STATE ADVOCACY CONFERENCE
September 18 – 19, 2015
The Westin O’Hare
Rosemont, Illinois

PROGRAM BOOK
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American Association of Clinical Urologists
8th Annual State Advocacy Conference

September 18 – 19, 2015
The Westin O’Hare
Rosemont, Illinois

Corporate Members and Conference Supporters.......................................................... Inside Cover
2014 – 2015 AACU Board of Directors.............................................................................. 2
Welcome Message................................................................................................................. 3
Program Schedule .............................................................................................................. 4
AACU Distinguished Leadership Award ............................................................................. 6
Speaker Biographies ............................................................................................................ 7
Speaker Presentations .......................................................................................................... 13
Plan to Attend the Urology Joint Advocacy Conference................................................  Back Cover

The AACU and WJ Weiser & Associates are committed to making the 2015 AACU State Society Network Advocacy Conference an enjoyable and informative experience.

Please contact event staff if you have any questions or concerns.
American Association of Clinical Urologists
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Welcome Message

Empowering Urologists to Advocate for their Patients, Practice and Profession

September 18, 2015

Welcome!

After nearly a year of planning and preparation, we are thrilled to welcome you to the 8th Annual AACU State Society Network Advocacy Conference.

The informative agenda addresses urology advocacy, current socioeconomic issues and technological innovations sure to benefit your practice. The sessions will not only provide information, but also serve as tools to use when you return home. We hope you will leverage the knowledge and resources obtained at this conference with colleagues concerned about the changes happening in health care and the socioeconomic issues they are facing.

We are honored to have you here, and thank the AACU’s Corporate Members and healthcare industry supporters for their assistance. Speakers and panel participants similarly deserve our recognition and appreciation. For every presentation, we all know that hours of preparation are necessary. Finally, we are grateful for the support of the AACU Board of Directors, especially that of President Mark D. Stovsky, MD, MBA, and the extraordinary effort of our staff led by Executive Director Wendy Weiser.

Thank you for taking time away from your patients, friends and families to attend this event. We understand this sacrifice and have done everything possible to make the 8th Annual AACU State Society Network Advocacy Conference a valuable investment of your time.

Sincerely,

Charles A. McWilliams, MD
AACU State Society Network Chair

Martin K. Dineen, MD, FACS
AACU President-elect and State Society Network Vice-Chair
8th Annual
AACU State Society Network
State Advocacy Conference

September 18 - 19, 2015

All sessions will be located in LaSalle BC unless otherwise noted.

FRIDAY, SEPTEMBER 18, 2015

6:15 p.m. Ground Transportation to AACU Annual Dinner Departs from the Hotel Lobby

6:30 p.m. - 9:00 p.m. Welcome Reception and AACU Annual Dinner
   Location: Gibson’s Steakhouse, Rosemont, IL
   AACU Distinguished Leadership Award Presentation
   Speaker: Congressman Ted Lieu (CA-33)
            U.S. House of Representatives
            Los Angeles, CA

SATURDAY, SEPTEMBER 19, 2015

GENERAL SESSION

7:00 a.m. - 8:00 a.m. Industry Sponsored Breakfast
   Sponsored by: NeoTract
   UroLift for BPH: Changing the Game in BPH Care
   Presenter: Dave Amerson
              President & CEO, NeoTract, Inc.
              Pleasanton, CA
   UroLift Prostatic Urethral Lift: The Kaiser Experience
   Presenter: Eugene Rhee, MD, MBA
              Chief, Urologic Surgery, Kaiser Permanente San Diego Medical Center
              San Diego, CA

8:00 a.m. - 8:45 a.m. Presidents’ Forum – Views on State Advocacy from Urology’s National Organizations
   Moderator: Martin K. Dineen, MD
              President-elect, American Association of Clinical Urologists
              Daytona Beach, FL
   Panelists: William F. Gee, MD
              President, American Urological Association
              Lexington, KY
              Gary M. Kirsh, MD
              President, LUGPA
              Cincinnati, OH
              Mark D. Stovsky, MD, MBA, FACS
              President, American Association of Clinical Urologists
              Cleveland, OH

9:00 a.m. - 9:45 a.m. Economic Impact of the Affordable Care Act
   Speaker: Mark E. Rust, JD
            Managing Partner, Barnes & Thornburg LLP
            Chicago, IL

9:45 a.m. - 10:00 a.m. Medicare CACs: The Role of Specialist Physicians and Organizations
   Speaker: Jeffrey E. Kaufman, MD
            President, Western Section of the AUA
            Santa Ana, CA
10:00 a.m. - 10:15 a.m.  Break

10:15 a.m. - 10:45 a.m.  Telehealth Policy Update
   Speakers: Eugene Y. Rhee, MD, MBA
              AACU Western Section Representative
              San Diego, CA
   Aaron Spitz, MD
              AUA Delegate to the AMA House of Delegates
              Laguna Hills, CA

10:45 a.m. - 11:00 a.m.  Snapshot: 90-Day Grace Period/Medical Liability Reform
   Speakers: Dan Shaffer, JD
              AACU Associate Director and Legislative Attorney
              Schaumburg, IL
   Ross E. Weber
              AACU State Affairs Manager
              Schaumburg, IL

11:05 a.m. - 12:05 p.m.  Breakout Sessions
   Risk Mitigation in the Integration of Electronic Health Records
   Location: LaSalle A
   Speaker: Stacey A. Cischke, JD
           Partner, Cassiday Schade LLP
           Chicago, IL

   Prescriptions and Medications in the Doctor's Office: The Physicians' Dilemma; Battling
   Insurance Authorization and Inadequate Cost Coverage for In-Office Medications
   Location: LaSalle BC
   Speaker: Rick Rutherford
           Baltimore, MD

12:15 p.m. - 1:15 p.m.  Industry Sponsored Lunch
   Sponsored by: Astellas/Medivation

   XTANDI (Enzalutamide) Capsules in the Urology Practice: Continuing Care for Your Patients
   with Metastatic CRPC
   Presenter: Aaron Berger, MD, PhD
              Associate Urology Specialists
              Chicago, IL

1:30 p.m. - 2:30 p.m.  Health Care in 2020: Where Uncertain Reform, Bad Habits, Too Few Doctors, and
                      Skyrocketing Costs Are Taking Us
   Speaker: Stephen Jacob, MPH, MA, MSBA
            Health Care Journalist and Author

2:30 p.m. - 3:15 p.m.  Private Payer Reform: Relieving the Administrative Burden of Prior Authorization
   Speakers: Richard S. Pelman, MD
              Immediate Past President, AACU
              Seattle, WA
   William C. Reha, MD, MBA
              President, Medical Society of Virginia
              Woodbridge, VA

3:15 p.m. - 3:30 p.m.  Snapshot: AMA Economic Impact Study - A Valuable Advocacy Tool
   Speaker: Annalia Michelman, JD
            Senior Legislative Attorney, AMA Advocacy Resource Center
            Chicago, IL

3:30 p.m. - 3:45 p.m.  Break

3:45 p.m. - 4:30 p.m.  How to Preserve Independent, Private Practice: Urologic Practice as an Employer or
                      Employee, an Integrated Approach
   Speakers: Michael D. Fabrizio, MD, FACS
             Virginia Beach, VA
   Brian M. Jumper, MD
             Past President, Maine Medical Association
             South Portland, ME

4:30 p.m. - 4:45 p.m.  AACU Annual Business Meeting
Congressman Ted Lieu (Los Angeles, CA)
*U.S. House of Representatives*

In 2014, Ted W. Lieu was elected to an open seat for the 33rd Congressional District, succeeding retiring 40-year incumbent Henry Waxman. He was elected president of the Freshman class of Democrats by his colleagues and serves on the House Budget Committee, and the House Committee on Oversight & Government Reform. Ted is a former active duty officer who currently serves as a reservist in the United States Air Force.

In February of 2011, Ted was elected to the State Senate in a special election.

In the State Senate, Ted was Chair of the Business, Professions and Economic Development Committee, Chair of the Select Committee on Air Quality, and Chair of the Joint Committee on Arts. Ted’s legislative accomplishments include co-sponsoring landmark legislation regulating the subprime mortgage industry, state tax reform that saved small businesses from billions in retroactive taxes, increasing planning for climate change, increasing tax incentives for film/TV production, and banning the state from investing in or doing business with companies doing business with Iran.

Ted was elected to the Torrance City Council in 2002. In 2005, Ted was elected to the State Assembly, where he served until 2011. Ted chaired the Assembly Rules Committee, the Banking and Finance Committee, and sat on the Governmental Organization Committee, Judiciary Committee, Water, Parks & Wildlife Committee, and Veterans Affairs Committee. Ted was also Chair of the Asian Pacific Islander Legislative Caucus, and Chair of the Assembly Select Committee on Aerospace.

Ted’s wife, Betty, is a former California Deputy Attorney General. They have two sons, Brennan and Austin.

The AACU Distinguished Leadership Award recognizes elected officials and executive-level appointees who support the organization’s priorities and the interests of the urologic community before state government.

Recent AACU Distinguished Leadership Award Honorees:

- **2014**
  - Conn. Rep. Prasad Srinivasan, MD

- **2013**
  - Oregon Senator Alan Bates, DO

- **2012**
  - N.J. Assemblyman Herb Conaway, MD
Stacey A. Cischke, JD (Chicago, IL)
Partner, Cassiday Schade LLP

Stacey Cischke is a partner with Cassiday Schade and a member of the firm’s healthcare practice group. She has extensive experience in the representation of physicians, dentists and healthcare institutions. She represents several Chicago area teaching hospitals as well as individual physicians and practice groups. Ms. Cischke handles all aspects of litigation, including prelitigation planning and strategy. She has tried a number of medical malpractice cases to verdict.

Ms. Cischke also frequently speaks to physicians and medical practice groups focusing on topics such as understanding the defense of birth injury cases, preparing for depositions, legal issues involving EMR’s and improving reliability in discovery responses. In addition to presentations for the firm’s clients, she has been invited by local and national healthcare and risk organizations to speak about a variety litigation issues, including ediscovery, litigation holds, and incorporating principles of enterprise risk management into litigation strategy.

Ms. Cischke is an adjunct professor of law in the Online Legal Education Beazley Institute for Health Law and Policy, Loyola University Chicago School of Law, and she coauthored a chapter titled “Principles for Strategic Discovery” in the book, Principles of Risk Management and Patient Safety.

