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- Cybersecurity Risk Prevention in 2023: Three Gaps to Close
- Coming Soon to a Hotel Casino and Spa Near You – The 47th Annual Institute

New Jersey & Metro Philadelphia HFMA

47th Annual Institute

September 27 - 29
Borgata, Atlantic City

Wednesday Kickoff Speaker

Dennis E. Dahlen
FHFMA, CPA

HFMA National Chair
Chief Financial Officer, Mayo Clinic

Keynote Speaker

Robert C. Garrett
FACHE

Chief Executive Officer
Hackensack Meridian Health

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DEADLINE FOR SUBMISSION OF MATERIAL

Issue Date	Submission Deadline
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Winter	November 1
Spring	February 1
Summer	May 1

IDENTIFICATION STATEMENT

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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 Communications Committee reserves the right to accept or reject contributions whether solicited or not. All correspondence is assumed to be a release for publication unless otherwise indicated. All article submissions must be typed, double-spaced, and submitted as a Microsoft Word document. Please email your submission to:
Scott Besler
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The President's View . . .

Brian Herdman

Dear Colleague,

As an officer in our HFMA Chapter, I am fortunate to have worked with so many people across our community of peers. Through the pandemic and our "stop-start" recovery, HFMA has been a critical resource for information on work arounds and new reimbursement considerations.

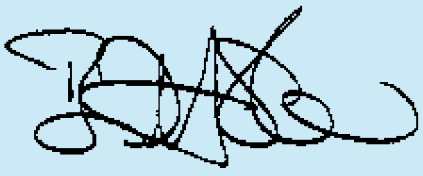
The spring was busy for the Chapter. We gathered for three important events with very different focuses. Our Golf Outing continues to be a day for networking and sport, and I am proud that we could bring back scholarship awards in the name of past president Tom Shanahan – who was always an advocate for spreading the knowledge through HFMA's opportunities. A week later we held our annual Women's Professional Development Session, bringing in over 100 attendees and welcoming back Jersey Girl Caitlin Zulla to speak about the progress of her career at Optum in addition to many conversations on work/life balance. Finally, we moved up our summer networking event at the shore to accommodate the July vacation season – it was great to see all of you!

I am grateful to the officers who have preceded me for their counsel, and I am excited for what is to come. I do not envy their challenge ahead - while the thirst for reimbursement knowledge is as intense as ever, our members have more constraints on their ability to convene together. The chapter has continued to push as much virtual education as we can, but this is no substitute for the organic conversations and discussions tableside at a day of HFMA education.

We are learning to overcome these barriers with your feedback. Insofar as HFMA is a volunteer organization, our committee leaders and board members are working to overcome their own barriers while revamping how we operate so we can bring as many people as we can together for the benefit of the healthcare mission in the State.

I challenge our members to consider their role in our industry and the impact they can have on their peers. So many of our members don't realize that they have the skills and knowledge to be a Chapter leader – either as a subject matter expert or a member of a standing committee focused on an area of Chapter operations. If you're not already involved, your first step is to check the committee listing on page 24. I hope that you can join a committee, or perhaps you can encourage a rising star with limited opportunity to lead. An organization like ours can only go as far as it has volunteers to convene education and networking together. I am amazed and thankful for the passion– and I am excited to participate in what comes next!

Sincerely,
Brian Herdman



From The Editor . . .

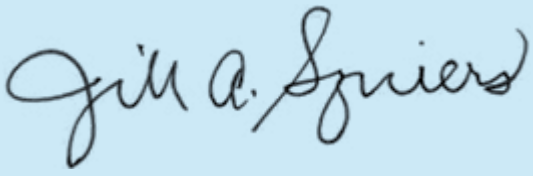
Jill Squiers

Summer is usually a time of transition for the New Jersey Chapter of HFMA, and this edition of the *Garden State FOCUS* reflects this change with the list of Who's Who on page 2; congratulations to the new Chapter leaders! While the Chapter is undergoing its own transition of volunteer leadership, within these pages we show how the Chapter continues to move forward with education and networking events post-pandemic.

The 47th Annual Institute comes early this year, beginning September 27 with three days of timely and topical education led by our master of ceremonies Mike McKeever, who highlighted the event's agenda on page 8. Mike also authored a retrospective of this spring's ever-successful Women's Leadership & Development event, where we gladly welcomed an at-capacity crowd. Included in this edition are articles showing how healthcare organizations are impacted by the end of the public health emergency, as well as the business case to address cybersecurity risks and plan for extended downtime resulting from a breach. Rounding out our terrific selection of topics is a review of the No Surprises Act and a summary of a recent court decision affecting the 340B drug program. Lastly, our new feature Committee Corner returns with an interview of the chairs of the Chapter's Education Committee, giving us a more personal look at the leaders responsible for so many of the programs our members attend throughout the year.

This time of transition means that my tenure as interim editor has also come to an end! I've enjoyed this role and feel better informed having read every article submitted in this past year, and am happy to hand the baton to Jim Robertson, new editor of the FOCUS.

I encourage you to check hfmanj.org often for events throughout the Summer and Fall, please make special note of the dates for our Annual Institute, hosted earlier this year on September 27-29 at the Borgata.



Cybersecurity Risk Prevention in 2023: Three Gaps to Close

Gerry Blass

by Gerry Blass

Health care investments in privacy and security are set to explode in the wake of ongoing cyberattacks and rising risk. Know the three most important risk areas to fortify and be prepared for the 2023 surge

Investments in cybersecurity are a top priority for health care executives, according to a recent survey from Bain & Company conducted in collaboration with KLAS Research. Along with revenue cycle management software and patient flow automation, investments in privacy and security lead 2023 technology investment priorities following a wave of cyberattacks and rising risk.

For example, data breaches are up nearly 40% since 2020, according to the same report, and they are growing increasingly expensive. One of health care's most recent breaches, a ransomware attack at CommonSpirit Health that forced EHR shutdowns and patient appointment cancellations, emphasizes the need for immediate cybersecurity risk prevention. If ransomware can attack a 142-hospital health system, it can strike us all.

There are three specific gaps for provider organizations to watch in the year ahead: vendor risk management (VRM), internal audits, and disaster recovery plans.

Investments in cybersecurity are a top priority for health care executives, according to a recent survey from Bain & Company conducted in collaboration with KLAS Research. Along with revenue cycle management software and patient flow automation, investments in privacy and security lead 2023 technology investment priorities following a wave of cyberattacks and rising risk.

Inadequate Vendor Risk Management Programs

Most health care data breaches reported to the Health and Human Services (HHS) Office for Civil Rights in 2022 involved third-party vendors. This upturn in vendor-related breaches implies that nefarious actors are targeting business partners rather than the health systems. The trend also elevates the importance of an effective VRM program as a crucial component of an organization's complete cybersecurity and disaster recovery business continuity (DRBC) plan.

Here are three points to consider when updating your VRM program.

- All third-party vendors that capture, store, receive, exchange, or use an organization's electronically protected health information (ePHI) should be assessed annually and ranked as low, medium, or high risk.
- The type of third-party vendor is less important than how the company uses ePHI.
- More third-party vendors will enter the health care ecosystem in 2023, in-cluding digital apps for patient disease manage-ment, hospital-at-home technology, revenue cycle automation, and more.

The National Institute of Standards and Technology is updating its Cybersecurity Framework from version 1.0 to version 2.0 in 2023. Compliance with the new framework should be another evaluation factor for an organization's third-party vendors.

Incomplete Risk Registers

Health care's workforce shortage is well documented. Organizations nationwide are experiencing tremendous personnel gaps. This often includes insufficient IT resources to conduct internal privacy and security audits or mitigate cybersecurity risks.

When internal cybersecurity audits get pushed out, updates to the organization's risk register are a practical next step. A complete risk register provides vital information in the case of an audit, details risks that could affect business, and gives

continued on page 6

continued from page 5

departments an autonomous roadmap for the year ahead.

At a minimum, the organization's risk register should include the following:

- An inventory of all identified risks
- Grading the risks based on likelihood and/or impact;
- The best course of action to address each risk; and
- Targeted list of risks for additional attention to manage.

Risk registers and VRM programs are both parts of a complete DRBC plan. Now is also the time to update the DRBC for 2023.

Outdated Disaster Recovery Business Continuity Plan

Extended downtime, as experienced during the CommonSpirit Health breach mentioned above, is a frequent outcome following cybersecurity attacks. Patient care applications, biomedical devices, ePHI, and patient safety are all at risk when extended downtime occurs.

DRBC plan updates should address extended breaks in system access—even beyond three full business days. Here are three new questions to include in an organization's 2023 plan.

- What does extended downtime look like for each department?
- What is the business impact analysis of extended downtime?
- What additional education is needed to prepare for extended downtime?

The three gaps mentioned above are solid starting points for cybersecurity risk prevention activities. To further support the healthcare industry's efforts, HHS produces and continually updates a health industry cybersecurity practices (HICP) quick start guide. The guide is a valuable resource for all health care organizations.

HICP Guide Is Essential Cybersecurity Risk Prevention Playbook

The HICP guide is designed to help small, medium, and large health care provider organizations prioritize what is important and support the national health sector's cyber preparedness. All five HICP threats and 10 controls mentioned in the guide should continue to be highlighted during 2023.

