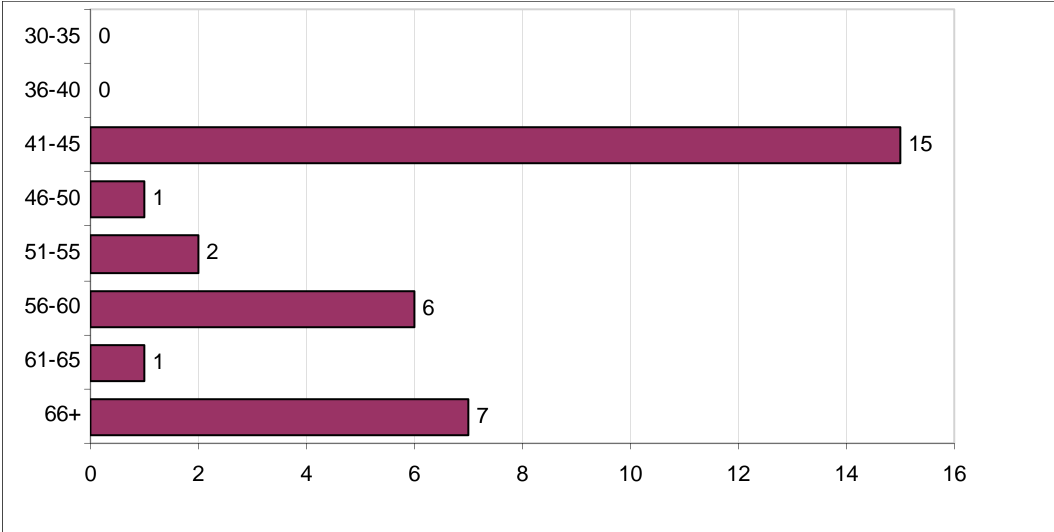
MA AUA

Mid-Atlantic Section of the
American Urological Association

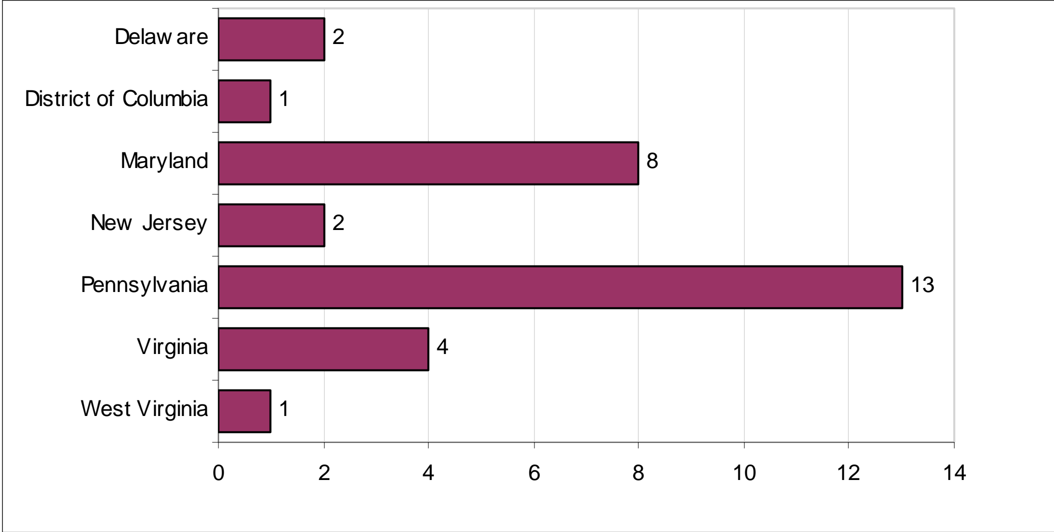
Health Policy Needs Assessment Survey

32 individuals filled out the survey.

