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This is the opening line of a letter I received a few months back from an anonymous sender. The envelope was postmarked in Salt Lake City, but there was no return address, and the author didn’t have the backbone to sign a name to the letter.

It goes on to call organized medicine a “criminal cartel” and lodge accusations of murdering older Americans with ineffective COVID treatments and “wantonly killing and maiming children, adolescents and adults with these Clot Shots” referring to the COVID-19 vaccine.

Of course, I don’t give any credence to much of what this person wrote, but it makes me question what would move a person to write a two-page letter of accusations and threats. Maybe this is someone who sits at home because they lost their job due to COVID shutdowns and doesn’t have much to do beside contemplate conspiracy theories. Maybe this person lost a family member to COVID and has done their own “research” and came to these conclusions. Whatever the case, I believe this is but a symptom of a much larger issue - the politicization of medicine.

I am reminded of the polio epidemics in the US that happened every few years from the late 1800s to the mid-1900s, most recently in 1953. In talking to a person who was a child during that time, he told me how parents would not let their children swim in public pools because of the fear of contracting polio. In 1953, Jonas Salk injected himself and his family with the polio vaccine that he had developed. There were many others working on vaccines at the same time, but this act showed the confidence he had in the product he had developed. By 1955, people were lining up to get the vaccine. Throughout this process, there was no political agenda, just a hope of preventing illness, paralysis and death, mostly among children.

Today, the COVID-19 pandemic has been politicized to the point it has become a societal wedge. On one side are those who see the benefit of widespread vaccination and feel that it should be mandatory for all to get immunized, and on the other side are those who feel they should have a choice in what is put into their bodies, especially when it comes to something that they feel was rushed and is still unproven. The same principle can be applied to the mask-wearing argument. Another interesting point is that in the first year of the pandemic, healthcare workers were seen as heroes, putting their lives on the line to care for patients infected with the SARS-CoV-2 virus. A year later, many of those same healthcare workers are being vilified for taking a stance, either for pushing the vaccine or pushing against vaccination.

A major difference between the response to the polio vaccine and the COVID-19 vaccine is the element of trust. In our current society, the ability to trust has been degraded by media influence, namely the constant barrage of conflicting information from news outlets and opinions posted to social media platforms and the polarization of political ideologies. Early in the pandemic, fear ruled the narration; fear of a new virus that we didn’t understand, fear of dying because there wasn’t an established and proven treatment for the disease, fear of losing loved ones to a disease that was poorly understood, and later, fear of injecting a foreign substance from previously unproven technology into our bodies. I believe that most people are not malicious (some people are, but that is a discussion for a different day!) and are not intentionally putting out misleading information, but rather, are ill-informed and may not understand just what they are saying.

In today’s world, when there is something we don’t understand or a topic we want to know more about, we go to the internet to find information and improve our knowledge. Even board testing has changed in format to allow test-takers the ability to search online for information to answer the questions. Our patients, or really just about anyone with a smartphone, will do the same thing. However, we understand the dangers of self-diagnosis and the overabundance of untrustworthy information that is available on the internet. The MAs in my office gave me a mug as a Christmas gift a few years ago (see photo), and the saying is even more apropos now than it was then. Our patients need to be able to look to physicians as sources of valid information when it comes to issues related to health and medicine, and trust that the science of medicine has no political agenda.
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Nearly all physicians participate in volunteer service at some time in their careers. Whether it be in providing uncompensated care, serving on committee, or helping to coach a kid’s soccer team, volunteering just seems to be a part of the make-up of the average physician.

The 2022 Utah Doctor of the Year, however, has gone and continues to go well beyond the average. Spanning the past 45 years since completing an emergency medicine residency at the University of Utah, Jim Antinori’s career in medicine has been peppered with nearly constant volunteer service in one form or another.

Most astonishing may be his continued service as Chair of the UMA Legislative Committee for the past 15 years (2007 – present), after serving on the committee for another 20 years (1987-2007) before taking the chair. According to Dr. Eric Millican (a member of the UMA Legislative Committee), “As with all things related to politics, [the Legislative Committee] could easily develop into a contentious and dysfunctional group. Jim is an even-handed and effective leader who ensures all perspectives are heard and keeps the focus where it should be: protecting patients and safeguarding the practice of medicine.”

Dr. Antinori is somewhat famous for actually reading and then summarizing each bill proposed by Utah legislators each year which might have ramifications for Utah physicians or patient care. Richard Fryer, MD, nominated Dr. Antinori as Utah Doctor of the Year noting Jim’s “dedicated service ensuring that the welfare of every patient in Utah is carefully considered, and that the rights of every physician in Utah are protected.”

In addition to his long service to the Utah Medical Association, Dr. Antinori has also been very active in both his state and national specialty societies, having served in nearly every possible role (including President) for the Utah Chapter of the American College of Emergency Physicians (ACEP). For the national ACEP, Dr. Antinori has served on 10 different committees and as Editor of the Physicians Guide to State Legislation, 2nd Edition, and the StateStat monthly legislative newsletter.

Dr. Antinori served a long tenure volunteering with the Salt Lake City Rape Crisis Center (1978–1993), and currently with the Salt Lake Sexual Assault Nurse Examiner Program (SL SANE)/Wasatch Forensic Nurses (since 2004) as their Medical Advisor and a Board Member. He is also an Oral Board Examiner for the American Board of Emergency Medicine.

Along the way, he found time to help design and supervise construction of various clinics/urgent care centers and an expansion of a hospital emergency department. Dr. Antinori continues to serve as Chief of Staff at Mountain West Medical Center, where he is also Medical Director and Chairman of the Department of Emergency Medicine. He also is on the Board of Directors for Carepoint/EPIC (Emergency Physicians Integrated Care) for which he also previously served as Chair of the Board.

“I cannot think of a more thoughtful, dedicated, deserving physicians for the Utah Doctor of the Year,” said Dr. Millican. Dr. Fryer added, “Dr. Antinori is an amazing leader, fantastic physician, and well deserving of this honor, given his many long years of dedicated service.”

