CUA REPORT

Spring/Summer 2014

A POWERFUL VOICE FOR CALIFORNIA UROLOGISTS

President's Report

For Those Who Are Prepared Chaos Brings Opportunity

By David S. Benjamin, MD

2014 will bring large challenges for members of the CUA as medicine across the country and specifically Urologists in California bear witness to one of the most significant years in recent medical social/economic history. As the fight over MICRA takes center stage in Sacramento, the probable repeal of the SGR affects every physician in America. Last year, 2013, yet another Urologist was murdered by his/her patient resulting in multiple Urologic organizations uniting to try to find a way to provide safety for its members.

The CUA is excited that Dr. Vito Imbasciani is the first Urologist to run for a California senate seat and CUA proudly endorses him and his campaign. With all that is in store for Urologists in the coming year there is no better and essential time for Urologists to support and contribute to the CUA, CMA and UROPAC. (See more about Dr. Imbasciani's campaign on page 6.)

In 2013 physicians won the battle on MICRA, but only scratched the surface when it came to winning the war. Trial lawyers and their supporters filed a proposed November 2014 ballot measure that would potentially increase the non-economic damages cap from $250,000 to over $1 million and therefore tripling the trial lawyers' legal fees. The ballot measure has recruited people such as Dennis Quaid who is speaking out in favor of the measure as a form of patient safety advocacy. The Consumer Attorneys of California, (CAC) the lobbyists that represent trial lawyers have contributed over a million dollars in an effort to obtain signatures to support the measure. The lawyers have loaded the measure with provisions meant to "distract" the voters such as mandatory drug testing for physicians and requiring physicians to report other physicians suspected of drug or alcohol impairment or medical negligence. Finally the measure does not only raise the trial lawyers' fees, but will increase health care costs to state and local governments to the tune of 9.9 billion dollars.

A recent study conducted by William G. Hamm former head of the nonpartisan California legislative Analyst's Office examined the effect of increasing MICRA's cap on cost of and access to health care. Raising the cap on noneconomic damages in medical injury cases to $1 million would increase health care by $1,000 a year for an average family of four.

Outgoing President Eugene Rhee (L) receives a plaque for 2 terms of service as President from David Benjamin, incoming President during the CUA meeting in Monterey

The CUA is a member of Californians Allied for Patient Protection (CAPP), a coalition of more than 800 organizations representing doctors, community clinics, nurses, hospitals, and others that support MICRA and are actively opposing the trial lawyer ballot measure.

In 2013 the House Ways and Means Committee and the Senate Finance Committee passed bills to eliminate the badly broken Medicare sustainable growth rate (SGR) and replace it with a stable payment system for the foreseeable future. As we all know for the last 10 + years there have been mandated Medicare fee cuts that have been deferred at the last minute, much to the distress of physicians. The initial proposal was not supported by the AUA and

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President's Report continued

AMA as it called for a 10 year freeze on physician payments.The new proposal has found physician support as it does call for modest fee increases of 0.5% over the first 5 years. The new alternative to the SGR comes with a hefty price of an estimated 138 billion dollars and will likely include cuts to in-office ancillary services and cuts to hospital reimbursements to offset the cost.

Pertinent to Urologists in California, is a letter written by six of the largest medical societies in the United States, representing the majority of the nation's Medicare beneficiaries. This letter was sent to the chairman of the Senate Finance Committee and the House Ways and Means Committee, asking them to incorporate the California locality update into the SGR repeal measure. This would update the California county-based localities to the same Metropolitan Statistical Areas used to determine payment rates for hospitals.

On March 6th 2014 the House stated it will vote next week on legislation to delay the ACA's "individual mandate and prevent a cut in Medicare payments to" physicians. GOP lawmakers are putting this new legislation together with the SGR repeal bill so that revenue generated by delaying the individual mandate could be used to pay for preventing a cut in doctors' payments. So this recent change puts the entire SGR repeal in jeopardy as House Democrats now have to either vote against the SGR repeal that they have been fighting for so long or vote against a key, but unpopular piece of the Affordable Care Act. As this report goes to print the SGR repeal patch or "Doctor-fix" has been passed by both the House of Representatives, Senate and signed by President Obama. It did include the California based locality update which will take several years to implement. It also delayed the costly and burdensome ICD-10 coding system till Oct 2015. We must remember this is only a patch and has not replaced the SGR but only delayed the Medicare fee cuts once again. We will have to wait and see as to whether congress can find a long lasting replacement for the SGR.

Though the murder of Dr. Ronald Gilbert by a patient in January, 2013 was a shock to the Urologic community, it was actually the third assault on an Urologist in a 2 year period. Since then another Urologist, Dr. Charles Gholdoian (Reno, Nevada), was shot and murdered by a patient and his partner shot and injured in December, 2013 bringing the total to 5 Urologists murdered or assaulted in the last 3 years. This has raised grave concerns for Urologists and their staff safety at the local, state and national level. The CUA is currently working with the CMA on a "Threat Awareness Program." This program would potentially allow California providers to share information on high risk patients in an attempt to thwart potential attacks on physicians and their staff. There are still definite hurdles to clear as HIPPA requirements must be adhered to and the realistic ability to prevent violence in the workplace is still in doubt.

In early February, Dr. Vito Imbasciani, a CUA past president, announced his candidacy for the 26th Senate District seat. Vito, a Democrat, is a veteran of two wars with active duty tours in Desert Storm and Iraq. He has over 28 years of service as an officer of the US Army Medical Corps and is a state surgeon for the California Army National Guard. Dr. Imbasciani is running against Betsy Butler who is anti MICRA and pro-attorney as well as 5 other pro-lawyer candidates. The CUA has endorsed him and will assist Vito in speaking to the state Urologic county chapters as well as county Medical societies as his campaign ramps up. It is truly exciting to have a potential friend in Sacramento. Vito urgently needs your support. No matter what your personal politics may be, Vito is a friend of urology and will fight for us. If you care about your malpractice insurance rates rising and legislation relevant to your practice, then please take a moment now and make a donation to his campaign.

It would be a shame for us to lose this rare opportunity to have a urologist and friend in Sacramento working for us instead of someone else working against us.

