Government Relations of the ACR 101

Every day decisions are made in Washington DC regarding health care policy, the profession of radiology, and more recently, physician reimbursement. These processes and health policy happen with or without our involvement. Without our voice being heard in the decision process for things like self referral, someone else's voice is being heard instead. That person may or may not be your ally. And in the realm of self-referral, our allies are few and far between!

Without our active involvement, future policy could not only affect the way you do your job as a radiologist but who does your job in the future. Your profession depends on the ACR's proactive stance!

So how does it work? What goes on in Washington DC?

The Creation of A Bill
In order for health care policy to be adopted, there are a number of things that need to happen. The official legislative process begins when a bill or resolution is numbered (H.R. signifies a House bill and S. a Senate bill), and then referred to a committee.

Once in the committee, it is considered by the committee or by a subcommittee within the committee to report back to the main committee. If a bill is referred to a subcommittee, a hearing may take place on the bill. Pertinent testimony from all sides may be recorded for the record, in addition to expert testimony and opinions from the executive branch. Following the hearing, the subcommittee can refer the bill with any amendments made, or vote for it to not pass out of the subcommittee. Again, if this is the recommendation, the bill goes no further.

"Ordering a Bill Reported" is the next process. After the committee hears a bill that has been reported on by a subcommittee and votes on the subcommittees amendments and the bill itself, the committee then votes on its recommendations to the House or Senate. These recommendations are then written into a final report that is presented to the House or Senate, which also includes dissenting committee members opinions, the effects on current law and practice, as well as the scope and intent of the legislation.

After the report is submitted, the bill is placed on a docket. The order in which the legislation reaches the floor is determined by the Speaker and Majority Leader. Once on the floor, the bill is debated and amended. The final form is then voted on, and, if it passes, it then goes to the other "side" (House or Senate) for the same process, beginning at the committee level. If significant changes are made, the House and the Senate must agree on the changes or the bill dies.

Exhausting isn't it?

Finally, once approved by both the House and Senate, it is sent to the President. If the President approves of the legislation, he signs it and it becomes law. Or, the President can take no action for ten days, while Congress is in session, and it automatically becomes law. If the President opposes the bill he can veto it; or, if he takes no action after the Congress has adjourned its second session, it is a "pocket veto" and the legislation dies.

So what does the ACR do?
In addition to the process of bill creation, those who create and debate the policies that will ultimately become law play a significant role in what happens on the Hill. Without their support, policy simply does not happen. Thus, in order to affect health policy, you must have a connection and a voice with these policy makers. The Government Relations department of the ACR does this for all of us. The GR staff attend numerous fundraisers throughout the year to talk with the congressmen and congresswomen who ultimately will have the final say in the outcome of policy that pertains to the profession of radiology. They also attend meetings such as the AMA on your behalf to address legislative concerns or to foster a general awareness of the issues.
But this is only a portion of the government relations job. Developing constituent-based political effectiveness is also one of the primary goals of the Government Relations Department. An example of this was the recent Call to Action held on Tuesday, September 20th. Despite the technical difficulties, your involvement resulted in over 2,000 ACR members calling their U.S. House Representative. Every state participated, and 373 of the Representatives were called, representing 86% of the total House of Representatives. This sends a clear message that not only are we an organization that pays attention to the health policy that affects our profession, but we are also voting constituents. The ACR also provides annual funding for a visit by a member from the Government Relations department to travel to your state to facilitate involvement and awareness at the state level.

**How does RADPAC fit in?**
In DC, like anywhere, money talks. To address this, the ACR formed the RADPAC in 1999. The goal of RADPAC is to support and elect pro-radiology candidates at the federal level through the voluntary contributions of dues-paying ACR members. RADPAC works through the political process to keep the concerns of radiologists in the legislative forefront. With the support of radiologists nationwide, the recently released financials of RADPAC show that we are now the second largest health subspecialty group PAC! Currently to date, we have 1,365 members who have donated funds to RADPAC, raising $434,004.37. It is this kind of monetary support that allows the PAC to actively support those candidates who support us.

For more information, visit [www.radpac.org](http://www.radpac.org), or email hkaiser@acr.org for more information.