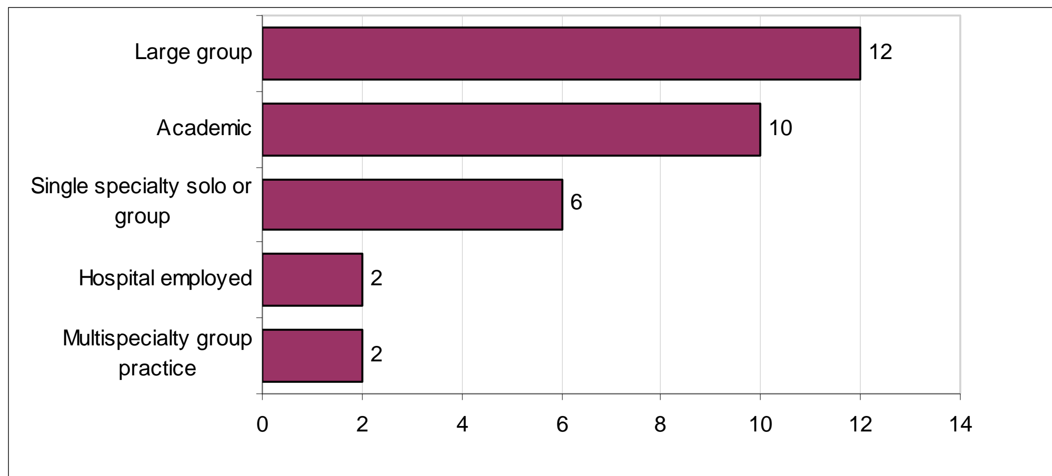
1. **Age**



2. **State**



3. **Describe your practice setting**



Single Specialty Group Size:

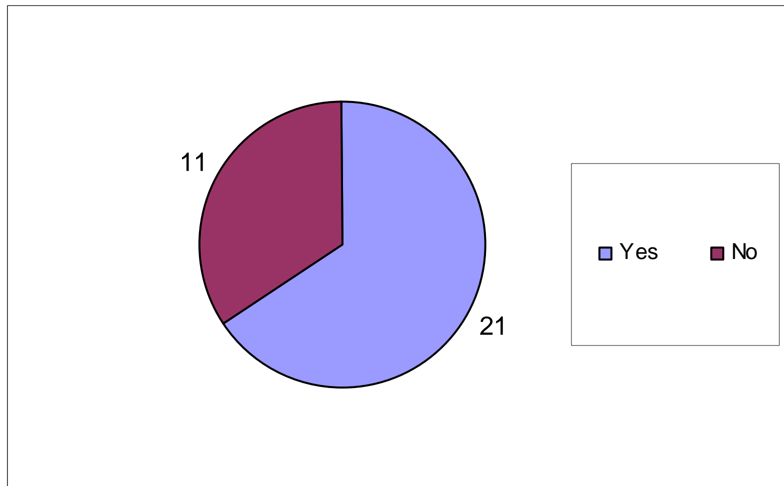
- 1
- 7
- 14
- 17
- 30
- 31

Other:

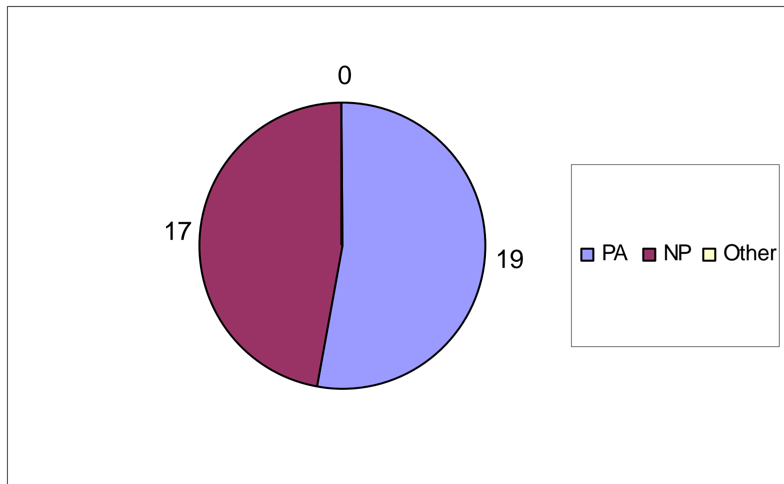
- DOD
- Health system employed and academic
- Retired

4. ***If you're in an Academic practice:***
GME funding, urology workforce and academic workforce issues are getting significant AUA policy attention. Are there other academic policy issues that we need to bring to the AUA?
   - Importance of support for NIH/research. Less basic science research means more demands on clinical revenue to help fund the research effort.
   - Not as long as increasing the number of training slots is being addressed within that framework
   - Residency hours
   - Resident GME funding should go to Dept not institution
   - RRC work hour regulations, academic conflict of interest policies, academic IRB issues limiting clinical trial enrollment at academic settings.

