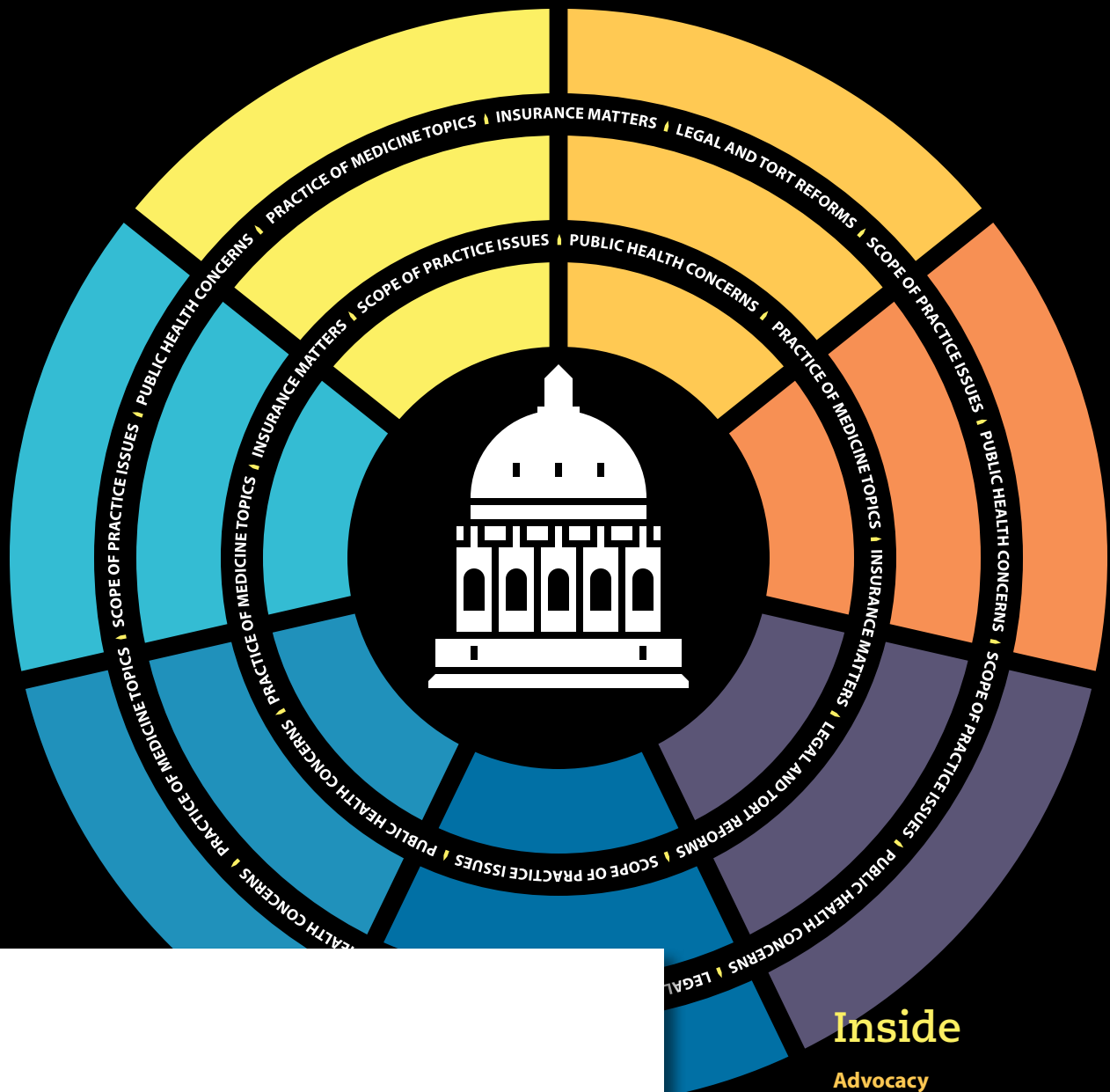


ST. LOUIS METROPOLITAN MEDICINE

VOLUME 41, NUMBER 6

DECEMBER 2019 / JANUARY 2020

Getting Involved in Advocacy: Now Is the Time



Inside

Advocacy

- 2 ➤ Advocacy: A Call to Action
- 12 ➤ Tips on Reaching Legislators
- 13 ➤ Ten Things You Can Do



ST. LOUIS METROPOLITAN
MEDICAL SOCIETY

2020 Annual Meeting and Installation Banquet



SATURDAY, JANUARY 25, 2020

The Saint Louis Zoo
The Living World
One Government Drive, St. Louis

6:00 p.m. Cocktail Reception
7:00 p.m. Dinner and Installation Program

CELEBRATING 183 YEARS OF ORGANIZED MEDICINE IN ST. LOUIS

HONORING THE INSTALLATION OF

Jason K. Skyles, MD, as SLMMS 2020 President and the Members of the 2020 SLMMS Council

PRESENTATION OF SLMMS AWARDS

Robert E. Schlueter Leadership Award ♦ Sam Page, MD
Award of Merit ♦ Richard Bucholz, MD
President's Award ♦ William Huffaker, MD

Reservations due before Friday, January 10, 2020

SLMMS Members: Invitations were mailed the first week of December

Complimentary parking in the North Zoo Lot on Government Drive, adjacent to The Living World

Information: Liz Webb, 314-786-5473 ext. 0, or lizw@slmms.org

David M. Nowak, Executive Editor
dnowak@slmms.org

James Braibish, Managing Editor
Braibish Communications
editor@slmms.org

Publications Committee

Samer W. Cabbabe, MD
Emily D. Doucette, MD
Arthur H. Gale, MD
Richard J. Gimpelson, MD
Erin S. Gardner, MD
Harry L.S. Knopf, MD
Jennifer L. Page, MD
Pearl Serota, MD

St. Louis Metropolitan Medicine (ISSN 0892-1334, USPS 006-522) is published bi-monthly by the St. Louis Metropolitan Medical Society, 1023 Executive Parkway, Suite 16, St. Louis, MO 63141; (314) 786-5473, FAX (314) 786-5547. Annual Subscription Rates: Members, \$10 (included in dues); nonmembers, \$45. Single copies: \$10. Periodicals postage paid at St. Louis, MO. POSTMASTER: Send address changes to: St. Louis Metropolitan Medicine, 1023 Executive Parkway, Suite 16, St. Louis, MO 63141. Copyright © 2019 St. Louis Metropolitan Medical Society

Advertising Information: www.slmms.org/magazine, or editor@slmms.org or (314) 786-5473. Online copies of this and past issues are available at www.slmms.org/magazine.

Printed by Messenger Print Group, Saint Louis, MO 63122.
Graphic design by Lisa Troehler Graphic Design, LLC.



ST. LOUIS METROPOLITAN
MEDICAL SOCIETY

www.slmms.org

Facebook: saint.louis.metropolitan.medical.society
Twitter: STLMedSociety

Officers

Ramona Behshad, MD, President
Jason K. Skyles, MD, President-Elect
Jennifer L. Page, MD, Vice President
Robert A. Brennan, Jr., MD, Secretary-Treasurer
Christopher A. Swingle, DO, Immediate Past President

Councilors

Christopher C. Bowe, MD
Emily D. Doucette, MD
Kirsten F. Dunn, MD
Munier El-Beck, MD
Erin S. Gardner, MD
Luis A. Giuffra, MD
Mark C. Gunby, DO
Kimberly G. Perry, DO
David L. Pohl, MD
Pearl Serota, MD
Inderjit Singh, MD
Alan P.K. Wild, MD

Council Medical Student Liaisons

Emily Johnson, Washington University
Monica Ou, Saint Louis University

Executive Vice President

David M. Nowak

Cover Feature: Physician Advocacy

Getting Involved in Advocacy: Now Is the Time	12
<i>Commentary: Ten Things You Can Do to Get Involved That Don't Require Money</i>	13
By State Rep. Jonathan Patterson, MD	
Local Physician Enters Sixth Year in Missouri Senate	14
Campaign to Place Medicaid Expansion on November 2020 Ballot	14
Physician Spouse Elected to Missouri House	15
Needed: Physicians in White Coats to Fill the Missouri Capitol on March 3	15

Features

Benefits Extend the Value of Your SLMMS Membership	8
Models of Collaboration to Address Psychiatric Needs	10
By Suzanne L'Ecuier, MD	
Proposed Stark Law Changes Would Support Value-Based Payment	16
By Todd A. Zigrang and Jessica L. Bailey-Wheaton	
Managing Taxes on Your Investments	20
By Rich Fitzer	

Columns

<i>President's Page: Advocacy: A Call to Action</i>	2
<i>It is increasingly important that physicians join the conversation and embrace the role of physician-advocate</i>	
By Ramona Behshad, MD	
<i>Executive Vice President: The Price We Pay</i>	4
<i>Making the case for improved price transparency in health care</i>	
By David M. Nowak	
<i>Harry's Homilies: On Physician Advocacy</i>	5
By Harry L.S. Knopf, MD	
<i>Parting Shots: The Opioid Crisis, Part II</i>	24
By Richard J. Gimpelson, MD	

News

Help Organized Medicine Build its Agenda Through the Resolutions Process	6
Sponsorships Available for SLMMS Annual Meeting	6
"Medicare for All" Would Reduce Cost and Administrative Burdens and Improve Health	19

Departments

22 Alliance
23 Obituaries
25 Welcome New Members

The advertisements, articles, and "Letters" appearing in St. Louis Metropolitan Medicine, and the statements and opinions contained therein, are for the interest of its readers and do not represent the official position or endorsement of the St. Louis Metropolitan Medical Society. SLMMS reserves the right to make the final decision on all content and advertisements.

Advocacy: A Call to Action

It is increasingly important that physicians join the conversation and embrace the role of physician-advocate

By Ramona Behshad, MD, Medical Society President



Ramona Behshad, MD

Many opportunities for engagement in advocacy activities are available, and advocacy can take different forms at different times, beginning with medical school.

A changing regulatory environment has led to diminished physician autonomy in patient care. Hospitals, health care organizations, insurance companies and governmental regulatory agencies have buried physicians under mountains of laws and regulations. Although physicians welcome changes that improve patient outcomes, many of our colleagues are troubled by the increasing regulatory and administrative burdens that compromise the patient-doctor relationship. It is increasingly important that physicians join the conversation and embrace the role of physician-advocate to support optimal care of patients and the well-being of the medical profession.

With an upcoming presidential election, the future of the nation's health care system is at stake. Unfortunately, physicians are statistically less involved than the general public on civic matters as simple as voting.¹ This troubling fact demonstrates that physicians have not overcome several barriers to becoming voices of change. However, if physicians can get away from torturous EHR and get a real seat at the table, we might guide health care reform instead of being a disenfranchised remnant of yesterday's health care model.

Unquestionably, physicians are overburdened at every stage of their development. Medical school removes physicians from the community setting during a long, arduous, academically demanding formative period. Time pressures in practice make it difficult for physicians to take on anything more than the clinical problem at hand. We are expected to be adept while serving in clinics, remain current with medical literature, participate in quality improvement efforts, and, in academic environments, mentor

trainees and conduct research. Adding the expectation that physicians become advocates for their profession and their patients seems overwhelming. That being said, many opportunities for engagement in advocacy activities are available, and advocacy can take different forms at different times, beginning with medical school.

Medical School

Physicians at all stages of their careers, and in every professional setting, need to participate in advocacy. One way to encourage participation and underscore the importance of such effort is to start early. As students begin medical school, we must introduce the theory, practice and modeling of physician advocacy at the same time they are learning basic anatomy and physiology. The Royal College of Physicians and Surgeons of Canada mandates advocacy as a core competency. Early exposure to examples of how physicians interweave advocacy into their clinical work may lead to higher likelihood of engaging young trainees. Mandating this exposure ensures it will be consistently incorporated into training programs across the country.

