Urologists to Convene in Washington, Urge Action on Specific Priorities

Urologists from across the country will gather in the heart of our nation’s capital March 10 – 12, for the eighth annual Urology Joint Advocacy Conference, an event intended to educate policymakers about the important role specialists play in the health system as well as their specific public policy concerns.

Featured speakers include Rep. Phil Roe, MD, R-Tenn., who recently reintroduced legislation to repeal the Independent Payment Advisory Board, a.k.a., MedPAC on Steroids. Attendees will also hear from noted health care economist Stuart Altman, PhD. Dr. Altman chairs the Massachusetts Health Policy Commission, a newly formed state agency that monitors the reform of the health care delivery and payment systems. Since the national Affordable Care Act was based, in large part, on Massachusetts reforms, Dr. Altman’s influence may very well extend beyond the Bay State. CMS Chief Medical Officer Patrick Conway, MD, MSc, will hopefully bring clarity to urologists besieged by complex Medicare regulations and quality standards. Following a day-and-a-half of insightful, engaging and energetic general sessions, attendees will storm Capitol Hill, armed with issue briefs and talking points on urology’s joint legislative priorities:

• Repeal the Independent Payment Advisory Board.
• Increase federal support for urologic residency training programs.
• Protect Medicare patient access to high-quality urologic care.
• Establish a National Commission on Urotrauma.
• Improve U.S. Preventive Services Task Force processes and recommendations.

AACU members unable to attend the conference in person are encouraged to monitor their electronic mail boxes those few days in March, as grassroots calls to action will reinforce on-site activities.

Featured in this issue:

AACU PRESIDENT: JOIN US ON CAPITOL HILL: IN SAN DIEGO  
UROLOGIST LEADS AMA PUSH FOR DIRECT TRANSITION TO ICD-11  
ILLINOIS PHYSICIANS PUNISHED AFTER YEARS OF BUDGET RAIDS  
AFFORDABLE CARE ACT IMPLEMENTATION ROLLS ON
Dear Colleagues,

As progress toward the full implementation of the Affordable Care Act marches on, I am pleased to report that the AACU has been very active in federal and state campaigns that impact independent, employed and academic urologists. The Government Relations Report in this edition summarizes a number of noteworthy initiatives, many of which will be discussed during the 8th Annual Urology Joint Advocacy Conference, scheduled for March 10 – 12 in Washington, DC. That event features an exciting agenda complete with relevant policy updates, new advocacy training tools and nationally-recognized speakers who shape the laws and regulations that govern our varied practices.

The conference officially kicks off at noon on Sunday, March 10, with Vanderbilt University’s Larry Van Horn, PhD. Dr. Van Horn’s expertise in health care economics and management influences his thought-provoking research on optimal physician behavior in response to at-risk contracts. We will also hear from the current chair of the Relative Value Scale Update Committee (RUC) on if/how that panel will continue to inform Medicare payment policies. Each of our jointly-established legislative priorities will be the subject of a full session with Reps. Marsha Blackburn and Phil Roe, MD, taking on US Preventative Services Task Force reform and IPAB repeal respectively. Influential staff of physician Members of Congress and key committee chairs will provide insight as to priorities for 2013 and what’s required of individuals and organizations to finally put the SGR to rest and possibly achieve national medical liability reform. We will also be energized by an engaging and interactive advocacy training session from a new partner who has expertise working with groups of physicians. Additional featured speakers are referenced in this edition’s cover story and there will be more than sufficient opportunities to exchange ideas with colleagues at social and evening functions.

Another event receiving considerable attention of late is the AACU – AUA Health Policy Forum, which will be held in conjunction with the AUA Annual Meeting on May 6 at 1:00 p.m. We are in the final stages of securing an outstanding line-up of speakers who will address health information technology and emerging public and private payment models. The days of fee-for-service, no matter the patient population, appear to be waning. The information presented during the health policy forum will be tailored such that urologists will better understand what the future holds.