**What are the Issues?**

- **Self Referral**
  Self referral is the practice of non-radiologists referring patients for studies to imaging equipment in which they have a financial stake. This creates an economic incentive and conflict of interest that is not in the best interest of the patient. Furthermore, these studies are often interpreted by non-radiologists or "farmed out" to a radiologist, while the referring doctor is still collecting technical fees for every study he or she orders. The end result is a disproportionate growth in imaging utilization of 50% compared to a 30% growth in overall cost (based upon Medicare data.) Because of this, there is a push to cut costs. Proposals to do this range from getting preauthorization to do cross sectional imaging, to across-the-board cuts in funding, including physician reimbursement (more on that later). Other suggestions have been cuts in the technical components for consecutive body parts and establishing a unique conversion factor for imaging.

Although the self referring subspecialty groups would like to attribute this growth to new technology, the data clearly shows that there is disproportionately higher rates of utilization among self-referring physicians. Blue Cross data from 2003-2003 demonstrates an approximate 15% discrepancy in utilization comparing radiologists to non-radiologists for the cross sectional modalities. A US GAO report further confirms this data showing that self referring doctors are 2-5 times more likely to order a study than those who have no financial incentive.

Although Stark I and Stark II attempted to combat self referral, the in-office exemption loophole has made it possible to continue to self-refer. While closing the loophole would solve the problem, this is not felt to be feasible or sustainable at this point. Thus, in an effort to combat this growing problem, the ACR is actively supporting the recommendations of the MEDPAC (Medicare Payment Advisory Commission), which promote imaging quality and standards for both the physician interpreting the studies as well as the facilities that carry out imaging, similar to programs already in effect for Mammography. While this will not fully solve the problem, the hope is to eliminate the substandard imaging occurring on outdated equipment or with inadequate training. This
is projected to save $4-6 billion.

We have very few friends on this issue:

AMERICAN MEDICAL ASSOCIATION
HOUSE OF DELEGATES
Resolution: 235(A-04)

RESOLVED, That our American Medical Association reaffirm current policy relating to physician self-referral; and be it further

RESOLVED, That our AMA work collaboratively with state medical societies and specialty societies to actively oppose any and all federal and state legislative and regulatory efforts to repeal the in-office ancillary exception to physician self-referral laws, including as they apply to imaging services.

Resolution Sponsors:
- American College of Cardiology
- American College of Physicians
- American Urological Association
- American Association of Neurological Surgeons
- Congress of Neurological Surgeons
- American Gastroenterological Association
- American Academy of Orthopaedic Surgeons
- American College of Obstetricians and Gynecologists
- American Medical Group Association

For more information on Self Referral:


There is more to the story!

For a more in depth discussion on self referral, visit the Current Issues section on the RFS website.

- Physician Reimbursement and the Medicare Conversion Factor
  Physician reimbursement is determined by an extremely complex medicare physician conversion factor. Problems with the formula arise because it is tied to the GDP and to the sustainable growth rate (SGR). This means that when imaging exceeds expected expenditures, physician reimbursements are subsequently cut to compensate for the excess expenditure. In the past, the formula would have required a 4.2% cut in reimbursement for 2004. The Medicare Modernization Act created a temporary fix for 2004 and 2005, instituting a 1.5% increase in reimbursement. It was the ACR that lobbied for this fix at the 2003 Annual meeting! More recently, largely in part due to our Government Relations department, the Senate Finance Committee did recently pass a
The fallout from decreased physician reimbursement is a well recognized problem for the health community. Decreased reimbursement by medicare means less participation in Medicare by physicians. This limits access to health care for those who need it most and most often… the elderly.

- **Medical Liability Reform**
  Medical Liability Reform has been an ongoing issue for the past decade. Frivolous lawsuits drive malpractice costs through the roof, and as a result, rural community doctors cannot afford the insurance to sustain their practice. The result is limited health care. As an example for the rapid rise in malpractice, overall indemnification for breast cancer malpractice litigation averaged $438K in 2002, up 45% from 1995. The ACR Government Relations actively supports legislation that caps non-economic damages, in cases where gross negligence is not established. Some states already have well established caps, such as California's MICRA (1975) ($250K cap on non-economic damages). This has slowed the growth of insurance premiums, increasing 182% since 1976, compared with 569% nationally. State legislation is extremely variable on the issue. There is such a discrepancy between the neighboring states of Oklahoma and Texas, who recently passed Liability reform in the last three years, that a trial attorney in Oklahoma sent letters to attorneys in Texas telling them to send their clients north for the better business. Grassroots action at a state level will continue to pressure legislators to advocate reform.

For more information on Medical Liability Reform, go to [www.ama-assn.org](http://www.ama-assn.org).

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**Secretary**