Post-Graduate Trainees

Academic physicians have a special role in advocacy. Academicians are directly involved in not only the development of residents' understanding of disease and diagnosis, but also in the development of residents' professional lives. It is critically important that residents learn the place of advocacy as an inseparable and indispensable component of their professional responsibility.

Personal experience often predisposes an individual to participate in advocacy, and

can be further augmented by formal training and mentorship. In my personal case, Dr. George Hruza encouraged me to become a member of SLMMS as his fellow in Mohs surgery. Because of him, I became the Young Physician Councilor for the MSMA. If *he* had the time to commit to organized medicine, then *I* had the time to commit to organized medicine. After a gratifying year as his fellow and a member of these organizations, it was an easy decision to continue. Without his encouragement, I would never have joined.

Outside of one-on-one mentorship, results of pilot programs specifically designed to address advocacy skills have been described. An American orthopedics residency program designed a series of lectures and journal clubs on specific advocacy-related topics and concepts.² Specific topics addressed included geriatric advocacy and Medicare, orthopedics-industry relationships, orthopedic state-specific advocacy, and underinsured and uninsured patients. Prior to curriculum implementation, 76% of participants (n=21) indicated they had never received any specific advocacy training, with 100% indicating they felt they should receive such training. Further work should be done to create advocacy curriculum for our future physicians, who must be prepared to handle these challenges.

Advocacy is not some abstract concept that can be left to others. It is the professional obligation of every physician to be involved in some level of advocacy.



Physician Well-Being

The need for advocacy becomes magnified after training. Individual patients, the general public and the government have all become increasingly wary of physicians. Doctors are presented as interchangeable pieces on a checkerboard. Medicine's primary goal is the betterment of patient safety and quality medical care; however, payment is a necessary and appropriate component to both and has a central role in advocacy. Physicians, like everyone else, are motivated by financial incentives and job security. Even if their organization's noble shared purpose resonates with them, they also care intensely about what measures are being used to gauge their performance and how they are being compensated. This natural self-interest should be channeled to protect the future of our profession, so that the brightest students pursue medicine. Physician payment plays a critical role in this decision. Medicine requires many long, hard years of training and physicians need to be paid reasonably given all of these considerations. If this is compromised, then the best and brightest will assuredly pursue other careers. I don't want my neurosurgeon to have graduated ranking in the middle of his class, and I'm certain other patients will agree with me.

Being educated on issues facing medicine is a key component of advocacy. As the Medicare Access and CHIP Reauthorization Act (MACRA) re-engineers Medicare payment systems, I worry that the average doctor fails to understand MACRA, much less understand its implications on pay-for-performance. The education provided by SLMMS and MSMA have prevented me from falling into ignorant bliss. SLMMS has long been a leader in advocacy, and the MSMA assists us with significant state legislation that threatens our patients and our profession.

The MSMA White Coat Rally, where physicians visit face-to-face with their legislators and legislators' staff, educates participants about legislation currently being considered in Jefferson City. This annual event is valuable for advocacy novices and veterans alike in developing and maintaining an understanding of the breadth of advocacy, its complexities and physicians' most complex current issues.

MSMA's *Legislative Report*, delivered to members via email, also provides valuable timely education to members and others regarding the legislative and regulatory issues facing physicians. These time-saving materials allow us to be informed without spending hours reviewing legal documents. Given the volume and complexity of the challenges we face as a profession, we should double efforts to build membership and promote these grassroots organizations.

Closing Thoughts

Engagement in advocacy has been paralyzed by denial, misunderstanding of its urgency and a sense of being overwhelmed. Time pressures in practice may make it difficult for practicing physicians to take on anything more than the pressing clinical problem at hand. However, advocacy is not some abstract concept that can be left to others. It is the professional obligation of every physician to be involved in some level of advocacy. It is not hard to get involved. The two steps of becoming a member of one's state medical society and donating to one's state society and PAC are a reasonable minimum involvement for even the most politically timid physician.

The charge remains to strive for excellence in the care of our patients and to honor our profession. If we do not, our profession will no longer be an icon of accomplishment. ➡

Ramona Behshad, MD, is an assistant professor in the Department of Dermatology at Saint Louis University School of Medicine and director of the Division of Mohs Surgery and Cutaneous Oncology.

References

1. Grande D, Asch DA, Armstrong K. Do doctors vote? *J Gen Intern Med*. 2007 May;22(5):585-9.
2. Daniels AH, Bariteau JT, Grabel Z, DiGiovanni CW. Prospective analysis of a novel orthopedic residency advocacy education program. *R I Med J*. 2014;97(10):43-6.

The Price We Pay

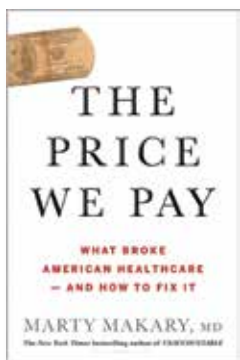
Making the case for improved price transparency in health care

By David M. Nowak, Medical Society Executive Vice President



David M. Nowak

Dr. Makary commented that in a national poll, only 23% of Americans surveyed said they had a great deal of confidence in the health care system, and that expensive, unpredictable and hard-to-understand bills are to blame.



For the past several years, the Signature Healthcare Foundation and its parent organization, Signature Medical Group, have presented their annual Health Policy Forum. This half-day program includes a national keynote speaker, usually a noted author or clinician, followed by a “reactor panel” made up of St. Louis area or regional experts in the health care field. In recent years I have had the opportunity to hear noted speakers such as Michael Leavitt, former Secretary of Health and Human Services; Elisabeth Rosenthal, MD, editor-in-chief of Kaiser Health News and author of the best-selling *An American Sickness*; and Joe Flower, CEO of The Change Project. Each has been interesting and informative, and were followed by an enlightening exchange of ideas that managed to “localize” their topics.

The 2019 Health Policy Forum held on October 2 continued that trend, and did not disappoint. This year’s keynote was delivered by Martin Makary, MD, MPH, professor of surgery at Johns Hopkins University School of Medicine and professor of health policy management of Hopkins’ School of Public Health. Dr. Makary is a member of the National Academy of Medicine and has been named one of America’s most influential people in health care by *Health Leaders* magazine. His research and writings focus on the appropriateness of medical care, health care costs, drug prices and low-income populations. His earlier book, *Unaccountable: What Hospitals Won’t Tell You and How Transparency Can Revolutionize Health Care*, became the basis for the television series, “The Resident.” His latest book *The Price We Pay: What Broke American Health Care – And How to Fix It* was published earlier this year.

Dr. Makary was the perfect choice to lead a discussion on “health care transparency and real issues in the price of health care.” Much

of Dr. Makary’s research is focused on health care economics and waste in the health care system. His new book is filled with real-life, on-the-ground stories that illustrate how so much of health care spending goes toward things that have nothing to do with care. Dr. Makary observes that research shows Americans are losing trust in their doctors, and he argues that part of the reason is that medical care is just too expensive.

In a recent interview with National Public Radio, Dr. Makary commented that in a national poll, only 23% of Americans surveyed said they had a great deal of confidence in the health care system, and that expensive, unpredictable and hard-to-understand bills are to blame. The stories he shares in *The Price We Pay* illustrate issues with price-gouging, middlemen, and elusive money games that are confusing to consumers. But he also points out that there are “disruptors who are innovating health care,” and that “the movement to restore medicine to its mission—and rebuild public trust—is alive and well.”¹

Surprise billing is one of the unpredictable culprits that is helping erode consumer confidence in medical care. We have seen recent legislative efforts to combat surprise billing when unanticipated coverage gaps occur. Patients either unknowingly or without a choice end up receiving care from an out-of-network physician or other provider. Take for instance, the recent news coverage in St. Louis on air ambulance coverage. In an emergency or anytime for that matter, who is carrying around their provider directory to make sure their physician is in-network, or who would choose not to receive necessary services in a life-threatening situation?

Organized medicine has taken a firm stand on the issue of surprise billing. The American

Medical Association and 110 other organizations representing hundreds of thousands of American physicians recently signed onto a letter urging Congress to refine surprise billing legislation so that targeting unanticipated out-of-network care “represents a fair, market-based approach that treats all stakeholders equally while protecting patient access to care.” Further, the AMA’s position is that “patients should be completely removed from any subsequent payment disputes between their health insurance company and an out-of-network provider when they experience an unanticipated coverage gap.”²

“Transparency’s time has come,” he observes in his closing comments. “And for the sake of our patients, health professionals should lead this charge.”



Dr. Makary’s call for common-sense reform is even broader. He encourages medical professionals to speak out and take a leading role, and that patients push back and demand more price transparency. “Physicians can join the grassroots groundswell of physicians working toward a fair and functional health care system,” he writes. “The national Choosing Wisely project, the Hopkins-based Improving Wisely project, and the High Value Practice Academic Alliance represent a few simple ways to get involved. Developing sound measures of appropriateness across thousands of areas of medical care requires input from clinicians on the front lines of medicine.”³

On a local level within the St. Louis Metropolitan Medical Society, there are already two separate initiatives that have responded to Dr. Makary’s challenge:

- In the August issue of *St. Louis Metropolitan Medicine*, SLMMS member Scott Hardeman, MD, wrote about

national grassroots efforts via a non-partisan coalition, Free to Care, working for physician-led reforms for patient-centered care. Free to Care’s physicians, patient advocacy groups and business leaders seek to restore the doctor-patient relationship. One of their five primary areas of focus is making health care prices transparent, and Dr. Hardeman encourages other physicians to lend their voices to the coalition.

- For the past several months, SLMMS has partnered with the Midwest Health Initiative to analyze Choosing Wisely opportunities in the St. Louis market. The overall goal of the Choosing Wisely project is to meaningfully improve adherence to recommended care and reduce low-value care in the region, through an engaged, multi-stakeholder community approach that uses measurement, education and aligned, coordinated interventions. SLMMS physicians are working with MHI board physicians to offer input and direction on Choosing Wisely’s shared opportunities so that the physician voice is heard.

I highly recommend Dr. Martin Makary’s *The Price We Pay*. “Transparency’s time has come,” he observes in his closing comments. “And for the sake of our patients, health professionals should lead this charge. It’s central to our great medical heritage. As witnesses to birth, sickness, and death, we know that all humans are created equal and deserve to be treated with fairness and dignity.”³ —

References

1. M. Gordon, “The Price We Pay Argues Rising Health Care Costs Undermine Public Trust in Medicine,” www.NPR.org, October 22, 2019.
2. American Medical Association, “Surprise Medical Bills: Physicians Want Market-Based Fixes,” *AMA Issue Spotlight*, October 18, 2019.
3. M. Makary, *The Price We Pay: What Broke American Health Care – And How to Fix It*, Bloomsbury Publishing, 2019.

HARRY’S HOMILIES®

Harry L.S. Knopf, MD

ON PHYSICIAN ADVOCACY

Is There a Doctor in the House?
Or Senate?

In this issue, *St. Louis Metropolitan Medicine* discusses physician advocacy. This can take several forms: One can run for office, largely giving up the practice of medicine. A physician may also advocate for “medicine” or specifically for a specialty by supporting a legislator and advising him/her about medical legislation. This latter option works particularly well for those who provide medical care to a member of the state legislature, such as through the MSMA Physician of the Day program. This is certainly not an exhaustive list. But what is most important to all of us is that each of us should do something to help our patients by maintaining high standards and protecting our profession from governmental overreach. —

Dr. Knopf is editor of Harry’s Homilies.® He is an ophthalmologist retired from private practice and a part-time clinical professor at Washington University School of Medicine.