Ms. Cischke was named one of the “40 Illinois Attorneys Under Forty to Watch” as a result of the 2014 annual survey by Law Bulletin Publishing Company. Individuals selected to the “40 Under Forty” list are nominated and recognized by colleagues as the most talented and successful “up and comers” in Illinois. She has also been named a 2015 Emerging Lawyer by Leading Lawyers Network.

Ms. Cischke attended James Madison College at Michigan State University where she graduated with honors and a member of Phi Beta Kappa. At Loyola University Chicago School of Law, Ms. Cischke was a member of the Thomas Tang Moot Court team, and was awarded the honor of Best Brief.

Michael D. Fabrizio, MD, FACS (Virginia Beach, VA)
Chief Executive Officer, Urology of Virginia

Dr. Fabrizio earned his medical degree from the Medical College of Virginia in 1992 after receiving his bachelor of science degree in biology from the College of William and Mary in 1988. He completed his residencies in surgery and urology at the Thomas Jefferson University Hospital in Philadelphia, Pennsylvania. Dr. Fabrizio was awarded a fellowship in endourology and laparoscopic surgery at The Johns Hopkins University, Brady Urological Institute in Baltimore, Maryland. Dr. Fabrizio was involved in the FDA trials for the Zeus Robotic system and an early adopter of robotic surgery.

Dr. Fabrizio specializes in urological laparoscopy for benign and malignant conditions including prostate and kidney cancer, adrenal surgery, kidney donation and complex kidney and ureteral stone surgery. With the support of his partners, he created the laparoscopic radical prostatectomy and robotic assisted prostatectomy program as well as the laparoscopic kidney donor program in Norfolk, Virginia. He also started a training fellowship in endourology and laparoscopy in 2003, which has received national recognition in Quality of Life Outcomes research for prostate cancer treatments. The fellowship has won awards for publications and been cited by USA Today and Reuters News. He has published many peer-reviewed articles and book chapters as well as lectured around the world on topics in endourology and outcomes. Dr. Fabrizio was recognized by the local and national media for performing a national kidney swap. He has been recognized as a Hampton Roads Top Doc multiple times (most recently in 2013) and is listed among America’s Top Docs in Castle and Connolly Top Docs recognition. Dr. Fabrizio notes that he is “proud to be associated with a urology practice that offers specialty care in areas of our field. We have assembled one of the best trained faculty in the country, and our practice offers not only outstanding clinical care but access to ground breaking clinical trials and the most up to date surgical techniques”.

Dr. Fabrizio is board certified by the American Board of Urology and the National Board of Medical Examiners and is a fellow in the American College of Surgeons. He is a member of the AUA, Mid-Atlantic Section of the AUA, Endourology Society, and the Society of Urologic Oncology. In addition to being the Chief Executive Officer of the practice and the endourology fellowship director, he is currently serving as the treasurer of the Mid-Atlantic Section of the AUA.

He enjoys spending time with his wife and three children. His hobbies include hunting, fishing, and anything outdoors.
William F. Gee, MD (Lexington, KY)
President, American Urological Association

Dr. Gee is clinical professor of surgery (urology), voluntary faculty, at the University of Kentucky College of Medicine, and Emeritus urologist at Commonwealth Urology in Lexington, Kentucky. He has spent much of his career training University of Kentucky PGY-4 urology residents during their six-month rotation with private practice urologists at St. Joseph Hospital. He received his medical degree from the University of Wisconsin in Madison and did his urology residency in Seattle at the University of Washington, which included a year as an NIH Senior Research Fellow. Additionally, Dr. Gee served two years on active duty as a medical officer in the United States Naval Reserve, which included service in Vietnam.

From 2005 to 2009, Dr. Gee was AUA Treasurer and a member of the Executive Committee and Board of Directors. He has held numerous leadership positions, including president and secretary-treasurer of AACU, and president of both the Southeastern Section of the AUA and the Kentucky Urological Association. Dr. Gee represented the AUA as a delegate to the AMA House of Delegates prior to becoming AUA President-elect. In addition, he served as AUA representative to the “RUC” (AMA Relative Value Update Committee) for over 15 years; the RUC determines the Relative Values for the Medicare Fee Schedule. Over the years, Dr. Gee has served on numerous AUA committees, including Urology Core Curriculum, Investment, and Future of Urology Residency Training Task Force. He has also been Chair of the AUA Health Policy Council and has testified before Congress on urology issues. Dr. Gee has received several AUA awards, including the AUA Distinguished Service Award and the AUA Presidential Citation.

Stephen Jacob, MPH, MA, MSBA (Fort Worth, TX)
Health Care Journalist and Author

Stephen Jacob is an award-winning veteran health care journalist. He has spent four decades as a daily newspaper and magazine editor and publisher and writes about health policy for Texas newspapers, magazines and health care organizations. Mr. Jacob’s health commentaries were distributed nationally by the McClatchy Tribune News Service. Based on more than 1,000 references and a year of in-depth research, Jacob offers non-partisan a look at the future of America’s health care in Health Care in 2020: Where Uncertain Reform, Bad Habits, Too Few Doctors, and Skyrocketing Costs are Taking Us (January 2012, Dorsam Publishing). In it, he takes on the challenge of explaining what’s wrong with health care and presents solutions that rise above partisan politics.

Brian M. Jumper, MD (South Portland, ME)
Past President, Maine Medical Association

Dr. Jumper is an assistant clinical professor of urology at Tufts University School of Medicine. He is the director of pediatric urology at the Maine Medical Center Urologic Residency in Portland, Maine, and the senior member of the Maine Medical Partners Urology group practice. He had been in private practice for 20 years, and is now employed for the last six years by the Maine Medical Center.

Dr. Jumper graduated from Vermont College of Medicine and did his urologic residency at MCHV in Vermont. He completed a one-year clinical fellowship in pediatric urology at the Hospital for Sick Children in Toronto, Canada. He has been in urologic practice in Portland continuously since 1989. He has been the AACU State Representative from Maine since 2006, past-president of the Maine Medical Association 2000-2001, and past president of the New England Section of the AUA, 2005-2006.
Jeffrey E. Kaufman, MD (Santa Ana, CA)

**President, Western Section of the AUA**

Dr. Kaufman is a leader in new technologies that provide cutting edge choices for all areas of urologic diseases. For 30 years, Dr. Kaufman has taught, lectured, performed research and practiced urology. He is a recognized leader in his field, named by Orange Coast magazine as one of the best urologists in Orange County, and he has held numerous leadership positions throughout the urologic community. He is a past president of the AUA, a current member of the AUA Board of Directors, AACU Delegate to the AMA House of Delegates and current President-elect of the Western Section of the AUA. As a urologist, certified by the American Board of urology since 1984 and a Fellow of the American College of Surgeons, Dr. Kaufman treats a wide range of male and female problems in children and adults.

Gary M. Kirsh, MD (Cincinnati, OH)

**President, LUGPA**

Dr. Kirsh is a founder and the President of the Board of Directors of the Large Urology Group Practice Association. He is a Past President of the AUA and of the Ohio Urologic Society. Dr. Kirsh is currently Chairman of UROPAC, the national political action committee of organized urology, and he is a board member of The Ohio State Medical Association Political Action Committee (OSMAPAC). He also serves as treasurer of the North Central Section of the AUA.

Dr. Kirsh graduated from the University of Chicago Pritzker School of Medicine in 1984. He received his surgical training at the University of Cincinnati Medical Center and his urology training at University Hospitals of Cleveland, Case Western Reserve University.

Dr. Kirsh has been certified by the American Board of Urology and is licensed in the state of Ohio. He is a member of the AUA, the AACU, LUGPA, The Ohio State Medical Association and the Cincinnati Academy of Medicine.

Anallia Michelman, JD (Chicago, IL)

**Senior Legislative Attorney, AMA Advocacy Resource Center**

Anallia Michelman, JD, MPP is a Senior Legislative Attorney in the American Medical Association (AMA) Advocacy Resource Center. In the Advocacy Resource Center, she works with state and specialty medical associations on state legislative and regulatory issues, specializing in physician business issues, Medicaid policy, state budget issues, and health information technology. Prior to joining the AMA, Annalia was a Health Policy Specialist with the National Alliance to Advance Adolescent Health in Washington, DC, where she focused on Medicaid and behavioral health programs. Annalia earned a law degree and master’s degree in public policy from Georgetown University.

Richard S. Pelman, MD (Seattle, WA)

**Immediate Past President, AACU**

Dr. Pelman has been a clinical professor of urology with the department of urology, University of Washington School of Medicine, since 2000. His relationship with the department began in 1986 after establishing his private practice in Bellevue, Washington. He has served as faculty at the Seattle Veterans Hospital and Consultant to the hospital’s Spinal Cord Injury Unit. Dr. Pelman attended the University of Washington for his baccalaureate degrees in zoology and anthropology, as well as his Doctor of Medicine degree, graduating in 1979 from the School of Medicine. Since completing his urology training at Boston University, he has successfully maintained a thriving private practice in Bellevue, Washington. In March of 2014, he joined the University of Washington Department of Urology, and is practicing in their new Eastside Multispecialty Clinic. As an early advocate in men’s health, he developed the men’s health program for the Washington State Urology Society and is the chair of that committee. In 2009, he proposed to the AUA Board of Directors the concept of an AUA Committee on Male Health. He served as Chairman of the AUA Ad Hoc Committee on Male Health until 2010, as well as having served as Course Director and Faculty for the inaugural AUA instructional course on Male Health, and subsequent courses. He is a Past-President of the Washington State Urology Society, Northwest Urological Society, and the AACU.
William C. Reha, MD, MBA (Woodbridge, VA)
President, Medical Society of Virginia

Dr. Reha is a board-certified urologic surgeon in Woodbridge, Virginia, and president of the Medical Society of Virginia (MSV). He has been practicing urology for 26 years.

In addition to his private practice, Dr. Reha has been an active advocate for organized medicine. He has served as delegate, director, vice-speaker and speaker of the MSV House of Delegates. Additionally, he has served as president of the Potomac Hospital medical staff, Prince William County Medical Society, and the Virginia Urological Society. On a national level, he has served as an alternate delegate to the American Medical Association (AMA) and is a state society network representative for the AACU. He is a Medical Society of Virginia Foundation (MSVF) Claude Moore Physician Leadership Institute fellow, and the recipient of the MSV 2009 Clarence A. Holland Award, which is presented annually to a Virginia physician for outstanding contributions promoting the arts and science of medicine and the betterment of public health through political service.