HICP is voluntary for health care organizations. Use of HICP is not required by law. It is a carrot incentive for better health care cybersecurity prevention versus a stick. And there are significant benefits for organizations that document at least 12 months of compliance with HICP guidelines:

- Mitigation of any HIPAA fines;
- Early favorable termination of any HIPAA audit; and
- Easing of remedies within any HIPAA resolution agreement with HHS.

Prioritizing cybersecurity risk using the HICP in combination with the new technology investments planned by health care executives will place health care provider organizations on solid ground for the year ahead. Risks will always abound but adopting a culture of cybersecurity hospitals prepares health systems and physician groups to stay ahead of the game and protect their organizations.

About the author

Gerry is President and CEO of ComplyAssistant, which provides GRC software and healthcare cybersecurity service solutions to over 100 healthcare organizations of all sizes, focusing on HIPAA-HITECH-OMNIBUS, PCI, NIST, and other federal and state healthcare regulations. He can be reached at gerry@complyassistant.com.

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Please note that on April 18, 2023, HHS updated the 405d (HICP) website to include a more information, including "Knowledge on Demand", and much more. You can access the website at www.405d.HHS.gov

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Coming Soon, to a Hotel Casino and Spa Near You, the 47th Annual Institute

Michael McKeever

by Michael McKeever

On September 27, HFMA members and friends from the NJ Chapter, Metropolitan Philadelphia Chapter, HFMA Region 3 and beyond will be gathering once again at the Borgata for the 47th Annual Institute. Building on the post-pandemic success of the last two Annual Institutes, the planning committee has been working feverishly to ensure an unbelievable experience for all attendees. As you may recall, the Institute transitioned during 2020 to online an online event due to the pandemic, but returned to the Borgata the next year, implementing those precautions recommended for in-person events. The 46th Annual Institute, which was held in October of last year, saw an increase in attendance over the prior year as those restrictions expired, and this year we're looking forward to an even bigger crowd.

Dennis E. Dahlen

Starting off this year's event is Dennis E. Dahlen, FHFMA, CPA, our Kickoff Speaker, who is scheduled to present at 12:00 noon on Wednesday, September 27. For those of you who haven't heard of Dennis, or aren't sure how you know the name, he is the Chief Financial Officer of Mayo Clinic, a $16 billion enterprise that includes clinical practice, research, and medical education operations, and the 2023 – 2024 HFMA Chair. I had the pleasure of meeting Dennis, as well as the 2022 -2023 HFMA Chair, Aaron Crane, when they joined the Region 3 table for breakfast at the 2022 Leadership Training Conference last year in Phoenix. I'm looking forward to hearing him address our members, focusing on the 2023 – 2024 Chair's Theme "It's Time".

After the Kickoff Presentation attendees will be invited to enjoy dessert in the Vendor Hall, while visiting with those partners who are so essential to the successful presentation of the Annual Institute. The remainder of Wednesday afternoon is devoted to nine unique breakout education sessions during three time slots, touching on such topics of common interest as the impact of the end of the Public Health Emergency, navigating payer contracts, tax credits available to healthcare entities through the Inflation Reduction Act, and debt covenant compliance, to name a few. That evening we'll return to the Vendor Hall for the Annual Charity Event, which always includes tasty treats and inviting libations.

Thursday morning has the Chapter's Award Ceremony immediately after breakfast, wherein we celebrate the achievements of our members. Dr. Ronald Hirsh begins the day's educational agenda with a general session that will examine the relationship between case management's role and the revenue cycle. Immediately following Dr, Hirsch will be Day Esquiza, who will focus on the post-pandemic revenue cycle challenges faced by all providers. After a short networking break this year's Keynote Speaker, Robert C. Garrett, Chief Executive Officer at Hackensack Meridian Health will address the conference. As the leader of New Jersey's largest healthcare system, he is uniquely positioned to address the strengths and weaknesses of our regional delivery system, as well as what the future might hold for providers of all sizes and structures. We're happy to have Bob as our 2023 Keynote.

Robert C. Garrett

Immediately following lunch on Thursday there are two rounds of breakout sessions, featuring eight topics relevant to various areas of healthcare operations. Included are sessions on cyber security, merger and acquisition transactions, and an

update on recent fraud and abuse investigations. The Thursday afternoon break included the ever-popular Ice Cream Social, which takes place in the Vendor Hall. We'll all need a cool treat after such an engaging day of educational sessions. The final round of breakout session on Thursday afternoon includes a discussion of the CFO/CIO collaboration, the use of artificial intelligence in the revenue cycle, using data analytics to support the transition to value-based care, and partnering compliance with revenue integrity when performing investigations.

This year the committee decided to wrap up Thursday's educational sessions with the Revenue Cycle Roundtable. We've invited leading revenue cycle leaders from the New Jersey and Pennsylvania region to discuss those things that keep them up at night, as well as those strategies that lead to a better night's sleep. This is a not-to-be missed session, and we're excited to hear the different perspectives from providers across the region. Currently scheduled to participate are Steven Honeywell from Penn Medicine, Anne Goodwill-Pritchett from Hackensack Meridian Health, Sandy Gubbine from AtlantiCare, Christy Pehanich from Geisinger, and Joe Scargle from RWJ Barnabas Health.

After a short break we'll gather for the always popular President's Reception. As of this time and depending on the weather we're hoping to use the Borgata indoor pool for this event. It's been a couple of years since we've had access to this venue, but those who remember it will recall what a dramatic setting it is for a formal event like the President's Reception. Later in the evening, for those of us who are still awake and looking for additional networking opportunities, we'll have the Late-Night event at the Premier Nightclub. Hope you're all able to join us!

Friday morning includes two general sessions, with the event ending after the CFO Panel. As has been our tradition, the Annual Institute provides outstanding value in healthcare education and networking opportunities. A special thanks is owed to the members of the Annual Institute Committee, including our Co-Chair for Education, Sandy Gubbine, and the Chapter President, Heather Stanisci. And I would be remiss if I didn't thank our sponsors, whose continual support allows us to bring you such an exciting event at such a reasonable cost.

I hope this article gives you a peek into what we have planned, and that you'll be able to join us at the Borgata on September 27. You know you want to be there, so register now!

For more information on the 47th Annual Institute, including the agenda, hotel information, to register and sponsorship opportunities please visit the website at: https://web.cvent.com/event/317d8ff7-28f0-4dc6-82be-9e28ce54cd46/summary

COVID-19 Public Health Emergency Transition

Fatimah Muhammad

by Fatimah Muhammad

The COVID-19 Public Health Emergency policy provides a roadmap for combating the spread of the SARS-CoV-2 virus. This approach by the US Department of Health and Human Services (HHS) is aimed at building a better emergency response as the government carries out a transition from emergency phase of the COVID-19 operations. The policy has an impact on healthcare, healthcare financial management, public health and the national 340B program. This essay discusses the expectations of the Public Health Emergency and what it means for the healthcare system.

The Public Health Emergency ended on May 11, 2023. This policy will have an impact on some healthcare areas therefore altering the standards of care provided for patients. As reported by HHS (2023), the healthcare sections that will not be affected include: accessibility of treatments and vaccines for COVID-19; authority of the Food and Drugs Administration (FDA) towards COVID-19 products such as vaccines, tests and treatments; Medicare and Medicaid telehealth flexibilities; eligibility of Medicaid redeterminations and accessibility to opioid use treatment for disorders and expansion to methadone doses. The areas that will be affected by the policy include: some COVID-19 Public Health Emergency waivers for Medicare and Medicaid, coverage of COVID-19 testing, recording COVID-19 immunization information and lab results by the Center for Disease Control, guidance documents for FDA approval, detection of early shortages for COVID-19 by the FDA, liability protections by Public Readiness and Emergency Preparedness (PREP) Act and disbursement of controlled substances using telemedicine by healthcare providers (U.S. Department of Health & Human Services, 2023).

After the expiration of the PHE declaration, the responsibility for testing, treatment and vaccination of COVID-19 will move towards individuals and health insurance companies accordingly. Notably, the health care system had prior increased flexibility when responding to surges by patients (Adam, 2023). Additionally, hospitals were able to expand their telehealth systems. Sadly, as Adam (2023) reports, healthcare systems will lose their flexibility on deployment of staff and be unable to increase their capacity beds and medical care for patients in the facility as a result of the expiration. This will reduce the effectiveness of telemedicine provided by healthcare institutions.

It is worth further noting that the healthcare financial management of treating COVID-19 will shift towards individuals and their health insurance plans. Based on this, Medicare and Medicaid will not be able to cater for the coverage of all COVID-19 treatments. Consequently, the ability of private hospitals to cover COVID-19 tests without cost sharing will eventually end. Coverage will only be as agreed on by healthcare insurance providers or patients will have to pay out-of-pocket (Tanne, 2023). The flexibilities of the 340B program have not been completely clarified by the US Health Resources and Services Administration (HRSA). However, they did state that covered entities need to clarify their telehealth and other technologies in their 340B policies and procedures as well as ensuring compliance of the covered entities with all the 340B requirements. The cost of Pfizer and Moderna COVID-19 vaccines will increase by four times from between $30 per dose to between $110 and $130 (Tanne, 2023). Further, the state and local governments will be affected in their public health response to future emergencies. This will affect their ability to provide rapid emergency responses in the future.

Based on the above sentiments, it will be difficult for public health to effectively ensure proper delivery of equitable health to society. Therefore, most people will be unable to meet the required bill of enrollees who will be affected by the emergency as well as receiving medical care at out-of-network healthcare facilities. The proposed COVID-19 Public Health Emergency policy transitional roadmap has left many United States citizens and associated healthcare systems wondering whether the policy will bring more harm than good to the country.

