

Self-referral Toolkit



for State-level Advocacy

AMERICAN SOCIETY FOR RADIATION ONCOLOGY

ASTRO

TARGETING CANCER CARE

Preface

ASTRO Role

Self-referral
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ASTRO's Role in State Advocacy

The American Society for Radiation Oncology now boasts a mature government relations department that has demonstrated an ability to promote radiation oncology in Washington, DC, and defend the specialty from threats to its future. ASTRO's government relations activities consist of legislative and regulatory advocacy on issues facing the specialty in Congress and the federal government, including direct lobbying, organizing and mobilizing grassroots support for legislation and issues, political giving through ASTRO's Political Action Committee, comment letters to federal agencies or proposed regulations, building strategic alliances with patient and provider groups, and numerous other efforts.

At the direction of ASTRO's leadership, ASTRO's government relations activities are focused on policy at the federal level. ASTRO maintains a qualified staff of registered federal lobbyists with experience and relationships geared toward advancing ASTRO's policy agenda in Washington, DC.

ASTRO's government relations staff does not include individuals with experience or relationships to advance policy issues at the state level. With limited resources available, ASTRO's leadership has continued to stress that government relations activities remain focused at the federal level, while supporting and coordinating with individual ASTRO members interested in moving policy at the state level.

It is in this context that ASTRO created its Grassroots State Captain network in 2008, with a dual purpose of leading efforts in each state to influence health care policy at the federal and state level. To support the work of the State Captains and others who wish to lead efforts to combat abusive self-referral at the state level, ASTRO's Government Relations Committee and staff have created this State Self-Referral Toolkit. It is our hope that this toolkit will provide ASTRO members significant guidance and support in their efforts to change self-referral laws in their states. In addition, we urge advocates to ensure that they keep ASTRO staff and leaders well informed of their efforts and progress, as well as coordinating with ASTRO staff to ensure that gains at the state level can support change at the federal level.

Step 1

Introduction to Self-Referral

Self-referral
Toolkit



for State-level Advocacy

AMERICAN SOCIETY FOR RADIATION ONCOLOGY

Self-Referral: The Basics

Background—Self-Referral in Radiation Oncology

Physician self-referral is the practice of a physician ordering a service on a patient that is performed either by themselves or by a facility from which they derive a financial benefit for the referral. Most states have some restrictions on the practice of physician self-referral. However, each state is varied when it comes to which physician services are regulated by self-referral laws and to what degree they are restricted.

For patients with localized prostate cancer, external beam radiation therapy, radioactive seeds (brachytherapy), prostate surgery and active surveillance are all considered “clinically equivalent” treatments, according to a 2008 Agency for Healthcare Research and Quality comparative effectiveness review. The report noted that because the treatments have varying side effects, patient preferences are an important factor in determining a management strategy. The National Comprehensive Cancer Network clinical guideline states that a patient with clinically localized prostate cancer should be informed about the commonly accepted interventions, and a discussion of the anticipated benefits and risks of each intervention should occur with the patient.

Determining the most appropriate prostate cancer treatment option is an involved process that depends on the patient’s preferences, age, concerns, co-morbidities and physiology. We believe that when referring urologists own radiation therapy facilities, they are so heavily incentivized to refer their patients for external beam radiation therapy services that their clinical decision-making becomes biased and likely leads to overutilization of radiation therapy. Specifically, these models channel referrals to a particular radiation therapy, called intensity modulated radiation therapy (IMRT). IMRT is particularly of interest because of the technical fees that are billed by the owner of the linear accelerator. In January 2009, the Institute for Clinical and Economic Review produced a report comparing the clinical benefit and costs of the various treatments for low-risk prostate cancer. The report concluded that the rates of survival and tumor recurrence are similar among the most common treatment approaches, although costs can vary considerably, with surgery and brachytherapy costing significantly less than IMRT.

Physicians, especially those who are in a position to refer patients for radiation therapy services, have realized that if the provision of these services and the related billing of the technical fees for the equipment can be “captured,” financial gain can be achieved based upon the referral decisions. This business dynamic has been identified, packaged and is being marketed to physician groups, particularly within the urology community, by for-profit companies that specialize in fueling the enthusiasm about lucrative joint ventures with financially aggressive physicians.

Consequences of Self-Referral

Self-referral business models run counter to crucial health care policy goals, including patient choice, quality of care and access to services. By setting up a business model that holds radiation oncology

services captive to the referring physician, and by driving patient referrals only in that direction, cancer patients are denied the independent clinical judgment and choice they need and deserve.

Under these arrangements, the quality of cancer care suffers. The physician practice will steer patients toward the services they wish to offer, rather than those that might be better for the patient. Perhaps of even greater concern is the fact that for some prostate cancer patients, it may simply be that “watchful waiting” is the most prudent course of treatment, while for others, surgery might be the best approach. However, with the financial return that a urology group can realize on IMRT treatments, there is considerable risk that “watchful waiting” or surgery will not be thoroughly presented to the patient as a viable treatment options. In addition, there is a population of patients who generally should not be treated at all, such as the elderly or those with serious co-morbidities.

On December 8, 2010, *The Wall Street Journal* investigated several urology group practices, including one of the largest, Integrated Medical Professionals (IMP), that have used the self-referral exception to bring external beam radiation therapy services into their offices. The article revealed two major findings:

- Urology groups that brought IMRT into their practices had utilization rates well above national norms for use of that treatment for prostate cancer. Moreover, the practice patterns for these groups showed dramatic utilization increases following equipment purchase.
- These practices treated a higher than average number of men over the age of 80 with radiation therapy for their low-risk prostate cancer. Experts agree that in most instances, 80+ year-old men with low-risk prostate cancer do not need aggressive treatment.

On February 15, 2011, *The Washington Post* also published a story exposing self-referral abuses in radiation oncology. The article quotes world-renowned Johns Hopkins urologist Patrick Walsh, MD, criticizing the “for-profit motive” affecting treatment decisions for some physicians involved in self-referral arrangements.

A *Baltimore Sun* article in January 2012 described how a Maryland urology clinic’s prostate cancer referrals for IMRT tripled after they purchased a radiation therapy machine. As the article states, “The more patients the Baltimore-area urologists referred for that expensive therapy alternative, the more revenue and profits they would generate.”

- The Maryland data is part of a national study by Georgetown University coming out in mid-2012. It is expected to show that urology practices across the country drastically increased expensive IMRT referrals after they acquired a radiation therapy machine.

A published survey of radiation oncology residency program directors across the country revealed that 27 percent of residency programs in communities with these business arrangements reported a negative impact on residency training as a result of decreased referrals to their centers. While this is a small survey sample, it foreshadows large quality problems in the future if residents do not see the appropriate case mix of patients necessary to develop the skills they need to treat prostate cancer patients.

In 2012, independent reports from the Government Accountability Office and the Congressional Budget Office are expected to be released showing the clinical and economic impact to the Medicare program of physician self-referral on the provision of radiation oncology services.

Those benefitting financially from their ability to control radiation therapy services and the resultant revenues within their business unit assert that they are delivering “integrated care” or providing access in underserved areas. The notion that these are the driving forces in the creation of these financially lucrative business models is contradicted by the marketing materials published by at least one national for-profit purveyor of this approach, URORAD, based in McAllen, Texas, which highlight the potential for huge revenues by incorporating IMRT into a urology practice.

Politics at Play

Politically, groups supporting laws that limit the restrictions on self-referral are outspoken, willing to defend their business arrangements to their elected officials, and understand the concept of strength in numbers. Urology groups have been strategic in their approach to political giving, donating hundreds of thousands of dollars to their federal lawmakers. This is likely occurring with the same force at the state level.

Restricting physician self-referral at both the state and federal level is an uphill battle that will take a significant investment of resources, require a strong will, and likely will take years to achieve success. In some states, it may even be an impossible task. There are many factors at play that affect this issue. Before attempting to advance state legislation to restrict self-referral in radiation oncology, it would be wise to undertake a careful environmental scan of the various stakeholders, political relationships and existing state regulations.

State and Federal Intersection of Self-Referral

I. Federal Stark Law

Overview of Stark Law

The federal self-referral law, otherwise known as the Stark Law, prohibits a physician from referring Medicare patients for certain “designated health services” to an entity with which the physician or the physician’s immediate family member has a financial relationship (ownership, investment or compensation), unless one of the Stark Law’s many enumerated exceptions applies. Not only does the Stark Law prohibit such referrals, it also prohibits the entity receiving such a referral from presenting or causing to be presented a claim to Medicare for the designated health service that was provided pursuant to the prohibited referral. Violations of the Stark Law can result in severe penalties, *e.g.*, denial or refund of Medicare payments for services provided pursuant to the prohibited referrals, civil monetary penalties, exclusion from federal health care programs and potential False Claims Act liability.

Applicability Outside of Medicare

The Stark Law statute, regulations, government sub-regulatory pronouncements and enforcement of the law all make clear that the Stark Law currently applies only to referrals of Medicare patients and claims for Medicare payments. While the language of the Stark Law mentions Medicaid, the Centers for Medicare and Medicaid Services has made clear in its rulemakings that the Stark Law is not applicable to Medicaid at this time.

II. State Laws Prohibiting Self-Referrals

Scope of State Self-Referral Laws

In part because the Stark Law only applies to Medicare referrals and payments, the vast majority of states have enacted laws similar to the Stark Law. Like the Stark Law, these laws are fundamentally designed to prohibit or limit the ability of a physician from referring certain patients to certain entities if the physician has a financial relationship with the entity. While a few states, like Michigan, merely incorporate the federal Stark Law and its implementing regulations by reference and apply it to *all* payers of health care services (such as Michigan’s health care programs), other states’ self-referral laws deviate in scope, substance and interpretation – not only from the federal Stark Law, but also from each other. For example, state laws may differ with respect to the type of entities to which referrals are prohibited (*e.g.*, hospitals only versus all health care providers), the type of conduct that is prohibited (*e.g.*, all ‘self-referrals’ versus only ‘self-referrals’ if the physician’s financial relationship with the entity has not been disclosed to the patient), the type of services covered (*e.g.*, a defined set of designated health services versus *any* service) or the type of claims that are prohibited (*e.g.*, claims to Medicaid, workers compensation, and/or any commercial payor or self-pay patient, etc.).

Example of the Differences Between State Self-Referral Laws

A comparison of Connecticut's and Ohio's self-referral laws demonstrates this variance. Connecticut's self-referral law applies to "each practitioner of the healing arts" (not just physicians), covers the referral of any diagnostic or therapeutic service, and does not prohibit all 'self-referrals' but instead requires disclosure of the practitioner's financial interest to the patient prior to the referral, along with a reasonable referral alternative. Ohio's self-referral law, on the other hand, applies solely to physicians, covers referrals of only certain "designated health services," including clinical laboratory services, home health care services and outpatient prescription drugs, and prohibits all 'self-referrals' unless an exception applies – regardless of whether the referring physician's financial relationship is disclosed to the patient. Moreover, the limitations and exceptions to the states' self-referral laws vary as well. Some states' laws provide no exceptions while other states' laws provide few or numerous exceptions – and they often vary in scope and substance. For these reasons, all practitioners would be wise to understand the significance of not only the federal Stark Law, but also the self-referral laws of the state(s) in which they practice.

Enforcement

Various state regulatory bodies have the authority to enforce the states' self-referral laws. These state regulatory bodies include states' Boards of Medicine or Boards of Physicians (licensing and discipline), and/or state Attorneys General (civil and other penalties). Although various regulatory bodies have the authority to enforce the states' self-referral laws, many states have little or no history of enforcing their state's law. Among the states that have enforced these laws, some have done so by prosecuting physicians and/or entities who violate the law, while others (through either the state's Attorney General or Board of Physicians) have issued advisory opinions in response to requests for guidance regarding the scope of the state's self-referral law. Examples include South Carolina's Attorney General opining on whether the scope of South Carolina's self-referral law includes chiropractors, the Attorney General of California addressing whether a physician may prescribe for a patient a medical device that is distributed by a company in which the physician has an ownership interest, and the Attorney General of Virginia's opinion on whether a health practitioner who has an ownership interest in an entity that operates a licensed hospital may refer patients to that hospital for health services.

The Issue of Preemption

In general, the federal Stark Law is not considered to have a preemptive effect on the states' self-referrals laws, in part because the federal Stark Law applies to conduct affecting the Medicare program and the states' self-referral laws typically apply to state and other programs. In other words, the federal Stark Law and the states' self-referral laws often complement each other, rather than conflict with each other. Nonetheless, the Florida Supreme Court in 2006 raised the possibility that the federal Stark Law might, in certain circumstances, preempt a conflicting state self-referral law. In *State of Florida v. Harden*, 938 So.2d 480 (Fla. 2006), the Florida Supreme Court ruled that the federal health care program anti-kickback statute preempts Florida's anti-kickback statute. The Court examined material differences between the two laws, including the lack of a safe harbor in the Florida law that is included in the federal anti-kickback law. According to the Court, this

difference could result in Florida law criminalizing conduct that federal law specifically intends to be immune from scrutiny. Based on such material differences, the Court concluded that the federal health care program anti-kickback statute preempts the Florida anti-kickback law because the latter stood as an obstacle to the accomplishment of Congress' purposes and objectives. Thus, to the extent the federal Stark Law materially conflicts with a state's self-referral law, the former may be found to preempt the latter. However, no ruling made by any authority has yet to conclude that the federal Stark Law actually preempts any state's self-referral law.