Dr. Reha received his bachelor’s degree in biochemistry from Binghamton University, his medical degree from New York Medical College, his residency in surgery/urology at Georgetown University, and his MBA from Strayer University.

Furthermore, Dr. Reha also serves on the board of trustees at Strayer University and was recognized by Strayer in 2005 as the Outstanding Alumni Award winner, and he also serves as a delegate for the National Association of Parliamentarians.

Eugene Y. Rhee, MD, MBA (San Diego, CA)
Western Section Representative, AACU Board of Directors

Dr. Rhee is the Chief of Urologic Surgery at Kaiser Permanente, San Diego, California, and the 2013-2014 AUA Gallagher Health Policy Scholar. He is a Past President of The California Urological Association and The San Diego Urologic Society. He is the Section Editor for Health Policy for Urology Practice. He serves on the AUA Health Policy Committee as the Western Section AUA Health Policy Representative, the AUA Legislative Affairs Committee and the Nominations Committee of the Western Section AUA. He serves on the Board of Directors of the AACU as its Western Section Representative. He is also Clinical Instructor of Urology at Balboa Naval Medical Center and the University of California, San Diego. Dr. Rhee is considered an international expert in the field of incontinence, urologic reconstruction and minimally invasive techniques for BPH. Dr. Rhee earned his medical degree from Emory University School of Medicine in Atlanta, Georgia, and completed his residency at the Kaiser Permanente Foundation Hospitals in Los Angeles, California. He received both his Bachelor of Science in Biology and his Bachelor of Arts in Political Science from Emory University. He received his MBA from The Anderson School of Management at UCLA in 2008, and is a graduate of the 2009 – 2011 AUA Leadership Class.

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Review Dues Payment History and Pay Online

www.aacuweb.org
Mark E. Rust, JD (Chicago, IL)
Managing Partner, Barnes & Thornburg LLP

Mark Rust is Managing Partner of the Chicago office of Barnes & Thornburg, LLP, and is the immediate past Chair of the firm’s national healthcare department. Mr. Rust concentrates his practice in transactional, regulatory and medical-legal issues affecting healthcare entities and provider organizations. For nearly 30 years he has written about or practiced in healthcare law, writing in a wide variety of publications from the Journal of the American Bar Association to USA Today. He is listed as a notable healthcare lawyer in Chambers USA, Top Healthcare Lawyers of Illinois, SuperLawyers® and The Best Lawyers in America®.

Mr. Rust has represented large radiology and cardiology groups, multi-specialty clinics, hospitals and hospital-physician joint ventures, medical staffs and managed care organizations including provider-sponsored insurance companies and HMOs. He routinely is engaged to advise on mergers and acquisitions, contract formation and negotiation, and regulatory issues. In addition to state healthcare regulation, and federal fraud and abuse and Stark analysis, Mr. Rust has focused on the application of antitrust law and ERISA pre-emption to the healthcare field.

He and his firm appeared before the U.S. Supreme Court in Rush Prudential v. Moran, 536 U.S. 355 (2002), successfully arguing, for the first time, how the relationship between providers, patients, managed care and state regulation should work under the federal law known as ERISA; and Mr. Rust was counsel of record on behalf of the American Medical Association and fifty state medical societies on the same topic before the Supreme Court the following year in Kentucky v. Miller, 538 U.S. 329 (2003).

For Thompson West Publishing, Mr. Rust regularly updates the antitrust section of The Law of Medical Practice in Illinois, Third Edition, and co-authored and updates the Mosby Elsevier textbook, Legal Medicine, published in conjunction with the American College of Legal Medicine. He is the author of “CO-OPs and Accountable Care” published in the American Medical Association’s (AMA) January 2011 educational resource ACOs, CO-OPs and Other Options: A “How-To” Manual for Physicians Navigating a Post-Health Reform World. He and his firm helped found the only two government-funded, provider-sponsored CO-OPs in the country. Mr. Rust has appeared before the United States Congress and several state legislatures providing testimony on healthcare delivery and managed care.

Mr. Rust is the current Chair of the Better Government Association, and actively involved in the Tri-State Regional Alliance, which has brought together the business and political resources of Indiana, Illinois and Wisconsin to emphasize common strengths and opportunities. Mr. Rust is Past Chair of the Illinois State Bar Association’s Health Law Section, the Chicago Bar Association’s Health Law Committee, and the American Bar Association’s Medicine and Law Committee (Tort and Insurance Practice Section). He regularly addresses organizations on current topics in healthcare law.

Mr. Rust received his JD from Loyola University, Chicago, Illinois, in 1989, and his BA from the University of Notre Dame in 1981, and is the former national legal affairs reporter and business editor for the American Medical News (1983-1989). He is admitted to practice in Illinois and the federal appellate bar, including the U.S. Supreme Court.

Rick Rutherford, CMPE, CHA (Baltimore, MD)

Rick Rutherford has been involved in managing medical practices for 30 plus years. As a veteran or perhaps survivor of "the trenches," he brings a perspective of experience and realism to any practice management discussion. He earned a bachelor of science degree in business administration from the Kenan-Flagler School of Business at the University of North Carolina. He is a Certified Medical Practice Executive (CMPE) through the American College of Medical Practice Executives, and a Certified Healthcare Auditor (CHA) through the American Institute of Healthcare Compliance. For more than 15 years, he led the AUA’s practice management efforts with a vision of how to run a successful and profitable urology practice while never losing sight of the essential core value of excellent patient care.
Aaron Spitz, MD (Laguna Hills, CA)
AUA Delegate to the AMA House of Delegates

Dr. Spitz was born in Miami Beach, Florida. He has specific training and interest in male reproductive medicine. He is highly skilled at microsurgical vasectomy reversal. He performs both vasovasostomy and vasoepididymostomy, and he has extensive experience salvaging previously failed vasectomy reversal. Dr. Spitz performs microsurgical varicocele surgery and sperm retrieval surgery for in vitro fertility. He can treat even the most severe cases, such as Klinefelter’s syndrome, where there are no sperm.

A nationally recognized expert, Dr. Spitz performs no-needle, no-scalpel vasectomy, employing the most advanced minimally invasive techniques for male birth control. He is also a recognized expert on male hormone replacement and sexual dysfunction. And, he provides expert treatment for men suffering from low testosterone, erectile dysfunction and Peyronie’s disease.

As the author of several peer-reviewed journal articles and chapters regarding treatment for male fertility, Dr. Spitz is a frequent media spokesperson on male health issues. He is also actively involved in medical politics, frequently advocating on behalf of urologists and their patients nationally. Dr. Spitz and his wife, Sarah, enjoy living in Laguna Beach with their three wonderful sons.

Mark D. Stovsky, MD, MBA, FACS (Cleveland, OH)
President, American Association of Clinical Urologists

Dr. Stovsky serves as Science and Technology Innovation Officer at Cleveland Clinic Innovations as well as associate professor of surgery (urology) and staff urologist in the Cleveland Clinic Glickman Urological and Kidney Institute. Prior to joining CCF and CCF Innovations, Dr. Stovsky was an attending urologist at University Hospitals Case Medical Center where he served as Director of the Men’s Health and Genitourinary Stone Center and Urology Institute Quality Officer as well as Chief of the Division of Urology and Medical Director for Urology Services at UH Richmond Medical Center.

Dr. Stovsky earned undergraduate and medical degrees from Northwestern University. He also holds an MBA (strategic planning) from the Katz Graduate School of Business at the University of Pittsburgh where he was elected to Beta Gamma Sigma. Dr. Stovsky completed his urology residency training at University Hospitals Case Medical Center in Cleveland, Ohio.

Dr. Stovsky is the current President of the American Association of Clinical Urologists (AACU) and Treasurer of the North Central Section (NCS) of the American Urological Association (AUA). He is Past President of the Cleveland Urological Society, and the Ohio Urological Society, as well as a past board member of the Academy of Medicine of Cleveland/ Northern Ohio Medical Association. Dr. Stovsky completed the AUA Leadership Program (2012/2013 class). He has also been honored with selection to Best Doctors in America (2010 - present).
Economic Impact of the ACA on Providers; Narrow Networks and Private Exchanges

• Introduction

• What is the health care system devolving to - and why?
  – Individual choice for 15 million newly covered Americans
  – Information and exchanges – development of private exchanges
  – New mandates/new costs

• What pressures will drive this change?
  – The price of care
  – The price of benefits
  – Employers stepping back and promoting cost-conscience behaviors
  – Retail medicine
  – Consolidation of hospital systems
  – Consolidation of insurers who do not want to take “risk”
Economic Impact of the ACA on Providers; Narrow Networks and Private Exchanges

• What are the signs to look for - and how do you react
  – Employers who do what Walgreens did - what did they do?
  – Rationale for defined contributions vs. defined benefits
  – Result: individual choice, price sensitivity
  – Be the first responder to a narrow network product

• What are Narrow Networks - and why will the law protect, rather than prohibit, their development
  – Historic attempts: the gatekeeper HMOs of the 1990's (think 'Hillarycare')
  – The realization of a promise: more patients exclusively for reduced price
  – Legal pushback: suits in CA and CT, insurance commissioners in several states
  – How network regulation works; why narrow networks will be only lightly regulated*
  – Why do narrow networks respond to these pressures/evolution?

