American Association of Clinical Urologists
9th Annual State Society Network Advocacy Conference
August 19 – 20, 2016
The Westin O’Hare
Rosemont, Illinois

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The AACU and WJ Weiser & Associates are committed to making the 2016 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  
2015 – 2016 Board of Directors

### OFFICERS

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<tr>
<th>Position</th>
<th>Name</th>
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<tr>
<td>President</td>
<td>Martin K. Dineen, MD</td>
<td>Daytona Beach, FL</td>
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<td>President-Elect</td>
<td>Charles A. McWilliams, MD</td>
<td>Oklahoma City, OK</td>
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<td>Secretary/Treasurer</td>
<td>Mark T. Edney, MD</td>
<td>Salisbury, MD</td>
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<td>Health Policy Chair</td>
<td>Jeffrey M. Frankel, MD</td>
<td>Seattle, WA</td>
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<td>Immediate Past President</td>
<td>Mark D. Stovisky, MD, MBA, FACS</td>
<td>Cleveland, OH</td>
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<td>State Society Network Chair</td>
<td>Patrick H. McKenna, MD, FAAP, FACS</td>
<td>Madison, WI</td>
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### SECTION REPRESENTATIVES

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<tr>
<td>Mid-Atlantic</td>
<td>Mark L. Fallick, MD</td>
<td>Voorhees, NJ</td>
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<td>New England</td>
<td>Kevin R. Loughlin, MD</td>
<td>Boston, MA</td>
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<td>New York</td>
<td>Elliott R. Lieberman, MD</td>
<td>Plainview, NY</td>
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<tr>
<td>North Central</td>
<td>Peter M. Knapp Jr., MD, FACS</td>
<td>Carmel, IN</td>
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<tr>
<td>Northeastern</td>
<td>Kevin J. Barlog, MD</td>
<td>Cheektowaga, NY</td>
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<tr>
<td>South Central</td>
<td>Damara L. Kaplan, PhD, MD</td>
<td>Albuquerque, NM</td>
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<tr>
<td>Southeastern</td>
<td>Jonathan Henderson, MD</td>
<td>Shreveport, LA</td>
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<tr>
<td>Western</td>
<td>Eugene Y. Rhee, MD, MBA</td>
<td>San Diego, CA</td>
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### REPRESENTATIVES TO AFFILIATED ORGANIZATIONS

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<th>Organization</th>
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<tr>
<td>UROPAC President</td>
<td>Arthur E. Tarantino, MD</td>
<td>Hartford, CT</td>
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<td>AMA Delegate</td>
<td>Richard S. Pelman, MD</td>
<td>Seattle, WA</td>
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<tr>
<td>Executive Director</td>
<td>Wendy J. Weiser</td>
<td>Schaumburg, IL</td>
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August 19, 2016

Welcome!

After nearly a year of planning and preparation, we are thrilled to welcome you to the 9th Annual AACU State Society Network Advocacy Conference. Our program this year is structured to give you not only an overview of the complex issues we face as urologists but also to address the needs of independent physicians, the employed and those in academic urology. We hope you can leave with a better grasp on the challenges we all face and renewed relationships that will facilitate working solutions to those challenges.

The informative agenda addresses urology advocacy, current socioeconomic issues and technological innovations that are 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 over the next 24 hours 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 Patrick H. McKenna, MD, Chair, AACU State Society Network and Charles A. McWilliams, MD, Vice Chair and President-elect AACU. President Martin K. Dineen, MD, and, finally, we appreciate 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 9th Annual AACU State Society Network Advocacy Conference a valuable investment of your time.

Sincerely,

Patrick H. McKenna, MD, FAAP, FACS
Chair, AACU State Society Network

Charles A. McWilliams, MD
Vice Chair, AACU State Society Network
President-Elect, AACU
All sessions will be located in the *Michigan Ballroom* unless otherwise noted.

**FRIDAY, AUGUST 19, 2016**

6:15 p.m.  Ground Transportation to Welcome Reception and AACU Annual Dinner Departs  
*Location: Hotel Lobby*

6:30 p.m. - 9:00 p.m.  Welcome Reception and AACU Annual Dinner  
*Location: Gibson's Steakhouse, Rosemont, IL*

**Welcoming Remarks**
Program Chair:  Patrick H. McKenna, MD, FAAP, FACS  
Chair, AACU State Society Network  
*Madison, WI*

**AACU Distinguished Leadership Award Presentation**
Recipient:  John M. O'Bannon, III, MD  
Delegate, Virginia General Assembly  
*Richmond, VA*

**SATURDAY, AUGUST 20, 2016**

7:00 a.m. - 8:00 a.m.  Industry Sponsored Breakfast – “Key Clinical Findings for Patients with mCRPC Who Have Progressed on an Androgen Deprivation”  
*Sponsor:  Janssen*

Speaker:  William K. Johnston, III, MD  
Michigan Institute of Urology Associate Professor - Beaumont School of Medicine  
*Novi, Michigan*

8:00 a.m. - 9:00 a.m.  Presidents’ Forum - Views on State Advocacy from Urology's National Organizations  
*Moderator:  Patrick H. McKenna, MD, FAAP, FACS*  
Chair, AACU State Society Network  
*Madison, WI*

Panelists:  Richard K. Babayan, MD  
President, American Urological Association  
*Boston, MA*

Martin K. Dineen, MD  
President, American Association of Clinical Urologists  
*Daytona Beach, FL*

Deepak A. Kapoor, MD  
Health Policy Chair, LUGPA (On behalf of President Gary M. Kirsh, MD)  
*Melville, NY*

8:50 a.m. - 9:00 a.m.  UROPAC Update  
*Speaker:  Jeffrey M. Frankel, MD*  
Vice President, UROPAC - Urology's Advocate on Capitol Hill  
*Seattle, WA*

9:00 a.m. - 9:45 a.m.  Health Care Industry Consolidation  
*Speaker:  Mark E. Rust, JD*  
Managing Partner, Barnes & Thornburg LLP  
*Chicago, IL*

9:45 a.m. - 10:00 a.m.  Snapshot: Effective Advocacy: How to Form the Question?  
*Speaker:  Deepak A. Kapoor, MD*  
Health Policy Chair, LUGPA  
*Melville, NY*

10:00 a.m. - 10:15 a.m.  Break

10:15 a.m. - 11:00 a.m.  Post-SGR Medicare Payment Programs: MACRA 101  
*Speakers:  J. Quentin Clemens, MD*  
Chair, AUA Data Committee  
*Ann Arbor, MI*

Robert A. Dowling, MD  
Vice President for Scientific Affairs and Policy, IntrinsiQ Specialty Solutions an AmerisourceBergen Company  
*Fort Worth, TX*
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<th>Time</th>
<th>Event</th>
<th>Speaker/Panelists</th>
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<tr>
<td>11:00 a.m. - 11:15 a.m.</td>
<td>Break</td>
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<tr>
<td>11:15 a.m. - 12:00 p.m.</td>
<td>Breakout Sessions</td>
<td><strong>Surviving MACRA, Applying MIPS</strong>&lt;br&gt;Panelists: J. Quentin Clemens, MD Chair, AUA Data Committee Ann Arbor, MI&lt;br&gt;Jason J. Jameson, MD President, Arizona Urological Society Phoenix, AZ&lt;br&gt;Tom S. Lee, PhD CEO &amp; Founder, SA Ignite Chicago, IL <strong>Employed Physician Leadership in the Medical Center Setting</strong>&lt;br&gt;Location: Madison&lt;br&gt;Panelists: Richard K. Babayan, MD Chief of Urology, Boston Medical Center Boston, MA Barry A. Kogan, MD Past President, Society of University Urologists Albany, NY</td>
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<td>12:15 p.m. - 1:15 p.m.</td>
<td>Industry Sponsored Lunch - “Continuing Care for Your Patients with Metastatic CRPC”&lt;br&gt;Sponsor: Medivation/Astellas&lt;br&gt;Speaker: Aaron Berger, MD Associated Urology Specialists Chicago Ridge, IL</td>
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<td>1:15 p.m. - 2:15 p.m.</td>
<td>Winners and Losers Under the Affordable Care Act&lt;br&gt;Speaker: Scott Becker, JD, CPA Publisher, Becker's Healthcare; Partner, McGuireWoods LLP Chicago, IL</td>
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<td>2:15 p.m. - 3:00 p.m.</td>
<td>Breakout Sessions</td>
<td><strong>Surviving MACRA, Applying MIPS</strong>&lt;br&gt;Panelists: J. Quentin Clemens, MD Chair, AUA Data Committee Ann Arbor, MI&lt;br&gt;Jason J. Jameson, MD President, Arizona Urological Society Phoenix, AZ&lt;br&gt;Tom S. Lee, PhD CEO &amp; Founder, SA Ignite Chicago, IL <strong>Independent Physician Practice Strategies for Reimbursement</strong>&lt;br&gt;Location: Madison&lt;br&gt;Panelists: Peter M. Knapp, Jr., MD, FACS Past President, Urology of Indiana Carmel, IN Earl L. Walz, MBA CEO, The Urology Group Cincinnati, OH</td>
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<td>3:00 p.m. - 3:15 p.m.</td>
<td>Break</td>
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<td>3:15 p.m. - 3:30 p.m.</td>
<td>Snapshot: Certificate of Need Reform Across the U.S.&lt;br&gt;Speaker: Jonathan Henderson, MD Southeastern Section Representative, AACU Board of Directors Shreveport, LA</td>
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<td>3:30 p.m. - 4:00 p.m.</td>
<td>The Role of Specialty Certification in Post-SGR Payment Programs&lt;br&gt;Speaker: Thomas Granatir Senior V.P., Policy &amp; External Relations, American Board of Medical Specialties Chicago, IL</td>
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<td>4:00 p.m. - 4:15 p.m.</td>
<td>AACU Annual Business Meeting</td>
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Delegate John O’Bannon (Richmond, Virginia)

Dr. O’Bannon is a lifelong Virginian dedicated to caring for others. A graduate of Hargrave Military Academy and the University of Richmond, Dr. O’Bannon attended medical school at the Medical College of Virginia (MCV), where he was elected President of the Student Body. Later, as a resident at MCV, he was elected President of the Housestaff Council, served as Chairman of the Dean’s Advisory Committee, and was named Chief Resident in Neurology.

