CUA REPORT

A POWERFUL VOICE FOR CALIFORNIA UROLOGISTS

If It's California and It's Urology ~ It's CUA

President's Report

by Vito Imbasciani, Ph.D., M.D., FACS

The Board of Directors of the CUA met for its interim meeting during the AUA annual meeting in San Antonio in May. Also attending were Martin Dresner, M.D. and Dean Hadley, M.D., the Western Section's Past President and District Representative, respectively. We had occasion to look both backwards and forwards over the political and economic landscape of our urological world.

The CUA home office had several occasions during the year to send out legislative alerts to our members. These included a heads-up on AB516, the attempt by the American College of Radiology to restrict imaging use to radiologists only, by exempting themselves from self-referral rules. This could potentially make it difficult for urologists to own imaging equipment. In related proposed legislation, AB1572 would amend the Labor Code's worker's compensation section to prohibit any person other than diagnostic radiologists from billing for diagnostic imaging procedures. The CUA is weighing in against both of these initiatives.

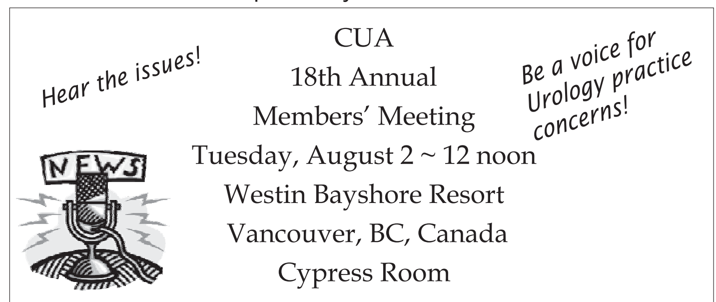
The Medicare Prescription Drug and Modernization Act will next year change the payment means for many drugs, including cancer agents and other drugs currently covered under Medicare.

Many new proposals, such as AB1195 which would mandate 16 hours of cultural and linguistic learning for physicians, try to further expand the recent legislative penchant for mandating unfunded CME requirements for California's physicians and surgeons. I argue against these well-intentioned but misguided intrusions into our profession's ability to define our own educational needs in many venues, including the Council on Scientific Affairs and the House of Delegates of the CMA.

Looking ahead, the CUA has taken the lead again, under Dr. Jeffrey Kaufman's able aegis, in organizing what promises to be a spectacular Socioeconomics Forum at the August meeting of the Western Section AUA in Vancouver. He has lined up eminent authorities and speakers to discuss tort reform, countersuits to abate nuisance actions, and asset protection. The Forum will offer three practice management courses: on coding, risk management and electronic medical record-keeping.

Our finances are good, and membership is rising, with active membership at 77% of the total. Balloting before the Western Section meeting should succeed in putting in place a new President: President-Elect Douglas Chinn of Pasadena, who has been representing the CUA at the Council on Legislation for many years now. I will continue to represent the CUA in the House of Delegates and the Scientific Affairs Council.

It's been a professional inspiration and personal delight to have met and worked with so many of California's urologists over the last two years, and I thank you humbly for the opportunity you have afforded me to represent you.



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CUA Mission Statement:

CUA is a political and socio-economic urologic organization whose purpose is to actively represent, organize and integrate urologists into the current healthcare system by means of communication and representation to similar organizations and to maintain the highest quality of urologic care.

A Publication of the California Urological Association, Inc.

By Jeffrey Kaufman, M.D., FACS, Past President, NHIC Carrier Advisory Committee, Representative to AACU & UROPAC

Over the past couple of years, our two great urology organizations, the AUA and the AACU, have become more closely affiliated in an effort to better coordinate their efforts. Both now jointly sponsor our political action committee, UROPAC (to which every single one of you should be making an annual contribution), in an effort to raise more funds to better lobby Congress to better protect our interests and those of our patients. At the same time, each has considered its areas of strength to focus on what each does best. While the AACU has maintained an interest in national affairs and continues to act as an effective lobbyist in Washington, it has also realized that too often, the important legislative questions are being considered at the state level. As many of you know, all politics is local. Recognizing this, the American Association of Clinical Urology has created the State Society Network. Already this year, the SSN has worked with California urologists on issues that may be of national concern, but are being considered at the local level. With its resources and national scope, the SSN has been able to identify common challenges that affect all of us but are no longer being legislated in Washington. As such, it is able to coordinate, educate and activate members in various local districts to write, phone and visit their local legislators. The best example of this to date has concerned our ability to perform imaging studies on patients in our own offices.