DONATE NOW at drvitoforsenate.com

Whether it is the absolute need to defeat the trial lawyers trying to do away with MICRA, supporting and defining the best alternative to the SGR, keeping Urologists safety at the forefront of awareness or endorsing Vito Imbasciani's candidacy for the 26th Senate District seat, the CUA as well as the CMA, UROPAC, WSAUA and county or local Urologic organizations will play a vital role in representing California Urologists best interests. As this report goes to print a massive crises task force is being organized and mobilized by the CUA and CMA to stop SB 1215 before it reaches the legislative floor for vote. This bill would eliminate all "In office ancillary services"/(IOASE) as we know them now. The CUA needs your continued membership as well as your personal involvement at any and every level.

David S. Benjamin MD
President, California Urologic Association

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Report of the AMA Urological Association

By Aaron Spitz, MD

Delegate to the American Medical Association

CUA Membership Meeting, Monterey, California, November 4, 2013 – For the past several years I have been serving as both an alternate delegate and a delegate to the American Medical Association House of Delegates on behalf of the American Urological Association. The AMA convenes twice a year for meetings that span approximately 5 days. We meet annually in Chicago and semiannually in rotating host cities. This report is from the annual meeting in Chicago this past June, 2013. *(Editor's Note: Please see page 10 for a report of the Interim meeting in November 2013.)*

The House of Delegates is the democratic policy making body of the American Medical Association. Twice a year over 500 delegates and a corresponding number of alternate delegates convene to establish broad policy on health, medical, professional and governance matters. Delegates are members of the AMA and they represent national medical specialty organizations, state medical associations, professional interest medical associations, the five federal services, and several other AMA's member sections and groups. Representation in the House is proportional to the number of the AMA members in a society with every member organization allowed a minimum of one delegate. The AACU maintains one delegate and there are a small aggregate number of urologists who represent other state societies, professional interest associations, and federal services. There is an urology caucus which is comprised of all the various urologist delegates, and it is convened and led by the American Urological Association lead delegate, currently president elect William Gee, MD. There are several other caucuses that delegate urologists participate in such as the Surgical Caucus which is comprised of delegates from all the surgical specialties and the Pacific Rim Caucus representing the geographic area for which it is named. This year, representation for the American Urological Association dropped from 3 delegates to 2 because too many members of the American Urological Association dropped their membership with the AMA.

The House of Delegates can be the engine that drives the American Medical Association. The resolutions introduced and passed by the delegates establish policy positions of the AMA. In some cases these positions calls for creation or modification of existing laws. In other cases they call for guidelines directing or admonishing the actions of hospital, insurers, pharma or other key players in healthcare. These resolutions do not carry the authority of law, but they set a bar to which legislators may capitulate or springboard from. They also serve as the foundation for many healthcare institution rules and regulations. These resolutions inform the actions of the leadership of the AMA including the elected officers, Board of Trustees, and executives. At significant expense, legal teams are dispatched and AMA lobbyists are mandated to pursue the goals explicitly stated in the resolutions adopted by the House of Delegates.

In most instances the leadership carries out the will of the House but on occasion it acts independently and even contradictory to the will of the House. The most publicized and ultimately damaging occasion was the "endorsement" of the Patient Protection and Affordable Care Act by the then president of the AMA James Rohack (Texas cardiologist). The majority vote of the 500 plus AMA delegates had clearly adopted resolutions creating official AMA policy opposing the tenets of PPACA prior to this endorsement and the majority of the delegates were outraged. Dr. Rohack initially defended his action stating that the AMA leadership had worked out a behind the scenes deal with Obama to eliminate the SGR in exchange for this support, and the

Jeannie and Kathy DeSantis at the CUA Alliance Exhibit in the convention center at the AUA's Annual Meeting in San Diego.

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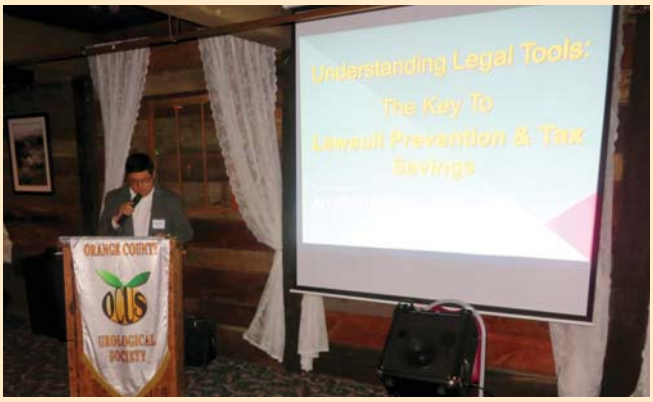
Report of the AMA continued

AMA leadership thought that it was in the best interest of America's physicians to get this deal, despite the explicit opposition to PPACA by the delegates. This deal never materialized and Dr. Rohack, facing an angry House just days after the ratification of PPACA, went on to apologize and lament that in the end the politicians in Washington had "screwed over (his words)" the AMA, likening them to "the worlds second oldest profession (his words)." From that moment on, the leadership of the AMA has been aligned with the will of the House of Delegates and postured in opposition to many of the tenets of PPACA in a clear and overt manner but, unfortunately, outside of any significant media spotlight. There continues to be some tension between how hard lined the House of Delegates wants the leadership and lobbyists to be versus what posture the leadership feels they ought to take to maintain relationships and continue to "be at the table." The critical point is that the leadership of the AMA currently remains aligned with the will of the House of Delegates.

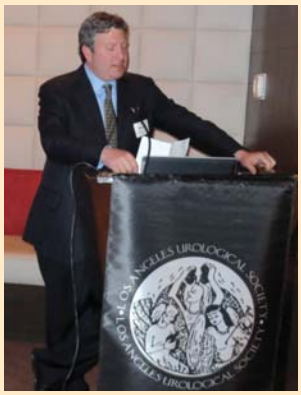
The vast majority of policy that is created and action items that are pursued are practically and philosophically aligned with the best interests of the majority of physicians including Urologists. Much of the policy is generally applicable to physicians and patients regardless of specialty but inevitably, resolutions arise placing Urologists squarely on center stage. Some resolutions are friendly, and some are overtly threatening. Urologist delegates in the House have been effective at creating alliances with delegations from other specialties and key geographic regions all who have come to the defense of Urology when it was under fire from the usual suspects: radiation oncologists and pathologist and most recently the USPSTF. Excellent argumentation and persuasion by Urology delegates from the floor of the meeting proceedings continue to successfully convince the majority of the House of Delegates that what is good for Urology is good for the majority. Longstanding relationships engendered over the years have aligned urology delegates with now key leaders in the AMA. Our Urology delegates are also rising through the ranks of leadership providing increased leverage to our concerns. **The greatest challenge we face is that although we are mighty, Urology delegate numbers are small, and until our AUA membership rejoins the AMA, our presence is diminished and our future is uncertain.**

This past session of the HOD generated some key resolutions of interest to Urologists. First and foremost

CUA Alliances Offer Urologists Local Connections within the State



In March, the Orange County Urological Society and Los Angeles Urological Society provided attendees an informative and useful lecture on how to protect against lawsuits. The lecture was provided by Legally Mine and illustrated the potential liability of loss and described strategies for physicians to legally obtain more tax deductions while safe guarding assets.