About the author

Fatimah has extensive experience in pharmacy, public health, and professional research while possessing an eclectic blend of interpersonal skills. She serves as the 340B Pharmaceutical Services Director at Saint Peter's University Hospital where she presides over all projects related to 340B. Her current endeavors focus on Health Disparities, Health Equity, Patient-Reported Outcomes, Community Health Promotion, and Disease Prevention and Health Services Research. She can be reached at fmuhammad@saintpetersuh.com.

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All certification costs and study materials are included in your membership dues when you join HFMA, whether you pursue one or all of our designations! So if you have not thought about it yet, now may be the time you should!

Congratulations to Jacid Soto, the newly CRCR certified member and employee of the Valley Hospital!

If you have any questions about certification, please contact Amina Razanica, FHFMA at arazanica@njha.com or careerservices@hfma.org.

SAVE the DATE

September 27-29, 2023
47th Annual Institute
The Borgata
Atlantic City

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

Third Circuit Finds That Plain Language of Section 340B Does Not Require Drug Makers to Provide Discounted Drugs to Unlimited Contract Pharmacies

Mary E. Toscano

by Mary E. Toscano

The 340B Drug Price Program (340B Program) is a drug-pricing discount regime established by Congress in 1992 within the Public Health Service Act, which is administered by the Secretary of Health and Human Services (HHS).[1] In order to have their drugs covered through Medicaid and Medicare Part B, drug manufacturers are required to participate in the 340B Program.[2] More specifically, pharmaceutical manufacturers must sell their "covered outpatient drugs"[3] at a heavily discounted price to "covered entities," which are defined by statute to include fifteen enumerated types of public and not-for-profit hospitals, community centers and other federally funded clinics serving low-income patients.[4] Notably, all pharmaceutical manufacturers participating in the 340B Program must "offer each covered entity covered outpatient drugs for purchase at or below the applicable ceiling price if such drug is made available to any other purchaser at any price,"[5] thereby requiring drug makers to sell their drugs at or below a price cap. The resulting 340B "ceiling prices," which are calculated according to a prescribed statutory formula,[6] are significantly lower than the amount(s) other purchasers would pay. Covered entities can opt to pass the savings along to uninsured and underinsured patients to subsidize what would otherwise be cost prohibitive rates for medications. As such, the discounted drugs benefit both patients, by helping them to afford costly medications, and covered entities, which use the discounts to take full advantage of federal resources and serve a greater number of uninsured and under-insured patients.[7]

Between 1996 and 2010, covered entities could only use one contract pharmacy to order and pay for 340B drugs. In 2010, HHS issued new guidance that allowed covered entities to use an unlimited number of contract pharmacies. As a result, the use of contract pharmacies increased dramatically, causing drug makers to grow concerned about contract pharmacies increasing duplicative discounting and diversion.[8] To combat these fears, several pharmaceutical manufacturers modified their policies to limit the use of contract pharmacies by covered entities. In response, HHS took three actions: (1) it issued an Advisory Opinion in December 2020 (the Advisory Opinion) requiring drug makers to deliver 340B drugs to an unlimited number of contract pharmacies;[9] (2) it issued Violation Letters to certain drug makers for issuing unlawful policies that limited the number of contract pharmacies, requiring those drug makers to rescind their policies and reimburse covered entities for any overcharges; and (3) following an initial proposed rule-making in 2016, it issued a final Administrative Dispute Resolution (ADR) Rule in 2020 to establish a process through which drug

makers and covered entities could resolve Section 340B-related disputes.

Against this backdrop, three drug manufacturers, namely Sanofi Aventis U.S. LLC, Novo Nordisk Inc./Novo Nordisk Pharma, Inc. and AstraZeneca Pharmaceuticals LP, sued the United States Department of Health and Human Services, among others, to invalidate the Advisory Opinion as arbitrary and capricious and challenge HHS's Violation Letters.[10] In Delaware, the Court held that the Advisory Opinion was arbitrary and capricious because it erroneously found that 340B was unambiguous,[11] and vacated the Violation Letter issued to AstraZeneca on the same basis.[12] HHS appealed.

Meanwhile, in New Jersey, in *Sanofi-Aventis U.S., LLC v. HHS*,[13] the Court held that Sanofi's and Novo Nordisk's challenges to the Advisory Opinion were moot, largely upheld the Violation Letters on the basis that the statute's purpose and legislative history required delivery to at least one contract pharmacy (but remanded to HHS to consider whether 340B required delivery to an unlimited number of contract pharmacies), and upheld the ADR rule. Sanofi and Novo Nordisk appealed.

On January 30, 2023, the Third Circuit resolved the district court split between the Delaware and New Jersey courts in favor of the drug makers. Finding that the plain language of the 340B statute omits any reference to the delivery of drugs to an unlimited number of contract pharmacies, the Third Circuit held that the statute's requirement that drug makers "offer" drugs to "covered entities" did not require the drug makers to deliver goods "wherever and to whomever the buyer demands," observing that all of the drug makers' policies at issue had allowed for the use of at least one contract pharmacy, and in some instances, more than one contract pharmacy.[14] Nor did the "purchased by" provision of the 340B statute require anything more than a price term for drug sales to covered entities. The Third Circuit found that the statute's legislative purpose did not require a different result.[15] The Third Circuit invalidated the Violation Letters for the same reasons it found that the Advisory Opinion was unlawful.[16]

Finally, the Third Circuit addressed Sanofi's challenge to the ADR Rule, rejecting its argument that the Government's 2017 withdrawal of the rule proposed in 2016 required the agency to recommence the notice and comment period under the Administrative Procedure Act (APA). Judge Bibas found that nothing in the APA required such a reading, and that HHS had complied with the notice and comment period before publishing the final rule in 2020.

Undoubtedly, drug makers will use this victory in the Third Circuit to challenge any effort by HHS to expand the number of contract pharmacies utilized by covered entities now that there is precedent that drug makers "need not help [covered entities] maximize their 340B profits."[17] Will other circuits reach the same conclusion? Only time will tell, but for now, unless or until another Circuit Court decides the issue differently from the Third Circuit, thereby creating a split in the circuit courts, it is unlikely that the United States Supreme Court will weigh in on the issue. Accordingly, the Third Circuit Court of Appeals decision will remain the leading authority for other courts to follow.

What will the impact be on 340B entities, which are already facing hardships due to the pandemic and severe financial cuts to reimbursement rates by the Centers for Medicaid and Medicare Services between 2018 and 2022?[18] At least in New Jersey, Pennsylvania, Delaware and the Virgin Islands, the provision of care to vulnerable, low-income populations may be impacted.

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Endnotes

[1] *See* Veterans Health Care Act of 1992, Pub. L. No. 102-585, § 602, 106 Stat. 4943, 4967-71 (codified as amended at 42 U.S.C. § 256b). The Health Resources and Services Administration ("HRSA"), a sub-department of HHS, is responsible for administering the 340B Program.

[2] *See* 42 U.S.C. § 1396r-8(a)(1); 42 U.S.C. § 256b(a).

[3] Covered outpatient drugs are those drugs defined under section 1927(k) of the Social Security Act, 42 U.S.C. § 1396r–8(k) (1994). See 42 U.S.C. § 256b(a)(3).

[4] *See* Veterans Health Care Act of 1992, Pub. L. No. 102-585, § 602, 106 Stat. 4943, 4967–71 (1992), codified at § 340B Public Health Service Act, 42 U.S.C. § 256b (1992).

[5] 42 U.S.C. § 256b(a)(1).

[6] *See* 42 U.S.C. § 256b(a)(1), (a)(4), (b)(1),

[7] *See* H.R. Rep. No. 102-384, pt. 2 at 12 (1992) (conf. report) (These significant drug pricing discounts are intended to "enable [covered entities] to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.").

[8] *See Sanofi-Aventis U.S., LLC v. U.S. Dep't of Health & Hum. Servs.,* 570 F. Supp. 3d 129, 152 (D.N.J. 2021), *aff'd in part, rev'd in part sub nom. Sanofi Aventis U.S. LLC v. United States Dep't of Health & Hum. Servs.,* 58 F.4th 696 (3d Cir. 2023), judgment entered, No. 21-3167, 2023 WL 1325507 (3d Cir. Jan. 30, 2023).

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[9]*See* HHS Off. Gen. Couns., *Advisory Opinion 20-06 on Contract Pharmacies Under the 340B Program* (Dec. 30, 2020).

[10]Only Sanofi challenged the ADR Rule on the basis that the ADR rule was unconstitutional and violation the APA. *See Sanofi-Aventis U.S., LLC*, 570 F. Supp. 3d at 159.

[11]*See AstraZeneca Pharms. LP v. Becerra*, 543 F. Supp. 3d 47, 58-62 (D. Del. 2021).

[12]*See AstraZeneca Pharms. LP v. Becerra*, 2022 WL 484587, at *3 (D. Del. Feb. 16, 2022).

[13]*See Sanofi-Aventis U.S., LLC*, 570 F. Supp. 3d at 159 n.3.

[14]*See Sanofi Aventis U.S. LLC v. United States Dep't of Health & Hum. Servs.*, 58 F.4th 696, 701, 703-04 (3d Cir. 2023), *judgment entered*, No. 21-3167, 2023 WL 1325507 (3d Cir. Jan. 30, 2023)).

