



On Tuesday, March 23rd, President Obama signed the Patient Protection & Affordable Care Act of 2010 (PPACA) into law. As the only political action committee for Urology, UROPAC has been dedicated to promoting and protecting the interests of urology and urologic patients for years. UROPAC has never been more active than over the past eighteen months. We have worked with the House and the Senate, both Democrats and Republicans, to advocate for the interests of our members as this healthcare reform legislation was being formulated. We have sent dozens of letters, made countless personal visits to members of Congress, and participated in many grassroots campaigns to bring our message forward. While our voices were heard on some issues, we were not heard on others. While we applaud some of the provisions in PPACA and support the need for healthcare reform, we were forced to oppose this bill.

The fight for healthcare reform in Congress is not over; in fact, in many ways, it has just begun. As Congress and the Administration move forward to begin implementing the various provisions in PPACA, we will need to continue to be right there to ensure that the interests of urology and our patients are protected. We will need to advocate for revisions to some of the more troubling provisions that were included in the bill. We will also need to advocate for additional reform that would address some of the significant issues which were ignored by PPACA. UROPAC will be very important over the next several months and years.

The Board of Directors of UROPAC, which is composed of leaders from both the AUA and the AACU, met during the Urology Joint Advocacy Conference held in Washington, DC, in March, and identified the top three issues facing urology today. Moving forward towards the 2010 elections, UROPAC will pay close attention to these issues and will support those Members of Congress or Congressional Candidates that support them. These three top issues are the Sustainable Growth Rate (SGR), the Independent Payment Advisory Board (IPAB), and the In-Office Ancillary Exception to the Stark Physician Self-Referral Law (IOAE).

In addition, the AUA has two bills that are in the process of being introduced into the House and Senate: one on prostate cancer and one on urotrauma. To date, on April 21, Representatives Zack Space (D-OH) and Carol Shea-Porter (D-NH) introduced the urotrauma bill in the House (H.R. 5106). These bills address urologic conditions of national importance and will help our field in its mission to provide the highest quality care to our patients. Both the AACU and UROPAC support the promotion of these bills.

Sustainable Growth Rate (SGR)

Despite intensive efforts by organized medicine, a permanent fix to the SGR continues to elude us. In recent months, the SGR situation seems to be getting worse, not better, with Congress approving a series of last minute extensions of the 2009 rates to stave off the impending 21.3 percent cut. Indeed, since January, 2010, when the 21.3 percent cut was due to go into effect, there have been three separate last minute extensions passed, each providing only a 30- or 60-day reprieve (December, March and April). In March and April, the cuts actually went into effect for a limited period before Congress acted, and CMS had to hold off processing claims for 10 days until Congress passed the next short term patch. As a result, as of May 31, we once again face the 21.3 percent cut, without any permanent fix in sight. For years, Congress has provided temporary fixes to the SGR. This is unacceptable. Short term fixes do nothing to address the underlying problems of the SGR that place patient access to high quality urologic care at risk. We cannot support



another short-term “fix”, and will continue our efforts to ensure enactment of a permanent solution to the SGR that fairly and accurately reimburses physicians for the services they provide to Medicare beneficiaries.

Independent Payment Advisory Board (IPAB)

Currently, the Medicare Payment Advisory Commission (MedPAC), composed of 17 appointed commissioners, including two practicing physicians (one of whom happens to be a urologist), is charged with providing guidance to Congress on Medicare payment and quality. Congress has the power to accept or reject the twice yearly reports produced by MedPAC. The new healthcare bill creates a new entity, the Independent Payment Advisory Board (IPAB), which supersedes MedPAC and is comprised of fifteen members appointed by the President. Moreover, this board does not advise Congress, but instead has the authority to unilaterally make policy. Thus, the new board greatly limits, if not effectively ends, Congress’ authority over Medicare payment policy. The non-elected, unaccountable IPAB essentially assumes authority over the Medicare program; its recommendations will become law unless opposed by a joint resolution of Congress passed by a two-thirds vote. This new Board is scheduled to submit its first set of recommendations by January 15, 2014. While the purpose of the IPAB is to reduce the per capita rate of growth of Medicare spending indefinitely, in most years, Medicare’s per capita growth has been below or equal to growth in the private sector. Since the SGR formula already routinely mandates payment reductions, the IPAB will inevitably force physicians’ payments to be subject to a “double jeopardy.” The Congressional Budget Office (CBO) estimated the IPAB’s savings to the Medicare program to be approximately \$13.3 billion over 10 years.

Congress must retain proper oversight of the process that determines how services are provided and paid for under Medicare and not relegate it to another entity. If the goal of a new Advisory Board is to find new ways to eliminate spending in the Medicare program, the end result may well be detrimental to patient care for our nation’s elderly. Already, Medicare reimbursement rates are well below market rates for similar services, and by requiring coordination with other payers, it will likely only get worse. Finally, the Board seems to selectively exempt certain providers, such as hospitals and hospices, from its purview – placing more pressure to cut Medicare in those areas under its jurisdiction, namely physicians.