LAUS President Michael Safir, MD, reads announcements to attendees at the meetings which are held several times a year at the Hotel Angeleno in Brentwood.

The San Diego Urological Society, an alliance organization of the CUA, meets several times a year at the Yacht Club and Marina.

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Report of the AMA continued

was the adoption of resolution 227 proposed jointly by the AUA, AACU and the American Congress of Obstetricians and Gynecologists: "Resolved that our American Medical Association support legislation and/or regulations to ensure both Active Duty members of the Armed Forces and Veterans suffering from genito-urinary injuries receive the best possible surgical and mental health care (Directive to Take Action). This resolution will serve to reinforce favorable action by the Senate when they vote and then reconcile the National Defense Appropriations Act for fiscal year 2014 which was passed by the house with the successful inclusion of amendment 78 which "requires a comprehensive policy on improvement to the care, management, and transition of recovering service members with urotrauma from DoD to VA. Urotrama is a class of wounds to the genitourinary system which includes the kidneys, reproductive organs and urinary organs.(Guthrie R-KY)."

Policies opposed to PPACA continued to resonate with the House. The AMA was mandated to develop a policy statement that strongly restrains pay for performance, continues to oppose the SGR while developing an alternative model, calls for the repeal and possible replacement of the IPAB (Independent Payment Advisory Board), supports private contracting within and without Medicare, and calls for the repeal of the non-physician provider non-discrimination provisions of the PPACA.

Adopted resolutions explicitly called for the preservation of a diversity of practice configurations with no less emphasis given to private practice. Physicians should be free to determine the basic method of compensation for their services and its level of value. The AMA will also call for CMS to impose additional restraints on Recovery Audit Programs limiting their ability to use extrapolation accounting.

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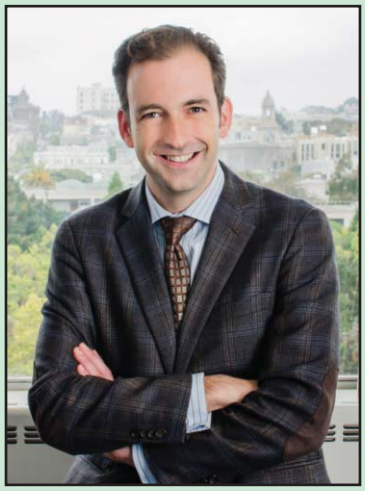

Why The CUA is Important to Urologists in Academics

By Matthew Cooperberg, MD, Secretary Treasurer

I grew up on the East Coast, majored in English at Dartmouth College, and earned my MD and MPH degrees at Yale University before following my wife to California for residency and fellowship training in urology and urologic oncology under Peter Carroll. I am now a urologic oncologist in academic practice at the UCSF Helen Diller Family Comprehensive Cancer Center, where I am associate professor in the Departments of Urology and Epidemiology & Biostatistics, and at the San Francisco VA Medical Center.

I have had a longstanding interest in health policy, which was my concentration during my MPH degree. In fact, part of what led me to develop my academic focus on prostate cancer was the opportunity to work from molecules to patients to the health care system, and I firmly believe that ultimately solving intractable controversies surrounding the disease will take concerted, coordinated efforts at all these levels.

As I have embarked on a career in a public-sector academic medical center, the special challenges facing academic centers—particularly in California—have become increasingly clear. We have to cope with a payor mix which often doesn't even cover costs (Medi-cal pays the 4th worst Medicaid rates in the country), with an increasingly competitive grant environment, with a generally unfunded educational mandate, and with regulatory burdens in all three domains—clinical, research, and education—which are growing exponentially. I have not seen enough engagement in policy and politics by academic urologists, and we cannot assume that anyone else will speak for us.

Report of the AMA continued

Several newly ratified policies defend the position of the physician versus competing stakeholders. The AMA will seek legislation or regulation preventing managed care companies from offering contracts below Medicare rates. There should be no relationship between the medicare fee schedule and "usual and customary" fees. Pharmacies must cease from the disruptive practice of inappropriate inquiries regarding the rationale for prescriptions. The AMA will continue to assist states in opposing legislation that would allow for the independent practice of certified registered nurse practitioners.

Our Urology delegates strategic coalitions came to bear in the nuancing of a new policy limiting the scope of practice for non physician providers engaged in invasive procedures. Board of Trustees report 16 was introduced to prevent non physicians from engaging in "invasive treatments" for chronic pain management by preventing them from administering fluoroscopy which is an integral part of such procedures. The Urology delegation recognized the potential for unintended consequences limiting practice patterns amongst some of our fellow urologists in which non physicians may operate fluoroscopy or participate in procedures that could fall under the definition of invasive procedures such as testosterone pellet insertion, cystoscopy, and prostate ultrasound and biopsy. Although these are areas of controversy within the Urology community, it would be undesirable to allow non urologists to mandate our practice patterns.

Our strong relationship with the author of the report and the Chair of the Board of trustees, Dr Steven Stack which dates back to my mutual service with him in the Young Physicians Section of the House of Delegates, coupled with our strategic alliances with other surgical and procedural specialists allowed for a win-win in which the report was adopted with amendments specifically limiting the prohibition to invasive procedures utilizing fluoroscopy for the treatment of chronic pain but not for other situations.

Policies were adopted to attempt to mitigate the burdens of implementing electronic medical records. The AMA will request CMS to provide an outside independent assessment of the impact of EMRs on patient safety, but also on the financial solvency of hospitals and physician offices. The AMA will seek regulations or legislation to require EMR vendors to provide interoperability software and petition CMS to encourage hospitals and health systems to achieve interoperability. ICD-10 looms on the horizon. It will incorporate 68,000 diagnostic codes, a more than five fold increase over our existing ICD-9. At the House of Delegates meeting in November 2011, policy was adopted placing the AMA in direct opposition to its implementation. AMA advocacy resulted in the introduction of H.R.

