

Socioeconomic Report

Datta G. Wagle, M.D., F.A.C.S.
Northeastern Section AUA



Legislative Outcome

The Tax Relief and Health Care Act of 2006 retroactively averted the 5 percent cut in Medicare reimbursements for physicians. The bill freezes the Medicare conversion factor for one year. The AUA, AACU and UROPAC applaud this action and will continue our work to stop this yearly exercise and push for permanent reform of the flawed Medicare payment update based on the sustainable growth rate (SGR). Working with our colleagues over the past year, we have identified numerous problems and steadfastly lobbied for a halt to the payment cuts and negotiated with the administration and Congress over implementation of pay-for-performance (P4P). As a UROPAC chair, I cannot thank our grassroots urologists enough for taking the time to help effect this important change. Here is the summary of the provisions in the legislation that will most affect urologists:

- A 0 percent update in Medicare payments in 2007 for all physicians.
- A 1.5 percent bonus for physicians choosing to participate in the Physician Quality Reporting Initiative (PQRI), which begins in July 2007.
- No change in 2008 reimbursement – which means a cut of 10 percent starting in 2008.
- A one-year extension of the geographic adjustment for physician services.
- The pilot project on Recovery Audit Contractors (RAC) will be expanded from three states (California, Florida and New York) to all 50 by 2010.
- By 2009, quality reporting requirements for Hospital Outpatient Services and Ambulatory Surgical Centers in order to receive a full update. The withhold will be 2 percent and measures will be developed by the Centers for Medicare & Medicaid Services (CMS).

Payment Cuts to In-office Imaging Procedures

The Deficit Reduction Act of 2005 capped the technical component portion of the payment for in-office imaging at the hospital outpatient department payment rate. This change represents a \$10 million cut for urology, with Current Procedural Terminology (CPT) code 76942 and CPT code 93975 taking the biggest hits at 42 percent and 48 percent respectively. The AUA, along with radiology and manufacturers, is launching a major lobbying campaign to reverse the DRA imaging cuts. Also, in the final rule for the 2007 physician fee schedule, the Centers for Medicare & Medicaid Services (CMS) finalized at 25 percent the multiple procedure reduction for imaging services within the same code family performed on the same day on contiguous body parts.

Pay-for-performance (P4P)

There are already more than 100 P4P programs in the private sector and P4P is also on Medicare's radar as a potential tool to reduce spending on physician services while also reducing variation in health care that has been linked to higher spending. The AUA is

working to take the lead on defining quality urologic care to ensure that P4P programs are implemented properly and achieve expected results and to educate practicing urologists about how to participate in Medicare's 2007 Physician Quality Reporting Initiative, which was established by the Tax Relief and Health Care Act of 2006.

Ambulatory Surgery Centers (ASCs)

ASC services that are paid more in the ASC than in hospital outpatient departments (HOPD) were reduced to the HOPD rate effective January 1, 2007. No change in payment occurs for the 2,267 procedures paid more in the HOPD than in the ASC. According to the Federated Ambulatory Surgery Association (FASA), two urology codes are included in the list of top ten procedures by volume paid higher in the ASC compared to HOPD. They are 55700 (biopsy of prostate) and 51726 (complex cystometrogram).

Evaluation & Management (E&M) Coding

CMS made changes to the work and practice expense relative value units (RVU) in the 2007 physician fee schedule. Work and PE RVUs respectively comprise an average of 52 percent and 44 percent of the total relative value for any given procedure. Work RVU changes resulted from the five-year review of work values, with the largest changes stemming from the review of evaluation and management codes (E&M), which were increased substantially. These increases will also be applied to the visits that are included in the global periods for surgical procedures which extends the effect of E&M increases even more. Urology will benefit from both of these changes to some degree and this will also provide an offset to any potential negative impacts from practice expense changes.

CMS also changed the methodology for calculating practice expense RVUs and finally confirmed that it would use the AUA's supplemental practice expense data to calculate practice expense RVUs for urology procedures from 2007 forward, until new multi-specialty data is collected. Use of AUA data is only part of many changes CMS made to its methodology for calculating practice expense RVUs and the new RVUs will be phased in between 2007 and 2010. Although these RVU changes do not result in a payment increase for urology, the updated data we submitted helped to thwart losses that could have occurred due to the methodology change.

Denied Medicare Claims

There are five levels of appeals for denied Medicare claims that include, 1) re-determination, 2) re-consideration, 3) administrative law judge (ALJ) hearing, 4) departmental appeals board (DAB) review and 5) federal code review. All requests for claim appeals must be in writing. If a claim is rejected because of minor errors or omissions, requests for adjustments resulting from clerical errors must be handled as "re-openings." Tell your legislator that the SGR formula is ineffective and unfair and must be replaced by a system that takes into account the actual cost of providing care to beneficiaries. Also emphasize how the cuts will affect your practice, including your ability to provide timely care for Medicare beneficiaries, invest in your equipment and technology, maintain staffing levels and benefits, etc.

December 22, 2006

AUA Section Name
Address
City, State, Zip

Dear Section President:

As you know, in October 2005, the AUA Board of Directors appointed an AUA task force to assess current and future urologic residency training. This group, chaired by Dr. John McConnell, included a broad constituency with representatives from private and academic practice; large groups and small groups; American Board of Urology (ABU); Residency Review Committee (RRC); AUA Leadership and Urology Program Directors.

Several planning meetings occurred and the task force met in person at AUA Headquarters on April 1-2, 2006 to discuss a wide range of issues associated with urological residency training. On May 19th, Dr. McConnell provided a presentation of the task force's preliminary report and recommendations to the AUA Board of Directors. The task force submitted its final recommendations in a white paper which was reviewed and approved by the AUA Board who agreed that the white paper be distributed to the leadership of AUA Sections, urology specialty societies and other affiliated organizations. In addition, the AUA Board approved distributing the entire white paper to the AUA membership through AUA News. Therefore, the white paper will be published in its entirety in December's issue of AUA News and before it reaches the hands of our membership in early January, I wanted to provide an advanced copy of the white paper to you so that it may be shared with your organization's leadership. I have also enclosed a copy of the slide presentation presented by Dr. McConnell to the AUA Board in May, which may assist you in communicating key points of the report to your leadership.

The white paper identifies a number of priorities for the specialty of Urology and makes specific recommendations in order to respond to a rapidly changing environment while providing flexibility for urologic residency training, including:

- Clearly communicating that a two-tiered model in the U.S. is not in the best interest of our patients or the specialty.
- Development of a national core curriculum for urologists to include both cognitive and manipulative skills.
- Urologic sub-specialty societies should define what knowledge and skills should be acquired during core versus fellowship training.
- Put Urology program directors in charge of the PGY1 year.
- Move away from all residents needing equal surgery logs; focus more on the minimal number of total cases than specific types of cases.

If you have any questions regarding the white paper, please feel free to contact me. The AUA anticipates convening a committee in March 2007 to discuss comments on the white paper and commence planning and coordinating implementation of the recommendations. I welcome any comments you or your organization may have regarding the document as we strive to ensure that the field of urology is well positioned for further prosperity and advancement.

Sincerely yours,

Lawrence S. Ross, M.D.
President, AUA

Enclosures

cc: AUA Board Section Representative

policy division including expediting the recruitment for the Health Policy Vice-Chair position which has been approved at \$35,000.

Michael Pretl, AUA General Council, joined the meeting by telephone and reported that the AUA health policy division and general council recommend AUA joining in a brief Amicus Curiae with other specialty organizations supporting appeal of a rigid interpretation of Maryland's self-referral statute to prohibit physician's use of in-office imaging devices. The directors approved AUA joining in the Amicus Curiae brief quoting that the AUA propose adding a section to the brief, describing the specific value of such devices to the specialty and asserting the lack of self-referral abuse by urologist

URO PAC

Activities ended on a very upbeat note in 2006 for UROPAC which raised more than \$760,000, the most it ever raised in a one-year period. In addition, UROPAC raised close to \$500,000 during the 2005-2006 election cycle. To continue the momentum, the AUA has just launched an ambitious fund raising campaign to raise \$100,000 between now and the annual meeting. To help this effort along, two UROPAC events at the Joint Advocacy Conference will be featured -- lunch with political commentator and humorist Charlie Cook and the first "Friend of Urology" award to be presented to representative Tom Price, M.D. (R-6-GA).

In concert with the Alliance for Specialty Medicine, AUA government staff made rounds reaching out to some of the new democratic legislators now in charge of key committees. Democrats have indicated a willingness to work with physicians to avoid the looming 10% SGR cut slated for 2008. We also discussed SGR, medical liability, and P4P were discussed with Senator Sherrod Brown (D-OH), Ron Wyden (D-OR) and House Majority Leader Stenny Hoyer (D-MD-5).

Another Health Policy Scholar Program

Materials were finalized, arrangements are made to aggressively promote the new program in several different venues during the month of March and April in time to notify interested parties before the end of April application deadline. Per the board's request individual letters describing the program are being sent to section presidents, secretaries, health policy chairs and copied to section administrators and individual letters encouraging application to the program are being sent to the leadership classes. In addition, a generic letter, accompanied by a color brochure will be sent to every AUA domestic member, to encourage them or someone they know to apply. Article describing the program is in the February Health Policy Brief and one by Dr. Jim Regan will appear in the March AUA News, the description also appears in the February AUA Net News. It is planned for this year's awardee to be announced by Dr. Regan at the health policy plannery session during the annual meeting.

David
Person



P4P

✓ The health policy staff drafted a work plan based on the P4P strategic plan to submit to the P4P work group for review and feedback focusing both on the incoming 2007 CMS P4P effort and on strategies for testing AUA's prostate cancer measures currently in development with the AMA's PCPI and including those measures in the 2008 P4P.