A well-regarded physician, Dr. O’Bannon is a partner in Neurological Associates, a leading Richmond medical practice. He has served as Chief of Staff of Henrico Doctors’ Hospital and is currently on the hospital’s Board of Trustees, where he chaired the Quality Committee. His peers have named him one of the “Outstanding Physicians of the Year” in Richmond Magazine’s annual poll.

Dr. O’Bannon is a national leader in improving the medical profession. A leader in the American Medical Association (AMA), he served on the AMA Delegation from the Medical Society of Virginia (MSV) and served as a member of the AMA’s Council for Ethical and Judicial Affairs from 1997 through 2004. In Virginia, Dr. O’Bannon is a past Chairman of the Board of the Richmond Academy of Medicine. He also served as Chairman of the MSV’s Legislative Committee, where he helped pass the Virginia Patients’ Bill of Rights.

Dr. O’Bannon is a leader in his community. He is a member of the West Richmond Rotary Club, the Glen Allen Ruritan Club, and the Board of the Central Virginia Chapter of the National Multiple Sclerosis Society. A member of the Henrico County Republican Committee, Dr. O’Bannon has been active in numerous federal, state, and local campaigns.

Dr. O’Bannon is one of only four physicians in the General Assembly. He serves on the Appropriations, Health, Welfare and Institutions, and Privileges and Elections Committees. He also serves as Chairman of the Health Subcommittee of the Health, Welfare and Institutions Committee and of the Campaign Finance Subcommittee of the Privileges and Elections Committee. He is a member of the Secure Commonwealth Panel and the Joint Commission for Healthcare for all Virginians, and he currently serves as chairman of JLARC and of the Virginia War Memorial Foundation board.

Recent Distinguished Award Honorees

The AACU Distinguished Leadership Award recognizes 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:

2015  
Congressman Ted Lieu

2014  
Conn. Rep. Prasad Srinivasan, MD

2013  
Oregon Senator Alan Bates, DO
Richard K. Babayan, MD, FACS

Dr. Babayan, MD, is Professor and Chair of the Department of Urology, Boston University School of Medicine, and Chief of Urology at Boston Medical Center. Dr. Babayan is a graduate of Tufts University and received his medical degree at Indiana University School of Medicine in 1975. He did his surgical training at Yale-New Haven Hospital before completing his urology residency at Boston University Medical Center in 1980. From 1980 to 1982, Dr. Babayan was an AUA Research Scholar, performing basic science research in the field of hyperthermia at both MIT and BUSM. His clinical interests center on endourology and the use of minimally invasive approaches (including robotics) for prostate cancer, urinary stones, BPH and urologic oncology.

Dr. Babayan has been an active participant in local, national and international urologic organizations. He has held numerous leadership positions in the New England Section of the AUA, including president and treasurer, and served as New England Section representative to the AUA Board of Directors from 2005 to 2009. In 2011, Dr. Babayan received the AUA’s Distinguished Service Award, and the New England Section presented him with the Joseph B. Dowd Lifetime Achievement Award in 2013. Dr. Babayan has been a member of the Development Council for the AUA Foundation (now the UroCare Foundation) and has been a mentor for the AUA Leadership Program. He served on the Editorial Board of the Urological Survey for *The Journal of Urology*®, and the AUA Publications Committee. Dr. Babayan is the past president and member of the Board of Directors of the Massachusetts Association of Practicing Urologists and serves on the Medical Advisory Board of the Massachusetts Prostate Cancer Coalition.

He has been a member of the AUA since 1983.

Scott Becker, JD, CPA

Mr. Becker has been on the Board of Partners since 2008 and is former chairman of the firm’s healthcare department. He practices exclusively in the healthcare regulatory and transactional area.

He provides counsel on healthcare transactional and regulatory matters to hospitals, health systems, hospital chains, ambulatory surgery centers, ambulatory surgery center chains, private equity funds and lenders, and healthcare industry entrepreneurs.

During the past several years, Mr. Becker has devoted a majority of his time and efforts to ambulatory surgery centers and ASC chains, hospitals and health systems, private equity funds and healthcare industry entrepreneurs. He provides advice and counsel on a broad range of business and legal issues. Scott is a Harvard Law graduate and a certified public accountant in Illinois.

J. Quentin Clemens, MD, FACS, MSCI

Dr. Clemens is professor of urology and director of the Division of Neurourology and Pelvic Reconstructive Surgery at the University of Michigan. He also directs the urology fellowship in Female Pelvic Medicine and Reconstructive Surgery. Dr. Clemens received his medical degree from the Johns Hopkins University School of Medicine, and then completed his urology residency at Northwestern University. He subsequently completed fellowship training in neurourology, reconstruction and incontinence under Edward J. McGuire at the University of Michigan. His clinical interests include urinary incontinence, fistulas, mesh erosions, neurourology, and complex lower urinary tract dysfunction. He is a member of the SUFU Executive Committee and the ABU Examination Committee. In 2014, he received the Paul Zimskind Award from SUFU for his accomplishments in the field of female pelvic medicine and reconstructive surgery.

Dr. Clemens’ research interests are in the areas of epidemiology and health services research related to benign urologic diseases. He has been principal investigator or co-investigator on multiple NIH-funded projects related to urinary incontinence, interstitial cystitis and chronic prostatitis, including the current NIDDK MAPP Research Network and NIDDK LURN Research Network. He is currently serving as chair of the MAPP Network.

He has also been actively involved in health policy issues with the AUA, where he was named the Gallagher Health Policy Scholar for 2008-2009. He is past chair of the AUA Quality Improvement and Patient Safety Committee, and current chair of the AUA Data Committee, which is leading the development of the AQUA registry.
Martin K. Dineen, MD

Dr. Dineen has been a leader in urologic health policy for over two decades. Beginning in the middle 1990’s as a member of the AUA Terminology Committee (CRC of today), Dr. Dineen has remained an active member of several AUA committees related to issues of health policy, including Chairman/Founder of the NIAW from which he retired after 17 years this past spring.

In addition Dr. Dineen has been very active in, and committed to, organized medicine and the support of Urology by serving as: President of the AACU (2015/2016), Southeastern Section AUA (2008/2009), Florida Urological Society (2002/2003). He has served as a member of the Board of Directors of the Urology Care Foundation since its inception in 2012, was an early proponent of Ambulatory Surgical Center (ASC) development and the movement of inpatient urological services to the outpatient environment.

Dr Dineen received his medical degree and residency training from the Louisiana State University School of Medicine in Shreveport, and completed fellowship training in urologic oncology at Roswell Park Memorial Institute in Buffalo, New York. He holds appointments as a Clinical Assistant Professor of Urology at the University of South Florida Medical School in Tampa and has held an Associate Professor of Urology title at the University of Florida Health Science Center in Gainesville, Florida for many years as well. For more than ten years he has served as a peer review editor for UROLOGY and since its inauguration in the spring of 2014 has done so for UROLOGY PRACTICE.

He has organized volunteer rotations of several AUA urologists to help eradicate the urogenital scourge of elephantiasis in Leogane, Haiti. Since October of 2006, Marty, fellow AUA members and residents have performed over 1,000 hydrocele surgeries in a difficult third world environment. He continues this voluntary work 3 weeks each year. February of 2016 marked his 26th trip. Dr Dineen was recognized by his University of Notre Dame physician Alumni peers with the 2014 “Dr. Tom Dooley Society” Founders Award for these humanitarian efforts. Additionally the AUA has recognized Marty’s efforts with a Distinguished Service Award for 2016.

Robert A. Dowling, MD

Dr. Dowling was appointed vice president of Medical Affairs and Policy for ION Solutions, an Amerisource Bergen Specialty Group company, on February 9, 2015. His responsibilities include creation and review of scientific content, oversight of key medical advisors, maintenance of relationships with medical associations, and acting as medical, clinical informatics, and health policy expert for the company.

Prior to his appointment, Dr. Dowling served as the consulting medical director of Data and Analytics for HealthTronics IT Solutions from 2012-2015 (3 years). His duties and accomplishments included establishment and oversight of an integrated clinical data warehouse containing over 5 million patient records, design and content management of Clinical Analytics for specialty practices, content development for business intelligence products, and strategic advisor to management regarding application development, business development, and secondary uses of healthcare data. He is a recognized authority on health care information technology in urology, has served on the advisory board for a large publicly traded HIT company, and has spoken and written extensively about the electronic medical record in private practice, quality measures in specialty practice, clinical and business intelligence, and issues related to large group practice management. Dr. Dowling has been continuously certified by the American Board of Urology since 1989, and in 2014 became a Diplomate of the American Board of Preventive Medicine- Clinical Informatics.

Dr. Dowling received a BA in biology from Vanderbilt University, and completed his medical education and residency at the University of Texas Medical School and Affiliated Hospitals (Hermann Hospital and M.D. Anderson Cancer Center) in 1987. He opened a private urology practice in 1990 in Ft. Worth Texas, and was a founding leader, medical director, and chief medical information officer of Urology Associates of North Texas (now USMD Health System) from 1997-2011. Dr. Dowling has held several positions of leadership in health care including past president of the Medical Staff at two acute care hospitals. Dr. Dowling is a member of the American Medical Informatics Association, Association of Medical Directors of Information Systems, American Society of Clinical Oncologists, and a number of state and local medical organizations. He resides in Ft. Worth, Texas.
Jeffrey M. Frankel, MD

Dr. Frankel is a practicing urologist in Seattle, Washington. He is the current Health Policy Chair of the AACU and an AACU State Society Network Representative. He serves as a member on the AUA Public Policy Committee and serves as Chair of the Health Policy Committee of the Western Section of the AUA. He previously served as president of the AACU and Washington State Urology Society (WSUS) and is currently Chair of Governmental Affair for WSUS. He is Medical Director of Seattle Urology Research Center. Dr. Frankel attended the University of Washington Medical School, and completed his urology training at Baylor College of Medicine in Houston.