[15]*See id.* at 705-06.

[16]*See id.* at 706.

[17]*See id.* at 704.

[18]*See* F. Muhammad and M. Kass, "The Relief of Some Financial Burden: CMS to Pay Back 340B Hospitals in 2023," Garden State FOCUS (Winter 2022).

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What the Expiration of the Public Health Emergency Means for Telehealth

John W. Kaveney

by John W. Kaveney

The Public Health Emergency (PHE) enacted by the federal government on January 31, 2020, and by the State of New Jersey on March 9, 2020 provided for increased flexibility for the provision of telehealth services. As a result, the healthcare industry witnessed an explosion of this delivery method for healthcare services with many providers and patients favoring its convenience. What started as a tool to allow the ongoing delivery of healthcare services in a pandemic-isolated world, quickly became a common tool in the industry and an expected norm by patients. However, with the PHE having expired here in New Jersey on June 4, 2021, and the federal PHE having expired on May 11, 2023, providers must reassess the status of the law to ensure ongoing compliance with applicable federal and state telehealth laws if they wish to continue providing services via this medium. As noted by Fatimah Muhammad in her FOCUS magazine article entitled *COVID-19 Public Health Emergency Transition*, all aspects of the delivery of care during the pandemic, including for the treatment of COVID-19 and otherwise, are now in flux and must be closely reviewed to ensure compliance with the laws going forward.

While many have noted that certain aspects of the telehealth flexibilities and waivers have been extended past the conclusion of the PHEs, there are also certain aspects of the telehealth laws that are returning to their pre-pandemic status. Thus, it is important for providers to not only take stock of how the laws are changing post-PHEs, but also to take note of when some of the extended flexibilities and waivers will expire in the future, absent further action by the federal and state governments.

Extensions of Telehealth Flexibilities Via the Consolidated Appropriations Act

One of the most notable legislative acts to extend many of the telehealth flexibilities came with the passage of the Consolidated Appropriations Act (CAA) of 2023.[1] The CAA extended many of the pandemic-era telehealth flexibilities including, but not limited to, the following items, through December 31, 2024:

- ***Telehealth services provided at home will continue to be covered by Medicare*** – The *originating site* has historically served as a significant restriction to where a patient could receive telehealth services. During the pandemic this definition was relaxed to include locations such as a patient's home or temporary residence and to eliminate the exclusivity of patient's being located only in rural areas. The CAA extended this relaxed definition through December 31, 2024. For behavioral health services, this relaxation of the definition has been made permanent.
- ***Audio-only telehealth will continue to be covered by Medicare*** – Post-PHE behavioral and mental audio-only telehealth services will be permanently covered by Medicare while certain non-behavioral telehealth services offered via audio-only will be covered through December 31, 2024.
- ***Federal Qualified Health Centers and Rural Health Clinics can continue to serve as distant site providers*** – Pursuant to the CAA, these providers can continue to offer telehealth services to Medicare beneficiaries rather than being limited to being an originating site provider for telehealth.
- ***Continued expanded list of qualified telehealth providers*** – The list of providers eligible to continue offering telehealth services to Medicare beneficiaries will remain expanded to include physical therapists, occupational therapists, speech language pathologists and audiologists. Prior to the PHE, only physicians, nurse practitioners, physician assistants, and limited other specified providers could provide telehealth services under Medicare. This expanded list of telehealth providers will remain in effect until December 31, 2024, unless additional action is taken to change the law.
- ***Continued utilization of at-home acute hospital care through telehealth*** – Under the CAA, the acute hospital care at home program was extended to allow the contin-

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ued utilization of acute care hospital services to patients in their homes, including through telehealth. Similar to some of the other extensions, for behavioral health services Medicare beneficiaries will be able to permanently receive these services at home, whereas for non-behavioral health services, Medicare beneficiaries will only be eligible to receive the services via telehealth from home through December 31, 2024.

- ***Delaying of the in-person requirement for telehealth mental health services*** – A relatively new CMS rule requires an in-person visit within six months of the first behavioral or mental telehealth service provided to a patient and an in-person visit with the patient at least every twelve months thereafter to qualify for Medicare coverage. This requirement has been delayed by the CAA and will not go into effect until after December 31, 2024. Many in the behavioral health space have questioned the need for this in-person visit and thus it remains to be seen if further changes will be made between now and the end of 2024.

While the CAA extended many of the flexibilities and waivers put in place during the PHE, there are several that have now expired with the conclusion of the PHE and will have a direct impact upon the continued provision of telehealth services.

Expiration of the Office of Civil Rights' Enforcement Discretions

The US Department of Health and Human Services Office of Civil Rights (OCR) exercised its enforcement discretion during the PHE to relax various requirements of the Health Insurance Portability and Accountability Act (HIPAA) rules.[2] This enforcement discretion was only to remain in effect during the pendency of the PHE to allow greater flexibility so that providers could creatively ensure healthcare delivery to patients while not fearing penalties from the government for certain failures to demonstrate absolute compliance with HIPAA.

In the months leading up to the expiration of the PHE, OCR announced that these enforcement discretions would expire, and HIPAA enforcement would return to its pre-pandemic standards post-PHE. However, prior to the May 11, 2023 expiration of the PHE, OCR announced it had decided to provide for a 90-calendar day transition period for covered healthcare providers to come back into compliance with the HIPAA rules with respect to the provision of telehealth. Thus, providers now have until August 9, 2023, at 11:59 p.m. before penalties will again begin to be imposed for certain aspects of HIPAA.

Prescribing of Controlled Substances Via Telemedicine

The ability of providers to prescribe certain controlled substances via telemedicine was also at risk of significant change upon the expiration of the PHE. During the course of the PHE, providers were permitted to prescribe controlled substances via telemedicine without the need for in-person examinations of the patients. However, with the expiration of the PHE, and pursuant to a pending new rule published in February 2023 by the federal Drug Enforcement Administration (DEA), in-person examinations would again be a requirement to ensure continuity of care. Under the proposed DEA rule, if a patient had not been seen in-person, and was in need of a controlled medication, providers would be limited to prescribing a 30-day supply of Schedule III-V non-narcotic controlled medications, or a 30-day supply of buprenorphine for the treatment of opioid use disorder without an in-person evaluation or referral from a physician that conducted an in-person evaluation. For Schedule II medications or Schedule III-V narcotic-controlled medications, an initial in-person exam would again be required before any such prescriptions.[3]

Despite this proposed rule remaining under review, the DEA recently published a statement advising that, "[w]e recognize the importance of telemedicine in providing Americans with access to needed medications, and we have decided to extend the current flexibilities for six months while we work to find a way forward to give Americans that access with appropriate safeguards."[4] Thus, the industry is awaiting further guidance from the DEA regarding what it will do with its pending proposed rule and whether it will reverse course on its current proposal to require in-person evaluations.

Virtual Direct Supervision Set to Expire

Another key PHE waiver was the permission by the Centers for Medicare and Medicaid Services (CMS) for providers to utilize remote, real-time, interactive audio-video technology to satisfy Medicare Part B's direct supervision rules for certain types of services. Historically, Medicare has required a supervising professional to be physically present in the same office suite and immediately available to furnish assistance and direction for it to qualify as "direct supervision" and thus be covered by Medicare. In CMS' 2023 Medicare Physician Fee Schedule final rule[5], CMS declined to extend the utilization of virtual direct supervision. As a result, it is set to expire at the end of the calendar year in which the PHE expires, which is December 31, 2023. Thus, providers will again need to be physically present in the same suite and immediately available to assist for services to be considered rendered under the direct supervision of a provider.

Parity of Medicare Payments for Telehealth

Another area of change for providers is the parity in Medicare payments that providers were receiving during the pandemic despite providing services via telehealth instead of in-

person. For services rendered via telehealth at non-facilities (*i.e.* at a patient's home), CMS has been reimbursing the telehealth services at the same rate as a regular, in-person visit. These higher reimbursement rates for telehealth services are scheduled to expire at the end of the year. It remains to be seen whether lawmakers or CMS will attempt to change this policy and either extend or make permanent the reimbursement rates.[6]

Parity of Payments in New Jersey for Telehealth

At the outset of the PHE, New Jersey mandated that health benefit plans similarly reimburse providers for telehealth services at the same rate as in-person services, with limited exceptions. In December 2021, New Jersey enacted a law extending this requirement for a two-year period.[7] Thus, through the end of 2023, New Jersey health benefit plans, Medicaid and NJ FamilyCare, and the State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) must reimburse providers at the same rate as those rendering care in-person.

In 2020, the New Jersey Legislature passed a bill stating that during the PHE and state of emergency declared by the Governor in Executive Order 103, the State Medicaid and NJ FamilyCare programs shall provide coverage and payments for expenses incurred in the delivery of healthcare services through telemedicine or telehealth in accordance with the provisions of P.L.2017, c.117.[8] While the New Jersey PHE expired on June 4, 2021 via Executive Order 244, the state of emergency has continued to remain in place ever since.[9] Consequently, Medicaid and NJ FamilyCare continue to be a source of reimbursement and payment for telehealth services in New Jersey.