VI. Historian

The board recommended that the Historian position be changed from an officer to an AUA board consultant at an appropriate time, possibly at the end of the current historian term since he was elected by the membership for a full term. It was recommended that the job description and the title of Historian otherwise remain the same, and that the salary support be given based on work effort relative to other board consultants. The appointment would be based upon recommendation of the History Committee. The motion was also amended to combine the Curator and Historian positions, with salary provided at an appropriate level.

VII. Membership

- ✓ 1. The AUA should employ a two-pronged initiative to expand membership. By targeting European and other developed countries, the AUA will maintain influence and relevance and accrue additional members who are likely to participate in the AUA's annual meeting and other educational products. Simultaneously the AUA should direct its attention to developing countries with recruiting campaigns that emphasize appropriate educational interactions which will promote AUA visibility and loyalty. Again, the focus is to actively pursue recruitment in Asia, India and South America.
- ✓ 2. The board agreed the AUA should not institute a dues reduction program for developing countries.
- ✓ 3. The AUA should expand its recruiting efforts in Mexico and Central America where fewer than 10% of urologists are AUA members. While not international members, they represent an untapped resource and as near neighbors deserve AUA outreach efforts.
- ✓ 4. The AUA should continue current plans with publishers to expand ~~to expand~~ translation and dissemination of the Journal of Urology (JU) and AUA's printed educational material (e.g. update series, guidelines and SASP) according to request and need.

- ✓ 5. The AUA should pursue developing joint international guidelines, with the EAU. Any joint guidelines for development must be based upon AUA's guidelines priorities.
- ✓ 6. The AUA should formalize its international societies component of the annual meeting into language programs endorsed by national or international societies. Currently these include Spanish, Japanese, French and Chinese program with a pending request from Brazil.
- ✓ 7. The AUA should offer the basic meeting package (room and AV, no translations, no staffing, etc.) to requesting national societies to have a governance/business meeting with their members. This will recognize the society and its president will be invited to the international reception and encourage collaboration.
- ✓ 8. The AUA should develop a program of courses and symposia for export to the international community. Again, the primary focus is on Asia, India and South America. Any request of such educational activity in Europe should be coordinated with the EAU. The scheduling of AUAs international meeting/symposia should take into consideration the location of AUA's annual meeting (East/West coast).
- ✓ 9. The directors agreed to pursue collaborative efforts for an education bridge between the AUA and India (Urology Society of India). This should be a face program which will allow the AUA to evaluate the program before committing major resources. In the initial phase the AUA is to fund an "AUA speaker" at the annual USI meeting and wave registration for two USI identified Indian residents/scholars to attend the AUA annual meeting. The AUA should commence longer term planning and Office of Education collaboration for a board review course with USI and subsequent assistance to help USI establish an education office in India.
- ✓ 10. The board agreed that an AUA/SBU exchange program should be established in light of AUA's effort on South America, regardless of whether industry support can be obtained. Given that the SBU meet biannually, the board agreed to pursue this program for 2009.
- ✓ 11. The AUA should continue with the current AUA/CAU visiting scholar program at a cost of \$10,000 subsidized by the AUA. Greater accountability for CAU's partnering with AUA on this program should occur through regular communication and updates.
- ✓ 12. A similar opportunity for a visiting scholar program should be considered for India and urology societies in Asia (\$10,000).

✓ 13. Dr. Ross reported the representatives of the AUA and EAU met on January 10 - 11, 2007 to discuss collaborative efforts between the two organizations. It was reported that the meeting was positive and productive. The following recommendations were submitted and approved by the board a) that both organizations work together to develop broad based guidelines on various urologic topics that could be customized by each organization with more evidence based science if needed, b) that a steering committee be formed with representatives from the AUA and EAU to recommend topics of joint broad based guidelines, development and evaluate how two organizations can work together on the overarching guidelines. In addition, the committee should develop recommendations as to goals for the guidelines process, identify what is different in both organization's guidelines and why, as well as identify how the guidelines could be quickly implemented by each organization. Each organization should ensure that the most current guidelines are utilized for review in this process, c) that the AUA continue its support of the AUA/EAU Academic Fellowship Program. Changes will be made to the program in order to position it for industry support in 2008. If industry is still unwilling to support the program at that time, both the AUA and EAU are committed to continuing the program and sharing expenses.

✓ Dr. Ross summarized a document received from Dr. Sad Khoury that proposes new objectives of the ICUD. The new objectives would include that ICUD's future role would be to utilize AUA/EAU joint guidelines and to make them compatible with clinical practices in lower income or developing countries.

✓ 14. The AUA section 2007 dues collections through January include the Northeastern Section 87%, New York Section 82% and North Central Section 84%.

✓ 15. The 2007 National Urology Residency match was successful with results distributed to applicants, program and medical schools on January 22nd. Of the 348 preference list - submitting applicants, 239 matched, leaving only two program vacancies. The program was processed through the board approved review process. Twelve programs and 33 applicants have registered for the 2008 pediatric match. One program and one applicant have registered to date for the 2008 andrology match.

✓ 16. The directors agreed to increase the age qualification requirement for senior membership status from 62 years of age and 25 years of AUA membership to 65 years of age and 25 years of AUA membership.

✓ 17. Dr. Schellhammer suggested better interaction with the ABU due to convergence of a number of urology issues and initiatives including maintenance of certification, imaging, future of urology residency training, core curriculum, etc. The board agreed to invite two ABU representatives to

the AUA board meeting in Anaheim. The ABU board will be asked to reciprocate by inviting two AUA representatives to attend the ABU board meeting.

VIII. AUAs Committee Structural Assessment

Mr. Sheppard outlined various changes at the AUA over the past seven years that have resulted in inefficiencies relating to committees, including corporate restructuring, consolidation, and new programs. The board of directors reviewed a number of recommendations to provide more effective use of human resources, communications, reporting and accountability of AUA committees and to provide for better alignment of committees under councils reporting to the board. The directors approved the following actions based on report recommendations. They are:

1. Health Policy Council

- A. Practice Management Committee and the Quality Improvement in Patient Safety (QIPS) Committee are to become standing committees and report to the council.
- B. The Chair of each committee reporting to the Health Policy Council is to become a member of the Health Policy Council. The Health Policy Council should re-visit the council's mission statement to incorporate pay-for-performance and QIPS activities. In addition, the council should evaluate and recommend composition requirements and terms of service for QIPS.
- C. The pay-for-performance taskforce is to be included as a work group under the Health Policy Council, however, not listed as an official AUA committee. Terms for P4P workgroup members will be aligned to coincide with the terms of their related positions.
- D. The Urology Carriers Advisory Committee is to become a workgroup and a representative of the workgroup should provide a report(s) to the Health Policy Council.

IX. Section Secretary's Committee Meeting Minutes

The Section's Secretary's Committee discussed ways to enhance communications between the AUA and the sections as well as future activities and expansion of the committee's mission. Dr. Flanigan reported that the Section's Secretary's Committee discussed its anticipated expanded role and concept of restructuring the committee to either comprise or be part of a council to become closer to the AUA in leadership and governance. He noted that Mr. Sheppard would be presenting a detailed analysis of AUA's committees with specific recommendations to realign AUA's committees within the governance structure. As such, Dr. Flanigan and the Section's Secretary's Committee recommended that the committee be designated the Section's Secretary's/Membership Council which would include oversight of the Young

Regulatory Affairs Update
May 2007

Robin Hudson, Senior Manager for Quality Initiatives and Health Policy

Items included

- ASC Payment Reform
- Urology Specialty Labs
- Durable Medical Equipment Competitive Acquisition Program

ASC Payment Reform

The medical community is still waiting with much anticipation for the Centers for Medicare & Medicaid Services (CMS) to release a final rule for ASC payment reform, which will be effective January 1, 2008 as mandated by the 2003 Medicare Modernization Act (MMA). As you know, the MMA gave CMS discretion to implement ASC reform based on the results of a Government Accountability Office (GAO) study and report comparing the costs of procedures furnished in ASCs and hospital outpatient departments (HOPDs). The GAO was also to recommend whether it is appropriate to use outpatient groups of covered services and relative weights as a basis for ASC payments and whether ASC payment rates should be based on a uniform percentage of the outpatient prospective payment system (OPPS) payments.

The GAO report, originally due on January 1, 2005, was issued in November 2006. It is clear that CMS will base ASC payment rates on some percentage of OPPS payments. However, CMS did not have the GAO report before they released the proposed rule, and it is unclear whether CMS will change the proposed rate of 62% of OPPS based on the GAO report. Meanwhile, legislation that would require CMS to pay ASCs 75% of OPPS payment has been reintroduced in the 110th Congress. The various possibilities for the percentage of OPPS payments upon which ASCs will be paid are:

GAO report median <i>unweighted</i> ASC to HOPD cost ratio	39%
CMS proposed rule	62%
FASA proposal	73%
Existing bills in Congress	75%
GAO report median <i>weighted</i> ASC to HOPD cost ratio	85%

We will provide more information to the Board about CMS's decisions and the impacts on urology ASCs as soon as the final rule is released.

Urology Specialty Labs

In October 2006, the AUA submitted comments to CMS regarding proposed changes to its reassignment and physician self-referral regulations to address concerns about the recent growth of "pod labs." Specifically, pod labs that rent space to urology groups were cited by CMS as an example of the types of abusive arrangements that are proliferating. CMS said it was "concerned about the existence of certain arrangements that are not within the intended purpose of our physician self-referral rules, which allow physician group practices to bill for services furnished by a contractor physician in a centralized building."