CUA Past President Seeks Senate Seat

CUA Past President Vito Imbasciani, MD, a full-time practicing urologist with the Southern California Permanente Medical Group in Los Angeles and the State Surgeon of the California Army National Guard became the first person to announce his candidacy to succeed Ted Lieu in the 26th Senate District seat. Imbasciani represents urologists in the many professional societies at the state level in order to guarantee access to health care by protecting MICRA. He has served as the CUA representative to the Council on Scientific Affairs at the California Medical Association since 2005. Imbasciani, 57, has 28 years' service as an officer in the U.S. Army Medical Corps and is a veteran of two wars, with active-duty tours in Desert Storm and Iraq.

The CUA supports Imbasciani as a knowledgeable physician in the State Senate.

Learn more about Dr. Imbasciani's campaign for the California Senate (SD-26: Torrance, Redondo Beach, Manhattan Beach, Venice, Santa Monica, Pacific Palisades, Beverly Hills and Hollywood) on his website: www.drvitoforsenate.com or write to him directly at drvito@drvitoforsenate.com.

Consider making a donation for the preservation of MICRA through the Californians Allied for Patient Protection (CAPP).

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Report of the AMA continued

1701 "cutting costly codes act of 2013" into both the House and Senate. It seeks to set aside implementation of ICD-10 and mitigate the disruption to physician practices when advancing to a new diagnostic code. Additional policy was adopted that mandates the AMA to educate America's physicians as to these efforts and to support legislation that in the event of adoption of either ICD-10 or ICD-11(perhaps better) mandates a two-year "implementation" period by all payers, including CMS. During this period there shall be no payment penalties for incorrect coding, and educational feedback from payers shall be required.

Resolutions of interest to education and training included requesting formal education regarding insurance systems and Medicare at the medical student and resident level. Other resolutions relevant to training called for a reduction on student loan interest charges, expansion of public service loan forgiveness, and reexamining resident work hour limits with input from specialty societies with a call for evidence based evaluation of such limits.

Maintenance of certification was a topic of great interest and several resolutions were proposed designed to protect the physician from inordinate interference. These resolutions were re-crafted into amendments to a report generated on the topic by the Council on Medical Education (report 4), and emphasis was placed on increasing transparency by ABMS specialty boards regarding revenues, expenses and conflicts of interest. The AMA will work with the ABMS to minimize expense and workload to the physician particularly those with multiple certifications. Additionally the AMA will commission and independent study examining the evidence justifying the components of MOC with attention to its impact on physician workforce, practice costs, patient outcomes, patient safety and patient access.

Much of the policy adopted by the AMA addresses public health concerns ranging from cigarettes to soft drinks. Of mutual concern to all physicians is the topic of obesity. AMA policy now recognizes obesity as a disease state. The consequence of this policy will likely be an increase in allocation of resources including insurance coverage and research funding. Oncofertility and fertility preservation is supported by new AMA policy that mandates lobbying for legislation requiring all payers to cover fertility preservation therapy when iatrogenic infertility may be caused directly or indirectly by necessary oncologic treatments. Neonatal circumcision received support with a policy encouraging Medicaid reimbursement for the procedure and formally stating that the health benefits outweigh the health risks and that access to this procedure should remain unfettered. Renal transplantation will be aided by policy lending AMA support to the efforts of private and public mechanisms that work to extend insurance coverage for evidence based treatment of transplant care for as long as the transplant remains viable. The AMA will also offer technical assistance to individual state and specialty societies when they lobby state or federal legislative or executive bodies to implement evidence based cost-saving policies within public health insurance programs.

The majority of AMA policy is relevant to and supportive of the academic or clinical Urologist. The AMA provides other support critical to our practice of medicine. There are legal teams working not only nationally but even more critically state to state to put out fires. They are engaged in battles protecting the scope of practice of physicians, defending the independent practice of medicine from undue state governmental oversight or payor influence, and fighting for gains in tort reform. Executive staff provide resources helpful to state and specialty societies. The AMA's public relations infrastructure can message rapidly and effectively. Often the issues that may impact urologists come disguised as issues involving other specialties or primary care. Although Organized Urology has a very effective PAC and lobbyists, they can-

Leading the CUA in 2014 - Pictured at the CUA Member's meeting in Monterey, CA are new officers: Aaron Spitz, MD, President Elect (L); David Benjamin, MD, President; Eugene Rhee, MD, Immediate Past President (2 terms). In addition to being the voice of urology to the state's legislation, the CUA generously made possible the obtainment of Radiology credits (ASRT) for the attendees of the Western Section AUA's Annual meetings and has done so for the past three annual meetings.

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Report of the AMA continued

not be responsive to all things at all times. The AMA has extensive resources at its disposal and whether we like to admit it or not, the AMA is still considered the representative body of America's physicians by legislators, regulators, other stakeholders and the media. Sadly under 15% of practicing physicians are members of the AMA and few urologists amongst those ranks. The AMA has certainly alienated its membership with historical failures but currently, they are moving in the right direction and past lack of performance is not a guarantee of future results.

The AMA House of Delegates is populated by physicians with whom we urologists have more in common than not. These delegates by and large defy the stereotype of the hand wringing socialist. They more typically are entrepreneurial in their own practice and highly concerned with their independence in decision making and in contracting. Some are academic faculty trying to meet the pressures of reduced grants and increasing manpower demands. Some are armed services personnel trying to achieve equitable care for soldiers and returning veterans. Many primary care physicians in the House of Delegates have opted out of Medicare and fight hard to reclaim the right to private contracting. Others oversee the public health demands of inner cities or disaster relief. Some serve as high level administrators in private and public institutions ranging from surgery centers to Medicare. Many participate in a variety of ancillary services. These AMA delegates are by and large good and thoughtful people. They listen carefully and then deliberate. When Pathology and Radiation Oncology delegates attempted to introduce policy directing the AMA to oppose the in office ancillary exemption for Urologist, the House of Delegates refused, understanding that such turf wars were not appropriate for the House. When family practice delegates attempted to introduce policy directing the AMA to demand that the RUC be reconfigured with proportional representation which would have resulted in overwhelming disadvantage for specialists, the House of Delegates refused, acknowledging that the AMA should have no jurisdiction over the RUC. These levelheaded outcomes did not occur in a vacuum. Urology delegates moved rapidly behind the scenes and from the floor to secure these protections. However, we are fewer in number now then we were last year. **We Urologists need to be amongst the House of Delegates to both influence their deliberations and take back what we learn. The only way to increase our presence is to increase our membership in the AMA. If you haven't already, rejoin the AMA. Its worth every penny.** Report by Aaron Spitz, MD

Minutes of the 25th Annual Membership Meeting California Urological Association

Monday, November 4, 2013 ~ Portola, Hotel, Monterey, CA ~ DeAnza Ballroom, (Held in conjunction with the Western Section AUA's Annual Meeting)

Officers Present:
Eugene Rhee, M.D., MBA, President
Joseph Kuntze, M.D., Imm. Past President CUA
David Benjamin, M.D., Secretary-Treasurer

Past-Presidents Present:
Jeffrey E. Kaufman, M.D.