Tom Granatir

Mr. Granatir has more than 30 years of experience in health policy with a particular focus on quality and public accountability. He has worked in mental health policy for the state of Illinois; hospital policy for the American Hospital Association, the Health Research and Educational Trust, and the Joint Commission on Accreditation of Healthcare Organizations; long-term care policy for the Health and Medicine Policy Research Group; and in public health policy for Humana Inc., both in the United States and in the United Kingdom. He has served on the governing boards of the American Health Quality Association, the Institute for Safe Medication Practices, Bridges to Excellence, the National Association of Health Data Organizations, the Alliance to Make US Healthiest, and The Henry Booth House, a service agency for poor residents of Chicago. He has been an examiner for the Malcolm Baldrige National Quality Award Program, a member of the Health Policy Roundtable of the Michael Reese Health Trust and served on the Roundtable on Ethnic and Racial Disparities of the Institute of Medicine. He was educated at the University of Chicago, where he has taught in the Graduate Program in Health Policy and Administration.

Jonathan Henderson, MD

Dr. Henderson obtained a Bachelor of Science Degree at LSU in Baton Rouge in microbiology. After receiving his MD at LSU Medical Center in Shreveport, he completed his internship and residency in Urology at LSUMC Hospital. During this time he authored a number of papers and presentations pertaining to prostate cancer-from screening to advanced disease and renal malignancies.

Dr. Henderson spent the next six years in practice in Alabama where he specialized in laparoscopy, which was in its infancy then, in 1996, as well as female pelvic dysfunction. During this time he served as a representative of Alabama to the Southeastern Section of the American Urology Association. He also served as an assistant clinical professor of Urology at the University of Alabama.

In 2002 he answered a call to move back to Louisiana, joining Regional Urology, which was founded in 1998. As one of the first large groups in the country to coalesce under one roof, the opportunity was exactly what he had been endeavoring to accomplish in Alabama. Serving as the laparoscopic surgeon, he eventually became the sole provider in the group of 16 urologists for urologic oncology. Additionally, Dr. Henderson took on administrative tasks asked of him, as well as assuming Assistant Directorship of Clinical Research. In that role, he continues to author papers relevant to cutting edge urology.

He is most proud of his involvement in the nascent, yet monolithic organization LUGPA. There he has served on the Health Policy Committee, Chair of the Communications Committee, representative to the JAC Planning Committee, and representative to UROPAC.

Dr. Henderson also serves organized urology in other roles: he is in his second term on the Board of the Southeastern Section(SESAUA); Vice Chairman of the SESAUA Health Policy Committee; SESAUA Representative to the AUA Public Policy Council; member of the SESAUA By-laws Committee; Louisiana CAC representative and delegate to the AUA National Insurance Advisory Workgroup (NIAW); President-Elect of the Louisiana Urologic Society; and Southeastern Section Representative to the AACU Board of Directors.

Dr. Henderson is certified by the American Board of Urology. He is a member of the American Urologic Association, Shreveport Medical Society, Louisiana State Medical Society, the Society of Laparoscopic Surgeons, and the Alpha Omega Alpha Medical Honor Society.
Jason Jameson, MD

Dr. Jameson is a Senior Associate Consultant at the Mayo Clinic in Arizona. He was involved in the development of the Men’s Health Program at Mayo Clinic and has spoken at local and national conferences and patient support groups on Men’s Health issues. He currently serves on the Board of Directors of the American Society of Men’s Health. He received a BS in Biology at Nebraska Wesleyan University, his medical degree at the University of Iowa, and he completed urologic residency at the University of Utah. He was in private practice for 10 years prior to working at Mayo. He currently is the vice president of the Arizona Urologic Society and serves on AUA committees at both the Western Section and National level. He has been a State Society Network Representative for the AACU since 2013 and is the urologic representative to the Arizona Medical Association, interacting regularly with Arizona State Representatives.

Deepak A. Kapoor, MD

Dr. Kapoor, Chairman and Chief Executive Officer of Integrated Medical Professionals (IMP) headquartered in Melville, NY, is one of the youngest physicians to have been certified by the American Board of Urology and comes to IMP with over 20 years of clinical and business expertise. His medical background is diverse with both laboratory and clinical experience, both in the academic and private sectors. Dr. Kapoor’s expertise includes basic science research in molecular biology as well as extensive experience in oncologic and reconstructive surgery.

Under his leadership, Dr. Kapoor’s organization, Integrated Medical Professionals (IMP) has become the largest comprehensive urology group practice in the United States, and is regarded as a national leader in the areas of quality management, utilization review, compliance and the development of coordinated clinical pathways.

In addition to his duties with IMP, Dr. Kapoor is Clinical Associate Professor of Urology at the Icahn School of Medicine at Mount Sinai, Chairman of Health Policy and Past President of LUGPA (a trade organization representing nearly 25% of all practicing urologists in the United States), is Chairman of SCRUBS RRG (the only national urology specific medical malpractice carrier), has served on the Board of Directors of UroPAC (the national political action committee representing the interests of the specialty of urology), founder of the New York Urology Trade Association (representing the business interests of urology group practices in the State of New York), past Chairman of Access to Integrated Cancer Care (an informal advocacy group representing the rights of patients to access integrated services of the highest quality), is a member of the Board of Directors of Allied Urological Services, (the largest lithotripsy partnership in the United States), where he also functions as Chairman of the Finance Committee) and is Founder and Past-President of the Integrated Medical Foundation. Dr. Kapoor is a Fellow of the American College of Physician Executives.

Dr. Kapoor has published and lectured extensively on both clinical and business medical issues, and serves on a number of medical advisory boards, including the New York State Governor’s Prostate Cancer Advisory Panel. He is the 2014 recipient of the Russell W. Lavengood Distinguished Service Award from the New York Section of the American Urological Association as well as the 2011 Ambrose-Reed Socioeconomic Essay Award from the American Urological Association. Dr. Kapoor continues to enjoy an active clinical practice along with his administrative duties.
Peter M. Knapp, MD

Dr. Knapp is a practicing urologist with over 30 years of healthcare experience in medical group practice growth and development, medical association leadership, and medical product development and strategic marketing.

He is co-founder and past president of Urology of Indiana, a 35-physician Urology and UroGynecology specialty practice, serving 17 hospitals in central Indiana. In association with Urology of Indiana, Dr. Knapp has experience developing medical service companies and service lines including ambulatory surgery centers, imaging centers, cancer centers, equipment leasing companies, clinical and anatomical pathology laboratories and medical office buildings as independent entities and as joint ventures with hospitals, other medical practices and industry partners.

Dr. Knapp has been active in urologic association development, leadership and advocacy. He was a founding board member and past president of LUGPA. He participated in association growth and expansion and remains active on committees and health policy advocacy.

As a past president of the North Central Section of the AUA, Dr. Knapp served nine years on the board and remains active with presentations on practice development and healthcare advocacy.

He is a graduate of Indiana University School of Medicine and completed his general surgery internship and urology residency at the University of Michigan. He is certified by the American Board of Urology and is a fellow of the American College of Surgeons. He has a special interest in the management of urinary incontinence and obstruction in men and women, neurourology, uroprosthesis, and pelvic reconstructive surgery with subspecialty certification in Female Pelvic Medicine and Reconstructive Surgery. He has published and presented on these topics as well as quality control and outcome initiatives in urology group practices and is Volunteer Clinical Associate Professor of Urology at the Indiana University School of Medicine.

Barry A. Kogan, MD

Dr. Kogan is the Chair of Urology at Albany Medical College, is a Professor of Surgery and Pediatrics and holds the Falk Family Chair in Urology. He went to medical school at Northwestern University and did his residency at the University of Michigan. After a fellowship in Pediatric Urology in Liverpool, England, he joined the faculty at the University of California, San Francisco where he was promoted from Assistant Professor to Professor of Urology and Pediatrics over 15 years. In 1997, he came to Albany Medical College.

Dr. Kogan has an active clinical practice in Pediatric Urology, with a wide range of primary to tertiary care cases. These include the full range of pediatric urology, including hypospadias, undescended testes, childhood neurogenic bladder, urinary tract infections, vesicoureteral reflux, prenatal and neonatal hydronephrosis and especially disorders of sex development. He has developed a number of new techniques that have altered pediatric urology.

Dr. Kogan is also an active investigator with experience in NIH funded basic and clinical research, investigator initiated clinical research and industry-sponsored clinical trials. He has published extensively in many areas of pediatric urology and investigative urology.

Dr. Kogan has also been a major contributor to many organizations within urology, including the Northeastern Section (Past-President), American Academy of Pediatrics, Section on Urology (Past-Chair), Society for Pediatric Urology (President), the Society of University Urologists (President), the Residency Review Committee for Urology (Vice-Chair) and the American Board of Urology (former trustee and Vice President). His personal motto and the one he teaches is: “Make a Difference.”
Tom S. Lee, PhD

Dr. Lee is a serial entrepreneur and leading expert in healthcare value-based programs such as MIPS, MACRA, Meaningful Use, and PQRS. He is the father of two small children and after a frightening personal healthcare experience, his concern for their future in the world inspired him to create a company that matched his personal passion: driving innovation in the public healthcare system. Leveraging its cloud-based physician performance analytics and reporting platform, SA Ignite has grown to serve 15,000+ physicians in 80+ healthcare organizations. Dr. Lee is a member of the Young Presidents’ Organization and earned a Bachelor of Science with Distinction in Physics from Stanford, a PhD in Physics from U.C. Berkeley where he was a National Science Foundation Fellow, and an MBA with Distinction from the Kellogg School of Management at Northwestern University.

Patrick H. McKenna, MD, FAAP, FACS

Dr. McKenna is the Mark and Karen Koulogeorge Family Chair in Urology, Professor and Chief Division of Pediatric Urology in the Department of Urology at the University of Wisconsin School of Medicine and Public Health. Dr. McKenna received his medical degree from George Washington University, and completed his residency at Naval Medical Center in Portsmouth, Virginia, and fellowship at the Hospital for Sick Children in Toronto, Canada. Dr. McKenna is a Specialty Diplomat of the American Board of Urology. He serves as State Society Network Chair for the AACU and is the Immediate Past President of North Central Section of the AUA. He is a past president of The Society of University Urologists and the Chair of the SUU Health Policy Committee. He serves on the Science and Quality Committee and Judicial and Ethics Committee of the AUA and is the former Chair of the Judicial and Ethics Committee. He is the Past Chair of the American Academy of Pediatrics Section on Urology and serves as the Chair of the AAP health Policy Committee.

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Speaker Presentations

Mark E. Rust, JD

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.