New Jersey Utilization of Out-Of-State Physicians

New Jersey has taken additional action regarding telehealth during and post-PHE. In 2020, New Jersey acted to allow out-of-state providers to treat residents of New Jersey both in-person and via telehealth. While those relaxations of the licensure rules were originally set to expire with the conclusion of the New Jersey PHE, the signing of Senate Bill 4139 extended the temporary authorization of such providers to practice within New Jersey. That extension is currently in effect and runs until 60-days after the conclusion of the federal PHE. Thus, providers must be prepared to move away from the utilization of out-of-state providers not licensed to practice medicine in the State of New Jersey.[10]

While the above discussion outlines several of the key flexibilities and waivers of the pandemic that are either continuing beyond the PHE, or which expired with the conclusion of the PHE, there are still many other flexibilities and waivers, both on a federal level and in New Jersey, that could be discussed herein, and which will impact providers across the State of New Jersey. Providers must be vigilant to ensure they remain updated on any new changes that occur, especially since this is a dynamic area of the law that is changing by the day. Thus, it is safe to assume the current status of these flexibilities and waivers will continue to evolve as we move further from the PHE, and federal/state legislatures and agencies evaluate the future of telehealth services.

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Endnotes

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The No Surprises Act IDR: A Process Plagued with Challenges That Needs Improvement

Colleen Picklo

Joe D'Onofrio

by Colleen Picklo and Joe D'Onofrio

The federal independent dispute resolution (IDR) created under the No Surprises Act is the process by which arbitrators decide disputes between providers and payors in certain situations that qualify, by the law, as a surprise bill.

While the law provides important consumer protections it also exposes providers who have provided services to delays in payment during the IDR process. The potential for payment delays has been exacerbated by numerous legal challenges as well as operational setbacks since the IDR process went live on April 15, 2022.

On July 1, 2021, several federal Departments – including Health and Human Services, Labor, and Treasury (the Departments) – issued an Interim Final Rule implementing, among other things, methods for calculating the Qualifying Payment Amount (QPA). The QPA plays an important part in the IDR process, acting as one of several factors to be considered in resolving a billing dispute between an out-of-network provider and an insurer.

On October 7, 2021, the Departments published a second Interim Final Rule that included specific processes related to the federal IDR process, but it also established the QPA as the presumptive reimbursement amount to be selected by IDR arbitrators.

Subsequently, the US District Court for the Eastern District of Texas found that the rules didn't properly reflect what was allowed under the No Surprises Act by establishing a rebuttable presumption in favor of the qualifying payment amount and failed to give appropriate weight to the other factors identified in the law.

This decision led to the Departments modifying the original rules and in August 2022, a final rule was issued that eliminated the rebuttable presumption relating to the QPA in response to the court's decision. However, once again the court found that the revised rules continued to favor the QPA and vacated parts of the final rule.

These legal challenges led to a significant backlog in determinations because the vendors permitted to hear disputes – called certified IDR entities – experienced ongoing changes to the parameters to consider in making decisions, which led to the pending of decisions while guidance was changed.

While the law provides important consumer protections it also exposes providers who have provided services to delays in payment during the IDR process.

The backlog from these disruptions is highlighted in two federal reports issued in April 2023: the Federal Independent Dispute Resolution Process –Status Update (cms.gov) and the initial fourth quarter 2022 quarterly report Partial Report on the Independent Dispute Resolution (IDR) Process (cms.gov).

Between April 15, 2022 and March 31, 2023, disputing parties, in most instances providers, initiated 334,828 disputes, nearly fourteen times greater than the Departments initially estimated would be filed in a year. However, during that same time only 106,615 disputes were resolved.

Of the disputes that were resolved, certified IDRs determined that 39,890 were ultimately ineligible for the IDR process, rendered payment determinations in 42,158 disputes and the remainder were closed due to reasons other than ineligibility or payment determinations. For example, disputes are closed because the disputing parties withdraw or reach an outside settlement, or due to unpaid fees.

That means there are almost a quarter of a million disputes needing resolution, leaving providers awaiting payment for these services.

Further delaying the issuance of determinations is the complexity in determining whether disputes are eligible for the IDR process. Recently, the Departments have made enhancements intended to ensure that dispute filings are identified as appropriate upon filing, including three data elements to assist with eligibility screening:

- A question about the start date of the parties' open negotiation period
- A question to determine if a dispute was initiated within the four-business-day time frame after open negotiation ended
- An attestation confirming the dispute is appropriate for the federal IDR process rather than an available state process

That means there are almost a quarter of a million disputes needing resolution, leaving providers awaiting payment for these services.

The intent is that the questions will assist in ensuring a dispute is appropriate for the process, thereby mitigating delays in processing.

However, the more detailed Q4 2022 reporting indicates that non-initiating disputing parties challenged the dispute's eligibility in 42,504 of the 110,034 disputes filed during 2022 Q4, representing approximately 40 percent of initiated disputes. Ultimately, 8,343, or 64 percent, of the 13,022 disputes closed during that quarter that were challenged as ineligible were found ineligible for the Federal IDR process.

Conversely, that means 36 percent were challenged inappropriately, delaying processing. The Departments have an opportunity to consider requirements that provide for penalization of inappropriate challenges to ensure a lack of process gaming.

Furthermore, given that the report has indicated initiating parties, which are predominately providers, are prevailing 71 percent of the time it is likely providers will continue to avail themselves of the process, which has the potential to exacerbate the ongoing backlog.

The Departments should identify opportunities to ensure the backlog is dealt with expeditiously. For example, encouraging participation among arbitration firms that haven't applied to be a certified IDR entity, assisting existing certified IDR entities with staffing augmentation where possible or identifying possibilities to partner with states like NJ that have surprise billing dispute resolution processes that predate the NSA.

It is imperative that the Departments identify process improvement measures quickly in order to ensure the financial viability of providers.

About the authors

Colleen Picklo is the deputy director of managed care and insurance at the New Jersey Hospital Association, analyzing insurance-based regulations and legislation to gauge the policy implications for NJHA's membership, as well as participating in the association's advocacy efforts related to legislative and regulatory initiatives. Colleen also provides member assistance related to current regulatory and legislative compliance by managed care companies and by facilitating outreach to managed care companies or regulatory agencies.

She also holds a seat on New Jersey's Individual Health Coverage Board. Colleen can be reached at CPicklo@NJHA.com.

Joe D'Onofrio partners with health systems & physician practices across the East Coast and South as Panacea's director of business development. He provides healthcare leaders in revenue cycle, compliance, managed care and finance teams with financial & clinical solutions to ensure compliance, maximize reimbursement, and improve net revenue. Joe provides subject matter expertise on price transparency and the No Surprises Act to HFMA Education committees, state and regional webinars, panels and as a speaker. He serves as the North Florida HFMA Education Committee chair. Joe can be reached at jdonofrio@panaceainc.com.

•Who's Who in NJ Chapter Committees•

2023-2024 Chapter Committees and Scheduled Meeting Dates

***NOTE:** Committees have use of the NJ HFMA conference Call line.
If the committee uses the conference call line, their respective attendee codes are listed with the meeting date.

PLEASE NOTE THAT THIS IS A PRELIMINARY LIST - CONFIRM MEETINGS WTH COMMITTEE CHAIRS BEFORE ATTENDING.

COMMITTEE	PHONE	DATES/TIME/ ACCESS CODE	MEETING LOCATION
CARE (Compliance, Audit, Risk, & Ethics)			
Chair: Fatimah Muhammad – fmuhammad@saintpetersuh.com	(732) 745-8600 Ext. 8280	First Thursday of the month	Conference Call
Co-Chair: Ryan Peoples – RPeoples2@virtua.org		9:00 AM	(667) 770-1469
Board Liaison: Lisa Hartman – lisa.weinstein@bancroft.org	(856) 348-1190	Access Code 473803	
Communications / FOCUS			
Chair: James Robertson – jrobertson@greenbaumlaw.com	(973) 577-1784	First Thursday of each month	Conference Call (667) 770-1479
Board Liaison: Brian Herdman – bherdman@cbiz.com	(609) 918-0990 x131	8:00 AM Access Code: 868310	In-person Meetings by Notification
Education			
Chair: Lisa Hartman – lisa.weinstein@bancroft.org	(856) 348-1190	Second Friday of the Month	Zoom Meeting
Co-Chair: Tara Bogart – tara.bgart@pmmconlne.com	(704) 618-1531	9:00 AM	(646) 876-9923
Board Liaison: Kim Keenoy – kim.keenoy@bofa.com	(732) 321-5935	Access Code: 89425417190	via Zoom
Certification (Sub-committee of Education)		See Schedule for	
Board Liaison: Chair: Amina Razanica – arazanica@njha.com	(609) 275-4029	Education Committee	
FACT (Finance, Accounting, Capital & Taxes)			
Chair: Alicia Caldwell – alicia.Caldell@bakertilly.com	(732) 687-3535	Third Wednesday of each month	Conference Call
Co-Chair: Mia Morse – mmorse@matheny.org	(908) 234-0011 x1380	8:00 AM	(872) 240-3212
Board Liaison: Alex Filipiak – Alexander.Filipiak@rwjbh.org	(732) 789-0072	Access Code: 720-430-141	via GoToMeeting
Institute 2023			
Chair: Michael McKeever – m.mckeever2@verizon.net	(609) 731-4528	Last Monday of each month	Zoom Meetingl
Board Liaison: Heather Stanisci – Hstanisci@annuityhealth.com	(862) 812-7923	1:30 PM	
Membership Services/Networking			
Chair: Nicole Rosen – nrosen@acadia.pro	(862) 325-5906	Third Friday of each month	MS Teams meeting
Co-Chair: Ari Van Dine – Ari.VanDine@rsmus.com	(212) 372-1278	9:00 AM Access Code: 267693	In person Meetings
Board Liaison: Heather Stanisci – Hstanisci@annuityhealth.com	(862) 812-7923	Call Line (667) 770-1400	by notification
Patient Financial Services and Patient Access Services			
Chair: Daniel Demetrops – ddemetrops@medixteam.com	(845) 608-4866	Second Friday of each month	Conference Call
Co-Chair: Marco Coello – mcoello@affiliatedhmg.com	(973) 390-0445	at 10:00AM	Call Line (667) 770-1453
Board Liaison: Amina Razanica – arazanica@njha.com	(609) 275-4029	Access Code 120676	
Payer/Provider Collaboration			
Chair: Tracy Davison-DiCanto – tracy.Davison-DiCanto@scasurgery.com	(609) 851-9371	Contact Committee	
Board Liaison: Lisa Maltese-Schaaf – LMaltese-Schaaf@childrens-specialized.org	(732) 507-6533	for Schedule	
Physician Practice Issues Forum			
Chair: Michael McLafferty – michael@mjmaes.com	(732) 598-8858	Third Wednesday of the Month 8:00 AM	Wilentz, Spitzer &
Board Liaison: Maria Facciponti – maria.facciponti@elitereceivables.com	(973) 583-5881	In person with call in available	Goldman offices
		via WebEx (Contact Committee)	90 Woodbridge Center Dr.. Woodbridge, NJ
Regulatory & Reimbursement			
Chair: James OConnell – OConnellJ@ihn.org		Third Tuesday of each month	MS Teams Call
Co-Chair: Paul Croce – pcroce@greenbaumlaw.com	(973) 577-1806	9:00 AM Call Line: (732) 515-4266	
Board Liaison: Chris Czvornyek – chris@hospitalalliance.org	(609) 989-8200	Phone Conference ID: 670 733 396	
Revenue Integrity			
Chair: Tiffani Bouchard – tbouchard@panaceainc.com	(651) 272-0587	Second Wednesday of each month	Conference Call
Co-Chair: Jonathan Besler – jbesler@besler.com	(732) 392-8238	9:00 AM Access Code: 419677	
Board Liaison: Jonathan Besler – jbesler@besler.com	(732) 392-8238	Call Line (667) 770-1275	
CPE Designation			
Chair: Lew Bivona – lewcpa@gmail.com	(609) 254-8141		