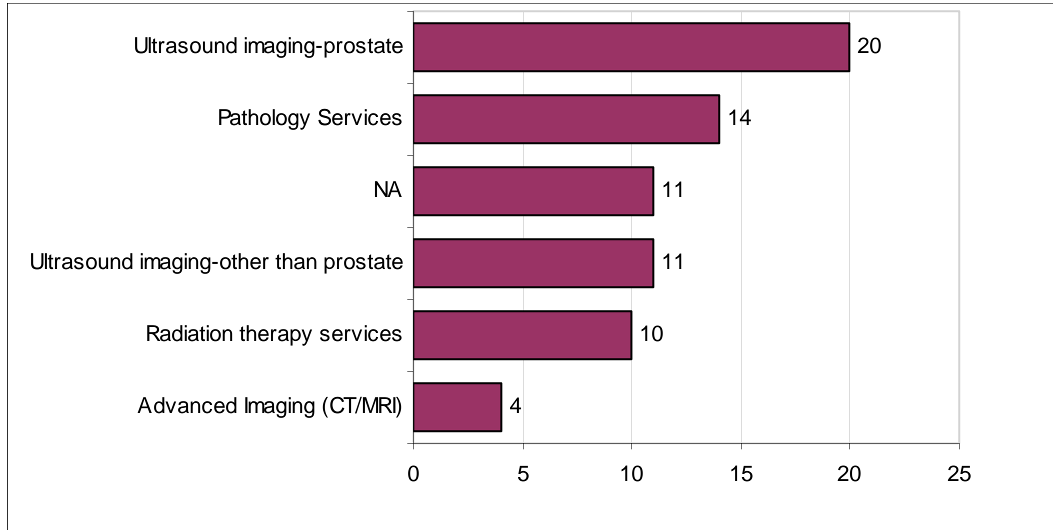
5. **Does your practice employ non-physician providers (NP/PA)?**



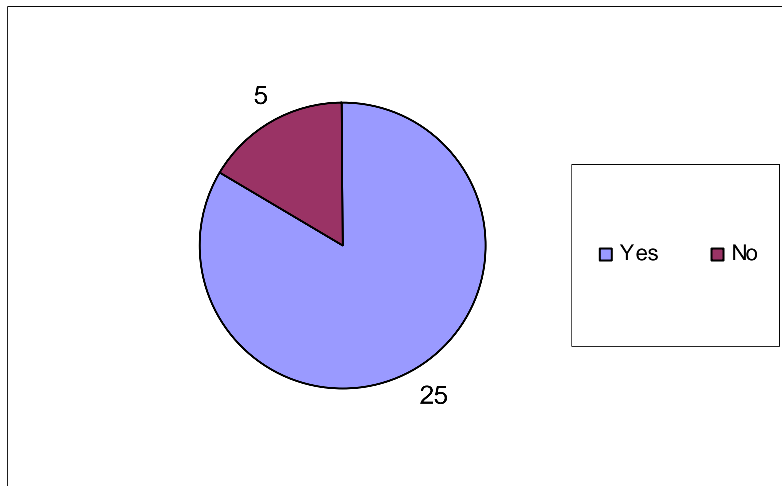
Non-Physician Providers Distribution:



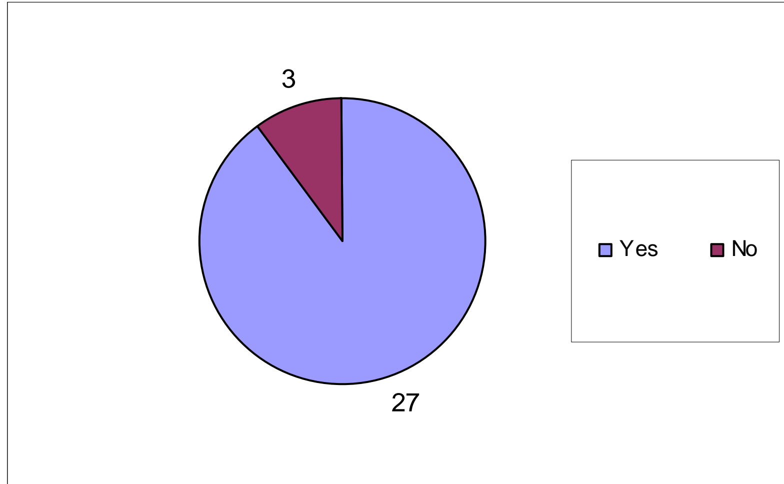
6. **Does your practice's business model include revenue from pathology services, ultrasound imaging, advanced imaging (CT/MRI), and/or radiation therapy services?**



Is the protection of the ability to provide in-office ancillary services important to you?