As outlined in the Government Relations Report in this edition, AACU staff members are actively monitoring hundreds of bills that have been introduced in state legislatures across the country. Noteworthy medical liability reform measures are near the top of legislators’ agendas in Connecticut, Kansas, Missouri, New Hampshire and Oregon. At the behest of 2011 AACU Distinguished Leadership Award recipient Sen. Randi Becker, the Washington State Legislature is taking another look at the Medical Practice Freedom issue that’s detailed in the AACU Action Center (www.bit.ly/WashStFreedom). When legislation that positively or negatively impacts the urologic community requires grassroots mobilization, I strongly encourage you to respond to Calls to Action issued by our staff are composed draft messages that you can send to elected officials in a matter of seconds.

This year promises to be both interesting and challenging. Our legislative team will continue to educate members and policy makers on how regulations, budget provisions and soon-to-be-deployed health insurance exchanges (a.k.a. “marketplaces”) impact the urologic community. I urge you to be vigilant and to stay informed. Urologists can (and do) influence public policies, but that can only be accomplished by your continued support of the AACU and assertive action when called upon to engage in a mobilization campaign.

Thank you for being a member of the AACU. I look forward to seeing many of you at the upcoming Joint Advocacy Conference and then the Health Policy Forum at the AUA Annual Meeting. Please email, write or call our executive office with questions or concerns relative to your membership or any socioeconomic issue so that we may continue to serve you.

See you soon!

Mark Austenfeld, MD
President
American Association of Clinical Urologists

If you would like more information on legislation mentioned in this newsletter, please visit the AACU website at www.aacuweb.org or email us at info@aacuweb.org
UROPAC Update
By: Gary M. Kirsh, MD, Chair

Since Election Day, UROPAC – The Political Action Committee of Urology – has poured over fundraising and contribution reports, as well as 113th Congress leadership and committee assignments, to inform the development of an efficient giving strategy for the 2013 – 2014 election cycle.

The recently restructured board of directors, described in the fall 2012 edition of the Sentinel, is committed to representing our specialty’s interests and making the most effective use of your generous support. Many urologists have already made their first contributions for the year, tying donations to the Joint Advocacy Conference. Can’t make it to the JAC, but want to handle your membership dues in person? UROPAC will maintain a forward presence at the 2013 AUA Annual Meeting in San Diego, where you can swing by our exhibit and learn about the development of our slate of candidates and policy priorities.

UROPAC’s 2013 legislative agenda outlines issues of importance to urologists across the country and in every practice environment. The ongoing education of elected officials on these concerns is a key function of your support. With your faithful and frequent donations to UROPAC, our outreach and education will achieve a wider audience.

For information regarding UROPAC or to make a contribution I encourage you to visit us at www.uropac.org
UROPAC 2013 Legislative Agenda

Urology Lead Issues:
- Promote appropriate Prostate-Specific Antigen (PSA)-based screening for Prostate Cancer and reform of U.S. Preventive Services Task Force (USPSTF) recommendation processes.
- Preserve appropriate use of In-Office Ancillary Exception (IOAE).
- Address workforce shortages in all urologic practice environments (e.g., community and academic practice) and advocate for increased GME funding and resources for urology positions.
- Promote a comprehensive study and improvement of the prevention, initial treatment, chronic care coordination and research associated with battlefield urotrauma.

Urology Working with Coalition Partners:
- Permanent fix to the Sustainable Growth Rate (SGR).
- Repeal the Independent Payment Advisory Board (IPAB), or modification of the current law to provide for Congressional oversight of board decisions, appointment of practicing physicians and review by medical specialty societies.
- Monitor new payment models including bundled payments, accountable/coordinated care and value-based purchasing for their impact on physician reimbursement.
- Prevent legislation that attempts to tie provider licensure to participation in any public or private payment program.

Urology Continuing to Monitor:
- The promotion of patient safety as it relates to scope of practice for non-physician providers.
- The promotion of medical liability reform and caps on non-economic damages.
- The implementation of ICD-10 and ICD-11 as it effects the practice of urology.
- Advocate for the fair implementation of HIT and meaningful use to maximize benefit, safety and confidentiality for both patient and provider.