Earl L. Walz, MBA

Mr. Walz is the CEO of The Urology Group in Cincinnati, Ohio, a 35-urologist single specialty practice. Mr. Walz is a founding LUGPA member and is a past treasurer and Board member. Mr. Walz is a member of many organizations, including LUGPA, Medical Group Management Association, College of Medical Group Management Association, Kentucky Medical Group Management Association, American Management Association, Regional Chamber of Commerce (Cincinnati), Northern Kentucky Chamber of Commerce, American Association of Blood Banks, American Urology Association, Ambulatory Surgery Centers and Physician Hospital Association. Mr. Walz received his BS from Northern Kentucky University, and his MBA from Xavier University in Cincinnati. Mr. Walz resides in Fort Mitchell, Kentucky, with his wife and has three children.
Advocacy Priorities

• Preserving Access to PSA Test
  – Paused the CMS Effort to Develop Non-PSA Measure
  – Met with MedPAC
  – 64 Co-sponsors (H.R. 1151)

• Bladder Health
  – Secured Bladder Cancer Research Funding
  – Resolution introduced in the U.S. House of Representatives

Member Resources

• Published free Workplace Violence Preparedness Tool Kit.
  – A series of templates practices can modify to provide a basic format to initiate a workplace violence preparedness program.

• Webinar on Implementing MACRA

• Forthcoming: Tool kit for MACRA

AQUA QCDR and MACRA

• The AQUA Registry was approved as a Qualified Clinical Data Registry (QCDR) by CMS in 2016

• QCDR meets a higher standard of data management and provides an opportunity for measure development

• QCDR can report three MIPS areas: Quality, Clinical Performance Improvement Activities and Advancing Care Information. QCDRs also may possibly report resource use (costs) in the future

Member Resources

• Worked with NCHS on ICD-10 codes
  – Developed ICD-9 to ICD-10 Crosswalk
  – Updated edition out this month
  – Live, recorded session on ICD-10 basics, discussion of expanded documentation requirements

• Developed a prior authorization checklist, as well as a short guide to help navigate payer forms.

AUA Advocacy Facts

• Our DC headquarters: 444 N. Capitol Street

• 4 registered lobbyists on Capitol Hill + contract lobbyists
AUA Advocacy Facts

- Participate in more than 40 Coalitions and partner with dozens of medical societies.
- Hill visits: 203 with urologists, 76 by AUA staff
- As of June 2016: Reviewed 2,522 insurance policies for potential impact on urology
- Seat on AMA RUC and CPT Editorial Panel
- Practice Managers Network: 800 members
Presidents’ Forum: Views on State Advocacy from Urology’s National Organizations

Martin K. Dineen, MD
President, American Association of Clinical Urologists

Empowering Urologists to Advocate on Behalf of Their PATIENTS, Practice and Profession

- Public Health
  - Prostate cancer screening and prevention
  - USPSTF
- Prior Auth/Step Therapy
- Scope of Practice
- Medicare/Medicaid
  - MACRA
  - Part B drug reimbursement
  - Cancer survivor quality of life

Empowering Urologists to Advocate on Behalf of Their Patients, Practice and PROFESSION

- Physician Workforce
  - Medical Education
- Licensing, Certification and Privileging
- Employed Physician Empowerment

About the AACU

- Active role shaping national conversation regarding federal and state issues
- Numerous federal comments, letter writing campaigns, coalition activities, UROPAC donations
- Influential presence at the AMA House of Delegates
- Sole sponsor of UROPAC

UROPAC
Urology’s Advocate on Capitol Hill

- AACU sole sponsor of UROPAC
- UROPAC is the only PAC advancing the interests of ALL urologists
- Bipartisan and bicameral donations
- Targeted giving strategy to identify and support key allies within Congress
- Fosters relationships between urologists and their elected representatives
- Lawmaker education through sponsored events and meetings
UROPAC sponsored Dr. Mark Stovsky’s attendance at the 2016 Republican National Convention, providing access to leaders and key decision makers within GOP leadership.

**Urology’s Advocate on Capitol Hill**

**AACU State Society Network**

- Organizational Support and Development

- Bringing together states, sections, subspecialties to comment on big issues
- Opportunities to mobilize members on state and national campaigns
- Annual SSN conference
- Facilitate state medical association relationship
- Lobby day participation

**AACU State Society Network**

- Proactive Campaigns

**AACU State Society Network**

- Organizational Support and Development

- In-District Activities, Federal Action Center

**Future Growth**

- Member buy-in / Urologist engagement
- AACU Action Center
- Prostate Cancer Screening & USPSTF: www.bit.ly/aacu-psa
- Organizational support, Proactive campaigns
- In-District Federal Advocacy
- Increased UROPAC activity and visibility
SUCCESS STRATEGIES UNDER MACRA

DEEPAK A. KAPOOR, MD
CHAIRMAN AND CEO
INTEGRATED MEDICAL PROFESSIONALS, PLLC
CLINICAL ASSOCIATE PROFESSOR OF UROLOGY
THE ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI
CHIEF, HEALTH POLICY
LUGPA
August 26th, 2016
Rosemont, IL

SGR REPEAL AND REFORM

The Medicare Access and CHIP Reauthorization Act (MACRA)

- The SGR mechanism is permanently repealed
- Physicians will receive an annual update of 0.5% in each of the years 2015 through 2019
- Starting in 2019, providers will be paid under one of two systems:
  - the Merit-based Incentive Payment System (MIPS);
  - Alternative Payment Models (APMs).
- CMS proposes that the agency will evaluate whether a provider fits under either model based on data two years in advance of payment adjustment date
- CMS proposes that 2019 payments will be based on 2017 physician experience.

MACRA PROVIDES FOR 4 DIFFERENT "STATUSES"

- MIPS Only
  - Practices are only participating in MIPS with no APM Model
- MIPS With APM
  - Practices participate in MIPS and an APM Model
- Partial Qualifier
  - Practices achieve partial qualifying thresholds and participate only in the upwards adjustments of MIPS as well as an APM Model
- Qualified for APM Bonus
  - Practices are participating in an Eligible APM and receive APM Bonus (5%) as well as APM Model payments.

MIPS

- Positive or negative adjustments of 4% in 2019, increasing through 2022 + five years of "exceptional performance" bonuses.
- CMS to calculate new Composite Performance Score score based on:
  - quality
  - resource use
  - advancing care information (previously known as EHR meaningful use)
  - clinical practice improvement activities (CPAs).
- All participants required to submit data in performance years (because a provider’s APM participation is assessed only after the performance year)

APMs

- In contrast to the statute, CMS proposes three different categories of participants in APMS.
  - Providers with large portion of payment through APM treated as "Qualifying Participants," totally excluded from MIPS & evaluated solely through APMs.
  - Providers with slightly less portion of payment through APM treated as "Partially Qualifying Participants," and can elect whether to be evaluated through MIPS.
  - Providers participating in APMS who don’t meet either threshold will still be scored under MIPS, but may be eligible for special, more lenient scoring.
APMs: Qualifying APM Participant

- Must receive at least 25% of reimbursement through Advanced APM or
  (starting in 2021) Other Payer Advanced APM, or see 20% of patients
  through one of these two models (standard increases over time);
- Excluded from MIPS adjustments.
- Will receive bonus equal to seven percent of prior year’s Medicare
  reimbursements.

APMs: Partially Qualifying APM Participant

- Must receive at least 20% of reimbursement through Advanced APM or
  Other Payer Advanced APM or see 10% of patients through one of these
  two models (standard increases over time);
- May elect whether or not to participate in the MIPS;
- No APM participation bonus.

MIPS APM Participant

- Identified as a participant by any APM (even if not “advanced”).
- Quality measures either reported at APM level or (depending on type of
  APM); exempted from resource use requirement; receive automatic
  credit for Clinical Practice Improvement Activities.
- This will be particularly useful for participants in “upside only” APMs
  like the Medicare Shared Savings Program Track One.

Economics of MACRA Statuses

Summary

- CMS proposed rule substantively different in implementation of MIPS/APMs from statute
- Virtually impossible for any group not presently engaged in two sided risk to qualify for advanced APMs by deadlines proposed
- Essentially all practices will be subject to MIPS Year 1
- MIPS – APM pathway has potential for greatest economic upside
Legislative Advocacy: Framing the Question

Deepak A. Kapoor, MD
Chairman and CEO
Integrated Medical Professionals, PLLC
Clinical Associate Professor of Urology
The Icahn School of Medicine at Mount Sinai
Chairman, Health Policy

August 20th, 2016
Rosemont, IL

Drivers of Legislative Decision Making

- Political leaders interested in input from providers
- Genuine interest in constituent well-being
- Commitment to ensure long term viability of health care system

Legislative Advocacy

Average Political Contribution/Urologist 2013-14:

$ 47.03
TARGETED COMMUNICATION IS KEY

- Legislators do not want to hear what you have to say
- Legislators want to hear what supports their political bias
- Need to frame argument differently for different audiences
- Excellent example is Stark regulations
  - Existing Stark regulations significantly limit the ability to implement changes in MACRA due to:
    - Inability to use “volume or value” of services as guide to reimbursement
  - Challenges to creating innovative “under arrangements” between hospitals and physicians

TARGETED COMMUNICATION

- Bias: Dislike Stark law
- Predisposed to modify
- Arguments:
  - Urology committed to success of MACRA
  - Stark law was an aggressive government overreach
  - Stark regulations are an antiquated relic that stifles competition and impedes shift to value based medicine
  - CMS has asked for Congressional action
- Bias: Support Stark law
- Skeptical of changes
- Arguments:
  - Urology committed to success of MACRA
  - Stark law played an important role in fee-for-service paradigms
  - Stark regulations should be modified to allow flexibility in the context of developing value based payment methods
  - CMS has asked for Congressional action

SUMMARY

- Physicians must engage in the legislative process
- Get to know your congressional representatives, both in the House and the Senate
- Be prepared to “get in the game” financially
- Make sure they understand how relevant you are to their constituents
- If you do everything right, there is no guarantee that you will prevail; if you do not engage, there is 100% chance you will fail
Overview of the AQUA Registry and the New Merit-Based Incentive Payment System

J. Quentin Clemens, MD, FACS, MSCI
Professor of Urology
Director, Division of Neurourology and Pelvic Reconstructive Surgery
University of Michigan Medical Center
Chair, AUA Data Committee

The AUA Quality (AQUA) Registry

The AQUA Registry collects detailed national process and outcomes data for patients with urologic diseases.