CMS proposed to amend its reassignment regulations to clarify how the purchased test and purchased test interpretation rules apply in the case of a reassignment made under the

contractual arrangement exception. This exemption also would modify the definition of a centralized building in the physician self-referral regulations and would place certain restrictions on what types of space ownership or leasing arrangements qualify for purposes of the physician self-referral in-office ancillary services and physician services exceptions. Although the proposed change in regulations was targeted at laboratory services, CMS also sought input on expanding the proposed regulatory changes to other diagnostic services such as imaging.

To assess the impact of the proposed changes on AUA members and to formulate a plan of action on this issue, the AUA conducted a survey of the AUA Practice Managers' Network, received input from the AUA Health Policy Council and worked with outside legal counsel (Julie Kass at Ober Kaler in Baltimore) to draft our comments. At its November 4 2006 meeting, the Health Policy Council voted to form a Urology Specialty Lab Workgroup consisting of Drs. James Regan, Jeff Dann, Steve Schlossberg, Mike Grable, Larry Jones, Jeff Kaufmann, Marty Dineen, Paul Schellhammer, Herb Riemenschneider, Dennis Corcoran, Bob Flanigan, James Giblin and Richard Gilbert.

Although it was anticipated that CMS would publish a final rule on this issue in November, 2006, in the final rule for the 2007 physician fee schedule, CMS instead indicated that it had received a number of comments and concerns on the proposed changes and would be issuing a final rule on the issue sometime in early 2007.

AUA Meeting with CMS

On March 5, the Urology Specialty Lab Workgroup held a conference call to review a draft agenda for a meeting with CMS and to identify articles to share with CMS to substantiate the clinical reasons for an increase in the number of biopsy cores. On March 7, the AUA met with the director and deputy director of CMS's technical payment division, with Drs. Dann and Grable as AUA representatives. At the meeting, we focused on how the evidence substantiates an increased number of cores, the benefits to beneficiaries of using specialty labs and that we are willing to help resolve any problems on the billing side that may be causing a wrong perception about why these lab arrangements have formed. The billing issues will have to be dealt with in any entirely different department at CMS—the division of practitioner services. The department we met with, which is the technical payment policy division, only handles the financial arrangements and whether they violate self-referral and reassignment rules and regulations.

At the meeting, CMS staff said that the final regulation will be released later than they originally expected, probably sometime in May. Indications from the meeting are that they are focusing more on an anti-markup provision that would apply to the reassignment of the professional component of diagnostic tests performed under a contractual arrangement so that, for example, a urologist could not pay a pathologist \$50 for a test that Medicare pays \$100 for and then keep the remaining \$50. The effects of this would depend whether the pathologist is employed, paid by the hour or paid by the test. CMS also indicated that if they did go this route, it would be up to the individual practices to determine, through their accounting mechanisms, the correct amount that should be billed to Medicare. On April 5, we sent the attached (*See Attachment 1*) follow-up letter, paper on the changing utilization of prostate biopsies and the articles that are referenced in the paper to CMS.

DME CAP Final Rule

The Centers for Medicare & Medicaid Services on April 10, 2007 issued a final rule establishing a competitive bidding program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) furnished to Medicare beneficiaries under Medicare Part B. Initially, the program will operate in competitive bidding areas (CBAs) that include ten of the largest

Metropolitan Statistical Areas (MSAs), excluding the New York, Los Angeles, and Chicago MSAs. The program will apply initially to ten categories of DMEPOS, chosen for a variety of factors, including high price and high utilization. None of the initial categories include urology items. The final rule goes into effect on June 11, 2007.

The Medicare DMEPOS Competitive Bidding Program was mandated by the 2003 MMA after demonstration projects in Texas and Florida that produced significant savings for beneficiaries and taxpayers without hindering access to DMEPOS and related services. CMS built on the experiences with those demonstration projects to design the competitive bidding program, which will be phased in over several years. According to CMS, the new competitive bidding program will offer beneficiaries in the designated CBAs access to quality DMEPOS products and services and will lower out-of-pocket costs. The final rule also provides opportunities for small suppliers to participate in a competitive market. When fully implemented by 2010, the program is projected to save Medicare about \$1 billion annually.

Impacts on urologists

✓ In response to comments from the AUA and other physician groups on the proposed rule, CMS added new protections for physicians. Although the AUA and other physician groups had urged a blanket exception for physicians who provide DMEPOS items in their offices to patients, CMS instead created a narrow exception for physicians that includes only the DME items that are allowed to be provided in the office under the physician self-referral law such as crutches, canes, and folding manual wheelchairs. Because there are no urology items in the first round of the DME CAP, urologists will not be affected if they supply their patients with catheters, ostomy bags or other prosthetics and orthotics items in the office. However, there are still physician issues to sort out before the DME CAP is extended in future years, including whether prosthetics should be included in the DME CAP and self-referral issues that relate to supplying orthotics in the office under the in-office ancillary services exception.

This will be very important for urologists in the future if CMS adds urology items to the list of DMEPOS items that must be competitively bid. The AUA will continue to provide information to CMS to ensure that future DME CAP rules will not negatively affect urologists who provide these items to patients in the office.

April 4, 2007

(NOTE: SENT ON AUA LETTERHEAD)

Donald H. Romano
Director, Technical Payment Division
Center for Medicare Management
Centers for Medicare & Medicaid Services
Room C4-01-13; Mail Stop C5-02-23
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Romano:

Thank you for meeting with the American Urological Association (AUA) on March 7, 2007 to discuss our views on urology specialty labs. We have attached the follow-up items you requested to substantiate the fact that the number of prostate biopsies, as well as the number of cores taken for each biopsy, is a direct result of the evolving understanding of the nature of prostate cancer rather than the result of the formation of urology specialty lab arrangements between urologists and pathologists.

Included in the attachments are a paper titled *Changing Utilization of Transrectal Ultrasound Guided Prostate Biopsies for the Diagnosis of Prostate Cancer*, a reference list and copies of the articles that are referenced.

Several factors relating to the medical practice of diagnosing and treating prostate cancer account for the increase in biopsies and biopsy cores. These include:

- The evolution of using ultrasound guided biopsies to find early, curable prostate cancer;
- Medicare approval of PSA screening, which has led to a greater referral of patients with elevated PSAs;
- Greater medical indications for when to perform biopsies (i.e., lower cut point for PSA, PSA velocity, free PSA, etc); and
- Public awareness campaigns leading to greater numbers of PSA screening.

Although there is no specific subcertification for urologic pathology, concentrating experience in the hands of pathologists dedicated to evaluating a high volume of urologic pathology specimens increases the quality of care for Medicare beneficiaries. Such a benefit is evident in the literature, where reproducibility of prostate pathologic diagnoses such as high-grade prostatic intraepithelial neoplasia (PIN) is high among those pathologists who specialize in urology and low among those who don't (Epstein et. al. pg. 822; #21 on attached reference list).

Additionally, the integration of clinical urologists, who understand the patient's medical history, and a pathologist who communicates regularly with the urologists and has immediate access to the patient's medical record provides a better, more reliable interpretation of the pathology specimen.

The patient's health needs should always be the driving force behind any medical care. Responsible treatment provided by qualified, board certified physicians should never be forbidden simply because there may be legitimate profit involved. Just as financial incentives

should never be the reason behind choosing a particular test or treatment, they should never be used to deny the highest quality care.

Urology practices have begun to subspecialize in urologic oncology. Such urology practices may find it more efficient and better for patient care if they have greater interaction with the pathologists interpreting biopsies. This can be accomplished through relationships with pathologists as employees or independent contractors or by sharing pathologists in a specialty lab arrangement. Any data potentially showing that urology-owned lab practices perform a higher volume of prostate biopsies than practices not owning a lab, may be accounted for by practices that subspecialize in urologic oncology and consequently have a patient population that is more likely to require prostate biopsies. Further, with medical advances, there is research that supports the increase in the number of biopsy cores. The attached articles clearly support appropriate indications for taking more biopsy cores than five to ten years ago.

Also, we have reviewed CMS data available to the public, and have not found any data to support the claims of fraudulent billing, over-utilization or abusive billing patterns of urology groups that contract with pathologists for prostate biopsy interpretations. If CMS has such data, we would be very interested in discussing it more specifically with CMS.

Anti-markup

As we discussed at the meeting, urologists are first and foremost interested in collaborating with pathologists to provide the best care to their patients, rather than being driven wholly by financial gains. The anti-markup provisions for the technical component of a purchased diagnostic test that were provided by statute were intended to eliminate financial incentives in situations where a physician simply referred a billable service to another Medicare provider with no associated expense and billed it as their own.

In pathology labs located in group practices under the Stark ancillary services exception, the urologists are not merely purchasing a pathology interpretation from the pathologists. The pathologists are independent contractors and physicians in the group practice. Accordingly, there are risks and expenses born by the urology group in such instances that are different than a mere purchased test. For instance, the group practice is responsible for the overhead of the pathologist.

Thanks again for meeting with the AUA and allowing us to provide you with some additional information about urology specialty labs. If you have any questions or need more information, please contact Robin Hudson, Senior Manager of Quality Initiatives & Health Policy, at 410-689-3762 or rhudson@auanet.org.

Sincerely,



James B. Regan, M.D.
Chair, AUA Health Policy Council

cc: Lisa Ohrin, Acting Deputy Director, CMS Technical Payment Policy Division
Joanne Sinsheimer, Health Insurance Specialist, CMS
Jeffrey A. Dann, M.D., Chair, AUA Coding & Reimbursement Committee
Julie Kass, Esq.