III. State Self-Referral Laws as 'Laboratories' for Policy Initiatives

Given the various constituencies to which state congressional and general assemblies must attend, some states' self-referral laws are deliberately designed (and amended) to address real or perceived economic and market infirmities particular to their region. For instance, the Maryland General Assembly enacted Maryland's 'self-referral' law to substantially restrict the ability of non-radiologist physicians to 'self-refer' their patients for MRI scans, CT scans and radiation therapy services. In recent years, some non-radiologist physicians questioned the scope of the law, claiming that exceptions to the law allowed them to 'self-refer' their patients for MRI services, CT scans and radiation therapy services provided on equipment in which the physician has a financial interest. The Maryland Attorney General and the State Board of Physicians opined on the issue and both concluded that non-radiologist physicians could *not* refer their patients for these services. Dissatisfied, several non-radiologist physicians sought (but did not obtain) relief from the judicial branch. In *Potomac Valley Orthopedic Associates v. Maryland State Board of Physicians*, 12 A.3d 84 (Md. 2011) (a case in which ASTRO filed an amicus brief in support of the Maryland State Board of Physicians), Maryland's highest court considered the State Board of Physicians' interpretation of the law, several opinions of Maryland's attorney general and evidence of legislative intent before affirming the lower court's ruling that, in Maryland, the state self-referral law prohibits non-radiologist physicians from self-referring a patient for an MRI, CT scan or radiation therapy service, even if the service would be performed by another member of the physician's practice group. In other words, legislative and other efforts in Maryland have created a situation in which state law prohibits a urologist from 'self-referring' a patient for radiation therapy services, even if another physician in the urologist's group practice would perform such services.

IV. Conclusion

Physicians and the financial arrangements in which they participate are under increasing scrutiny not only by government agencies who enforce self-referral laws but also by other health care practitioners who are concerned that permitting practitioners who lack the particular expertise to perform certain services could lead to inappropriate patient selection, technically inadequate treatment delivery and poor patient outcomes. Due to this scrutiny, to the varying scope of the federal Stark Law and the states' self-referral laws, and the evolving interpretations of those laws, it is critical to understand and be able to navigate all applicable self-referral laws in order to comply with such laws, avoid penalties flowing from such laws, or urge legislative or government enforcement activity concerning such laws.

ASTRO's Progress on Self-Referral

ASTRO has been working vigorously to close the in-office ancillary services exception for radiation therapy services. ASTRO is very concerned that abuse of this exception has led to some cancer patient's treatments being driven by considerations of profit rather than sound clinical judgment. Here is a timeline of milestones:

2008

- **March:** ASTRO brought 100 physicians to Washington, DC, for its annual "Advocacy Day" event. ASTRO members were urged to tell Congress about radiation oncology and that is not an ancillary service.
- **March:** ASTRO leaders followed up on official comments to CMS urging the removal of radiation therapy from the Stark exception by meeting with CMS officials.
- **April:** ASTRO filed second comment letter expanding comments on this issue.
- **August:** The HHS Office of Inspector General issued Advisory Opinion 08-10 on a joint urology/radiation oncology venture to offer IMRT services. The OIG concluded that the proposed arrangement could potentially generate prohibited remuneration under the anti-kickback statute.

2009

- **January:** ASTRO sent a letter to the AMA Board of Trustees in support of House of Delegates Resolution 842, which affirmed that radiation therapy is not ancillary to any service and affirmed that AMA would oppose any legal or other designation of radiation therapy as ancillary.
- **February:** ASTRO requested that the Office of Inspector General (OIG) issue a Special Fraud Alert highlighting the legal and health care policy concerns that may arise when physician groups reorganize to capture certain radiation therapy service referrals.
- **February:** ASTRO sent the first of three letters to the Obama Administration urging the end of abuses of the physician self-referral law by removing radiation therapy services from the in-office ancillary services exception to the Stark Law.
- **April:** ASTRO staff met with numerous members of Congress and staff on self-referral in radiation therapy, following up on Advocacy Day meetings and initiating high-level meetings with staff on key committees. Hill staff said data is needed on the extent of abuse of self-referral in radiation therapy. Until such data is provided, Hill staff have been reluctant to close the ancillary services loophole.
- **May:** ASTRO's President Tim Williams, MD and ASTRO staff met with Medicare Payment Advisory Commission (MedPAC) staff and requested MedPAC analyze self-referral in radiation therapy.
- **June:** ASTRO's Louisiana state captain initiated an effort that resulted in both state legislative bodies passing self-referral resolutions that were signed by the Secretary of State.

- **August:** A new urology coalition formed to “oppose” ASTRO’s efforts to remove radiation therapy from the IOAE.
- **September:** ASTRO staff worked with the Tennessee state captain and local organizations against a certificate of need application filed by several urology groups to open a prostate cancer treatment center that included radiation therapy services. The group helped convince a Tennessee state agency to deny the urologists’ application. ASTRO staff also briefed the staff for the two federal Senators from Tennessee on the decision and elicited their support for future self referral efforts.
- **October:** Following up on ASTRO’s May meeting, MedPAC considered whether to do further research and possibly recommend changes to the Stark law exception. MedPAC’s chairman and others noted concerns about how ownership might skew treatment decisions in radiation therapy. During the public comment session and in written comments, ASTRO staff expressed concerns about self-referral in radiation therapy.
- **October:** ASTRO staff met with the new CMS officials reviewing self-referral issues and provided them with information on ASTRO’s desire to remove radiation therapy from the Stark exception.
- **October:** ASTRO secured language in House health reform bill to study self-referral in radiation oncology.

2010

- **January:** ASTRO secured self-referral study language in reconciled House-Senate reform bill; however, Massachusetts Senate election forced Congress to pursue legislative vehicle that could not include study language.
- **February:** ASTRO’s board approved a proposal to contract with Jean Mitchell, PhD, of Georgetown University to study the impact of self-referral on radiation oncology practice patterns and patient choice. ASTRO physicians testified before two House committees examining cancer treatment issues discussed concerns about the impact of physician self-referral in radiation therapy.
- **April:** Reps. Waxman, Stark and Levin requested that the Government Accountability Office conduct a study to review self-referral and radiation therapy services.
- **May:** In New Jersey, the state’s Senate health committee unanimously approved legislation to create a two year ban on new, non-radiation oncology owned freestanding centers.
- **June:** MedPAC’s June report included a discussion about self-referral and possible changes to the in-office ancillary services exception.
- **August:** ASTRO joined forces with groups representing radiology, pathology, and physical therapy, by creating an informal coalition, called the Alliance for Integrity in Medicare (AIM), to jointly work to close the self-referral loophole for these services. The groups met jointly with numerous members of Congress and sent letters on the issue to the Obama Administration.
- **September:** ASTRO leadership met with GAO analysts conducting the self-referral in radiation oncology to express ASTRO’s serious concerns about abuses.

- **October:** ASTRO sent MedPAC a letter reiterating its concerns about self-referral. In conjunction with coalition partners, ASTRO sent a letter to the Obama Administration requesting that they close the loophole.
- **December:** After six months of numerous interviews and information sharing between ASTRO staff and leaders with *The Wall Street Journal*, the newspaper published its extensive investigation into self-referral in radiation oncology. The article presented first-of-its-kind data showing overutilization among urology-owned radiation oncology centers.

2011

- **January:** The Maryland state appeals court affirmed a lower court's ruling against a challenge by physician groups to the state's self referral law, which protects against self-referral for radiation therapy as well as MRI and CT scans. ASTRO worked to ensure the state legislature did not repeal the ban.
- **February:** After speaking with ASTRO staff and leaders, *The Washington Post* published a story exposing self-referral abuses in radiation oncology. The article quotes Johns Hopkins urologist, Patrick Walsh, MD, criticizing the "for-profit motive" that is affecting treatment decisions in self-referral arrangements.
- **March:** Key Members of Congress and staff tell Advocacy Day attendees about interest in reviewing data on self-referral in radiation oncology and potentially making policy changes to address problems.
- **September:** ASTRO and colleagues in the AIM self-referral coalition secured a Senator to officially request the Congressional Budget Office to develop a cost-estimate of legislation to close the self-referral loophole. ASTRO and its coalition partners sent a letter to the Joint Deficit Reduction committee urging them to close the self-referral loophole.
- **October:** ASTRO developed self-referral state toolkit to help ASTRO members advance legislation at the state-level. Interim data from the ASTRO-sponsored self-referral study was presented at ASTRO Annual Meeting.

State Self-Referral Laws

State	Directly Related to Radiation Therapy	Indirectly Related to Radiation Therapy
Arizona		<p>Professions and Occupations- Board of Chiropractic Examiners- A.A.C. R4-7-902- Unprofessional or Dishonorable Conduct Activities</p> <p>http://www.azsos.gov/public_services/Title_04/4-07.pdf</p>
	<p>Professionals and Occupations- Medicine and Surgery- A.R.S. § 32-1401- Definitions</p> <p>http://www.azleg.gov/FormatDocument.asp?inDoc=/ars/32/01401.htm&Title=32&DocType=ARS</p>	
		<p>Professionals and Occupations- Naturopathic Medicine- A.R.S. § 32-1501- Definitions</p> <p>http://www.azleg.gov/FormatDocument.asp?inDoc=/ars/32/01501.htm&Title=32&DocType=ARS</p>
		<p>Professions and Occupations- Board of Optometry- A.A.C. R4-21-303- Affirmative disclosures in advertising and practice; warranties, service, or ophthalmic goods replacement agreements.</p> <p>http://www.azsos.gov/public_services/Title_04/4-21.htm</p>
		<p>Professionals and Occupations- Osteopathic Physicians and Surgeons- A.R.S. § 32-1854- Definitions of unprofessional conduct.</p> <p>http://www.azleg.gov/FormatDocument.asp?inDoc=/ars/32/01854.htm&Title=32&DocType=ARS</p>
		<p>Professionals and Occupations- Board of Physical Therapy- A.R.S. § 32-2044- Grounds for disciplinary action.</p> <p>http://www.azleg.gov/FormatDocument.asp?inDoc=/ars/32/02044.htm&Title=32&DocType=ARS</p>
		Professionals and Occupations- Physician

		<p>Assistants- A.R.S. § 32-2501- Definitions</p> <p>http://www.azleg.gov/FormatDocument.asp?inDoc=/ars/32/02501.htm&Title=32&DocType=ARS</p>
Arkansas	<p>Home Intravenous Drug Therapy Services - Ark. Code Ann. § 20-77-804</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=A.C.A.+%25A7+20-77-804</p>	
California	<p>Business and Professions Code § 650 (d)</p> <p>http://www.leginfo.ca.gov/cgi-bin/displaycode?section=bpc&group=00001-01000&file=650-657</p>	
	<p>Business and Professions Code §§ 650.01-650.02</p> <p>http://www.leginfo.ca.gov/cgi-bin/displaycode?section=bpc&group=00001-01000&file=650-657</p>	
	<p>Business and Professions Code 654.2</p> <p>http://www.leginfo.ca.gov/cgi-bin/displaycode?section=bpc&group=00001-01000&file=650-657</p>	
	<p>Labor Code §§ 139.3-139.31</p> <p>http://www.leginfo.ca.gov/cgi-bin/displaycode?section=lab&group=00001-01000&file=110-139.6</p>	
	<p>Welfare and Institutions Code § 14022</p> <p>http://www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=13001-14000&file=14000-14029.8</p>	
	<p>Title 22 California Code of Regulations § 51466</p> <p>http://weblinks.westlaw.com/result/default</p>	