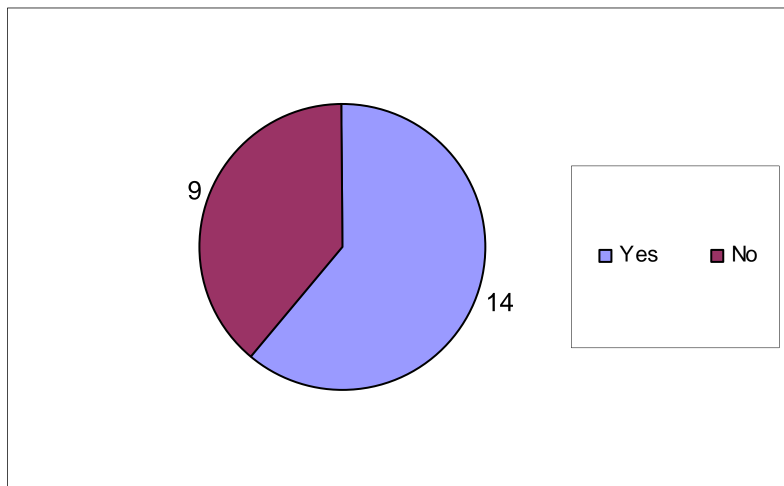
Is the Protection of the ability to provide in-office ancillary services a worthy public policy issue for urology regardless of one's business model?



Comments:

- Come see our practice in action Timely efficient service with centralized and reasonable ancillaries
- Cost containment!! why doesn't the public understand this? gets everything done in 1 visit instead of 3 . . .
- Depends on what services.
- It is hard to justify the tremendous scrutiny that providing non-specialty specific services such as pathology, radiology and radiation brings upon the specialty as a whole.
- Need to recognize that some people are abusing this
- Not sure
- Provided the services are not being performed without a solid medical indication - for instance, i am aware of urologists who have patients undergoing annual renal sonograms to follow simple cysts
- Thanks Mark

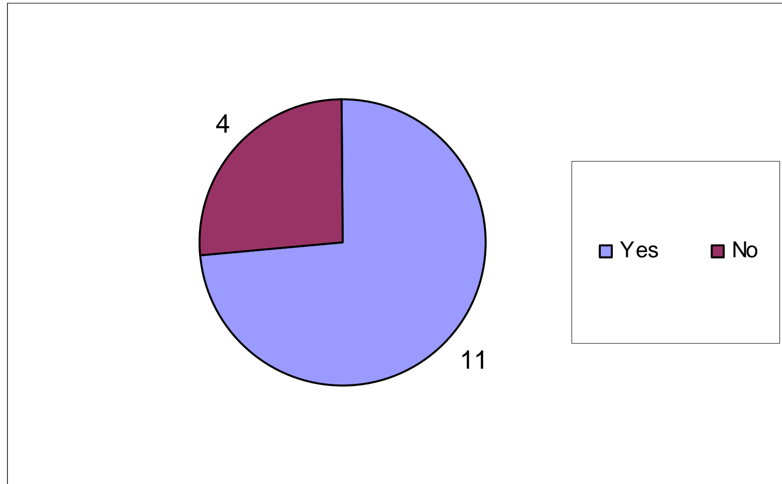
7. **If you practice in MD, PA, or NJ, does your practice participate with the state coalition?**



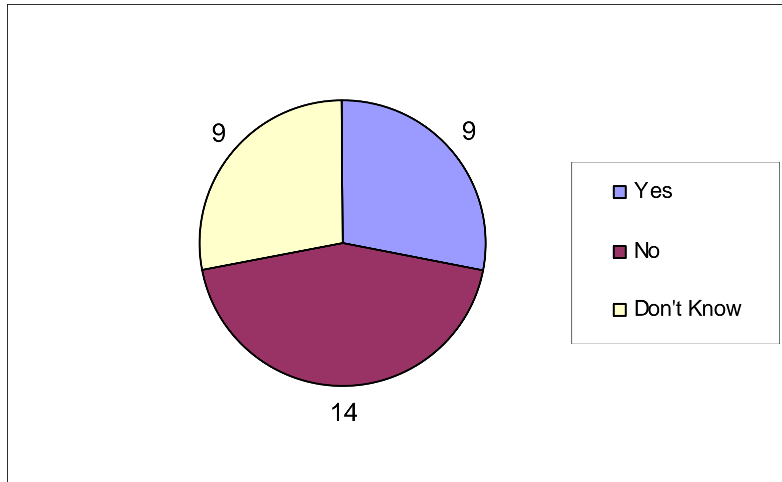
If 'no', why not?