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FEATURE

YOUR REPRESENTATION IN THE UMA HOUSE OF DELEGATES

BY UMA STAFF

The following two articles are presented to encourage UMA members to get involved in the annual House of Delegates (HOD) Meeting and foster understanding of how the process of developing UMA policy works. This year’s HOD is scheduled for September 9–10 at Thanksgiving Point in Lehi, Utah.

The House of Delegates is the highest authority and policy-making body of the Utah Medical Association. Any UMA member is eligible to be a delegate who may vote at the meetings. The House of Delegates directs the issues that will be addressed by UMA annually, setting policy via the resolution process. This is why it is so important for each member to be fully represented. The House of Delegates conducts its business at the annual meeting, normally held on a Friday and Saturday in September.

Under the Bylaws of UMA, the House of Delegates debates and adopts the policies of the organization, receives reports from UMA officers and component societies, considers any Bylaws amendments, approves the annual budget and membership dues, and elects UMA officers.

There are three ways by which each UMA member is represented in the House of Delegates: by county or regional medical society, by chartered state specialty society, and by mode of practice.

County or Regional Medical Societies
All UMA members are automatically members of their respective county or regional medical societies. Those county or regional societies are allocated delegates to represent their members in the House. Each of the 15 county or regional medical societies in the state can send at least one delegate to the annual meeting; larger societies get multiple delegates at a rate of one delegate per 30 members.

Chartered State Specialty Societies and Group Practices
State specialty societies and large group practices are able to send delegates if a majority of their members are members of UMA and they meet chartering requirements of UMA. They get one delegate per 30 UMA members they represent. UMA members may choose which chartered specialty society will represent them in the House, even if they are not members of the specialty society chosen.

All UMA members not represented by a qualified large practice group
are represented by the solo and small group delegates, which are allocated by the members’ county society.

RESOLUTIONS
Individual delegates may introduce resolutions to be considered by the House of Delegates. Component or specialty societies may also introduce resolutions if reviewed and approved by the membership or leadership of the societies. The article on page 10, Guide to Developing UMA Policy by Resolution, can get you started on drafting a resolution. UMA’s General Counsel can respond if you have questions. The Speaker of the House appoints delegates to serve on reference committees, which consider the resolutions, offer opportunity for discussion, and prepare their recommendations to the House. As the reference committees report their recommendations to the House, the resolutions may be debated, amended, and finally voted on by the full House. Resolutions adopted by the House become official UMA policy.

Resolutions need to be submitted to the UMA office by 9 am 30 days prior to the convening of the House, to be considered on-time. For 2022, the deadline is August 10. Resolutions submitted after that time, but at least two weeks before the House convenes (Aug. 26, 2022), will be considered “late resolutions,” and only considered by the House if agreed to by a majority of the delegates.

OFFICERS
UMA officers are elected at the annual House of Delegates meeting. They include President-elect, At-large Directors, Delegates and Alternate Delegates to the AMA, Speaker and Vice Speaker of the House of Delegates. A physician who is elected as UMA President-elect, will go on to serve as President and then Immediate Past President the following two years. The President also serves as chair of the Board of Directors.
GUIDE TO DEVELOPING UMA POLICY BY RESOLUTION

BY UMA STAFF

The Utah Medical Association is the voice of Utah physicians, and UMA policies and actions help protect our patients and drive the health care agenda in our state. That’s why it’s so exciting that a UMA member can seek to become a delegate to the UMA House of Delegates and then influence UMA policy and action by introducing a resolution!

WHAT’S A RESOLUTION?
A resolution is a written proposal to the UMA House of Delegates. It may suggest a change or addition to UMA policies (i.e., enduring statements of UMA’s position on an issue), or it may call for UMA to take specific actions (such as supporting legislation or introducing a resolution to the House of Delegates of the American Medical Association)—or both.

Resolutions consist of two parts: The Whereas clauses, which lay out the reasons and supporting evidence for the proposal(s) that follow, and the Resolved clause(s), which specify what policy or action UMA should take. Only the Resolved clauses become policy and are acted upon, and each must stand alone. See the sample resolution.

WHO CAN SUBMIT A RESOLUTION AND WHAT IF I NEED HELP?
Any UMA delegate, county or regional medical society, chartered specialty society, or qualified practice group can submit a resolution. UMA is here to help. Contact resolutions@utahmed.org for assistance in crafting and submitting a resolution.

WHAT HAPPENS ONCE A RESOLUTION IS SUBMITTED?
Once a resolution is drafted and submitted (by email, to resolutions@utahmed.org), it will be reviewed by UMA’s CEO and legal counsel and will be assigned to a reference committee of the House. Prior to the reference committee review, input may be solicited from UMA members, typically through the online Resolutions web page at https://utahmed.org/UMAHOD/Resolutions. Resolution authors and interested delegates participate in the reference committee meeting, typically Friday afternoon, at which the resolution is discussed. The committee then makes a recommendation to the House, to act on the resolution.

Sample Resolution

Resolution #___
(A-22)

Introduced by: [Delegate name or sponsoring society]
Subject: [Brief title]
Referred to: Reference Committee X

WHEREAS, [describe the problem or circumstances your resolution addresses]; and
WHEREAS, [provide further description, background]; and
WHEREAS, [other info that supports your call for action or policy statement or helps others understand why the actions or policy are needed]; therefore, be it
RESOLVED, that UMA [take certain actions (promote legislation, introduce a resolution to the AMA House of Delegates, negotiate or work with other organizations) or support a certain policy position]; and be it further
RESOLVED, that UMA [additional actions or policy statements, if needed].

Fiscal Note: [provided by staff]
Legal Note: [provided by staff]
References: [optional]
Current UMA Policy: [if any]

Continued on page 12
NO TIME TO SEARCH THE CSD? NO PROBLEM! YOUR ASSISTANT CAN DO IT FOR YOU!