The American College of Radiology has identified stopping independent physician self referral for imaging studies as its number one priority and has published this on their website. They seem to have never gotten the message that "when circling the wagons, it's best to shoot outward!" Fortunately, as those of you who attended the Spring Washington, D.C. political action meetings of the AACU and the AUA know, we were able to effectively lobby Congress in advance of the radiologists. It appears we were successful in preventing them from altering the Stark rules that exempt this activity from the general prohibition against self-referral. Shortly after, we learned that the radiologists had changed their strategy and decided to fight this battle state by state.

In more than 20 different locations, bills suddenly appeared in legislatures that would have stopped independent physicians from performing their own ultrasounds, CT, MRI or PET scans. In California, we were able to defeat 2 such proposals in Sacramento and amend one at the state Medicare carrier level to allow us to continue to perform our own studies. So far, all other states have been similarly successful, even though some larger insurance payers are considering placing restrictions that would limit any such studies to offices run by a board certified radiologist. I personally couldn't imagine practicing in today's environment without the ability to perform my own ultrasound studies of kidney, bladder and prostate. Moreover, I have yet to meet the radiologist with skills equal to ours at interpreting a prostate ultrasound and doing a satisfactory biopsy. To have denied us that opportunity would have seriously impacted our practices.

The AACU has been very active in coordinating with local urology members and other local medical societies to lobby effectively on this and other topics. Many of you have seen email and fax messages from the AACU State Society Network alerting you about legislative threats. The success of these efforts depends on your involvement. When the AACU or the CUA notifies you, please respond with a letter, email or fax to your representatives educating them on the issues and giving your opinion. They vote based on what they know and what their constituents tell them. We need to remain vigilant and alert to any threat to our ability to provide quality care for our patients and respond quickly and vigorously. The AACU SSN has established a contact person in almost every state to provide a grassroots network thus allowing quick dissemination of important information in a timely fashion to local urologists and, in turn, allowing each of us to notify the AACU of local concerns. What is happening to us is probably happening elsewhere. Alert to the issues, the AACU SSN can mount a coordinated response. At any time, please contact me directly or through the CUA with questions in this regard or go directly to the AACU SSN at their website listed in this bulletin.

On the Medicare front, notes from the CAC (Carrier Advisory Committee) on CAP, RAC and LCA: By the time you read this bulletin, the Final Draft Rule concerning the Competitive Acquisition Program (CAP) for office administered drugs to begin 2006 will have been released by CMS. As you know, this new system will allow the doctor to either continue to purchase drugs and bill Medicare at 106% of average sales price or obtain them through a vendor contracted with CMS. We have been actively providing comments and suggestions to CMS for the past 9 months on this topic as they grappled with how to implement this law passed by Congress to provide medications to doctors under part B Medicare payments (part B Medicare will reimburse physicians for medications they purchase and provide to patients when those drugs are generally provided to patients by doctors more than 50% of the time and patients cannot provide the medication themselves, such as LHRH agonists, intravesical therapy, IM or IV injections, etc.). Sadly, they have not listened to most of our concerns. By now, most of you will have realized how difficult it has become to purchase and provide certain drugs to Medicare patients without losing money.

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CMA Council on Legislation

By Joseph Kuntze, MD - COL, Alternate

In my role as alternate representative of the California Urologic Association to the Council on Legislation, I attended the March 24, 2005 meeting. This was an informative and educational experience and increased my understanding and respect for the work Dr. Douglas Chinn has done over a number of years.

The meeting was called to order at approximately 10:00 AM on March 24 in Sacramento at the CMA offices.