**Changing Utilization of Transrectal Ultrasound Guided Prostate Biopsies
for the Diagnosis of Prostate Cancer**

**Submitted by the American Urological Association
to the Centers for Medicare & Medicaid Services (CMS)
Technical Payment Policy Division
April, 2007**

BACKGROUND

The increasing rate of PSA screening in our population as a means of detecting early prostate cancer has increased the rate of referrals to urologists for prostate biopsy. Since 1999, the number of new prostate cancer cases has steadily increased, while the number of deaths from prostate cancer has steadily decreased (American Cancer Society Cancer Statistics). This implies that the impact of early detection of prostate cancer by means of prostate biopsy is having an impact on patient survival. Prostate biopsy is used to confirm the diagnosis of cancer, to stratify tumor aggressiveness (Gleason Score) and to determine the extent of disease within the prostate. In most cases, management of prostate cancer can be decided by using biopsy data supplemented by clinical (age, general health) and biochemical (PSA) data without the need for further staging. Therefore, prostate biopsy is critical to prostate cancer management.

To date, non-invasive techniques such as color doppler, CT and MRI have all proven unpredictable in diagnosing prostate cancer since most cancers are either invisible or have a non-specific appearance (1). Unique among image guided biopsies, prostate biopsy is not lesion-directed. Rather, it samples those areas of the gland where tumors are most frequent in a systematic fashion. Since the disease is often multi-centric, the whole gland needs to be sampled. Accordingly, zone based methods of prostate biopsy were developed to accurately diagnosis cancer of the prostate.

HISTORICAL EVOLUTION OF PROSTATE TECHNIQUES

The first transrectal ultrasound (TRUS) guided prostate biopsies, in the early 1980s, were targeted at focal hyper and hypoechoic nodules. Unfortunately, most of these nodules proved to be historically benign. Faced with the knowledge that targeted biopsies were inaccurate, various sampling techniques were tried. Hodge first reported the use of sextant (six) biopsies in 1989 (2). It was a major advance with a 20-25% positive biopsy rate for men with elevated PSA. However, with wider experience, even the sextant technique was found to be inaccurate, primarily because it under-sampled the peripheral zone of the prostate. In 1994, Keetch showed a 20% positive rate on re-biopsy (missed cancer on initial biopsy) (3).

In 1997, Eskew introduced the systematic extended biopsy technique which combined the sextant biopsy method with additional biopsy cores from the far lateral lobes and three cores from the middle of the gland. This study demonstrated that 10 biopsies will improve the diagnosis of prostate cancer by 20-30% over traditional sextant protocol (4). This study, along with Chan (20) demonstrated that extended biopsy techniques do not increase the detection of insignificant tumors and seem to detect earlier stage significant tumors.

During this period, several articles suggested a relationship between the number of biopsies required to diagnose cancer of the prostate and gland volume. Researchers showed that there is an inverse relationship between prostate size and the likelihood of finding prostate cancer in a sample (5-7). The relative amount of gland that should be sampled relates directly to the size of

the gland and thus the ideal number of cores to take may be dependent on the size of the gland as calculated by TRUS. Stricker used this theory to demonstrate that for a fixed percentage volume of prostate cancer, the probability of finding cancer increases as the number of biopsies increases (8). Naughton suggested a linear relationship between the number of biopsies required to find prostate cancer and gland size (9). Mariappan found that volume-adjusted increased biopsy core regimens significantly increased the positive biopsy rate of TRUS guided prostate biopsies. According to his findings, taking additional cores based upon prostate volume detected 65.5% of cancer while sextant biopsy detected only 34.5% (10).

Multiple studies have revealed that increasing the number of prostate biopsies enhances prostate cancer detection (11-13). Published articles have recommended additional core systematic biopsy techniques combining sextant techniques with additional biopsies of the peripheral and transitional zones of the prostate. Levine investigated 2 sets of sextant biopsies at a single sitting. The second set of biopsies provided a 30% incidence of undetected prostate cancer (14). Babaian investigated an 11 core technique which increased the incidence of cancer detection by 33% (15). For the last several years, several authors have suggested utilizing saturation biopsy techniques to increase prostate cancer detection. Initial techniques were introduced by Borborgue and consisted of 20 cores or more. In most saturation biopsy studies, between 20-34% of men have cancer despite two previously negative biopsies (11). In a series by Walz, this rate is as high as 41% (16). Saturation biopsy techniques allow adequate sampling of the whole prostate, especially in large glands and selected high-risk patients.

PATIENTS REQUIRING REPEAT BIOPSIES

In some cases, clinical suspicion of undiagnosed cancer persists after a negative first biopsy. Examples include: 1) persistently elevated or rising PSA; 2) High Grade PIN, which is thought to be a pre-cancerous condition with up to 40% of PIN patients having prostate cancer on repeat biopsy; 3) Atypia or non-diagnostic sample which is thought to be a sampling error with up to 50% of repeat biopsy proving positive (17-19). In these cases, there remains a high degree of suspicion of prostate cancer in spite of repeated negative biopsy; therefore, saturation techniques of 20 cores or more evenly distributed throughout the gland is a logical procedure. The larger number of evenly distributed samples increases the likelihood of discovering an underlying cancer regardless of tumor size or location (1).

CONCLUSIONS

1. The increase in the number of PSA tests performed annually has contributed to the increase in the number of prostate biopsies.
2. There is a linear relationship between the number of biopsy cores required to diagnose prostate cancer and gland volume.
3. The literature clearly supports the concept that a greater number of prostate biopsy cores performed at a sitting yields a greater incidence of prostate cancer (i.e. "the more you take the more you find"), causing urologists historically to increase the standard number of cores per biopsy sitting from 6 to 12 cores.
4. The growing recognition that high risk patients with PIN, atypia and rising PSA despite negative previous biopsies are clearly associated with a high incidence of prostate cancer on repeat biopsy has prompted an increased repeat biopsy rate in this population of patients.
5. Saturation biopsy techniques further increase the incidence of positive biopsies compared to current standards and should be considered in high-risk patients.

6. The demographic increase in the number of prostate biopsies overall and the increased number of cores per sitting has resulted in a growing number of prostate biopsy specimens. This reflects a scientific evolution of biopsy technique and has increased our ability to detect early prostatic cancer, which leads to enhanced patient care and survival.

Reference List

- 1) Raja et al. Current status of transrectal ultrasound-guided prostate biopsy in the diagnosis of prostate cancer. *Clinical Radiology* 2006; 61:142-53.
- 2) Hodge et al. Random systematic versus directed ultrasound guided transrectal core biopsies of the prostate. *J Urol* 1989; 142:71-5.
- 3) Keetch et al. Serial prostatic biopsies in men with persistently elevated serum prostate specific antigen values. *J Urol* 1994; 151:1571-4
- 4) Eskew et al. Systematic 5 region prostate biopsy is superior to sextant method for diagnosing carcinoma of the prostate. *J Urol* 1997; 157:199-203.
- 5) Uzzo et al. The influence of prostate site on cancer detection. *Urology* 1995; 46: 831-6.
- 6) Karakiewicz et al. Outcome of sextant biopsy according to gland volume. *Urology* 1997; 49:55-9.
- 7) Vashi et al. A model for the number of cores per prostate biopsy based on patient age and prostate gland volume. *J Urol* 1998; 159:920-24.
- 8) Stricker et al. Detection of non-palpable prostate cancer. *BJU* 1993; 71:43-6.
- 9) Naughton et al. Clinical and pathologic tumor characteristics of prostate cancer as a function of the number of biopsy cores: a retrospective study. *Urology* 1998; 52:808-13.
- 10) Mariappan et al. Increasing prostate biopsy cores based on volume vs the sextant biopsy: a prospective randomized controlled clinical study on cancer detection rates and morbidity. *BJU* 2004; 94:307-10.
- 11) Stewart et al. Prostate cancer diagnosis using a saturation needle biopsy technique after previous negative sextant biopsies. *J Urol* 2001; 166:86-92.
- 12) Stamey. Making the most out of six systematic sextant biopsies. *Urology* 1995; 45:2-12.
- 13) Presti et al. The optimal systematic prostate biopsy scheme should include 8 rather than 6 biopsies: results of a prospective clinical trial. *J Urol* 2000; 163:163-67.
- 14) Levine et al. Two consecutive sets of transrectal ultrasound guided sextant biopsies of the prostate for the detection of prostate cancer. *J Urol* 1998; 159:471-76.
- 15) Babaian et al. A comparative analysis of sextant and an extended 11-core multisite directed biopsy strategy. *J Urol* 2000; 163:152-57.
- 16) Walz et al. High incidence of prostate cancer detected by saturation biopsy after previous negative biopsy series. *European Urology* 2006; 50:498-505.
- 17) Ellis et al. Repeat prostate needle biopsy: who needs it? *J Urol* 1995; 153:1496-8.
- 18) Perachino et al. Results of rebiopsy for suspected prostate cancer in symptomatic men with elevated PSA levels. *European Urology* 1997; 32:155-9.
- 19) Matlaga et al. Prostate biopsy: Indications and technique. *J Urol* 2003; 169:12-9.
- 20) Chan et al. Does increased needle biopsy sampling of the prostate detect a higher number of potentially insignificant tumors? *J Urol* 2001; 166:2181-4.
- 21) Epstein, J et al, Prostate Needle Biopsies Containing Prostatic Intraepithelial Neoplasia or Atypical Foci Suspicious for Carcinoma: Implications for Patient Care, *J Urol*: 2006;175:820-34.

Threats to Urology.

In the past year, urology has come under assault from a number of different sources in areas that are not necessarily of primary concern to other specialties. These attacks demand effective action on all fronts—insurer, regulatory and legislative-- because they pertain to core medical practice issues of our members. For example, we have been notified by our members of state legislative actions supported by pathologists in Arkansas, Maryland and other states that threaten urologists' ability to engage in different kinds of lab arrangements; have been asked by members across the country to help them fight arbitrary payment denials by insurers; and have been informed of demands for certification so that urologists can continue to conduct essential in-office imaging services. The AUA staff has mobilized to respond to all of these requests as they come in. Included are:

- Threats to in-office imaging at the national, state, and individual insurer levels;
- Attacks by pathologists at the AMA and state level re: accusations of Stark violations, and in particular, urology specialty or "pod" labs;
- Sudden terminations of payment for common procedures;
- Scrutiny by MedPAC, the influential commission that advises Congress on Medicare payment and quality, for being only one of two outliers that show a substantial increase in volume of procedures, and interest by its Chair, Mark Miller, in newspaper coverage of IMRT.

