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MEDICAL CANNABIS USE IN UTAH

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INAUGURAL SPEECH TO UMA HOUSE OF DELEGATES

BY UMA PRESIDENT NOEL NYE, DO

We live in an amazing state with incredible natural beauty, and great people. Red rocks and incredible geology in the south and world class skiing in the north —not to disparage Brian Head. I live in a beautiful area in Northern Utah. Across the street is a mountainside that will never be developed. We love to hike and play outdoors.

By our home is a trail that makes a 3.1-mile loop. It has about a 530 ft. elevation gain on the north side, a little up and down as you go across the top, then a drop back down on the south end to follow a fire break road back to our house. We call it "The Loop," and in our home we have made it not only a noun, but a verb. For example, I might say to my wife Valerie, "Let's go loop" and we'll both go change our shoes and head out for the hike.

One day I had had a somewhat frustrating afternoon in the office and needed to decompress outside. As I was walking out to my car, I pulled out my phone, and dictated a text message to Valerie and said, "Do you want to go loop with me?" then hit send. Her reply was an almost instant, and succinct - "NOPE" with a poop emoji. I thought that was kind of weird, since she loves to get outside just as much as I do. Then I looked back at the text I had sent, and immediately understood her response. The message was transcribed incorrectly, and said, "Do you want to go POOP with me?"

This demonstrates the importance of clear communication.

There is a woman name Kenya who works in the cafeteria at Davis Hospital who is always happy, cheerful and lifts the spirits of everyone around her. Her hair color changes weekly, and her eye shadow matches it. Her communication style is like this: "Good morning! It's so good to see you today! Do you want some bacon and eggs? I got that for you right here! You have a great day now!" She exudes goodness and kindness. One cannot help but be happy in her presence.

There is so much rancor, animosity, and division in our country, both politically and societally right now—with those of one party arguing that anything the other party does is terrible and must not be allowed, without taking the time to understand what the other side is really saying. This type of in-fighting is neither productive nor beneficial and does not promote any positive action within the institution in which it occurs. It seems that most of the vitriol spawned in our society is from a select few, fueled largely by news and social media among other sources.

"The Loop" - not the poop

We as individuals are better than that, and we as the UMA are better than that.

I believe that if we can take the time to effectively communicate with one another, paying attention to not only what is being said but also why, we can reduce or eliminate the animosity that is so prevalent—or at least have a positive effect in our little corner of the world.

Unfortunately, if one group is not willing to listen, there is no benefit of having the discussion. Years ago, I saw a 4-year-old boy in my office for an urgent-care issue. His father acknowledged an article from the AAP News titled "If not vaccines, then what?" that I have posted on the inside of the door in my exam room. (AAP News, April 2012) This article explains how in the early 1900s and before that, one in five children died before age 5, most from some now vaccine-preventable illness. In looking over my own family history, I found this to be the case in both my mother's and my father's families.

This child's father told me that he was a financial analyst and had looked into where the AAP gets its money and that 85% of it came from vaccine manufacturers. He was convinced that vaccines were a money-making scam that the AAP is paid to promote. I just about said, "If your child

Dr. Nye and his friend Kenya at Davis Hospital in Layton

dies from a Strep. pneumo meningitis, do you really care where the money comes from?" But the speech filter kicked in, I thanked him for the opportunity to address his child's issue for the day, and they went on their way.

Through this and many other experiences, I have learned that you can't reason with an ideologue.

Several months ago, I had the opportunity to talk with someone who is on the opposite side of the abortion issue than I. Through that discussion I was able to gain some insight into the reasoning that influences her beliefs on the subject. I was able to explain my points of view, and hope that she could understand my reasoning as well. In the end, neither of us changed our minds, and while we differed on the ultimate outcome, we found some common ground which could serve as a baseline from which to launch further discussions. I appreciated her willingness to talk candidly and congenially about such a divisive topic.

I've said a lot about talking and discussing and even listening. Everyone knows the saying "Talk is cheap." Our discussions and debates don't mean anything unless we put them into action. However, whatever the issue, we need to move forward as a unified body. As Abraham Lincoln said, "A house divided against itself cannot stand." As we look back through history, every great civilization has fallen not because of outside forces, but because of internal conflict and division.

The UMA will be facing many issues this year, and many concerns within the household of medicine: scope of practice expansions (or encroachments, depending on your perspective), sensitive and potentially divisive legislative issues, the ongoing COVID-19 pandemic, decreased physician reimbursements, continued physician shortages in rural and some urban areas, just to name a few.

There are a host of other things that will require our best efforts to work through. The UMA's job is to look out for and promote the interests of physicians and patients in the state of Utah. I am excited for this coming year and the opportunity I will have to serve Utah physicians. I will do my best to be attentive, responsive, proactive when possible, and communicate well with anyone with whom I may interact as I work to represent you, the body of the UMA.

I won't ask you to go poop with me—that would just be weird— but I am asking that we continue to work together as we advocate for Utah physicians and patients.

Thank you. ■

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TAKE NOTE

BY MICHELLE S. MCOMBER, MBA CAE, UMA CHIEF EXECUTIVE OFFICER

Happy Holidays to all UMA members and friends! The past two years have been filled with challenges for physicians, challenges that have stretched you professionally, economically, and personally in unexpected ways. Facing a pandemic the likes of which none of us has ever seen before, you have lost patients, neighbors and perhaps even family as the profession has raced to keep up with a disease that spreads nearly as quickly as the misinformation promulgated about it by its deniers.

I have been inspired by the outstanding care that all of you give and by the speed and cooperation of the global scientific community in trying to address the challenges posed by COVID-19. But I have also been chagrined as the training and education of scientific and medical experts has routinely been dismissed by the misled and activists hiding behind keyboards, spewing drivel and obfuscation across the internet. Somehow what is heard at the backyard barbeque or on talk radio seems now for some to hold as much weight as a paper presented at an Immunology conference.

And yet, medicine moves forward. We now have vaccines to prevent or mitigate the most devastating outcomes of COVID-19, and new medicines and techniques to treat those who are ill. Some were carefully developed in laboratories, and some discovered via trial and error on the front lines while trying anything to keep patients alive. For instance, when ventilators were in short supply, physicians developed protocols and kludged together devices to keep patients oxygenated as they struggled for breath.

There is no substitute for scientific knowledge coupled with ingenuity. The history of medicine is replete with examples of physician heroes facing incredible challenges during disease outbreaks who have found innovative ways to fight back on behalf of their threatened patients. The initial development of inoculations, convalescent plasma and the wearing of face masks all came about as physicians battled previous pandemics. I suspect history will look back on the current crisis and identify similar heroes and medical advances that propelled the profession forward.

I would ask each of you to take care of yourselves and your families. You give so much of yourselves that sometimes you do not take care of yourselves. We have seen unfortunate and tragic consequences when this happens. We hope that some of what your UMA does for you helps alleviate some of your worries and concerns while encouraging you to take care of the caregiver. With this in mind, I remind you that there are resources available to help you when needed. One of those resources is the SafeUT Frontline app that you can download through your mobile app store. We have been working with SafeUT to make sure that physicians have access to confidential help at the touch of a fingertip. While you work to take care of patients and fight to control this devastating pandemic, we will continue to fight for you, your expertise and training and the physician profession in general.