There was an item scheduled for discussion, that would have been **AB 512** (*Yee Healthcare Practitioners Unlawful Referrals*). This item was highly contentious, involved the proposed legislation to make it illegal for practitioners other than radiologists to refer patients to an imaging center for MRI, CT and PET scans that if they owned an interest in the receiving facility. This was withdrawn from discussion because the CMA voted to oppose it. I highly recommend that you contact your legislators and oppose this trend in the assembly. Substituted in its place were two bills. **Assembly Bill 1050** would allow demonstration project in Los Angeles to determine the impact on receiving centers on stand alone emergency rooms. Assembly Bill 1050 introduced by Assembly member Gordon and **Assembly Bill 717** introduced by Gordon/Horton would allow the establishment of stand alone emergency centers not on the campus of a hospital. The American Hospital Association has an interest in that the Centinela Airport Clinic currently in operation would upgrade this to a free standing emergency center and University of California San Diego is seeking to move its inpatient services from Hillcrest campus to their La Jolla campus and leaving basically a stand alone emergency center. The background of this bill following the failure of Proposition 67, looks at new approaches to be considered to stabilize the economic uncertainties at California emergency medical services failure. The California Hospital Association has sponsored **AB 1050** which would require the State Department of Health Services to approve up to four general acute care hospital applicants in LA County to operate demonstration projects involving freestanding emergency receiving centers. These centers would have a number of restrictions on them including: 1) Being open 24 hours 7 days a week; 2) Laboratory services performing blood gas analysis and electrolytes;3) Radiologic services capable of providing necessary services; 4) Staffing by licensed physicians and surgeons with medical staff privileges at the sponsoring hospital and access to the hospitals on call panel; 5) Staffing by licensed nurses in compliance with current California code; 6) The capability of transferring patients in need of a higher level care to an appropriate hospital. **Assembly Bill 717** is similar. It has the added proviso of providing data to Department of Health Services and emergency medical services agency to enable monitoring.

In speaking in favor of this the California Hospital Association representative indicated that there are certain unique situations with Centinela Hospital and UCSD that would make this a benefit and would help shore up the highly stressed emergency safety net. It was emphasized these are demonstration projects only. Dr. Levy speaking for the American College of Emergency Physicians indicated that such an action would impose a significant financial burden on already burdened existing full service emergency rooms on hospital campuses. She felt that this was an effort to allow billing at higher emergency room rates for what would essentially be boutique emergency rooms in highly selected areas. The discussion revolved around a number of issues, the effect of this on the safety net and the burden that this would place on already overburdened emergency room back-up panels. After thorough discussion of all issues this bill was voted to be watched.

There are a number of other pending legislation. In general terms legislation that imposed specific requirements on health plans was opposed. Legislation that would did not have a direct impact on organized medicine was left neutral and legislation that increased access to care and expanded our abilities to provide care to our patients was supported. Specific items of concern are legislation banning the selling of physician panels. The CMA vigorously opposes this highly questionable activity and efforts by our lobbyists are continuing. Of specific interest are **AB 598** *Fairness in Contracting Act*. This CMA sponsored bill is intended to increase access to care by establishing new protections to insure fair and reasonable contracts between healthcare providers and managed care plans. **AB 757** *the silent PPO reform* would insure that PPOs are no longer silent and force transparency of profits and force PPOs to seek provider's affirmative permission before selling his or her name to another payer. If such an agreement is reached it would also insure that the provider has actual knowledge of who that payer is and would insure that the provider not be forced to participate in any product or business line materially different from that to which his initial agreement dictates. **SB 367** *Patient Physician PPO Protection Act* would extend the protections under health plans regulated by the Department of Managed Care to those plans regulated by the Department of Insurance. SB 367 provides the same level of oversight to Department of Insurance Plans, i.e. PPOs as Department of Managed Healthcare Plans have. This bill would provide all covered patient and their healthcare providers with a single portal that is visible, accessible and able to resolve complaints. **SB 634** *Protection from Unfair Payment Practices* does the same thing in terms of payment practices, that is extends the Department of Managed Healthcare rules and regulations to Department of Insurance regulated plans. Additionally, SB 364 Healthcare Service Plans would require health plans to assure

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Beginning January 2005, reimbursement for these part B medications has been paid at 6% over Average Sales Price even when no practicing physician could obtain the drug for the ASP and 6% was insufficient to cover our overhead costs. For many of the medications used for bladder cancer and advanced prostate cancer, this has meant either giving the patient a prescription to fill (for which he would not be reimbursed by Medicare), taking a loss when the doctor provides the medication or denying care altogether. Even though the law creating this program required it to be "inherently reasonable" and we have repeatedly shown CMS that setting prices below our costs is anything but reasonable, CMS has refused to increase payments. To solve the problem, Congress established the CAP to identify vendors who would provide medications to us with no cost on our part. The billing for the medication would go straight to Medicare and payment would be sent directly to the vendor. Of course, no risk to the doctor also means no potential profit either.