Staff :
Frank J. DeSantis, CAE
Chris DeSantis, MBA
Jeannie DeSantis, MBA

1. Call to Order

A quorum was established with 45 members present and approximately 70 in total attendance, President Eugene Rhee, M.D. called the meeting to order at 1:15pm.

2. Approval of Minutes

The minutes of the previous meeting of the 25th Annual Membership Meeting held on October 8, 2012 and minutes of the Interim Members Meeting held on May 5, 2013 were read and presented; a motion to approve the minutes was seconded and passed.

3. Report of the President–
Eugene Rhee, M.D., President

Dr. Rhee began his report by thanking everyone in attendance and introducing the officers and DeSantis Management Group. Dr. Rhee reviewed the roster of officers who contribute to the goals of the CUA. Dr. Rhee stated that the Health Policy Forum which occurred on Sunday in conjunction with CUA and WSAUA touched on many areas in which urologists have many concerns.

Dr. Rhee then addressed the issue of workplace violence. He said he has heard of many issues but nothing is really reported. He stated that lists of potentially violent patients) cannot be kept due to compliance. Also because of MICRA we protect access to health care and patient safety. He hopes that urologists will begin to report or at least make a phone call to police themselves against potentially violent patients.

Dr. Rhee then discussed the CUA State Integration Plan / Alliance. The goal would be to increase the

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25th Annual Membership Meeting Minutes continued

voice and force of urology. CUA would integrate with the local societies under the same network. The hope is to consolidate and expand advocacy outreach to physicians and keep everyone informed in regard to state issues, increase political clout and be able to have a rapid response network. Dr. Rhee stressed that there is a need for powerful physician leaders who will communicate and get things rolling. He said that now is the time that urologists need to get involved in what is going on in our political environment, if not, others will take over. The CUA focus is to be effective against legislation that damages the practice of urology. He said that increasing membership in the CUA is of importance, as it is numbers which will carry weight to change legislation. Dr. Rhee said that the CUA is a powerful state organization and thanked the work effort of everyone involved.

He also noted that CUA member certificates had been mailed to all members. He also said that the CUA has an excellent website with useful information and that weekly email bulletins called the "CUA Frontline Briefing" are being sent to keep members informed.

He also said that as another huge added benefit to CUA members was free radiology credits that were acquired from the scientific sessions during the meeting

The motion to approve the President's Report was seconded and passed.

4. Report of the Secretary/Treasurer, David Benjamin, MD

Dr. Benjamin stated that of the 544 regular members, 159 are exempt as seniors and 385 are dues paying. At this point 251 have paid their dues (64%) and 134 (35%) have not. Reviewing the financial reports, he noted that the CUA remains stable considering the current economy. He reported that for the 2012 year end there was a gain of $1,608. With this gain, the CUA reserve balance has increased to over $122,000 from $120,000 in 2011. The net gain was due primarily to a decrease in various expenses as dues and industry support income remain flat.

Chris DeSantis reported that he met with Dr. Prince at the CUA office to review the affairs of the CUA. Dr. Prince conducted the audit of the CUA by reviewing the books and records and found all to be in order.

The motion to approve the Secretary/Treasurer's & Audit Committee Report was seconded and passed.

5. Report of the AMA House of Delegates – Aaron Spitz, MD

Dr. Spitz reported that the number of AMA urologist members are down which has cost us one less seat at the House of Delegates – which is critical because it reduces our voice in urology's favor. He stated the AMA has done a lot of good. The AMA supplies legal action defending in our favor in-house ancillary clause and rights to urologists to pursue ancillary. He stated that the AMA is a positive force for urology and to join as we need to get our seat back at the House of Delegates. Most importantly to get our voices heard on Capitol Hill. He said there is a need to get our medical students and residents in at a grass roots level joining the CMA then progressing to the AMA. He concluded saying to read his four page report about the current work of the AMA.

6. Report of the CMA Representative & Commission on Legislation – David Benjamin, MD

Dr. Benjamin reported that the CUA is a huge part of the specialty delegation, noting that the CUA is one of the strongest state supporting organizations at the CMA level. He said that one of the major points of the meeting was the defeat of MICRA. He said that other meeting items are listed in his report.

Dr. Benjamin also attended the CMA COL meeting in March, stating that this meeting focused on newly proposed State and Assembly bills that would affect the majority of physicians and health care providers in California in the coming year. He spoke on 3 bills [SB: 491, 492, 493] which are all intended to increase the scope of practice for each of the specific providers.

He said that on his report there is more detail to the bills. He concluded it is still extremely important to continue our support for the CMA, CUA, CALPAC and UROPAC.

A motion to approve the CMA/COL Report was seconded and passed.

7. Report of the Commission on Legislation – Demetrios N. Simopoulos, MD

Dr. Simopoulos reported that beginning in October 2013, patients in California will be able to buy health care through Covered California due to the passage of the Patient Protection and Affordable Care Act. He noted that there will be cuts to medical providers. His report reviewed the scope of practice bills.

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25th Annual Membership Meeting Minutes continued

The motion to approve the COL Report was seconded and passed.

8. Report "Legal Battle" – Vito Imbasciani, MD

Although not present, Dr. Rhee asked everyone to read Dr. Imbasciani's report. His report outlined the impending legal battle to involve all physicians regardless of their specialty. His report stressed the need for urologists to heed to a new development in medical malpractice in regards to MICRA. His report further details on this new development.

7. Slate of Officers 2011 – 2013-2015

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CMA COL Alt: Joseph Kuntze, MD, Past President CUA
Carrier Advisory Committee: Jeffrey E. Kaufman, MD
CTAF Rep: Matthew Cooperberg, MD
CMA Young Urologist: Ja-Hong Kim, MD

8. Adjournment

There being no further business the meeting was adjourned at 1:45 pm on Monday, November 4, 2013.