Imaging: Urology is one of only a few specialties that heavily rely on the use of ultrasound in the office. Therefore, preservation of the ability to do so is essential to our members. In the past year, this area has witnessed a surge of activity by third party payers, and state and national legislators. We face an unprecedented assault from a variety of sources, including other medical specialties, like ACR and ACC that seek to limit in-office imaging. While we have been part of the Coalition for Patient Centered Imaging (CPCI), it has lost its coherence and effectiveness. Urology must be prepared to respond quickly and effectively to such challenges. Specific examples of the kinds of actions we must counter are provided below.

- *Federal Action:* The Deficit Reduction Act (DRA) of 2005 placed restrictions on imaging in the belief that an explosion in imaging is responsible for a significant portion of rising healthcare costs. However, although Congress did not intend for such restrictions to apply to ultrasound, it did not craft language in such a way as to explicitly exempt it. Therefore, a handful of specialties that rely on the unrestricted use of ultrasound, notably urology and ob/gyn, have been faced with having to ensure that ultrasound is exempted from restrictions at every turn. Ob/gyn engaged an experienced lobbyist to work solely on this issue for them on the Hill. In late 2006, *both ACR and ACC proposed that mandatory accreditation be included in the Medicare program,* claiming that such accreditation would save money on imaging. Moreover, Radiology Benefit Management (RBM) companies engaged in a multi-million dollar lobbying effort to get pre-authorization for imaging services and tried to insert corresponding language into the Tax Relief and Healthcare Act of 2006. We were made aware of this move by ob/gyn, and

alerted our members. Because of an overwhelming response from our members, 2200 of whom emailed, faxed and phoned members of Congress in just over 4 days, we were able to stop this action from becoming law. More coordination of such critical member action will be required in the future.

- State Action: The state of Maryland is one of the most restrictive when it comes to imaging, permitting only radiologists to perform and interpret CT and other scans. However, orthopaedists and urologists in the state organized to fight a particularly rigid interpretation of Maryland's already strict self-referral statute. Seeing this as a harbinger of national action, the AUA, in partnership with several other specialties in the state signed on to an amicus brief. We have also actively supported the fight by Maryland urologists in the state house, where we supplied testimony, and hosted an organizational meeting for them here at AUA headquarters. We expect such threats to gain momentum.
- Third Party Payers (Highmark, BCBS): A few months back, Highmark began demanding additional evidence that our members were qualified to conduct imaging, and were demanding specific accreditation through ACR or the like; otherwise, it was going to require the use of a radiologist to perform all imaging. Health Policy Chair, Dr. James B. Regan and our Director of Reimbursement and Regulatory Affairs worked diligently to effect some less draconian requirements. Highmark then offered the possibility of a weekend credentialing course as an alternative. In addition, Dr. Pat Fulgham, incoming chair of the Urologic Diagnostic and Therapeutic Imaging Committee, has been extremely involved in addressing this issue in concert with Health Policy. Finally, we have been exceedingly fortunate in having Dr. Thomas Rohner, a member of the AUA Board as well as that of Highmark, to act as a liaison for us in negotiations. However, we do not expect to be so lucky with the many insurers that are pursuing such options, such as United HealthGroup which just announced it is requiring accreditation (as opposed to certification) for all facilities that engage in imaging. Part of the urgency in revising the AUA's imaging policy stems from this threat to urologists' ability to continue their practice of medicine unencumbered.

Stark, Pod Labs: At the November AMA meeting, pathologists tried to introduce a resolution that accused urologists of circumventing the Stark law through creative reimbursement arrangements; fortunately, the resolution was withdrawn. However, we have received member reports that indicate pathologists are attacking urology at the state level with similar charges. In addition, CMS has cited urology as one a few specialties that may be engaging in contractual arrangements for lab services that border on Stark violations. Finally, the Senate Finance Committee wants to investigate ancillary services by physicians in the coming session.

Assaults by third party payers. Both volunteer physicians and staff can attest to the newly aggressive actions taken by insurers across the country. Refusals to pay for previously covered procedures without any warning or justification whatsoever are becoming

increasingly common. Moreover, such attacks require immediate response from urology before they become entrenched and more widespread; this means that our physician volunteers must quickly locate expert colleagues, assemble literature reviews in record time, and instantly engage in negotiations to reverse or forestall such action. This has happened in the following instances: 1) Renal Ablation (Noridian); 2) Deflux (United); 3) Mytomycin.

✓ Even the *threat* of such action has influenced our members' behavior. Thus, the recent formation of a panel to address cryotherapy arose because many members feared its absence from the newly updated prostate cancer guidelines would lead to elimination of payment by insurers.

In order to effectively prepare for such attacks that require instant, yet still well prepared, responses, we need to be more proactive and ready in advance of such assaults: This must include close and constant monitoring and tracking of such activity at the individual insurer, local and state levels. Currently, we do not have the manpower to perform this basic yet essential activity. Such tracking would provide the needed foundation to support a major new initiative of the newly formed Reimbursement and Regulatory Affairs Department, to address such occurrences more proactively. To try to prevent and limit the actions described above, staff, armed with physician experts and all available evidence, plan to establish regular, ongoing contact with major insurers throughout the country *in advance* of any insurer action.

✓ However, as noted, an essential element of this strategy is active monitoring of incidents and legislative action at the state level. Currently, one of the primary ways we become aware of such actions is through member reports. While these alerts are most helpful, we should not rely upon them exclusively; rather, we should be tracking what is happening on a daily basis through all credible sources, so that we can begin to identify areas that need to be aggressively targeted, and which may be harbingers of national action. Finally, armed with this intelligence, we can then be proactive legislatively by leveraging the relationships we have cultivated.

Opportunities for Urology

✓ On the positive side, urology has a unique opportunity to carve out an enviable niche for itself on the Hill and among the general public, with respect to prostate cancer. Attention to prostate cancer is increasing, in part due to greater attention to diseases of an aging population. Prostate cancer is a priority of federal agencies, including CMS, CDC and NCI, among others. However, urology is not very visible in these circles, missing potential funding opportunities as well as the chance to ensure consultation by policy makers at critical junctures. In general, it is safe to say that not many key policymakers in Congress or in federal agencies, let alone the general public, readily associate urology with prostate cancer. To gain greater visibility for the field, highlight our contributions, be in a position to offer expertise when needed, and thereby wield greater influence for our members when it counts, we should actively cultivate individual leaders and groups around this issue. Unless we claim this territory for ourselves, others will claim it.

Medical oncology is well organized and financed, and is ready to declare jurisdiction over this cancer, as well as those where it legitimately predominates.

Our foray into the development of prostate cancer measures as the lead organization with the AMA Physician Consortium for Performance Improvement (PCPI) provides us with a national platform from which to launch the kind of campaign alluded to above. In addition, the disproportionate impact of this disease on African Americans has caught the attention of the Congressional Black Caucus, which sponsors a yearly forum on health. In concert with the AUA Foundation and key external partners, we could plan and execute a national strategy that would reach out to legislators, their constituencies, patients, the general public, and the media, and provide a service to both the public and our members by solidifying the connection between urology, prostate health, and early detection and treatment of prostate cancer.

To do so, we need an effective legislative team to carry out any agreed upon strategy. With our prostate cancer measures due for release and testing this spring and summer, and their inclusion in the 2008 CMS Physician's Quality Reporting Initiative (PQRI, formerly Physician Voluntary Reporting Program or PVRP) we are perfectly situated to embark upon such an effort with success and gain greater visibility and influence for urology. This also helps us strengthen and defend ourselves against the assaults enumerated above.

Available Resources

Internal AUA Staff

At present, the GA department has two positions: the Director for which we are currently recruiting and a Coordinator, Brian Reuwer, who is responsible for helping to administer UROPAC, work with our AMA delegates, collaborate with AACU to plan and execute the annual Urologic Joint Advocacy Conference, and work on grassroots issues, particularly with respect to our Sections. While we have analyzed and revamped the entire operation over the past several months, Brian Reuwer has pitched in with attendance at many of the lobbying and coalition meetings on behalf of the AUA.

External Lobbyist

Over the past five years, the AUA has employed the services of an experienced outside lobbyist, Hart Health Strategies, to lobby NIH and Congress on our TRU bill. The lobbyist had also assisted us in the past with other tasks, such as obtaining speakers for our Advocacy Conference and gaining entrée to key legislators and their staff. At present, while we are in the process of recruiting a new director, Vicki Hart and her staff are providing key services to ensure that the AUA is properly represented on the Hill and in the legislative process. The precise role of the outside lobbyist will be part of a larger assessment that will take place when we get our full government team in place.

Volunteer Physicians

The Chair of Health Policy is a paid position. The Chair plays a key role in advising staff on a daily basis; representing the AUA to outside organizations, including various

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**Report to AUA Board
Update on Quality Activities
Submitted by Beth Kosiak Ph.D., AED for Health Policy and Robin Hudson, M.P.A., Senior
Manager for Quality Initiatives and Health Policy
May 2007**

- Update on 2007 PQRI and prostate cancer measures
- AMA Physician Consortium for Performance Improvement (PCPI)
- Quality Alliances
- Update on P4P Workgroup
- NQF

2007 Physician Quality Reporting Initiative (PQRI)

The Medicare 2007 Physician Quality Reporting Initiative (PQRI), as mandated by the 2006 Tax Relief & Health Care Act, goes into effect on July 1 2007 and Health Policy is gearing up to provide member education so that urologists who choose to participate in this voluntary program will be able to do so. PQRI participants who satisfactorily report on measures between July and December 2007 will be eligible to receive a one-time, lump-sum bonus payment of up to 1.5 percent of total Medicare allowed charges for that same time period. However, the AUA is *not* citing the bonus as the main reason to participate in the program, but is encouraging urologists to participate so that they will be prepared when such a program becomes mandatory, which will most likely be in the near future.