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Colorado	Colorado Medical Assistance Act, Colorado Revised Statutes / Prohibition of Certain Referrals – Colo. Rev. Stat. § 25.5-4-414 http://www.lpdirect.net/casb/crs/25_5-4-414.html	
Connecticut	Conn. Gen. Stat. §20-7a, Billing for clinical laboratory services. Cost of diagnostic tests. Financial disclosures to patients. http://wcc.state.ct.us/law/rel-stat/2003/20-7a.htm	
Delaware		Del. Code Ann. tit. 24 § 1731 (b)(3) and (7) (Professions and Occupations) http://delcode.delaware.gov/title24/c017/sc04/index.shtml#1731B
	24 DE Admin Code 1700 (Board Of Medical Practice) http://regulations.delaware.gov/AdminCode/title24/1700.shtml	
		Del. Code Ann. tit. 24 § 2616(a)(8) (Professions and Occupations) http://delcode.delaware.gov/title24/c026/index.shtml#2616
Florida	Section 456.053. Patient Self Referral Act of 1992	

	http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0456/Sections/0456.053.html	
		Section 456.052. Disclosure of Financial Interest http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0456/Sections/0456.052.html
	Section 400.518. Prohibited Referrals to Home Health Agencies http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0400/Sections/0400.518.html	
		Section 400.9935. Clinic Responsibilities http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0400/Sections/0400.9935.html
Georgia	<p>O.C.G.A. §§ 43-1B-1 to 43-1B-8 ("Patient Self-referral Act of 1993")</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=O.C.G.A.+%A7+43-1B-1</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=O.C.G.A.+%A7+43-1B-2</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=O.C.G.A.+%A7+43-1B-3</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=O.C.G.A.+%A7+43-1B-4</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=O.C.G.A.+%A7+43-1B-5</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=O.C.G.A.+%A7+43-1B-6</p>	

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		O.C.G.A. § 34-9-25 http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=O.C.G.A.+%A7+34-9-25
Hawaii	Hawaii Revised Statutes § 431:10C-308.7(c) Client-patient referrals, health care provider practices prohibited http://www.capitol.hawaii.gov/hrs2006/Vol09_Ch0431-0435E/HRS0431/HRS_0431-0010C-0308_0007.HTM	
Illinois	Health Care Worker Self-Referral Act, 225 ILCS 47/1 http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1304&ChapterID=24	
Indiana	Indiana Code § 25-22.5-11-3 http://www.in.gov/legislative/ic/code/title25/ar22.5/ch11.html	
		Indiana Code § 25-22.5-11-4 http://www.in.gov/legislative/ic/code/title25/ar22.5/ch11.html
	844 IAC 5-2-11 http://www.in.gov/legislative/iac/T08440/A00050.PDF?	

		846 IAC 1-3-3 http://www.in.gov/legislative/iac/T08460/A00010.PDF?
		845 IAC 1-6-2 http://www.in.gov/legislative/iac/T08450/A00010.PDF?
Iowa	Iowa Standards of Practice and Medical Ethics 653 I.A.C. 13.7(2) http://www.legis.state.ia.us/aspx/ACODOCS/DOCS/653.13.7.pdf	
	Iowa Standards of Practice and Medical Ethics 653 I.A.C. 13.20 http://www.legis.state.ia.us/aspx/ACODOCS/DOCS/653.13.20.pdf	
	Iowa Standards of Practice and Medical Ethics: Grounds for Discipline 653 I.A.C. 23.1(19) http://www.legis.state.ia.us/aspx/ACODOCS/DOCS/653.23.1.pdf	
Kansas	K.S.A. 65-2837(b)(29), (g) and (h) http://kansasstatutes.lesterama.org/Chapter_65/Article_28/65-2837.html	
	K.S.A. 65-2837(b)(19) http://kansasstatutes.lesterama.org/Chapter_65/Article_28/65-2837.html	
	K.S.A. 65-2836, 2862 and 2863a http://kansasstatutes.lesterama.org/Chapter_65/Article_28/65-2836.html http://kansasstatutes.lesterama.org/Chapter_65/Article_28/65-2862.html http://kansasstatutes.lesterama.org/Chapter_65/Article_28/65-2863a.html	

	_65/Article_28/65-2863a.html	
Kentucky	KRS 205.8461- Unlawful Referral Practices http://www.lrc.ky.gov/krs/205-00/8461.PDF	
	KRS 216.2950- Self-Referral Restrictions http://www.lrc.ky.gov/krs/216-00/2950.PDF	
Louisiana	Fraudulent Remuneration (Medicaid – criminal) La. R.S. § 14:70.5 http://www.legis.state.la.us/lss/lss.asp?doc=78643	
	Illegal Remuneration (Medicaid – civil) La. R.S. § 46:438.2 http://www.legis.state.la.us/lss/newWin.asp?doc=100867	
	Payments for Patient Referrals La. R.S. § 37:1745 http://legis.state.la.us/lss/lss.asp?doc=93441	
	Rural Physician Self-Referrals La. R.S. §§ 37:1306-10 http://legis.state.la.us/lss/lss.asp?doc=410732 http://legis.state.la.us/lss/lss.asp?doc=410733 http://legis.state.la.us/lss/lss.asp?doc=410734 http://legis.state.la.us/lss/lss.asp?doc=410735 http://legis.state.la.us/lss/lss.asp?doc=410736	
	La. Admin. Code 46:XLV:§§ 4231-39 http://doa.louisiana.gov/osr/lac/46v45/46v45.doc	
	Medical Practice Act La. R.S. § 37:1285(A)(19)	

	http://legis.state.la.us/lss/lss.asp?doc=93167	
	La. Admin. Code 46:XLV:§§ 4205-09 http://doa.louisiana.gov/osr/lac/46v45/46v45.doc	
Maine	Health Care Practitioner Self-Referrals Title 22 Maine Revised Statutes Annotated, Ch. 414, §2081 et. seq. http://www.mainelegislature.org/legis/statutes/22/title22ch414.pdf	
	Bureau of Insurance Rules 02-031 Code of Maine Regulations Ch. 870 http://www.maine.gov/sos/cec/rules/02/031/031c870.doc	
		MaineCare Benefits Manual 10-144 Code of Maine Regulations Ch. 101, §1.19(J) http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s101.doc
Maryland	Maryland Health Occupations Article, §§ 1-301 through 1-306 (Maryland Self-Referral Law) http://dhmh.maryland.gov/boardsahs/regulations/Title_1_Subtitle_3.pdf	
	COMAR 10.01.15 (Maryland Self-Referral Law Regulations) http://www.dsd.state.md.us/comar/testgetfile.aspx?file=10.01.15.00.htm http://www.dsd.state.md.us/comar/testgetfile.aspx?file=10.01.15.01.htm http://www.dsd.state.md.us/comar/testgetfile.aspx?file=10.01.15.02.htm http://www.dsd.state.md.us/comar/testgetfile.aspx?file=10.01.15.03.htm http://www.dsd.state.md.us/comar/testgetfile.aspx?file=10.01.15.04.htm http://www.dsd.state.md.us/comar/testgetfile.aspx?file=10.01.15.05.htm	

	http://www.dsd.state.md.us/comar/testgetfile.aspx?file=10.01.15.06.htm http://www.dsd.state.md.us/comar/testgetfile.aspx?file=10.01.15.07.htm	
	Maryland Health Insurance Article, § 15-110 http://mlis.state.md.us/google_docs\$/Google Statutes/Statutes Feb 11/gin/15-110.pdf	
	Maryland Health-General Article, § 19-712.4 http://mlis.state.md.us/google_docs\$/Google Statutes/Statutes Feb 11/ghg/19-712.4.pdf	
Michigan	Public Health Code, Michigan Compiled Laws § 333.16221(E)(IV) and (V) http://www.legislature.mi.gov/%28S%28iry3pqetmgk02svyyvseoajo%29%29/mileg.aspx?page=getobject&objectname=mcl-333-16221&query=on&highlight=16221	
	Mich. Ad. Code R 338.7003 http://www.state.mi.us/orr/emi/admincode.asp?AdminCode=Single&Admin_Num=33807001&Dpt=&RngHigh=33923405	
Minnesota		Disclosure of Financial Interest—Minnesota Statutes Section 144.652 https://www.revisor.mn.gov/statutes/?id=144.652
	Board of Medical Practice—Minnesota Statutes Section 147.091 https://www.revisor.mn.gov/statutes/?id=147.091	
	Audits of Exempt Providers—Minnesota Statutes Section 62J.23 Subdivision 5 https://www.revisor.mn.gov/statutes/?id=62J.23	

Missouri	Revised Statutes of Missouri §§334.252 and 334.253 http://www.moga.mo.gov/statutes/C300-399/3340000252.HTM http://www.moga.mo.gov/statutes/C300-399/3340000253.HTM	
	Revised Statutes of Missouri §334.100.2(21) http://www.moga.mo.gov/statutes/C300-399/3340000100.HTM	
		Revised Statutes of Missouri §334.100.4 http://www.moga.mo.gov/statutes/C300-399/3340000100.HTM
Montana	Mont. Code Ann. § 39-71-315 http://data.opi.mt.gov/bills/mca/39/71/39-71-315.htm	
	Mont. Code Ann. § 39-71-1108 http://data.opi.mt.gov/bills/mca/39/71/39-71-1108.htm	
		Mont. Code Ann. § 37-2-103 http://data.opi.mt.gov/bills/mca/37/2/37-2-103.htm
Nevada	Nevada Revised Statutes, Section 439B.425 http://www.leg.state.nv.us/nrs/NRS-439B.html#NRS439BSec425	
	NAC 439B.5205-5408 http://www.leg.state.nv.us/nac/NAC-439B.html#NAC439BSec5205	
	Unprofessional Conduct: NRS 630.305(c), 634.140.5 http://www.leg.state.nv.us/nrs/NRS-	

	630.html#NRS630Sec305 http://www.leg.state.nv.us/nrs/NRS-634.html#NRS634Sec140	
New Hampshire	Public Health General Provisions: N.H. Rev. Stat. Ann. § 125:25-a, § 125:25-b http://www.gencourt.state.nh.us/rsa/html/X/125/125-25-a.htm http://www.gencourt.state.nh.us/rsa/html/X/125/125-25-b.htm	
	Public Health General Provisions: N.H. Rev. Stat. Ann. § 125:25-c http://www.gencourt.state.nh.us/rsa/html/X/125/125-25-c.htm	
		Workers' Compensation: N.H. Rev. Stat. Ann. § 281-A:23(IV) http://www.gencourt.state.nh.us/rsa/html/XXIII/281-A/281-A-23.htm
		Pharmacists and Pharmacies: N.H. Rev. Stat. Ann. § 318:29(V)(i) http://www.gencourt.state.nh.us/rsa/html/XXX/318/318-29.htm
New Jersey	New Jersey's "Codey Law", N.J.S.A. 45:9-22.4 and 22.5 http://lis.njleg.state.nj.us/cgi-bin/om_isapi.dll?clientID=39308276&Depth=2&depth=2&expandheadings=on&headingswithhits=on&hitsperheading=on&infobase=statutes.nfo&record={12E93}&softpage=Doc_Frame_PG42	
	Board of Medical Examiners Self-Referral Prohibition, N.J.A.C. 13:35-6.17 http://www.michie.com/newjersey/lpext.dll/uanjadmin/1/75910/7c5c6/7cbf5/7cdb8?fn=document-frame.htm&f=templates&2.0#	

	<p>Board of Medical Examiners Additional Prohibitions Concerning Laboratory, Physical Therapy, Radiology, and Ophthalmology Services, N.J.A.C. 13:35-6.16(i), (j), (k), and (l).</p> <p>http://www.michie.com/newjersey/lpext.dll/uanjadmin/1/75910/7c5c6/7cbf5/7cd83?fn=document-frame.htm&f=templates&2.0#</p>	
New Mexico	<p>Health and Safety Code § 24-1-5.8</p> <p>http://www.conwaygreene.com/nmsu/lpext.dll?f=FifLink&t=document-frame.htm&l=query&iid=1ce95e25.7bd11288.0.0&q=%5BGroup%20%2724-1-5.8%27%5D</p>	
	<p>Title 7 New Mexico Administrative Code § 7.7.2.8(B)(3)</p> <p>http://www.nmcpr.state.nm.us/nmac/cgi-bin/hse/homepagesearchengine.exe?url=http://www.nmcpr.state.nm.us/nmac/parts/titl e07/07.007.0002.htm;geturl;terms=7.7.2.8</p>	
	<p>Title 7 New Mexico Administrative Code § 7.7.2.8(N)</p> <p>http://www.nmcpr.state.nm.us/nmac/cgi-bin/hse/homepagesearchengine.exe?url=http://www.nmcpr.state.nm.us/nmac/parts/titl e07/07.007.0002.htm;geturl;terms=7.7.2.8</p>	
	<p>Professional and Occupational Licenses § 61-9-13(5)</p> <p>http://www.conwaygreene.com/nmsu/lpext.dll?f=FifLink&t=document-frame.htm&l=query&iid=1ce95e25.7bd11288.0.0&q=%5BGroup%20%2761-9-13%27%5D</p>	
New York	<p>Public Health Law § 238-a</p> <p>http://public.leginfo.state.ny.us/LAWSSEAF.cgi?QUERYTYPE=LAWS+&QUERYDATA=\$\$PBH238-A\$\$@TXPBH0238-A+&LIST=LAW+&BROWSER=BROWSER+&TOKEN=11033761+&TARGET=VIEW</p>	