•Focus on Finance•

Take the BAIT – Why NJ Business Owners Should Reconsider the Business Alternative Income Tax

Jason Rosenberg

By Jason Rosenberg, CPA, CGMA, EA, MST

You likely have heard of the NJ BAIT (Business Alternative Income Tax) by now, but is your healthcare organization taking advantage? If you haven't ever made the election before, there's good news! The election is made on an annual basis and you have up until the due date of the return to make the election. Don't miss out on the opportunity to reduce your taxable income for your practice. Learn how we can help you determine if BAIT makes sense for you.

Q. What is BAIT and should I take advantage of it?

A. New Jersey business owners who have not previously taken advantage of the NJ BAIT, may want to reconsider making a NJ BAIT election for the 2023 tax year. In January 2022, Governor Murphy signed into law a bipartisan bill (S4068) that enhanced the state's electable pass-through entity (PTE) tax. The BAIT legislation, along with other administrative fixes, remedies a number of implementation issues with the originally enacted BAIT statute that impeded many business owners from making the election.

Since the BAIT was originally enacted in 2020, many changes have taken place over the past few years. This includes changes in how the BAIT is computed, subjecting more income to the BAIT tax for resident owners, thereby allowing a larger state and local tax (SALT) workaround benefit for certain business structures.

Background

As we have previously discussed on PTE taxes, a PTE tax allows for business owners to sidestep the limitation on the amount of SALT that individuals may deduct for federal income tax in order to mitigate the impact of the Tax Cuts and Jobs Act SALT limitation.

The BAIT applies to tax years beginning on or after January 1, 2020, and permits pass-through entities (i.e. partnerships, New Jersey S corporations, and Limited Liability Companies) to pay tax at the entity level based on New Jersey sourced income. In exchange for the BAIT entity paid tax, owners receive a corresponding pro rata share of a BAIT credit.

Q. What are some of the more recent changes to BAIT that may make New Jersey business owners reconsider their hesitancy with making an election?

A.

1. Increased Opportunity for Deductions

The Issue: Previous law only covered New Jersey-sourced income which limited the amount of credit available to New Jersey resident partners.

The Change: The new law expands the PTE tax base to all income allocated to New Jersey resident partners, regardless of source, while maintaining only New Jersey-source income allocated to nonresident partners. This fix will allow resident partners or members of an LLC to claim a larger SALT deduction on business income sourced from other states.

However, this fix only applies to partnerships and multi-member LLCs. S corporation shareholders will still be limited to income allocated to New Jersey.

2. Tiered PTE Passthrough Credit

The Issue: Multi-tiered partnerships may have not elected NJ BAIT because of fear that the credit would get stuck at the lower tiered entities and not pass through to the ultimate taxpayer.

The Change: The new law would permit partnerships and S corporations to allocate PTE tax credits to their partners and shareholders when those entities are themselves partners/members of an electing PTE. Additionally, the lower tiered entities may elect to apply the PTE against their own PTE taxes such as nonresident withholding, minimum taxes and filing fees or apply overpayments of the PTE tax against following year estimated payments.

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Networking Event at the Laundromat Speakeasy

Recently NJ HFMA along with NJ ACHE collaborated on a networking event at the Laundromat Speakeasy in Morristown. "The event was well attended as members from both organizations enjoyed making new friendships along with renewing old acquaintances."

•Committee Corner•

Spotlight on the Education Committee

Most HFMA Chapters have a Programming Committee that is responsible for the educational content provided to their members. The New Jersey Chapter has traditionally followed a different path, with the individual forums focusing on content of interest to their members, delivered through monthly conference calls and periodic full and half-day meetings. The role of the Education Committee in New Jersey is somewhat unique, being responsible for providing educational content – through webinars and in-person events – of interest to all members that fall outside those areas addressed by the forums. The Education Committee is also responsible for increasing members' awareness of the HFMA certification process. In addition, the committee assists members in achieving their certification goals through seminars and by providing study materials to interested participants.

Managing the multiple activities of the committee for the prior Chapter year were co-chairs Hayley Stout, Sandy Gubbine and Lisa Weinstein. Amina Razinaca participates in the management of the committee as certification chair. I recently reached out to them with a list of questions regarding their roles in the Chapter, with their answers listed below. With the beginning of the 2023-2024 Chapter year Hayley has rolled off her role as co-chair, being replaced by Tara Bogart, an active member of the committee for several years. Thanks, Hayley, for your years of service and welcome Tara!

How did you first become involved with the Chapter's Education Committee?

Hayley Stout

Hayley: I first became involved within the Education Committee in 2016 when I was first introduced to the NJ Chapter of HFMA. Once elected as an associate board member in June 2017, I transitioned to the Education Committee board liaison role and have served as Co-Chair of the committee since 2018. As board liaison I was responsible for communicating the committee activities to the chapter board of directors, and reporting back to the committtee any information shared by the board for wider distribution.

Lisa Weinstein

Lisa: I was new to the NJ Chapter (circa many years ago when the committee met in person at a law office in the Princeton Area) and I was very interested in the Education Committee. I was very nervous about joining it because I did not know anyone, and I thought it would be intimidating and a clique. Boy was I wrong! Everyone was super friendly and if you were willing to volunteer it was most appreciated! Before I knew it, I became the chairperson, and I chaired it for several years and then went on to chair many other committees. As in the circle of life, a few years ago I was invited back to be co-chair!

Amina Razinaca

Amina: After I got my Certified Healthcare Financial Professional certification, I was offered to take over the role of the Certification Committee chair. I already had some colleagues/ friends on the Education Committee, so I was familiar with the work they do and was excited to join.

Sandy Gubbine

Sandy: I joined the education in 2013 when Chair - Michael McKeever - put out a request for members. I love education and teach at Rowan University as a hobby, I thought it was a good fit for me and have been active ever since joining the committee.

Tell us a little about yourselves, such as what you do in your daytime job, and how you like to spend your off hours. Is there anything you'd like to share with our readers?

Hayley: I am a senior tax manager at WithumSmith+Brown, PC and spend 100% of my time within our Healthcare Services Team. I provide tax compliance and consulting services to our firm's integrated healthcare delivery systems and hospital clients.

When not working, I enjoy spending time with family, friends and my babies - Franklin (my 10 year old beagle) and Theo (my 8 year old grumpy Chihuahua) . I'm surrounded by

some amazing people so it's always a rambunctious time with lots of laughs. Other hobbies include gardening (or learning how because that's still a work in progress), crocheting, watching bad reality television (we all have to have a guilty pleasure) and Pure Barre.

Lisa: In my "real" job (AKA my salaried job) I serve as the corporate compliance and privacy officer for Bancroft. Bancroft helps people with autism, intellectual and developmental disabilities, brain injuries, and neurological conditions "realize their best life". It serves children and adults in a number of different settings. I oversee compliance, HIPAA privacy, Commission on Accreditation of Rehabilitation Facilities accreditation and policy management. Off hours, I spend time working on other NJ HFMA activities such as the chair of the Women's Education and Development Event and other committees! I enjoy spending time with family and friends. I enjoy taking long walks and I walk very fast after spending 1/2 of my life in NYC. I love to be busy! During my quiet time I enjoy reading. In addition, my husband and I love to travel!