We face another brutal legislative session with groups such as the optometrists, chiropractors and nurse practitioners pushing scope expansion, legislation pushing back on science and scientific recommendations, medical billing mandates, and many other issues. On the flip side, we are working on expanding your ability to treat your patients and give them access to full care service, coverage for treatment, and funding for opioid alternatives among other things.

As you have heard in our Medibytes, the Governor is pushing health care reform in Utah focused on quality and cost. We will make sure that your voice is heard in this process. We would like to hear from you if you have innovative ideas to add to this dialogue. Feel free to email me at michelle@utahmed.org.

It is an incredible honor to represent you in your professional association. Our members are the best of the best. Your courage, drive, and resourcefulness during this taxing and demanding time will continue to inspire your association staff and leaders to give you our best efforts in return. ■

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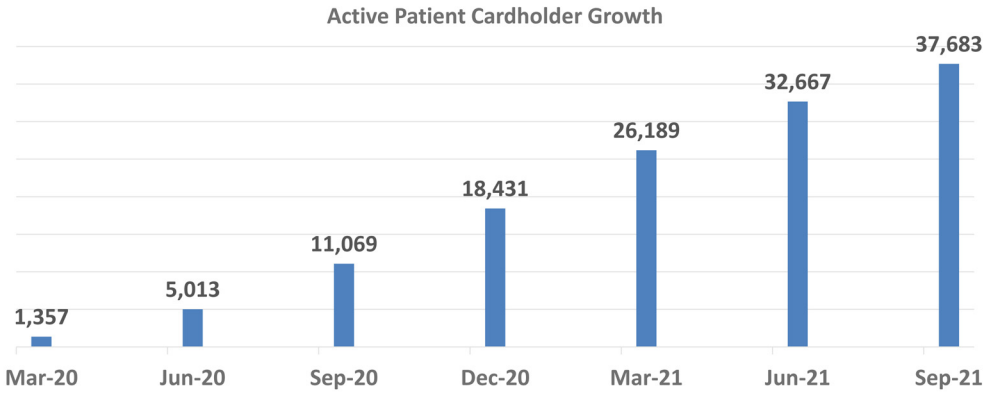
MEDICAL CANNABIS USE IN UTAH

HIGHLIGHTS FROM THE 2021 ANNUAL REPORT FROM THE UTAH DEPARTMENT OF HEALTH'S CENTER FOR MEDICAL CANNABIS

Patient Cardholder Registration



- 39,467 medical cannabis cards with active status as of October 31, 2021.
- 4 out of 5 of all medical cannabis cardholders have renewed their card at least once.

Key program developments from the past year include:

- **Number of Active Medical Cannabis Cardholders More than Tripled.** The number of medical cannabis cardholders with active status more than tripled from September 30, 2020 (11,000) to September 30, 2021 (37,683).
- **Number of Licensed Medical Cannabis Pharmacies More Than Doubled.** There are currently 14 licensed medical cannabis pharmacies in operation with locations in North Logan, Brigham City, South Ogden, West Bountiful, Park City, Salt Lake City, South Jordan, Lehi, Provo, Springville, Payson, Cedar City, and St. George. In October 2020, there were only seven medical cannabis pharmacies open. Seven opened during the past year. A 15th medical cannabis pharmacy location will open in a rural location in 2022.
- **Launch of Medical Cannabis Home Delivery Service.** After months of planning, coordination, and software testing, medical cannabis was home delivered in Utah for the first time in January 2021. This key development made medical cannabis more accessible to individuals living in rural areas and those unable to visit pharmacies in-person due to the COVID-19 pandemic. Between January 2021 and September 2021, medical cannabis pharmacies made 6,990 deliveries of medical cannabis to cardholder homes.
- **Number of Participating Medical Providers Has Increased by 38%.** As of September 30, 2021, there were 781 qualified medical providers (QMPs) registered by the Utah Department of Health. The number of QMPs has increased by 38% during the past year.

Patient Cardholder Demographics by Age as of September 30, 2021

Patient Age	Count	Percentage of Total
10 yrs and under	22	Less than 1%
11-17	40	Less than 1%
18-20	81	Less than 1%
21-30	7,978	21%
31-45	15,065	40%
46-55	5,749	15%
56-65	4,811	13%
66 and older	3,937	10%
Total	**37,683**	**100%**

Qualified Medical Providers by DOPL License Type as of September 30, 2021

Qualified Medical Provider DOPL License Type	Number of QMPs Registered
Medical Doctor (MD)	261
Osteopathic Doctor (DO)	49
Physician Assistant (PA)	105
Advanced Practice Registered Nurse (APRN)	324
Podiatrist	0
Total	**739**

PROVIDER RESOURCES

Various resources for medical cannabis providers are available at https://medicalcannabis.utah.gov/resources/provider-resources/. Among other resources, the site includes condition-specific guidance on the suggested use of medical cannabis for the following conditions:

- Chronic Pain
- ALS
- Alzheimer's
- HIV/AIDS & Chronic Pain
- Multiple Sclerosis
- Autism
- Cancer
- Cancer and Chemotherapy-induced Nausea & Vomiting
- Crohn's Disease & Ulcerative Colitis
- Epilepsy
- PTSD

Patient Cardholders by Medical Conditions as of September 30, 2021

*All current cardholders with Qualifying Condition = Other conditions have been reviewed by the Compassionate Use Board

Qualifying Condition	Patient Certification Count	Percentage of Total
AIDS	19	< 1%
ALS	22	< 1%
Alzheimer's	33	< 1%
Autism	235	1%
Cachexia	41	< 1%
Cancer	1,098	3%
Chronic Pain	29,012	77%
Crohn's Disease	436	1%
Debilitating Seizures	108	< 1%
Epilepsy	349	1%
HIV	155	< 1%
Hospice	48	< 1%
MS	503	1%
Nausea	1,001	3%
Other*	23	< 1%
Persistent Muscle Spasms	257	1%
PTSD	3,976	11%
Rare Condition	87	< 1%
Terminal Illness	75	< 1%
Ulcerative Colitis	205	1%
Total	**37,683**	**100%**

UMA INITIATES PUBLIC MEDIA CAMPAIGN

BY MARK FOTHERINGHAM, UMA V.P. OF COMMUNICATIONS

With the increasing frequency of mid-level providers attempting to expand their scope of practice and encroach legislatively into areas of medical practice more appropriately reserved for those with the extra training and experience to preserve patient safety and quality care, the Utah Medical Association has initiated a public media campaign to remind Utahns that physicians are the highest trained of all medical care givers and that it is O.K. to request to be seen by a physician when medical care is needed.

The campaign is designed to avoid confrontational messages. "It is important to recognize that all members of the healthcare team have their place, but that a fully trained and licensed physician is best suited to lead that team," said UMA President Noel Nye, DO. "It's what will most likely lead to the best outcomes for patients needing the highest quality of care possible."

The media campaign will feature a heavy social media component as well as radio, TV and billboard ads. The campaign will likely have begun by the time you read this article.

A few images from the social media messages are reproduced here.

Clicking links in the social media messages will take users to an internet landing page that reinforces the messages, and which includes an opportunity to search for physician members of the Utah Medical Association by city and specialty, giving them physician names, office addresses and office phone numbers. If you as a UMA member would prefer not to be included in any such search results, contact the UMA office and we can exclude your information.