	Public Health Law § 238-b http://public.leginfo.state.ny.us/LAWSSEAF.cgi?QUERYTYPE=LAWS+&QUERYDATA=\$\$PBH238-B\$\$@TXPBH0238-B+&LIST=LAW+&BROWSER=BROWSER+&TOKEN=11033761+&TARGET=VIEW	
	10 N.Y.C.R.R. § 34-1 et seq. http://www.wadsworth.org/labcert/regaffairs/clinical/341122601.pdf	
North Carolina	Self-Referrals Prohibited. N.C. Gen. Stat. § 90-406 http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_90/GS_90-406.html	
	Exceptions for Underserved Areas. N.C. Gen. Stat. § 90-408 http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_90/GS_90-408.html	
	Title 10A North Carolina Administrative Code § 14G.0100 et seq. http://ncrules.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2014%20-%20director,%20division%20of%20health%20service%20regulation/subchapter%20g/subchapter%20g%20rules.html	
North Dakota	North Dakota Century Code § 23-17.5-01 http://www.legis.nd.gov/cencode/t23c17-5.pdf	
Ohio	Ohio Revised Code § 4731.65-71 http://codes.ohio.gov/orc/4731.65	

	http://codes.ohio.gov/orc/4731.66 http://codes.ohio.gov/orc/4731.67 http://codes.ohio.gov/orc/4731.68 http://codes.ohio.gov/orc/4731.69 http://codes.ohio.gov/orc/4731.70 http://codes.ohio.gov/orc/4731.71	
		Ohio Revised Code § 4731.22 http://codes.ohio.gov/orc/4731.22
Pennsylvania	Pennsylvania Health Care Cost Containment Act 35 P.S. § 449.22. Disclosure of interest in referral facilities. **not found**	
	Workers Compensation Medical Cost Containment 34 Pa. Code § 127.301. Referral standards. http://www.pacode.com/secure/data/034/chapter127/s127.301.html	
		Pennsylvania Workers Compensation Act 77 P.S. § 531 (3): Surgical and Medical Services **not found**
Rhode Island	R.I. Gen. Laws § 23-17-46 http://www.rilin.state.ri.us/Statutes/TITLE23/23-17/23-17-46.HTM	
		Department of Health Rules and Regulations for Licensing of Hospitals (R23-17-HOSP) §18.4-18.6 http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/4831.pdf
	R.I. Gen. Laws § 23-17.4-33 http://www.rilin.state.ri.us/Statutes/TITLE23/23-17.4/23-17.4-33.HTM	
		R.I. Gen. Laws § 42-66-17 http://www.rilin.state.ri.us/Statutes/TITLE42/42-66/42-66-17.HTM

	<p>R.I. Gen. Laws § 5-37-22(e)</p> <p>http://www.rilin.state.ri.us/Statutes/TITLE5/5-37/5-37-22.HTM</p>	
	<p>R.I. Gen. Laws § 5-37-22(f)</p> <p>http://www.rilin.state.ri.us/Statutes/TITLE5/5-37/5-37-22.HTM</p>	
		<p>R.I. Gen. Laws § 5-40-13(c)</p> <p>http://www.rilin.state.ri.us/Statutes/TITLE5/5-40/5-40-13.HTM</p>
	<p>Department of Health Rules and Regulations for the Licensure and Discipline of Physicians (R5-37-MD/DO) § 12.1.5</p> <p>http://sos.ri.gov/documents/archives/regdocs/released/pdf//DOH/5311.pdf</p>	
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South Carolina	<p>Provider Self-Referral Act of 1993 § 44-113-10, et.seq.</p> <p>http://www.scstatehouse.gov/code/t44c113.htm</p>	
South Dakota	<p>S.D. CODIFIED LAWS § 36-2-19. Practitioner prohibited from referring patient to certain unaffiliated health care facilities.</p> <p>http://legis.state.sd.us/statutes/DisplayStatute.aspx?Statute=36-2-19&Type=Statute</p>	
Tennessee	<p>Tennessee Code Annotated § 63-6-601 <i>et seq.</i> (2007)</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=Tenn.+Code+Ann.+%A7+63-6-601</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=Tenn.+Code+Ann.+</p>	

	<p>%A7+63-6-602</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=Tenn.+Code+Ann.+%A7+63-6-603</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=Tenn.+Code+Ann.+%A7+63-6-604</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=Tenn.+Code+Ann.+%A7+63-6-605</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=Tenn.+Code+Ann.+%A7+63-6-606</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=Tenn.+Code+Ann.+%A7+63-6-607</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=Tenn.+Code+Ann.+%A7+63-6-608</p>	
	<p>Tennessee Code Annotated § 63-6-501 <i>et seq.</i> (2006)</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=Tenn.+Code+Ann.+%A7+63-6-501</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=Tenn.+Code+Ann.+%A7+63-6-502</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=Tenn.+Code+Ann.+%A7+63-6-503</p>	

	<p>Tennessee Code Annotated, § 63-6-204(f)(1)(B)(i)-(iii) (2006)</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=Tenn.+Code+Ann.+%A7+63-6-204</p>	
	<p>Tennessee Code Annotated § 68-11-205(b)(11) (2006)</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=Tenn.+Code+Ann.+%A7+68-11-205</p>	
	<p>Tennessee Code Annotated § 68-11-232(b) (2006)</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=Tenn.+Code+Ann.+%A7+68-11-232</p>	
	<p>Tennessee Code Annotated § 63-9-106(b)(1)-(2) (2006)</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=Tenn.+Code+Ann.+%A7+63-9-106</p>	
	<p>Tennessee Code Annotated § 33-8-309(a)-(c), (e) (2006)</p> <p>http://web.lexisnexis.com/research/xlink?app=00075&view=full&interface=1&docinfo=off&searchtype=get&search=Tenn.+Code+Ann.+%A7+33-8-309</p>	
Texas	<p>Texas Occupations Code § 105.002 – Unprofessional Conduct; Texas Health and Safety Code</p> <p>http://www.statutes.legis.state.tx.us/Docs/OC/htm/OC.105.htm#105.002</p>	
	Chapter 142; Title 1 Texas Administrative	

	<p>Code § 371.161</p> <p>http://info.sos.state.tx.us/pls/pub/readtac\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=371&rl=1611</p> <p>http://info.sos.state.tx.us/pls/pub/readtac\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=371&rl=1613</p> <p>http://info.sos.state.tx.us/pls/pub/readtac\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=371&rl=1615</p> <p>http://info.sos.state.tx.us/pls/pub/readtac\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=371&rl=1617</p> <p>http://info.sos.state.tx.us/pls/pub/readtac\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=371&rl=1619</p>	
Utah	<p>Utah Code § 58-67-801 (Medical Practice Act)</p> <p>http://le.utah.gov/~code/TITLE58/htm/58_67_080100.htm</p>	
	<p>Utah Code § 58-68-801 (Osteopathic Medical Practice Act)</p> <p>http://le.utah.gov/~code/TITLE58/htm/58_68_080100.htm</p>	
		<p>Utah Code § 58-69-805 (Dentist and Dental Hygienist Practice Act)</p> <p>http://le.utah.gov/~code/TITLE58/htm/58_69_080500.htm</p>
		<p>Utah Code § 58-71-801 (Naturopathic Physician Practice Act)</p> <p>http://le.utah.gov/~code/TITLE58/htm/58_71_080100.htm</p>

Virginia	<p>Va. Code Ann. § 54.1-2410 through 54.1-2414. Practitioner Self-Referral Act.</p> <p>http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+54.1-2410</p> <p>http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+54.1-2411</p> <p>http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+54.1-2412</p> <p>http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+54.1-2413</p> <p>http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+54.1-2414</p>	
	<p>18 Va. Admin. Code §75-20-60 through 18 V.A.C. §75-20-110. Regulations governing practitioner self-referral.</p> <p>http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+18VAC75-20-60</p> <p>http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+18VAC75-20-70</p> <p>http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+18VAC75-20-80</p> <p>http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+18VAC75-20-90</p> <p>http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+18VAC75-20-100</p> <p>http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+18VAC75-20-110</p>	
	<p>18 Va. Admin. Code §110-40-70. Compliance with statutes and regulations</p> <p>http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+18VAC110-40-70</p>	
	<p>Va. Code Ann. § 54.1-2964. Disclosure of interest in referral facilities and clinical</p>	

	laboratories. http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+54.1-2964	
Washington	RCW 74.09.240(3) http://apps.leg.wa.gov/rcw/default.aspx?cite=74.09.240	
West Virginia	West Virginia Code § 30-3-14(c)(7) http://www.legis.state.wv.us/WVCODE/ChapterEntire.cfm?chap=30&art=3&section=14#03	
Wisconsin	Chapter HFS 106 Provider Rights and Responsibilities Wis. Admin. Code HFS § 106.06(11)- (12) http://legis.wisconsin.gov/rsb/code/dhs/dhs106.pdf	
		Chapter HFS 107 Covered Services Wis. Admin. Code HFS § 107.13(2)(d)(4) - Health and Family Services-Outpatient Psychotherapy Services: Non-covered Services. http://legis.wisconsin.gov/rsb/code/dhs/dhs107.pdf

States That Do Not Appear to Have Physician Self-Referral Laws
Alabama
Alaska
Idaho
Massachusetts
Mississippi
Nebraska
Oklahoma
Oregon
Vermont

Step 2

Understanding the State Legislative Process

Self-referral
Toolkit



for State-level Advocacy

AMERICAN SOCIETY FOR RADIATION ONCOLOGY

Understanding the Structure and Procedure of State Legislatures

Influencing a state legislature requires a basic understanding of state government’s structure and functions.

Legislative structure

Most state legislatures meet every year, although there are a few that meet every other year. State legislative sessions are not full-time or year-round because most legislators often have full-time or part-time jobs outside of their government responsibilities. Most legislative sessions begin in January and end between May and June. When not in session, committees will often hold legislative and oversight hearings.

With the exception of Nebraska, all state legislatures consist of two houses: a Senate and a House of Representatives (sometimes called an Assembly). Most of the work in a state legislature is conducted through its committee structure. Often the most critical part of passing legislation is getting it approved by a committee. Committees can make or break a bill, as it is the responsibility of the committee to prepare the bill for floor debate, line up support, or decide to kill the legislation.

Most state legislatures have a hierarchy. Typical leadership arrangements include:

Senate	House or Assembly
<i>President of the Senate</i>	<i>Speaker</i>
<i>President Pro Tempore</i>	<i>Speaker Pro Tempore</i>
<i>Majority Leader</i>	<i>Majority Floor Leader</i>
<i>Majority Floor Leader</i>	<i>Minority Leader</i>
<i>Minority Leader</i>	<i>Minority Floor Leader</i>
<i>Minority Floor Leader</i>	

How a bill becomes a law

- *Introduction:*
Every member of the state legislature has the power to introduce a bill. After an idea is drafted into bill form (this can be done by the legislature’s legislative counsel or by outside counsel), it is introduced by a bill sponsor and assigned a bill number. This step is known as the bill’s “first reading.” Be careful to choose a sponsor or author who is respected and who is regarded as having expertise in the subject matter. Optimally, the sponsor should be in a leadership position or chair or serve on the committee with jurisdiction over the bill’s content.
- *Committees:*
After introduction, a bill usually is referred to one of the standing committees and/or subcommittees for consideration. Typically there are one or two committees/subcommittees

that handle health care legislation. Major pieces of legislation will usually have a hearing during which testimony is taken. At this point, the role and power of the committee chair usually will determine a bill's fate. Be sure to do your research and learn about the committee leadership and members.

Whether the committee holds a hearing or not, it has a number of options available with respect to the bill's fate. The committee can simply sit on a bill, thus eliminating it from further consideration. The committee may also report the bill out of committee with either a favorable or negative recommendation. Amendments may be added to the bill during the committee proceedings.

Bill hearings are opportunities for advocates and opponents to argue the merits of the bill. Work with partners and lobbyists behind the scenes to influence committee members discussion of the bill during the hearing. Also, line up powerful speakers with convincing arguments in support of your bill.

- *Floor debate:*

The bill is then scheduled for consideration and placed on the calendar to be debated by the full chamber – known as the “Second Reading.” In most states, bills may be amended at this stage. However, in some states, the introduction of amendments may prove to be more difficult at this point.

- *Final vote:*

Following floor consideration, a bill is put to a final vote, sometimes referred to as the “third reading.” In some states, a majority of the total membership of the legislative body is required to pass a measure. In others, only a majority of those voting is necessary. If defeated in one house, a bill is usually considered “dead” for the session.

- *Second chamber:*

If a bill passes the first chamber it goes to the second chamber where it must go through the same process again. If the bill passes the second chamber without amendments being added it goes to the governor. If the second chamber amends the bill in any way it must be sent back to the first chamber for approval. If the two chambers disagree on the amendments added in the second chamber, a conference committee is formed to resolve the differences.