Sandy: I am the assistant vice president of revenue cycle at AtlantiCare. I am responsible for revenue cycle in our hospital, professional and behavioral health lines of business. My job is always focused in getting paid for the services we provide, which is not an easy task in healthcare. I enjoy the challenge of figuring out how to fix problems regardless of size; every penny counts. I spend significant time facilitating conversations between clinical and financial colleagues, so we ensure we all understand what is needed to get paid.

I have lived all my life in South Jersey in either Salem or Cumberland County. I have three adult children and three grandchildren. In my spare time, I enjoy spending time with family who are mostly within a thirty minute drive, reading, adjunct teaching at Rowan University, and just relaxing with my husband at our lakefront home in Cumberland County.

Amina: I am the manager of health economics and policy at the New Jersey Hospital Association and am responsible for a variety of senior-level research duties. Some of those are: collecting and auditing healthcare financial and utilization data, monitoring statutory requirements, performing analysis and modeling functions to reflect statutory changes, and creating timely reports critical to understanding the state of the NJ healthcare industry.

I love to spend my off-hours with my family, reading or baking.

The NJ Chapter provides educational content through its various forums. How do you view the role of the Education Committee and are there certain events that belong solely to the committee?

Hayley: The Education Committee strives to provide high quality, timely educational programs on topics of interest to the healthcare industry in New Jersey, which are geared towards all levels of experience. In addition, our committee assists members in achieving their education objectives. We focus on partnering with other healthcare organizations to provide quality education programs. In addition, the Education Committee is also responsible for increasing members' awareness of the HFMA certification process, and the committee assists members in achieving their certification goals through certification seminars.

The Education Committee assists other NJ HFMA committees with their education programing needs but also focuses on providing certain events to our members. The Education Committee is in charge of several education programs on an annual basis which include (1) Cost Report Education Session; (2) Chargemaster Education Session and (3) Women's Leadership and Development Session, which was held recently to very good feedback while attracting over 125 attendees. The Committee is also working to bring back a Data Analytics Education Series and Finance for Clinicians Education Series.

The Committee is always looking for new and innovate ideas on education we can provide to our chapter's membership. We encourage anyone who is interested to join the committee and provide ideas of how we can best serve our members' educational needs!

Lisa: I think the committee has evolved over the years. All of our activities used to be in person and during COVID we adapted to webinars. The Education Committee works with speakers to develop content topics such as Cost Reporting, Finance for Clinicians, and of course the Annual Institute!

Sandy: My colleagues have covered the topic well. I will just reiterate, we are always looking for people to join us.

Amina: The roles of different forums sometimes overlap, but the Education Committee is the glue that keeps them together on the same track and with aim to provide timely educational material for all members. Very few topics do not fit Forums' formats so for those topics, the committee can take charge.

How does the Education Committee assist in the planning and execution of the Annual Institute? Is this a formal relationship, or has it just evolved over time?

Hayley: Sandy Gubbine, co-chair of the Education Committee serves as a leader in planning the education offered at the Annual Institute. Members of the Education Committee also assist in several capacities i.e abstract reviewers, room monitors, volunteers at the charity event, etc.

Lisa: As mentioned by Hayley many members of the Education Committee support the Annual Institute by reviewing abstracts from speakers, serving on the Institute Committee and volunteering as room monitors.

Sandy: Hayley did a great job explaining my role. This also a place for volunteers who want to get involved and learn more about the chapter…..and you get two free shirts if you volunteer at the Institute.

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Business Continuity Planning (BCP) for Extended Downtime

Gerry Blass

by Gerry Blass

Evolution of Risk

The growth of the risk of successful cyberattacks has been evident since 2010. That is the year the Affordable Care Act (ACA) was signed, resulting in a transition from paper to electronic medical records. Healthcare organizations began implementing new electronic medical record applications to comply with Meaningful Use (MU) requirements. Over the years, MU has introduced new criteria with a heavy focus on interoperability among applications. MU efforts, merger and acquisition activity, and the pandemic-induced remote workforce have increased healthcare organizations' risk profile, motivating cyber attackers to do what they do. Healthcare organizations remained a prime target in 2022.

University of Vermont Health System

The headline of a June 2021 article in Health IT Security stated, "The University of Vermont (UVM) Health Network Continues to Feel Effects of Ransomware Attack—Eight months after a ransomware attack that incurred costs upwards of $63 million, UVM Health continues to experience setbacks and financial losses."

Since that article was published over a year ago, motivation for attacks has grown due to a number of factors, including the war in Ukraine. The US sanctions against Russia have resulted in additional cyber threats, especially against US healthcare organizations, which have been a prime target for several years.

Healthcare Breaches are on the Rise

US government data shows that the number of healthcare breaches in the first five months of 2022 nearly doubled from the prior year. A list created by the US Department of Health and Human Services (HHS) includes at least 125 electronic data breaches of healthcare organizations reported since the beginning of April 2022. One notable example is the Yuma Regional Medical Center in Arizona; the hospital disclosed last year that it was struck by a ransomware attack that exposed the data of 700,000 individuals.

The Partnership HealthPlan of California breach disclosed in May, 2022, had 854,913 victims, and the breach of Shields Health Care Group in Quincy, Mass., had 2 million victims across more than 50 facilities. Shields Health Care said personal data such as names, Social Security numbers, dates of birth, medical records, addresses, and insurance information could have been accessed in the breach.

Cybersecurity vendors have also seen increased data breaches in the healthcare industry, increasing the importance for covered entities to vet their inherently high-risk vendors. Chester Wisniewski, principal research scientist at Sophos, said that while Russian threat actors may have at first shown restraint from attacking the US, now, deep into Russia's invasion of Ukraine, "the gloves are off."

Aligning DRBC Plans

Disaster Recovery (DR) defines how an organization's information technology (IT) department will recover from a natural or manufactured disaster, such as by restoring critical applications.

Business Continuity (BC) focuses on the business operations side of DRBC, such as downtime procedures for critical departments and applications.

It is essential to ensure the DRBC plan aligns with an organization's Emergency Management Plan (EMP), Incident Response Plan (IRP), and Business Impact Analysis (BIA).

Definition of Business Continuity (BC)

BC is a process-driven approach to maintaining operations during unplanned disruptions, such as cyber-attacks or natural disasters.

It is focused on more than just IT infrastructure and business systems. It covers the entire business—processes, assets, workers, and more.

Business Continuity Plans (BCP)

BCPs are "playbooks" that organizations follow when critical applications are down for any period of time. Plans from years ago assumed an average downtime of up to 72 hours.

Recent cyberattacks have resulted in extended downtimes of up to four to five weeks or more. Extended downtimes have resulted in significant impacts:

- Financial
- Patient Care / Lives
- Reputational

Here is a comment for a CIO of a large health system:
"As a CIO, leading the Health System's security strategy was paramount to my responsibility. After going through a number of incident response (IR) table-top exercises, internal audits, and evaluating the many cyber events occurring in healthcare, we decided to strengthen our BC plan to align our response more closely with industry best practices."

Extended BCP Considerations

Here are considerations that should be considered in your BCP for extensive downtime:

- Notification to Authorities
- Payment of a ransom (can it legally be paid?)
- Reduction of cash flow and hospital revenue
- Compensation of employees and critical vendors
- Ability to provide elective procedures
- Diversion of ICU, chemo, dialysis, and other patients for urgent care
- Potential for a complete shutdown

Enterprise Participation

Here is a typical list of departments that need to participate in the development, testing, training and updating of an enterprise BCP:

- Legal
- Risk Management
- Compliance
- Information Technology / Security
- Nursing
- Ancillary Departments (Radiology, Laboratory, Pharmacy, etc.)
- Intensive Care Unit, Emergency Department, Labor & Delivery
- Finance/Human Resources/Public Relations/Accounts Payable
- Facilities

Business Impact Analysis (BIA)

A BIA is critical to evaluating any downtime period's effects on your organization and must be updated periodically for change management. The process of establishing a BIA includes identifying critical applications and documenting:

- Business activity affected
- Potential operational loss
- Potential financial loss
- Minimum recovery time and recovery point to restore an application
- Other critical application dependencies

An updated, accurate BIA will help you assess which controls need to be implemented to reduce the risk of extended downtimes, such as a Cloud backup or colocation redundancies.

Training, Testing & Maintenance

Here are important considerations:

- Orient staff to the BCP during onboarding. Incorporate knowledge of BCP into job description and evaluation
- Test plan *at least* annually:
  - Table-top with Response Team
  - Integrate into a hospital-wide drill
  - Drill with dependent departments (Information Services, Facilities, etc.)
  - Drill with critical vendors
- Document orientations, test results and revisions
- Update dates of plan revisions and tests

Third-Party (BA) Vendor Risk Management

Over 60 percent of successful cyber attacks in 2021 were caused by business associates (BAs). Covered entities must therefore have a process to vet BAs during onboarding and periodically for change management. Third-party BAs that rank as inherently high-risk for your organization (e.g., electronic medical record vendor, cloud host vendor) must demonstrate that they have a process in place to identify and mitigate risk by implementing control.