AMA House of Delegates Report

By: Jeffrey Kaufman, MD, FACS

The 2012 Interim Meeting of the AMA House of Delegates featured reports and discussions on issues of great concern to the physician community, although very little impacted the practice of urology specifically. The Urology Caucus, which includes myself as the AACU Delegate, as well as two delegates (and alternates) from the American Urological Association and urologists representing states and special interest groups such as the armed forces, worked in concert and voiced positions on issues that impact urologists generally such as Medicare payment reform, Medicare physician participation, in-office ancillary services exceptions to the Stark referral law, non-physician provider scope of practice expansion and restructured healthcare delivery and payment models.

In recent years, the Urology Caucus has broadened its influence by working with various coalitions, caucuses and alliances whose interests align with ours. This principle has worked well for us in our advocacy efforts in Washington and state capitols as well. To further that cooperation and ensure that our specialty’s interests are supported, I was elected to a three-year term as member-at-large on the Surgical Caucus executive committee.

Though there were many resolutions addressed that covered a wide range of topics, this interim meeting was focused primarily on advocacy. The topics debated can be broken down in the following manner:

**Regulatory Relief**

We are all impacted by increasing regulation and oversight. Resolutions were considered directing the AMA to cancel or further delay implementation of ICD-10. A suggestion to work to delay implementation and move directly to ICD-11 when it’s ready was defeated. AMA leadership explained that they already pressed the administration to cancel ICD-10 completely and the one-year delay was the best they were able to achieve. A resolution to continue an all-out effort to avoid the pending transition through legislative relief and/or legal action was submitted by urologist W. Jefferson “Jeff” Terry, MD, who had been instrumental in the previous AMA resolution turned policy that delayed ICD-10. Dr. Terry’s resolution invoked spirited discussion, including an eloquent comment by AUA Alternate Delegate Aaron Spitz, MD, who urged the House of Delegates to “ask for another cookie.” The outcome was a clear mandate from the House instructing the AMA leadership to continue reasonable efforts to further delay ICD-10 beyond October 1, 2014. However, at the appeal of AMA Board Chair Steven Stack, MD, the mandate for legal action was rescinded.
The House of Delegates voted to continue work to overturn health insurance anti-trust exemptions, although the potential for unintended consequences was emphasized. Efforts in the past have been unsuccessful. Delegates reaffirmed AMA opposition to mandatory physician participation in government programs such as Medicare or Medicaid. Another policy was reaffirmed that calls for patients’ freedom of choice regarding their physician while sanctioning balance billing if that doctor did not fully participate in Medicare. The House also reaffirmed its opposition to RAC audits of E&M codes and asked again that RAC contractors reimburse physicians for the costs of supplying records or filing appeals. Several resolutions were introduced regarding use of EHR, including fines for failing to adopt usage or meet meaningful use criteria and seeking reimbursement of all costs associated with conversion to EHR. Several more resolutions addressed the value based payment modifier asking that it be delayed or avoided or, if implemented, that better definitions of “quality” and appropriate metrics be developed before it begins. The AMA supported efforts to simplify administrative demands attached to healthcare delivery as exemplified by a policy passed in Colorado.

AMA Governance and Organization

There is ongoing concern that participation and representation in the AMA House of Delegates be reflective of the entire House of Medicine. Despite shrinking membership in recent years (a trend we were told has now been reversed), the AMA remains the leading voice for the interests of all physicians. Fortunately, there are accomplishments the organization points to showing that it remains a viable force working on our behalf and deserving of our support. We will follow this report with another in the near future providing a list of examples of AMA successes in recent years that have defended and supported the practice of medicine by well-trained physicians. Recognizing that shrinking membership will disenfranchise some specialties even while we strive to remain inclusive and speak for all physicians, discussion took place on how to allocate delegate positions and a decision made to lower thresholds. Despite a temporary resolution to this challenge, it is obvious that all specialties, including urology, must encourage its physicians to join the AMA. The number of delegates allocated to the AACU and AUA is proportional to the percentage of urologists nationwide who maintain their membership in the AMA. It is critical that urologists play a role in shaping AMA policy and thereby defending urology interests. If urologists leave the AMA, our ability to influence the policies of the nation’s largest organization of physicians will diminish.