- Utah controlled substance prescribers registered with the CSD can have an unlimited number of CSD-authorized proxies/designees/delegates.
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Controlled Substance Database
csd@utah.gov
801-530-6220
In the general session of the annual meeting, typically Saturday morning, the delegates present will have an opportunity to debate and vote on the reference committee recommendations regarding the resolutions and make any changes they choose, before deciding whether to make the resolutions UMA policy.

**CONCLUSION**

UMA is committed to transparency and maximizing member input, and this process was designed with these goals in mind. Thank you for your membership and participation. Please make your voice heard by crafting and submitting a resolution today!

**Tips for success:**

- Be clear about whether you are proposing a policy change or a specific action (e.g., say “RESOLVED, that UMA support [idea],” or “RESOLVED, that UMA support legislation or work to have legislation introduced that…”).

- If you are calling for a resolution to be submitted to the AMA, say so explicitly (“RESOLVED, that the Utah delegation to the AMA submit a resolution directing the AMA to…”). Note that resolutions to the AMA require reference to current AMA policy.

- Do not refer to your Whereas clauses or any external documents in your Resolved clauses. Footnotes are acceptable for Whereas clauses, but not for Resolved clauses.

- Write clearly and concisely. Don’t be afraid to ask for help—expert staff are available at any time to help with the wording and format of a resolution.
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The Utah Medical Association is encouraging every physician in the state to visit the American Society for Gastrointestinal Endoscopy (ASGE) ‘Colorectal Cancer Screening Appropriate Use’ web page to download great patient education resources, including a printable office/practice poster, patient letter templates (for positive and negative test results), and an article for local newspapers.

“We are appealing to every physician—especially gastroenterologists and primary care physicians—to support ASGE’s effort to educate patients about the risks associated with colorectal cancer and the life-saving screening options that are available to them,” said UMA President Noel Nye, DO.

ASGE President Douglas Rex, MD, MASGE, explained, “More than 30 percent of U.S. adults aren’t getting screened for colon cancer and it’s a disease that has a 90 percent survival rate when detected early. Further, most cancers can be prevented through polyp removal at colonoscopy. So, this campaign will save many lives.”

Dr. Rex also stressed that, “It is crucial for physicians to help their patients understand which colorectal cancer screening option is appropriate for them, keeping in mind that this can vary for each individual based on their history and risk factors.”

Today, colorectal cancer screening is recommended to begin at 45 years of age and screening options include colonoscopy, fecal immunochemical test (FIT) and MT-sDNA (Cologuard).

Dr. Rex said, “Colonoscopy can be used to screen high- and average-risk patients, meaning patients with no history of precancerous colorectal polyps or cancer, or who have no symptoms. For those who have had previous colorectal cancer or precancerous polyps, then surveillance colonoscopy is the only appropriate tool to monitor the patient and prevent cancer. The same is true for patients with colorectal symptoms, who should only be evaluated by colonoscopy.”

He added, “For asymptomatic average-risk patients undergoing screening, stool tests are also appropriate options for screening. Average-risk means that age is the only risk factor, and particularly when there is no strong family history of colorectal cancer. For such patients, FIT and MT-sDNA tests can also be used for screening and are an alternative to colonoscopy. These tests aren’t appropriate options for high-risk screening patients, surveillance patients who have a history of adenomatous polyps, sessile serrated polyps or colorectal cancer, or symptomatic patients.”

ASGE recommends that patients of any age who are exhibiting symptoms (e.g., rectal bleeding, anemia, a change in bowel habits, persistent abdominal pain, or unintentional weight loss) or who are high-risk (e.g., they’ve had a pre-cancerous colorectal polyp or colorectal cancer) or whose family has a strong history of colorectal cancer should talk to their gastroenterologist or primary care physician about the need for colonoscopy.

Visit ASGE.org/Screening-Physicians to download ASGE’s ‘Colorectal Cancer Screening Appropriate Use’ resources for physicians.

Physicians can refer their patients to ASGE.org/Screening for an easy-to-understand infographic on the appropriate screening test.

Visit www.ASGE.org for additional information.
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**MEDICALLY VULNERABLE PERSONS (MVP) PROGRAM**

People experiencing homelessness can have unique and heightened risks of health complications. The COVID-19 pandemic exacerbated these risks, highlighting the potential value of a new model to address the risks beyond the pandemic.

The problem: When the COVID-19 public health emergency took effect in March 2020 and Utahns were instructed to stay home to slow the spread, some populations faced difficulty in doing so. People experiencing homelessness were often unable to isolate, as congregate settings were their only option for shelter. For the subset of this population at heightened risk of severe complications from COVID-19 infection—older and medically vulnerable folks—this inability to isolate was especially problematic.

The stakeholders: The primary stakeholders include the collaborating organizations: Fourth Street Clinic, Shelter the Homeless, the Road Home, and Salt Lake County. They also include medically vulnerable persons experiencing homelessness who were able to benefit from the program. Secondary stakeholders include the health systems that often treat these persons in high intensity and expensive settings.

The solution: The Medically Vulnerable Persons (MVP) Program was a joint effort between Fourth Street Clinic, Shelter the Homeless, the Road Home, and Salt Lake County that worked to get medically vulnerable and aging individuals experiencing homelessness into non-congregate settings. The program was initiated by Salt Lake County as part of the “Stay Home Stay Safe” effort, which ran from April 2020 to June 2021. The county rented out a 150-room motel so that these individuals could isolate and eventually added partners to provide additional services—Fourth Street Clinic for medical care and the Road Home for management. In time, this program transitioned into the MVP Program, which began in January 2022 and added Shelter the Homeless to its list of partner organizations.

The program provided supportive services to beneficiaries during their stay: medical care, long-term housing support and placement, and case management, while working directly with health systems that were discharging members of this population. The MVP Program wound down in April 2022 and these partners are working with the state, county, city, and nearby health systems to secure long-term funding and a location to continue operations. In the meantime, the beneficiaries of the program will be transitioned back into skilled nursing facilities, other motels, or homeless resource centers.