Like many programs, the devil is in the details and these are now available. While we asked that the program be phased in by region, by medical specialty and by drug category, CMS has decided to begin the program all at once, covering all drugs and making the nation one single region. Physicians will be given a single open enrollment opportunity once every Fall, after which they will be either all in or all out of the program until the following year. The overhead requirements to the physician's office will be burdensome and no reimbursement will be available for this increased administrative expense. Your office will be responsible for all up-front insurance screening for all patients and you will be required to assist the vendor in getting paid all co-insurances and co-pays. You will need to notify the vendor in advance of any needed medications in time to have them sent, you will be required to track identification codes that allow the vendor to get paid, and you will be responsible for any mis-step in providing the medication to the patient that might prevent payment to the vendor. For this effort, you will not be paid. The vendor has the freedom to substitute another less costly medication for the one you ordered at his discretion or provide a dose different from what you requested (a one month depot instead of a three or four month dose) if it is less costly to him. If your patient fails to make payment to the vendor for his co-pay or deductible, the vendor may elect to refuse to provide any other medication to him and you can't simply buy it expecting reimbursement at ASP+6% unless you leave the program entirely at that point (remember, once you decide your participation status, you are either all in or all out for the entire year, for all medications and for all patients). The few national vendors participating might expect huge discounts from the manufacturers based on the volume of their business. But, these discounts will be figured into future ASP calculations which will hurt most independent physicians, making it even harder to supply patients with medications profitably. In the end, we believe the rules proposed for this program make it unworkable for most physicians' offices and it is likely that few will choose to participate. If it does fail, we hope to work with CMS to develop a better program that will meet the needs of patients without shifting costs onto the shoulders of the providers.

Tied in with this issue is the ongoing question of the Least Costly Alternative policy. We are continuing to discuss with NHIC the propriety of this concept that prevents patients and physicians from choosing the drug treatment they prefer without suffering financial penalties. Although the final decision has not been made for California, there is great pressure on the state's Medicare intermediary from CMS to continue this policy. If you have opinions on this, please address them to Bruce Quinn, M.D., the medical director for NHIC. I will post a follow up with his final decision in the next bulletin.

Finally, be aware that CMS has begun a new program known as RAC (Recovery Audit Contractor) that employs an independent auditing firm to review part A medical claims from the past few years for over-charges. Reimbursement to this firm is a bounty on all collections: if they collect they get paid, otherwise they get nothing. As you can imagine, there is a great incentive for them to find fault. We have yet to hear of any outcomes since this program began only last month. If you are challenged by them and demands are made for reimbursement, we encourage you to carefully review your charges, coding and documentation and appeal if appropriate. Although CMS has promised that this program is limited to part A charges and will not focus on E&M codes, it does allow for examination of these codes and part B charges if they suspect a pattern of abuse. Further, if the program is successful at recovering large sums of money, we can expect it to be expanded in the near future. For this reason, please document fully all that you do, code carefully to avoid criticism but charge properly for everything you do.