- *Conference committee (if needed):*

The conference committee usually consists of members of both chambers. The committee appointments are critical because the members write the conference report, which then must be passed by both chambers. Usually the two houses can only accept or reject a conference committee's report, even though the report may substantially alter the bill. Conference committees are powerful and can undo much of what has been accomplished up to this stage of the legislative process.

- *The governor:*

The governor of a state has several options when considering the fate of a bill:

- The governor may sign the bill, in which case it becomes law.
- The governor may permit the bill to become law without a signature. There is a specified number of days for the bill to be signed or vetoed, and if the governor does neither, it becomes law as if it had been signed.
- The governor may veto the bill.

While the steps outlined above typically play out in the open political arena, moving legislation forward requires constant advocacy with legislators and staff behind the scenes to support champions and overcome barriers from the opposition and undecided.

Additional resources

No two states are the same so it is important to take the time to learn about your state's unique procedures. You can visit your state legislature's website for more information or contact ASTRO's government relations staff for additional guidance.

2012 Governors and Legislatures

As of February 8, 2012

State	Governor	Next Election	Senate				House				Projected Session Dates	Carryover (2011-2012)
			Dem	Rep	Oth	Vac	Dem	Rep	Oth	Vac		
Alabama	<i>Robert Bentley</i>	2014	12	22	1		40	65			02/07/12 - 05/21/12	no
Alaska	<i>Sean Parnell</i>	2014	10	10			16	24			01/17/12 - 04/15/12	yes
Arizona	<i>Jan Brewer</i>	2014 (L)	9	21			20	40			01/09/12 - 04/17/12	no
Arkansas	<i>Mike Beebe</i>	2014 (L)	20	15			54	46			02/13/12 - 03/13/12	no
California	<i>Jerry Brown</i>	2014	25	15			52	28			01/04/12 - 08/31/12	yes
Colorado	<i>John Hickenlooper</i>	2014	20	15			32	33			01/11/12 - 05/09/12	no
Connecticut	<i>Dan Malloy</i>	2014	22	14			98	52		1	02/08/12 - 05/09/12	no
Delaware	<i>Jack Markell</i>	2012	14	7			26	15			01/10/12 - 06/30/12	yes
Florida	<i>Rick Scott</i>	2014	12	28			39	81			01/10/12 - 03/09/12	no
Georgia	<i>Nathan Deal</i>	2014	20	36			63	116	1		01/09/12 - 04/13/12	yes
Hawaii	<i>Neil Abercrombie</i>	2014	24	1			43	8			01/18/12 - 05/03/12	yes
Idaho	<i>Butch Otter</i>	2014	7	28			13	57			01/09/12 - 04/27/12	no
Illinois	<i>Pat Quinn</i>	2014	35	24			64	54			01/11/12 - 05/31/12	yes
Indiana	<i>Mitch Daniels</i>	2012 (L)	13	37			40	59		1	01/04/12 - 03/14/12	no
Iowa	<i>Terry Branstad</i>	2014	26	24			40	60			01/09/12 - 04/17/12	yes
Kansas	<i>Sam Brownback</i>	2014	8	32			33	92			01/09/12 - 04/30/12	yes
Kentucky	<i>Steve Beshear</i>	2015 (L)	15	22	1		59	41			01/03/12 - 04/09/12	no
Louisiana	<i>Bobby Jindal</i>	2015 (L)	15	24			45	58	2		03/12/12 - 06/04/12	no
Maine	<i>Paul LePage</i>	2014	14	19	1	1	72	78	1		01/04/12 - 04/18/12	yes
Maryland	<i>Martin O'Malley</i>	2014 (L)	35	12			98	43			01/11/12 - 04/09/12	no
Massachusetts	<i>Deval Patrick</i>	2014	36	4			125	33		2	01/04/12 - 07/31/12	yes
Michigan	<i>Rick Snyder</i>	2014	12	26			47	62		1	01/11/12 - 12/31/12	yes
Minnesota	<i>Mark Dayton</i>	2014	30	37			62	72			01/24/12 - 04/30/12	yes
Mississippi	<i>Phil Bryant</i>	2015	21	31			58	64			01/03/12 - 05/05/12	no
Missouri	<i>Jay Nixon</i>	2012	8	26			56	106	1		01/04/12 - 05/30/12	no
Montana	<i>Brian Schweitzer</i>	2012 (L)	22	28			32	68			no regular 2012 session	no
Nebraska	<i>Dave Heineman</i>	2014 (L)			49						01/04/12 - 04/12/12	yes
Nevada	<i>Brian Sandoval</i>	2014	11	10			26	16			no regular 2012 session	no
New Hampshire	<i>John Lynch</i>	2012	5	19			104	294		2	01/04/12 - 07/01/12	yes
New Jersey	<i>Chris Christie</i>	2013	24	16			48	32			01/10/12 - 12/31/12	no
New Mexico	<i>Susana Martinez</i>	2014	27	14		1	36	33	1		01/17/12 - 02/16/12	no
New York	<i>Andrew Cuomo</i>	2014	29	32		1	96	49	1	4	01/04/12 - 12/31/12	yes
North Carolina	<i>Beverly Perdue</i>	2012	19	31			52	68			05/16/12 - 06/29/12	yes
North Dakota	<i>Jack Dalrymple</i>	2012	12	35			25	69			no regular 2012 session	no
Ohio	<i>John Kasich</i>	2014	10	23			40	59			01/03/12 - 12/31/12	yes
Oklahoma	<i>Mary Fallin</i>	2014	15	31		2	31	69		1	02/06/12 - 05/25/12	yes
Oregon	<i>John Kitzhaber</i>	2014	16	14			30	30			02/01/12 - 02/29/12	no
Pennsylvania	<i>Tom Corbett</i>	2014	20	30			87	110		6	01/03/12 - 11/30/12	yes
Rhode Island	Lincoln Chafee	2014	29	8	1		65	10			01/03/12 - 06/22/12	no
South Carolina	<i>Nikki Haley</i>	2014	19	27			48	76			01/10/12 - 06/07/12	yes
South Dakota	<i>Dennis Daugaard</i>	2014	5	30			19	50	1		01/10/12 - 03/19/12	no
Tennessee	<i>Bill Haslam</i>	2014	13	20			34	64	1		01/10/12 - 05/24/12	yes

Texas	<i>Rick Perry</i>	2014	12	19			49	101			no regular 2012 session	no
Utah	<i>Gary Herbert</i>	2012	7	22			17	58			01/23/12 - 03/08/12	no
Vermont	<i>Peter Shumlin</i>	2012	20	8	2		94	48	8		01/03/12 - 05/24/12	yes
Virginia	<i>Bob McDonnell</i>	2013 (L)	20	20			32	67	1		01/11/12 - 03/10/12	no
Washington	<i>Christine Gregoire</i>	2012	27	22			56	42			01/09/12 - 03/08/12	yes
West Virginia	<i>Earl Ray Tomblin</i>	2012	28	6			65	35			01/11/12 - 03/10/12	yes
Wisconsin	<i>Scott Walker</i>	2014	16	17			39	59	1		01/17/12 - 05/23/12	yes
Wyoming	<i>Matt Mead</i>	2014	4	26			10	50			02/13/12 - 03/09/12	no

Red = Republican

Blue = Democrat

Italic = Full Party Control

(L) = Lame Duck

Oth = Other Party

Vac = Vacant

State Government Websites

Alabama - <http://www.alabama.gov/portal/index.jsp>
Alaska - <http://www.state.ak.us/>
Arizona - <http://az.gov/webapp/portal/>
Arkansas - <http://www.accessarkansas.org/>
California - <http://www.ca.gov/>
Colorado - <http://www.colorado.gov/>
Connecticut - <http://www.ct.gov/>
Delaware - <http://delaware.gov/>
Florida - <http://www.myflorida.com/>
Georgia - <http://www.georgia.gov/>
Hawaii - <http://pahoe.hoe.ehawaii.gov/portal/>
Idaho - <http://www.accessidaho.org/>
Illinois - <http://www.illinois.gov/>
Indiana - <http://www.in.gov/>
Iowa - <http://www.iowa.gov/>
Kansas - <http://www.accesskansas.org/>
Kentucky - <http://www.kentucky.gov/>
Louisiana - <http://www.louisiana.gov/>
Maine - <http://www.maine.gov/>
Maryland - <http://www.maryland.gov/>
Massachusetts - <http://www.mass.gov/>
Michigan - <http://www.michigan.gov/>
Minnesota - <http://www.state.mn.us/>
Mississippi - <http://www.ms.gov/index.jsp>
Missouri - <http://www.missouri.gov/>
Montana - <http://mt.gov/>
Nebraska - <http://www.nebraska.gov/>
Nevada - <http://www.nv.gov/>
New Hampshire - <http://www.nh.gov/>
New Jersey - <http://www.state.nj.us/>
New Mexico - <http://www.newmexico.gov/>
New York - <http://www.state.ny.us/>
North Carolina - <http://www.ncgov.com/>
North Dakota - <http://www.nd.gov/>
Ohio - <http://ohio.gov/>
Oklahoma - <http://www.ok.gov/>
Oregon - <http://www.oregon.gov/>
Pennsylvania - <http://www.state.pa.us/>
Rhode Island - <http://www.ri.gov/>
South Carolina - <http://www.sc.gov/>
South Dakota - <http://www.state.sd.us/>
Tennessee - <http://tennessee.gov/>
Texas - <http://www.state.tx.us/>
Utah - <http://www.utah.gov/>
Vermont - <http://www.vermont.gov/>
Virginia - <http://www.virginia.gov/>
Washington - <http://access.wa.gov/>
West Virginia - <http://www.wv.gov/>
Wisconsin - <http://www.wisconsin.gov/>
Wyoming - <http://wyoming.gov/>
United States - <http://www.usa.gov/>

State Legislature Websites

Alabama - <http://www.legislature.state.al.us/>
Alaska - <http://w3.legis.state.ak.us/index.php>
Arizona - <http://www.azleg.gov/>
Arkansas - <http://www.arkleg.state.ar.us/>
California - <http://www.leginfo.ca.gov/index.html>
Colorado - <http://www.leg.state.co.us/>
Connecticut - <http://www.cga.ct.gov/>
Delaware - <http://legis.delaware.gov/>
Florida - <http://www.leg.state.fl.us/Welcome/index.cfm?>
Georgia - <http://www.legis.state.ga.us/>
Hawaii - <http://www.capitol.hawaii.gov/>
Idaho - <http://www.legislature.idaho.gov/>
Illinois - <http://www.ilga.gov/>
Indiana - <http://www.state.in.us/legislative/index.html>
Iowa - <http://www.legis.iowa.gov/>
Kansas - <http://www.kslegislature.org/li>
Kentucky - <http://www.lrc.state.ky.us/home.htm#search>
Louisiana - <http://www.legis.state.la.us/>
Maine - <http://www.maine.gov/legis/>
Maryland - <http://mlis.state.md.us/>
Massachusetts - <http://www.mass.gov/legis/>
Michigan - <http://www.legislature.mi.gov/>
Minnesota - <http://www.leg.state.mn.us/>
Mississippi - <http://billstatus.ls.state.ms.us/>
Missouri - <http://www.moga.mo.gov/>
Montana - <http://leg.mt.gov/css/default.asp>
Nebraska - <http://nebraskalegislature.gov/web/public/home>
Nevada - <http://www.leg.state.nv.us/>
New Hampshire - <http://gencourt.state.nh.us/ie/>
New Jersey - <http://www.njleg.state.nj.us/>
New Mexico - <http://www.nmlegis.gov/lcs/>
New York (Assembly) - <http://assembly.state.ny.us/leg/>
New York (Senate) - <http://www.nysenate.gov/>
North Carolina - <http://www.ncga.state.nc.us/homePage.pl>
North Dakota - <http://www.legis.nd.gov/>
Ohio - <http://www.legislature.state.oh.us/>
Oklahoma - <http://www.lsb.state.ok.us/>
Oregon - <http://www.leg.state.or.us/>
Pennsylvania - <http://www.legis.state.pa.us/>
Rhode Island - <http://www.rilin.state.ri.us/>
South Carolina - <http://www.scstatehouse.net/>
South Dakota - <http://legis.state.sd.us/index.aspx>
Tennessee - <http://www.legislature.state.tn.us/>
Texas - <http://www.legis.state.tx.us/>
Utah - <http://www.le.state.ut.us/>
Vermont - <http://www.leg.state.vt.us/>
Virginia - <http://legis.state.va.us/>
Washington - <http://www1.leg.wa.gov/legislature>
West Virginia - <http://www.legis.state.wv.us/>
Wisconsin - <http://www.legis.state.wi.us/>
Wyoming - <http://legisweb.state.wy.us/>
United States - <http://thomas.loc.gov/>

Step 3

Building a Coalition

Self-referral
Toolkit



for State-level Advocacy

AMERICAN SOCIETY FOR RADIATION ONCOLOGY

Building a Coalition

Should we form a coalition?