The outcomes: The MVP Program was able to keep an incredibly vulnerable population safer and healthier than they otherwise would have been. Projections made early in the pandemic indicated there would be more hospitalizations and deaths in this population than ultimately materialized, demonstrating the program’s success in saving lives and reducing demand for already overwhelmed health systems. The program also gave providers a glimpse of a healthcare system that could provide this population with the continuity of care and the extra support they needed but hadn’t previously had, to make an impact on health. Further, it offered a blueprint for future efforts toward providing high-quality and efficient care and targeting social determinants of health for this population and building effective partnerships for doing so.
The problem: Utah is facing a behavioral health and addiction crisis. Utahns in recovery from substance use disorders (SUDs) are living with a chronic condition that requires ongoing services and support; however, access to this individualized support is often limited by availability, insurance stipulations, and the ability to pay.

The stakeholders: Utahns seeking recovery from substance use, family members of Utahns who are struggling with substance use, healthcare providers, the justice system, and insurers, particularly Medicaid.

The solution: Founded in 2006, Utah Support Advocates for Recovery Awareness (USARA) empowers people in recovery from SUDs to be their own advocates in long-term recovery. Recovery Support Services are provided by a network of Peer Recovery Coaches who have lived experience managing long-term recovery from an SUD and who come from diverse backgrounds. USARA offers three primary services:

Peer Recovery Coaching aims to provide clients in recovery with a variety of non-clinical peer supports and assistance in building “recovery capital,” the resources and networks that enable long-term recovery, like access to transportation, housing, employment, and social connections.

Family Support Services offer a much-needed way for family members and friends of a person with an SUD to get support from USARA Family Peer Coaches.

Addiction Recovery Coaching in Healthcare and Emergency Settings (ARCHES) helps to transition patients from addiction to recovery by becoming the point of contact after discharge from an SUD-induced healthcare encounter. Peer Recovery Coaches help these patients get integrated into treatment and services available to help them onto the path to recovery.

The funding: USARA’s primary source of funding is tied to grants, which often have preconditions on how money can be spent, and recovery support services especially in rural areas, have few Peer Recovery Coaches available. A larger and more sustained source of funding would enable the scaling of these important services and Recovery Community Centers across the state.

The outcomes: During a behavioral health crisis like the one Utah is facing, USARA offers people affected by SUDs services that are tailored to their needs, delivered by peers with lived experience, at no charge to the individual. In 2021, USARA’s team served 2,376 individuals and family members with one-on-one services to assist them in finding and sustaining long-term recovery. Supporting people in recovery from an SUD improves their lives, families, and wellbeing while reducing expensive healthcare costs and producing overall savings for the people of Utah.

Medical Professionals Needed

The Utah State Hospital (USH) is seeking medical professionals willing to provide their services to the patients in their facility when that service is not available in the USH on-campus clinics. Any willing provider should contact Dr. Paul Whitehead, Clinical Director at 801-344-4200.
HIPAA has been with us now for two decades, and providers often complain about the burdens caused by compliance. Former U.S. Senator Larry Craig observed that what started out as a kernel of legislative intent “grew into a towering tree of regulatory complexity.” One of the challenges with compliance is that its complexity is heavily on the side of prohibitions: HIPAA is widely understood as a set of rules restricting the release or disclosure of protected health information. In fact, an important initial purpose was to facilitate the release and disclosure of information as health insurance became more “portable.”

Because that was to be done electronically, concerns over information privacy took center stage. Nevertheless, ease of access as employees moved from job to job was the initial goal of the legislation; under this federal law, patients have a near-absolute right of prompt access to their health information.

In recent years, the Office for Civil Rights (OCR) has received many complaints that providers are delaying, obstructing or refusing requests from patients for copies of their records. In these complaints, the compliance problem is not improper disclosure, but improper refusal to disclose. As an enforcement response, OCR announced its “Right of Access Initiative” in 2019. This focused regulatory initiative relies on educational interactions, imposing civil penalties, and publication of resolutions to address failures of providers to ensure that patients receive their records in a timely and efficient manner. Published resolutions suggest opportunities for process improvements that will reduce regulatory exposure and patient dissatisfaction.

The rules for patient access are not complicated. A provider must act on a request in not more than 30 days. If the provider elects to invoke one of a very few exceptions to the obligation to produce the requested records, the requesting party (either the patient or the patient’s personal representative) must be given a written explanation of the decision. If the records are to be produced, they must be produced within that 30-day period.

If extenuating circumstances cause delays in production of the records, a single 30-day extension is available, but only if the provider notifies the requestor within the 30-day period that there will be a delay, the reason or reasons, and the date on which the records will be provided. In other words, it is not an automatic extra 30 days for no reason other than delay. Also, any fees charged must be limited to a reasonable cost-based amount.

There have now been twenty-nine published enforcement resolutions for the Right of Access Initiative: three examples are instructive. In the first, a small primary care practice received several requests from a patient for his records in late 2018 and early 2019. When the records were not provided, the patient filed a complaint with the OCR. In response, OCR provided educational guidance to the practice and closed the matter. In October of 2019, OCR received a second complaint; the patient had still not received his records. A second investigation was opened and even then, the patient did not receive the records until May of 2020, 18 months after the requests began. A penalty of $36,000 was imposed.

In the second example, less egregious but less defensible, a large regional health system with a team of health information professionals was penalized $200,000 in resolution of complaints from two unrelated patients, each alleging that records requests were not responded to for more than 6 months.
In the third example, in a resolution announced March 28, 2022, OCR imposed a $28,000 penalty and a two-year corrective action plan to resolve allegations that a psychiatric practice failed to provide records in a timely manner, imposed an excessive charge for the records, and had inadequate written policies for patient access to records.

Several themes emerge from these and the other twenty-six resolutions. First, do not delay when a patient requests records. Responses should be prompt and complete; few practices can justify taking more than a few days to respond, especially if the records are stored electronically.