Economic Issues

In this era of increasing overhead, falling reimbursement and increasing regulation, financial sustainability was the focus of great debate. Much time was spent refining “Principles of Physician Employment,” recognizing the increasing number of physicians who are forsaking solo or small group practice in favor of contracted relationships with a health system. The AMA will continue to work for reimbursement for non-face-to-face encounters and for time spent on forms and other administrative work. The House overwhelmingly supported a resolution calling on the AMA to pressure CMS to accept RUC recommendations adjusting fees rather than substituting their own valuations (seemingly sometimes arbitrary or based on mistaken assumptions or bias). An amendment by AUA Delegate Bill Gee, MD, that clarified actual RUC practices was overwhelmingly approved by the House. This principle is very important to urology, in that it both acknowledges the work done by AUA RUC representatives, and preserves urology fees as much as possible. The AMA will also resurvey practice expense data used to update relative value calculations. Recognizing increased pressures on graduate training, the House approved a policy to seek increased federal funding for an expansion of residency positions. Additionally, efforts will be made to make student loan interest fully tax deductible.

In many forums during the meeting, the impact of the Affordable Care Act and the changing landscape of health care delivery were discussed and debated. Although no one is certain where all the changes will lead us, the AMA is well-positioned to indentify and influence the various challenges we are certain to face. It’s difficult for any single organization to speak for such a diverse group of members but it’s increasingly important to retain a cohesive message. Urology organizations should encourage members to join the AMA and extend our own impact there. The AMA speaks loudly – we need to influence what they say.

Scope of Practice

Several resolutions addressed scope of practice issues regarding pharmacists providing vaccinations, non-physician providers extending their encroachment into the practice of medicine and retaining MD or DO physicians as leaders of integrated healthcare teams in training and practice.

On Sunday morning, the Scope of Practice Partnership Summit met by invitation only. The discussion was led by the lead AMA attorney heading a division of six lawyers primarily focusing on state policy and advocacy. Their efforts and focus mirrors our own concern that many of the major battles that failed to gain traction in Washington are now being fought on a state-by-state basis. Since many of these concern creeping scope of practice initiatives by non-physicians, the AMA has become proactive stepping up to challenges wherever and whenever they occur. It was pointed out that in a few years, the country projects a nursing shortage of 240,000 RNs while at the same time, forecasts estimate almost the exact same number of new Nurse Practitioners will be available. We are all aware of the looming physician shortage. It may well occur that the system is cannibalizing nursing to replace physicians, utilizing less well-trained individuals to provide more advanced levels of care. This has worrisome implications for quality of care in many respects. Much of the AMA work is spent keeping medical care in the hands of physicians. Examples of the partnership’s efforts include oral-maxillary surgeons seeking to perform plastic surgery, naturopaths seeking to independently diagnose and treat illness, expanding retail pharmacy minute clinics staffed by nurses with little or no oversight by physicians fracturing patient care and increasing costs, Truth in Advertising laws that attempt to inform patients about who is providing their care and their level of training, the increasing tendency of mid-level providers to award “doctor” degrees confusing consumers and challenging highly-trained specialists.

Fueling the scope of practice problem, the Federal Trade Commission, apparently representing the current administration’s devaluation of physicians, has filed lawsuits against various state Medical Boards who have ruled that mid-level providers including nurses may not practice medicine without a medical license. The FTC claims that such efforts are anti-trust violations ignoring the value placed on quality of care by these boards. Fortunately, the AMA litigation center has been successful in this area but the battle is ongoing and deserves our support. There were 400 incidences of legal
activity that posed threats to scope of practice. The AMA legal team successfully litigated 100 cases across all 50 states. Much of the challenge to scope of practice was fueled by the IOM report released a couple of years ago that suggested that health care quality could be maintained while cutting costs by allowing nursing to increase their scope of practice. This creeping infringement on physician care is a dangerous threat to patient care and has been opposed by our AMA. However, anti-discrimination language in the health reform bill PPACA is likely to exacerbate this problem. Urology is no less likely to be impacted by this than other physicians and so we need to continue to work in collaboration with the AMA.

Public Health
At the end of the day, the AMA is a public service organization dedicated to improving the health and well-being of Americans, not a trade organization. Consequently, many resolutions addressed public health issues including the regulation of medical marijuana, payment for vaccinations, redirecting federal funds for disease prevention and addressing national drug shortages. Debate reflected how best to pursue targets we all agree are important.