Lastly, a revision to the sustained growth rate formula that governs Medicare fee updates is finally being realistically considered in Washington. With no change in the current formula, we will see a 4.3% decrease in 2006 and a steady drop totaling 26% through 2011. Combined with expected 15% inflation for medical costs over that interval, you will be paid 41% less for your services in 2012 compared to today. Senate bill 1081 seeks to change the 2006 update to a 2.7% increase followed by another 2.8% increase in 2007. However, this is to be followed by a return to the SGR formula which means reimbursements will fall off the cliff beginning in 2008 if a permanent change is not enacted (temporary increases without a permanent change in the formula must be paid back out of future payments-just like an advance on your allowance). House bill 2356 provides a similar 2.7% raise next year and then ce an

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CMA Council on Legislation - continued from page 3

that subcontracting medical groups comply with laws regulating the reimbursement of provider claims and would also allow in some cases a provider to build a health plan directly. Most of the proposed legislation had no direct impact on urology specifically but affected us as physicians in general. For example, **AB 21** would require pharmacists to dispense contraceptives irrespective of their personal beliefs. This won support from the CMA Council on Legislation. Legislation allowing the importation of drugs from Canada specifically **AB 73** is something that I think our patients would be interested in. A number of the bills have to do with establishing pharmaceutical purchasing pools for State programs. One provision that concerned urology, **AB 17** *and* **SB 770** would allow those people who are approved as Medicare providers to be enrolled in the Medi-Cal provisional providers potentially speeding up the number of providers available to see Medi-Cal patients. Our providers in Los Angeles County would be interested in **AB 166** which would allow the Los Angeles Board of Supervisors to establish a hospital board to run the county hospital. This was referred back to LA County Medical Society for review. The CMA Council on Legislation supported **AB 218** which would give an income tax credit to medical care professionals who provided services to Medi-Cal beneficiaries in under served areas of the state. Those urologists interested in transplantation will be interested in **AB 288** which would prohibit healthcare service plans and health insurers from denying coverage of the cost of organ and tissue transplantation if the patient tests HIV positive. It was recommended this bill be watched. **AB 366** would allow payment for services for hearing officer involving medical staff hearing activities. This is opposed by the CMA because it might project a perceived or real conflict of interest to the hearing officer. **AB 433** would provide the licensure and regulation of clinical labs and their personnel by the State Department of Health Services. This would also exempt physician office laboratories as defined from licensure and regulatory requirements. This is sponsored by the California Medical Association and physician office labs are currently subject to licensing requirements and this exempts us for the yet to be established State licensing requirements. **AB 598,** a sponsored legislation, would require that prior regulatory approval of standardized contract forms be obtained and a contract renewal be done on a yearly basis and that there be a clear delineation of contractual amendments. This bill is intended to increase access to care by establishing new protection to ensure fair and reasonable contracting between healthcare providers and managed care plans.

On the senate side, senate bills were largely similar to the assembly bills, nothing in particular seemed to stand out in terms of the senate side. Continuing efforts in the assembly exist to reform the funding of healthcare particularly uncomplicated care. As of yet none of these have come to fruition there is just a variety of plans out there and I think this area needs to be followed.

Of specific interest on the senate side **SB 279** sponsored by the California Hospital Association would prohibit a physician who contracts with an organization that links hospital emergency departments with physicians who wish to provide hospital services to patients from being considered an employee or agent of either the hospital organization. This is being opposed unless amended as it potentially undermines the corporate practice of medicine laws in the state of California. Another bill of specific interest to urology, **Senate bill 650**, the prostate cancer improving access counseling and treatments for Californians with prostate cancer program. As a pertinent program within the department of health services cancer control branch, this program administered through UCLA pays for prostate cancer treatments given to the indigent. It includes medications, office visits, surgical procedures along with radiation therapy and other modalities.

Senate Bill 689, the Council on Legislation recommended support of this bill. It would require DMV to collect organ donor designations on all new and renewed drivers' licenses. This would potentially increase the supply of donated organs including kidneys.

Of interest to all physicians **Senate Bill 932** would establish an unbiased process for conducting peer review proceedings. It would add procedural protections common in the civil court setting such as the requirement that no person sitting on the peer review panel have any financial connection to the hospital or physician.

The Council on Legislation voted to oppose **Senate Bill 840,** this would create a single payer system in the state of California. This bill was introduced last year and defeated. The CMA policy supports multiple approaches to achieving universal coverage.

In summary, the challenges facing organized medicine and urology continue to be formidable. The Council on Legislation, the CMA and our legislative team continue to work very hard on our behalf to protect access of patients to care, providing care for the uninsured, to fight against the intrusion into the practice of medicine by ancillary specialties and most importantly continue to wage a fight for just compensation for our services by insurance plans. I look forward to the next meeting. If you have any questions, please contact me.