"Our hope is that by reminding people that physicians are the highest trained of all clinical care givers, we might be able to forestall unreasonable and unnecessary expansions in scope of practice by those who want to practice medicine without going to medical school," said Dr. Nye. ■

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PHARMACIST DISPENSING, FLEXIBILITY

BY MARK BRINTON, ESQ., UMA GENERAL COUNSEL

Prescribing physicians need to know about laws (effective as of May 2020) that give pharmacists additional flexibility in dispensing to patients.

CHANGES IN DOSAGE FORM OR QUANTITY

Unless a prescriber writes "dispense as written" on the prescription, a pharmacist may be able to change the dosage form or quantity dispensed. If you prescribe a quantity of a drug that is not commercially available, the pharmacist filling your prescription will be able to dispense the prescription in a different quantity, without specific authorization from you. Similarly, the pharmacist can change the dosage form of your prescription if the pharmacist believes dispensing a different dosage form is in the best interest of the patient. The pharmacist cannot make these changes if they would change the treatment parameters or the bioavailability of the medication or if the prescription says, "dispense as written." *(Utah Code Section 58-17b-602.1)*

THERAPEUTIC SUBSTITUTION FOR INSULIN AND RELATED DEVICES

Unless a prescriber indicates that an insulin prescription is "dispense as written," a 2020 law allows a pharmacist to substitute the prescribed insulin for an interchangeable biological product. This is an exception to the general requirements in Utah Code Section 58-17b-605.5, which allows substitution of prescribed interchangeable biological products under certain circumstances. *(Utah Code Section 58-17b-608.2(8))*

A pharmacist may dispense a therapeutic equivalent when dispensing a prescribed glucometer, diabetes test strip, lancet, or syringe. *(Utah Code Section 58-17b-608.2(9))*

EXTENDED EMERGENCY REFILLS

A new option was added in May 2020 to the amount that can be dispensed under the law on emergency refills. Under long-existing law, if the prescriber is not available promptly to authorize a refill, a pharmacist may dispense enough to address an emergency, but no more than a three-day supply. It was generally understood that an emergency refill would only be available one-time, for a non-controlled substance that the patient is currently using; the new law spells

this out. Under the new option, if the prescription expired in the past 30 days, it is on file with the pharmacy, no refills remain, and all the other emergency refill requirements are met, the pharmacist can dispense the amount last dispensed by the pharmacy, up to a 30-day supply. And, as before, the pharmacist is to let the prescriber know about the refill as soon as practicable. *(Utah Code Section 58-17b-608)*

EMERGENCY REFILLS FOR INSULIN

A 2020 law has a special rule for refilling an exhausted insulin prescription. If the prescription expired less than six months ago, the pharmacist may dispense a one-time 60-day supply, based on the prescriber's original instructions. The pharmacist must let the prescriber know about the refill within 30 days. *(Utah Code Section 58-17b-608.2)*

PRESCRIPTION DEVICES

Patients generally need a prescription to get insurance coverage for nebulizers, spacers for nebulizers or inhalers, or diabetic testing supplies. If one of these devices is indicated by a written record of a patient's current diagnosis or treatment protocol that a pharmacy has on file, the 2020 law enables the pharmacist to consider the document as a prescription for dispensing that device. This may enable the patient to get reimbursement for the item from their insurance. *(Utah Code Section 58-17b-610.8)* ■

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THE FALSE CLAIM ACT: UNDERSTANDING THE SERIOUSNESS OF ALLEGATIONS

BY JOHN HUBER, JD

"A popular adage declares that if one's only tool is a hammer, then everything looks like a nail."

Over the course of the Civil War, Congress perceived rampant fraud amongst profiteer contractors who sold decrepit work animals and faulty equipment to the Union Army in return for healthy payments. Because of strapped federal funding, there were not enough government inspectors to pursue claims of fraud. So, in enacting the False Claim Act ("FCA") in 1863, Congress provided an incentive for private citizens to turn in those committing fraud against the government. In what became known as *qui tam* actions, a whistleblower private citizen could receive a percentage of recovered funds and penalties.

For a time, the FCA seemed to be working well. In those days, motivated private claimants were guaranteed 50% of recovered funds which generated a flow of false claim cases. Then, over the first half of the 20th Century, changes in the law dulled down incentives for whistleblowers, and *qui tam* actions dwindled into obscurity. Nevertheless, over the ensuing decades fraud against the United States continued to the point that Congress resurrected the viability of *qui tam* actions.

In 1986, Congress re-strengthened the *qui tam* provisions of the FCA. The revisions guarantee a return for whistleblowers (also known as "relators") in successful claims. At the government's discretion, whistleblowers could earn rewards ranging from 15% to 30% of the recovered funds. The revised law also offers protection to *qui tam* whistleblowers against retaliation or wrongful termination for bringing the allegations to light.

As a result, the FCA has since become one of the most popular tools for the federal government to recover Treasury funds that were lost in fraud or false claims, and an ever-increasing percentage of FCA actions focus upon healthcare. In fiscal year 2020, the Department of Justice obtained over $2.2 billion in settlements and judgments through the FCA. Of that, $1.8 billion—or over 80%—related to the healthcare industry. These recent targets of FCA actions included drug and medical device manufacturers, managed care providers, hospitals, pharmacies, hospice organizations, laboratories, and physicians.

While the Department of Justice can bring actions independent of whistleblowers, over half of the 2020 recoveries, or $1.6 billion, were a result of *qui tam* whistleblower lawsuits. During that period, the federal government paid out $309 million to the individual whistleblowers who exposed the fraud and false claims. Undoubtedly, the FCA has helped expose fraud, waste, and abuse, and it has led to big recoveries of taxpayer funds. As such, it is an effective tool.

Civil actions pursuant to the FCA enjoy the lowest standard of proof in our judicial system—preponderance of the evidence. In other words, to prevail in court a federal prosecutor need only show that it is "more likely than not" that a false claim occurred. In addition, prosecutors tout a generous standard for proving culpable knowledge on the part of the accused. For example, they are not required to show that an individual or company had specific intent to defraud.

Then there are the onerous penalties that the government can impose on those culpable for false claims. The FCA authorizes up to $23,000 for each false claim violation and up to three times the amount of actual damages. In other words, penalties can pile up quickly. For those who defraud the government and line their pockets with taxpayer funds, the penalties seem appropriate. There must be accountability for those who cheat the system.

On the other hand, individuals and practices who did not knowingly violate the FCA may find themselves as subjects of disconcerting allegations and mounting liabilities. Allegations may include billing for services not rendered, submitting inaccurate claims for services, and receiving or offering kickbacks for referrals. Keep in mind, as well, that the Department of Justice will often broadcast the false claims allegations with public statements that attract media attention.

Because of past success, federal authorities may view the FCA as an exclusive tool to address perceived fraud against Medicare and Medicaid. While the government may value the FCA as an effective tool, for someone on the other side it may look like a big, unwieldy hammer. Certainly, nuance and variation may be lost within the rigid one-size-fits-all FCA. That is, the FCA may not recognize technicalities, limited knowledge, and good intentions. As such, if the FCA is like a hammer, those being scrutinized begin to feel like nails.

Physicians and healthcare professionals must navigate labyrinth-like federal regulations as they provide and bill for care to others. It is the rare case when professionals set out to defraud the government. With that FCA hammer looming, it would be best to avoid allegations altogether, and professionals can mitigate exposure through a strong compliance culture and safeguards in billing practices. Nonetheless, an office or individual may unexpectedly become the subject of government inquiries related to false claims, especially when a whistleblower reports perceived wrongdoing. If that happens, seek the best counsel in how to respond. The ramifications of being subject to FCA investigation and prosecution are all too serious. ■

John Huber offered 27 years of public service as a prosecutor in state and federal courts. From 2015–2021, Mr. Huber served as the United States Attorney for the District of Utah, having been appointed by both President Obama and President Trump and unanimously confirmed twice by the United States Senate. He is now in private practice with global law firm Greenberg Traurig and is based in Salt Lake City.