Help Organized Medicine Build its Agenda Through the Resolutions Process

Are there issues of concern to you on which organized medicine should be taking action or establishing a position at the state or national level? The resolutions process is your chance to be heard.

SLMMS-sponsored resolutions as well as those from other component societies and individual members will be considered at the 2020 annual convention of the Missouri State Medical Association, scheduled for April 3-5 at the Renaissance St. Louis Airport Hotel.

Once resolutions are approved by the MSMA House of Delegates, they may be advanced to the American Medical Association House of Delegates in June, or may result in actions taken at the state level.

If you're considering a topic for a 2020 resolution, even if it's still in its conceptual stage, SLMMS invites you to bring it forward in accordance with the following schedule:

- For a resolution to be introduced and sponsored by SLMMS, it must be presented and reviewed twice by our body of delegates. The first opportunity will be at the **SLMMS Delegates' Briefing Session on Wednesday, January 8, 2020 at 7:00 p.m.** in the offices of Conner Ash, 12101 Woodcrest Executive Drive, Suite 300 in Creve Coeur (off Olive Boulevard west of I-270 behind Kohl's). All District 3 delegates will receive a mailing announcing this meeting, but all SLMMS members, including medical students, are invited to attend.

Sponsorships Available for SLMMS Annual Meeting

Sponsorship packages are available for the 2020 SLMMS Annual Meeting and Installation Dinner on January 25 at the Living World at the Saint Louis Zoo. This is the Society's largest event of the year and an excellent opportunity to support the physician community and organized medicine in the St. Louis area. Gain recognition for your practice, hospital or business through these sponsorship levels:

- Gold Advocate Sponsorship (with table of 8) – \$2,500
- Silver Table Sponsorship (with table of 8) – \$1,500
- Bronze Event Sponsorship (with two dinner seats) – \$500

For more information, visit www.slmms.org or contact Liz Webb in the SLMMS office at 314-786-5473, ext. 0 or lizw@slmms.org. Sponsorships are due by Monday, January 13 in order to be included in the event materials. ➤

- Resolutions accepted at that meeting will go forward for a second review to be held in conjunction with the monthly **SLMMS Council meeting on Tuesday, February 11, 2020 at 6:00 p.m.** at the West County Radiology Group office, 11475 Olde Cabin Road, Suite 200, also in Creve Coeur. Resolutions receiving final approval at this meeting will be submitted as sponsored by SLMMS.

The deadline for submitting resolutions to MSMA for inclusion in convention materials is Tuesday, February 18, 2020 at 5:00 p.m.

If you are a member of MSMA, you are free to submit your resolution on your own, but for it to be reviewed and sponsored by SLMMS, you must follow the above-mentioned process. Please watch the SLMMS website for updates as well as a link to MSMA's Guidelines on Resolution Writing. If you are researching or planning a resolution, please notify the SLMMS office for it to be included in the January 8 meeting agenda. If you have questions, contact the SLMMS office at 314-786-5473 or email dnowak@slmms.org. ➤

Get to know New City!

Join us for our
**WINTER
OPEN
HOUSE**

January 9th
at 6:00pm



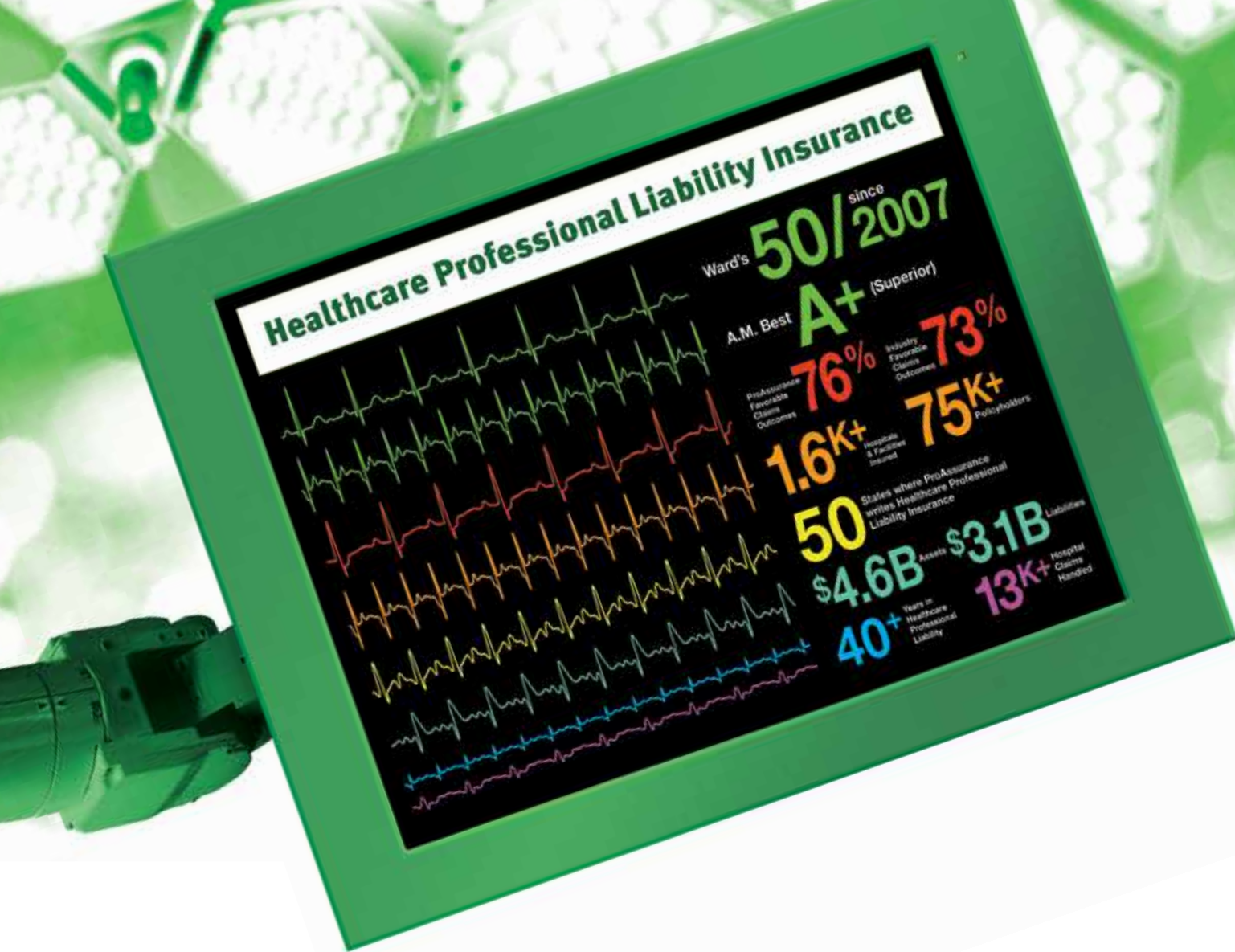
RSVP ONLINE (required)
newcityschool.org/openhouse



age 3 through 6th Grade

5209 Waterman Blvd
St. Louis, MO 63104
(314) 361-6411
www.newcityschool.org





healthy vitals

ProAssurance has been monitoring risk and protecting healthcare industry professionals for more than 40 years, with key specialists on duty to diagnose complex risk exposures.

Work with a team that understands the importance of delivering flexible healthcare professional liability solutions.



PROASSURANCE

Treated Fairly

**Healthcare Professional Liability Insurance
& Risk Resource Services**



800.282.6242 • ProAssurance.com

When you are **treated fairly** you are confident in your coverage.

Benefits Extend the Value of Your SLMMS Membership

Take advantage of members-only liability insurance, investments, medical billing, accounting and other programs

Did you know that your St. Louis Metropolitan Medical Society (SLMMS) membership provides you with access to a wide variety of extra benefits for you and your practice? Thanks to our membership of more than 1,100 physicians and medical students, SLMMS is able to partner with several organizations in our community who provide services or discounts that give your membership increased value. These benefits range from discounts on medical malpractice insurance and reduced portfolio management fees, to preferred pricing on staffing and personnel services and identity theft protection. All in all, they significantly expand the value of your SLMMS membership.

The following is a quick synopsis of current SLMMS member benefits:



- Our newest member benefit announced this past August is discounted medical billing services and revenue cycle management consultation provided by **Integrity Healthcare Solutions**. Based in St. Louis, Integrity is a medical billing and consulting company focused on providing services for the advancement and sustainability of the independent physician. They offer billing and coding services based on the current processes of the practice and assist doctors with increasing their efficiency and revenue. SLMMS members receive a 7% discount on medical billing services for the first year of service; SLMMS members also receive a free initial revenue cycle management consultation. In addition, the Medical Society receives a small revenue share payment for services scheduled by SLMMS members. Contact Eric Knudtson at eknudtson@integrityhealthcommunity.com or call 636-299-8088 or visit www.integrityhealthcommunity.com.



- **Triad Financial Group** offers SLMMS members access to many discounts and services, most notably, a reduced annual portfolio management fee of 0.5%, less than half the rate typically charged by financial advisors. Triad also provides SLMMS members with discounted disability insurance, no cost student loan debt counseling and more. Visit the SLMMS page on the Triad website at www.triadfinancialgroup.net/slmms-services for more information.



- **Keystone Mutual Insurance** provides one of the most widely used SLMMS member benefits—a 10% discount on medical malpractice insurance premiums. This benefit more than pays for your annual SLMMS membership. Based here in St. Louis, Keystone can also provide other insurance services through its parent organization, Cogeris Insurance Group. Request a SLMMS-member rate quick quote at <https://www.keystonemutual.com/slmms/>.



- **Favorite Healthcare Staffing** offers SLMMS members preferred pricing for staffing and personnel services, including short-term temporary coverage as well as temp-to-perm and permanent placement solutions for both full- and part-time positions. They partner with medical societies across the country and provide a revenue share with SLMMS for all services booked by members. To learn more, call the SLMMS dedicated staffing line at 314-561-8066 or email medicalstaffing@FavoriteStaffing.com.



- **OMiga** provides discounted full-service accounting programs and practice consulting services to SLMMS members, as well as add-on options such as outsourced payroll, HR, bill payment services and income tax preparation. To grow your practice's profitability, contact OMiga, Your Office Engine, at 314-269-0311 to learn more.



- SLMMS members in need of legal assistance qualify for small business, individual and family legal services plans (monthly subscription) at preferred rates through **LegalShield**. Contact Rick Shore, local LegalShield associate at 636-299-6345 or rrshore@legalshieldassociate.com for details.



- Add identify theft protection with family, individual and employer plans (monthly subscription) at preferred rates for SLMMS members through **IDShield**. Discount packages can be bundled with LegalShield services. Contact Rick Shore at the above contact number or email to set up your service package.



- The **Medtech Community Investment Program**, made available through **iSelect Fund Management, LLC**, allows SLMMS members to assemble a diversified portfolio that includes some of the country's most promising emerging growth companies. This SLMMS benefit includes preferred pricing, educational programs and participation in selection committees. Contact Dan Schaub, iSelect chief operating officer at 314-288-7855 or dschaub@iselectfund.com for more information.



- **Regions Bank** allows SLMMS members to simplify the mortgage process with the Doctors Mortgage Program. Members qualify for extra benefits and the ability to exclude deferred student loans from the loan qualification process. Contact Thomas Shepherd at Regions Bank at 314-239-0539 or thomas.shepherd@regions.com for information.



- Travel with peace of mind through **MedJetAssist**, which provides emergency consultation and evacuation services from anywhere in the world in the event of illness or injury when you are 150 or more miles away from home. SLMMS members receive discounted rates on short- and long-term coverage plans. Visit the link on the SLMMS member benefit web page to learn more.
- SLMMS is a member of the **AAIM Employers Association**. AAIM provides our members access to a variety of management and human resources training programs through reduced-rate memberships in the organization. Contact the local AAIM office at 314-968-3600 for more information.
- **Missouri General Insurance** has partnered with SLMMS for decades to provide in-depth health insurance consultations to help determine what plans and services are best for you or your practice. Contact



Matt Reardon at Missouri General at 314-983-2357 or mreardon@missourigeneral.com for personalized assistance.