• Conclusion
Medicare Carrier Advisory Committees and Urology

A SHADOW STATE SOCIETY NETWORK

JEFFREY KAUFMAN MD, FACS
AACU SSN MEETING
CHICAGO, IL

HISTORY OF CACs

• 1965 ONWARD PAID WHAT WAS BILLED
• LATE 1980’s HCFA ADMINISTRATOR WILLIAM ROPER MD ADDRESSED “MEDICAL NECESSITY” AND COST EFFECTIVENESS
• PREVIOUSLY, CLAIMS PROCESSING WAS MANUAL, INFORMAL—“STICKY NOTES”
• MOST ABUSE LOCAL, NEEDED LOCAL APPROACH

HISTORY OF CACs

• A MORE FORMAL AND DELIBERATIVE PROCESS
• STATE-BASED ADVISORY BODIES
• REPRESENTING ALL THE MAJOR SPECIALTIES
• WRITTEN POLICIES (LMRP)
• CACs AND LMRPs REQUIRED FOR PART B
• NO LEGISLATION
• REVISION TO SECTION 7500 OF THE CARRIER’S MANUAL
• TRANSMITAL 1497
• AUGUST 28, 1994
**HISTORY OF CACs**

- Advisors self-appointed by specialty groups
- Divergent experience from carrier to carrier
- Policies were local
- National discussions among CMDs
- Provisions of the Benefits Improvement and Protection Act of 2000 (BIPA)
- LMRP became LCD
- Rarely NCD

---

**HISTORY OF CACs**

- LCD determines coverage
  - Indications (ICD-9), frequency or intervals, CPT, limitations
- FDA approved, off label use, commonly used
- Rarely specify which specialist is eligible
- Not fees (RUC and MPFS)
- Not cost effectiveness
- Shepard Medicare resources, limit abuse
- Coverage depends on utility

---

**CACs AND UROLOGY**

- AUA national CAC members
- Represent state urology interests
- Broad discussions regarding indictions and coverage
- National insurance advisory committee
- Martin Dineen MD
- Lane Childs MD
NIAW
- REPORT AND SHARE EXPERIENCE
- PHONE CONFERENCES EVERY OTHER MONTH
- FACE TO FACE AT ANNUAL MEETING WITH LOCAL CMD
- REPORT TO AUA HEALTH POLICY COMMITTEE
  - RUC
  - CODING AND REIMBURSEMENT
  - AUA ADMINISTRATION SUPPORT
  - LOBBY PRIVATE PAYERS
  - AUA WHITE PAPER/ POLICY (BEER’S CRITERIA)

CAC MEMBERSHIP BENEFITS
- PERSONAL RELATIONSHIP WITH CMD
- OMBUDSMAN FOR UROLOGIST
- CREDIBILITY
- CONSULT AND INPUT TO LCD
- ADVANCED DISCUSSION AND CONSULT ON LCD
- COORDINATE WITH OTHER SPECIALTIES
  - RADIOLOGY
  - RADIATION ONCOLOGY
  - “THERE BUT FOR THE GRACE OF GOD GO I”

CAC ISSUES OVER THE YEARS
- BILATERAL ORCHIDECTOMY vs LHRH AGONISTS
- 12 OR 13 “MONTHS” IN A YEAR FOR LHRH AGONISTS
- CARVE OUT FOR TERTIARY SPECIALIST
- UDS
- BLADDER TUMOR MARKERS
- TURP (inpt or outpt)
CAC ISSUES OVER THE YEARS

- LOW T CLINICS (endocrinology)
- CRYOABLATION RCCa (w/ or w/o biopsy)
- E&M CODING CRITERIA AND DOCUMENTATION
- 2 NITE STAY RULE (entire CAC)
- CYBERKNIFE (radiation oncology)
- IMAGING CRITERIA (radiology)
- RECOVERY AUDITOR CONTRACTORS

CAC UROLOGY BENEFITS

- MEDICARE POLICIES DRIVE THE SYSTEM
- MEDICARE COVERAGE INFLUENCES PVT PAYERS
- DESIRE FOR CONFORMITY
- OUR SMALL VOICE IS MAGNIFIED NATIONALLY
- CMD WILL CALL FOR COVERAGE OR UTILIZATION QUESTIONS
- SUPPORT RAC AUDITS
- CMD ATTENDS SECTION MEETINGS FOR 1 ON 1
Risk Mitigation in the Integration of Electronic Medical Records

AACU Presentation: Stacey A. Cischke, JD

2015 AACU State Society Network State Advocacy Conference

- Impact on medical documentation
- Privacy and security concerns
- Regulatory obligations
- Impact on litigation
- Expense

Overview

- Charting overload
- Confusion during periods of transition
- More does not necessarily mean better
- Disconnect between live entry record and printed version
- General EMR vs. Specialty driven EMR
- Alteration in the standard of care
- Errors, inconsistencies, omissions

Documentation

EMR's: Friend or Foe?
Day 1 of Admit - PMH Documented

71 M w/ end stage COPD/CHF, p/w 4-5 worsening SOB w/ bilat edema, R>L
SOB and LE edema
COPD
ARF
h/o TB treated in 1990's

Day 3 of Admit Documented PMH

69 M w/ multiple recent ED visits for CHF exacerbation requiring IV diuresis, NICM, V-tach s/p AICD, HTN, colon CA, Pulm HTN, ETOH cirrhosis
1. CHF exacerbation
2. Penile lesion
3. Colon CA – no signs of active disease
4. ? Amyloid
5. CKD, unclear etiology

What’s in Play?

Information and facts that are relevant to any claim or defense of any party to the case:

a. indirectly relevant information: information or facts that could lead to the discovery of other admissible evidence
b. Non-privileged information
c. Scope of discovery has officially expanded to specifically include ESI
Ill Supreme Court Rule 201 (b)(4)

- Electronically Stored Information. ("ESI") shall include any writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations in any medium from which electronically stored information can be obtained either directly or, if necessary, after translation by the responding party into a reasonably usable form.

EMR Plus

- Examples:
  - Metadata (e.g. audit trail)
  - Medical Device Data (e.g. telemetry data, monitor data)
  - Policies and Procedures
  - Paging Data
  - Staff Coverage Schedules
  - Credential Files and Employment Files
  - Swipe Card/ID Badge Data
  - Surgeon Preference Data
  - Emails between providers and patients

Metadata

- Sedona Conference: “Data About the Data”
  - Tells the “Who,” “What,” “When” about electronic data.
  - Electronic evidence of the history, management and/or tracking of an electronically created document or record – “Electronic Footprint”.
Substantive: reflects substantive changes made by user (display of fonts, spacing) and remains with the document when moved.

Embedded: track changes, comments, formulas, hidden columns, external links.

System: Reflects information created by the information management system, such as author, date, time modification information.

Protective Order

ORDER

THIS CAUSE COMING on to be heard on Emergency Motion of plaintiff for Protective Order of Protection to preserve the evidence, the Court being fully advised in the premises;

IT IS HEREBY ORDERED that a Protective Order is entered to preserve any and all specimen blocks, slides, blood samples, tissue samples, fluid samples, MRIs, CTs, x-rays, metadata and all computer medical records and the paper medical records in their original forms.

Second Case Illustration: Metadata

- Metadata results in an expansion of the world of information now in play in lawsuits
- Patient presents to hospital with history of vomiting for several hours and epigastric pain
- Patient’s history significant for aortic valve replacement 1 year ago
- CT of abdomen questionable for splenic infarcts and patient is admitted
Day 3 of hospitalization patient begins spiking fevers
MD orders blood cultures “now”
Cultures never done and “NSR” entered into lab computer and results form
Lab audit trail shows the ordering MD viewed the lab results on the computer the next day
MD states in discharge summary that blood cultures were negative
**Bottom Line = blood cultures were not done before discharge and metadata says the MD was aware of this**

---

**Sample E-Discovery**

**Jones v. University Hospital**

1. State the database used to create, store, manage, maintain, record, and print the records of Michael Jones.
   **ANSWER:** Oracle.

2. State the applications used and manufacturer thereof, used for creating, storing, managing, maintaining, recording, editing, and printing the of the medical records of Michael Jones.
   **ANSWER:** Care Connections by Cerner and MR View by Cardone.

3. Does your information system comply with any national or proposed national standard for gathering, storage, preservation and/or retention of ESI in order to comply with HIPAA requirements? If so, state the national standard with which it complies.
   **ANSWER:** Said Interrogatory is vague as stated and not reasonably calculated to lead to the discovery of relevant information. Answering further, the EMR system is in compliance with the HITECH Act.

4. State the name of the individual(s) who was appointed data custodian, or the person who otherwise made efforts to gather or preserve ESI, once Defendant received service of plaintiff's complaint in this matter.
   **ANSWER:** Jane Johnson, Health Information Management Correspondence Clerk and Mary Smith, Manager, HIM.

5. Which specifically identifiable pieces of equipment were used to monitor and treat Michael Jones?
   **ANSWER:** Objection. Said interrogatory is overly vague and unduly burdensome. Mr. Jones was admitted to Large Teaching Hospital for several weeks and numerous pieces of equipment may have been used to monitor and treat the patient.
Impact of EMRs on Defense of Case: Lessons

- More data to disclose in discovery
  - absorption
  - navigation of data
  - questions of completeness
- Testimony is affected
  Credibility: stronger vs. weaker
  Defense theories may be expanded or constricted by what is available in the EMR

Know When to Hold ‘Em

- Issue: what, when, where does medical data have to be preserved?
- Not just the EMR
- Identifying “trigger” point is crucial—standard of reasonable anticipation
- Suspend routine data management practices

Litigation Hold Overview

- Patient Event
- Litigation Reasonably Anticipated?
  Yes: Trigger event and duty to preserve arises
  No: Follow routine data management practices
- Identify relevant information
- Suspend all routine data management practices
- Issue written litigation hold
UNIVERSITY HOSPITAL LITIGATION HOLD POLICY

SITE/LOCATION: Large Teaching Hospital; Affiliated Clinics
POLICY NUMBER: 0012
DATE: November 20, 2014
APPROVED BY: Office of Legal Affairs, Risk Management, HIM, Medical Records

POLICY:
In recognition of Large Teaching Hospital's (and affiliated clinics) obligation to preserve all patient information, regardless of format and location (hard copy or electronically/digitally), when litigation is reasonably anticipated, it is the policy and practice of Hospital and its affiliated clinics to reasonably and in good faith identify those events and/or circumstances, which may give rise to an obligation to preserve all identifiable medical information regarding a patient, including the suspension of any information management practices that would result in the loss, destruction or substantial alteration of such information.

SCOPE:
This policy applies to all Hospital and affiliated clinic employees, staff members, vendors, subcontractors and ancillary staff members who have access to patient information, electronic and otherwise. This policy shall apply to all forms of patient information, regardless of form in which it is stored (hard copy/electronic) and regardless of location and shall not be limited to only that information which is part of the formal patient chart.