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YEAR-END FINANCIAL CHECKLIST

BY JEFF ZESIGER MS, CFP®
UMA FINANCIAL SERVICES

As we approach the end of 2021, it's time to ensure you're still on track with your financial goals. Year-end provides a great opportunity to review your goals, accounts, and investments to get ready for the new year. Also, with a new tax year just around the corner, reviewing your portfolio and personal finances now could potentially help you reduce your tax liability.

Here are eight tips to help you take needed action before the end of the year, allowing you to head into 2022 feeling confident about your financial health.

1. PERSONAL SPENDING

For many physicians, the COVID turmoil of the past year has challenged planned expenses and habits. However, this can also be a great opportunity to reconsider which areas we value in our lives. Start by reviewing your spending over this past year and re-evaluate your priorities, ensuring your expenses reflect your priorities. Then update your 2022 personal spending plan with necessary changes. If your goals are off track, set a new target for 2022. Ideally, your investing goals are your top budget priority, meaning you set aside those funds, hopefully automatically, before any other expenses. Put another way, pay yourself first.

2. SAVINGS

The pandemic has also reminded us of the importance of having an appropriate emergency fund. Your priority should be to ensure your emergency fund is on track. In an ideal world, you'd have three to six months' worth of emergency savings set aside.

Are you on track with your investing goals? If you participate in a 401(k) plan, be sure to contribute at least enough to take full advantage of your employer matching contribution. If you are not maximizing your personal deferral, you have until December 31 to make any last-minute contributions. For those 50 or older, you are also potentially eligible for an additional catch-up contribution. With IRAs and Roth IRAs, you have until April 15 to maximize your contributions but remember Roth conversions must be completed by year-end to be included on your 2021 tax return.

3. CREDIT AND DEBT

Start by evaluating how you target debt reduction with your other goals and make sure you're prioritizing each accordingly. Did you achieve your desired progress paying down debt this past year? With today's low-rate environment, now is a great time to review your current loans and ensure you are getting the most favorable rates and terms.

As you review your plan, are there ways to minimize your total interest payments by prioritizing high-interest debt or consolidating?

With identity theft on the rise, checking your credit report should also be part of your year-end review. Be sure to review your credit reports from all three credit bureaus, especially if you are planning a significant borrowing event in 2022. Remember you can receive a free credit report annually from AnnualCreditReport.com.

4. INVESTMENTS

It's also important for physicians to review investment portfolios and how they relate to your goals during your annual review process. This is especially true when the economy undergoes a shift. Periodically rebalancing your portfolio ensures that you are targeting and maintaining your desired risk, while making sure your current portfolio reflects your investment strategy.

For example, stocks and bonds in your investment portfolio should be appropriate for your age and how well you tolerate risk, while also considering your tax status and time horizon. Consider how changes in your life may have impacted your overall financial goals. Finally, when reviewing your investment plan, don't forget to consider the tax implications of financial changes you may be making.

5. INSURANCE

Year-end is also a great time to review your insurance coverages to ensure they still reflect your needs. Start by reviewing your existing policies and coverage; is your current coverage sufficient? Does the original purpose for your insurance policies still exist? If not, do you need to review your insurance coverage options?

Don't forget to monitor your disability coverage at least annually and during major life changes. Where possible, the policy coverage amount should be sufficient to allow continued living and saving at your comfort level.

Reviewing your life insurance coverage is also important. For many, term coverage can be cost-effective, thereby allowing you to direct more of your financial resources to accomplishing your goals. However, a word of caution since the coverage does eventually mature. Continue to use your resources wisely, focusing not only on building your savings towards your respective goals, but also reducing your liabilities. That way, you should be adequately covered as the term coverage expires.

Finally, if you haven't checked your liability coverage recently, this would be a good time to do so. Typically, the liability coverage provided through your homeowner's and auto insurance policies is limited. Physicians should consider purchasing additional liability coverage through a personal umbrella liability policy, which is another cost-effective way to reduce your risk.

6. ESTATE PLAN

It's always a good idea to review your overall estate plan annually, thereby ensuring it is still aligned with your wishes. Pay close attention to the funding for trusts, trustees, power of attorney provisions and health care directives.

Also, review your beneficiaries to ensure they are up to date, especially if you had a major life event recently (i.e., births, marriage, deaths, divorce, retirement etc.). With potential future changes to estate laws, you may also consider strategies such as gifting opportunities to transfer assets and reduce your taxable estate.

7. TAXES

Start by reviewing this past year; have you experienced any life transitions that could affect your tax withholding status (i.e., marriage, births, divorce, deaths, retirement, etc.)? Did you have any major investment gains or losses? Based on next year's anticipated income, would deferring, or accelerating bonuses, property sales, other taxable transactions, deductible expenses, charitable gifts, etc., create a tax benefit?

Do you contribute to a health savings account (HSA), which could benefit you in many ways (i.e., pretax contributions - saving on current taxes, tax-free earnings on investments inside the HSA, tax-free withdrawals when used to pay for eligible medical expenses)?

If you have a flexible spending account (FSA), in most cases you have until the end of the year to spend the money in your account on eligible medical expenses or lose it. Consider now you might be able to utilize the funds to avoid forfeiture.

Another strategy to consider may be tax-loss harvesting. A strategy performed within your portfolio by deliberately creating losses. The process involves selling a position at a loss, which generates a capital loss. The loss can then be used to reduce capital gains or to reduce taxable income up to $3,000 a year. Losses greater than $3,000 can be carried forward to reduce capital gains or income in future years.

The Qualified Charitable Distribution (QCD) strategy, for those over 70 ½, allows you to donate up to $100,000 a year from your IRA directly to a charity, without having to include the distribution as taxable income. Remember, any charitable contribution must be made before December 31 to be allowed for the 2021 tax year.

8. YEAR-END MEETINGS

Finally, your year-end checklist should include scheduling reviews with financial health team members: your financial advisor, tax advisor, and attorney.

Schedule a meeting with your financial advisor to review your year-end financial checklist. Your financial advisor can not only help to review many items on this list but can also serve as your financial coach. Someone with whom you can share your goals, guides you to develop strategies to achieve them, and helps hold you accountable for your actions and decisions.

Your tax advisor can also help you review the items on this list with tax implications. Year-end is an ideal time to assess your overall tax situation to ensure you are properly taking advantage of the tax code. If you anticipate a change in your circumstances that will impact your taxes, now is the time to make the necessary adjustments.

Lastly, don't forget to meet with your attorney every few years to review your estate plan or as you experience any life transitions that could affect your plans.

An annual financial review is an excellent tool for your life (and peace of mind) now and for your future. If you would like a year-end review of your financial situation, or if you have questions regarding year-end strategies, contact our UMAFS team at questions@umafs.org or 801-747-0800. ■

ELECTRONIC PRESCRIBING REQUIRED FOR CONTROLLED SUBSTANCES

BY MARK BRINTON, JD, UMA GENERAL COUNSEL

New Law Goes into Effect January 1, 2022

As of January 1, 2022, Utah prescriptions for controlled substances will need to be transmitted electronically using two-factor authentication, with few exceptions. This applies to controlled substances in schedules II through V.