- Also, your SLMMS membership includes **medical library privileges** at both Saint Louis University and Washington University schools of medicine. Just show your SLMMS membership card.
- Each spring, purchase discounted season tickets to The Muny through the **Muny Corporate Advantage Program**. The benefit is for new season subscriptions only and excludes renewals or single ticket purchases. Watch for more information every March.

Remember to take advantage of these many benefits that expand the value of your SLMMS membership. If you have questions, contact the SLMMS office at 314-786-5473 or dnowak@slmms.org. ➤

New SLMMS Contact at Favorite Healthcare Staffing



Deneke Bakalar

Favorite Healthcare Staffing, which provides staffing services at reduced cost to Medical Society members, has appointed Deneke Bakalar as the new St. Louis branch director. She will be the prime contact for SLMMS members utilizing Favorite's services.

She brings a broad range of leadership and customer service experience including 12 years with the Target Corporation in its St. Louis area stores. More recently she served as the director of business development and customer service for Kaldi's Coffee Roasting Company.

Deneke's unique skill set enables her to work closely with clients to understand both the needs of patients and physicians throughout the staffing process. She will be reaching out to SLMMS members and their staffs to make them aware of preferred pricing and special benefits offered by favorite.

She holds a Masters of Public Administration and a Bachelor of Arts in Communication, both from the University of Missouri-Columbia.

Contact Deneke or one of Favorite's staffing experts via email at medicalstaffing@FavoriteStaffing.com or the SLMMS dedicated phone line at 314-561-8066. You can learn more about Favorite Healthcare Staffing by visiting www.FavoriteStaffing.com.

Models of Collaboration to Address Psychiatric Needs

Aligning mental health with primary care can help reach more patients who have mental health needs

By Suzanne L'Ecuier, MD

Inadequately addressed mental health needs of patients both in primary care settings and specialty medical settings can lead to feelings of frustration, hopelessness and helplessness in both the patient and the physician.

According to Primary Care Collaborative, the following sobering statistics illustrate the pervasive need:

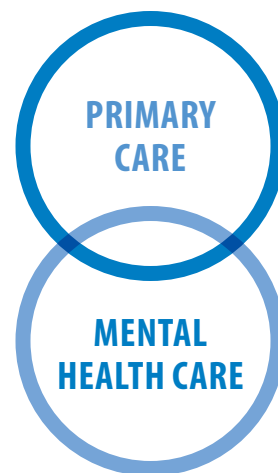
- 80% of individuals with psychiatric needs will visit their primary care physician at least annually.
- 66% of primary care physicians report inability to access outpatient behavioral health for patients.
- As much as 50% of referrals to outpatient behavioral health care do not make their first appointment.¹

In 2016, Missouri lost 1,113 people to suicide and 1,317 to lethal drug overdoses.² Combined, there were over 259% more suicides and overdose deaths than traffic fatalities in the state in 2016.³

In addition to improving the health and well-being of patients, there are systemic benefits to addressing behavioral health needs. It is well established that mental health disorders are the strongest predictor of disability; behavioral health disorders account for half of all disability days. Of the top five conditions driving health care costs, depression is ranked number one. Use of health care services and total health care costs significantly decrease when mental health needs are addressed. For example, depression treatment in primary care lowered total health care costs by \$3,300 over four years.⁴

Barriers to mental health care are numerous. They include shortages of psychiatric providers, health plan barriers, inadequate coverage, as well as stigma. The Missouri Federation of Behavioral Health Advocates issued a report

It is well established that mental health disorders are the strongest predictor of disability; behavioral health disorders account for half of all disability days.



Nowhere to Turn in March 2018 which describes behavioral health provider networks being so limited that health plan beneficiaries find it difficult to get in-network help.⁵ Financial barriers to out-of-plan care can make getting help unaffordable; this leads patients to delay care or opt out of care completely. Of those receiving care, outpatient psychotherapists and substance use counselors were three times more likely to be out-of-network compared to other medical specialties; psychiatric prescribers were twice as likely to be out-of-network.

The Federation recommends that the states enact insurance parity laws aligned with the federal Mental Health Parity and Addiction Equity Act of 2008. In Missouri, House Bill 2384 proposed in 2018 would have addressed barriers attributable to health care plans, but did not address the shortage of psychiatric health providers or the stigma that creates resistance to seeking and accepting psychiatric care.

There is far better access to primary care and less stigma associated with what is perceived as purely somatic health care seeking. The first contact for behavioral health concerns is usually the primary care physician, not a behavioral health specialist. Out of necessity, most primary care physicians have become comfortable with diagnosing and treating common psychiatric conditions autonomously.

However, because of time constraints for evaluations, broadness of differential diagnoses and an increasing number of black box warnings, diagnosing and managing more complex patients can be overwhelming. This is why a working knowledge of different models of collaboration of psychiatric care can be helpful. A single primary or medical specialty care practice can incorporate one or all four models.



Dr. Suzanne L'Ecuier

Suzanne L'Ecuier, MD, is an assistant professor of psychiatry at Washington University School of Medicine, specializing in child and adolescent psychiatry. She graduated from the University of Louisville School of Medicine and completed her residency at Yale University. She was president of the St. Louis Chapter of the American Academy of Child and Adolescent Psychiatry from 2002 through 2009. She can be reached at slecuyer@wustl.edu.

Models of Collaboration Between Primary Care and Mental Health Care

The basic four models of collaboration of care are: Independent, Coordinated, Co-located and Integrated.

- **Independent care** is the least intensive level of collaboration and historically the most common. This is when a practice has an informal relationship of commonly referring to a familiar therapist or psychiatrist who is a private practitioner in the community. The expectation is that the referred psychiatric clinician assumed responsibility for the behavioral health complaint. It is preferable to just calling the number on the back of the insurance card.
- **Coordinated care** is the most basic and easiest to accomplish level of collaboration. The psychiatric provider has a separate treatment location and specific treatment issues drive the relationship. Through professional networking, primary care physicians and specialists develop a menu of contacts in the community with whom they have learned are adept with specific types of needs (substance use, OCD, PTSD, ADHD, psychosis, behavior problems, etc.) These cultivated relationships often have the additional benefit of availability by phone for general guidance or to determine if a psychiatric specialist referral is necessary. Although referral from one's primary care physician to someone known and trusted by the PCP can somewhat alleviate stigma, there still can be significant emotional and self-esteem hurdles to "going to a psychiatrist." This can lead to the patient not showing up for even the first appointment.

This can greatly decrease the stigma of accepting psychiatric care if it is "part of the package" of other medical services in a non-psychiatric setting.

- **Co-located care** is the norm for many large health care systems whose primary care physicians and specialists are almost all employees. The psychiatric care providers, the medical specialists and primary care physicians all share the same facility but may not share the same space. That space may be material, such as a different physical office, or virtual, as in telemedicine. The affiliated physicians get preferential or exclusive referral to psychiatric care. Patients are typically referred for diagnostic clarification and treatment assistance with the goal of shorter term treatment and referral back to the primary care physician. The relationship is more as a consultant rather than primary long-term management.
- **Integrated care** is the most intensive level of collaboration. Psychiatric care providers are co-located and embedded at the elbow in the primary care or specialty care setting. There is a shared record system and a shared treatment plan. There may be shared real-time multidisciplinary evaluations and

follow-up. This began with meeting the needs of populations of medically and socially complex patients, but very recently is including primary care settings, some of which are in the St. Louis area. In primary care settings this may be a co-located psychiatric provider who is only in the office part-time, but is a reliable presence. This can greatly decrease the stigma of accepting psychiatric care if it is "part of the package" of other medical services in a non-psychiatric setting. This may be a physical co-located presence, or a virtual telemedicine contact which is made in the primary care office. Coordination of interventions addressing medical complaints and psychiatric complaints can be accomplished much more efficiently in this model. This model however requires the most commitment of resources.

Ignoring psychiatric complaints is not helpful for our patients. This can lead to unnecessary expenses and suffering, and it also can contribute to physician helplessness leading to burnout.

Challenges to psychiatric care collaboration can include limited opportunities to exchange information, concerns about patient confidentiality and resistance to change. Other challenges include achieving collaboration between different systems and multiple levels of staff, recognizing and defining the roles of participants in care, and the inevitable evolution of roles in response to expectations, levels of collaboration and learning from one's peers.

The shortage of swift availability of psychiatric providers to all of those in need is a challenge not going away any time in the foreseeable future. Ignoring psychiatric complaints is not helpful for our patients. This can lead to unnecessary expenses and suffering, and it also can contribute to physician helplessness leading to burnout. Adopting a model, or models, of collaboration of psychiatric care within a primary care or specialty care practice can be an effective way to meet these needs. The ideal model adopted will depend upon the population's needs and available infrastructure and administrative support. —

References

1. Primary Care Collaborative. Benefits of Integration of Behavioral Health. <https://www.pccpc.org/content/benefits-integration-behavioral-health>
2. Centers for Disease Control and Prevention, National Center for Health Statistics. Stats of the State of Missouri 2016. <https://www.cdc.gov/nchs/pressroom/states/missouri/missouri.htm>
3. Missouri Coalition for Roadway Safety. <https://savemolives.com/facts-and-figures>
4. Unutzer J, Katon W, Fan M, et al. Long-term Cost Effects of Collaborative Care for Late-life Depression. *American Journal of Managed Care*. February 2008.
5. Missouri Federation of Behavioral Health Advocates. *Nowhere to Turn: Findings from a survey on access to mental health and addiction treatment among Missouri health plan beneficiaries*. <https://namimissouri.org/wp-content/uploads/sites/94/2018/03/MO-Federation-BH-Coverage-Report-Final.pdf>

Getting Involved in Advocacy: Now Is the Time

Legislative and policy issues will help shape the future of medicine

During this fourth quarter of the year, the groundwork is being laid for the issues that will be debated in the 2020 session of the Missouri Legislature. In addition, 2020 is an election year, so candidates are making preparations for their campaigns, and work is underway to place initiatives such as Medicaid expansion on the ballot.

What can physicians do to make their voices heard? How can they influence the discussion?

“Physicians are respected by the legislators. All we need to do is make our voices heard. We can make a tremendous impact,” said physician and state Sen. Bob Onder, MD, at the Missouri State Medical Association (MSMA) “Medicine’s Muscle” presentation on July 24 in St. Louis.

Tips on Reaching Legislators

The key to success in grassroots lobbying is to build relationships with legislators, said Heidi Geisbuhler Sutherland, MSMA director of legislative affairs at “Medicine’s Muscle,” which was attended by SLMMS members and local medical students.

Physicians should determine, if they haven’t already, who are the state representatives and senators for the districts where they live and where they practice. The Missouri House and Senate websites each have a “legislator lookup” tool.

In contacting a legislator by email, you should “make sure to note that you are a physician who lives or practices in their district,” Geisbuhler Sutherland said. If you are following a form letter, be sure to add personal details.

She suggested that email can serve a variety of purposes:

- Ask your legislator’s position on a bill.
- Urge your legislator to act on a bill.
- Thank your legislator for supporting physicians and patients.
- Offer to be a resource on health care issues.

She also described using phone calls to reach legislators. “Be prepared to speak with legislative staff. They are more often able to devote the time necessary to talk about your topic. If you are calling about legislation, make sure to have the bill number on hand. Keep your message clear and concise. Offer to send a follow-up email.”