Practices who conduct a cost/benefit analysis of their participation in the PQRI would most likely decide not to participate based on the small amount of the financial reward. Therefore, we are conducting an ad campaign to raise awareness among urology practices that they should participate in the PQRI so that they will be prepared in the future when participation is mandatory and when CMS could use withholds instead of bonuses, similar to what they have done with other providers such as hospitals.

Physician education

CMS's new special program office for Value Based Purchasing (VBP), led by Thomas Valuck, M.D., J.D. has created a website at <http://www.cms.hhs.gov/PQRI/> which provides educational resources, including frequently asked questions, slide shows and technical information about how to participate in the PQRI. CMS has also held regular open forum conference calls for providers.

Urology-specific education

AUA staff held a conference call on March 1 with Drs. Tom Valuck and Mike Rapp from CMS to discuss urology-specific issues related to the 2007 PQRI and to let them know of our preparations for 2007 and beyond. We have also attended briefings for the medical specialties conducted by Tom Valuck. AUA Staff has also participated in CMS's conference calls with Q&A sessions on the PQRI, and continues to review new educational items released by CMS. AUA will use such tools to guide us in preparing to help urologists interested in participating in the July kickoff of the program that allows physicians to earn a 1.5% bonus in 2007. The AUA is conducting a urology-specific webinar on June 5 with a CMS speaker and we are also preparing a toolkit for urology practices who wish to participate in the PQRI.

Urology measures for 2007

There are five measures available for urologists to report on in 2007. They are:

Perioperative Care: Timing of Antibiotic Prophylaxis - Ordering Physician	Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics, who have an order for prophylactic antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)
Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis	Percentage of patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time
Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months
Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older	Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence whose urinary incontinence was characterized at least once within 12 months
Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months

Measure specifications

Although the list of measures (74 total in the entire PQRI) is finalized for 2007, the law does allow modifications or refinements (such as code additions, corrections, or revisions) to the existing measures up until July 1, 2007. CMS has recently indicated that the specs will be finalized one month prior to the July 1 start date to allow enough time to accurately program CMS computers to handle the measure reporting. The AUA Pay for Performance Workgroup worked with Health Policy staff to ensure that the specifications are correct for the urology measures. The AUA guidelines panels on antibiotic and dvt prophylaxis were very helpful in this effort and we are looking forward to the completed documents being released so that we can share this information with the medical community at large for future efforts.

Data registry

The law also specifies that CMS must consider a process to put a national data reporting process in place to utilize currently-available registries. CMS is considering appropriate avenues to meet this requirement and has been approached by many groups with existing registries. The AUA is investigating the possibility of creating a registry for urology, either alone or in conjunction with other surgical specialties through the Surgical Quality Alliance, which has formed a data registry workgroup.

2008 and beyond - prostate cancer measures

Although Congress did not create bonus payments for reporting quality measures in 2008, it did specify that measures must be adopted or endorsed by a consensus organization such as the National Quality Forum or AQA, submitted by a physician specialty and developed using a consensus-based process. Congress also requires that structural measures such as the use of electronic health records and electronic prescribing technology must be added in 2008. To that end, CMS is required to publish by August 15, 2007 a proposed set of 2008 quality measures on which the public can comment and to publish a final list of 2008 measures by November 15, 2007.

We anticipate that the prostate cancer measures, which we are developing through the AMA PCPI, will be available for use in the 2008 quality reporting program. The draft measure set was sent to PCPI members and others, including the AUA Board and other relevant committees for public comment during April 20 to May 11. The prostate cancer workgroup has a conference call scheduled for May 22 to review public comments and the measures will be presented by Dr. Penson and voted on at the PCPI meeting on June 1.

PCPI

First Consortium Meeting in Washington, D.C.

On March 9, 2007, the AMA-convened Physician Consortium for Performance Improvement (Consortium) held its first meeting since its inception in 2000 in Washington, DC. The meeting helped raise awareness among key Washington policymakers of the Consortium's work. Leslie Norwalk, CMS Acting Administrator, gave the keynote address to the standing room only crowd and CMS staff discussed implementation and measure development issues related to the CMS Physician Quality Reporting Initiative with Consortium members. The Consortium also heard directly from a representative of the Medicare Payment Advisory Commission (MedPAC) regarding efficiency measurement in Medicare and the challenges of integrating different methodologies into the program. In order to continue to educate Washington officials regarding medicine's efforts on measurement development, the Consortium will meet again in DC from its May 31-June 1 meeting.

PCPI Oncology Workgroup

ASTRO and ASCO are lead organizations for the Consortium's oncology workgroup, and Dr. Penson is the AUA representative to this group. To date, they have held one face-to-face meeting and one conference call. We thought it would be important to monitor this workgroup to assure that urology's interests were represented. Although most of the measures do not apply to urological cancers, it is possible that urologists will be able to report on some of the measures, so we will continue to monitor this effort and provide input as necessary. We will provide more information once the measure set is complete and approved.

Quality Alliances

The AUA continues to be an active member of the Surgical Quality Alliance (SQA), Cancer Quality Alliance (CQA) and the AQA Alliance. Dr. Saigal is the AUA representative to the newly-formed SQA Data Registry Workgroup, which is exploring whether surgery can work together to create a database for reporting quality measures. So far, they have discussed goals, possible common elements of a clinical registry to populate required performance measures, and whether the surgical groups could work together to identify core and additional elements of such a data base.

Dr. Saigal will represent the AUA at the upcoming SQA meeting on May 29 and the AQA meeting on May 30 in D.C. Drs. Miller and Sanda attended a CQA meeting on March 29. The CQA agenda focused on the CQA's role in national implementation of measures and whether they should fold into the AQA.

P4P Workgroup

✓ The P4P Workgroup held a conference call on February 5 to review and discuss the P4P work plan devised by staff to guide P4P activities this year, 2007 CMS PQRI and the available measures for urology, health plan tiering of physicians, various intelligence collected on possible databases for urology, and appointed a group to work on specifying the PQRI perioperative measures for urology—Antibiotic Prophylaxis and DVT. This special workgroup is comprised of Drs. Dmochowski, Forrest, Wolf, Penson, Dann and Clemens. The procedures chosen by the group for inclusion in these measures were forwarded to CMS for inclusion in the 2007 PQRI. The ACS, as lead organization for the AMA Consortium's perioperative workgroup, also coordinated review of these measures by the NQF.

Unfortunately, the NQF did not agree with some of the procedures the AUA chose for inclusion in the antibiotic timing measure, and these procedures were removed. Although we shared an executive summary of our BPP for antibiotic prophylaxis with these groups, we now must wait until the document is finalized to go back to the NQF and the AMA and change these measure specifications. Therefore, we are now going to express our concerns to the NQF about the fact that the panel reviewing these measures was a closed panel and a urologist was not allowed to be present. Although the ACS was representing the groups in the perioperative workgroup during the NQF review, they are certainly not as familiar with urological procedures as a urologist would have been.

The P4P workgroup will meet in Anaheim on May 20, and although we do not anticipate any action items, if there are action items we will forward them to the Board for its May 22 meeting.

Quality Improvement and Patient Safety Committee

✓ The QIPS Committee has not met since we last reported to the Board in February. However, Dr. Penson did identify two neuro-urologists to help with a project we have been working on regarding catheter reuse. This issue is twofold: there is a request from Hollister for the AUA to support its petition to CMS for increased coverage of catheters for spinal cord patients and there is a request from a spinal cord patient to revise the language on the urologyhealth.org website regarding catheter reuse. Drs. Claire Yang and Michael Chancellor and Diane Newman, a registered nurse, are going to review the literature surrounding this issue. Stephanie Chisolm from the AUA Foundation is also in the loop on this project due to her role with urologyhealth.org. The QIPS committee reviewed this issue on its January 29 conference call, but wanted to take a more in-depth look at the literature with urologists who are more familiar with the topic.

The Quality Improvement and Patient Safety Committee will meet in Anaheim on May 21. Again, we do not anticipate any action items but will forward any such items to the Board for review and approval.

CMSS NQF Liaison

The AUA nominated Dr. Brent Hollenbeck from the University of Michigan to be the CMSS liaison to NQF and the CMS approved this nomination. Drs. Penson and Hollenbeck and Beth Kosiak, Ph.D., AED, Health Policy and Robin Hudson, MPA, Senior Manager for Quality Initiatives and Health Policy, held a conference call to discuss Dr. Hollenbeck's new role and

how staff can assist him. Basically, we will coordinate comments on NQF measures for CMSS members and will now attend NQF meetings twice a year and Dr. Hollenbeck will also be required to attend CMSS meetings. It will be advantageous for the AUA to have a urologist in this role, because it gives us an opportunity to familiarize ourselves more with the inner workings of the NQF and to have more of a voice without actually becoming members and to allow us to use this information to determine whether we do need to become NQF members. This will be especially important now, because the NQF at its May 9-11 meeting will unveil its new strategic plan.

Legislative Update
Health Policy Council
May 2007

Overview of Major Activities since the November Health Policy Council Meeting:

- Hosted the Urology Joint Advocacy Conference with the AACU. This year, the meeting had a record attendance with over 94 urologists at the meeting and 88 urologists visiting Capitol Hill.
- Closely monitored the content and focus in the passage of the HR 6111, the Tax Relief and Health Care Act of 2006.
- Developed and disseminated a grassroots alert that resulted in a record number of grassroots advocates speaking out against mandatory accreditation for ultrasound.
- Played a key role in defeating restrictive pathology legislation in Maryland.
- Wrapped up UROPAC activities for the 2006 election year with record donations and launched new fundraising initiatives for UROPAC in 2007.