PROCESS:
A. All employees, medical staff members, vendors, subcontractors and ancillary staff members shall report any patient events or circumstances, which may raise a concern for litigation to Hospital's Risk Management Department. Such reporting may be done in person or through Hospital's confidential online risk management tool.
B. Risk Management shall communicate any patient events and/or circumstances to the Office of Legal Affairs within 24 hours of notice.
C. The determination of whether litigation is Reasonably Anticipated and whether a Litigation Hold is warranted shall be made by the Office of Legal Affairs in collaboration with Risk Management and if warranted, any others deemed to have relevant knowledge regarding the relevant facts and circumstances.
D. If it is determined that a Litigation Hold is warranted, The Office of Legal Affairs shall issue a written Litigation Hold to all custodians of information and individuals with access to the patient's medical information, detailing:

- The patient by name and MR identifier;
- Dates of treatment involved;
- Information subject to the Hold;
- Instructions to suspend any and all data management practices with respect to the patient’s information;
- The identity of an e-discovery liaison or other individual(s) knowledgeable regarding the full body of information preserved, the format in which information is stored and the location of any and all preserved information.
E. All recipients of a Litigation Hold shall acknowledge receipt of the Litigation Hold in writing or via email to the Office of Legal Affairs within 24 hours of receipt.

F. The Office of Legal Affairs shall be responsible for continued communication regarding Litigation Holds, including, but not limited to relevant information regarding the progress of discovery, updates regarding additional information to preserve, and any changes to the ongoing duty to preserve.

H. The termination of a Litigation Hold shall issue in writing from the Office of Legal Affairs. Upon written notice of termination of Litigation Hold, routine data management practices shall resume.

- Have a practice and routine for the early investigation of events.
- A multidisciplinary approach goes far for good faith argument.
- Once trigger event is identified, issue hold and suspend all routine data management practices. Document same.
- Circulate the Litigation Hold in a reasonable fashion.
- Continue to monitor your Litigation Hold.
- Sticking to the process should get Hospital ready for the Rule 26 meet and greet and/or be positioned to answer e-discovery questions strategically and efficiently.

Questions?
Prescriptions and Medications in the Doctor's Office: The Physicians' Dilemma

Battling Insurance Authorization and Inadequate Cost Coverage

Discussion Topics

- How to break even on "Buy and Bill" medications
- Improving efficiency of the medication prescribing hurdles
- Opportunities for a retail service line through in-office dispensing

Why ASP+6% is a misnomer

- Volume discounts – buy low, sell high
- Zaltrap example – colon cancer drug introduced in 2012
  - Initial price set equivalent to average dosage of existing drug
  - Colon cancer required only half the average dosage
  - Oncologists at MSK boycotted so manufacturer cut price by 50%
  - Medicare ASP+6% formula is lagged by two quarters
  - Users of Zaltrap after the price cut made large spreads for six months
- What is the result if the opposite happens?
  - Consider Mitomycin example

- Why ASP+6% is a misnomer
Mitomycin ASP+6% history

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Drug</th>
<th>Units</th>
<th>Q1-2015</th>
<th>Q2-2015</th>
<th>Q3-2015</th>
<th>Q4-2015</th>
<th>% increase/yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9280</td>
<td>Mitomycin</td>
<td>5mg</td>
<td>$39.86</td>
<td>$65.85</td>
<td>$75.80</td>
<td>90.1%</td>
<td></td>
</tr>
</tbody>
</table>

Because of 2 quarter lag in formula, Mitomycin purchased in December 2014 showed loss of $26/5mg

Audience Discussion – Survival Tactics

- Join a Group Purchasing Organization
- Negotiate with vendor for long term pricing
- Shop the compounding pharmacy market
- Discuss referrals with hospitals or Federally Qualified Health Centers
- Engage in patient transparency
Pre-authorizing prescribed medications

- Retail price of brand name drugs increased by 13 percent in 2013
- Generic drug prices are falling at a slower rate than in the past AND 27 percent of generics had price increases in 2013
- Payers try to control outlays by placing more hoops in the path
  - High cost medications are often associated with patients with limited life spans
  - Advertised name brands are requested by patients when a generic will do
- Manufacturers seek approval for additional indications after FDA approves initial application (e.g., Cialis for BPH)

Audience Discussion – Survival Tactics

- Develop in-office expertise for particular drugs
  - Continuously update formulary information
  - Monitor and master the specific requirements (approval duration, approval criteria, quantity limits, etc.)
  - Create a one to one relationship with approving agency staff
- Leverage usage of electronic approval processes
- Stay up to date on pharma assistance programs
- Engage in patient transparency

In-office dispensing = boon or boondoggle

- Pros
  - Additional revenue – National Center for Health Statistics reports average of 1.4 prescriptions per patient visit
  - Patient convenience – avoid unfilled prescriptions reported to be 30% of new prescriptions
- Cons
  - Logistics – required inventory space and management software
  - Reduction of pharmacist cooperation in patient management
  - Reliance on internally maintained comprehensive drug lists
  - Variable state regulations to comply with

9/19/2015 AACU 8th Annual State Advocacy Conference
Typical In-Office Dispensing Operation

- Practice builds a generic formulary for commonly prescribed medications
- Practice contracts with a third-party packaging service
- Patients are charged the typical generic drug co-pay in cash
- No insurance filed

Audience Discussion – Survival Tactics

- Consult legal counsel for hurdles in your location
- Conduct a thorough analysis of the typical prescribing patterns and co-pays for your patients
- Analyze the enthusiasm of your providers and staff to identify candidates and effectively market the service
- As with other ancillaries, accept the inevitable profit reduction efforts by payers and the government
- Don't sign long term contracts with service contractors

Speaker’s Contact Information

- Rick Rutherford, CMPE
- Email: rruth1949@gmail.com

Simply drop me a line if you want a copy of these slides.

Thanks for your attention!
The slowest cost growth since 1960

Why we can’t predict future costs
1. The economy
2. The pace of technological change
3. Payment reforms
4. The effect of higher out-of-pocket costs
5. Narrow networks: Will they stick?
Most households face financial challenge

Source: Pew Charitable Trusts

Workers with $2,000+ deductible

Source: American Association of Colleges of Nursing, 2015

SELF-RATIONING

In the past 12 months, have you or another member living in your household ... because of the cost?

- Replied "yes" to any
- Relied on home remedies or OTCs instead of going to doctor
- Skipped dental care
- Put off or postponed getting care you needed
- Skipped recommended medical test or treatment
- Not filled prescription for medicine
- Cut pills in half or skipped dose
- Had problems getting mental health care

Patients wish doctors would discuss costs

Do you think your doctor should discuss the cost of recommended medical treatment with you ahead of time, or do you think that is necessary?

<table>
<thead>
<tr>
<th>Should discuss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not necessary</td>
</tr>
<tr>
<td>No opinion</td>
</tr>
</tbody>
</table>

Source: New York Times/CBS poll

Focus Groups Highlight that Many Patients Object to Clinicians’ Focusing on Costs

Would you favor or oppose a government-administered health insurance plan — something like the Medicare coverage that people 65 and older get — that would compete with private health insurance plans?

<table>
<thead>
<tr>
<th>Favor</th>
<th>Oppose</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>69%</td>
<td>34%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Would you favor or oppose a single-payer health care system, in which all Americans would get their health insurance from a government plan that is financed by taxes?

<table>
<thead>
<tr>
<th>Favor</th>
<th>Oppose</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>43%</td>
<td>50%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Source: New York Times/CBS poll
Trump’s sway on universal health care

[Barack Obama/Donald Trump] has praised the idea of universal health care. Do you agree or disagree with [Obama/Trump] about universal health care?

<table>
<thead>
<tr>
<th>Democrats</th>
<th>Republicans</th>
</tr>
</thead>
<tbody>
<tr>
<td>80</td>
<td>30</td>
</tr>
<tr>
<td>Agree with Obama</td>
<td>Agree with Trump</td>
</tr>
</tbody>
</table>

Source: HuffPost/YouGov

Physician advocacy

‘Quality care through science, education and advocacy’

Doctors protest legal constraints

HEALTH SPENDING AND GDP
National health expenditures as share of Gross Domestic Product, in percent

First-quarter lobbying by healthcare interest groups
($ in millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>American Hospital Association</th>
<th>American Medical Association</th>
<th>America’s Health Insurance Plans</th>
<th>PhRMA</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$4.32</td>
<td>$6.55</td>
<td>$2.70</td>
<td>$4.92</td>
</tr>
<tr>
<td>2015</td>
<td>$4.92</td>
<td>$7.01</td>
<td>$3.12</td>
<td>$6.43</td>
</tr>
</tbody>
</table>

Source: Senate Lobbying Disclosure Act Database
Advocacy expense, Q1 2015

FUTURE OF HEALTH SYSTEM
Q: Most physicians today are focused on their daily responsibilities and unsure where the health system will be or how they will fit into it three to five years from now.

Mostly disagree 5.6%
Somewhat disagree 5.6%
Somewhat agree 18.5%
Mostly agree 55.2%

Curbing drug costs, by party

ACA next steps, by party
Whither the independent physician?

**KEEPING THE PRACTICE**

Most physician practice owners want to stay independent

Not looking to sell: 58%

Considering selling: 21%

Actively looking to sell: 11%

Already sold/other: 10%

**Doctors by practice size, 1983 and 2014**

Source: AMA

**Physician profitability trends**

2014 Practice Profitability Index

**Negative impact factors**

2014 Practice Profitability Index
Independent practice alternatives

- IPAs
- Clinical integration
- Micropractices
- Concierge medicine
- Physician-owned groups

Disproportionate share hospital cuts

Obamacare narrow networks

FEELINGS ABOUT HEALTH REFORM

Q: How has passage of the Patient Protection and Affordable Care Act (PPACA/Health Reform) affected your feelings about the direction and future of healthcare in America?