- **Primary goal:** quality assessment and improvement through local feedback to practices
- **Secondary goals:** provide fuel for next-generation HSR and clinical/outcomes research and information for urology policy efforts

Benefits

- AQUA Registry has operated as a Qualified Clinical Data Registry (QCDR) as of April 2016
  - Participating urologists earn automatic PQR and Meaningful Use credit
  - AQUA Registry participation will help substantially with MIPS reporting
- Participation may help satisfy MOC reporting requirements
- “Blue ribbon” certification (AUA)
- Clinician dashboard for patient-level tracking and practice-level QA/QI initiatives
- Improved care through local/internal data exposure
- “Next-generation” research opportunities for health services, outcomes and comparative effectiveness research

Rationale

- Complex conditions require clinical data, ideally collected prospectively
- Existing clinical registry efforts have excellent track records in research and quality improvement but are based on manual data collection and are difficult to scale

Key Principles

- Software (FiGmd) to minimize data entry burden—data extracted from EMR
- Data ownership by individual practices and the AUA only
- Practice-level data will be shared only with the individual practice, benchmarked against the aggregate data—no practice will see any other individual practice’s data
- Incorporate patient-reported outcomes (PROs)
Quality Measure Development

- Documentation quality
- Processes of care
- Clinical outcomes
- Patient-reported outcomes

Multiple data elements are also needed for adequate risk stratification

Progress Update

- Approximately 400 practices have joined the AQUA Registry with more than 2,300 providers
- 46 states + DC + Puerto Rico and USVI represented across the US, including all regions (no attempts so far to force diversity)
- Mix of small, medium and large practices (including major academic medical centers)
- 1.38 million patients with 4.38 million patient visits
- n > 29,000 new prostate cancer patients from the first 36 practices 2014-16
- PRO program piloted at four sites

Recruitment Progress

Number of Practices by State

Practice Signups and Installations

AQUA Registry Measures (34 Total)

- PQR5
  - 18 measures
- Non-PQR5 Prostate Cancer Measures
  - 7 measures
- PRO Prostate Cancer Measures
  - 3 measures
- Non-Prostate Cancer Measures
  - 6 measures
  - BPH, cryptorchidism, T replacement, PNB complications

SGR Repeal – April 2015

MACRA – Medicare Access and Children’s Health Insurance Program Reauthorization Act of 2015
Stable Payment Updates
0.5% per Year 2016-2019

2019 – Big Changes!
Option 1: Merit-Based Incentive Payment System (MIPS)

Maintains Fee-for-Service

Four Categories in the Composite Performance Score (CPS):
1. Quality (replaces PQRS) (50%)
2. Resource Use (replaces Value-Based Payment Modifier) (10%)
3. Advancing Care Information (replaces EHR Incentive Program) (25%)
4. Clinical Practice Improvement Activities (New Category) (15%)

PARTICIPATION IN THE AQUA REGISTRY WILL HELP WITH ALL OF THESE REQUIREMENTS

MIPS Category 1: Quality (50% of CPS)

- Claims Reporting (G Codes)
  - Going away
- Direct Reporting via an EHR
  - Limited number of measures
- Registry
  - Receives data from practices and submits the data
- Qualified Clinical Data Registry (QCDR)
  - Provides feedback
  - 6 measures including 1 outcome measure and 1 cross-cutting measure
  - Results publicly reported by CMS
  - QCDR status received in April 2016

MIPS Category 2: Resource Use (10%)

- This category is a continuation of two measures from the Value-Based Modifier:
  - Total per costs capita for all attributed beneficiaries
  - Medicare Spending Per Beneficiaries (MSPB) with minor technical adjustments
- There is no additional MIPS data submission required for this category
- Key change from current Value-Based Modifier Program:
  - Adding 40+ episode specific measures to address specialty concerns

MIPS Category 3: Advancing Care Information (25%)

The Advancing Care Information (ACI) Category is a combination of Base and Performance scores

- Base Score: (Overall 50 points)
  - Protect Patient Health Information
  - Electronic Prescribing
  - Patient Electronic Access
  - Coordination of Care Through Patient Engagement
  - Health Information Exchange
  - Public Health and Clinical Data Registry Reporting

MIPS Category 3: Advancing Care Information (25%) Cont’d

- Performance Score: (Up to 80 points; 10 points per measure)
  - Objective 1: Patient Electronic Access
    - Measure 1: Patient Access
      - Measure 2: Patient-Specific Education
  - Objective 2: Coordination of Care Through Patient Engagement
    - Measure 3: VT
    - Measure 4: Secure Messaging
    - Measure 5: Patient-Generated Health Data
  - Objective 3: Health Information Exchange (HIE)
    - Measure 6: Patient-Care Record Exchange
    - Measure 7: Request/Accept Patient Care Record
    - Clinical Information Reconciliation
MIPS Category 4: Clinical Practice Improvement Activities (15%)

- Clinical Practice Improvement Activities (CPIAs) are a series of weighted activities.
- Activities are broken down to high (20 points) and medium (10 points) to achieve a total of 60 points for this category.
- ECs and Groups can achieve additional credit for performing more activities.

QCDR & Clinical Practice Improvement Activities (CPIAs)

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Activity</th>
<th>Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary Engagement</td>
<td>Use of QCDR patient experience data to inform and enhance improvements in beneficiary engagement</td>
<td>Medium</td>
</tr>
<tr>
<td>Beneficiary Engagement</td>
<td>Participation in a QI effort to improve patient satisfaction scores</td>
<td>Medium</td>
</tr>
<tr>
<td>Beneficiary Engagement</td>
<td>Participation in a QI effort to improve patient satisfaction scores with respect to adherence to treatment plan</td>
<td>Medium</td>
</tr>
<tr>
<td>Access and Equity Engagement</td>
<td>Participation in a QI effort to improve performance in the smoking cessation program</td>
<td>Medium</td>
</tr>
<tr>
<td>Access and Equity Engagement</td>
<td>Participation in a QI effort to improve performance in the smoking cessation program</td>
<td>Medium</td>
</tr>
</tbody>
</table>

Nonparticipation

<table>
<thead>
<tr>
<th>Year</th>
<th>Penalties</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>1%</td>
</tr>
<tr>
<td>2016</td>
<td>2%</td>
</tr>
<tr>
<td>2017</td>
<td>3%</td>
</tr>
<tr>
<td>2018</td>
<td>4%</td>
</tr>
<tr>
<td>2019</td>
<td>5%</td>
</tr>
</tbody>
</table>

MACRA Option 2: Alternative Payment Models (APMs)

- Accountable Care Organization, Bundled Payment, etc.
  - Details to be provided
- Must assume ‘substantial’ financial risk
  - Not quantified yet
- Must include substantial number of patients
  - 25% of total Medicare reimbursement (to start)
- 5% bonus per year
  - Increased professional fee payments in 2026
- Who holds the purse-strings, attribution issues, etc.
If you choose MIPS, participation in the AQUA Registry will help satisfy all four components as well as prepare you for the transition from MIPS to Advanced APM to be a QP.

- The AQUA Registry can report on behalf of AQUA Registry participants for ALL CMS required reporting categories (Quality, ACI and CPIAs)
- Demonstrate practice improvement
- AQUA Registry participants will achieve an ACI BONUS POINT for participating in a QCDR

You will learn things about your practice!

The ABMS has recently clarified how a clinical data registry can fulfill MOC requirements.

The AQUA Registry is working with the ABU to make this happen.
MACRA: Overview and Implications for Specialty Practice

Robert Dowling MD
VP Medical Affairs and Policy
IntrinsiQ Specialty Solutions
August 20, 2016

MACRA
Medicare Access And CHIP Reauthorization Act 2015

Legislative Details

• HR 2 Sponsor Michael Burgess (R-TX)
• Passed House March 26, 2015
  - 392-37
• Passed Senate April 14, 2015
  - 92-8
• Signed April 16, 2015

Summary

• Repeals SGR for Part B
• Moderate fee increases short term
• Payments tied to quality long term
• MIPS (fee for service tied to performance) is DEFAULT.
• APMs (population level risk tied to quality; payments tied to participation) including PFFM

Who is in MIPS?
Almost All Eligible Clinicians

First year of Medicare
Low volume threshold
Not in any APM
In non advanced APM
In advanced APM, non qualifying
In advanced APM, partial qualifying
In advanced APM, qualifying

*Status is determined each performance year by CMS
Exempt from MIPS

Merit Based Incentive Payment System

MIPS

MACRA Timeline
Fee Schedule, Adjustments, and Bonus

High level Summary

MIPS

• MIPS Eligible Clinicians defined
• Sunsets payment adjustments under MU, PQRS, VM and creates new measures, activities, reporting, and data submission standards across four performance categories (MIPS Composite Score)
• 2017 is the performance year for 2019 MIPS
• MIPS EC can submit
  • Individually
  • Group
  • APM entity
• Feedback mechanism proposed
• Review process outlined
• Aligns submission methods and expands role for Third parties in submission
MIPS Eligible Clinicians

Definitions
- Physician
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- A certified registered nurse anesthetist
- A group that includes such professionals.