The Urology Joint Advocacy Conference The Urology Joint Advocacy Conference was held at the Washington, D.C. Ritz-Carlton from Sunday, March 25th through Tuesday, March 27th. 94 urologists attend the two-day meeting, an increase of 20 participants over the previous year, with 88 of those urologists participated in Hill visits on Tuesday. AUA Leadership Program participants and their mentors learned about the importance of legislative advocacy on the path to becoming leaders of urology.

The meeting kicked off Sunday with speeches from AUA members, Ron Castellanos, MD, member of MedPAC, David Penson, MD, chair, Quality Improvement & Patient Safety Committee and Steven M. Schlossberg, MD, chair, AUA Practice Management Committee. The keynote address on Sunday was given by AMA President William Plested, MD, a thoracic surgeon from California who roused the audience with a clarion call to "take back the profession" listing numerous actions from non-physicians that threaten physicians' livelihood and autonomy. On Monday, the meeting started with a State Society Network Update by the AACU, followed by a talk on pay-for-performance given by Bob Berenson, MD of the Urban Institute, who gave a comprehensive critical assessment of the strategy, unveiling its many flaws and unproven claims and a talk on ambulatory surgical centers given by Craig Jeffries, the Executive Director of American Association of Ambulatory Surgery Centers (ASC) who discussed legislation that they will seek to have reintroduced into Congress to try to get ASC payments linked to Hospital Outpatient payments. Concurrent courses on imaging, medical liability reform, NIH, men's health/prostate cancer advocacy and the SGR allowed attendees to pick the courses most attractive to them. .

The UROPAC sponsored luncheon featured Representative Tom Price, M.D. of Georgia and renowned political analyst and humorist Charlie Cook, also a writer with the *National Journal*, to speak at the UROPAC luncheon. Representative Price received the first UROPAC *Friend of Urology* award and gave an update on what medicine is facing in the Halls of the 110th Congress. Returning by popular demand, Cook gave a rousing and humorous insider's view on the upcoming presidential races with a perspective that only a long-time insider can provide. A multitude of other valuable presentations were given on medical liability reform, least costly alternative (LCA) policies on Medicare Part B drugs, and a discussion on the Recovery Audit Contractors (RACs), hired by CMS to look for over and under payments to physicians and a discussion on urologic research at the National Institutes of Health (NIH). Monday culminated with a reception and banquet that featured the popular and highly entertaining Capitol Steps.

On Tuesday, prior to Capitol Hill visits, urologists started the day learning about CMS's Physician's Quality Reporting Initiative (PQRI), from Tom Valuck, M.D., JD, director of the newly formed Office of Value Based Purchasing. A luncheon was held Tuesday to allow the attendees the opportunity to give feedback and ask questions of the AUA and AACU staff before finishing their Capitol Hill visits. This busy day was a rewarding one for attendees. As a direct result of their advocacy efforts, there will be introduction of legislation to remove therapeutic ultrasound from the Deficit Reduction Act, a huge victory for urology, and one that simply would not have occurred without our urology advocates.

✓ The success of the conference was reflected in the high level of Hill activity: 88 urologists from 34 different states participated in 150 Capitol Hill visits with members of Congress. Urologists visited with 67 Senate offices and 83 House offices and those visits to 71 Democrats, 78 Republicans and 1 Independent). The conference is designed to strengthen the advocacy skills of urologists so they may become powerful voices on the state and federal level — these numbers show we are well on our way to success.

The AUA and the AACU are following up with those Congressional offices who have indicated that they are interested in assisting us to stop the cuts to the ultrasound guidance codes. The AUA and the AACU will be evaluating the attendees' experience by sending out a form to garner feedback about their experience at the JAC.

Update on AUA's Efforts to Avert Planned Medicare Physician Payment Cut and the Passage of HR 6111, the Tax Relief and Health Care Act of 2006

✓ The week after the November election, the AMA, along with several medical societies, convened a series of meetings with Congressional staff to investigate the possibility of getting an SGR fix. Almost every physician group with a Washington, DC presence, including several physician extender groups participated. The meetings revealed that both sides were focused on the best way to address a physician payment fix. Although none of the staffers could give a definitive answer on a solution to the impending 5 percent cut, the meetings were successful in putting the SGR issue back on Congress's radar and gave them critical information helpful to their deliberations in December.

Reimbursement & Regulatory Affairs Update

May 2007

Nancy Edwards, Director, Reimbursement and Regulatory Affairs

Coding and Reimbursement Committee

AMA CPT Presentations: Dr. Dann, Chair of the Coding and Reimbursement Committee and the AUA representative to the AMA CPT Advisory Committee, presented at the February CPT Editorial Panel meeting on the following issues:

- Laser Enucleation of the Prostate: Request for CPT Category I code.
- Transurethral Balloon Dilation of Prostatic Urethra: Request for deletion of 52510.
- Percutaneous Cryoablation of Renal Tumors: Request to transition from Category III to Category I code status.

Dr. Dann was successful in having the AUA's recommendations accepted by the AMA CPT Editorial Panel.

CMS Reimbursement Initiatives

- CCI Correct Coding Edits: The Committee will be reviewing 19 pages of proposed edits for prostate resection which is likely to entail CPT coding changes as well. The AUA was able to get an extension from the original April 30th comment deadline to June 1st.
- Medically Unlikely Edit Initiative: The Committee continues its review of quarterly proposed MUE edits. The MUE initiative has been renamed Medically Unlikely Edits and will be phased in gradually with input and dialog with medical specialty organizations. The first phase of edits concerning anatomic considerations was implemented January 1, 2007. The second phase of edits was implemented April 1, 2007. The AUA will submit comments on the third phase scheduled for September 1, 2007 implementation. None of the proposed MUE edits in phases one through three have included surgical pathology which was our major area of concern with the MUE initiative.
- RAC (Recovery Audit Contractors): CMS has piloted this program in three states, California, Texas and Florida, to determine whether substantial money could be recouped by contracting with outside audit contractors. The audit contractors receive a percentage of the reimbursement recouped through their examination of old CMS claims data and physician documentation. This initiative has been very problematic in California where the RAC contractor seems to be targeting urologists for "overpayment" for LH/RH drugs. Although CMS has indicated that the majority of recovered reimbursement has been on the facility side rather than from physicians, this initiative may become a major focus in 2007. Congressional legislation to freeze physician payment for 2007 was funded to a significant extent by anticipated expansion of the RAC initiative to all fifty states.

RUC Activity

Relative Value Update Committee (RUC) Presentations: At the February 2007 RUC meeting, Dr. Giblin presented proposed changes to direct practice expense and physician work for 51797, intra-abdominal voiding pressure study. Dr. Giblin, AUA RUC Advisor, and Dr. Lingeman presented the results of a survey of physician work for laser enucleation. The AUA's recommendation for a work RVU was accepted and AUA physicians and staff were complimented by the RUC on their work. Dr. Giblin also presented the results of a joint survey on percutaneous renal cryoablation.

Multi-Specialty Practice Information Survey: At the February RUC meeting, the Gallup organization presented the preliminary results of the pilot survey on practice expense. Results indicated that telephone interviews with physicians were completed within 15 minutes; however the practice manager piece of the survey took considerably longer (25 minutes for phone interview and 3.5 hours of prep work). Gallup recommended that the practice manager phone interview be pared down to 15 minutes and that the prep time be trimmed to 1.5 hours. The full survey launched in March but was considerably pared down from what was originally proposed in order to focus on the indirect practice expense questions and specific questions critical to certain specialty societies. An additional area of revision was the communication and involvement of specialty societies in the survey process. Gallup recommended that the AMA send a specialty branded "call to action" letter 7-10 days in advance of the mailing of the survey packet. The branding included the specialty's logo as well as the signature of the specialty president. Other key recommendations included how to calculate expenses for employed physicians and to condense the medical equipment utilization questions to less than five items of equipment, rather than the 30-35 listed in the pilot survey. The results of the multi-specialty survey will be used to update RBRVS data on practice expense. It is anticipated that the survey results will be implemented in 2009.

Third Party Payer Activity

United Healthcare & Reimbursement for Vesicoureteral Reflux (Deflux): The AUA has spent extensive time on resolving this issue. United has discontinued payment for injection of a bulking agent to treat VUR, citing the AUA's practice guideline. The guideline is in the update process as it was last updated in 1997 when the use of injectable bulking agents was in the trial stage in the United States. The AUA has discussed this issue with United Healthcare's chief medical officer who is requesting either an AUA position paper with an updated summary of the literature or the updated practice guideline endorsing this procedure. It is anticipated that a draft AUA position paper will be presented to the Board of Directors at the May meeting.

Imaging Issues: Third party payers have begun to require either certification or accreditation as reimbursement criteria for ultrasound and other imaging modalities. The AUA will be meeting with Dr. Carey Vinson from Highmark (PA) on certification requirements for urologists in order to perform imaging for organs other than the prostate. United Healthcare is requiring that physician offices providing CT and MRI imaging become accredited by March, 2008. Several of the Blue Cross Blue Shield plans are also requiring either use of a certified radiology tech or ultrasonographer in order to receive reimbursement for imaging studies. An additional issue related to imaging is that some payers such as Aetna are requiring that physicians obtain pre-authorization for certain imaging studies. The AUA Health Policy Council and the Coding and

The Congress passed legislation that will stop the impending cuts in physician Medicare reimbursements for 2007 and froze them at 2006 levels. The legislation also provided the opportunity for physicians to get a 1.5% bonus payment if they choose to report on quality measures included in the Physicians Quality Reporting Initiative (PQRI), originally entitled the Physicians Voluntary Reporting Program (PVRP) in the December legislation.