Coalitions allow organizations to more effectively focus their collective resources, can help avoid duplication of efforts and can promote uniform messaging between member groups. Before you decide to form a coalition, make sure that there isn't already an effective organization in place. Check in with other organizations involved in the issue to be sure that they are willing to relinquish control of the issue to a coalition.

Define the scope

Once you have decided to form a coalition, you will need to define the scope of the coalition. You should do an analysis of your needs, problems, challenges and resources. What type of funding will you need? Do you need to hire staff or a lobbyist? The results of the analysis will provide the framework for a purpose statement and assist in formulating the scope and direction of an action plan.

Identify leadership

The leadership of your coalition can be an individual, group or existing organization and should serve the following purposes:

- Perform the initial steps in forming the coalition.
- Be responsible for all communications.
- Provide information and management expertise.
- Facilitate consensus building.
- Provide materials and staff resources.
- Assume any fiscal and fiduciary responsibilities.
- Supervise any fundraising activities.

Outline the goals of the coalition

Coalition leaders should propose goals and objectives to the membership for consideration. Initial goals should be flexible so that the membership can help establish discrete goals and objectives that are relatively uncontroversial and widely supported. There should also be a mechanism for adding or changing goals and objectives over time.

Define the lifespan

For planning purposes, coalition members will need to know what milestones to expect in terms of coalition longevity. You should consider your goal completion in terms of one year, six meetings, the end of next year's legislative session or the accomplishment of a specific objective or objectives.

Name the group

The name of your coalition can attract or distract you from gathering possible supporters. The name should also give outsiders a sense of the collective goal. Consider naming the coalition after an issue rather than an organization. For instance, ASTRO is a member of the "Alliance for Integrity in Medicare" coalition fighting self-referral abuse at the federal level in partnership with radiologists, pathologists, physical therapists and others.

Coalition membership

Coalitions should encourage diverse membership representation, multifaceted skills, temperaments and levels of involvement. Coalitions require a range of talent, so it is best to invite all who express a desire to be involved and then make them feel welcome and assist in defining their roles. It is important that the coalition be viewed as diverse instead of narrow. Depending on your state, consider all levels of involvement (i.e. community, county, region, state).

Think outside the box when looking to engage members. Consider all stakeholders, including:

- Hospital-based cancer programs.
- State and local hospital advocacy organizations.
- Patient advocate groups.
- Nursing organizations.
- Community cancer groups.

Coalition message

Your image is everything. Focus on how you present the coalition and its views. Your materials should provide a clear and concise description of the coalition and its members, goals and objectives, accomplishments, facts on the coalition's issue and how to get further information.

Coalition finances

Financial resources for coalition activities may be available from various sources including:

- Membership fees. These can offer start-up capital and demonstrate commitment to the coalition.
- Corporate contributions. These can be tricky. Be sure to keep in mind the image you want to present.
- Shared expenses. A pay-as-you-go model could be agreed upon within coalition members to fund expenses.

Engage ASTRO

ASTRO can be a useful tool in helping you identify other like-minded ASTRO members in your state. ASTRO has numerous resources and materials for your coalition to utilize and can help keep you updated on the progress in other states. ASTRO is always willing to provide guidance and some educational support. Feel free to contact ASTRO's government relations staff for assistance.

Presented at ASTRO's 2010 Annual Meeting
HP/GR Educational Session
October 31, 2010

A State-Based Model for Addressing Self-Referral Abuses

Richard Emery, MS, MBA, DABR
Executive Director
Beth Israel Comprehensive Cancer Center, West Side Campus
Vice President
Aptium Oncology

Disclosure Slide

Nothing to disclose

Objectives

- Share the experience of an effort in New Jersey to address the Radiation Therapy (RT) self-referral issue at the local level
- Inform, empower, and (hopefully) inspire ASTRO members in other states to pursue their own initiatives

New Jersey Senate 1837

- A proposed amendment to impose a two-year moratorium on certain new outpatient radiation oncology services and establish an Outpatient Radiation Oncology Services Task Force led by the Dept of Health and Senior Services (DHSS).

New Jersey Senate 1837

- Primary Sponsors:
 - Senator Robert Gordon
 - Senator Loretta Weinberg
- Introduced May 10, 2010
- Passed unanimously out of the Senate Health Committee on 5/27/10

New Jersey Senate 1837

- Two-year moratorium on the licensing and registration of any new radiation therapy service in which a physician other than a radiation oncologist or a radiologist holds a significant beneficial interest.
 - Does not apply to hospital-based facilities
 - Does not apply to facilities that are substantially completed as of the effective date of the bill

New Jersey Senate 1837

- Establishes an Outpatient Radiation Oncology Services Task Force in the DHSS.
- Purpose: to review the economic impact on hospitals and any effects of practice patterns on patients of a non-radiation oncologist physician referring patients for radiation therapy in which the physician or his immediate family has a significant beneficial interest.

New Jersey Senate 1837

The Task Force shall determine:

1. How and where outpatient RT is delivered in New Jersey;
2. The economic impact that outpatient RT performed in non-hospital settings has on hospitals;
3. Whether physician practice patterns are affected;

New Jersey Senate 1837

4. Any resulting economic impact to the State of New Jersey and other payers;
5. The patient safety, staffing, and quality standards of RT in non-hospital settings;
6. Whether further requirements concerning non-radiation oncologist physician referrals to services in which they have a significant beneficial interest are necessary.

Composition of Task Force

- Nine members as follows:
 - The Commissioner of DHSS,
 - The Executive Director of the Office for Cancer Control and Prevention,
 - The Director of the Division of Consumer Affairs in the Department of Law and Public Safety,
 - or their designees, who shall serve ex officio; and

Composition of Task Force (cont'd)

- Two physicians who are licensed by the State Board of Medical Examiners
 - A radiation oncologist who shall be appointed by the Senate President
 - A urologist who is a member of an integrated medical group that, prior to the effective date of this act, provided RT to patients with prostate cancer and who shall be appointed by the Speaker of the Assembly

Composition of Task Force (cont'd)

- A medical radiation physicist appointed by the President of the Senate
- Two representatives of general hospitals in New Jersey that provide RT
 - One appointed by the Senate President and one appointed by the Assembly Speaker
- One representative of health insurance carriers, appointed by the Speaker of the Assembly

Task Force Work Product

- The Task Force shall report its findings and recommendations to the Governor and to the Legislature, 12 months after the effective date of this act.
- The Task Force shall expire upon issuance of the report.

Current Status of S1837

- Primary Senate sponsors actively working with their Senate colleagues and other stakeholders to gain majority support in preparation for a vote on Senate floor
- Assembly version already created with primary sponsors. Progress is pending:
 - Passage of Senate version of bill
 - Vote in Assembly Health Committee

How Did We Get Here?

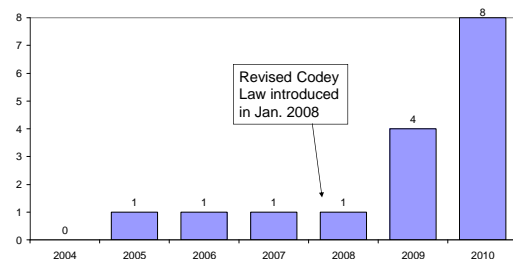
A Short History of RT Self-Referral Law in New Jersey

- Codey Law: prevents physicians from referring to entities in which they have a “beneficial interest”
- Previous Codey law excepted RT
- The revised Codey law proposed to repeal the exemption, except for “significant beneficial interests” held before 3/20/10

A Short History of RT Self-Referral Law in New Jersey

- Attention to the subject that the revised Codey law created, confusion, misinformation, and fear regarding whether physicians other than radiation oncologists would be able to invest in RT centers in the future acted as a catalyst for physicians to race into these business ventures.

Increasing Number of Self-Referral RT Facilities in New Jersey



However, the Codey law never affected, and does not affect RT provided as an in-office ancillary service

Why is this Trend Happening?

- Perceived necessity to race to enter the Self-Referral RT business model before the opportunity disappears
- New Jersey lacks a CON law for RT
 - No other regulatory means exist in New Jersey to restrict their development
- Regulatory permissibility of referring physicians to receive significant benefit from ownership in free-standing RT facilities
- Large financial incentives combined with low risk

Significant Financial Motivation

- In Northern New Jersey, for a 9-week course of Radiation Therapy to the prostate with IMRT and IGRT, Medicare pays:
 - \$25,900 to a Hospital-based facility*
 - \$42,100 to a Free-Standing facility*
 - This represents a 62% premium
- Hospitals left at a competitive disadvantage

*Technical revenue alone

What is the Suspected Impact to States?

- Increased healthcare costs through over-utilization of RT services
- Reduced operating efficiencies and weakened financial performance of Hospitals
- Less healthy Hospitals will require greater financial assistance from the State of New Jersey, thereby further increasing costs to the taxpayer

The Current Situation in NJ

- So far, there are 8 radiation treatment centers in New Jersey that take advantage of the in-office ancillary exception.
- It is expected that these centers will expand their services beyond prostate to other clinical sites, thereby increasing the negative impact to patients, hospitals, and the state of New Jersey.

The Current Situation in NJ

- New Jersey is experiencing:
 - Suspected loss of objective medical decision-making in RT
 - Creation of excess RT capacity in NJ
 - A deterioration in the Comprehensive Cancer Center model of care, creating
 - Greater fragmentation of care
 - Less multidisciplinary care
 - A decline in Hospital-based RT volumes
 - A corresponding loss of Hospital ROI

What Can We Do?

- Protect patients by preventing profit-motivated self-referrals and the potential corresponding loss of objective medical decision-making that patients deserve.
- Help protect Hospitals from the loss of a profit center that is used to offset losses associated with providing care for the uninsured and other services.

Identify Potential Allies

- American Hospital Association
- NJ Hospital-based Oncology Programs
- ASTRO
- American Association of Physicists in Medicine (AAPM)
- Association of Comprehensive Cancer Centers (ACCC)
- Society of Radiation Oncology Administrators (SROA)

S1837: Actual Allies and Opponents

Allies	Opponents
NJ Hospital-based Cancer Coalition	NJ Patient Care and Access Coalition (NJPCAC)
ASTRO	Access to Integrated Cancer Care (AICC)
NJ Hospital Association	
American Hospital Association	

What You Can Do

- Identify and Organize Your Base
 - Develop a network of Hospital-based Cancer Programs within your State
 - Note: this may not already exist
 - Enlist the support and involvement of local hospital advocacy organizations and ASTRO
- Understand the arguments for and against RT self-referral business models

What You Can Do

- Create a Communication Plan to educate your base. E.g. Seminars, meetings, etc.
- Develop an action plan appropriate for your State and the local environment
- Follow-up accordingly as per the specifics of your plan. E.g. engage local politicians, the media, patient advocacy groups, etc.

Acknowledgements

- Senator Robert Gordon
- ASTRO
 - A tremendous resource but they can't do the work for you. Each state has to take lead.
- Members of the New Jersey Hospital-based Cancer Centers Coalition
- The New Jersey Hospital Association

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Step 4

Hiring a State Lobbyist

Self-referral
Toolkit



for State-level Advocacy

AMERICAN SOCIETY FOR RADIATION ONCOLOGY

How to Hire a State Lobbyist

Abuses of the legislative process have tainted the view of lobbying, but in reality, when done ethically and in compliance with lobbying laws and regulations; it is a vital component of the political process. While physicians are busy treating patients, lobbyists focus full-time on legislative issues. Deciding to hire a lobbyist is an expensive and intensive endeavor. Before hiring a lobbyist, look closely at the political environment of your state and your legislative agenda.

Choosing the right lobbyist

After deciding to hire a lobbyist, ask around for recommendations from the state medical association or other physician colleagues. After compiling a list of lobbyists or lobbying firms, look into the following:

- What connections do the lobbyists have?
- Who are their clients? Are there any conflicts of interest?
- What experience do they have?
- Do they work solely on health care issues or have a broader portfolio?

Writing the job description

Determining the objectives and goals of your legislative efforts is the first step to writing a lobbyist job description. Once that has been defined, discuss the following:

- What is the scope of lobbying you expect? Will they lobby the legislature, regulatory agencies or both? Will they organize political fundraisers? Will they mostly set up meetings for you or be expected to personally communicate messages and requests on their own?
- What non-legislative services you need? Will your lobbyist set up a political action committee (PAC), file state compliance reports, attend hearings?
- What type of arrangement do you need? Full time or on an as-needed basis? Will you pay per legislative issue, session, annually or on retainer? Do you want monitoring services, an advocate, or both?