- I am more positive: 18.5%
- My feelings have not changed: 22.2%
- I am less positive: 59.3%
Growing administrative burden

U.S. Employment Growth in Healthcare and All Other Industries, 2003Q1-2013Q1

Source: Brookings Institution

Warped health care labor market

Health care’s negative productivity

Spending on Health Insurance Administration per Capita, 2011
Adjusted for Differences in Cost of Living

* Source: OECD Health Data 2013.
Health Care in 2020

Speaker Presentation: Stephen Jacob, MPH, MA, MSBA

2015 AACU State Society Network
State Advocacy Conference

Health Care in 2020: Where Uncertain Reform, Bad Habits, Too Few Doctors, and Skyrocketing Costs Are Taking Us

Stephen Jacob, MPH, MA, MSBA
stevejacob@healthwriterandspeaker.com

Value of payer interactions

<table>
<thead>
<tr>
<th>Payer</th>
<th>United States ($)</th>
<th>Canada ($)</th>
<th>Canada costs with US salary ($)</th>
<th>Canada costs with US salary and US salary ratio ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physican</td>
<td>687,755 (467)</td>
<td>68,715 (1,734)</td>
<td>68,715 (1,734)</td>
<td>68,715 (1,734)</td>
</tr>
<tr>
<td>Medical staff</td>
<td>319,515 (903)</td>
<td>319,515 (903)</td>
<td>319,515 (903)</td>
<td>319,515 (903)</td>
</tr>
<tr>
<td>Medical administration</td>
<td>293,215 (631)</td>
<td>67,715 (415)</td>
<td>67,715 (415)</td>
<td>67,715 (415)</td>
</tr>
<tr>
<td>Total</td>
<td>620,485 (465)</td>
<td>668,955 (1,954)</td>
<td>668,955 (1,954)</td>
<td>668,955 (1,954)</td>
</tr>
</tbody>
</table>

Source: Health Affairs

Insurance Complexity and Restrictions Create Concerns for Patients and Doctors

Adults, 2013
Insurance did not cover as expected/spent a lot of time on paperwork in past year*

Primary care physicians, 2012
Insurance coverage restrictions pose major time concern**

The ACA: What’s Most/Least Popular?

Percent who say they feel ‘very favorable’ about each of the following health reform law elements:

- Repeal easy-to-understand plan summaries (46%)
- Gradually phase out Medicare ‘cost-shock’ (41%)
- Tax credits to small business (81%)
- ‘Obamacare’ law favored by most respondents (48%)
- 2010 medical loss ratio (43%)
- No cost sharing for preventative services (81%)
- Medical error (83%)
- Increase Medicare payroll tax or upper income (10%)
- ‘Obamacare’ provisions for high-risk (8%)
- Individual mandate/penalty (85%)

Source: Kaiser Family Foundation

ObamaCare’s ‘Tower of Red Tape’
Megamergers

Value-based reimbursement

Value based care is spreading quickly

Medicare value-based goals
**Shared risk**

Shifting Risk and Accountability to Providers

Providing an Incentive to Remake the Delivery System

**Global capitation: Provider at total risk**

Where the burden of risk lies in the reimbursement system

Risk of the payer side

Free for Service

Global budget and population

A myriad of systems in between

Single, easy to administer

Consistent, accountable

set of incentives

Source: K. Kramer analysis

**Bearish outlook on Wall Street**

Moody's Investors Service

**ACO patient growth**

Change in All-Cause 30-Day Hospital Readmission Rates

<table>
<thead>
<tr>
<th>Percent</th>
<th>Jan-10</th>
<th>Jan-11</th>
<th>Jan-12</th>
<th>Jan-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Patrick Conway, Office of Information Products and Data Analytics, Centers for Medicare and Medicaid Services.

**Providers Are Largely Negative About Increased Use of Quality Metrics to Assess Provider Performance**

Do you think the increased use of quality metrics to assess provider performance is having a positive, negative, or no impact on primary care providers’ ability to provide quality care to their patients?

<table>
<thead>
<tr>
<th>Providers</th>
<th>Not sure</th>
<th>Negative</th>
<th>No impact</th>
<th>Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>10%</td>
<td>50%</td>
<td>17%</td>
<td>22%</td>
</tr>
<tr>
<td>Among those receiving incentive payments based on quality of care</td>
<td>6%</td>
<td>56%</td>
<td>15%</td>
<td>28%</td>
</tr>
<tr>
<td>Among those receiving such incentive payments</td>
<td>13%</td>
<td>90%</td>
<td>16%</td>
<td>17%</td>
</tr>
</tbody>
</table>

**Nurse practitioners/Physician assistants**

<table>
<thead>
<tr>
<th>Providers</th>
<th>Not sure</th>
<th>Negative</th>
<th>No impact</th>
<th>Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>22%</td>
<td>38%</td>
<td>12%</td>
<td>27%</td>
</tr>
<tr>
<td>Among those receiving incentive payments based on quality of care</td>
<td>14%</td>
<td>41%</td>
<td>10%</td>
<td>35%</td>
</tr>
<tr>
<td>Among those receiving such incentive payments</td>
<td>25%</td>
<td>36%</td>
<td>13%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Source: The Commonwealth Fund/Kaiser Family Foundation 2015 National Survey of Primary Care Providers.
Other frequent criticisms of value-based care

- Incentives are weak
- Payments are not targeted
- It’s not about motivation

Quality’s ‘Tower of Babel’

Some predictions

- Two-tier health-care system
- Universal coverage possibly with all-payer rates
- Fee-for-service replace by something (TBD)
- Income expectations moderated
- Hospitals that shouldn’t exist, won’t
- Doctors will work for large well-managed independent groups and/or health systems
- Health systems will consolidate, limit services

Source: Kaufman Strategic Advisors LLC

Some predictions

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- Universal coverage possibly with all-payer rates
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Source: Kaufman Strategic Advisors LLC

Steve Jacob contact information

- steve@unitedstatesofhealth.com
- (817) 605-0931
- Back of your business card: “eBook” means you want a free copy of How Health Reform Affects Texas; “Speak” means you would like to talk to me about addressing another group

Questions?
Upon research, we found practices were devoting almost 20 hours a week on prior authorization – taking time away from patient care and valuable resources away from the business.

PRESCRIPTION PRIOR AUTHORIZATION REFORM
Focused Activities

MSV helped develop legislation to provide increased efficiency, transparency, and uniformity. We also secured language that required these reforms apply to Medicaid Managed Care.

HB 1942
SB 1262

Legislative Success!

Gov. Terry McAuliffe signed both bills on March 23.

The laws went into effect on July 1.

Primary Physician Impacts

- **Urgency** – Requires a 24-hour turnaround on prior authorization requests for urgent medical needs

- **Timely response** – Establishes a deadline of two business days for health plans to act on a prior authorization request

- **Interoperability** – Requires health plans to accept electronic prescription prior authorizations that can be transmitted by electronic medical record, e-prescribing, or health information exchange.
Other Impacts

**Accountability** – Health plans must provide a reason for denials.

**Stability** – Requires health plans to honor an approved prior authorization from a patient’s previous health plan within a specific timeframe.

**Transparency** – All prior authorization forms and information must be located in one place on the health plan’s website.

Future Impacts

**Continues the conversation** – Requires health plans to participate in a workgroup with physicians. MSV staff has already met with health plan representatives to discuss data collection and future conversations pursuant to the legislation.

An extraordinary team effort

MSV did not succeed on its own. We partnered with the Virginia Academy of Family Physicians (VAFP) from the beginning. MSV also assembled a coalition of health care organizations to support these efforts, recognizing the power of working together.
Prescription Prior Authorization Coalition

American Academy of Pediatrics, VA Chapter
American Cancer Society Cancer Action Network
American College of Physicians, VA Chapter
American College of Radiology, VA Chapter
American College of Surgeons, VA Chapter
American Congress of Obstetricians and Gynecologists, VA Section
American Heart Association
EPIC Pharmacies Inc.
Lupus Foundation of America, DC/MD/VA
Medical Society of Northern Virginia
Medical Society of Virginia
National Alliance on Mental Illness in Virginia
Patient Services Inc.
Psychiatric Society of Virginia
Richmond Academy of Medicine
Riverside Medical Group
Virginia Academy of Family Physicians
Virginia Academy of Physician Assistants
Virginia Academy of Sleep Medicine
Virginia Chapter of the National Multiple Sclerosis Society
Virginia College of Emergency Physicians
Virginia Community Healthcare Association
Virginia Council of Nurse Practitioners
Virginia Medical Group Management Association
Virginia Nurses Association
Virginia Optometric Association
Virginia Orthopaedic Society
Virginia Urological Society
Virginia Pharmacists Association
Virginia Society of Eye Physicians and Surgeons
Virginia Society of Health-System Pharmacists
Virginia Society of Otolaryngology

Attracting support
We executed a multi-channel communications plan to ensure our position was known and understood

• Press releases
• Op Eds
• Regional letters to the editor
• Press call
• Press conference

MSV White Coats on Call
We couldn’t have done it without you!

We couldn’t have done it without you!
Looking to 2016 and beyond
We look forward to finding new opportunities to partner and achieve new successes.
AMA Economic Impact Study

Advocacy Resource Center tools:
- Model bills, issue briefs, talking points, testimony, letters, trend tracking, behind the scenes analysis and support
- Geographic Mapping Initiative
- Health Workforce Mapper
- National Managed Care Contract
- Scope of Practice Data Series Modules
- Economic Impact Study

Beyond their role of safeguarding a healthy community and a productive work force, physicians have a huge positive impact on the national and state economies, as demonstrated in a recent American Medical Association study that was completed in conjunction with state medical associations.

www.ama-assn.org/go/eis
AMA Economic Impact Study: Data

Data Sources
- 2012 AMA Masterfile
- 2012 MGMA Cost Survey
- 2011 IMPLAN

Measures
- Output
- Jobs
- Wages and benefits
- State and local tax revenue

Regions
- Each of the 50 states and the District of Columbia
- National

Specialties
- Anesthesiology
- Cardiology
- Family medicine
- General surgery
- Internal medicine
- Obstetrics/Gynecology
- Orthopaedic surgery
- Otolaryngology
- Pediatrics
- Urology

View the reports at www.ama-assn.org/go/eis

AMA Economic Impact Study: National Results and Comparator Industries

<table>
<thead>
<tr>
<th>Economic Measure</th>
<th>Total</th>
<th>Per Physician</th>
</tr>
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<tbody>
<tr>
<td>Output ($ in billions)</td>
<td>$1.6 trillion</td>
<td>$2.2 million</td>
</tr>
<tr>
<td>Jobs</td>
<td>9.9 million</td>
<td>13.84</td>
</tr>
<tr>
<td>Wages &amp; Benefits ($ in billions)</td>
<td>$775.5 billion</td>
<td>$5.1 million</td>
</tr>
<tr>
<td>State &amp; Local Tax Revenue ($ in billions)</td>
<td>$65.2 billion</td>
<td>$93,449</td>
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</table>