Respectfully Submitted
Matthew Cooperberg, M.D., Secretary/Treasurer

Special Report on the American Medical Association House of Delegates 2013 Interim meeting: The SGR fix

By Aaron Spitz, MD
American Urological Association Delegate to the American Medical Association House of Delegates

The American Medical Association House of Delegates convened in National Harbor, Maryland on November 16 through November 19, 2013 to set policy on issues ranging from graduate medical education to medical marijuana. One issue emerged as a clear priority: The SGR fix.

The House Ways and Means and the Senate Finance committee are preparing draft legislation to eliminate the SGR. The GAO has priced the SGR fix at 189 billion dollars which is nearly half of its peak price. The pay-fors are to be determined and may come from a variety of sources including hospital cuts, but physicians are asked to make sacrifices in exchange for this fix. In their own words the draft states:

"The proposal would permanently repeal the SGR update mechanism and provide updates of zero percent through 2023. Beyond 2023, professionals participating in an advanced APM (advanced payment models) would receive annual updates of two percent, while all other professionals would receive annual updates of one percent….Under the proposal, Medicare payments to professionals would be adjusted based on performance on a single budget-neutral incentive payment program. " The performance metric will be known as "VBM" (value based performance). This metric will be a consolidated, unified replacement for the current measures, Physician Quality Reporting System, or PQRS, Value-Based Modifier, or VBM, and meaningful use of certified EHR technology (EHR MU). "The penalties that would have been assessed under PQRS, VBM, and EHR MU would now remain in the physician payment pool. The VBP program would apply to: physicians beginning with payment year 2017; physician assistants, nurse practitioners, and clinical nurse specialists beginning with payment year 2018; and all others paid under the physician fee schedule (as the Secretary determines appropriate) beginning with payment year 2019. Professionals who treat few Medicare patients, as well as professionals who receive a significant portion of their revenues from an advanced APM(s) would be excluded from the VBP program….The VBP program would assess eligible professionals' performance in the following categories: 1) Quality; 2) Resource Use; 3) Clinical Practice Improvement Activities; and 4) EHR meaningful use."

So the deal, as being formulated, calls for a 10 year Medicare fee freeze as well as pay for performance that is zero-sum, taking from some and giving to others with total payments to physicians remaining budget neutral.

Artis Hoven MD, President of the AMA, flanked by lobbyists and the CEO James Madera MD, held a spe-

Continued on next page

Report of the AMA House Delegates continued

cial session at the conclusion of the opening day of the House of Delegates proceedings to lay out before the delegates these terms of this legislative framework. In a unified front, the messaging to the audience was that there was a very narrow window of opportunity due to the current GAO scoring of the SGR liability, coupled with a seemingly bipartisan and bicameral will to finally eliminate the SGR by years end and these terms were likely the best physicians could hope for. Then, in an unusual twist, she stated that the AMA's tactic would be to fully disclose how much they would be willing to concede prior to further negotiations by publicly asking the House of Delegates at this convening how low they would be willing to go while simultaneously entreating the House to set no actual boundaries so as not to jeopardize what may be a take it or leave it proposition. And by the way, they went on, don't even mention private contracting (balanced billing) because its "non starter" on Capital Hill.

The next day we broke into reference committee hearings to discuss various resolutions that had been submitted on topics ranging from medical marijuana to graduate medical education. However, a late resolution submitted by the Organized Medical Staff Section, entitled "Sustainable Growth Rate Repeal" had been submitted directly in response to the legislative framework pending on SGR. Inconvenient to previous evening's appeal by the AMA leadership, it called for pushing for private contracting as a payment option, as well as upholding the principals of Pay for Performance previously codified by the House of Delegates in previous years, chief amongst which is no zero sum payment schemes. Several delegations, seemingly compelled by the prospect that a SGR fix was possible but ever so fragile maneuvered to minimize the "obstructionist" nature of the language of this resolution prior to its formal discussion on the floor of the House. **Led by California, a delegation that included otherwise strange bedfellows crafted an amendment to soften the rhetoric of private contracting while feeling safe enough to "reinforce existing policy" on pay for performance. The new language of the amendment stated, "RESOLVED, That our AMA advocate with CMS and Congress for alternative payment models, developed in concert with specialty and state medical organizations, including private contracting as an option."** This was received with an outpouring of good will and excitement that a compromise had been found that seemed to appease the stalwarts of balanced billing while liberalizing the AMA leadership to make concessions as needed for the "greater good."

No mention was made in this resolution or the amendment about resisting or otherwise addressing the proposed 10-year pay freeze. Although principals of pay for performance were to be upheld, nothing was explicitly stated in the resolution or its amendment that identified the obvious contradictions to these principles in the proposed framework legislation. But most everyone seemed happy. "Kumbaya" was even publicly uttered.

That evening the Urology caucus convened and our discussion eventually turned to the SGR fix and this

Join the Key Contact Rapid Response Network

The CUA is looking for members who have some type of personal acquaintance with state and/or federal elected officials, know influential members in the CMA, or themselves have a leadership position at the CMA. The objective is for CUA to have greater access to communicate information about health care issues and convey the CUA and/or the CMA's view on pending health care legislation or take fast action on other issues. Key Contacts play an integral role in our legislative advocacy activities and can play a role in quickly responding to threats to our Urological practice.

What Do Key Contacts RRN Have to Do?

As a key contact, you will be periodically asked to convey the CUA and/or CMA's view on specific legislation to the legislator(s) in your network. It is, of course, at the discretion of the key contact to convey the message on any given issue or bill. Additionally, key contacts may serve on the CUA Legislative Committee.

How Do I Become a Key Contact?

Our continued ability to react quickly and effectively to influence health care policy is dependent on cultivating and expanding our cadre of key contacts. If you currently have or want to develop a relationship with an elected official or have a leadership position at the CMA and have not yet become a key contact, please send us an email to info@cuanet.org and we will send you a sign up form. Or call us at 714-550-9155. Thank you.

Continued on next page

Report of the AMA House Delegates continued

SGR resolution and amendment. We concluded that a 10 year Medicare payment freeze with no adjustments for cost of living or inflation, in the face of what was already a significant decline in real reimbursement going back to the inception of SGR, was a concept that would likely greatly upset many physicians throughout America. We concluded that if the legislators could announce that the AMA supported such legislation, which they strongly desire to do, there could be another mass resignation of membership akin to the reaction to the ill fated AMA support of the Affordable Care Act. We theorized that if the AMA had an official position that was contradictory to a 10-year pay freeze such that the AMA leadership could not be implicated as giving such updates away, outrage and exodus could be averted. We agreed to test the waters.