2019-2020
- Physical and Occupational therapists
- Speech language pathologists
- Audiologists
- Nurse midwives
- Clinical social workers
- Clinical psychologists
- Dieticians/nutritionists

2021-

MIPS Composite Performance Score
Weights in first three years

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>2019 MIPS</th>
<th>2020 MIPS</th>
<th>2021 MPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Resource CPIA</td>
<td>45%</td>
<td>30%</td>
<td>25%</td>
</tr>
<tr>
<td>ACI</td>
<td>15%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>MIPS Composite Score</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MIPS Quality Metrics
Common Generic Measures (PQRS)
- #236: Controlling High Blood Pressure (NQF0018)
- #113: Colorectal Cancer Screening (NQF0034)
- #119: Diabetes: Medical Attm for Nephropathy (NQF0062)
- #204: Use of Aspirin or Another Antithrombotic (NQF0068)
- #238: Use of High-Risk Meds in the Elderly (TOTAL)
- #130: Documentation of Current Medications (NQF0419)
- #226: Tobacco Use: Screening & Cessation (NQF0028)
- #111: Pneumonia Vaccination Status for Elderly (NQF0043)
- #128: BMI Screening & Follow-Up (TOTAL)
- #312: Use of Imaging Studies for Low Back Pain (NQF0052)

MIPS Quality Metrics
Urinary Incontinence Specialty Metrics (Proposed)
- Urinary Incontinence: Assessment of Presence or Absence Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older
- Prostate Cancer: Avoidance of Overuse of Bone Scan for staging Low Risk Prostate Cancer Patients
- Prostate Cancer: Adjuvant Hormonal Therapy for High Risk or very High Risk Prostate Cancer
- Biopsy Follow-Up
- Surgical Site Infection (SSI)
- Patient-Centered Surgical Risk Assessment and Communication

MIPS Quality Metrics
Implications
- Pure pay for performance
- Quality performance is the primary determinant MIPS composite score and therefore payment adjustment
- There are more measures to choose from and fewer required to report than in PQRS
  - Many EHRs not ready for these calculations (specialty set)
  - New metrics have no QRUR history
- Baseline benchmarks to be calculated from historical data (not performance period)
- Will require a cultural shift from “compliance” to “improvement”.
Advancing Care Information

Replaces Meaningful Use

- Base Score
- Performance Score
- Total Score

Clinical Practice Improvement

New Category

- Choose from 90 activities
- 90 day reporting period
- Attestation, multiple submission methods
- Scoring
  - High weight 20
  - Medium weight 10
  - Total 60 possible points
- Exceptions apply
  - 50% credit for APM participation

Clinical Practice Improvement

90 measures in Nine Domains

Examples

- Patient Engagement and Practice Improvement
  - Measure 1: Communication and Engagement
    -Ns of patients with two or more chronic conditions who report having trouble understanding
    -Ns of patients with two or more chronic conditions who rate their provider's communication
    -Ns of patients with two or more chronic conditions who report that their provider
      -Attestation required
      -Scoring
        - High weight 10
      - Exceptions apply
        - 50% credit for APM participation

Clinical Practice Improvement

Implications

- Additional reporting burden
- Many choices
- Should be easy for specialty clinicians to meet
- Favorable treatment under APMs
Post SGR Payment Programs: MACRA 101
Robert Dowling, MD

Cost (Resource)
Replaces Value Based Modifier
- Claims based reporting (no MIPS provider reporting effort)
- Three measures
  - Total per capita cost
  - MSPB (Medicare Spending per Beneficiaries) measure
  - Episode based measures (if applicable)
- 40 episode specific measures
- Attribution logic similar to VM
  - Acute care episodes
  - Procedural episodes

Cost
Urology Related Episode

MIPS Composite Score

MIPS Payment Adjustments

MIPS Adjustment
Estimates (2019)

NPRM MACRA

- MIPS fee schedule adjustments
  - $83 M

- 500 M in exceptional performance payments

- 60% of small (<25 eligible clinicians) practices will be penalized

- Advanced APM bonus payments
  - $146 million - $429 million

Estimates

<table>
<thead>
<tr>
<th>Specialty</th>
<th>#</th>
<th>Charge (Mil)</th>
<th>% Negative</th>
<th>% Positive</th>
<th>Negative Aggregate</th>
<th>Positive Aggregate</th>
<th>Exceptional Aggregate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oncology</td>
<td>11,705</td>
<td>$1,706</td>
<td>37.5%</td>
<td>62.1%</td>
<td>-$13</td>
<td>$24</td>
<td>$9</td>
</tr>
<tr>
<td>Family Practice</td>
<td>17,941</td>
<td>$5,888</td>
<td>40.2%</td>
<td>59.5%</td>
<td>-$60</td>
<td>$103</td>
<td>$38</td>
</tr>
</tbody>
</table>

Excluded from MIPS

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Allowed Charges (mil)</th>
<th>% of all excluded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oncology</td>
<td>$1,706</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Family Practice</td>
<td>$28,966</td>
<td>2%</td>
</tr>
</tbody>
</table>

Feedback

APMs

Alternative Payment Models

Key Definitions

- APM
  - A CMMI model under section 1115A of the Social Security Act
  - Shared Savings Program
  - Health Care Quality Demonstration Program under section 1866C
  - A demonstration required by federal law
  - Advanced APMs and other Payer Advanced APMS criteria:
    - require participants to use certified EHR technology
    - provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of MIPS
    - Either
      - Medical home Model
      - More than nominal risk

APMs under MACRA

Existing APMs

- Comprehensive ESRD Care
- Comprehensive Primary Care Plus
- Medicare Shared Savings I
- Medicare Shared Savings II
- Medicare Shared Savings III
- Next Generation ACO
- Oncology Care Model one sided
- Oncology Care Model two sided

Advanced APM

- Comprehensive ESRD Care
- Comprehensive Primary Care Plus
- Medicare Shared Savings II
- Medicare Shared Savings III
- Next Generation ACO
- Oncology Care Model one sided
- Oncology Care Model two sided
Advanced APMs

- Qualifying Thresholds

**APM Scoring Standard for MIPS**

- All scoring is done collectively at APM entity (e.g., ACO) level
- Resource Use 0 weight
- CPIA get 50% credit

**APMs Implications**

- Few APMs, fewer Advanced APMs available to specialists today
- APM status is based on design, not participation
- PFPM are not automatically Advanced APMs
- Bonus is based on participation, not performance
- Qualifying participation is based on collective determination, not individual clinician, during the "performance period"
- QP is only status exempt from MIPS
- Partial QP can opt out of MIPS
- Very tight timeline
- List of Advanced APMs published "before January 1, 2017"
- Performance period begins January 1, 2017 (snapshot 12/31/2017)
- Notification to QPs no sooner than summer of 2018

**Physician Focused Payment Model**

- An Alternative Payment Model wherein Medicare is a payer, which includes physician group practices (PGPs) or individual physicians as APM Entities and targets the quality and costs of physician services.
- A PFPM may or may not be an Advanced APM
- Very strict criteria
  - Incentives to pay for higher value care
  - Discrete Care Delivery Improvements
  - Information Enhancements: Improving the availability of information to guide decision-making
  - Specific supplemental information must be supplied

**Public Reporting and Transparency**

**Physician Compare**

- Names of providers in Advanced APMs
- As reliable, the names and performances of Advanced APMs
- MIPS scores for clinicians, including aggregate and individual scores for each performance category

**MACRA**

- Understand the basics of the legislation
- Review your experience with current federal incentive programs (QRUR)
- Review your ability to monitor and report quality
- Review your adoption of Health IT (EHR, Analytics, Population Health)
- Environmental scan of APMs in your area
- Appoint a MACRA czar
Post SGR Payment Programs: MACRA 101
Robert Dowling, MD

MACRA
Group v Individual Reporting Considerations

<table>
<thead>
<tr>
<th>Individual</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher reporting burden</td>
<td>Lower reporting burden</td>
</tr>
<tr>
<td>Promotes individual accountability</td>
<td>Promotes group culture and APM participation</td>
</tr>
<tr>
<td>Each NPI has a different payment adjustment</td>
<td>All TIN members will receive same payment adjustment</td>
</tr>
</tbody>
</table>

Providers Face Many Reimbursement Pressures all at Once
Confluence of Events

- MACRA 2017 Fee Schedule
- MU Stage 3
- Part B Demo Phase 1
- MACRA January 2017
- Medicare 2015 Fee Schedule
- PQRS 2015
- VBM 2015

MACRA

- MACRA is the law of the land and here to stay.
- Performance measurement starts January 2017
- Plan on starting in MIPS and appoint someone to monitor announcements, clarifications (CMS listserv, PTAC, specialty society)
- Review your QUR
- Measure Quality
  - PQRS measures
  - Start with education
  - Evaluate reporting platforms
  - Get used to transparency

Take Home Messages

- CMS MACRA Timeline https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Timeline.PDF
- Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models https://d3.tjziaztv3n4c6y.cloudfront.net/inspection/federalregister.gov/2016-18972.pdf

Resources

The End
Robert.Dowling@intrinsiq.com
Transform Urologic Care by Participating in the AQUA Registry

J. Quentin Clemens, MD, FACS, MSCI
Professor of Urology
Director, Division of Neurology and
Pelvic Reconstructive Surgery
University of Michigan Medical Center
Chair, AUA Data Committee

The AUA Quality (AQUA) Registry

Collects detailed national process and outcomes data for patients with urologic diseases
- Primary goal: quality assessment and improvement through local feedback to practices
- Secondary goals: fuel next-generation HSR and clinical/outcomes research; inform urology policy efforts

Data Sources

- Data Extraction, Transformation and Load (ETL)
  PHI is separately stored and protected

Stages from Initial Inquiry to Full Functionality

- Dashboard Preview
Quality Measure Development

**What to Measure:**
- Documentation quality
- Processes of care
- Clinical outcomes
- Patient-reported outcomes (PROs)

Multiple data elements are also needed for adequate risk stratification

2016 AQUA Registry QCDR Measures

**PQRS Measures**
1. Assessment of urinary incontinence (women)
2. Plan of care for women with incontinence
3. Avoiding bone scan for low-risk prostate cancer
4. Use of ADT with radiation for high-risk prostate cancer
5. VTE prophylaxis
6. Medication reconciliation
7. Advance care plan
8. Influenza screening

2016 AQUA Registry QCDR Measures (Cont.)

**Non-PQRS Measures (Derived from AUA Guidelines/Choosing Wisely)**
1. Prostate cancer: documentation of stage, 1<sup>+</sup> and/or 2<sup>+</sup>
2. Prostate cancer: Documentation of number of biopsy cores taken/positive in provider notes
3. Cryptorchidism: Non-use of ultrasound
4. Hypogonadism: Testosterone level ordered within 6 months of starting testosterone treatment
5. BPH: Do not order creatinine
6. BPH: Do not order upper tract imaging

Surviving MACRA, Applying MIPS
J. Quentin Clemens, MD
(Page 2 of 4)
2016 AQUA Registry QCDR Measures