In-Office Ancillary Exception to the Stark Physician Self-Referral Law (IOAE)

Since the early 2000’s, Congress and federal agencies like the Government Accountability Office (GAO), the Inspector General (IG), and MedPAC have been concerned with the rising cost of Medicare, predicting that the Medicare trust fund (Part A) would go bankrupt near the end of the decade, and that Part B services would claim unsustainable levels of funding from the general government funds that pay for those services. These analyses showed that diagnostic tests, labs and imaging were growing at rates double that of the approximately 3.6 percent overall growth of physician services in the program. Thus, the government began to more closely scrutinize these services. One of the areas they have honed in on as a possible source of the rate of increase is physicians’ ownership and use of in-office ancillary services, including advanced diagnostic imaging and radiation therapy. Unfortunately, despite evidence that numerous factors contribute to the increase in such services, physician ownership is seen as a primary reason for the growth. In its March 2010 meeting, MedPAC once again focused on the services provided under the IOAE, and recommended further study to determine whether or not there should be a change to the services included



under this exception. As recently as April 16, Congressmen Henry Waxman (D-CA), Chairman of the Energy & Commerce Committee, Sander Levin (D-MI), Chairman of the Ways & Means Committee, and Pete Stark, author of the IOAE and Chairman of the Health Subcommittee of the Ways and Means Committee, sent a letter to Acting Comptroller of the US, requesting for a GAO (Government Accounting Office) study to evaluate the extent of physician self-referral arrangements for advanced imaging and radiation oncology services provided to Medicare beneficiaries and the effects of such arrangements on Medicare spending. Urology has argued forcefully to Congress, MedPAC and federal agencies, alone and in concert with other specialties, that the IOAE is an integral part of the provision of superior patient care, and that the focus on physician ownership as the primary driver of increased use of such services is exaggerated at best, and inaccurate at worst. We will need to be more vigilant than ever as we work to protect access to in-office procedures for our patients in the future.

The PROSTATE Cancer Act

This bill seeks to have the federal government more effectively and efficiently use the resources it currently has allocated in a wide variety of existing programs across federal agencies to address prostate cancer research, outreach, education, and healthcare delivery, particularly among underserved populations.

Specifically, it will provide:

- *Interagency Prostate Cancer Coordination and Education Task Force:* Establishes a federal interagency Task Force led by the Department of Veterans Affairs that will identify and catalog prostate cancer activities by various federal agencies, develop a strategy to improve the research portfolio, eliminate unnecessary duplication between agencies, expand collaboration, increase patient and medical community participation, and develop a coordinated message related to screening and treatment for prostate cancer.
- *Research Coordination:* Requires the VA, DOD and HHS to coordinate and intensify prostate cancer research, including improvements or alternatives to the prostate specific antigen (PSA) test and additional tests to distinguish indolent from aggressive disease; advancing the understanding of the etiology of the disease; establishing clinical registries for prostate cancer; and assessing appropriate imaging modalities.
- *Underserved Minority Grant Program:* Such grants shall build upon existing knowledge gained from comparative effectiveness research; and recognize and address the racial and ethnic disparities in the incidence and mortality rates of prostate cancer.
- *Telehealth and Rural Access:* Establishes 4-year telehealth pilot projects in a variety of geographic areas, including rural, that contain high proportions of medically underserved populations. Such projects will promote efficient use of specialist care through better coordination of primary care and physician extender teams in underserved areas and more effectively employ tumor boards to better counsel patients.
- *Education and Awareness:* Requires the development of a national education campaign, including written material and PSAs, intended to encourage men to seek prostate cancer screening when appropriate.

Establishment of a National Commission on Urotrauma



There is insufficient data regarding the management of wartime genito-urinary (GU) trauma. Injury to urogenital organs accounts for between 1% and 10% of all war injuries. As battlefield rescues increase, more returning service personnel, particularly those who are victims of Improvised Explosive Devices (IEDs), are living with such injuries, but without the benefit of knowledge of the most effective treatments. Additionally, more information needs to be gathered on the use of modern body armor in the prevention or minimization of genitourinary injury and to encourage improvements in the design of body armor to better protect the genitourinary area.

The bill establishes a National Commission on Urotrauma. The Department of Defense will be the lead Agency and work with the Departments of Veterans Affairs and Health and Human Services.

The Urotrauma Commission will:

1. conduct a comprehensive study of the present state of knowledge of the incidence, duration, and morbidity of, and mortality rates resulting from urotrauma and of the social and economic impact of such conditions;
2. evaluate the public and private facilities and resources (including trained personnel and research activities) for the diagnosis, prevention, and treatment of, and research in, such conditions; and
3. identify programs (including biological, behavioral, environmental, and social programs) in which, and the means by which, improvement in the management of urotrauma can be accomplished.

In addition, the Commission will develop and recommend a long-range plan for the use and organization of national resources, especially within the federal health programs, to effectively deal with urotrauma.

The Role of UROPAC

UROPAC plays a critical role in urology's advocacy efforts. UROPAC raises funds from urologists which are used to support the campaigns of urology-friendly legislators. This is obviously critical with fall elections approaching. We are taking a hard look at who we have supported in the past, and who we will support in the future, in light of the new healthcare legislation and the legislative battles on the horizon. It is critical that we do all we can to elect legislators that are committed to our issues.

UROPAC also plays a crucial role in the advocacy process itself. UROPAC representatives—both staff and individual urologists—regularly attend events and lobby members of Congress for our issues. Often, access is achieved because of a UROPAC donation. UROPAC donations do not always lead to a result we favor, but UROPAC donations do lead to opportunity for dialogue with our elected representatives so that we can form critical personal relationships with legislators and advocate for our positions.

The UROPAC leadership is committed to our promise to advocate for our profession and our issues on the Hill and at the state level. We will continue to work with all member of Congress to mitigate or remove those provisions of the recent healthcare legislation that we found troublesome, and to include reforms that will improve our healthcare delivery system. UROPAC stands ready to support those Members of Congress committed to our values, and to support those candidates opposing those who do not. To be successful in protecting your interests and the interests of your patients, UROPAC needs your support now more than ever.