Second, charging anything for initial record requests poses more risk than it is worth, especially if records are provided electronically. The possibility that the charge will be found unreasonable is a regulatory risk; the likelihood that the patient will be annoyed at having to pay for their own information is a reputational risk.

Third, every provider, regardless of size, should have written policies governing patient access to records.

And fourth, when correspondence is received from the OCR, do not ignore it. That could add tens of thousands of dollars to a penalty and will typically result in the imposition of a corrective action plan of two years or more.

Lastly, the right of access is now augmented by the “Health Information Blocking” rules enacted as part of the 21st Century Cures Act. Those rules, and the additional enforcement options available to the government, will be covered in a later issue.

ED NOTE: Robert R. Harrison is a partner with Stilling & Harrison, PLLC, in Salt Lake City. He may be reached at rharrison@shhealthlaw.com.

* Utah law addresses what a physician can charge for medical records. This will be discussed in a future issue. ■
Fixed income can play an important role in a portfolio. The role of Fixed Income does vary according to an investor's financial needs and concerns. For example, many investors look to fixed income for safety, income, and stability within a portfolio; however, with current inflationary pressures and signaled interest increases by the Fed the yields on short maturity bonds have increased meaningfully in a short period of time. This change in yields has abruptly impacted the price of bonds eroding some of their benefits during this volatile environment. This has led some investors to question if fixed investments still have a role in a portfolio. Investors must weigh these priorities against their concerns over future interest rates, inflation, government debt, and other factors that might affect fixed income returns.

Striking this balance can be a challenge in any market environment, but especially now, as increasing interest rates and decreasing bond prices has sent many investors on a quest for higher-yield bonds or alternative investments. Depending on your approach, this pursuit of yield may invite more risk—some of which may be hard to see or understand.

So, what's an investor to do? How can you make prudent fixed income decisions given the changes in interest rates this year? Consider these principles:

REMEMBER HOW MARKETS WORK
The same core investment principles apply in any market environment. One key principle is that in a well-functioning capital market, securities prices reflect all available information. Today's bond values reflect everything the market knows about current economic conditions, growth expectations, inflation, Fed monetary policy, and the like. So, according to this principle, the possibility of rising interest rates is

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### INVESTMENT OBJECTIVE HELPS DETERMINE FIXED INCOME’S ROLE IN A PORTFOLIO

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<tr>
<td>Meet income needs</td>
<td>Liability management</td>
</tr>
<tr>
<td>Seek higher returns</td>
<td>Total return</td>
</tr>
</tbody>
</table>

For illustration purposes only
already factored into fixed income prices.

This is one reason investors should view future interest rate movements as unpredictable. Even the market experts who have access to vast amounts of research have a hard time predicting the direction of interest rates.

Rather than trying to predict macroeconomic forces that are difficult to foresee, investors can look to the market to set prices and focus on the variables within their control.

START WITH A CLEARLY DEFINED GOAL
Fixed income choices should follow a broader investment strategy that defines the role of fixed income in a portfolio. The portfolio can then be customized to meet those specific goals while managing tradeoffs.

The chart below illustrates how portfolio objectives can influence a fixed income approach. An investor who seeks to avoid losing market value might have a different fixed income allocation from someone who needs immediate income or is seeking higher returns. Investors with different objectives typically have different tradeoffs regarding risk, expected return, and costs.

KNOW WHAT YOU OWN
Strive for transparency in a portfolio. This means understanding an investment manager’s basic strategy and knowing how the instruments held in the portfolio might respond in different economic, market, and interest rate scenarios.

Unfortunately, investors who chase performance often make their investment decisions based on the past performance and perceived popularity of the strategy. For example, some of the mutual fund categories experiencing the heaviest inflows of cash in the industry are in asset groups that have recently experienced higher than average yields. Higher yields are typically accompanied by higher risks. But do investors know what risks their managers are taking to deliver those attractive yields?

UNDERSTAND THE TRADEOFFS
One benefit of the recent increase in interest rates is that fixed income instruments like savings accounts, certificates of deposits, annuities and bonds now have yields that are at more reasonable levels. When reaching for higher yield, investors should carefully consider the potential effects of their decisions on expected portfolio performance and risk. In the fixed income arena, investors have two primary ways to increase expected yield and returns on bonds. They can:

- Extend the overall maturity of their bond portfolio (take more term risk).
- Hold bonds of lower credit quality (take more credit risk).

These may be reasonable actions. But pursuing higher income means accepting more risk, as measured by interest rate movements, price volatility, or greater odds of losing value if the issuer defaults. Higher yield can also bring potentially higher volatility.

PAY ATTENTION TO COSTS
Investors typically do not realize that investment-related costs determine a large part of a portfolio’s yield and return. This also applies to fixed income securities. In fact, research has shown that a bond mutual fund’s expense ratio helps explain much of its net performance—and funds with the highest expenses tended to have the lowest performance within their peer group.

SUMMARY
No one really knows how quickly and by how much interest rates will change. Most physicians might be best served by building a fixed income strategy to complement their broader portfolio objectives, understanding the sources of risk and expected return, and paying attention to fees. Pursuing a defined strategy in a disciplined fashion has proven to be successful way to approach investing in bonds. One of our trained UMAFS financial planners would welcome the opportunity to review your fixed income strategy or assist you in establishing a sound strategy specific to your needs.

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Investing risks include loss of principal and fluctuating value. Fixed income securities are subject to increased loss of principal during periods of rising interest rates. Fixed-income investments are subject to various other risks including changes in credit quality, liquidity, prepayments, and other factors.

Endnotes
1. The study examined monthly alpha and expense ratios for bond funds in the CRSP survivorship-bias-free mutual fund database from January 1992 to December 2011. Source: Dimensional Fund Advisors.
After strong advocacy by the American Medical Association and other organizations, the U.S. Department of Health and Human Services (HHS) appears poised to extend the COVID-19 public health emergency (PHE) for a 10th time. This would be good news for the thousands of Utahns – predominantly postpartum women and children – who have benefited from continuous Medicaid coverage as a result of the federal disaster declaration. Nevertheless, these patients remain at risk of losing their coverage when the PHE does end, and Utah Medical Association officials are urging physicians and patients to prepare now for the implications of this looming coverage cliff.