Face-to-face meetings can be scheduled at the Capitol or in your home district, she said. Contact the legislator’s office. Before the meeting, note the bill number if you will be speaking about specific legislation. Prepare an outline of what you are going to say. If possible, you can develop a fact sheet or handout summarizing the topic. Be prepared to meet with a staff member.

During the meeting, be informative and non-confrontational, she advised. Thank the legislator for his or her time and offer your assistance with future health care issues.

After the meeting, send a brief thank-you note or email. You also can post a photo of yourself with the legislator on social media.

The MSMA legislative staff can provide support to physicians in setting up and conducting these meetings.

She offered tips on giving legislative testimony:

- Prepare notes and practice before you testify.
- Keep the testimony brief and concise—under three minutes.
- Share personal experiences and perspectives on how the issue affects you.
- Try to not read directly from a piece of paper.
- Contact MSMA legislative staff to let them know of your interest in testifying on a particular topic.

Two more actions that physicians can take:

- Sign up for the MSMA Physician of the Day program. Volunteer physicians serve in the Capitol from 9 a.m. to 2 p.m. as the on-call physician for legislators and staff. Contact MSMA.
- Make plans to attend White Coat Day at the Capitol on Tuesday, March 3, 2020. See accompanying article on page 15.

“One contact from a ‘doc back home’ is worth 100 visits from us lobbyists. That’s why we encourage members to establish a rapport and reach out,” MSMA wrote in a recent weekly legislative briefing.

Sen. Onder offered the legislator’s perspective: “You elected me, you sent me here. I want to hear from you.” ➤

Ten Things You Can Do to Get Involved That Don't Require Money



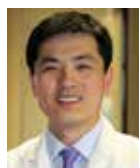
Reprinted with permission from Progress Notes, the newsletter of the Missouri State Medical Association

By State Rep. Jonathan Patterson, MD

During my first year in the Missouri House of Representatives in 2019, I learned quickly about how things get done in Jefferson City. It's not complicated. It is 197 elected members who are trying to learn about all the issues that are put before them and then vote in a way that would best serve their constituents.

There's no way to know everything about every one of the thousand bills that are filed each year. That is why advocacy matters. Ten people emailing their representative about a specific issue might be the only thing the representative hears about on that particular subject. Physicians need to advocate for medicine in Missouri. Here are ten easy ways to get politically involved:

- 1 **Look up your legislators at www.house.mo.gov and www.senate.mo.gov.** Know their names. Write down their email addresses. Write down their phone numbers.
- 2 **Email your representative about an issue that you care about.** Write your phone number and address on the email so that they know you are a constituent. They should at least read and respond to your email.
- 3 **Meet your representative back in your district.** Go to one of the representative's town halls. Call and ask him or her to come speak to a group of doctors at your office or hospital. Build relationships with your state legislators. Politicians are human. This doesn't mean you have to become hunting buddies. Just don't make the first time you meet your legislator be the time you call her to encourage her to vote one way on a certain bill.



Dr. Jonathan Patterson

Jonathan Patterson, MD, was elected to the Missouri House of Representatives in 2018. He represents the 30th District comprising the eastern Kansas City suburbs of Lee's Summit, Independence and Blue Springs. He is a general surgeon with United Surgical Associates in Lee's Summit. He can be reached at jon.patterson.md@gmail.com.

- 4 **Sign up to be MSMA Physician of the Day at the Capitol.** Both your representative and senator will go out of their way to meet with you. You'll be introduced and thanked on both the House and Senate floor. You'll be providing a public service. There will be little to no actual doctoring required.
- 5 **Take time to learn about issues that affect physicians in Missouri.** Read the weekly update emails from MSMA. Read the brief bill summaries online. All the bills have one-page summaries that are written in non-legalese and posted on the House and Senate websites.
- 6 **Go to your legislator's official website and sign up for their Capitol reports.** They'll email you every week about the issues that they are working on.
- 7 **Get upset sometimes.** It's okay to disagree. If you strongly disagree with your representative about an important issue, let them know. Respectfully tell them you're a constituent and you disagree with them, and tell them why. They are paid to represent you. It's part of the job to hear from their voters.
- 8 **Take time to write your legislator thanking them for a vote you agree with.** Legislators receive dozens of emails and letters a week, mostly from constituents that are unhappy with their vote. Be the bright spot in their day.
- 9 **Get your colleagues involved.** Talk with people in your specialty about issues that affect you directly. If it's a really important issue, get a group together for coffee and invite your representative.
- 10 **Actively participate in your local medical society.** They have people who are tied in politically and will get you more involved if you want.

Recently the House passed a certain piece of legislation. We gave it a first-round vote and then left for the weekend. By the next week when it was time to take a final vote on the bill and send it over to the Senate, eight members had changed their "yes" votes to "no." Why? Because over the weekend they received emails from constituents telling them they disagreed with their vote. Political advocacy matters. It's not hard. Get involved. ➡

Local Physician Enters Sixth Year in Missouri Senate



Dr. Robert Onder

State Sen. Robert F. Onder, Jr., MD, is one of three physicians currently serving in the Missouri Legislature and the only one in the Senate. He was elected to the Senate in 2014 and was re-elected in 2018. A Republican, he represents the 2nd District which covers much of St. Charles County. He previously served in the House in 2007-2008. He is the founder of Allergy & Asthma Consultants in Creve Coeur. In this interview, he discusses his work in the legislature and the importance of physicians being involved.

How and when did you become interested in politics?

I have been interested in politics and public policy since I was a teenager, but I always viewed my professional calling as being a physician. I became more involved in the political process and supporting candidates over the years, and I first ran for public office in 2006, for state representative.

Why did you decide to run for office?

My family and I have been very blessed living in this state and this country, and I felt called to give back through public service. When I ran for state senate, Missouri was 47th out of 50 in economic growth, and our business and legal climate were poor; it was clear we could be doing much better.

How does your practice manage in your absence?

I see patients on Monday and Friday during session, and I work more or less full time out of session. I have an associate, Dr. Sonia Cajigal, who covers in my absence.

What do you consider your biggest accomplishments in the area of health care?

I've worked on a number of issues important to our practice: prior authorization reform, scope of practice, direct primary care, reining in abusive maintenance of certification schemes. In 2019 I stopped a proposed new health insurance tax.

What was your biggest surprise transitioning from medical practice to legislative service?

Patients always have an incentive to tell you the truth. That is not always the case in politics. Our president talks about the "Washington swamp." There are swamps in state government as well.

What issues are you working on this year?

In 2020 I will be working on fighting the fentanyl epidemic, prompt credentialing, and limiting the ability of insurance companies and hospitals to mandate onerous and expensive MOC as a condition of participation.

Why is it important for physicians to be involved in advocacy in government?

"If you're not at the table, you're on the menu." For too long, physicians have not been active in advocacy, and more vocal groups like insurance companies, trial lawyers, hospitals and alternative practitioners have had their way in the legislature. We must speak up for our profession and our patients.

What can and should physicians do to make their voices heard?

Participate in MSMA activities like White Coat Day, Doctor of the Day, and MSMA PAC. Read MSMA newsletters, and call or email your representative and senator about important issues that arise. Try to get to know your legislators and make a personal connection, and they will listen to you when you need their help. And I'd strongly encourage physicians to support the campaigns of candidates that are on the same policy page as we are.

Is there anything else you would like to add?

Physicians need to be more involved. We are all busy, but public policy is extremely important. And much of the action—scope of practice, licensing, Medicaid, tort reform—is going on at the state level. —

Campaign to Place Medicaid Expansion on November 2020 Ballot

Supporters of Medicaid expansion in Missouri are gathering signatures on petitions to place the issue on the November 2020 ballot. They have formed the organization Healthcare for Missouri, www.healthcareformissouri.org. Major financial contributors to the effort to date include the Missouri Hospital Association, BJC HealthCare, Washington University and the Health Forward Foundation of Kansas City. A total of 172,000 signatures are needed on the petitions. Medicaid expansion would provide health coverage for an additional 200,000 Missourians who currently earn too much to qualify for Medicaid but not enough to afford marketplace health plans provided under the Affordable Care Act. Thirty-six other states and the District of Columbia have expanded Medicaid under the Affordable Care Act. —

Physician Spouse Trish Gunby Elected to Missouri House



Trish Gunby of west St. Louis County was elected to represent the 99th District in the Missouri House of Representatives in a special election held on November 5. Gunby, a Democrat, won the seat that had been vacated when



Trish Gunby

Rep. Jean Evans resigned earlier this year. She will serve the remaining one year left in the term. Gunby is the wife of SLMMS member and current councilor Mark Gunby, DO, and will be another “physician-friendly advocate” in the Missouri House.

Gunby ran on a platform to “restore representation in Jefferson City, and to protect Clean Missouri (proposition passed by voters in 2018), a fair wage and equal protections for every Missourian.” She supports Medicaid expansion in Missouri, and is concerned about access to care, especially in rural areas of the state.

What motivated her to run? “I was already doing work involving LGBTQ inclusion, racial justice and voting rights,” she explained. “Rep. Evans’ resignation opened up a seat and then folks reached out and encouraged me to run. I majored in political science in college and have an interest, and I felt that

given my situation with my kids grown and my husband still working, this would be my next chapter.”

Gunby shared that one of her goals for 2020 is the creation of a non-partisan election primer to better educate voters. “Many people are concerned about issues but then vote for candidates that do not always support those issues. We are bombarded by political messages and advertising, but need to be better informed as to who is paying for this advertising.”

She is passionate about many public health issues, including anti-vaping legislation and the opioid epidemic. Gunby also supports a statewide prescription drug monitoring program in Missouri.

Gunby is a longtime resident of St. Louis County. A graduate of Parkway West High School, she studied political science and advertising/public relations at the University of Tulsa. She worked for many years in marketing and project management at Citicorp Mortgage and Purina. She has been an active volunteer in community affairs with the Parkway School District, Manchester United Methodist Church and the St. Louis Area Voter Protection Coalition. —

Needed: Physicians in White Coats to Fill the Missouri Capitol on Tuesday, March 3

Please mark your calendar—the Missouri State Medical Association (MSMA) White Coat Day has been set for Tuesday, March 3, 2020. This event is specifically designed for physicians to visit the Missouri State Capitol in Jefferson City to advocate on behalf of their patients and the practice of medicine.

Legislators will deliver brief remarks on health care legislation beginning at 9 a.m. in the first floor rotunda of the Capitol. Physicians are then free to sit in on the legislative sessions, meet with their local legislators, explore the Capitol, and get to know your fellow doctors.

The objective of the event is to fill the Capitol with physicians in white coats to advance our political agenda. Recognizing that it is difficult to arrange a day away from your practice, the rally date was announced extra early this year. Please save the date and plan to join your fellow physicians in Jefferson City.

Lunch will be provided in the Capitol by MSMA. Registration is already open at www.msma.org/white-coat-day.html. For more information, contact Heidi Geisbuhler Sutherland at MSMA at heidi@msma.org. —



Physicians at the 2015 MSMA White Coat Rally (photo courtesy Missouri State Medical Association).

Proposed Stark Law Changes: Health Care Industry Implications

Lifting of restrictions would support shift to value-based payment models

By Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA & Jessica L. Bailey-Wheaton, Esq.

On October 9, 2019, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule to modernize and clarify the Stark Law.¹ The Stark Law governs those physicians (or their immediate family members) who have a financial relationship (i.e., an ownership investment interest or a compensation arrangement) with an entity, and prohibits those individuals from making Medicare referrals to those entities for the provision of designated health services.² Notably, the law contains a large number of exceptions, which describe ownership interests, compensation arrangements and forms of remuneration to which the Stark Law does not apply.