This is a summary of the provisions in H.R. 6111 that will most affect urologists:

- A **0 percent** update in Medicare payments in 2007 for all physicians.
- A **1.5 percent** bonus for physicians choosing to participate in the PQRI, (formerly PVRP), which begins in July 2007.
- No change in 2008 reimbursement – which means a cut of **10 percent** starting in 2008.
- A one-year extension of the geographic adjustment for physician services.
- The pilot project on Recovery Audit Contractors (RAC) will be expanded from three states (California, Florida and New York) to all 50 by 2010.
- A withhold of 2 percent from hospitals unless they report quality measures developed by the Centers for Medicare & Medicaid Services (CMS for Hospital Outpatient Services and Ambulatory Surgical Centers. The administration is still working out the details of how this legislation will be implemented. AUA staff and QIPS and Guidelines committee physicians are taking steps to ensure that appropriate urology codes are included in cross-cutting surgical measures that are already part of the PQRI, so that those urologists who wish to participate have measures they can report on. This is in addition to the creation of prostate cancer measures through the AMA PCPI, where AUA is the lead organization. Those measures will be ready for inclusion in the PQRI in 2008.

The AUA Imaging Grassroots Effort

Government Affairs was alerted in early December by the American College of Obstetricians and Gynecologists that there was an effort under way to stop imaging cuts to physicians in Medicare by mandating accreditation for imaging services. The mandatory accreditation would also include ultrasound imaging as one of the required services. Because ultrasound is such an important part of the practice of our members, Government Affairs felt it was necessary to issue a legislative alert to Congress.

Urology achieved a major victory. In a span of just four days, urologists and their supporters sent more than 2,200 e-mails, faxes and letters, and placed countless phone calls to Capitol Hill on the ultrasound issue. Due in part to our actions, Congress declined to add the problematic language to HR 6111. The alert was very successful and showed that urologists can be successful in their desire to fiercely protect their ability to conduct ultrasound.

Summary of Government Relations and Advocacy Maryland Activities

✓ The Government Relations department was made aware by representatives of several practices in Maryland that the state pathology association was seeking legislation that would prohibit urologists from employing pathologists in their practices, a legal arrangement that is popular with many larger practices. On Wednesday, February 21st, Brian Reuwer, Government Relations and Advocacy Coordinator, testified in front of the State House of Delegates meeting of the Health and Government Affairs committee against the proposed legislation. The following week, the AUA secured member and president of the Maryland Urologic Association, Ed Zagula, MD of Annapolis to speak, but he was unable to attend due to a last minute scheduling conflict. With the assistance of AUA Government Relations and Advocacy staff, he submitted testimony to the Committee. His testimony provided a personal account from his perspective as a prostate cancer survivor and urologist exactly how the legislation would harm patient care. In addition, the AUA coordinated with several urology practices and their Annapolis-based lobbyists to stop the legislation from coming up for a vote. We were successful in this effort. On April 9th, the Maryland General Assembly ended its session for 2007; the bill died and must be reintroduced next year in order to be reconsidered. We will continue to assist the Maryland Urologists in their efforts to defeat the legislation in subsequent sessions.

✓ On Monday, April 16th, the AUA hosted a meeting of nearly all of the urology practices in the state of Maryland to discuss forming a coalition to defeat further efforts to erode our ability to provide ancillary services (imaging, ASC, pathology etc.). The urologists will continue to discuss the possibility of uniting in a coalition or in strengthening up the Maryland Urologic Association.

UROPAC Update

✓ UROPAC has just wrapped up a very successful year. In 2006, UROPAC raised more than \$260,000. This is the most UROPAC has ever raised in a one year period. UROPAC raised just short of \$500,000 for the 2005-2006 election cycle--- the best effort since the Affiliation Agreement between the AUA and the AACU was instituted. UROPAC is well poised to expand its reach to urologists in 2007.

✓ The UROPAC Board of Directors held its annual meeting on Sunday, March 25th at the JAC. This is the only face-to-face meeting of the entire UROPAC Board. At this meeting, a new giving budget was approved for UROPAC which will allow the PAC to start supporting candidates this year. The UROPAC Board members also agreed to assist the AUA and AACU staff with fundraising this year by committing to personally contacting 10 urologists and asking for a contribution to UROPAC. UROPAC is coming off a record fundraising year and the Board wants to capitalize on the momentum.

UROPAC raised over \$18,000 from attendees to the Urology Joint Advocacy Conference in March. UROPAC sponsored a luncheon at the Advocacy Conference and paid for Charlie Cook to speak at the meeting, which cost the UROPAC corporate account \$10,000. UROPAC charged all eligible attendees \$250 to attend the lunch and most of the Joint Advocacy Conference attendees' donations exceeded the required minimum.

Reimbursement Committee are working with the Imaging Committee to strategize on a united response and strategic plan to handle these increasing challenges to urology reimbursement.

McKesson Initiative: The AUA has distributed mutual non-disclosure agreements to the Coding and Reimbursement and Practice Management committees which must be completed by those committee members who wish to participate. Through the Practice Managers' Network, a survey was sent asking for the most frequent line item claim denials related to bundling issues. The AUA will then prioritize issues which need to be resolved with current McKesson billing edits. This McKesson initiative reaches out to medical specialty organizations in order to have ongoing dialog on current and proposed software edits that impact a particular specialty. As McKesson currently has 85% of the payer market using its software, the AUA's ability to influence this process on the front end rather than trying to fight it on the back end will be a key strategy moving forward.

MedPAC Activity

MedPAC provided testimony to Congress on several issues impacting Medicare physician payment and practice. On March 6, 2007, MedPAC Chair, Glenn Hackbarth, JD, provided testimony on alternatives to the SGR (sustainable growth rate). In crafting the MedPAC report to Congress, MedPAC commissioners (including AUA member Ronald D. Castellanos, MD) debated the current SGR formula as well as several alternatives to SGR: geographic area spending targets; type of service targets; multi-specialty group practice participation reward/penalty; hospital medical staff targets; outlier identification. Dr. Castellanos strongly recommended that rather than trying to fix the current SGR formula, MedPAC instead focus on alternatives. He further stated that MedPAC discussions thus far appear to be predicated on the presumption that all volume growth is undesirable per se. Rather, the focus should be on identifying unnecessary and inappropriate volume growth.

The Deficit Reduction Act of 2005 (DRA) required MedPAC to examine alternative options in controlling the growth of physician expenditures. The current statutory formula, the sustainable growth rate (SGR) has been widely criticized in that it does not reward physicians who restrain expenditure growth nor does it punish those physicians who provide or order medically unnecessary services.

On April 18, 2007, MedPAC Executive Director, Mark E. Miller, PhD provided testimony to Congress. In his testimony, Dr. Miller stated that Medicare's rising costs, along with the projected growth in the number of beneficiaries threatens the sustainability of the current system. MedPAC's report focused on improving efficiency through a variety of means including:

- 1) Payment updates to physicians that would also factor in provider productivity.
- 2) Payment accuracy with close attention paid to any adverse reimbursement incentives that might cause patient and procedure selection to be driven by economic benefits rather than optimal clinical outcomes.
- 3) Bundling where larger units of payment would be created through the use of episode groupers to minimize incentives to increase profits by providing additional services. Episode groupers are a precursor to physician DRGs where payment would be capped based on the diagnosis.

- 4) Medicare Advantage (MA) plans would be monitored to ensure that capitated rates paid to plans are neutral to Medical Fee For Service (FFS).
- 5) Pay-for-performance programs: Designing payment system incentives to provide high-quality appropriate care.
- 6) Measuring provider resource use: Medicare would inform providers as to how their service utilization compares to that of their peers.
- 7) Care coordination: implementing payment incentives to promote coordination of care when multiple providers are involved in treating a patient.
- 8) Comparative effectiveness: Establishing a way to evaluate new clinical treatments and technologies as compared to currently available treatments and technologies in terms of quality and efficiency.

MedPAC also indicated that the current Relative Value Update Committee (RUC) needs assistance in identifying potentially over-valued procedures and recommended creating a group of experts outside the RUC process that would provide additional input and oversight to RBRVS update activity. Major topics to be discussed and developed into MedPac's Reports to Congress in 2007 include: sustainability of Medicare, Medicare's use of clinical and cost-effectiveness measures and data, alternatives to the sustainable growth rate (SGR) for physician payment formula, pay for performance, imaging standards, payment adequacy for all sites and types of service, physician practice expense and other major health policy issues.

Reimbursement & Regulatory Affairs Strategic Plan

AUA staff drafted a strategic plan for the newly created department of Reimbursement & Regulatory Affairs. The draft plan has been reviewed by AUA senior management and approved by the chairs of Health Policy Council, the Coding & Reimbursement Committee and the Carrier Advisory Committee.

So far in 2007, UROPAC has raised \$118,430 from 524 donors for an average of \$226 per donor.

G. James Gallagher Health Policy Scholar Program

The Gallagher Health Policy Scholar Program was widely advertised in a variety of electronic and print media, including the AUA News, Urology Times, the Health Policy Brief, and individual letters along with a flyer advertising the program were sent to every domestic member, thus creating a high profile for the new program in its inaugural year. By all accounts, the initial response has been extremely healthy, with 21 applicants filing for the honor. The Health Policy Council's Gallagher Health Policy Scholar Program Subcommittee met to review the applications on April 25th, and will notify the successful applicant by May 3rd. The awardee will be announced at the Health Policy Plenary on Sunday, May 20th, by Dr. James B. Regan, Health Policy Chair, and will also be announced in the AUA Daily News.

David Peterson