HHS has said it will give states 60 days’ notice of the end of the PHE, which is currently slated for July 16. The department’s self-imposed notification deadline of May 16 passed without any such announcement after organized medicine, among others, pressed for a continuance.

“We urge the [Biden] Administration to maintain the PHE until we experience an extended period of greater stability and, guided by science and data, can safely unwind the resulting flexibilities,” AMA, the American Academy of Pediatrics, and 10 other national organizations wrote in a May 10 letter to HHS.1

The federal Families First Coronavirus Response Act2 increased federal Medicaid matching dollars by 6.2% for states that agreed to maintain Medicaid coverage for anyone enrolled in the program from March 20, 2020, through the end of the PHE, including Utah.

The Centers for Medicare & Medicaid Services (CMS) has issued guidance3 around this unwinding of coverage, giving states 12 months after the PHE ends to initiate the eligibility process, plus an additional two months to complete any pending redeterminations.

Regardless of how the unwinding process unfolds, many of those deemed ineligible will not have another coverage option. This is largely because Utah has not extended health care coverage to low-income working adults and parents as allowed by the Affordable Care Act.

According to Utah’s new Medicaid Director Jennifer Strohecker, the state is prioritizing preparations for looming Medicaid redeterminations, as Utah saw the third highest pandemic-driven growth in Medicaid enrollees in the country.4

Additionally, Utah scores four out of five red flags indicating children enrolled in Medicaid and in the Children’s Health Insurance Program (CHIP) are especially at risk of losing their coverage when the PHE ends, according to a February report by the Georgetown University Center for Children and Families.5

4 https://stateofreform.com/featured/2022/05/utah-medicaid-policy-2/
As a result, Utah physicians caring for Medicaid and CHIP patients face a potential increase in uncompensated care when the PHE does end.

UMA encourages practices to prepare by:

- Urging their Medicaid patients to complete their eligibility redetermination as soon as possible;
- Scheduling services for patients who might lose coverage, familiarizing themselves with potential coverage options for such patients; and
- Evaluating the financial impact of a potential increase in uncompensated care.

Practices also should expect to reverify patients’ Medicaid eligibility when the PHE expires.

Ultimately, “States run Medicaid and CHIP, so that’s where responsibility lies to ensure that millions of children don’t lose coverage during this process,” said Joan Alker, executive director of the Georgetown University Center for Children and Families and co-author of its report, in a Feb. 17 news release.⁶

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With the Uvalde, TX massacre etched in the American psyche and the smug image of Wayne LaPierre firmly emblazoned on the NRA stage recently, good-willed Americans are in search of our true center. As a physician, I recall patients whose goodness and courage and kindness brought out the best in me and my colleagues. That after all is the true privilege and reward for doctors and nurses and all health professionals—the right to care.

Collectively health professionals have a unique role in American society. Across cities and counties, rural and urban, we are asked to be available and accessible to help keep people well and respond when they are sick or injured. Those wounds come in all shapes and sizes—wounds to the body, wounds to the mind, wounds to the spirit.

As important as are our diagnostic and therapeutic interventions to society, they pale in comparison to a larger, often overlooked function. Together, collectively, we process day to day, hour after hour, the fears and worries of our people, and in performing this function, create a more stable, more secure, more accepting and more loving nation. Our jobs are made so much more difficult by politicians who support destructive policies.

Along with other Americans this week, I have struggled to accept that our nation seems willing to once again accept the sacrifice of our young, innocent children to assure an 18-year old’s right to a weapon of war. I have settled on a different set of images, and a very different narrative—a counterpoint if you will—to share.

Eleven years ago, my wife and I were blessed with the arrival of our eighth and ninth grandchildren—two little girls, Charlotte and Luca. We were also introduced, for the first time as health consumers, to the Neonatal Intensive Care Unit (NICU). The girls came early, at 34 weeks, and struggled to work their way back up to their due date. They are about to enter Middle School, but in those early days, it wasn’t easy on them or their parents or the care teams committed to their wellbeing.

Viewing them from my grandparent perch, the Connecticut Children’s Hospital Center NICU team at Hartford Hospital did a great job, balancing high tech with high touch, providing wisdom and reassurance, encouragement and training to the girls’ parents, who were inclusively inducted as part of the team on day one. It was really a holy thing to observe.

Politicians like Greg Abbott and Ted Cruz might want to visit a NICU without their donors. They would encounter health professionals fully capable of collaborative and humanistic care, especially when faced with a complex threats and families in crisis. They would witness:

1. **Inclusion**: For most humans, the first instinct when faced with trauma or threat is flight. And yet, these NICU professionals’ first instinct is inclusion. With IVs running, and still groggy from her C-section, our daughter and son-in-law were escorted to the NICU and introduced to their 3 lb. daughters. They were shown how to wash their hands carefully, how to hold the babies safely and without fear, and—while given no guarantees—experienced the transfer of confidence from the loving and capable caring professionals to them. Those were remarkable first day gifts to this young couple.

2. **Knowledge**: Coincident with the compassionate introduction to their daughters, there was a seamless transfer of information—each of their daughter’s current conditions, an explanation of the machines and their purposes, the potential threats that were being actively managed, and the likely chance of an excellent outcome. This knowledge—clear, concise, unvarnished, understandable—delivered softly, calmly, and compassionately, reinforced these young and fearful parents’ confidence.
and trust in each other, and in their care team, on whose performance their newborn daughters’ lives now depended.