Welcome

New Member

Sean Derboghossians, Glendale

2005 Interim CUA Board Meeting Minutes

May 22, 2005, Hyatt Regency -Rio Grande Center Room, San Antonio, TX

Officers Present:
Vito Imbasciani, M.D., President
Daniel A. Nachtsheim, MD, Immediate Past President
Committee Members
David Benjamin, MD, Young Urologist Rep. Alt.
Stanley Brosman, MD, Audit Committee
Joseph Schmidt, MD,
Guests:
Martin L. Dresner, M.D., WSAUA Past President
Dean Hadley, M.D., WSAUA District Rep.
Staff Present
Chris DeSantis, MBA
Jeannie DeSantis, MBA

1. Call to Order

President Vito Imbasciani, M.D. at 11:45 a.m., called the meeting to order.

2. Report of the President Vito Imbasciani, MD

Dr. Imbasciani thanked everyone for their attendance and noted that this was a busy time for the CUA. Many of the officers and committee members were busy attending different meetings as representatives from the CUA.

2.a National vs. California Issues

Dr. Imbasciani reviewed the many legislative alerts that were sent over the past year to the members via email. These included: 1) AB516 - the turf battle of the American College of Radiology to restrict imaging use to radiologist by exempting only radiologists from the self-referral rules and difficult for urologists to own radiology equipment. The bill is currently awaiting a new hearing. 2) MMA Medicare Prescription Drug and Modernization Act includes major changes in Medicare payments for cancer therapies and other drugs currently covered under Medicare. As of the first of the year, payments for theses drugs are based on a new "Average Sales Price" percent formula. 3) AB1572 an act to amend the Labor Code relating to worker's compensation. The bill would prohibit any person other than diagnostic radiologists from billing for diagnostic imaging procedures. Dr. Dresner mentioned that when he was recently in Washington it was stated that AB516 would create an access to care problem. Dr. Imbasciani noted that the AUA, AACU and CUA will began working together as to not duplicate efforts. He stated that at the national level, the AACU worked to diminished more proposed cuts and discussed tort reform. He also noted that the ABU may change the recertification cycle from ten years to five. Dr. Brosman stated that many urologistst are not accepting insurance. For the next survey, it may be beneficial to ask this question and stratify what kinds of insurance they are accepting. Dr. Dean Hadley noted that the CUA may want to look into AB1195 which mandates 16 hours of cultural and linguistic learning for physicians.

2.b. Nominations

Dr. Imbasciani read the slate of nominations to be voted upon at the upcoming CUA Business Meeting in August. The slate is as follows:

President-Elect:	Douglas Chinn, MD
Secretary:	David Benjamin, MD
Treasurer:	Joseph Kuntze, MD
COL Rep:	Joseph Kuntze, MD
CMA Alt:	Vito Imbasciani, MD

A COL alternate and CTAF Representative will be needed.

2.c. Socioeconomics Forum

Dr. Imbasciani reviewed the Socioeconomics Program that will be held in conjunction with the Western Section. He noted that a great program is slated with speakers that are knowledgeable on how to survive the liability crisis in your practice. Discussed will be tort reform, counter suits to limit nuisance actions and how to protect your assets. He stated that Philip Kurzner, Chief of Urology at Kaiser, is running for Insurance Commission. This will be the first time that a Board Certified Urologist has run for the position. It was also noted that there will be three practice management courses offered on coding, risk management and EMR.

2.d. Support of the Ortiz Bill and Pain Management

Dr. Imbasciani noted that a letter was sent from the CUA to support the Ortiz Bill, SB19. He also noted that the CUA will support the American Academy of Pain Medicine and CUA members will receive discounts to the seminars. It was moved, seconded and passed to approve the report.

3. Report of the Secretary, presented by Vito Imbasciani, MD, President

3.a. Approval of Minutes

The minutes of the 17th Annual Membership Meeting in San Diego were approved as written.

3.b. Bylaws Report

Dr. Imbasciani reviewed the proposed bylaw changes which will be voted upon at the CUA Membership meeting in Vancouver. The changes include a new category of membership, Corresponding Membership which allows those physicians residing outside of California to join the CUA.