Contracting your lobbyist

Lobbyists are expensive and costs can vary drastically between states, but they can be worth the cost. Depending on the lobbyist's connections to your state's political leadership, the more costly (but more effective), they can be. Explore whether other radiation oncologists in the state are interested in offsetting the costs. Before signing a contract, make sure you discuss fees, payment schedule, legislative success, expense reimbursement and a termination clause.

Evaluating Performance

Just like any other employee or contractor, regularly assess the lobbyists' performance using realistic goals and expectations used in the hiring process. Schedule weekly or biweekly calls or meetings to receive reports, direct activities and assess performance. If goals are not being met, if skills don't meet promises made in the hiring process, or if the relationship isn't working out, don't be afraid to end the relationship and search for a new lobbyist.

Step 5

Developing Legislative Champions

Self-referral
Toolkit



for State-level Advocacy

AMERICAN SOCIETY FOR RADIATION ONCOLOGY

Getting to Know Your State Legislators

Creating personal relationships with state legislators is essential to influencing the legislative process. As a constituent, you are important to your legislators so don't be afraid to be the one to reach out first. Once you have decided to contact your legislator, keep in mind that:

- Face-to-face meetings are the most effective way to communicate.
- Once you have made personal contact, writing and calling your legislators becomes more valuable because there is a "face to the name."

Scheduling a meeting

To schedule a meeting, first:

- Find your legislators on the state government's website. Each website provides contact information for every legislator.
- Set up an appointment date and time that works best for both of you.

Meeting with your legislator

The first meeting will be the basis for all future communication, so choose somewhere you're most comfortable. Coffee, lunch, dinner, drinks, at home, your cancer center or the state capitol are all great locations for meetings.

- Unless you have a previous relationship, keep the first meeting short (30 minutes). Be sure to keep track of your time.
- Be friendly, sincere and non-threatening.
- Start from the beginning (i.e., What is radiation oncology? What is self-referral? Talk about patients you treat.)
- **Don't forget your legislative ask—Ask for their support in ending self-referral abuse.**

Be prepared

Preparation is critical to a successful meeting. Your legislator may ask questions or for advice on a specific topic — come prepared to discuss a variety of issues. Many legislators have not developed definitive positions on health issues. Having a trusting relationship is a great opportunity to help shape your legislator's views.

- Be ready to discuss current event topics that will peak your legislator's interest.
- Discuss current health-related headline news, particularly related to cancer.
- Have district-specific facts about your patients, your clinic, etc.

Follow-up

Gratitude goes a long ways in the political world. Follow up with a letter of thanks and include any additional information that you were unable to discuss during your meeting and any articles or resources that were discussed.

Make a point to stay in contact periodically with your legislators, even if it's a quick email every quarter. Legislators do not want to hear from you just when you need or want something.

Writing your legislator

Once you have established a relationship with your legislator, writing to them becomes much more effective. When writing be sure to:

- Write about one topic per letter.
- Be concise and direct.
- Include specific bill numbers and titles.
- Describe the impact on your practice, your patients and their legislative district.
- Ask your legislator to act on your issue.
- Do not use a form letter.
- Refer to the most recent meeting you had with your legislator. This helps with face and name recognition.
- Ask for a response.

Invite your legislators to tour your facility

Giving a tour of your cancer center is an excellent way to get to know your legislators, all while explaining what radiation oncology is in the environment where treatments are given.

During the tour, explain what radiation oncology is, walk through treatment planning and the different pieces of equipment in your facility.

Be sure to contact ASTRO government relations staff for additional help or tips before the tour.

It is never a waste of time

Don't see eye to eye with your legislator? Your legislator doesn't agree with your position on self-referral? It's ok! Educating and informing legislators is not a waste of time, regardless of their stance on the issue. Even if your legislator does not support you on self-referral, they may support you on other issues in the future.

Most legislators have medical advisory boards that they turn to when working on health care legislation. This is a great opportunity to develop a relationship with your legislator and is critical to ensuring that the voice of radiation oncology is heard on the state level. If your legislator doesn't have a radiation oncologist on their medical advisory board, ask to join. You should also let them know that you are willing to testify at hearings. This will help you and radiation oncology gain credibility with your legislator.

Political Fundraising

No one in politics likes to fundraise. Just like you would rather be treating patients, legislators would rather be working on policy and meeting with constituents than fundraising. Unfortunately raising money is necessary to stay in office. By becoming a part of this endeavor, you earn credibility with the candidate.

Hosting an event

Hosting a fundraiser is the perfect way to show your support for radiation oncology and the candidate. First, you will need to work with the legislator's fundraiser to:

- Set a fundraising goal/minimum expectation for the event.
- Schedule a date and time.
- Decide on a location. This can be at your home, cancer center, friend's home or wherever you are most comfortable.
- Determine the type of event. Most fundraisers are reception style with hors d'oeuvres or light refreshments.

Bringing in the money

After working out the logistics with the fundraiser, you will need to determine the scope of your fundraiser. Will your event be a radiation oncology-specific fundraiser or will it include other specialties?

When asking for money, make sure you:

- Ask colleagues within your practice to contribute.
- Communicate via phone, email, or in your practice's staff meeting.
- Ask those who have confirmed to attend your event to reach out to their own colleagues.

Fundraising do's and don'ts

Do:

- Practice your pitch before you approach your colleagues.
- Ask for more money than you think someone will give.
- Be personable when asking for money.
- Use peer pressure.
- Ask committed colleagues to reach out to their own network.
- Build a fundraising network. Create a list of colleagues you can go to next time you host an event.
- Introduce the legislator, then give them time to talk.
- Keep your comments brief at fundraisers.
- Check with the fundraiser to confirm that political contributions need to be made with personal, not business checks.
- Check your state's regulations before giving. State maximum giving levels vary between \$100 - \$500 per election cycle.

Don't:

- Be afraid to ask for money.
- Wait to the last minute to fundraise.
- Have fundraisers on Friday nights. This tends to be the most difficult day to schedule an event.
- Discuss political fundraising in federal or state official buildings.

Step 6

Other Policy Approaches

Self-referral
Toolkit



for State-level Advocacy

AMERICAN SOCIETY FOR RADIATION ONCOLOGY

Other Policy Approaches

In addition to a standard legislative fix, the dynamics in some states may necessitate more creative policy approaches to restrict self-referral. Alternative approaches that have been used include instituting Certificate of Need laws and challenging anticompetitive practices through your state's Attorneys General's office.

Certificate of Need laws

In order to open a new private practice, some states' laws require that the demand/need for the service in a given area be demonstrated and deemed appropriate. These are referred to as Certificate of Need (CON) laws. These laws are aimed at restraining overall health care costs and allowing coordinated planning of new services and construction. The laws vary from state to state and some states have laws specific to radiation therapy.

Challenging anticompetitive practices in radiation oncology markets

In 2011, Pennsylvania's Attorney General filed a complaint in federal district court challenging the 2005 merger of five urology practices. The complaint alleged that the urologists' merger violated federal and state law because it monopolized urology and radiation oncology services in and around Harrisburg. If your region has become monopolized by a urology practice this is an excellent alternative tactic to a legislative fix.

Certificate of Need Laws (CON Laws)

State/District	CON	CON-RT	State/District	CON	CON-RT
AL	Yes		MT		
AK			NE		¹
AZ			NV		
AR			NH		
CA			NJ	Yes	No
CO			NM	No	No
CT			NY	Yes	Yes
DC			NC	Yes	Yes
DE			ND	No	No
FL			OH	Yes	No
GA			OK	Yes	No
HI			OR	Yes	No
ID	No	No	PA	No	No
IL	Yes	Depends ²	RI	Yes	Yes
IN	No	No	SC	Yes	Yes
IA	Yes	Yes	SD	No	No
KS	No	No	TN	Yes	Yes
KY	Yes	Yes	TX	No	No
LA	Yes	No	UT	No	No
ME	Yes	Yes	VT	Yes	Yes ³
MD	Yes	Yes	VA	Yes	Yes
MA	Yes	Yes	WA	Yes	No
MI	Yes	Yes	WV	Yes	Yes
MN	No	No	WI	Yes	No
MS	Yes	Yes	WY	No	No
MO	Yes	Yes			

Last updated Dec.31, 2011

¹ Previously had a CON requirement, but was removed a few years ago.

² CON is required for new equipment/facilities over \$7 million.

³ CON is required for any new equipment/facility over \$1 million.

How to challenge anticompetitive practices in radiation oncology markets

A summary and brief guide based on recent actions taken by Pennsylvania's Attorney General

I. Summary of Pennsylvania Attorney General's Complaint and Consent Decree

In late August 2011, Pennsylvania's Attorney General filed a complaint in federal district court challenging the 2005 merger of five urology practices in the Harrisburg area, which formed Urology of Central Pennsylvania (UCPA). The complaint alleged that the urologists' merger violated federal and state law because it monopolized urology and radiation oncology services in and around Harrisburg. As the complaint points out, UCPA accomplished this by first recruiting a radiation oncologist to its practice that none of its five constituent practices could have afforded to support on their own, and by then making all radiation oncology referrals to that specialty practice. The complaint further alleged that the merger succeeded in concentrating market power in such a manner that the prices of such services were driven upwards for local businesses and patients.

The Attorney General and UCPA agreed to the terms of a consent decree that a federal district court approved on the same day the complaint was filed. That consent decree gives UCPA partial relief from potential legal exposure for the alleged antitrust violations, but on the condition that UCPA comply with a long list of constraints on contracting, pricing and referral practices from now until July 2015. Those constraints, which include a lengthy and public annual report to the Attorney General, are designed to undo the alleged market-concentrating effects of the 2005 merger. For instance, the constraints seek to assure competition in the region's radiation oncology market by (a) requiring UCPA to limit the level of reimbursement rate increases it demands from payers; (b) prohibiting UCPA from including provisions in its contracts with payers that prevent those payers from contracting with competing providers; (c) prohibiting use of an MFN clause in contracts with payers that supply more than 15 percent of UCPA's patient volume; (d) requiring UCPA to permit its physicians to refer patients to non-UCPA providers, including for brachytherapy; and (e) requiring UCPA to provide prostate cancer patients with a list of non-UCPA radiation oncologists and explaining why the list is being provided.

II. How the Pennsylvania Attorney General Sought to Show that UCPA Was a Monopolist

To persuade a court that a market actor is a monopolist in violation of federal law (specifically, Section 2 of the Sherman Act and Section 7 of the Clayton Act), one must show that the actor

- 1) holds monopoly power in a given market, having
- 2) willfully acquired or maintained that power, and
- 3) does so in a way that adversely affects consumers.

"Monopoly power" means the power to raise prices above costs for a significant period of time. Courts infer "willful" anticompetitive intent from anticompetitive effects. Consumers are "adversely effected" when they are exposed to higher prices, or when they experience reduced access to competing technologies or to services offered by rival businesses.

In any antitrust case, geography and demand for particular services define the context for analysis, called the “relevant product market.” In the case of UCPA, the Attorney General identified two product markets within the Harrisburg market: the market for urology services and the market for radiation oncology services. Having identified those markets, the Attorney General analyzed factors that federal and state courts, the Department of Justice and the Federal Trade Commission traditionally consider when assessing monopolistic characteristics and effects, including:

- the indispensability to commercial payers of including urology and radiation oncology service providers in their product (network) offerings;
- referral patterns between urologists and radiation oncologists that treat prostate cancer;
- the distances that patients would be willing and able to travel in order to seek urology and radiation oncology services from providers other than UCPA;
- market concentration, *i.e.*, how many urology and prostate radiation oncology patients sought services from particular providers in the region;
- post-merger changes to services and technologies available to regional urology patients;
- post-merger changes to prices and reimbursement rates in the regional markets for urology and radiation oncology services, as well as the transparency (or lack thereof) of such changes to patients; and
- the potential for new market entrants to put downward pressure on concentration levels or pricing.

The Attorney General presented evidence that (a) the 2005 merger had resulted in extreme market concentration, price and reimbursement rate increases, and the regional elimination of brachytherapy services in favor of IMRT, which is more expensive and requires more visits to a treatment facility; (b) UCPA had cornered the regional market for radiation oncology for prostate cancer and maintained that advantage by bringing radiation oncologists in-house and then referring patients only to its own radiation oncologists – steps that made UCPA’s service offerings indispensable to regional payer organizations; (c) changes in price were not transparent to patients and (d) new entrants to the market were unlikely.

It should be noted that self-referrals for radiation oncology services do not, by themselves, amount to an antitrust violation. Such patterns of referral can be legal (from an antitrust perspective) if competing regional practices have comparable resources, or if the pattern had developed organically – *e.g.*, because the nearby competing urology practice’s physicians recently retired (though this latter case would constitute an antitrust grey area). In the case of UCPA, however, their referral patterns were alleged to follow a merger that secured market dominance, and could help maintain that dominance.