UMA first addressed this coming requirement in a legislative report in the April/May 2020 issue of the Utah Physician. The Utah Division of Occupational and Professional Licensing just issued temporary "emergency" rules to guide compliance now and will finalize the rules in a couple of months. We will update you via the UMA MediByte newsletter when we know more.

Electronic prescribing means using an electronic application or program to generate and transmit an electronic data file to a pharmacy using the standardized protocol. It does not include sending a prescription by fax, phone call, text, or email. (And of course, texting and emailing should never be used for protected health information.)

There are a few limited exceptions to the e-prescribing requirement in Utah Code 58-37-22. IT does not apply to prescriptions:

- Issued when there is a temporary technical or electronic failure at the prescriber's or pharmacy's location;
- Issued in an emergency situation; or
- For patients residing in a long-term care facility or a jail or a prison.

A prescriber issuing a written prescription for a controlled substance during a technical or electronic failure needs to note on the prescription that there was a technical or electronic failure. Besides being an exception to e-prescribing, an "emergency situation" is also when a prescriber can issue a controlled substance prescription vocally. DOPL had not previously defined "emergency situation" but now defines it as when issuing a prescription that complies with all the requirements would cause a delay that would "adversely impact the patient's medical condition and immediate prescribing is necessary for the proper treatment of the patient." Consequently, this is an "emergency situation" that would excuse issuing a controlled substance prescription electronically.

There are also exclusions for prescriptions dispensed by a pharmacy of the US Department of Veterans Affairs or issued by a veterinarian.

If a prescriber is unable to comply with the electronic requirement, another part of the statute and regs allow the prescriber under certain circumstances to submit an application for two additional years to comply. The form is available at DOPL's webpage for physicians and surgeons or on our website at www.utahmed.org/ERX.

Prescribers can apply for a two-year extension if:

- they will retire by the end of 2023;
- the cost of compliance would exceed 5% of their annual income;

- the internet service providers available do not have the technological capabilities required by the e-prescribing platform;
- they are a free or low-income facility;
- they filed for bankruptcy in the past 12 months;
- they have a disability that limits their ability to use an e-prescribing platform; or
- they have another exceptional circumstance, which DOPL will review on a case-by-case basis.

An explanation should be submitted with the form. Then DOPL will approve or deny the extension. No additional extensions are available.

You should also be aware that a separate federal law requires that electronic prescriptions for controlled substances must be sent via a system or application using two-factor authentication that meets federal requirements. DOPL has compiled a list of vendors who may be able to provide you with electronic prescribing applications. Some are stand-alone, others are part of an electronic medical record system, though the law does not require physicians to use an EMR. For your convenience, we will post DOPL's list of vendors on our website at www.utahmed.org/ERX.

Note: this law also requires pharmacies to accept controlled substance prescriptions electronically; however, they have exclusions and extensions comparable to prescribers. There may be times when you issue a controlled substance prescription that a pharmacy cannot receive electronically. In that case, you can issue it on paper. If you issue an e-prescription to a pharmacy that cannot fill it, you may need to issue it again to another pharmacy. This is because pharmacies have until July 1, 2024, to be able to transfer an unfilled e-prescription to another pharmacy if requested by the patient or prescriber.

Some pharmacies can already do this. For pharmacies that cannot, the regulation directs the pharmacy to inform the prescriber that they cannot fill or forward the prescription, so the prescriber can reissue the prescription.

Generally, under these new requirements, you should write on any written prescription for a controlled substance the reason you are not issuing it electronically, in case there is any question about why you didn't when it is filled or later. ■

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PREDICTING AND RESPONDING TO FUTURE PANDEMICS

BY DOUG DOLLEMORE, SENIOR SCIENCE WRITER, U OF U HEALTH

Image licensed by Ingram Image

A multidisciplinary national research team led by University of Utah Health scientists has launched a comprehensive review and analysis of data collected about COVID-19 in hopes of improving the nation's ability to predict, detect, and respond to future pandemics.

The project is funded by a three-year, $4.9 million contract with the Centers for Disease Control & Prevention (CDC) and co-led by Makoto Jones, MD, MS, an epidemiologist and infectious disease specialist at U of U Health and the VA Salt Lake Health Care System, and Matthew Samore, MD, Chief of the Division of Epidemiology at U of U Health.

The contract is "part of the CDC's broader efforts to stand up a disease forecasting center to support public health decision-making and to address problems of health inequity" says Samore, who is also director of the Decision Enhancement and Analytic Sciences Center at the VA Salt Lake City Health Care System.

"The uncertainty arising from questions that couldn't be answered at the beginning of the pandemic contributed to a cascade of speculation and distrust among the public and policy makers," Samore says. "We hope that by improving our ability to foresee and prepare for pandemics, we can avoid those pitfalls in the future."

Based an analysis of COVID-19 data, the scientists hope to build on lessons learned during the current pandemic to identify gaps in knowledge and to refine epidemiological estimates during subsequent pandemics. They also plan to set priorities for improving detection and surveillance of infectious diseases, such as Zika and H1N1, capable of rapid and widespread transmission.
They will use a variety of methods, such as mathematical modeling, to predict pandemic onset and outcomes. The multidisciplinary team includes experts in biostatistics, informatics, health economics, and infectious disease epidemiology. The effort is a collaboration between scientists at U of U Health, the VA Salt Lake City Health Care System, the Utah Department of Health, and the University of North Carolina.

U of U Health scientists involved in the project represent the College of Pharmacy, School of Biological Sciences, and School of Medicine departments of Internal Medicine, Pediatrics, and Population Health Sciences. ■

Matthew Samore, MD, Chief of the Division of Epidemiology at U of U Health

NO SURPRISES ACT NEEDS TO CHANGE

UMA JOINS EFFORT TO AMEND ARBITRATION PROCEDURE

ADAPTED BY MARK FOTHERINGHAM FROM A TEXAS MEDICAL ASSOC. NEWS RELEASE

The Utah Medical Association recently teamed with the American Medical Association and others to engage the Biden administration outside court. UMA and scores of other state medical and national specialty societies sent a letter on Nov. 17 asking three federal agencies to reconsider the disputed portion of rulemaking for the No Surprises Act. The 2020 law established an independent dispute resolution (IDR) process governing ERISA-regulated insurers and other groups and individual plans in which an arbitrator selects either a physician's proposed amount or a health plan's proposed amount.

But the federal rule for the No Surprises Act requires an arbitrator to presume that the health plan's median contracted rate, also known as the qualifying payment amount (QPA), is "the appropriate out-of-network rate," and to select the offer closest to the QPA unless "credible information" demonstrates the QPA isn't the appropriate rate.

The Nov. 17 letter objects to that presumption, asking the secretaries of the Health and Human Services, Treasury, and Labor departments to restore the fair, balanced IDR process Congress intended when passing the law, in which the arbitrator would weigh all relevant factors.

"To be clear, our request is not to unravel the [No Surprises Act] or delay implementation of any of its patient protections," the physician organizations wrote. "Instead, we ask that you revise the most recent [rule] to conform with the [law's] language to allow an IDR entity the discretion to consider all the relevant information submitted by the parties to determine a fair out-of-network payment to physicians," without assuming that the QPA is the appropriate payment amount.