3.c. Membership Report

Dr. Imbasciani noted that the CUA's senior membership is rising and active membership is at 77% of the total membership. It was noted that we had 32 new members in 2004, as the CUA made everyone a member at no charge for one year and then on the second year a dues notice was sent. The board requested that we do the same again for 2006. They also noted to send CUA Newsletters to Arizona and Nevada. Dr. Imbasciani noted to be sure to invite Larry Goldenberg, WSAUA President, to the CUA Membership Meeting. It was moved, seconded and passed to approve the report.

4. Report of the Treasurer Chris DeSantis for Phillip Beck, MD

Chris DeSantis reported that the year-end income was over $12,000. He noted that the CUA has over $92,000 in reserves up from $80,152 in 2004. He reported that the commercial support received is "no strings attached" and somewhat difficult to obtain. The CUA is to receive a $3,000 grant this year from Pfizer to use for education on MMA. A release about the grant should be put into the CUA Report newsletter. He would like to keep the organization liquid for now. He noted that the CUA receives on average about $34,000 per year in dues. Chris DeSantis noted that the administrative office is utilizing email alerts, updating the website, working closer with the AACU and looking at other opportunities of services for CUA members. He noted that a plaque will be presented to Anthony Middleton for his outstanding service to health policy issues at the Socioeconomics Forum. Chris DeSantis stated that he is currently working on the 2006 Health Policy Survey and welcomed any questions to be put on the survey. Dr. Dresner said that the survey should list salaries paid to military/VA urologists as this is public information. On a side note, Dr. Brosman noted that another movie by Michael Moore is set for the theaters called "Sicko", based on the relationship of pharmaceutical companies with medical organizations and physicians. It was moved, seconded and passed to approve the report.

5. Committee Reports

5.a. NHIC Carrier Advisory Committee by Jeffrey Kaufman, MD (not present) Dr. Kaufman's report touched on the radiology issue, Competitive Acquisition Program, AACU Washington Update, MICRA legislation, ABU changes, and AACU outreach. Dr. Kaufman's report also noted that he is now President-Elect for the AACU. It was moved, seconded and passed to approve the written report.

5.b. Council on Legislation by Joseph Kuntze, MD (not present)

Dr. Kuntze's report reflected the meeting he attended in March as alternate COL Representative. Dr. Kuntze's report talked about the many assembly bills that were presented at the CMA's COL meeting. It was moved, seconded and passed to approve the written report.

5.c. Report of the AUA Representative by Daniel A. Nachtsheim, MD

Dr. Nachtsheim presented his report, stating that the AACU is now the go between to the state societies. They have employed Rai Flynn to head this area. He noted that UROPAC was doing well, there is support for Duke Cunningham's men's health initiative and that there will be discussion on a two-tiered residency training programs. It was moved, seconded and passed to approve the report.

5.d. CMA Delegate Report by Thomas Hildreth, MD

Dr. Hildreth's report stated that he attended the CMA Delegation meeting in March. His report noted that the biggest issue was AB516, the radiology issue. His report notes that the CMA will work to obtain financial support for physicians for the adoption of electronic health records. Dr. Brosman commented that he

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CUA Young Urologists Report

By Lamia L. Gabal-Shehab, M.D., CUA Representative to the Young Physicians' Section of the CMA

The CMA met at the Anaheim Hilton on 3/18/2005 for the Annual Assembly. Unfortunately, the attendance at the Young Physicians' Section was not as good as it has been in previous years, but there was a still lot of lively debate and many great decisions made.

One of the major decisions was to delay by one year the phasing out of the Young Physicians' discount for membership into the CMA. It appears that this discount has not been proven to bring in more young physicians nor to entice them to maintain their memberships. There are a few county societies, namely San Diego, which use it extensively and feel that it definitely works in getting their membership numbers up. For this reason, further study will be undertaken for one more year before definitely sunsetting out this discount.

Dustin Corcoran, one of the lobbyists working for the CMA in Washington, also discussed our position on various upcoming bills. He spoke on votes coming up relating to various topics such as MICRA, physician/insurance contracting, employee health coverage and silent PPO's which he feels is the most important financial issue facing physicians today. He also voiced the CMA's opposition to AB1321 which would give health plans protection from paying physicians poorly.

