operating activities	(25,525)	(18,305)	124,447
Cash flows from Investing Activities			
Purchases of Investment, net	(2,621)	(508)	(250)
Net decrease in cash	(28,146)	(18,812)	124,197
Cash at beginning of period	352,380	371,192	246,995
Cash at end of period	324,234	352,380	371,192

New Jersey Healthcare Financial Management Association 2024-25 Chapter Awards Listing

President's Award
Brian Herdman

Member Recognition Award - BRONZE
Kim Keenoy

Member Recognition Award - SILVER
David Murray, FHFMA
John Smith

Member Recognition Award - GOLD
Lisa Maltese-Schaaf

Medal of Honor
Jill Squiers

Member in a Non-Leadership Position
Annabelle Seippel, CRCR

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schemes, organizations that can rely on the accuracy of their cost data will have a distinct advantage over those that cannot.

About the authors

Byron Glasgow serves as Vice President of Finance at Temple University Health System, where he has been employed for 14 years. He oversees key functions, including managed care, government reimbursement strategy, service line profitability, patient cost accounting, and market analytics, to drive strategic decision-making. Byron launched his career with a Finance degree from the University of Richmond. While employed as a financial analyst at Temple Health, he earned an MBA from Temple University.

Bob Alexander has over 16 years of experience in healthcare finance and decision support. Currently serving as the Principal Cost Management Consultant at Health Catalyst, Bob has established and nurtured partnerships with dozens of health systems across the U.S. and globally. He specializes in the creation and implementation of activity-based cost accounting solutions for healthcare organizations. Before joining Health Catalyst, Bob was Lead Financial Analyst in the UPMC Cost Management Initiative to create a first of its kind activity-based cost management solution specific to healthcare. Bob has a passion for leveraging financial analytics to drive organizational success and improve patient outcomes in the healthcare sector. He lives in Pittsburgh, Pennsylvania.

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There is also a provision in the rule, called the case-by-case exception, that allows a physician to admit a patient as inpatient who has a one midnight expected in-hospital stay but the patient's comorbid conditions increase their risk of an adverse event, and those comorbid conditions and their stability, or lack thereof, are documented along with a statement that there is an increased risk. For example, "this patient's poorly controlled diabetes, heart failure and sleep apnea raise their perioperative risk and therefore inpatient admission is warranted." This documentation obviously needs to be present, with the inpatient admission order, pre-operatively, as once the surgery has been completed, much of that risk is gone and inpatient admission at that point is no longer indicated.

Finally, some patients having surgery, due to their living situation and family support, or lack thereof, will require post-hospital recovery in a skilled nursing facility (SNF). In order to access the part A SNF benefit, a patient must be admitted as inpatient to the hospital and have a three or more day inpatient stay. Once again, if that need for SNF is documented and is rational, the patient can be admitted as inpatient.

It is not feasible for finance staff to meet with doctors to explain these provisions and work with them on developing processes to ensure the proper documentation is obtained and the correct status ordered, nor would it be accepted by surgeons to have the CFO lecture them on admission status, but finance can ensure the utilization review and case management teams have adequate resources to perform those duties. The hospital physician advisor(s) should be intimately involved in this process, both in training and implementation, and the clinical department heads and other c-suite members should understand the importance of the process to provide support and coaching when necessary.

With a coordinated effort, the upcoming demise of the inpatient only list can be addressed and survived, only to wait for the next CMS proposal that will disrupt the status quo.

About the author

Ronald Hirsch, MD is vice president of regulations and education for R1 RCM Inc. He is on the national advisory committee for the American College of Physician Advisors and the National Association of Healthcare Revenue Integrity and the co-author of The Hospital Guide to Contemporary Utilization Review. Dr. Hirsch can be reached at ***rhirsch@r1rcm.com.***

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bear, alone, the cost of providing those services to those who cannot pay for them." However, it directed the hospitals to seek relief through the legislative process rather than the courts.

The next step is to petition SCOTUS to hear the hospitals' case on the grounds that the distinctions between the Horne and Cedar Point cases which were drawn by the New Jersey Supreme Court are misplaced. SCOTUS has never held that the formal transfer of title to property is a prerequisite to finding a taking. All that is required is for possession of property to be transferred for a third-party's use. Moreover, hospitals are not open to the public in the same way the shopping mall in Pruneyard was. Rather, the patient care areas of the hospital – which are the revenue-generating areas – are private and therefore, more akin to the individual retail stores in a shopping mall, access to which, the PruneYard Court acknowledged, could be prohibited.

These erroneous distinctions of Horne and Cedar Point plainly form the basis for petitioning SCOTUS to review the New Jersey Supreme Court's decision.

Next stop … SCOTUS!

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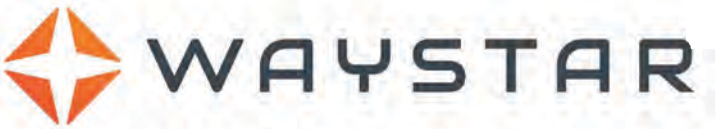


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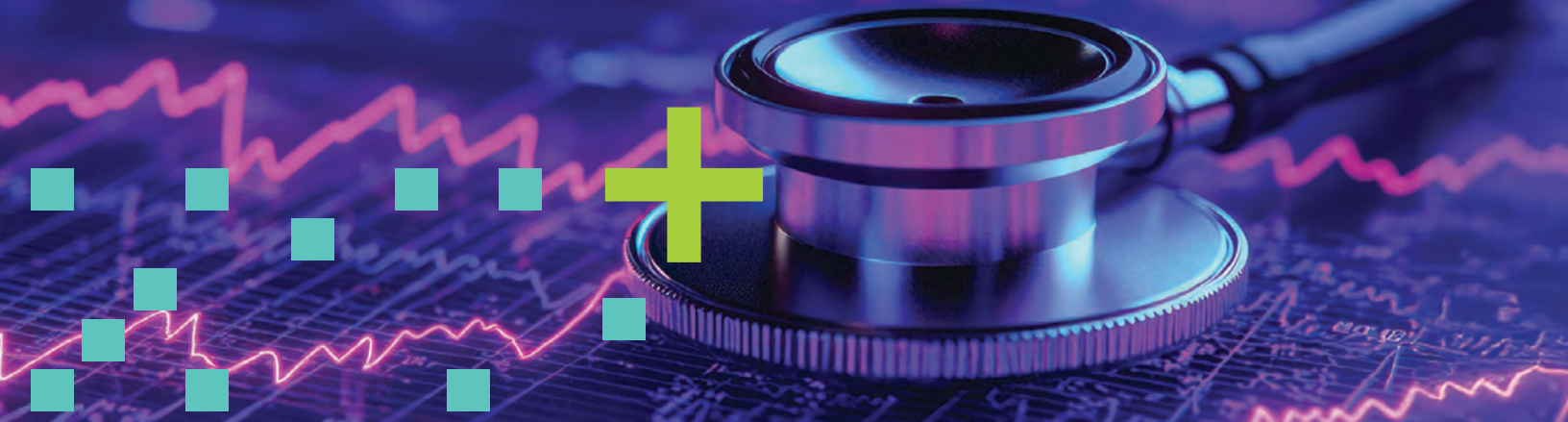

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