Non-PQRS Measures (Cont.)
7. BPH: IPSS change from baseline to 6 months after diagnosis (outcome)
8. Prostate biopsy: re-admission/complication within 30 days (outcome)
9. Prostate cancer: use of active surveillance/watchful waiting for men with low-risk disease (outcome)
10. Prostate cancer: urinary function 12 months after primary treatment (outcome – PRO)
11. Prostate cancer: sexual function 24 months after primary treatment (outcome – PRO)

AQUA Registry Non-QCDR Measures

- Prostate cancer: documentation of DRE findings
- Prostate cancer: documentation of family history of cancer
- Prostate cancer: bowel function 12 months after radiation (PRO)

A Snapshot of Patients in the AQUA Registry

<table>
<thead>
<tr>
<th>Urologic Condition</th>
<th>IK4</th>
<th>IK5/6</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptomatic urinary system</td>
<td>768</td>
<td>1102</td>
<td>795,472</td>
</tr>
<tr>
<td>Urethral prolapse of Prostate</td>
<td>600</td>
<td>640</td>
<td>467,705</td>
</tr>
<tr>
<td>Calculi at kidney and ureter</td>
<td>1540</td>
<td>H10</td>
<td>237,305</td>
</tr>
<tr>
<td>Disorders of penis</td>
<td>409</td>
<td>117,848,106,109</td>
<td>258,910</td>
</tr>
<tr>
<td>Malignant neoplasm of prostate</td>
<td>246</td>
<td>J01</td>
<td>120,509</td>
</tr>
<tr>
<td>Vescicoureteral dysfunction</td>
<td>277</td>
<td>J22</td>
<td>59,973</td>
</tr>
<tr>
<td>Cystitis</td>
<td>998</td>
<td>AN1,AN2</td>
<td>276,849</td>
</tr>
<tr>
<td>Pain and other symptoms associated with renal tract obstruction</td>
<td>825</td>
<td>N59, N79,110</td>
<td>61,118</td>
</tr>
<tr>
<td>Malignant neoplasm of bladder</td>
<td>389</td>
<td>C57</td>
<td>47,401</td>
</tr>
</tbody>
</table>

A Snapshot of Procedures in the AQUA Registry

<table>
<thead>
<tr>
<th>Urologic Procedures</th>
<th>CPT</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urethral, Anterior urethral Scope</td>
<td>81063</td>
<td>625,977</td>
</tr>
<tr>
<td>Assay of PSA</td>
<td>88358,83354</td>
<td>212,932</td>
</tr>
<tr>
<td>Measurement of Post-voiding Residual Urine and/or Bladder</td>
<td>91780</td>
<td>198,858</td>
</tr>
<tr>
<td>Routine Voiding</td>
<td>96415</td>
<td>124,074</td>
</tr>
<tr>
<td>Cystoscopy</td>
<td>52000</td>
<td>130,038</td>
</tr>
<tr>
<td>Biopsy Of Prostate</td>
<td>55700</td>
<td>32,686</td>
</tr>
<tr>
<td>Cystourethroscopy with insertion of indwelling Urethral Catheter</td>
<td>52332</td>
<td>3,301</td>
</tr>
</tbody>
</table>

Benefits

- Physician Performance Reports Based on Clinically Validated and Comparative Data
- National Benchmarks for Diagnosis, Treatment and Performance
- Reimbursement Support Through Submission of Quality Measures to CMS
- PQRS/MIPS Measure Submission Is Hassle-Free
- Treatment and Outcome Associations
- Patient-Reported Outcomes (PROs)
- Specialized Registry Reporting
- Maintenance of Certification (MOC)

Progress Update

- Approximately 400 practices have joined the AQUA Registry with more than 2,300 providers
- 46 states + DC + Puerto Rico and USVI represented across the US, including all regions (no attempts so far to force diversity)
- Mix of small, medium and large practices (including major academic medical centers)
- 1.38 million patients with 4.38 million patient visits
- n > 29,000 new prostate cancer patients from the first 36 practices (2014-16)
- PRO program piloted at four sites
Surviving MACRA, Applying MIPS
J. Quentin Clemens, MD

Distribution of AQUA Registry Participants - National Representation of Urologic Care Providers and Their Patients

Next Steps
- Expand PRO Program
- Expand Measures
  - Female Urology/Incontinence
  - Urinary Stone Disease
  - Urologic Oncology (including CRPC)
  - Male Sexual Health (e.g., ED, Infertility, T Replacement)
  - BPH/Male Voiding Dysfunction
  - Pediatric Urology
- Templates
  - Reduce Needs for Natural Language Processing

Contact The AQUA Registry

Contact the AQUA Registry Team for more information
Email: aqua@auanet.org
Toll-free: 1-855-898-AQUA (2782)
http://www.AUAnet.org/AQUA

Special note: If you are currently not an AQUA Registry participant and would like to use the AQUA Registry to fulfill your 2016 PQRS reporting, you must sign up with the AQUA Registry no later than September 15, 2016.
MACRA Legislative Update
AACU State Advocacy Conference 2016

Jason Jameson, MD
Arizona Urological Society, President

SGR History

• Medicare Sustainable Growth Rate (SGR) method was used by CMS to control spending on physician services
• Balanced Budget Act of 1997
• Goal to ensure yearly increase in Medicare expenses did NOT exceed the growth in GDP
• Physician fee schedule updated yearly with conversion factors to bring payments in line with SGR targets

MACRA History

House Passes SGR Repeal Bill, Action Moves to the Senate
• House of Representatives voted 392-37

Senate Passes Historic SGR Repeal Bill By Vote of 92-8
— Measure now heads to President Obama, who has said he will sign it.

H.R. 2: Medicare Access and CHIP Reauthorization Act (aka “MACRA”, “doc fix”)

• Repealed SGR, and the expected 21% Medicare Pay Cut
• Initial 5 year annual 0.5% update to physician payments
• Replaced PQRS, meaningful use, value-based modifier with MIPS (Merit-based Incentive Payment System)
• Supported by AACU, AUA, LUGPA, AMA, ACS

Surviving MACRA, Applying MIPS
Jason J. Jameson, MD
(Page 1 of 3)
MACRA History
April 16, 2015

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS Quality Measure Development Plan:
Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)

May 2, 2016

AACU
• Postpone performance period for one year
• Provide incentives to encourage transition to EHR technology, not penalties
• Protect physicians from EHR liability issues
• Raise the low-volume threshold exemption
• Reinstate the opt-out option for providers who would rather pay penalty

urologytimes.modernmedicine.com

Alliance of Specialty Medicine
• Delay and shorten performance period to 6 months
• CMS to provide more robust education
• CMS release key funds for quality measure development
• Advance specialty-specific Physician-Focused Payment Models (PFPMs)
Surviving MACRA, Applying MIPS
Jason J. Jameson, MD
(Page 3 of 3)

Sen. Orrin Hatch (R-UTAH)
Chair, Senate Committee on Finance
Wednesday, July 13, 2016
MACRA: Ensuring Successful Implementation of Physician Payment Reforms

- CMS Mr. Slavitt Comments
  - Regarding start date, reporting period concerns
    - “We remain open to alternative start dates, whether shorter periods should be used”
  - Regarding ongoing need for refinement, possible interim final rule this fall
    - “that is an option, and other options are on the table as well”
  - Regarding low volume threshold of $10,000
    - “we are looking at that, but the ‘juice has to be worth the squeeze’”

CMS, MACRA Panels
- MACRA Episode-Based Measures Clinical Committee
  - AUA appointed Dr. Jim Dupree, U of Michigan
  - Define episode triggers, windows of care
    - episodes, patient condition groups, episode group algorithms
- MACRA Episode Measures Technical Expert Panel
  - AUA appointed Dr. Chad Ellimoottil, U of Michigan

“Health Policy is 10% legislation and 90% implementation”
-Wilbur Cohen, principal architect of Medicare, 1965
Surviving MACRA, Applying MIPS

9th Annual AACU State Society Network Conference

Tom S. Lee, CEO & Founder, SA Ignite

08.20.2016

Agenda

• What We Do

• MIPS: The Basics

• The Most Popular Submitted Comments on MIPS/MACRA

• MIPS Readiness

• Q & A

About SA Ignite

We help healthcare organizations simplify complex value-based programs.

15,000 providers, 80+ organizations

What We Do

IgniteQ Platform: Program Management & Analytics to Maximize Performance Scores

Top-Ranked on Google for MIPS
Surviving MACRA, Applying MIPS
Tom S. Lee, PhD
(Page 2 of 5)

The Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)

Largest Change in a Generation to Medicare Reimbursement

- Passed 92-8 by Senate with bi-partisan support
- Shifts incentives from volume to value of care
- Introduces complex, multi-program rules and scoring
- Amplifies both financial and reputational impacts
- Classifies each Medicare Part B clinician as being in:
  - MIPS, alternative payment models (APMs), both, or none (minority)

MIPS: The Basics

MACRA Rulemaking Timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 27, 2016</td>
<td>MACRA draft rule released</td>
</tr>
<tr>
<td>June 27, 2016</td>
<td>Comment period ended</td>
</tr>
<tr>
<td>By Nov 1, 2016</td>
<td>Release of final rule</td>
</tr>
<tr>
<td>CY2017</td>
<td>First performance year</td>
</tr>
</tbody>
</table>

MIPS Components & Scoring

- New scoring model
  - Creates a 100-point system to increase and consolidate financial impacts, rank peers nationally, and report scores publicly

Example: CY2017 Financial Risk

Payment swing for every $10M in Part B payments = $1.8M

Every MIPS Point Counts

- Exceptional Performance Bonus Threshold
- Performance Threshold (25th percentile below PT)
- Max Incentive
- Max Penalty

*Assumes only 1X multiplier on base incentive, includes 15% Exceptional Bonus
Surviving MACRA, Applying MIPS
Tom S. Lee, PhD
(Page 3 of 5)

ACI Scoring System

- **BASE SCORE**: Makes up to 50 points of the total ACI Performance Category Score
- **PERFORMANCE SCORE**: Makes up to 80 points of the total ACI Performance Category Score
- **BONUS POINT**: Up to 1 point of the total ACI Performance Category Score

**COMPOSITE SCORE**

- Earn 100 or more ACI points and receive full 25 points of the ACI Category of the MIPS Composite Score

Takeaway:
Past high MU compliance does not guarantee a high ACI score.