The majority of the proposed changes to the Stark Law acknowledge the shift of health care reimbursement, from **volume-based** to **value-based** payment models. Under the proposed rule, CMS seeks to establish new exceptions and new definitions, as well as provide additional flexibility to support this necessary evolution of the U.S. health care delivery and payment system.³ This article will discuss CMS' proposed changes to the definitions of **fair market value** and **commercial reasonableness**; summarize the proposed new exceptions; and, review the potential implications of these rule changes on the health care industry.

Fair Market Value

The proposed revision of the fair market value definition seeks to clarify previous definitions and guidance on fair market value and separate the term and definition from other intertwined terms. CMS proposed three separate fair market value definitions as set forth below. Of note, the revised definition of fair market value eliminates the connection to the volume or value standard, as CMS considers that to be a "separate and distinct" requirement.⁴



Todd A. Zigrang



Jessica Bailey-Wheaton

Todd A. Zigrang, MBA, MHA, FACHE, ASA, is president of Health Capital Consultants, where he focuses on the areas of valuation and financial analysis for hospitals, physician practices and other health care enterprises. Jessica Bailey-Wheaton is vice president and general counsel. They can be reached at 314-994-7641. Their website is <https://www.healthcapital.com>.

In addition to the delineated definitions set forth below, CMS proposed a definition for **general market value**, separate and apart from **fair market value**. In juxtaposing the two terms, CMS provided clear guidance on the relationship—fair market value regards **hypothetical** transactions of a similar type, while general market value is **specific to a transaction** with identified parties.⁴ (See table on facing page.)

Significantly, CMS noted their understanding that the fair market value and the general market value of a transaction may not always be identical and provided examples as to when physician compensation may "veer from values identified in salary surveys and other hypothetical valuation data that is not specific to the actual parties to the subject...transaction."⁴

Commercial Reasonableness

Regarding the threshold of commercial reasonableness, CMS recognized that it has only addressed the concept once, in a 1998 proposed rule, interpreting the term "commercially reasonable" to mean an arrangement that appears to be:

*"...a sensible, prudent business agreement, from the perspective of the particular parties involved, even in the absence of any potential referrals."*⁴

In an effort to finally define the term, CMS proposed two alternative proposed definitions for the term "commercially reasonable:"

- (1) "the particular arrangement furthers a legitimate business purpose of the parties and is on similar terms and conditions as like arrangements;" or,
- (2) "the arrangement makes commercial sense and is entered into by a reasonable entity of similar type and size and a reasonable physician of similar scope and specialty."⁴

Significantly, CMS unequivocally stated that an arrangement may be commercially reasonable "**even if it does not result in profit** for one or more of the parties."⁴ [Emphasis added.] CMS was compelled by commenters who identified a number of reasons why parties may enter into non-profitable transactions, for example:

- Community need;
- Timely access to health care services;

Current and Proposed Fair Market Value and General Market Value Definitions

	Old Definition ⁵	Proposed New Definition ⁴	
		General	Rental of Equipment or Office Space
Fair Market Value	<p>The value in arm's-length transactions</p> <p>Consistent with the general market value</p>	<ul style="list-style-type: none"> With like parties and under like circumstances Of like assets or services Consistent with the general market value of the subject transaction 	<ul style="list-style-type: none"> With like parties and under like circumstances Of rental property for general commercial purposes (not taking into account its intended use) Consistent with the general market value of the subject transaction
General Market Value	<p>The price that an asset (or the compensation that would be included in a service agreement) would bring as the result of bona fide bargaining between well-informed buyers and sellers (or parties to the agreement) who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement.</p>	<ul style="list-style-type: none"> The price that assets or services would bring as the result of bona fide bargaining between the buyer and seller in the subject transaction on the date of acquisition of the assets or at the time the parties enter into the service arrangement 	<ul style="list-style-type: none"> The price that rental property would bring as the result of bona fide bargaining between the lessor and the lessee in the subject transaction at the time the parties enter into the rental arrangement

- Fulfillment of licensure or regulatory obligations, including those under the Emergency Medical Treatment and Labor Act (EMTALA);
- The provision of charity care; and,
- The improvement of quality and health outcomes.⁴

Volume or Value Standard and the Other Business Generated Standard

Many Stark Law exceptions require that the compensation arrangement at issue “not [be] determined in a manner that takes into account the volume or value of referrals by the physician...[or be] determined in a manner that takes into account other business generated between the parties.” In response to commentator concerns, CMS proposed four “objective tests [i.e., mathematical formulas] for determining whether compensation takes into account the volume or value of referrals or the volume or value of other business generated by the physician.” CMS also set forth “the narrowly-defined circumstances under which [the agency] would consider fixed-rate compensation...to be determined in a manner that takes into account the volume or value of referrals or other business generated.”⁴

New Stark Law Exceptions

In addition to these new definitions related to the Stark Law, CMS introduced a number of new exceptions to the Stark Law, the most pertinent of which are set forth below.

- **Value-Based Arrangements.** The proposed rule would create permanent exceptions to the Stark Law for value-based arrangements (VBAs). As part of the new exceptions, CMS introduced a number of new definitions, including those for VBA, value-based activity, value-based purpose, value-based enterprise (VBE), VBE participant and target patient population.⁶ The exceptions would only apply to compensation arrangements, but would apply to all patients, not just Medicare beneficiaries. These exceptions were proposed in order to reduce regulatory hurdles for providers seeking to pursue legitimate VBAs that are intended to coordinate care, improve the quality of care and lower costs for patients.³

Of note, CMS proposed not to require that remuneration associated with a VBA: (1) be consistent with fair market value; or, (2) not take into account the volume or value of a physician's referrals or the other business generated by the physician for the entity, although the agency is soliciting comments on these points.⁷

- **Limited Remuneration to a Physician.** CMS proposed a new exception for limited remuneration to a physician for items or services actually provided by the physician, on an “infrequent or short-term basis,” in an aggregate amount not exceeding \$3,500 per calendar year (as adjusted by inflation) if:

Continued on page 18

1. The compensation is not determined in any manner that takes into account the volume or value of referrals or other business generated by the physician;
2. The compensation does not exceed the fair market value of the items or services;
3. The arrangement is commercially reasonable; and,
4. Arrangements for the rental or use of office space or equipment do not violate the prohibitions on per-click and percentage-based compensation formulas.⁷

Of note, the remuneration does not need to be set in advance, and the arrangement does not need to be set forth in writing, in order to comply with this exception.

- **Cybersecurity Exception.** CMS also proposed the establishment of a new exception for donations of cybersecurity technology and related services that are “necessary to implement, maintain, or reestablish security,” provided the various exception conditions are met.⁸ CMS believes that the cybersecurity exception will be widely used by physicians because it helps address the growing threat of cyberattacks on data systems and health records.
- **Price Transparency.** In contrast to the above paragraphs, which discuss new exceptions, CMS did not make any specific proposals related to price transparency, but instead used the proposed rule to solicit comments as to the pursuit of the Trump Administration’s price transparency objectives⁹ and whether to require cost-of-care information at the point of a referral for a health care item or service provided to patients.⁴ Should the price of health care items and services become easily accessible and comparable, this increased choice may serve to increase competition among providers and apply price pressures on those health care organizations charging patients more for these items/services.

Implications

Historically, the application of the Stark Law has, at times, been at odds with the goals of health care reform. Specifically, the discord between the objectives of fraud and abuse laws, and the objectives of value-based reimbursement models, reflected the disjointed approach to health care reform by the numerous federal agencies tasked with regulation of the health care industry. Ultimately, this disjointed approach resulted in a scenario wherein the left hand didn’t know what the right hand was doing.¹⁰

The proposed rule changes from CMS clearly aim to remedy this catch-22 situation, making it easier for providers to provide value-based care without running afoul of the Stark Law. The agency has made significant strides in attempting to reduce the burden of compliance while also maintaining strong safeguards against fraud and abuse.¹

Perhaps the most significant takeaways from the proposed rule stem from CMS’ acknowledgment that not all physicians, or compensation arrangements are the same; and, that compensation arrangements may have qualitative benefits that outweigh quantitative costs, i.e., profitability. CMS’ proposals recognize that an arrangement may have inherently subjective, qualitative elements, e.g., there are plausible scenarios wherein a compensation arrangement deviates from industry normative benchmark data to account for the specific facts and circumstances related to a given transaction. This further demonstrates the need for physicians to obtain health care compensation valuation opinions that utilize an evidence-driven methodology, including both qualitative and quantitative assessments of the specific facts and circumstances related to the transaction, a documentation of the consideration of these facts and circumstances, and an articulation of their ultimate applicability to the transaction.

CMS’ proposed rules were published in the Federal Register on October 17, 2019, and all comments on the proposed rule will be due 75 days from the date of publication (by December 31, 2019). Upon the end of the comment period, CMS has no official timeline by which it must publish the final rule. ➤

References

1. “HHS Proposes Stark Law and Anti-Kickback Statute Reforms to Support Value-Based and Coordinated Care” U.S. Department of Health & Human Services, October 9, 2019, <https://www.hhs.gov/about/news/2019/10/09/hhs-proposes-stark-law-anti-kickback-statute-reforms.html> (Accessed 10/25/19).
2. “Limitation on Certain Physician Referrals” 42 U.S.C. § 1395nn(a).
3. “Modernizing and Clarifying the Physician Self-Referral Regulations Proposed Rule” U.S. Centers for Medicare & Medicaid Services, October 9, 2019, <https://www.cms.gov/newsroom/fact-sheets/modernizing-and-clarifying-physician-self-referral-regulations-proposed-rule> (Accessed 10/22/19).
4. “Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations” Federal Register Vol. 84, No. 201 (October 17, 2019), p. 55777, 55790-55799.
5. “Definitions” 42 CFR § 411.351.
6. “Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations” Federal Register Vol. 84, No. 201 (October 17, 2019), p. 55773.
7. “Medicare 55777; Modernizing and Clarifying the Physician Self-Referral Regulations” Federal Register Vol. 84, No. 201 (October 17, 2019), p. 55829.
8. “Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations” Federal Register Vol. 84, No. 201 (October 17, 2019), p. 55835.
9. The order articulated the Administration’s goal to give patients access to price and quality information to find low-cost, high-quality care. “Executive Order on Improving Price and Quality Transparency in American Health care to Put Patients First” The White House, June 24, 2019, <https://www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality-transparency-american-health-care-put-patients-first/> (Accessed 10/23/19).
10. For more information, see “Beyond FMV: Commercial Reasonableness of Physician Compensation Post-MACRA, by Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, Todd A. Zigrang, MBA, MHA, FACHE, ASA, John R. Chwarzinski, MSF, MAE, and Jessica L. Bailey-Wheaton, Esq., *Business Valuation Review*, Vol. 37, Issue 1 (Spring 2018), p. 20-46.

“Medicare for All” Single-Payer Plan Would Reduce Cost and Administrative Burdens and Improve Health, Speaker Says

Ed Weisbart, MD, CPE, FAAFP, described the case for Medicare for All to an audience of SLMMS members and medical students at the annual Hippocrates Lecture on September 17. An assistant clinical professor at Washington University School of Medicine, he is chair of the Missouri chapter of Physicians for a National Health Program.



Dr. Weisbart speaking.

Medicare for All would provide for a single payer system, but would retain the current structure of private physicians and hospitals.

He shared data on mortality showing that the U.S. ranks last or near last compared to 17 other industrialized nations for persons up to age 65. Past age 65, U.S. mortality improves greatly compared to these 17 nations, making the top five by age 80, showing the effectiveness of Medicare, he said.

“We spend double other countries on health care but don’t get the same results,” he emphasized.

A major argument for Medicare for All is reducing administrative cost, Dr. Weisbart said. Administrative overhead for the top four health insurance companies was 16%-20% in the first quarter of 2016, compared to 2.2% for Medicare Parts A and B.