Mr. Corcoran also reminded us all, as I would like to remind all of you, to take the time to write to your representatives. Letters received by our senators and congressmen are actually given a multiplier; you may think that you're only one voice but your voice would literally be speaking for 20-50 more constituents as they use these multipliers to estimate how many other people whom they represent may have the same opinions. So, the next time you receive an email from the CUA asking you to write to your rep about a very important topic, please take the time to do so! Your voice really counts and makes a difference.

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transitions to a new formula based on the Medical Economic Index, a much more realistic reflection of the cost of providing health care. This bill would permanently change the basis for future updates and create a much more fair system. With the current economic climate in Washington, and an estimated price tag of $110-150 billion for these changes, these bills face an uphill battle. Your support is needed. Please write your Congressman and Senators explaining the necessity of fixing the current reimbursement system. Tell them of your hardships and the threat of patients losing access to quality care. Give them personal examples if you can. The Congressional Budget Office and the Medicare Payment Advisory Committee are telling them that access is not threatened and that there is no need to revamp the system. We must make them understand that such cuts simply cannot be allowed.

Political involvement, communication with your elected officials, participation in our organized associations and financial support is necessary to maintain our ability to enjoy the practice of urology and provide for our patients while remaining economically healthy. Please join and financially support the CUA, AACU and AUA. Give generously to our political action committee UROPAC. The professional life you save may be your own.

Interim Board Meeting Minutes *Continued from page 6*

has looked into EMR systems and found an internet-based system, called VPN, for about $300/month which is HIPAA compliant. Dr. Dresner noted that the VA uses CPRS DHCP. Dr. Hadley noted that he recently heard a great speaker about EMR and he will get the name. Chris DeSantis also re-emphasized that an EMR workshop will be held in Vancouver at the WSAUA Annual Meeting. It was moved, seconded and passed to approve the written report.

5.e. Young Urologists Report by Lamia Gabal-Shehab, MD (not present)

Dr. Gabal noted that she attended the CMA's Young Urologist meeting in March. Her report noted that one of the major decisions was to delay by one year the phasing out of the Young Physician's discount for membership into the CMA. Many bills were discussed and the CMA urged its young physicians to write your representatives. It was moved, seconded and passed to approve the written report.

5.f. Specialty Delegation Report by Ronald Allison, MD (not present)

Dr. Allison reported that he attended the Specialty Delegation Meeting in January. His report included Dr. Hertzka's plans for the CMA. The report noted the demographics about those without insurance and in low income brackets and how the plan will attempt to resolve these problems. It was moved, seconded and passed to approve the written report.

5.g. Audit Committee Report

The Audit Committee Report for the calendar year of 2003 was completed by Joseph Kuntze who met with Chris DeSantis and reviewed CUA property, records, and financial documents. Dr. Kuntze stated that all of the fiscal affairs and financial administration of the CUA were satisfactorily performed. It was moved, seconded and passed to approve the report.

6. New Business

No new business to report.

7. Adjournment

There being no further business the meeting was adjourned at 1:30 pm on Sunday, May 22, 2005.

Visit CUA on the **WEB**

www.cuanet.org

Let your views be known, call your US Senator & Reps. directly at the US Capitol switchboard at **(202) 224-3121**. To find out who your Representative is, call Lisa Marie Brody at **(443) 524-1169.**

IMPORTANT MEETING DATES

- CUA & WSAUA Socioeconomics Forum
  Sun. July 31, 2005, 12:00 noon
  Vancouver, BC, Canada
  Westin Bayshore Resort & Marina
- CUA Annual Business Meeting & Luncheon, Vancouver, BC, Canada, Tues. Aug.2, 2005 - 12:00 pm, Westin Bayshore Resort & Marina
- Western Section 81st AUA Annual Meeting, Vancouver, BC, Canada
  July 31 - August 4, 2005
  Westin Bayshore Resort & Marin a

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

State Society Network page
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Email questions and issues to:
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The CUA listens:
The CUA REPORT is a publication for all California Urologists. Readers are welcome to write, email the CUA Board of Directors and visit the website.