A skewed IDR process "that restricts physicians' ability to make their case for a reasonable out-of-network payment removes a critical remaining incentive for insurers to negotiate fair contracts with physicians," medicine added.

"While none of our organizations anticipated a high volume of claims going all the way through the dispute process to IDR when the [law] was enacted, we knew that the possibility of a physician successfully making the case for a fair out-of-network payment to an IDR entity could help influence a health insurer to come to the negotiating table in the first place, offer a reasonable initial payment when a surprise bill happens, and settle most disputes in the open negotiations process," the organizations wrote. "But, in implementing the IDR process in a way that essentially predetermines the outcome to be at the 50th percentile of contract rates, that important check on negotiating incentives established by Congress has largely been stripped away."

The letter added that meaningful contract negotiations create health care system efficiencies, including not just reduced use of dispute resolution, but also reduced administrative waste and more value-based payment arrangements. A full copy of the letter listing all the signatories is available at https://utahmed.org/docs/letter_nov17.pdf

The No Surprises Act takes effect in January 2022 and the first arbitrations are expected to start taking place in March.

Editor's Note: See following story (pg 23) regarding a lawsuit by the AMA to change the No Surprises Act. ■

SUIT SEEKS CHANGE IN HOW ARBITRATORS SETTLE SURPRISE BILLING CASES

BY JULIE APPLEBY, SENIOR CORRESPONDENT, KHN

Editor's Note:
Just before going to press, the AMA filed the suit described in this story, changing and adding to the narrative of the story on Page 22 (No Surprises Act Needs to Change).

Two of the largest lobbying groups representing physicians and hospitals filed a lawsuit December 9th challenging a Biden administration decision on how to implement the law shielding patients from most surprise medical bills.

The lawsuit from the American Medical Association and the American Hospital Association does not seek to halt the law from going into effect in January. Instead, it seeks a change in a key provision in regulations issued in September.

At issue is how arbitrators will decide the amount insurers pay toward disputed out-of-network bills.

That was a main point of dispute in the long and contentious debate leading up to the passage of the No Surprises Act in late 2020 — and remains so a year later.

"Our legal challenge urges regulators to ensure there is a fair and meaningful process to resolve disputes between health care providers and insurance companies," AMA President Gerald E. Harmon said in a written release.

The No Surprises law is designed to address a common practice: providers sending large, unexpected bills to patients who receive out-of-network care from physicians, laboratories, hospitals or air ambulance services.

Starting in January, the law bars most such balance bills. Instead, insured patients will pay only what they would have if the care had been provided by an in-network facility or physician. It directs insurers and the medical providers to work out whether any more is owed.

If they can't agree, the dispute moves to "baseball-style" arbitration, in which both sides put forth their best offer and an arbitrator picks one, with the loser paying the arbitration cost, which the rule sets for next year as between $200 and $500.

The regulation issued Sept. 30 directs arbitrators to lean toward picking the amount closest to the median in-network rate negotiated for the type of care involved, although they can also consider other factors, such as the experience of the provider, the type of hospital and the complexity of the treatment.

Congress wrote into the legislation that arbitrators could not consider "billed charges," which are often highly inflated amounts hospitals and doctors set as what they want to be paid, nor could they consider the lowest payment amounts, including reimbursement rates from Medicaid and Medicare.

The lawsuit, filed in U.S District Court for the District of Columbia, alleges that giving weight to the in-network median rate "places a heavy thumb on the scale" against medical providers and "barely resembles" the process Congress created.

Congress, it alleges, prescribed "no particular weight or presumption for any one factor," instead directing arbitrators to consider all factors. Focusing on median in-network rates will "prevent fair and adequate compensation." ■

UTAH CARES: CARDIAC ARREST REGISTRY TO ENHANCE SURVIVAL

FROM THE UTAH DEPARTMENT OF HEALTH

KEY FINDINGS

Utah exceeds the national average of in-hospital survival rates—of cardiac arrest from the intense efforts made by EMS agencies—Survived to Hospital Discharge (9.7% vs. 9.0%) and Good/Moderate Cerebral Performance Category (CPC) (8.1% vs. 7.1%) (Figure 1).

A substantial proportion (45.2%) of cardiac arrests in Utah are witnessed by bystanders (Figure 2). If CPR is initiated by a bystander, the chance of the collapsed person surviving with intact brain function is twice as high as persons whose initiation of CPR is delayed.

Cardiac arrest, also known as sudden cardiac death, results when the heart suddenly stops beating as a result of a myocardial infarction (heart attack) or a severe disruption of the heart's normal rhythm.[1] This is the most severe cardiac event possible and unless the heart is restarted, this event will be fatal. Cardiac arrests can occur at any age, but are more common in older adults. In 2020, Utah emergency medical services (EMS) agencies responded to more than 1,400 cardiac arrests.[2]

Treatments for a cardiac arrest are immediate cardiopulmonary resuscitation (CPR) and immediate defibrillation. CPR helps to pump blood through the circulatory system keeping the brain and other vital organs alive. Defibrillation (applying an electrical shock to the heart using an automated external defibrillator, or AED) can restore the heart's internal rhythm, in effect "jump starting" the heart. It is important to know the chances of survival are greatly increased when CPR and defibrillation are applied promptly.3 Consequently, bystanders, including a family member or healthcare provider, play a critical role in the possible survival of cardiac arrest patients.

In 2012, Utah began the Cardiac Registry to Enhance Survival (the CARES Registry). CARES is a Centers for Disease Control and Prevention-supported standardized registry of cardiac arrests of non-traumatic etiology where rescusitative efforts were attempted by a 911 responder. It utilizes a standardized reporting format allowing results to be accurately compared between states, hospitals, and EMS agencies nationwide. In 2012, Utah began voluntary reporting of cardiac arrest information in an effort to evaluate and improve cardiac care statewide. In 2018, the Utah Legislature passed Senate Bill 150, formally establishing a statewide cardiac registry. As a result, we are now able to measure the management of cardiac arrest patients. This information will inform future improvements in emergency care protocols and public information campaigns in Utah.

Figure 1 indicates rates of cardiac arrest survival are higher for Utah in comparison with averages across the country. Pre-hospital Survival to Hospital Admission reflects those patients revived by EMS and admitted to the hospital. Please note the categories of in-hospital survival rates of persons with cardiac arrests—Survived to Hospital Discharge (9.7% vs. 9.0%) and Good/Moderate Cerebral Performance Category (CPC) (8.1% vs 7.1%)—represent, respectively, the patients who lived to be discharged from the hospital and those who were discharged with intact brain function and able to go back to a "normal" life, care for themselves with minimal assistance, and return to work and family. In these two categories, Utah exceeds the national average for survival. This is largely a result of intense efforts by EMS agencies in our state to

References:

1. National Heart, Lung, and Blood Institute. https://www.nhlbi.nih.gov/health-topics/sudden-cardiac-arrest#:~:text=What%20Is,it's%20not%20treated%20within%20minutes.
2. Utah CARES data 2020. https://mycares.net/
3. Center for Disease Control and Prevention. https://www.cdc.gov/heartdisease/cpr.htm
4. Hollenberg, Herlitz, Lindqvist. Improved Survival After Out-of-Hospital Cardiac Arrest Is Associated With an Increase in Proportion of Emergency Crew–Witnessed Cases and Bystander Cardiopulmonary Resuscitation
5. Center for Disease Control and Prevention. https://www.cdc.gov/dhdsp/docs/cardiac-arrest-infographic.pdf

apply evidence-based best treatment protocols of High-Performance CPR to cardiac arrest victims.