He added that a single-payer system would reduce stress on physicians. Family physicians in Canada spend an average of 2.4 hours per week on non-clinical administration, while U.S. family physicians spend 48% of each day on EHRs and desk work, according to one survey. A major culprit is U.S. EHR systems requiring much more detail for insurer payment, Dr. Weisbart explained. ➡



Hippocrates Society President Arthur Gale, MD; speaker Ed Weisbart, MD; and Medical Society President Ramona Behshad, MD.



Ernesto Gutierrez, MD; C.C. Taylor, MD; John Codd, MD; Antonio Penilla, MD.



Luis Giuffra, MD; Jo-Ellyn Ryall, MD.



Students Dominic DeMarco, Parth Joshi.

New Barnes-Jewish West County Hospital Opens

Calling it a “hospital of the future,” Barnes-Jewish West County Hospital opened its new facility on November 5. The new building replaces the existing 50-year-old facility on the same site on Olive Boulevard in Creve Coeur. The new hospital offers “maximum flexibility, efficiency and technological advancements,” according to the hospital’s news release. It features 14 operating rooms including one robotic operating room. There are 64 private rooms. ➡

Managing Taxes on Your Investments

Choices you can make to help lessen your income tax burden

By Rich Fitzer

When it comes to your money, it's not what you earn, it's what you keep. Here are some ideas that may help lessen your income tax burden, so you can keep more of your investment earnings.

Invest for the Long Term

Generally, income isn't taxed until it is received, so you may find it beneficial to delay realizing gains by investing for the long term. If you hold an asset for more than a year, earnings will be taxed at the lower long-term capital gains tax rate—currently 15% or 20% (0% for taxpayers in lower tax brackets). If assets are held for a year or less, earnings are considered short-term capital gains and taxed at ordinary income rates, which can be as high as 37%.

You may be able to invest for the long term and still receive current income from your investment in the form of dividends. If you receive qualified dividends, they are taxed at long-term capital gains rates, as long as you meet the holding period requirement. Generally, qualified dividends are those paid by domestic corporations or by foreign corporations whose stocks trade on an established U.S. stock exchange.

Harvest Losses

If you do realize gains, you may be able to offset them with losses. When your losses exceed your gains, you can offset up to \$3,000 (\$1,500 if married filing separately) of ordinary income, and the rest of your capital losses can be carried forward to be used in future years.

When harvesting losses, be aware of the wash sale rule. If you purchase a substantially identical position within the period that begins 30 days before you take a loss and ends 30 days after that date, you will have to delay recognizing the loss until you sell the new position. To keep a similar asset allocation while realizing a loss, you can reinvest in securities that are not substantially identical but are expected to move in the



Generally, income isn't taxed until it is received, so you may find it beneficial to delay realizing gains by investing for the long term.

same direction as the investment you sold, or you can buy the same security outside of the 61-day window. There isn't much IRS guidance on what is considered "substantially identical," but Congress' intent with the wash sale rule was to prevent investors from taking a loss and keeping the same economic position within the waiting period.

A companion to loss harvesting is individual security identification. To use this method, you must identify the specific lot (i.e., the set of shares bought at a given time and price) that you want to sell at the time of sale, and your broker must acknowledge your identification in writing within a reasonable time thereafter. By identifying a specific security, you can choose to sell for a long-term gain and for smaller gains or bigger losses. Individual security identification can be used for stocks and bonds. For mutual funds, you can specify shares if you are not using an averaging method.

Contribute to Charity

If you have a large long-term gain position in stock and a charitable intent, you might consider gifting the stock to charity. You may get a tax deduction based on the fair market value of the stock at the time of the gift, and the charity can sell the stock without paying taxes. Your deduction may be limited to



Rich Fitzer

Rich Fitzer is a financial advisor with Triad Financial Group. He offers securities and advisory services as a Registered Representative and Investment Adviser Representative of Commonwealth Financial Network®, Member FINRA/SIPC, a Registered Investment Adviser. He can be reached at (314) 392-6812 or at rcfitzer@triadfinancialgroup.net.

20%–30% of your adjusted gross income, and the excess can be carried forward for five years. You can use your tax savings to diversify your portfolio.

If you have more assets in traditional IRAs, you may consider converting some of those assets into a Roth IRA in a year in which you may have lower taxable income or when tax rates are low.



Diversify Bond Holdings

Bonds may be a part of your diversified portfolio. Interest from municipal bonds is exempt from federal taxes, and, for bonds issued in your state, it's typically exempt from state taxes as well. State tax treatment of out-of-state bonds varies. Although the tax-free income from investing only in your state's bonds might be alluring, consider diversifying into other state bonds to help minimize risk. Traditionally higher-quality bonds, such as Treasury bonds, may also be part of your holdings; Treasuries are state tax-free but subject to federal tax.

Consider the tax-equivalent yield of your investments. This is the pretax yield your taxable bonds would have to pay to equal the tax-free yield of a municipal bond in your tax bracket. For example, if you are in the 35% tax bracket, a taxable bond would have to yield 6.15% to equal a 4% yield on a municipal bond.

Consider Taxable vs. Tax-Deferred Vehicles

Another key to tax efficiency is the location of assets. You may want to keep investments that produce current income in a tax-deferred account and investments that produce long-term gains or tax-free income in a taxable account. For example, you can hold corporate bonds and dividend-paying stock in an IRA, so you can defer paying taxes until distribution. Likewise, you can keep growth stock and municipal bonds in a non-retirement brokerage account to get long-term capital gain treatment on the stock and tax-free treatment on the municipal bond interest.

Tax-efficient distributions are also important. Distributions from traditional IRAs are taxable, and qualified distributions from Roth IRAs are tax-free. If you have more assets in traditional IRAs, you may consider converting some of those assets into a Roth IRA in a year in which you may have lower taxable income or when tax rates are low. Income limitations for Roth conversions no longer apply.

During retirement, you can choose from which vehicles you withdraw money (traditional IRA, Roth IRA, variable annuities, or non-retirement brokerage accounts) to keep from going into a higher tax bracket. ➔

This material has been provided for general informational purposes only and does not constitute either tax or legal advice. Although we go to great lengths to make sure our information is accurate and useful, we recommend you consult a tax preparer, professional tax advisor or lawyer.

The Opioid Crisis ... ➔ continued from page 24

These numbers seem outrageous. It appears that there is a lot of money to be made on the current opioid crisis. The question is, who pays this cost?¹

Pharmacists are probably the most involved in fighting the opioid crisis. However, in the past, opioids were a thriving business for many pharmacies. Local, state and federal laws, as well as pharmacist organizations, have really put a damper on the ability to purchase opioids. Unfortunately, all these controls sometimes prevent patients with legitimate pain relief needs from getting adequate pain medication including opioids.

Physicians have followed in the footsteps of the pharmacists and have markedly reduced the prescribing of opioids. However, there are still some **physician-pharmacist** arrangements in which patients can get opioids easily. Other physicians have responded so aggressively against the opioid crisis that they are reluctant to prescribe significant pain medications when truly indicated.

Obviously, **patients** are involved in the opioid crisis. Once addicted, the patient often has one goal, and that goal is opioids.

Many patients who seek rehabilitation do well, but relapse is high. Contact with prior associates can rekindle opioid use. Going back into the prior environment can rekindle the seeking of opioids.

I am sure that many of you, my colleagues, could write a column on each of these 10 heads of Hydra just as well as or better than me. Feel free to submit your thoughts, corrections and mostly compliments. The third and final column on the opioid crisis will cover my recommendations for fighting this national problem.

I will not be discussing the wall for our southern border drug problem as that is a major political issue. I will leave that to President Trump and Congress to solve it in the very cooperative way that they have handled this problem over the past three years. ➔

Reference

1. Kimball TG. Recovery Durability: Addiction Recurrence Risk Lowers to General Population Levels in Long Term Recovery. *MAP Health Management*. July 29, 2019.

Alliance Honors Youth for Essays, Posters

County Executive Sam Page, MD, addresses group

St. Louis County Executive Sam Page, MD, joined the Medical Society Alliance in honoring students from Loyola Academy of St. Louis on November 5 at the annual awards luncheon for the “Drugs Are Not for Me” and “Smoking Makes Me Ugly” programs.

Seventeen students received awards for their essays and posters around the anti-drug and anti-smoking themes. Alliance volunteers have worked with the students over the past several months helping them develop their essays and posters.

Loyola Academy of St. Louis is a Jesuit middle school for boys from throughout the metro area who have the potential for college preparatory work but whose progress may be impeded by economic or social circumstances.

This ninth annual Alliance-Loyola luncheon was held at the Missouri Athletic Club in downtown St. Louis. —



In his remarks to the students, Dr. Page encouraged them to continue serving as positive role models to their peers.



Loyola honorees with St. Louis County Executive Sam Page, MD, back row, and Alliance members, from left, Sandra Murdock; Dianne Joyce, PsyD; Angela Zylka; and Kelly O'Leary. This was the ninth annual luncheon for Loyola boys at the Missouri Athletic Club.



These three sixth-graders performed an anti-drug rap song they created.



Students show their posters against drugs.



Seventh- and eighth-graders spoke out against smoking and vaping.



THANKS HOLIDAY SHARING CARD CONTRIBUTORS

The following SLMMS and Alliance members and friends contributed to the 2019 Holiday Sharing Card with donations to the American Medical Association Foundation and the Missouri State Medical Foundation.

- ★ Sally and Erol Amon, MD
- ★ Jim Braibish and Diane Hamill, OD
- ★ Rima and Edmond Cabbabe, MD
- ★ Amy Cabbabe, MD, and Samer Cabbabe, MD
- ★ Sophia Chung, MD, and John Holds, MD

- ★ Patricia and Jon Dehner, MD
- ★ Sue Ann and Thomas Greco, MD
- ★ Carrie Hruza, OD, and George Hruza, MD
- ★ Kay and Ravi Johar, MD
- ★ Sandra and Nathaniel Murdock, MD
- ★ Jill and David Nowak
- ★ Kelly and Timothy O'Leary, MD

- ★ Mrs. Jean Raybuck
- ★ JoEllyn Ryall, MD
- ★ Kate and Christopher Swingle, DO
- ★ Gail and Jeffrey Thomasson, MD
- ★ Gill and Stephen Waltman, MD
- ★ Mrs. Liz Webb
- ★ Mrs. Angela Zylka

OBITUARIES

M. Bryant Thompson, MD



M. Bryant Thompson, MD, an obstetrician and gynecologist, died May 20, 2019, at the age of 83.

Born in Chillicothe, Mo., Dr. Thompson received his undergraduate degree from Eastern New Mexico University and his medical degree from the University of California, San Francisco. He completed his internship at Parkland Memorial Hospital, Dallas, Tex. and his residency at Barnes-Jewish Hospital.

Dr. Thompson served in the U.S. Public Health Service from 1962-1964. He was in private practice for 42 years. He served on the staff at Barnes-Jewish Hospital, St. Luke's Hospital and Missouri Baptist Medical Center. He also held a faculty appointment at Washington University School of Medicine.

Dr. Thompson joined the St. Louis Metropolitan Medical Society in 1968.

SLMMS extends its condolences to his wife, Nancy Kuehn Thompson; children Linda Orfanos, Jeffrey Thompson, MD, and Holly Lehmann; and his seven grandchildren. —

John Paul Eberle, MD



John Paul Eberle, MD, an anesthesiologist, died November 5, 2019, at the age of 96.

Born in St. Louis, Dr. Eberle received his undergraduate and medical degrees from Saint Louis University. He completed his internship at the former St. John's Mercy Hospital and his residency at the Veterans Administration Hospital.