3. Accessibility: The members of their care team needed to demonstrate “presence.” The outreach needed to be “personal.” This was not a rote exercise for them, not just another set of parents, not just another set of tiny babies. These were these specific parents’ precious children, their lives, their futures were now in the balance. And the performance needed to be “professional.” The team needed to be consistent and collaborative, with systems and processes in place, no descent and little variability in performance, rapid response, anticipatory diagnostics and confident timely management of issues as they arose.

As we attempt to recover once again from a senseless massacre of the tiny victim of Uvalde, from poor leadership and self-inflicted wounds, we need to be reminded that there is a beating heart and a feeling soul in America. There is a better way— holistic and inclusive, humanistic and scientific, where goodness and fairness reside side-by-side.

How might each of us actively demonstrate a commitment to inclusion, knowledge transfer and accessibility, and in doing so, assure that these latest 19 children, and all those whose senseless slaughter preceded them, were not in vain. Our politicians, on state and federal levels, need to channel a NICU professional—not a RAMBO—when they next vote on gun policy. After all, our lives depend on it.

Author: Mike Magee, MD, is editor of HealthCommentary.org, Medical Historian at Presidents College at U. of Hartford, and author of CODE BLUE (Grove Atlantic/2020).
Years ago, when I was training to be a physician, the older, more experienced doctors passed down a morsel of wisdom to those of us who were just beginning our careers: “Never stand when you can sit. Never sit when you can lay down. And never stay awake when you can sleep.” They knew then what we would come to discover: that health workers, across clinical and community settings, whether caring for patients or managing a public health crisis, have long faced difficult, irregular hours in challenging, and extraordinarily stressful, working environments.

That so many health workers have been able to persevere and perform despite those conditions is a testament to our training, our teammates, and the ideals that have called us to serve. But day after day spent stretched too thin, fighting against ever increasing administrative requirements, and without the resources to provide our patients and communities with the care they need, drove many nurses, doctors, community health workers, and public health staff to the brink. Then came COVID-19. The pandemic has accelerated the mental health and burnout crisis that is now affecting not only health workers, but the communities they serve.

The initial reaction to the unprecedented public health impact of COVID-19, from Italy to New York City, was to recognize and honor the courage of health workers who stepped up in our collective moment of need. But after more than two years, multiple waves of infection, and more than one million precious lives lost in the United States alone, this sense of acknowledgment and gratitude has faded—one more victim of the fatigue and frustration wrought by a prolonged pandemic. Today, when I visit a hospital, clinic, or health department and ask staff how they’re doing, many tell me they feel exhausted, helpless, and heartbroken. They still draw strength from their colleagues and inspiration from their patients, but in quiet whispers they also confess they don’t see how the health workforce can continue like this. Something has to change, they say.

Instead, we can choose to make this moment a collective commitment to care for those who have always cared for us. When health workers look ahead, they should see a future where their dedication isn’t taken for granted, and where their health, safety, and well-being is as much a priority as the well-being of the people and communities in their care.

Addressing health worker burnout is about more than health. It’s about reflecting the deeper values that we aspire to as a society—values that guide us to look out for one another and to support those who are seeking to do the same. Health workers have had our backs during the most difficult moments of the pandemic. It’s time for us to have theirs.

The stakes are high. If we fail to act, we will place our nation’s health at increasing risk. Already, Americans are feeling the impact of staffing shortages across the health system in hospitals, primary care clinics, and public health departments. As the burnout and mental health crisis among health workers worsens, this will affect the public’s ability to get routine preventive care, emergency care, and medical procedures. It will make it harder for our nation to ensure we are ready for the next public health emergency. Health disparities will worsen as those who have always been marginalized suffer more in a world where care is scarce. Costs will continue to rise. Equally as important, we will send a message to millions of health workers and trainees that their suffering does not matter.

Instead, we can choose to make this moment a collective commitment to care for those who have always cared for us. When health workers look ahead, they should see a future where their dedication isn’t taken for granted, and where their health, safety, and well-being is as much a priority as the well-being of the people and communities in their care.

Endnotes

1 For more information on recommended corrective actions, see https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf
Early and regular prenatal care helps identify complications during pregnancy and prevent poor outcomes. In the early months of the COVID-19 pandemic, the Centers for Disease Control and Prevention (CDC) recommend people prioritize urgent visits and postpone elective care, while also advising pregnant women not to skip prenatal care appointments. Information about the effects of COVID-19 on pregnant people was rapidly evolving, and there were no standard recommendations specific to pregnancy regarding the evaluation or management of COVID-19. Subsequently, many providers restructured care for pregnant patients by converting some traditional in-person appointments to virtual appointments to minimize exposure for both patients and providers.

Results of the 2020 Utah Pregnancy Risk Assessment Monitoring System (PRAMS) survey demonstrate how the COVID-19 pandemic affected routine prenatal care. The most frequently reported reason for a delayed or canceled prenatal care appointment was the provider’s office was closed or they had reduced office hours (11.0%) (Figure 1). The survey found while 73% of pregnant people continued to attend in-person only prenatal care appointments, 25% attended a combination of in-person and virtual appointments, and 1% attended virtual only appointments. Of those who attended in-person only, 89% said they did not attend virtual appointments because they preferred to see their provider in person. Additionally, 25% said virtual appointments were not available through their provider, and 4% said they were unable to participate in virtual appointments due to a lack of resources such as a computer, internet, cellular data, or a telephone. Nearly 1 in 4 pregnant people experienced some delayed or canceled prenatal care appointments due to reasons related to the COVID-19 pandemic.

Footnotes:

Percentage of Eligible Utah American Indian and Alaska Native Population Who Received at Least One COVID-19 Vaccine by Different Race/Ethnicity Measurement Methods, Utah, 12/01/2020–12/31/2021

Figure 1. The current Utah Department of Health and Centers for Disease Control and Prevention racial group definitions reported the highest percentages received among people who identify as American Indian and Alaska Native.