The next morning our delegation split up amongst various caucuses and presented our position at open microphones. We were met with sympathy but temerity. Although delegations supported the concept, they would not introduce it for fear of loosing the current level of tolerance for the AMA leadership to negotiate on SGR reform. Urology stepped up and offered to be the delegation presenting an amendment addressing payment freezes and the other delegations voted to support it once introduced. With collaboration from the California delegation, the amendment was word smithed and the final product was accurate without being overly precise.

"RESOLVED, That our AMA will continue to advocate for future positive updates in the Medicare physician fee schedule" It was introduced that afternoon from the floor of the House and adopted unanimously with no arguments opposing it.

Although the amendment may seem tepid, it's remarkable that it sailed through because so many delegates were averse to the prospect of the AMA leadership and lobbyists being rendered unable to urgently work out an SGR fix due to any controversy in the House that might set up roadblocks. My informal polling of several delegates revealed that even if the AMA did endorse legislation with a 10 year freeze, they believed that the AMA could always come back the next year or two and renegotiate the terms. However, I attended an AMPAC (the AMA's PAC) luncheon guest hosted by congressman Kevin Brady (R, Texas) Chair of the Health subcommittee of the House Ways and Means committee, who highlighted the legislative framework to eliminate the SGR to the audience of several hundred donors. He was asked repeatedly from the floor how physicians could tolerate a 10-year freeze and he repeatedly rebutted that "its not really a pay freeze because there are built in bonuses...if you are a quality doctor." In my opinion, his enthusiastic embrace of a zero sum reimbursement paradigm renders the prospects of a renegotiation of a 10-year freeze, once agreed to, very problematic. When asked where the pay-fors for the 138 billion SGR liability would come from he said it was to be determined but that the hospitals may have to play a role in which case " (he) was afraid they would go Nuclear." And I sat there thinking what a shame it was that he wasn't afraid the doctors would go "Nuclear."

Many delegates I spoke with pressed for urgent negotiations on SGR because they feared the eventual rise of a freshman class of fiscally conservative legislators with no sympathy for physicians and no sensitivity to the need to avert the SGR cliff. However, I spoke with Tom Price, republican congressman and delegate from Georgia who is convinced that congress would not actually allow cuts to physicians of any significance and who felt that a 10 year freeze was an unnecessary concession. His position may be overly confident and shaped by a particular political viewpoint, but I certainly agreed that we were observing amongst the leadership of the AMA and amongst many delegates a posture almost of submissiveness. I actually heard the phrase "overlord" used to describe the legislators authoring the SGR legislation.

At this last interim meeting of the AMA House of Delegates, I feel that in some small way, Urology stood up to try to save the AMA from itself because ultimately Urology is an integral part of the AMA and if the AMA goes down, we all go down. I fear that if the payment freeze had not been addressed and this legislative framework were to be ratified with such a freeze, the collateral damage to AMA membership could be severe. I believe the House of Delegates recognized what Urology was doing, and in an almost unprecedented unanimous vote in favor of a more strongly worded resolution defining the limits of our concessions to an SGR fix, the house simultaneously breathed out a sigh of relief.

By Aaron Spitz, MD

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Government Relations Report

By Jeffrey Kaufman MD, FACS

AUA Board of Directors,
President elect, WSAUA

The Affordable Care Act put into motion a plan to substantially change the way health care was delivered and paid for in this country. It set forth goals that included shifting from our historic fee for service model to one where reimbursement is based on the value provided. The intent of this shift was to cut costs, improve quality and enhance transparency. In order to consider value, first you have to measure it. Consequently the law mandated that we all embrace electronic health records regardless of the productivity penalty and other associated costs. Even though this was intended to cut costs, improve quality and enhance safety, arguably it does little of these. What EHR unquestionably does is to improve data acquisition and control. You can't reward (or penalize) what you can't measure. Unfortunately, the metrics used to define quality and attribute costs have not been well established; but that's a discussion for another day. Most urologists have now adopted EHR and are participating in some type of quality metric reporting.

The ACA also established Alternate Payment Models that combine some type of bundled payment with quality controls. ACOs, Patient Centered Medical Home, Shared Savings Programs and Expanded Global Fees are just some of the innovations being tested. Each combines some type of risk sharing between physicians, hospitals, payers and others in an attempt to re-align incentives hoping to accomplish the stated goals. But, while these may have advantages for primary care physicians, they hold distinct challenges for urologists.

Nonetheless, the ACA proposals were hazy on details and of course, we all know the Devil resides there. Last year, the AUA had an opportunity to comment on Medicare's proposed 2014 Physician Fee Schedule which went into effect January 1. The overall impact on urologic fees is downward 1-2%, more or less depending on the type of practice you have. Far more important were the details buried in the proposal that took us much deeper into the shift toward Value Based Payments promised by the ACA. Not only does the MPFS increase PQRS reporting from 3 to 9 measures and substantially increase the number of procedures and CPT codes that will be revalued (most often shifting reimbursement away from specialists toward primary care), it spells out the details of the Value Based Payment Modifier that will be applied to physician payments beginning next year. The program is complex and depends on accurate, meaningful, relevant measures of quality and properly attributed costs. These metrics are still being developed and refined—but the program is going ahead whether CMS is ready or not. Many of the measures are not appropriate for specialty care which CMS appreciates but nonetheless they work under a mandate from Congress that requires that the program begin in 2015 based on 2013 performance and be fully integrated and applied to all physicians by 2017. At the same time, Alternate Payment Models are being developed and improved allowing physicians to share in overall savings. As fee for service is being squeezed by decreasing payments and increasing overhead, there is a promise that value will be rewarded creating bonuses, avoiding penalties and transitioning into a new payment paradigm.

As I write this, I am flying home from the 2014 Washington Joint Advocacy Conference. Given the historic low price now attached o repealing the SGR, we were hopeful that we could finally cross the finish line on this issue and move on to other concerns. Many of you realize that the legislation that repeals the SGR contains many more details concerning Value Based Payments and Alternative Payment Models (APMs). Although the current bills limit updates to 0.5% per year for 5 years, freeze for the next 5 years and then allow a differential update based on participation in APM, there are opportunities for significant bonuses depending on the practice's value reporting, APM involvement an risk sharing. These proposals are not what many would ask for but, realistically they are the best we are likely to get. Unfortunately, as I write this, it looks like the bills will fall prey to political infighting even though we have bipartisan, bicameral agreement on the principles. Congress is simply unable to resolve their differences on the pay-fors. It is most likely that we will get another temporary patch (moving the target back 9 months to January 1 will cost another $14 billion on top of the $150 billion already "spent" on past freezes as compared to an overall estimate of "only" $138.4 billion to fix the problem forever!). As tired as we all are of the uncertainty of repeated threats of fees being cut 25% every year, we are most likely to be back next year discussing the same issues. Stay tuned

Continued on next page

Government Relations Report continued

to this bulletin for updates on fee adjustments, coding changes, shifting quality reporting requirements and legislative updates on where medical care delivery is heading. Next time, some comments on the financial Armageddon known as ICD-10 (I hope you're all well on your way to implementing this new coding system due to begin October 1).