Figure 2 shows a substantial proportion (45.2%) of cardiac arrests in Utah are witnessed by bystanders compared with the nation (37.1%). Data indicate cardiac arrests witnessed by bystanders have a substantially higher survival rate than those not witnessed.[3]

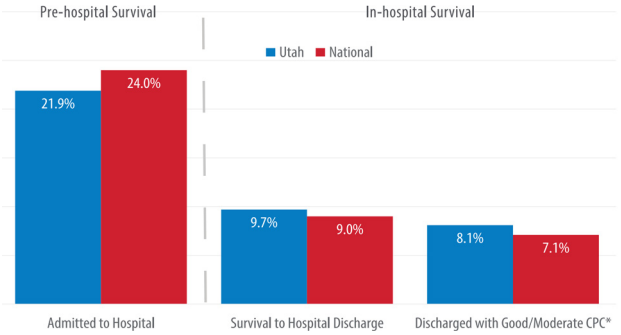
Bystanders can activate the 911 system and call EMS to the scene quickly and SHOULD initiate CPR until EMS arrives.[3] If CPR is initiated by a bystander, the chance of the collapsed person surviving with intact brain function is twice as high as persons whose initiation of CPR is delayed.[4] Even a few minutes of delay in beginning CPR greatly decreases the chances of a successful outcome.[3]

Efforts to improve bystander CPR rates in the state (Figure 3) will immediately be translated to improved outcomes from cardiac arrest. Every effort should be made to train all Utahns in CPR. Courses can be found at many hospitals and schools, and can also be organized by local EMS agencies at churches and community centers.[5]

Increasing the rate of bystander CPR will improve cardiac arrest survival in Utah, helping us to help each other return to our lives and families after cardiac arrest. The Utah Law U.C.A. 78B-4-501 can be found here: https://le.utah.gov/xcode/Title78B/Chapter4/78B-4-S501.html and the key language is "A person who renders emergency care at or near the scene of, or during, an emergency, gratuitously and in good faith, is not liable for any civil damages or penalties as a result of any act or omission by the person rendering the emergency care, unless the person is grossly negligent or caused the emergency." ■

Unadjusted Pre-hospital and In-hospital Out of Hospital Cardiac Arrest Patient Outcomes, Utah vs. National, 2020

Figure 1. Utah had a higher rates of patient in-hospital survival of cardiac arrest from hospital in conjunction with good/moderate CPC* compared with the nation.



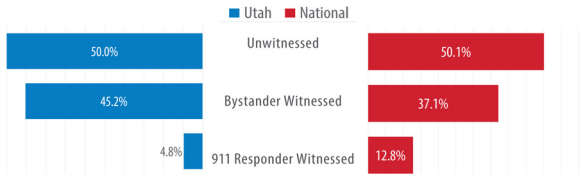
Source: Cardiac Arrest Registry to Enhance Survival (C.A.R.E.S) Annual Report, 2020

*Cerebral Performance Category scores reporting good/moderate were CPC 1 and CPC 2. See definitions here.

Note: ED outcome missing for 181 national cases (.1%) and discharge outcome missing for 196 national cases (.15%).

Percentage of Cardiac Arrests by Witness Status, Utah vs. National, 2020

Figure 2. Utah had a higher percentage of bystander witnessed arrests and lower 911 responder witnessed arrests compared with the national average.

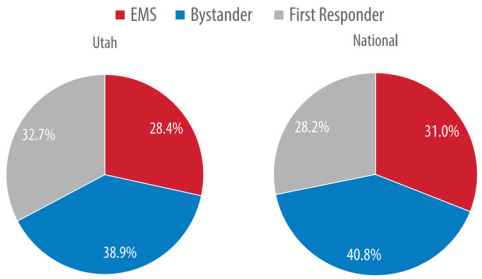


Source: Cardiac Arrest Registry to Enhance Survival (C.A.R.E.S) Annual Report, 2020

Note: Bystander Witnessed do not inlcude medical personnel or famliy members for witness status.

Percentage of CPR Performed by Who Initiated Total Cardiac Arrests, Utah vs. National, 2020

Figure 3. Utah had higher rates of CPR performed by first trsponders compared with the national average.



Source: Cardiac Arrest Registry to Enhance Survival (C.A.R.E.S) Annual Report, 2020

Note: Bystanders for CPR rates include: bystander, family member, or healthcare provider.

Who intiated CPR /Total CARES cases

STAY SAFE, STAY ACTIVE STREETS INITIATIVE

FROM THE UTAH DEPARTMENT OF HEALTH

COVID-19 impacted the ability of many individuals to access regular physical activity opportunities. As commercial and workplace gyms and recreation centers were closed during the early phases of the pandemic, many people turned to the outdoors to get physical activity. Salt Lake City implemented a Stay Safe, Stay Active Streets Initiative to open streets to provide opportunities for cyclists and pedestrians to be physically active while maintaining social distancing guidelines. In most cases, a single lane was reallocated to foot and bicycle traffic, while certain blocks were restricted to 'local traffic only,' allowing for the full use of the street space for non-vehicle use. This innovative response to pandemic social distancing guidelines provided opportunity to all; but in particular, to those who did not have space to move about without interacting with others and being put at risk, such as those living in apartments, condominiums, or other communal living arrangements. In November 2020, all streets participating in the Stay Safe, Stay Active Streets Initiative returned to normal operation.

A survey of more than 6,200 Salt Lake City residents helped guide the decision-making process for which streets would be opened. In the survey, 76% of respondents stated they generally support this effort with comments including the hope for these changes to remain after the pandemic. The success of this initiative has led to weekend closures during the 2021 summer season to vehicles traveling on Main Street from South Temple to 400 South. This "Open Street" enables pedestrians to enjoy dining, shopping, and entertainment in the downtown area. Visit https://downtownslc.org/openstreets for more information. ■

Stay Safe, Stay Active Streets Initiative Infographics, 2020

Figure 1. Infographics were developed to promote health and wellness by utilizing outdoor activities throughout the pandemic.

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CME CALENDAR

January 2022

14-15 2022 Cardiothoracic Surgery Symposium, Park City and Online, IHC (5.0)
20-22 Advanced Shoulder ArthroPlasty (ASAP) Conference, Snowbird or Virtual, UUCME (22.75)
21 Integrative Primary Care & Substance Abuse Disorder Treatment ECHO, Online, UUCME (1.0)

February 2022

4 Integrative Primary Care & Substance Abuse Disorder Treatment ECHO, Online, UUCME (1.0)
6-10 35th Annual PC Anatomic Pathology Workshop, Deer Valley, UUCME (21.5)
18 Integrative Primary Care & Substance Abuse Disorder Treatment ECHO, Online, UUCME (1.0)
20-24 67th Annual Update in Anesthesiology, Park City, UUCME (26.0)
25-27 6th Annual UAFP CME & Ski, Park City, UAFP (TBD)

March 2022

4 Integrative Primary Care & Substance Abuse Disorder Treatment ECHO, Online, UUCME (1.0)
5-7 Therapeutic Endoscopy Course, Park City, UUCME (24.5)
11 Utah Ophthalmology Society Annual Conference, SLC, UOS (7.25)
12-13 Rocky Mountain Inflammatory Bowel Disease (IBD) Conference, Teton Village WY, UUCME (9.0)
18 Integrative Primary Care & Substance Abuse Disorder Treatment ECHO, Online, UUCME (1.0)