Note: Population estimates based on 2000 data for ages 5 and older.
CME SPOTLIGHT

UPDATED COURSE for 2022

Title: Controlled Substances: Education for the Prescriber (2022)

When: On-demand Webinar
Where: Online at cme.utahmed.org
Provider: UMA Foundation
CME: 3.5 AMA PRA Category 1 Credits™

This education is specifically designed to comply with Utah State Law, which requires health care providers licensed to prescribe controlled substances to complete DOPL-approved continuing education on Schedule II and III controlled substances that are applicable to opioid narcotics, hypnotic depressants, or psychostimulants.

Following this activity, learners should be able to:

- Know existing laws and rules pertaining to prescribing controlled substances;
- Provide patients the care they need to restore and maintain their health;
- Mitigate the burdens of illness, injury and aging, including appropriate prescriptions for controlled substances when indicated;
- Minimize adverse effects of controlled substance use and reduce risks to the public health.
- Know Utah requirements and limitations in recommending medical cannabis.
The following websites offer online continuing medical education:

- cme.utahmed.org
- psnet.ahrq.gov/cme
- thedoctorschannel.com/cme
- freecme.com
- pri-med.com/pomo/OnlineCME.aspx
- medicine.utah.edu/cme
- cmelist.com
- ama-assn.org/education-center
- baylorcme.org
- medscape.org
- vlh.com
- nejm.org/continuing-medical-education
- reachmd.com/programs
- cms.gov/Outreach-and-Education/LearnEarn-Credit/Earn-credit-page.html
- primarycarenetwork.org
- emedevents.com

The following sites allow you to search databases to locate medical meetings throughout the country:

- ama-assn.org
- eMedEvents.com
A number of medical practices that recruit new physicians receive hospital assistance, often in the form of an income or collections guarantee. It is critical that such arrangements are properly structured in compliance with the physician recruitment exception to the “Stark” regulations administered by the Centers for Medicare and Medicaid Services (CMS), as well as the practitioner recruitment exception under the federal Anti-Kickback Statute (AKS) administered by the Office of Inspector General (OIG).

One key issue for medical practices under the Stark regulations is the extent to which practice “restrictions” may be imposed on the recruited physician. Over time, CMS has become somewhat more lenient in allowing restrictions. At present, the Stark regulations provide that the physician practice may not impose on the recruited physician practice restrictions that unreasonably restrict the recruited physician’s ability to practice medicine in the geographic area served by the hospital. In prior commentary, CMS indicated that a physician practice is permitted to impose the following restrictions: 1) restrictions on moonlighting; 2) prohibitions on soliciting patients and/or employees of the physician practice; 3) requiring that the recruited physician treat Medicaid and indigent patients; 4) requiring that the recruited physician not use confidential or proprietary information of the physician practice; 5) requiring the recruited physician to repay losses of the recruited physician’s practice that are absorbed by the practice in excess of any hospital recruitment payments; and 6) requiring the recruited physician to pay a predetermined amount of reasonable damages if the physician leaves the physician practice and remains in the hospital service area.

In addition to the above-described permitted restrictions, in the same commentary CMS stated they are persuaded that categorically prohibiting physician practices from imposing non-compete provisions may have the unintended effect of making it more difficult for hospitals to recruit physicians. Accordingly, CMS indicated that a physician practice may impose a limited, reasonable non-compete clause on the recruited physician. As a caveat to this, however, CMS noted that nothing in the applicable Stark regulation should be construed as prohibiting a hospital that provides financial assistance to the hiring physician practice from entering into an agreement with the practice that prohibits the hiring physician practice from imposing a non-compete agreement or other practice restriction.

In a prior CMS Advisory Opinion (AO), CMS determined that under the specific facts presented in the request for an opinion, a noncompetition provision did not impose practice restrictions that unreasonably restricted the recruited physician’s ability to practice medicine in the geographic area served by the hospital. Some of the key facts in the CMS determination in that situation included: 1) the time period was reasonable; 2) the distance requirement was reasonable based on the geographic area served by the hospital; 3) even with the time period and distance restrictions, the recruited physician would still be permitted to practice at certain other hospitals both within and outside of the subject hospital’s geographic service area; and 4) CMS relied upon the certification of the party requesting the AO that the non-competition provision complied with applicable state and local laws (if any) and did not not comply with applicable state and local laws (if any practice restriction or condition does not comply with applicable state and local laws it runs a significant risk of being considered “unreasonable” by CMS).

In relation to Utah law, a practice must also be careful to ensure that any restrictive covenants comply with the Utah Post-Employment Restrictions Act, as amended (PERA). In brief, under PERA, and in addition to any requirements imposed under common law, any postemployment restrictive covenant (as defined in PERA and subject to certain exclusions and exceptions) entered into after the effective date of PERA that is for a period of more than one (1) year is “void.” In addition, any employer that seeks to enforce a postemployment restrictive covenant that is determined to be “unenforceable” is liable for the employee’s costs associated with arbitration, attorney fees and court costs, and actual damages.

As a further wrinkle, at present it is too early to determine the impact, if any, that President Biden’s Executive Order on Promoting Competition in the American Economy will have on noncompete agreements in general, and in particular on the restrictive covenants that a practice may desire to incorporate into its employment agreement with a recruited physician. At this point, the Executive Order is simply directing and encouraging the U.S. Federal Trade Commission (FTC) to craft rules to ban or limit noncompete agreements. There is significant question whether the FTC has the legal authority to actually restrict or eliminate noncompete agreements as to all private employers. In addition, it is unknown at this time what any actual rules may specify, and any exclusions or limitations that may apply.

The primary takeaway for medical practices is that physician restrictive covenants are governed by aspects of both federal and Utah law. In addition, federal laws including the Stark regulations and the AKS are complex and are ever changing, an AO cannot be relied upon by any party other than the party that requested and received the AO from CMS, and the facts of every physician recruitment and the terms of every hospital recruitment agreement are different. Accordingly, every recruitment arrangement and any restrictive covenants must be properly reviewed and analyzed under both federal and Utah law, and an appropriate physician employment agreement must be prepared in a manner that is in compliance with both law and the terms of the recruitment agreement.
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