Change Management

Invest the time to assess your critical departments and applications thoroughly, and vendors. It is essential to keep your BIA current to account for change management. This activity impacts your DRBC plan and procedures, as well as the related plans listed above. Since a large percentage of successful cyberattacks have originated at the vendor location, implementing a comprehensive, third-party risk management program is vital. Whether you have one critical application from a vendor or multiple critical applications (e.g., medical devices vendor), it is important to vet them when they are onboarded and periodically after that.

Governance & Oversight

It is critical to report the results of enterprise-wide BCP table-top testing to your Governance Oversight Committee, Executive Steering Committee, and Emergency Management team, along with the results of the latest Security Risk Audit Remediation plan.

Don't Go IT Alone

Align yourself with a trusted partner and subject matter expert to help navigate the complexities of an extended BC plan, including long-term contingency strategies, ensuring plan maintenance, conducting a comprehensive BIA, table-top exercises, and more.

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About the author

Gerry is President and CEO of ComplyAssistant, which provides GRC software and healthcare cybersecurity service solutions to over 100 healthcare organizations of all sizes, focusing on HIPAA-HITECH-OMNIBUS, PCI, NIST, and other federal and state healthcare regulations. He can be reached at gerry@complyassistant.com.

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Talk about some of the recent sessions and those that are being planned.

Hayley: *The Women's Leadership and Development Session, 2023 – How to Be a Better You!* took place on May 17 at the DoubleTree by Hilton Hotel in Tinton Falls, New Jersey. This education session is always a hit, and this year included panel discussions on remote work and business experiences. In addition, other sessions included Caitlin Zulla from Optum Health as keynote speaker, as well as sessions on personal finance, managing stress and burnout and a lifeline exercise. And of course, we had the ever popular barista break in the afternoon as well as the networking hour at the end of the event.

Clinicians and Finance: Partnering Together – this will be a webinar series expected to begin in this summer and will be a collaboration with NJHA.

Data Analytics – this will be a 2-part webinar series that will begin with a presentation on healthcare analytics. The 2nd session will include a panel discussion regarding key reports for increasing collections, challenges encountered and ways to better use data analytics to achieve desired information/results.

Sandy: Our annual institute will be held September 27-29 this upcoming fall at the Borgata Hotel Casino & Spa. We are planning on some great educational sessions on various topics that are important to our members.

This committee has two separate but equally important roles. Tell us a little about how we assist members in becoming certified?

Amina: First, we try to make members aware of different certification programs, their requirements and the certification process. We assist with registration and study guides and provide help with any issues members may encounter on their way to certification.

Also, we organize certification webinars to provide a brief overview of the exam format and material covered in the exams. If there are any issues, we assist members in reaching out to the Association.

As you can see from the comments from the Education Committee leadership there's always a lot of good things happening. If you're interested in participating in this important and active committee, please reach out to any of the co-chairs or find information on scheduled calls on the committee master list maintained on the committees tab on the Chapter website at hfmanj.org/committees.

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3. Elimination of Nonresident Withholding

The Issue: Previous law required PTEs to pay both the NJ BAIT and nonresident withholding tax. This timing difference made it difficult for some taxpayers to make the election especially if they file their returns in October.

The Change: The new law allows partnerships to refrain from withholding on nonresident partners if the partner expects to receive a refund resulting from the PTE tax credit. This fix eliminates the duplicate estimate requirement and makes NJ BAIT more attractive.

About the author

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We Embraced our Better Selves: A Wrap Up of This Year's Women's Event

Lisa Weinstein

by Lisa Weinstein

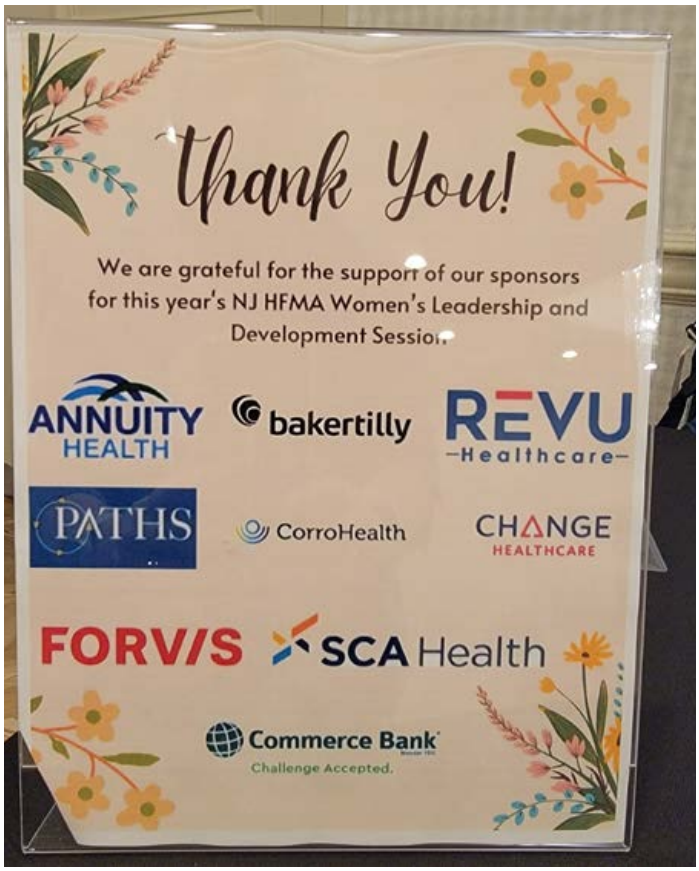
Recently over 125 of the Chapter's members and colleagues met at the Double Tree Tinton Falls for the Women's Leadership and Development Session. This is an annual event that returned last year after a two-year hiatus due to the pandemic, but based on attendance and the enthusiasm of the audiences during both recent years appears to be back better than ever. The title and theme of this year's event was 2023 – How to Be a Better You! If there was a downside to this year's gathering it was the limited parking at the hotel resulting from the ongoing renovations to guest rooms, lobby and restaurant areas. But despite that minor inconvenience, it was a fabulous day of education and networking.

The program opened with this this year's Keynote Speaker, Caitlin Zulla, Optum Health CEO of the East Region. Caitlin is no stranger to the NJ Chapter, having been active with various committees over the years. She spoke on the multiple facets of modern-day leadership, and the importance of embracing change in our professional lives. As the recent pandemic has shown, change can happen quickly due to circumstances beyond anyone's control.

The next session that morning was a panel discussion titled Embracing the Ever-Changing Work Environment, featuring Caitlin as moderator and Leslie Boles from Revu Healthcare, Stacey Medeiros from Penn Medicine Princeton Health, Christine Gordon from Virtua Health System and Jennifer Graves from Commerce Healthcare as panelists. This continues to be a hot topic both within healthcare and for the economy in general, as we transition from an office-based workforce to more of a hybrid arrangement post-pandemic.

The morning was rounded out with a presentation titled Are you Telling Your Money Where to Go?, by Denise Grove, Founder and CEO of Grove Solutions LLC. In today's uncertain economy, which at the time included the uncertainty regarding the federal debt limit, sound advice is essential for all employees, regardless of where they are on their career path and life cycle. Denise explained that we all need to act as our personal CFO, directing our funds to where they can safely help us achieve our financial goals.

After a delicious and satisfying lunch the second panel discussion of the day, titled Reinvent Yourself – It's Never too Late or too Early! took place. Stepping outside the box, the committee invited Iris Vargas, a Rutgers University Graduate



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Student, to ask as moderator. The panel, which included Jane Kaye, a NJ HFMA Board Member and Assistant Teaching Professor at Rutgers University, Annabelle Sieppel-Hunt from CorroHealth, Hayley Marsh from Waud Capital Partners, John Dalton, Senior Advisor Emeritus at Besler and Jean Bryll from RWJ Barbabas Health, brought a breath of experience and perspective to an open discussion of those factors affecting career advancement. It was an interesting discussion, focusing on assisting the attendees in identifying where they currently are career-wise and how to get to where they want to be.

After these intense sessions focusing on leadership, workplace changes, personal finance and career development it only seemed natural that we needed a session on handling the stress inherent in trying to become a better you. Melanie Sponholz from Waud Capital Partners session titled Uh oh It's Sunday – Does this Sound or Feel Familiar? was just what the attendees needed. Mel spoke about personal stress as well as the stress felt by your team that results from today's dynamic healthcare environment. She utilized research-based advice along with group participation activities to help attendees create burnout prevention plans.

As has been our tradition, the afternoon barista break provided an assortment of flavored beverages as well as delicious pastries to lift our spirits as well as give us the jolt of energy we so often need mid-afternoon.

The final educational session, titled Leadership Life Map – Are you Ready?, was presented by Tracy Davison-DiCanto from Surgical Care Associates. Tracy, a Past President of the NJ Chapter and no stranger to our audience, lead the attendees through a series of exercises that help to interpret patterns in life by building a comprehensive overview of family, education, work and other experiences. The results helped the participants focus on where they want to go with their professional and personal life.

After the last session a networking hour was held so that the participants could relax and spend quality time with their colleagues and peers. It was great to see so many of the attendees unwinding before heading home prepared to tackle those day-to-day issues that we all encounter on a regular basis, perhaps better equipped based on the knowledge gained at this very informative and successful event!

And I would be remiss if I didn't give a shout out to the great work the committee did in putting together this year's program, as well as to thank the many vendors who continue to support our educational and networking events.


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Intentionally
as You


DITCHING THE SUNDAY
SCARIES: BANISHING
BURNOUT

2023 Annual NJ HFMA Golf Outing May 11, 2023 at Mercer Oaks