Jeffrey Kaufman MD, FACS

Report of the Council on Legislation of the California Medical Association

By Joseph Robert Kuntze, M.D.

Enclosed is a summary of the Council on Legislation meeting of the California Medical Association held on March 20, 2014 in Sacramento, CA.

The meeting began with a summary of the upcoming expected filing of the petition to overturn MICRA. It was emphasized that it was essential to oppose this threat to our patients' wellbeing. Mr. Janus Norman, senior vice president, then spoke about CMA activities and Mr. Brett Johnson gave us a summary of covered California legislation.

A presentation on AB 1535 was made requesting that we support the ability of pharmacist to provide naloxone to prevent accidental overdose. A second presentation was then made discussing SB1005, legislation that would extend ACA benefits to undocumented worker's

CMA sponsored legislation was reviewed but not able to be commented on it.

Discussion was then entertained on assembly sponsored bills. Many of these bills; although not directly impacting urology, do impact long-term payment, primary care physicians, incentive programs to provide increased access to care in the central valley and financing of the ACA

AB 1576 could indirectly impact urology it would require condoms be used during the filming of adult feature films; thus reducing the health risk and transmission of STDs, CMA voted to support that.

AB 1759 would extend the term of primary care provider payment increases in the Medical program to Medicare rates, this was supported by the CMA. AB 1822 will allow surgery centers to store tissue allografts; this potentially would impact urology and making it easier for us to use these materials and perform our surgical procedure procedures in outpatient surgery centers; CMA took watch position on this bill.

AB 1841 would expand the role of medical assistants to dispensing prepackage medications under the supervision of a physician and surgeon. This might impact the practice of dispensing in the practitioners office. CMA opposes this bill unless amended.

AB 1886 would allow this California medical Board to post disciplinary actions on the website for an unlimited time. The CMA opposed this bill.

AB 1952 requires the establishment of the charity care fund. It will assess a surtax of 5 % and put this money into a fund to pay for charity care. The diversion of 5% of hospitals income potentially impacts reimbursement to physicians. CMA voted to watch.

AB 2051 would impose time limits on the Department of Healthcare Services to act on applications for provider enrollment to Medicare. CMA voted to support.

AB 2059 would require provision of a patient's records to be done electronically; this potentially impacts those of us to use the EHRs in that proposed but undefined fees reimbursements are included in this bill CMA voted to watch this legislation.

By far the most contentious discussion was a CR 107 this measure would have designated 2014 is the year of the family physician. After an hour of debate the most germane comment I heard was that the ophthalmologist requested that the year 2020 be reserved for them. After extensive and from this discussion was agreed to support this measure.

State Senate bills were then addressed.

SB 1005 the measured to extend ACA benefits to undocumented immigrants was discussed.. Since no funding mechanism was included in this bill CMA voted to take a neutral position.

SB 1256 would prevent practitioners from extending credit for noncovered services through her third party

Continued on next page

Legislation Council Report continued

without providing a treatment plan this could potentially affect those urologic services the patient sometimes make payments on i.e. vasectomy reversal.

The remainder of the bills discussed would have no impact in my opinion upon urology this alternate delegate dutifully sat through the entire discussion and although at times I felt my head would explode remained attentive and observant; restricting my comments to the pertinent.

Respectfully submitted
Joseph R. Kuntze, M.D.

Treasurer's Report

by Matthew Cooperberg, MD

For 2013, the CUA posted a net gain of $11,330. With this gain, the CUA reserve balance has increased to $133,373 up from $122,042 in 2012. The net gain was due primarily to an increase in industry support income and to a lesser extent, an increase in dues income – a result of the dues increase last year. Expenses were higher by $8,642 due to increased committee activity at the CMA level and the JAC meeting scholarship of $2,000. Operationally, the general fund produced total revenues of $61,300 against expenses of $49,969. There were no other funds or departments accounting for financial activity in 2013. The 2013 exempt organization tax return filings are in process and will be filed soon. The CUA is designated as a 501(c) 6 tax-exempt organization. Financial reports are prepared on a calendar year, cash basis method. Our fees to DeSantis Management Group (DMG) are currently a flat $2500/month which includes staff, office equipment, rent and overhead. 2013 was an extremely active year for CUA Leadership and 2014 is making the case for our watchdog role ever more clear. SB 1215, MICRA and looming state battles take time and money! We continue to be a much respected statewide organization in the non-profit medical community and are called upon more frequently as an organized power in California politics. The CUA is your "early warning detection" system and its importance has never been greater!

Please tell your peers to strengthen our membership and if they have any doubts about how we have added value to their livelihood, please ask them to look over our web site, www.cuanet.org, read the latest issue of the CUA Report or attend a meeting. The $150 dues is probably the cheapest form of practice insurance that you can purchase. Thank you.

Welcome New Members!

Will Brubaker, MD, Menlo Park
Susan Rusnack, MD, Los Angeles
Eric R. Freedman, MD, Sonora
Jonathan E. Perley, MD, Lakewood
Michael A. Sanford, MD, Palm Desert
Jenny Wong, MD, Alhambra
Christopher K. Tsai, MD, Upland

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CUA

The CUA is the largest state urological, non-profit organization that is dedicated to preserve and protect present and future Urological care for the people of California by means of education, representation, advocacy, legislative reform and leadership in various state and national health policy arenas.

2014 Meeting Calendar

CUA Meets in Orlando at the AUA Members Meeting
Sunday, May 18, 11:30 am
at Hyatt Regency

WSAUA Health Policy Forum and Practice Management Courses
Sunday, October 26, 2014
Grand Wailea Hotel
Maui, Hawaii
(during WSAUA annual meeting)

CUA 27th Annual Membership Meeting
Sunday, October 26, 2014

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AACU State Society

Information resource for pending legislation, up-to-date news on bills, and state Issues

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The CUA Listens: The CUA Report is a publication for California Urologists. Readers are welcome to write, email the CUA Board of Directors and visit the website.