<table>
<thead>
<tr>
<th>Industry</th>
<th>Output ($ in billions)</th>
<th>Jobs</th>
<th>Wages &amp; Benefits ($ in billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care Physicians</td>
<td>$1,581.6</td>
<td>9,968,342</td>
<td>$775.5</td>
</tr>
<tr>
<td>Higher Education</td>
<td>$583.1</td>
<td>3,843,986</td>
<td>$206.9</td>
</tr>
<tr>
<td>Nursing Home/Residential Care Facilities</td>
<td>$491.2</td>
<td>5,283,484</td>
<td>$200.6</td>
</tr>
<tr>
<td>Legal Services</td>
<td>$583.1</td>
<td>3,843,986</td>
<td>$206.9</td>
</tr>
<tr>
<td>Home Health</td>
<td>$180.8</td>
<td>2,173,800</td>
<td>$75.2</td>
</tr>
</tbody>
</table>

AMA Economic Impact Study: Urology Data

Total Economic Impact of Urologists in California
- Number of Physicians: 1,216
- Output ($ in millions): $2,757.7
- Jobs: 16,526
- Wages & Benefits ($ in millions): $1,386.5

Total Economic Impact of Urologists in Illinois
- Number of Physicians: 450
- Output ($ in millions): $932
- Jobs: 5,899
- Wages & Benefits ($ in millions): $472.3
AMA Economic Impact Study: Data Driven Advocacy

- Given the changing health care environment, it's crucial to show that physicians are vital economic drivers at state and national levels.
- Advocates can incorporate the AMA Economic Impact Study data in:
  - Issue briefs
  - Bill memos
  - Speeches
  - Talking points
  - Candidate surveys
  - Email action alerts
- Now you can use these data to quantify the importance of issues such as:
  - GME funding
  - Workforce development
  - Physician reimbursement
  - Business issues
  - Medical liability reform
  - Medicaid reform
  - GME funding
  - Workforce development
  - Physician reimbursement
  - Business issues
  - Medical liability reform
  - Medicaid reform
  - Business issues
  - Medical liability reform
  - Medicaid reform

AMA Economic Impact Study: Key Messages

“Physicians support the health of their local and state economies through the creation of jobs with their related wages and benefits, the purchase of goods and services, and support of state and local tax revenue.”

“Creating an environment which would attract new and retain existing physicians to meet expanding healthcare demands will also have the added benefit of increasing the number of good jobs in your state and improving the health of the local economy.”

Annalia Michelman, Senior Legislative Attorney
Advocacy Resource Center
annalia.michelman@ama-assn.org

View the AMA Economic Impact Study at www.ama-assn.org/go/eis
How to Maintain Your Independent Practice: Experiences of Our Private/Academic/Hospital Employed/Private Practice!

Michael D. Fabrizio MD FACS
Professor of Urology
Eastern Virginia Medical School
Urology of Virginia, CEO

Dana Adams, MSA
Urology of Virginia, CEO

Physicians Foundation Survey

- 630,000 email addresses representing 84% of the 750,000 physicians practicing in the U.S.
- Received 13,575 responses
- Over 72% of all practicing physicians in the USA are over 40 years of age. Average age of respondents in this survey was 54 (average age of the AMA listed physicians is 49.22).
- The Physicians Foundations is a 501c3 seeking to advance the work of practicing physicians. Comprised of numerous medical societies.
  - Physicians Foundation Survey by Merritt Hawkins, 2012
Survey
Some physicians believe that the medical profession is in decline, do you?
Mostly agree 41.6%
Somewhat agree 42.6%
Somewhat disagree 8.6%
Mostly disagree 7.2%

Survey
Hospital Employment of Physicians is a positive trend likely to enhance quality of care and decrease cost?
Mostly agree 4.6%
Somewhat agree 19.9%
Somewhat disagree 32.8%
Mostly disagree 42.7%

Summary
• Physicians spend over 22 percent of their time on non-clinical paperwork.
• 53% of physicians have limited access to Medicare patients and 26% closed their practices to Medicaid patients
• Over 92% of physicians are unsure where the health system will be or how they will fit into it in three to five years.
  – Merritt Hawkins Survey for the Physician foundation

Is it really that bad?
• Perhaps not……

Urology
• 270 new urologists produced a year.
• Roughly 8500 still practicing
• About 550 retiring annually and rising
• Several hundred hospitals without coverage this year!
• Rising patient population
• More complex procedures
• More complex treatment algorithms
• JOB SECURITY

Urology of Virginia
• 30 urologists in 2015.
• Started with the Devine family in the 1930’s.
• 1960’s developed world re-known reconstruction program
• 1972 –Dr Paul Schellhammer and started the residency program and Dr Gerald Jordan started fellowship program in GU reconstruction.
• 1997- consolidation of 8 groups into Urology of Virginia
• 2008- joined Sentara Health system
• 2011- left the health system – reestablished Urology of Virginia.
Urology of Virginia

• All sub-specialties covered.
• Research division – 30 clinical trials and growing
• PT, UDS, renal US, plain film imaging, specialty pharmacy, pathology lab with fellowship trained pathologist.
• 6 physician extenders
• Several scribes
• EHR – Epic
• Full-time faculty of EVMS – 8 residents, 2 fellowships
• I have been the managing partner since 2008. Prior to that was Steve Schlossberg.

Why Did We Enter a Health System

• Fear of things to come.
• Reimbursement going down for office and ancillary services
• Increased regulation
• Increased cost to practice
• EHR fears
• Administrative pressures resulting from healthcare changes.
• Ideas / Delusions of Grandeur !
  — Could recruit, expand, grow service lines, use data to negotiate better contracts, improve our Top 50 US News and World Report ranking, share in service line growth, etc.

Regulations: A Lot to Maintain and Manage

• HIPAA, HITECH & Security
• OSHA
• HR regulations: EEOC, ADA, ERISA
• Compliance: Stark, Anti-kick back, False Claims Act, FTC

EHR Hurdles:

• Meaningful Use
  — Is it really meaningful?
  — Limited measures for urology
  — Can you keep up the pace with increasing difficulty of stages?
  — Rules can change!
  — Switches from payment to penalty
  — Where will it end?

EHR Hurdles

• PQRS and Value Based Modifier (VBM)
  — Must have successful PQRS to meet VBM
  — VBM assesses quality of care and cost of providing care
  — Risk adjustments
  — Quality: 17 measures based on PQRS reporting
  — Cost:
    • Patient attributed to you if you provided the most primary care services based on Medicare allowables.
    • Costs for patient may come from providers outside your practice and come from Part A and Part B.
• Composite score of both quality and cost
• Score puts you into quality tiering category

Quality Tiering 2016
Groups >10 but <100

<table>
<thead>
<tr>
<th></th>
<th>Low Cost</th>
<th>Average Cost</th>
<th>High Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Quality</td>
<td>+2.0x</td>
<td>+1.0x</td>
<td>+0.0x</td>
</tr>
<tr>
<td>Medium Quality</td>
<td>+1.0x</td>
<td>+0.0x</td>
<td>+0.0x</td>
</tr>
<tr>
<td>Low Quality</td>
<td>+0.0x</td>
<td>+0.0x</td>
<td>+0.0x</td>
</tr>
</tbody>
</table>
Contract Considerations

- Length of contract
- Productivity terms
- Power to control aspects of practice
  - Where to practice
  - How many staff/FTE
  - Setting templates
  - Referrals
- Goals
- Financial viability of hospital system

Contract Considerations

- Exit strategy – very important
- What are your responsibilities in the health system
- Overall governance

Mechanics of Contract

- Large single system threatened to hire their own urologist in 2006– 8 joined as they shared called on the Peninsula.
- Sentara Health System – hired the other 26 of us.
- 12 months to negotiate the contract.
- Signing bonus
- Buying assets
- RVU and expense contract – threshold.
  - Maintain incoming RVU’s
  - Not greater than 5% increase in expenses

Mechanics of Contract

- Most importantly, we controlled the pool of dollars to pay our salaries – unique concept. Determined our total compensation pool prior to entering the system.
- Able to distribute using our compensation plan
- Point of contention which grew as the number of doctors decreased, the pool remained the same, and the WRVU threshold was maintained. Could not hire....
- Expenses- things cost more in a health system.
- Exit clause

How Well Do Health Systems Manage Physician Practices

- Dean, Dorton, Allen, and Ford
  Healthcare consulting survey.
41% of all respondents reported a loss

87% of all respondents reported a loss

41% of All Respondents Reported that their average annual loss for hospital-owned physicians groups is greater than $100,000.

When it came to losses...

• The size of the hospital didn’t matter
• The more physicians employed, the more likely operating losses became
• Hospitals reported that physician groups operating as separate legal entities had the highest losses
• Length of contracts did not impact results

Some other stats from the study

• Less than a quarter of respondents reported that their hospital had a unique board of directors that oversaw the operations of the physician group(s)
• 69% of the respondents reported utilizing productivity based compensation measured by RVUs
  o 67% of hospitals using RVU-based compensation also experienced the highest losses

Compensation models

• The model needs to incentivize patient encounters and the payer mix; physicians work harder and smarter with correct productivity goals (NO MENTION OF QUALITY).
• Negotiated compensation is not realistic to actual market forces; minimum base is too high, productivity incentives are too rich, or additional non-productivity compensation builds up.

Successfully employing physicians – is this offensive?

Problems with Acquisitions

• Misaligned goals usually surrounding revenue opportunities and cultures.
• Office based procedures/ASC provide $ for physicians while decreasing dollars for health systems.
• Joint efforts are required to control cost: length of stay, supply cost, upgrading to JHCO standards, etc but Stark regulations prevent physicians from directly sharing in those efforts.
• Provider based billing allows hospitals to charge Medicare patients for physician services(E/M) as well as building facility overhead. Patients now have 2 copays/deductibles to meet. $25 copay for E/M and usually 20% copay for the facility fee. Applies to any office within 35 miles.
How to Maintain Your Independent Practice

Problems with Acquisitions

- Stark Law, 42 U.S.C. – “bona fide employment must be compensated with at fair market value.”
- FMV’s are replete with errors including lack of baseline respondents, poor income data, lack of understanding of revenue streams.
- Avoidance of payments based on volume for value of referrals.
- Contracts are typically short and often revised. Limited in compensation and in your ability to augment income/revenue. Little control of expenses.
- Usually cannot participate in service line revenue – all the ancillary income you produce for the hospital.