Conclusion
Overall, the 2012 interim meeting was quite successful. However, it was the sense of the House that future interim meetings will have greater impact if held in conjunction with more active advocacy in Washington itself. Hopefully, leadership, who is charged with reporting back on this policy to the House, will find a way to coordinate lobbying efforts with many component societies creating a major annual event in the future to drive home our concerns to those in power. We need to do more.

AACU Board Member Educates Congress on Workforce and Graduate Medical Education

By: Patrick H. McKenna, MD

A specific strategy is emerging and supported by several legislative offices. The strategy involves attempting MEDPAC to complete a workforce survey on specialties and attempt to influence the Institute of Medicine to do the same. Secondly, work to improve the language of the bill on graduate medical education that legislators hope to introduce next year. Moving forward it will be important to work together with other specialty groups and have urologists write personal letters to key legislative leaders in their districts.

Government Relations Report

Medical Liability Reform
Legislators in more than 19 states have introduced bills concerning medical liability reform. The vast majority of these measures are physician-friendly and seek to implement reforms that affect different aspects of medical liability law and litigation. Some involve more traditional forms of medical liability reform such as capping noneconomic damages or requiring plaintiffs to file a certificate of merit in support of their medical liability claims. Other approaches include requiring the prevailing party in these types of lawsuits to be compensated for reasonable attorney’s fees incurred as a result of the litigation, which have been proposed in Indiana, Montana, New Hampshire and New Mexico. Some bills, like those introduced in Connecticut, Montana, Oregon and Pennsylvania, are more ambitious in scope and seek to create new procedures for resolving medical liability cases, such as implementing a mandatory arbitration system or creating special courts for medical liability cases.

Integrated Care and Facility Regulation
Several bills have been introduced in a number of states that would affect physician business issues, most of which concern patient referral laws, certificate of need laws and facility licensing laws. With respect to patient referral laws, some bills seek to relax the restrictions pertaining to referrals while others seek to impose additional ones. For example, New Jersey Assembly Bill 22 would require physicians to disclose to their patients their business relationship with out-of-state health care services providers if they refer their patients to such providers. On the other hand, in Oregon, Senate Bill 389 would require the state authority to adopt patient referral rules that are no more restrictive than those imposed by federal statute or rule. A similar bill has been introduced in Washington, which would require the interpretation of Washington’s patient referral laws in a manner consistent with that of federal statute and rules.
Likewise, legislation has been introduced that would either relax existing certificate of need and licensing laws or seek to impose additional ones. In Minnesota, both House Bill 164 and Senate Bill 118 would limit the construction of a radiation therapy facility to those owned, operated, or controlled by a licensed hospital, and place a moratorium on the construction of such facilities in certain counties. Iowa House Bill 48 would require the licensing of ambulatory surgery centers, while Nebraska Legislative Bill 347 would impose a three-year moratorium on the licensing of any new health care facilities if the state expands Medicaid pursuant to the Patient Protection and Affordable Care Act, under the theory that the expansion of Medicaid services would create an “unsustainable” growth in these facilities. At the other end of the spectrum is a Maine bill that would eliminate the state’s certificate of need laws. Similarly, bills have been introduced in other states that would eliminate the certificate of need requirement entirely except for certain facilities like hospitals or long term care facilities.

Medical Practice Act and Continuing Medical Education
Physicians are being targeted in Illinois to make up for years of medical disciplinary fund raids. The legislature already considered a bill to increase licensure fees by more than 100% amid threats that medical students and residents will not be certified unless or until physicians succumb.

In preparation of states’ Patient Protection and Affordable Care Act implementation, physician-friendly legislators in several states have introduced legislation prohibiting requiring physicians to participate in any public or private third-party reimbursement program as a condition of licensure. Such legislation ensures that providers are fully aware of the terms a carrier contact requires as well as transparency. For example, Washington State Senator Randi Becker, a former urology practice manager, re-introduced a bill to prohibit tying medical licensure to participation in Medicaid, which has been amended to include additional provider-friendly provisions, including a prohibition on “all products clauses” and required notification for changes to provider contracts. Senator Becker was recently named Chair of the Senate Health Care Committee.