April 2022

1 Integrative Primary Care & Substance Abuse Disorder Treatment ECHO, Online, UUCME (1.0)
15 Integrative Primary Care & Substance Abuse Disorder Treatment ECHO, Online, UUCME (1.0)
29 Integrative Primary Care & Substance Abuse Disorder Treatment ECHO, Online, UUCME (1.0)

May 2022

13 Integrative Primary Care & Substance Abuse Disorder Treatment ECHO, Online, UUCME (1.0)
14 Uof U School of Medicine Alumni CME Symposium, Salt Lake City or Virtual, UUCME (3.25)
27 Integrative Primary Care & Substance Abuse Disorder Treatment ECHO, Online, UUCME (1.0)

June 2022

10 Integrative Primary Care & Substance Abuse Disorder Treatment ECHO, Online, UUCME (1.0)
24 Integrative Primary Care & Substance Abuse Disorder Treatment ECHO, Online, UUCME (1.0)

Recurring Activities

Recurring activities are scheduled at St. Mark's Hospital, IHC Hospitals, Primary Children's Medical Center, and the University of Utah School of Medicine. Contact the sponsor for specific information. For more information on the above listings, please call the provider at the phone number listed on the following page.

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.

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STW	Steward Health Care Utah, South Jordan, 801/984-2384
TRH	Timpanogos Regional Hospital, Orem, 801/714-6505
UAFP	Utah Academy of Family Physicians, SLC, 801/587-3285
UHLF	Utah Healthy Living Foundation, SLC, 801/993-1800 or 801/712-8831
UDS	Utah Dermatology Society, SLC, 801/266-8841
UMAF	Utah Medical Association Foundation, SLC, 801/747-3500
UMIA	Utah Medical Insurance Association, SLC, 801/531-0375
UOS	Utah Ophthalmology Society, SLC, 801/747-3500
UUCME	University of Utah Continuing Medical Education, SLC, 801/581-8664
VA	VA Center for Learning, SLC, 801/584-2586

The following websites offer online continuing medical education:

cme.utahmed.org
psnet.ahrq.govcme
thedoctorschannel.comcme
freecme.com
pri-med.compmoOnlineCME.aspx
medicine.utah.educme
cmelist.com
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baylorcme.org
medscape.org
vlh.com
nejm.orgcontinuing-medical-education
reachmd.comprograms
cms.govOutreach-and-EducationLearnEarn-CreditEarn-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

PRE-ACQUISITION DILIGENCE: HOW TO GET AND STAY READY FOR ACQUISITION

Currently, the merger and acquisition (M&A) market in the United States is on a record-setting pace with transactions happening across many industries and company profiles.[1] While there are many reasons for the uptick in M&A transactions in the United States, effects stemming from the COVID-19 pandemic—such as, efficiencies through remote operations and increased confidence in sustaining growth as the economy has continued to open—have played a significant role in the booming M&A market.[2] Anecdotally, we have also seen this bear out here in our own practice, as we have assisted numerous healthcare providers (i.e., physician practices, ambulatory surgical centers, and assisted living facilities, among others) who found themselves swept up by the hot M&A marketplace, regardless of whether these healthcare providers were looking to sell.

This article provides an overview of the steps that companies, including healthcare providers, can take now to be prepared for an acquisition which can save time and costs during the due diligence phase of the acquisition. However, even if your company has no plans to sell, taking stock of and implementing the processes outlined in this article is still part of good corporate hygiene, and will likely prove valuable in other significant company transactions.

Compiling and Organizing Material Documents

Perhaps the most important function of due diligence is providing the buyer the means to assess the risk associated with the selling company. One main factor in determining a company's risk profile is the company's material agreements and documents, which allow both the buyer and seller to assess the tail of such documents and whether certain restrictive provisions in those documents may be triggered by the acquisition. While the agreements and documents requested by a particular buyer will vary depending on a multitude of factors—including the value and type of the M&A transaction (i.e., asset purchase, change of control, etc.), the industry in which the seller sits, and the seller's representations and warranties as negotiated between the parties—the seller will likely need to provide the buyer with the following general categories of agreements and documents:

- governing organizational documents;
- client/customer contracts;
- vendor contracts;
- employment agreements;
- contracts with governmental or quasi-governmental entities
- lease agreements (i.e., real property or equipment)
- licenses and permits necessary to operate the seller's business;
- insurance policies;
- tax returns;
- financial statements (typically, balance sheets, income statements, cash flow statements);
- loan documents; and
- documents pertaining to seller's capitalization (such, any options or warrants granted, or equity transfers).

Taking an inventory of these documents now and having them compiled and at the ready can save significant time (and cost) during due diligence, as sellers can find themselves inundated with checklists and emails from the buyer and the seller's own legal counsel requesting to review such information.

Staying Aware of Risks

Being aware of the general and specific risks associated with the seller's business is an important aspect of setting the tone for due diligence. The demanding nature of running the selling entity's business can understandably lead to certain blind spots on the part of administrators and executives when assessing the entity's risk profile. To guard against these blind spots administrators and executives should periodically assess the company's risk profile by determining whether any of the following "G-L-I-D-E-R" categories apply to the company. Doing so now, prior to an acquisition, can reduce the likelihood that closing is delayed due to late major surprises during due diligence.

- Governmental Notices: Has the entity received any notices from governmental entities (i.e., the Internal Revenue Services, state agencies, etc.)? This is meant to be a broad category so as to spur thought and discussion amongst the company's executive team. The key here is determining from which governmental agency the notice is from (federal, state, local) and the nature of the notice (whether that be a future deadline or non-compliance with law).
- Litigation or Other Threats/Claims: Has the company been part of any litigation, or is the company aware of any claims or threatened claims that may lead to litigation? This is an important category of risk and one in which the buyer will push to have indemnified post-closing.
- Insurance Issues: Has the company paid all premiums on time? Have there been any lapses in coverage with respect to material insurance policies? Here, sellers can typically look to their insurance brokers to provide detailed information regarding insurance issues. Still, administrators should be sure to maintain information from previous insurance providers, because this information may not be in the broker's possession.
- Data Incidents: Has any of the company's data been accessed or possessed by an unauthorized party? Has any service provider of the company been the subject of any data incident? With the constant updating of data privacy and security laws in various states, it is important that companies ensure that they and their service providers maintain best practices to keep data secure.
- Encumbrances: If the company has obtained a loan or has leased equipment, the company's assets may be subject to certain lender/lessor liens.
- Related-Party Transactions: The Company should document and ensure that any related-party transactions (i.e., between the company and officers/family of officers, between the company and owners/family of owners) remain at arm's length.

Conclusion

Whether or not your company is currently contemplating an acquisition, the foregoing recommendations provide practical steps that your company can take as a matter of corporate governance. Moreover, taking these steps now will streamline the due diligence process and may save needed time in the event the company finds itself in the throes of an acquisition.

Mr. Dhaliwal is a senior transactional associate with Ray Quinney & Nebeker, practicing in the firm's Corporate/Business, Banking and Finance, Cybersecurity and Privacy, and Health Care sections. Specifically, Mr. Dhaliwal focuses on M&A, finance, and health care transactions, including entity formation and planning, mergers and acquisitions, corporate finance, and corporate compliance.

1 *M&A Trends in the Opportunity Economy*, National Law Review, Volume XI, Number 252, dated September 9, 2021.

2 *Id.*

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