During the Korean War, Dr. Eberle was a captain in the U.S. Air Force and chief of anesthesia at Randolph Air Force Base Hospital in San Antonio. He headed the anesthesia departments at the former Deaconess and Incarnate Word hospitals and the former Bethesda Eye Institute.

Dr. Eberle joined the St. Louis Metropolitan Medical Society in 1950. He served SLMMS as secretary and as a councilor.

Dr. Eberle was predeceased by his wife, Peggy Eberle, and sons, Jerry Eberle, David Eberle and Larry Eberle. SLMMS extends its condolences to his children: John Eberle, Connie Schobel, Carolyn Hoerr, Nancy Eberle and Janet Stasney; his 14 grandchildren and 17 great-grandchildren. —

The Opioid Crisis, Part II

By Richard J. Gimpelson, MD

The prior Parting Shots column described the opioid crisis as a 10-headed Hydra and began to delineate the heads and the problem they cause. The heads of Hydra contributing to the problem are: dealers, pharmaceutical companies, insurance companies, government, attorneys, hospitals, rehabilitation centers, pharmacies, physicians and patients.

Dealers were covered in the previous column. The others and what they do are discussed in this column. The next column will cover my solutions.

The good: Opioids definitely have a benefit for the relief of pain from many causes.

The bad: Unfortunately, their long-term use may lead to addiction, debility, crime and death to the addicted and many victims of crime.

The **pharmaceutical companies** cannot be faulted for making money, but there are accusations and lawsuits placing significant blame on these companies for the opioid crisis. The initial culprit was Purdue Pharma, manufacturer of OxyContin. The basis of the claims was that Purdue Pharma vigorously marketed OxyContin as a non-addictive drug that could be used for treating most any type of pain without risk of addiction. Unfortunately, this claim was false.

A number of other pharmaceutical companies have joined the opioid market and with the aid of lobbyist groups have flooded the country with so-called safe opioids. In addition, the pharmaceutical companies have been helped by a number of allies: **insurance companies**, the **federal government**, **hospitals**, **attorneys** and **physicians**.

Insurance companies have often made admission to rehabilitation facilities difficult, requiring detailed authorization and limited days for treatment. In the past insurance companies

actually had stringent limits for psychiatric care related to drug addiction. Times are slowly changing, but much damage has already been done.

The **federal government**, through the FDA, has played a major role in many areas of the opioid crisis. In the past, FDA regulation for marketing opioids was very slow, but pharmaceutical companies were able to sell opioids before marketing regulations were in effect. Many elected representatives and senators have received large donations from pharmaceutical companies and lobbyists, thus influencing how opioid legislation has been slow in developing in the past. This “hush” money is slowly coming to light.

Thanks to the **American Pain Society** and the **Joint Commission**, pain has become a fifth vital sign. Thus **hospital personnel** now ask **patients** to rate the level of pain from 0-10. The **patient**, who is already being influenced by opioids, nearly always asks for more relief from pain in the form of more opioids. This is how all these groups contribute to the opioid crisis.

Attorneys definitely contribute to the opioid crisis, but they have no choice. Their occupation requires full representation for their clients. **Defense attorneys** get dealers and addicts no or reduced sentences, and **prosecuting attorneys** try to convict dealers and addicts. This is their job and they are sworn to perform to the best of their ability.

Rehabilitation centers are sometimes difficult for persons with addiction to gain admission to. This difficulty can be due to cost to patients, distance from the center and lack of treatment centers. A recent article reported that in Arizona:

- A non-profit sober living environment costs around \$400 per month.
- A non-profit inpatient environment can cost around \$15,000 per month.
- A for-profit inpatient environment can cost around \$40,000 per month.
- A for-profit inpatient luxury treatment center can cost as much as \$80,000 per month.



Richard J. Gimpelson, MD, is a retired gynecological surgeon and past SLMMS president. He shares his opinions here to stimulate thought and discussion, but these do not necessarily represent the opinion of the Medical Society. Your comments on this column are most welcome and may be sent to editor@slmms.org.

Dr. Richard J. Gimpelson

Continued on page 21

Thank you for your investment in advocacy, education, networking and community service for medicine.

Steven M. Couch, MD

660 S. Euclid Ave., CB 8096, 63110-1010
MD, Univ. of Missouri-Kansas City, 2006
Born 1981, Licensed 2010 ▶ **Active**
Certified: Ophthalmology

Azam J. Farooqui, MD

4225 West Pine Blvd., 63108-2862
MD, Rush Medical College, 2017
Born 1988, Licensed 2019 ▶ **Resident/Fellow**
Hematology/Oncology

John F. Gleeson, MD

12255 DePaul Dr., #460, 63044-2513
MD, Saint Louis Univ., 2007
Born 1980, Licensed 2010 ▶ **Active**
Certified: Pediatrics

Emily G. Goeller, MD

222 S. Woods Mill Rd., Ste. 710N, 63017-3625
MD, Univ. of Missouri-Columbia, 2011
Born 1984, Licensed 2015 ▶ **Active**
Certified: Dermatology

George J. Harocopos, MD

660 S. Euclid Ave., CB 8096, 63110-1010
MD, Virginia Commonwealth Univ., 2000
Born 1972, Licensed 2004 ▶ **Active**
Certified: Ophthalmology

Lynn M. Hassman, MD

660 S. Euclid Ave., CB 8096, 63110-1010
MD, Univ. of Virginia, 2012
Born 1980, Licensed 2018 ▶ **Active**
Certified: Ophthalmology

Augustine R. Hong, MD

660 S. Euclid Ave., CB 8096, 63110-1010
MD, Univ. of Illinois, Chicago, 2009
Born 1982, Licensed 2003 ▶ **Active**
Certified: Ophthalmology

Eboni C. January, MD

7700 Clayton Rd., Ste.100-17, 63117-1328
MD, Wright State Univ., 2010
Born 1981, Licensed 2014 ▶ **Active**
Certified: Obstetrics & Gynecology

Andrew R. Lee, MD

660 S. Euclid Ave., CB 8096, 63110-1010
MD, Washington Univ., 2013
Born 1987, Licensed 2018 ▶ **Active**
Certified: Ophthalmology

Andrew J. Lubniewski, MD

660 S. Euclid Ave., CB 8096, 63110-1010
MD, Univ. of Florida, 1985
Born 1958, Licensed 1990 ▶ **Active**
Certified: Ophthalmology

Robi N. Maamari, MD

660 S. Euclid Ave., CB 8096, 63110-1010
MD, Univ. of California, Irvine, 2014
Born 1986, Licensed 2018 ▶ **Active**
Certified: Ophthalmology

Brigid K. Marshall, MD

660 S. Euclid Ave., CB 8096, 63110-1010
MD, Washington Univ., 2014
Born 1986, Licensed 2018 ▶ **Resident/Fellow**
Ophthalmology

Kathleen M. Nemer, MD

4921 Parkview Pl., #5B, 63110-1032
MD, Vanderbilt Univ., 2013
Born 1987, Licensed 2017 ▶ **Active**
Dermatology

Tiffany M. Osburn, MD

660 S. Euclid Ave., CB 8109, 63110-1010
MD, Univ. of Texas, San Antonio, 1997
Born 1976, Licensed 2011 ▶ **Active**
Certified: Surgery

Anand V. Palagiri, MD

621 S. New Ballas Rd., #537, 63141-8232
MD, Saint Louis Univ., 2000
Born 1973, Licensed 2006 ▶ **Active**
Certified: Pediatric Urology

Christopher W. Palmer, DO

12639 Old Tesson Road, #100, 63128-2786
DO, Kirksville Coll. of Osteopathic Med., 2012
Born 1980, Licensed 2013 ▶ **Active**
Certified: Orthopedic Surgery

Kisha D. Piggott, MD

660 S. Euclid Ave., CB 8096, 63110-1010
MD, Emory Univ., 2011
Born 1979, Licensed 2015 ▶ **Active**
Certified: Ophthalmology

Margaret M. Reynolds, MD

660 S. Euclid Ave., CB 8096, 63110-1010
MD, Cornell Univ., 2014
Born 1987, Licensed 2018 ▶ **Active**
Certified: Ophthalmology

Brian J. Saville, MD

12255 DePaul Dr., #460, 63044-2513
MD, Washington Univ., 2001
Born 1957, Licensed 2004 ▶ **Active**
Certified: Pediatrics

Todd B. Silverman, MD

14825 N. Outer Forty Rd., #330B, 63017-2119
MD, Northwestern Univ., 1993
Born 1966, Licensed 2001 ▶ **Active**
Certified: Clinical Neurophysiology

Janiece N. Stewart, MD

4341 Washington Ave., 63108-2633
MD, Rush Medical College, 2001
Born 1975, Licensed 2019 ▶ **Active**
Certified: Pediatrics

Harris C. Sultan, MD

660 S. Euclid Ave., CB 8096, 63110-1010
MD, Univ. of Connecticut, 2014
Born 1987, Licensed 2018 ▶ **Resident/Fellow**
Ophthalmology

Nicholas C. Uffelmann, MD

8567 Watson Road, #A, 63119-5251
MD, Saint Louis Univ., 2012
Born 1986, Licensed 2016 ▶ **Active**
Certified: Dermatology

Gregory P. VanStavern, MD

660 S. Euclid Ave., CB 8096, 63110-1010
MD, Pennsylvania State Univ., 1993
Born 1964, Licensed 2009 ▶ **Active**
Certified: Ophthalmology

Melanie J. Wahl, MD

1011 Bowles Ave., #300, 63026-2387
MD, Ross Univ. School of Medicine, 2005
Born 1978, Licensed 2009 ▶ **Active**
Certified: Rheumatology

Edmond S. Weisbart, MD

63 Branford Dr., 63132-2001
MD, Univ. of Illinois, 1979
Born 1954, Licensed 2003 ▶ **Active**
Certified: Family Medicine

WELCOME STUDENT MEMBERS

Saint Louis University School of Medicine

Isha Pathak

Washington University School of Medicine

Jacqueline M. Hampton

IS YOUR MONEY WORKING AS HARD AS YOU ARE?

**A LOWER FEE COULD HAVE PUT
AN EXTRA \$143,485 IN YOUR POCKET.**

	1.00% Management Fee	0.50% Management Fee
12/31/08	\$1,000,000	\$1,000,000
12/31/18	\$3,137,917*	\$3,281,402*

At Triad Financial Group, we're pleased to offer SLMMS members a reduced annual portfolio management fee of 0.5%. That's half the rate typically charged by financial advisors,** and the difference in costs or fees can really add up. **So why pay more?**

Contact Rich Fitzer at 314.392.6812 or at rcfitzer@triadfinancialgroup.net for a **no-cost review of your portfolio.**



TRIAD *financial group, LLC*

680 Craig Road, Suite 309 | Creve Coeur, MO 63141

* Based on a hypothetical \$1 million invested in the S&P 500 Index. Over a 10-year period ending 12/31/2018, returns would have been \$143,485 higher with a 0.5% annual portfolio management fee versus a 1% fee. Past performance is not indicative of future returns.

** "Typical rate charged by financial advisors" claim is based on a 2016 *InvestmentNews* study (<http://blog.runnymede.com/how-much-to-pay-a-fee-only-advisor-a-look-at-average-annual-fees>) showing an average advisor fee of 1.01% for an account valued at between \$1 million and \$5 million. Rates charged by financial advisors vary. Other fees and transaction costs apply. Similar services may be available from other investment advisers at a lower cost.

All indices are unmanaged and investors cannot actually invest directly into an index. Unlike investments, indices do not incur management fees, charges, or expenses.

This is a hypothetical example and is for illustrative purposes only. No specific investments were used in this example. Actual results will vary.

Securities and advisory services offered through Commonwealth Financial Network®, Member FINRA/SIPC, a Registered Investment Adviser. Fixed insurance products and services offered through CES Insurance Agency.