Cost of Acquisitions – Society

- At the current rate, provider based billing shifts will increase Medicare spending by 2 billion dollars/year and beneficiary payouts by 500 million. 2011, Medpac.

Employed Versus Independent?

- Lifestyle – work hours and the “new generation”
- Debt
- Call coverage – In large group – less call overall
  – May have more facilities
- Administrative issues
- Are you new to the area or established? It makes a difference
  – Selling practice – established patients – will they go with you? Are they willing to accept hire fees? (provider based billing, increased procedure cost/labs)
  – are they a closed system?

Our Strategy

- Keep Everyone Happy
  - You want to offer all services short of employment.
  - Cover their facilities
  - Make a concerted effort to keep revenue and referrals in their system
  - Improve quality
  - Convince the system that is already nervous about hiring specialists that owning the practice will not achieve their goals or at least be a more expensive way to do so.
  - Exiting an employed position is not a “death sentence.”
  - You will still have a job!

Ideas for Staying Independent

- Mergers
  - Same specialty
  - Multi-specialty groups
- S.W.O.T analysis – strengths, weakness, opportunities, threats.
  - A good strategic review
- Think outside the box
  - Nonmedical revenue producing opportunities
  - Augmenting ancillaries
  - Getting paid for work you are already doing.
  - efficiency
### How to Align and Not Be Employed

- Adhere to a common vision – outlined contractually.
- Avoid mutual assured destruction.
- Leadership roles – getting paid to manage.
- Practice/performance management agreements
- Quality and safety goals - getting paid to improve.
- Strategic alignments
  - Joint Ventures
  - Centers of Excellence
  - Staffing Models
  - Co-directorships
- Referrals stay in system (OR cases, etc).

### Urology of Virginia Plan

- Consolidation of offices: 12 to 5.
- Bought a centralized office – 45,000 sq feet
- Started a process to own our offices.
- Virginia is a COPN state for OR’s, imaging, and radiation therapy.
- Hospitals fear losing revenue and their margins.
- Suggested that a local health system move an underutilized OR to our site. They applied for a COPN transfer of an existing OR on their campus.

### Our Plan – Real Estate

- They were approved for the transfer. We mutually agreed to a FMV for the lease of the ASC. Signed a lease and started construction.
- Second 45,000 sq foot building with a hospital-owned ASC on our campus.
- Applied for a COPN transfer of their local imaging center – approved. Hospital had an imaging partner and the deal fell apart.
- Alternative and probably better strategy – independent imaging center in Hampton Roads.

### Our Plan – Real Estate

- First floor imaging center – will provide CT Abd/Pelvis for 75 dollars and $125 for MRI pelvis if carrier does not cover service. Lowest cost alternative in Hampton Roads. Lower than deductibles for most insurance plans.
- Another building being planned with a large health system complete with hospital based services on one floor.
- REIT

### Our Plan – Management Agreements

- Four practice management agreements (PMA’s) in place with 4 different health systems.
- Varying responsibilities
  - Call coverage or hospital coverage agreements
  - Supply cost management
  - Quality committee
  - Management committee
  - Outcomes management
  - New technology
  - Radiation program

### Our Plan – Management Agreements

- Larger Health System Agreements – pay for quality!
  - DVT/PE
  - Readmission
  - UTI
  - Accidental punctures
  - Overall complications
- We established internal baselines
- Compared our data (their data) to large regional programs
- Paid to maintain or improve.
EHR

- Most practices have one at this point
- Expensive
- Variety of different systems.
- Epic may penetrate 60-70% of hospital systems
- The U.S. Department of Health and Human Services Office of the Inspector General (OIG) and the Centers for Medicare and Medicaid Services (CMS) issued final rules revising and extending, through 2021, the Stark Law exception and fraud and abuse safe harbor permitting physicians to accept electronic health record (EHR) donations. (HHS, 2013)

<table>
<thead>
<tr>
<th></th>
<th>First payment received in 2011</th>
<th>Received in 2012</th>
<th>Received in 2013</th>
<th>Received in 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment amount in 2011</td>
<td>$18,000</td>
<td>$12,000</td>
<td>$18,000</td>
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<tr>
<td>Amount in 2012</td>
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<td>$14,700</td>
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<tr>
<td>Amount in 2013</td>
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<td>Amount in 2014</td>
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<td>$7,840</td>
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<tr>
<td>Amount in 2015</td>
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<td>$3,920</td>
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<tr>
<td>Amount in 2016</td>
<td>$1,960</td>
<td>$3,920</td>
<td>$3,920</td>
<td>$3,920</td>
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<tr>
<td>TOTAL</td>
<td>$43,720</td>
<td>$43,480</td>
<td>$38,220</td>
<td>$23,520</td>
</tr>
</tbody>
</table>

Specialty Pharmacy

- Dispensing oral oncolytics
  - Xtandi
  - Zytiga
- Rank ligand inhibitors
- Better care for the patient
- Tracking
- Assure labs are ordered
- Assure that the patient if getting the RX and the continued counseling required.
- Group purchasing organizations – UroGpo.
- Software to track changes.

Research

- The perfect way to align patient care, quality, market differentiation, and revenue
- Large research consortiums – CUSP group
- Pharma trials
- Ability to offer therapies not available otherwise or not available in early phases of disease.
- Differentiates your practice from many other practices.

Other Opportunities

- Lab
- Physical therapy
- Ultrasound – in house. AIUS certification
- Imaging – depending on COPN
- Urodynamics
- Pelvic health programs
- Insurance captives – insuring risk under section 831b of the IRS code.
**Relevant Facts**

- Captives have been prevalent in the US for over half of a century.
- More than 35 states and 35 countries currently serve as domiciles for captive insurance companies.
- Over 90% of Fortune 1000 companies utilize a captive insurance company.
- The IRS provides specific Internal Revenue Code Sections and Revenue Rulings that serve as “safe harbors” for small business owners;
- Worldwide captive market exceeds $200 billion in annual insurance premiums.

**Potential Tax Benefits**

- **Tax Treatment of the Captive**
  - 831(b) - Operating profit from premiums paid to small captive insurance companies are tax exempt up to $1.2 million per year
  - Retain investment control on accumulated surplus from tax free underwriting profits
  - 70% Dividend Received Deduction
  - Offshore captives can file 953d election; avoids FET and state premium tax
- **Tax Treatment of the Insured**
  - Operating business can deduct the payment of insurance premium expense under IRC 162
  - Building company reserves for the payment of future loss obligation in a non-insurance manner is not deductible
- Under the new tax rates scheduled, the above can result in $450,000 to $510,000 in savings on annual income tax alone.
- *If captive is not structured properly, none of the above applies.

**Clinically Integrated Network**

- Virginia Association of Independent Physicians
- Group of specialist
- Creating a primary care backbone
- The two entities that will control payments in the future are INSURERS AND HEALTH SYSTEMS
- We have approached two large health insurers and are in the process of creating a health plan co-owned by the physicians.

**Algorithms**

- Standardize care in many disease states.
- BPH, prostate cancer, urinary incontinence, stone disease for example.
- Know your cost of managing each disease – bundled payments are upon us.
- Clinical guidelines - Lithotripsy

**Conclusion**

- Benefits and risk to each model
- **Hospital employment**
  - Benefits - Handle all aspects of your practice: HR, finance, regulatory, facilities, etc. Built in referral system in competitive markets.
  - Risk – maintaining your compensation model and expenses.
    - Loss of autonomy / control
    - Living in the bureaucratic system
    - different goals – change the character of the group. If group culture is important, employment will change that culture.
Conclusion

- Independent practice
- Benefits
  - Autonomy/control
  - Many options for your practice
  - Program opportunities
  - Increasing demand – better opportunities.
- Risk
  - Increasing regulations, bundled payments, revenue reductions (lab, pathology, E/M etc), highly compensated management positions, competition.
Context

- Maine: 1.3 million population
- #1 Oldest state in USA (Mean 43.6 yrs)
- #2 Incidence of bladder cancer
- #8 in overall cancer incidence
- #4 in Medicaid spending per capita 2009

Context

- 1989 there were 45 urologists in Maine
- By 2005, there were 33 (est 51 needed)
- Currently 57
- > 80% of PCP’s employed
- > 50% of specialists employed
- > 80% of Urologists employed
Why employment a necessity?

- Could not compete with hospitals for MD
- Increased overhead and loss of 2/7 MD
- EMR meaningful use
- Largest practice in state/ ED coverage
- Decreased Medicaid $ and SGR worries
- Unable to negotiate with 3rd party payers
- NP expectations
- Had a CT, unwilling to expand ancillaries

Advantages

- Income security
- Stronger recruitment effort
- Residency program started 2009
- Protected administrative time
- Provider-based reimbursement
- Payment reforms/ Quality metrics

Disadvantages

- LOSS OF AUTONOMY
- LOSS OF CONTROL OVER STAFF
- INEFFECTIVE AND BUREAUCRATIC
- LACK OF SUPPORT FOR EMR ROLLOUT
- HIGHER COSTS FOR PATIENTS
- LACK OF ADMINISTRATIVE SUPPORT
Employment Contracts

- No contract/ employee at will?
- Provisions with negative consequences:
  - Restrictive covenants
  - Pay for insurance tail coverage
  - Termination without cause
  - Indemnification provisions
  - Productivity based compensation
  - Little control over staffing and scheduling

Bottom Line

- Can be successful and satisfying IF:
  1) Respected by hospital
  2) Share a common culture and goals
  3) Valued for our education
  4) Valued for our training
  5) Valued for our experience

Conclusions

- Professional satisfaction is NOT determined by one issue
- It is the Culture and not the money that matters the most for the experienced urologist
Washington shouldn’t decide whether or not a man has access to prostate cancer testing.

The decision to test for prostate cancer is one best made between a man and his doctor. How can you answer his questions about prostate cancer if Washington tells him not to ask them?

UROPAC shares this message with lawmakers.
SAVE the DATE

11th Annual

UROLOGY JOINT ADVOCACY CONFERENCE

February 28 – March 1, 2016

New Location!
The Willard Intercontinental Hotel
Washington, DC

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