At least three states are considering new continuing medical education requirements to include training on prescription drug diversion and palliative care. Meanwhile, in South Carolina, the state medical association is distancing itself from a bill that mandates membership in that organization as a condition of licensure.

Scope of Practice
One of the most active issues across the country is scope of practice, which features more than 150 bills in 29 states. These range from licensure standards for naturopathy and midwifery to granting non-physician providers (NPPs) unprecedented unsupervised authority to treat patients. The common argument in favor of these bills is that the health system must prepare for the expected influx of tens of millions of new patients. Less expansive bills amend whether an NPP works in collaboration with, rather than with the approval of, physicians and limits their expanded authority to rural areas. Florida is considering nurse practitioner approval of treatment plans for physical therapy. Recently in Kansas, House and Senate committees approved bills to allow physical therapists to initiate treatment without a physician referral. In addition, at least a dozen bills have been introduced that would require private and public payors not distinguish between NPPs and physicians when it comes to reimbursement for the same service.

Screening, Prevention and Awareness Initiatives
The approval of ceremonial resolutions increase public education and awareness and often set the stage for more substantive attention to particular diseases states. A variety of such measures are being considered throughout the country, including: Bladder Cancer Awareness Month (Florida SR 414); Prostate Cancer; Light the State Capitol Blue (Hawaii HCR 33/HR 18); and Call on Congress to Withdraw USPSTF Recommendation Against PSA-based Screening for Prostate Cancer (South Carolina S 116). Of the more substantive variety so far, two bills stand out: a measure to require insurance policies to fully cover genetic testing for breast, ovarian, and prostate cancer (New York AB 3761) and a study on health care disparities including the increased incidence of prostate cancer in African Americans (Mississippi HB 212).

Private Payor Reform
Across the country in a total of 45 states, private payor reform measures have been introduced which seek to protect both physicians and patients by limiting unfair payment and contracting practices.

State legislators in 20 states have introduced approximately 100 bills addressing prior authorization. Most proposals would require health insurers to use and accept a uniform prior authorization form or provide for quicker authorization. More thorough measures provide that if a health insurance issuer fails to use or accept said form, or fails to respond within a certain period of time, the prior authorization request must be deemed to have been granted.

Growing in popularity are mandated notices of benefit reductions. Most proposals would prohibit an insurer from making certain modifications in prescription drug coverage unless (i) the modification occurs at the time of coverage renewal; (ii) the modification is effective on a uniform basis; and (iii) the insurer notifies affected insureds of the modification within 60 days before the effective date of the modification.

Legislation addressing assignment of benefits is being considered by 13 states. Texas House Bill 522 would require health insurance policy claim forms to provide an option for the claimant to assign benefits to a physician or health care provider who provided covered services. A health insurance policy may provide for payment of benefits directly to a physician or health care provider who provides covered services to a covered person, even in the absence of an assignment of benefits. In addition, an insurer that issues a preferred provider benefit plan must pay a preferred provider directly for covered services provided to a person insured under the plan without requiring an assignment of benefits.

Cost-sharing for diagnostic services is another issue. For example, Virginia HB 2024 would prohibit a health carrier from imposing cost-sharing requirements with respect to any diagnostic service, test, or related procedure that is administered or conducted as a result of, or in conjunction with, preventive care or screening if the health carrier is prohibited from imposing any cost-sharing requirements with respect to the preventive care or screening.

Step Therapy
The percentage of health insurance plans utilizing step therapy of fail first protocols has increased. In response, legislators in 10 states have filed proposals to limit this practice through the following measures: limiting the duration of step therapy protocols; prohibiting insurers from requiring the insured to try and fail on more than one
Affordable Care Act Update

Final Physician Payment Sunshine Act Rule Released
The much-anticipated regulations to implement the Physician Payments Sunshine Act were released February 1, 2013, after more than a year of delays. Required under the Affordable Care Act, the final rule requires manufacturers of Medicare/Medicaid-covered pharmaceutical and biological drugs, medical devices and medical supplies to disclose all consulting fees, travel reimbursements, research grants and other gifts with values over $10 that they give to physicians and teaching hospitals. Manufacturers and group purchasing organizations will also be responsible for reporting physician ownership and investment interests.