- ?
- Interests not aligned with non academic practices
- Lack of interest by the vast majority of staff
- Nature of my practice - large integrated health system
- The state coalition is loosely organized and there has been little activity to initiate significant action
- Unknown

If you are in a state with no formal state advocacy infrastructure, are you interested in establishing one?



8. Do you feel that urologists in your state have sufficient organization and access to state-level lawmakers to respond quickly to state-level legislative threats to your practice?



9. **What are your top 3 health policy concerns?**
    - 1) Kill the IPAB 2) Maintain reimbursement levels 3) Maintain the physician-patient relationship with no insuror or government interference
    - 1. protection of in office ancillary 2. Prostate biopsy coverage - Palmetto things 3. ED med coverage and Penile implant coverage on par with womens health issues
    - 1. providing coverage for everyone 2. adequately funding coverage (either by appropriate rationing of care or increasing funding by taxation, not by squeezing providers until they can't afford to take care of pts) 3.
    - Ability to provide ancillary services that improve patient care, and access to care
    - Ancillary and in office exception preservation
    - Continued cuts in payments to urologists. Urologists shortage due to increased patients with insurance under Obamacare. Urologists being forced to leave insurance plans due decreasing reimbursements.
    - Ensuring that Ultrasound requirements/certification for the non radiologist is not necessary to continue to receive reimbursement from third party payors. To ensure that ownership by physicians in ancillary services is not restricted by the govt. (ie. lithotripsy or ASC centers). Medical Liability reform ie.-How can we be allowed to effectively ration health care and eliminate futile testing that we think, as physicians, is inappropriate without the fear of reprisal from the legal system or our patients.
    - GME funding, Obamacare, IPAB
    - IMPLEMENTATION OF ACA IMPACT OF ACA ON OUR PRACTICE DECREASE IN REVENUE WITH HIGHER OVERHEAD
    - Loss of autonomy, overall loss of respect from patients, no progress in tort reform
    - Malpractice In office ancillary exception (RT) Pathology
    - Medicare cuts in office ancillary attacks The govenment's attempt to "de-disease" prostate cancer
    - Medicare funding, liability, overregulation
    - Medicare SGR, Obama care, reimbursement
    - Over regulation Useless regulations Useless documentation
    - Payment insurance company market doninance loo of ancillary services
    - Payments and reimbursement scales by 3rd party; GME funding
    - Predatory insurance company practices
    - Protecting private practice
    - PSA screening, continued access to in-office US, draconian govt regulations
    - Reimbursement GME support
    - Reimbursement malpractice medicaid funcding
    - SGR, IPAB, access
    - Uninsured/underinsured persons, differential reimbursement for similar services (ie, high reimbursement for prostate RT over surgery, when both equally effective; incentive drives higher use of RT). Rising cost of insurance when available.
    - Urology man power reimbursments for consults the present health plan and how it is going to get paid for

10. **How can the Mid-Atlantic Section Health Policy Committee best serve your needs?**
    - Advocacy with above in coordination with LUGPA, UROPAC, AUA
    - Coninue to monitor the policy changes , keep the membership informed , and respond when we can
    - Continue to promote excellence in local urologic care
    - Coordinate activities with the AUA for unified front to protect urologists.
    - Financial Support
    - FORM A STRONGER LOBBY THROUGHOUT THE MID-ATLANTIC STATES TO PROMOTE A STRONGER VOICE FOR THE PHYSICIAN AS OPPOSED TO THE HOSPITAL LOBBY

- Having data that supports the medical appropriateness of the care provided by urologists. If the data doesn't support the care, we should say so.
- Keep of aware of important issues
- NOt sure, but advocacy is always helpful.
- Organize urologists to make more and better contact with their legislators
- This is a good start

11. Do you have any topics to suggest for future MAAUA Health Policy Forums at Sectional meetings?

- No (3 responses)
- Effective lobbying on state and national levels
- It is always a good idea to have Howard Rubin Esq give an uptate. He works with LUGPA and several state organizations... UPAC MUPAC. The large groups organized PA... UPAC, a few years ago. Scott Owens of UCPa (Harrisburg) is now in charge
- Not at this time.
- See you at the Virginia Urological Society Mtg.