MIPS Quality Score Calculation: An Example

<table>
<thead>
<tr>
<th>Performance</th>
<th>Total Possible</th>
<th>Points Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQRS Measure 1</td>
<td>80th Percentile</td>
<td>10</td>
</tr>
<tr>
<td>PQRS Measure 2</td>
<td>70th Percentile</td>
<td>10</td>
</tr>
<tr>
<td>PQRS Measure 3</td>
<td>50th Percentile</td>
<td>10</td>
</tr>
<tr>
<td>PQRS Measure 4</td>
<td>50th Percentile</td>
<td>10</td>
</tr>
<tr>
<td>PQRS Measure 5</td>
<td>50th Percentile</td>
<td>10</td>
</tr>
<tr>
<td>PQRS Measure 6</td>
<td>50th Percentile</td>
<td>10</td>
</tr>
</tbody>
</table>

**Bonus Points**: Additional high-priority measures, CAHPS, end-to-end e-Reporting

- **TOTAL Points**: 60
- **Quality Contribution to MIPS Score**: 41/60 = 68%

Key Takeaway:
Past success avoiding PQRS/VBM penalties does not guarantee a high MIPS quality score.

The Most Popular Submitted Comments on MIPS/MACRA

- Analyzed comments from: AAFP, ACP, AHA, AMA, AMDIS, AMGA, AMIA, CHIME, HFMA, HIMSS, and MGMA.

Things To Do Now to Prepare for MIPS

1. Educate your organization, particularly the C-suite
2. Estimate MIPS score to identify gaps and best improvement opportunities
3. Optimize MU & PQRS/VBM comprising 75% of the MIPS score
4. Evaluate staff, resources and organizational structure
5. Seek assistance and partners
1. Educate Your Organization:
   Free Resources to Help
   - 10 FAQs About MIPS: Google “merit-based incentive”
   - 12 FAQs About the MACRA Proposed Rule:
   - Free MIPS Financial Calculator: Google “mips calculator”
   - Recorded MIPS monthly webinars and downloads: 350+ attendees/webinar
   - LinkedIn Group “Merit-Based Incentive Payment System” (no ads, 250+ members)

Surviving MACRA, Applying MIPS
Tom S. Lee, PhD
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2. Estimate Your MIPS Score:
   A MIPS Readiness Assessment
   - Qualitative & quantitative analysis of Client’s MIPS Readiness
     - Assessment of people, processes, & infrastructure impacted by MIPS
     - Analysis and calculation of ACI, Quality, CPIA, and MIPS score baselines and improvement opportunities
   - MIPS Readiness Summary

<table>
<thead>
<tr>
<th>GRADE</th>
<th>ESTIMATED SCORE</th>
<th>FINANCIAL IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>64</td>
<td>$1M</td>
</tr>
</tbody>
</table>

3. Example of PQRS Optimization:
   Selection of PQRS Reporting Method Can Greatly Impact Quality Scores
   - Reporting Method 1
   - Reporting Method 2
   - Quality Score

4. Evaluate Staff, Resources and Organizational Structure
   - Factor MIPS staff and resources into the CY2017 budget
     - Clinicians need to be educated and engaged
     - New performance score needs to be monitored and managed
     - Data submission options need to be vetted and resourced
   - Combine MU (ACI) & PQRS efforts under a single leader for MIPS
     - MU often under CIO, whereas PQRS often under CDO/VP Quality
     - Enables cross-category tradeoffs so as to maximize MIPS score with least effort
Surviving MACRA, Applying MIPS
Tom S. Lee, PhD
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Summary

- The financial stakes of MIPS are very high
- Penalties fund the incentives for the winners
- Every MIPS point counts
- Past success in MU or PQRS/VBM does not guarantee a high MIPS score nor avoiding MIPS penalties
- There are things you can do now to prepare for MIPS
Employed Physicians and MACRA

Subtitle: What is MACRA?

Good news

Gets rid of SGR
SII in physician payments

N.B. MIPS may be good for you!

Merit-based Incentive Payment System

MACRA also retains a modified fee-for-service model and consolidates former reporting programs

Payment based on
• Quality: 50% but going down
• Cost: 10% but going up
• Advancing Care Information (meaningful use...) 25%
• Clinical Practice Improvement Activities: 15%

NB: Payment starting 2019 but data from 2017!!!
NB: Zero sum game. +4% to +9%

Alternative Payment Models

MACRA supports physicians who choose to adopt new payment and delivery models approved by the Centers for Medicare & Medicaid Services.

Participation in these new models is entirely voluntary.

BK Thoughts:
ACOs: not very successful
APMs: Most hospitals and groups will not participate

BK opinion

If it is a zero sum game,
Some will win and some will lose.

If you want to be a winner,
Learn the rules and get in early.
BK Opinion Survey

6 Question Survey (in and out of medical center)

Note:
Not scientifically valid
No statistics

Warning: Results may be scary!!
Conclusion:

Lots of ignorance on MACRA.

Organizations have not done much to educate their staff.

If you bone up and follow the rules, you will likely come out ahead of the game.

If you are employed physician, you may want to prepare yourself (and push your hospital).
Winners and Losers Under the Affordable Care Act
Scott Becker, JD, CPA

I. Thank you for having me

II. Watched Urology for years – Fascinating Area, Nice, Great Doctors

III. Urology has been a very flexible and evolving arena
   1. Core practice + Evolving and Changing, Ancillaries*
      A. Lapars (90’s)
      B. Radiation Therapy (IMRT)
      C. Lithotripsy
      D. Laser and More
      E. Pathology Labs (in-office labs)
      F. ASC’s
      G. Bone density tests
      H. Drug infusion services
      I. CT Scanner
      J. Urodynamics

* See Current & Future State of Ancillary Services in Urologic Practices, Juan A. Reyna, MD, President Emeritus-Urology San Antonio

IV. Losers Under the ACA
   1. Smaller independent practices (but category killers and dominant in areas are doing ok)
   2. Smaller community hospitals
   3. Critical access hospitals
   4. Small urban hospitals
   5. FTC-DOJ – But the Empire is Striking Back
   6. The Republicans
   7. Taxpayers
   8. Savers
   9. Physicians and the American Medical Association
   10. People who pay retail for insurance, (i.e., between insurance costs and high deductible plans)
   11. States that didn’t expand Medicaid

V. Winners Under the ACA
   1. Big health systems
   2. Regionally dominant health care systems
   3. Hospital chains
   4. Kids (young adults i.e., up to 26) on parents payrolls
   5. Lower income families
   6. Larger companies that sell to health systems
   7. People with pre-existing conditions

A. Winners (continued)
   8. Revenue cycle companies
   9. President Obama
   10. HIT & data analytics companies
   11. Consultants and lawyers (for now)
   12. Pharmacy & device companies
   13. The uninsured
   14. Epic and Cerner
   15. States that expanded Medicaid (for now)

Questions or Comments?
Independent Physician Practice
Strategies for Reimbursement

Peter M. Knapp, Jr., MD, FACS
Earl L. Walz, MBA

Independent Physician Practice Strategies for Reimbursement

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Current FFS Environment:
Capture Facility Side Revenue

ASC
Equipment leasing
Litho, Laser, Cryo, HIFU
Clinical lab
Anatomic pathology
Radiology
US, CF, MRI
Radiation

Current FFS Environment:
Clinical Service Lines & Navigators

Advanced prostate cancer
IV Infusion Rx, Medication Dispensary
OAB clinic
Medication compliance, 3rd line therapy
Men’s Health clinic
Low T, ED, LUTS, Prostate Cancer early detection
Women’s Pelvic Health
FPMRS specialist
Practice pharmacy
APC
Sildenafil

Commercial Payors
Future Payment Models

FFS
Negotiate professional service & facility fees

Bundled payments – episode of care
Prostate surgery – PCa, BPH
Kidney stone – Litho, perc, URS

Value based care
Capitation
Global contract – PCMH, PCSP

I. Current reimbursement challenges.
II. Current FFS environment
III. Commercial payors future payment model
IV. Hospital as customer/payor
V. New community/regional independent physician collaborative

Current Reimbursement Challenges

Discount FFS
Commercial payer mergers
Anthem proposed acquisition of Cigna
Aetna proposed acquisition of Humana
POS antitrust lawsuit
Emergence of value based payment
Medicare Macra
Commercial payers to follow?
Threat or opportunity?

9th Annual State Advocacy Conference
Hospital as Payor / Customer

Physician Service Agreements
  Service line management
  Medical Director
  Pay for Call

Community / Regional
Independent Physician Collaborative

Focus on employers and community education

Contract with payors and/or self-insured employers
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CON History

- 1946 – U.S. Hill-Burton Act
- 1964 – New York State
- 1974 – U.S. Health Planning Resources Development Act
  – 1975 (20 states)
  – 1978 (36 states)

CON Reform Across the U.S. (2016)

Across the Country

North Carolina
- 4th most restrictive state
  - Includes CT
  - Gradual elimination (2015)
  - 5 year lead time, total repeal in 2021 (2016)
- www.reformCONnow.com
  - Organizations
    - Urological Assoc., Orthopaedic Assoc.,
      Ophthalmology Society, State
      Employee Assoc.
  - Large practices
    - Carolina Urological Associates, Blue
      Ridge Bone and Joint, Triangle
      Orthopaedic Associates, P.A.
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Across the Country

South Carolina
- Gov. zeroed-out enforcement agency’s budget (2014). Overturned by court.
- FTC concluded law is anticompetitive, urged repeal
- Bill to reform process failed (2016)
  - Service expansion at facility where CON already issued
  - Increase capital/equipment threshold

Florida
- Charity care exemption for facilities
  - Rebuffed by hospital, hospice and nursing home industries
  - Say the current law is working just fine.
  - Sponsor: if the issue was "decided on the weight of the evidence, I know this would pass."

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Across the Country

- Iowa: RT equipment < $5 million
- Kan.: APRN clinics
- Va.: MRI, CT, RT, PBT services and equipment based on charity care
- Wash.: Prohibit CON issuance that’d consolidate power

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Across the Country

- Massachusetts
  - REDUCE capital expenditures CON threshold from $25 million to $5 million
- Tennessee (LAW APPROVED)
  - Lithotripsy, critical access hospital closure, capital expenditures for EXISTING institutions, MRI services and equipment in population centers

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THANK YOU