The required data will be collected as of August 1, 2013, and released publicly by the Centers for Medicare and Medicaid Services (CMS) as early as August, 2014. Physicians may dispute payments attributed to them, but the resolution process does not allow for the incorrect information to be removed from the publicly-available report in all instances.

The 35 pages of regulations, preceded by 251 pages of explanations, also clarify that payments to a continuing medical education (“CME”) provider that relate to an accredited CME program are not to be reported under a physician speaker’s name if, among other requirements, the speaker is not selected or paid directly by the manufacturer. Wall models, anatomical models and flash drives with patient education materials are similarly excluded, but medical textbooks and journal reprints must be reported as a payment/gift.

It is estimated that complying with the new reporting requirements will cost drug and device companies $269 million the first year and $180 million each year after that. Failure to comply with the law can result in fines of between $1,000 – $10,000 up a maximum of $150,000 for the year and up to $1 million for deliberate failure to report.

Health Insurance Exchanges & Essential Health Benefits
Pursuant to the Patient Protection and Affordable Care Act, states must have a health insurance exchange by January, 2014, either by establishing a state-run exchange, partnering with the federal government or merging with other state exchanges. To date, 18 states and the District of Columbia have agreed to establish state-run exchanges, which have been approved by the Obama administration, including the following: California, Colorado, Connecticut, Hawaii, Idaho, Kentucky, Massachusetts, Maryland, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont and Washington.

Seven states announced their intention to launch a partnership exchange with the federal government. The overall goal of such a partnership exchange is to benefit from efficiencies when states have existing regulatory authority and to provide a framework for tailoring aspects of the partnership exchange to state markets and residents while maintaining a seamless experience for consumers. The partnership exchange affords states with a high level of participation in plan management and consumer assistance/outreach either on a permanent basis or as a stepping stone to a state-based exchange in the future.

In addition, all non-grandfathered public, private, and exchange insurance plans will be required to cover certain essential health benefits (EHBs) beginning January 1, 2014. Twenty-five states and Washington, D.C. have chosen their own EHB benchmark plan, while the other 25 states defaulted to a benchmark plan based on the largest small group plan in the state. EHBs must include ambulatory patient services, hospitalization, chronic disease management, prescription drugs, rehabilitative services, laboratory services, and preventive and wellness care. Approximately 68 million individuals are anticipated to access care covered by EHBs once the ACA is fully implemented.

Medicaid
Medicaid expansion and eligibility requirements are being introduced with increased regularity, with legislation in over 20 states. These proposals range from authorizing the expansion of the program pursuant to the option afforded states by the Supreme Court to resolutions stating that the jurisdiction will not expand the program. This class of bills also seeks to impose eligibility requirements, such as income limits and drug/alcohol testing. States considering this must walk a careful line, however, since the ACA mandates that states cannot impose new restrictions on eligibility before the act is fully implemented.

Six current and former members of the US Senate Finance Committee recently announced they will propose specific legislation and regulations to improve Medicare and Medicaid recovery efforts. Their work will be based on a report that recommended eliminating duplicative anti-fraud efforts; ensuring that audit contractors are efficient, effective and penalized if/when their findings are overturned; and including clinicians’ input as part of contractor oversight.

The information provided in this update is for information purposes only, and is not intended to be and should not be construed as legal advice or a legal opinion.
Thank You to Our 2012 AACU Promotional Partners

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AACU Corporate Membership and Promotional Opportunities

Promotional Partnerships are a vital part of our success. The AACU is currently seeking corporate members who share our commitment to growth and excellence in the field of urology. Through this program, we hope to work in tandem with our industry colleagues to identify ways to enhance our current member programs and implement new projects that will lead to improved patient care through better physician education and mentoring. Please invite your industry contacts to become AACU corporate members. Please ask them to contact Donna Kelly at donna@wjweiser.com for more information.

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If you have an article or item of interest that you would like to be considered for publication in the AACU Sentinel, please submit to:

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