III. How to Reproduce The Pennsylvania Result

Generally, there are two steps involved in facilitating an investigation of the sort that resulted in the consent decree described above: getting the attention of the state Attorney General; and supplying sufficient evidence to the Attorney General that could convince a court of a violation. One can also bring concerns to the Antitrust Division of the U.S. Justice Department or to the Federal Trade Commission, which often conduct investigations in conjunction with state Attorneys General, and which also might investigate where a state Attorney General would not. The following description applies to the production of information to any of the regulatory entities about antitrust concerns.

All states’ Attorneys General have a website that provides contact information, and many also provide a form for submitting a complaint. California even provides a brochure that describes different forms of antitrust

violations and encourages business owners to make use of the California Attorney General's contact information to advise of potentially anti-competitive activity. At the outset, however, a phone call is usually best.

Before initiating a call, we suggest coordinating with ASTRO's Government Relations Department to ensure that ASTRO is aware of your efforts and can coordinate its federal advocacy with you. The initial phone conversations with the Attorney General's office may include questions about evidence of potential violations. Evidence one could provide to an Attorney General in order to inspire further investigation might include documents, data or correspondence reflecting:

- a merger or other market change involving the consolidation of a particular set of service offerings;
- increases in regional prices or reimbursement rates in managed care contracts for a particular service offering that exceed or would appear to create power to alter the historic rate of annual increase in reimbursement rates, both in the referred-from line of service and in the referred-to line of service;
- a conspicuous increase or decrease in patient or referral volume to one or more practices or evidence indicating that such a change is planned or imminent;
- the inability of competitors in the referred-to service line to attract patients in light of the foreclosure or bottleneck created by the self-referring group.

Documentation that may demonstrate such information could include news reports, comments from third party payers or patients, statements by employees or owners of the dominant medical group, and, though more often only in the hands of third party payer health plans, recent contracts or contractual amendments, coordination of benefits materials (reverse-engineering other providers' prices), financial records, reports generated from a database used to track service volume and utilization, or written communications. At the initial stage, submission of such documents to the Attorney General can be informal and should take whatever form the Attorney General's website suggests – but be sure to redact documents as needed, and to be clear about whether particular documents must remain confidential. In addition, note that greater attention will likely be paid if more than one party submits materials relating to the same circumstances or source of concern, so examine coordinating your approach with other physicians, health plans, hospitals or other affected entities.

While it is difficult to generalize about what one should expect from an Attorney General at this initial stage, weeks or even months of silence from an Attorney General should not be taken to indicate a lack of interest or absence of preliminary investigative effort.

Once open, an investigation's success requires evidence that recounts in detail regional medical businesses' service offerings, market share, referral patterns, prices, and reimbursement terms and trends with third party payers. Gathering together these details is made possible by the cooperation of market actors that each hold a piece of the larger puzzle in their contractual agreements, correspondence, financial records and records of patient visits, treatments and referrals. This task often entails extensive – and sometimes expensive – cooperation, in the form of making staff available for interviews and production of documents in a manner that complies with the Attorney General's particular specifications and other applicable legal requirements (such as HIPAA). Often the Attorney General would, if it pursues a matter, send a voluntary request for information, subpoena, or "civil investigative demand" to both the investigation's target and other sources of information about the marketplace. In addition, one should expect some but not much flexibility

over deadlines for such interviews and submissions. The deadlines asked of a witness or declarant will be the product of logistics, strategic considerations, legal rules and court filing requirements, all of which constrain any Attorney General who undertakes such an investigation. While the use of local outside counsel may be an added cost, it may pay dividends through the proper collection, identification, organization, presentation and production of concise but relevant materials, even those available publicly; ability and likelihood of garnering Attorney General interest; and witness preparation.

Having provided information and documentation to an Attorney General, one should expect to receive only limited information about the status of the inquiry. Assembling the evidence and witnesses required to put on a successful antitrust case means reinventing a wheel. Understand that this information will likely be kept confidential not just for the duration of the investigation but thereafter as well, unless the case goes to trial.

IV. Conclusion

For radiation oncologists facing unfair or anti-competitive activity in their markets, the Pennsylvania Attorney General's recent consent decree with UCPA serves as an example of one form of legal recourse that may be available. However, as explained above, the path to a consent decree, let alone Attorney General action, can be a long and uncertain one and can demand contributions of time and resources.

If you are interested in pursuing this path, please let ASTRO's Government Relations Department know so we can coordinate activities with you and complement your efforts at the federal level.

Websites of the Antitrust Division within the Office of each State's Attorneys General⁴

Alabama	http://www.ago.state.al.us/consumer.cfm
Alaska	http://www.law.state.ak.us/departments/civil/consumer/cpindex.html
Arizona	http://www.azag.gov/consumer/
Arkansas	http://www.arkansasag.gov/about_office_what_we_do_public_protection_department_antitrust_div.html
California	http://ag.ca.gov/antitrust/ ; see also "Antitrust Enforcement in California: How You Can Help" pamphlet at http://ag.ca.gov/antitrust/publications/antitrust.pdf .
Colorado	http://www.coloradoattorneygeneral.gov/departments/consumer_protection
Connecticut	http://www.ct.gov/ag/cwp/view.asp?A=2095&Q=293174
Delaware	http://www.attorneygeneral.delaware.gov/consumers/index.shtml
Florida	http://myfloridalegal.com/pages.nsf/Main/17762D6E4A39E9E185256CC600581B94
Georgia	http://law.ga.gov/02/ago/home/0,2705,87670814,00.html
Hawaii	http://hawaii.gov/ag
Idaho	http://www.ag.idaho.gov/consumerProtection/consumerIndex.html
Illinois	http://illinoisattorneygeneral.gov/consumers/ http://illinoisattorneygeneral.gov/consumers/antitrust_settlements.html
Indiana	http://www.in.gov/attorneygeneral/2353.htm

⁴ In many states, the Attorney General's office conducts antitrust cases from its Consumer Protection Division; for some states, the Attorney General's website does not provide specific contact information for a consumer protection or antitrust division.

Iowa	http://www.iowa.gov/government/ag/contact_us/index.html
Kansas	http://www.ksag.org/page/contact-us
Kentucky	http://ag.ky.gov/
Louisiana	http://www.ag.state.la.us/Article.aspx?articleID=28&catID=0
Maine	http://www.maine.gov/ag/consumer/
Maryland	http://www.oag.state.md.us/contact.htm
Massachusetts	http://www.mass.gov/?pageID=cagoutilities&L=1&sid=Cago&U=Cago_contact_us
Michigan	http://www.michigan.gov/ag/0,4534,7-164-19441-60568--,00.html
Minnesota	http://www.ag.state.mn.us/Office/ContactUs.asp
Mississippi	http://www.ago.state.ms.us/index.php/contact
Missouri	http://ago.mo.gov/divisions/consumer-protection-division-faqs.htm
Montana	http://www.doj.mt.gov/consumer/default.asp
Nebraska	http://www.ago.ne.gov/complaint
Nevada	http://ag.state.nv.us/about/contact/contact.html
New Hampshire	http://doj.nh.gov/consumer/
New Jersey	http://www.njconsumeraffairs.gov/ocp/
New Mexico	http://www.nmag.gov/office/contact.aspx
New York	http://www.ag.ny.gov/bureaus/antitrust/enforcement.html
North Carolina	http://www.ncdoj.gov/Consumer.aspx
North Dakota	http://www.ag.nd.gov/cpat/CPAT.htm
Ohio	http://www.ohioattorneygeneral.gov/Legal/Antitrust
Oklahoma	http://www.oag.ok.gov/oagweb.nsf/
Oregon	http://www.doj.state.or.us/contact.shtml
Pennsylvania	http://www.attorneygeneral.gov/theoffice.aspx?id=71
Rhode Island	http://www.riag.ri.gov/civil/antitrust/index.php
South Carolina	http://www.scag.gov/contact-us
South Dakota	http://atg.sd.gov/TheOffice/ContactUs.aspx
Tennessee	http://www.tn.gov/attorneygeneral/contact.html
Texas	https://www.oag.state.tx.us/agency/civil.shtml
Utah	http://attorneygeneral.utah.gov/antitrust.html
Vermont	http://www.atg.state.vt.us/issues/antitrust.php
Virginia	http://www.oag.state.va.us/Consumer%20Protection/index.html
Washington	http://www.atg.wa.gov/antitrust.aspx
West Virginia	http://www.wvago.gov/contact.cfm
Wisconsin	http://www.doj.state.wi.us/ag/contact.asp
Wyoming	http://attorneygeneral.state.wy.us/index.html

Step 7

Engaging the Local Media

Self-referral
Toolkit



for State-level Advocacy

AMERICAN SOCIETY FOR RADIATION ONCOLOGY

Engaging Your Local Media

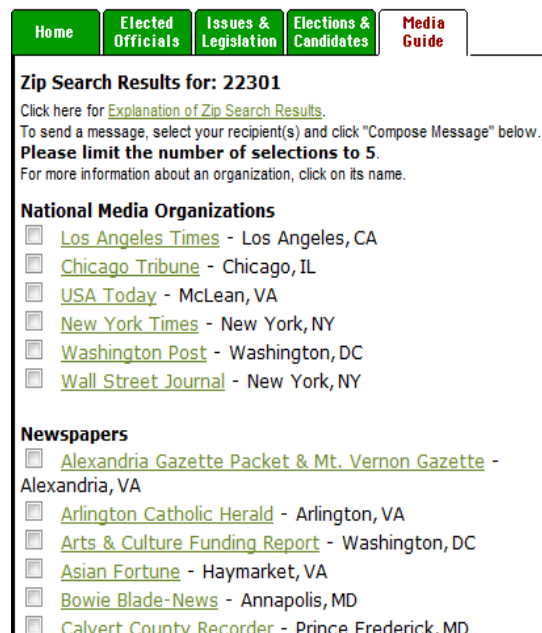
Engaging your local media is one of the most effective methods to bring attention to your issue. When your issue is highlighted by the media you can also influence other constituents, which your legislators will find compelling.

You can involve your local media by writing editorials or an op-ed, sending out press releases from your coalition, establishing relationships with reporters, or organized news events or press conferences.

ASTRO's media resources

ASTRO has many resources to help you involve the media with your state legislative activities, including:

- [ASTRO's website](#) - Find out who your local media are through our online database.



The screenshot shows the ASTRO Media Guide website. At the top is a navigation bar with five tabs: Home, Elected Officials, Issues & Legislation, Elections & Candidates, and Media Guide (which is highlighted). Below the navigation bar, the page title is "Zip Search Results for: 22301". There is a link to "Click here for Explanation of Zip Search Results." and instructions to "To send a message, select your recipient(s) and click 'Compose Message' below. Please limit the number of selections to 5. For more information about an organization, click on its name." The page is divided into two main sections: "National Media Organizations" and "Newspapers". Each section contains a list of media organizations with checkboxes next to them. The "National Media Organizations" list includes Los Angeles Times, Chicago Tribune, USA Today, New York Times, Washington Post, and Wall Street Journal. The "Newspapers" list includes Alexandria Gazette Packet & Mt. Vernon Gazette, Arlington Catholic Herald, Arts & Culture Funding Report, Asian Fortune, Bowie Blade-News, and Calvert County Recorder.

Home	Elected Officials	Issues & Legislation	Elections & Candidates	Media Guide
Zip Search Results for: 22301				
Click here for Explanation of Zip Search Results .				
To send a message, select your recipient(s) and click "Compose Message" below.				
Please limit the number of selections to 5.				
For more information about an organization, click on its name.				
National Media Organizations				
<input type="checkbox"/> Los Angeles Times - Los Angeles, CA				
<input type="checkbox"/> Chicago Tribune - Chicago, IL				
<input type="checkbox"/> USA Today - McLean, VA				
<input type="checkbox"/> New York Times - New York, NY				
<input type="checkbox"/> Washington Post - Washington, DC				
<input type="checkbox"/> Wall Street Journal - New York, NY				
Newspapers				
<input type="checkbox"/> Alexandria Gazette Packet & Mt. Vernon Gazette - Alexandria, VA				
<input type="checkbox"/> Arlington Catholic Herald - Arlington, VA				
<input type="checkbox"/> Arts & Culture Funding Report - Washington, DC				
<input type="checkbox"/> Asian Fortune - Haymarket, VA				
<input type="checkbox"/> Bowie Blade-News - Annapolis, MD				
<input type="checkbox"/> Calvert County Recorder - Prince Frederick, MD				

- ASTRO staff - Contact ASTRO's Communications Department for talking points, background material, B-Roll and stock photos for the media. Remember that ASTRO's communication team is always willing to assist you with your interactions with the media.
- ASTRO Media Guide – ASTRO has resources for you to use that include a guide to speaking with the media.

Utilizing new media

Social media can be intimidating, but when working with the press, it is an essential component to getting coverage on your issue. If you prove to be useful to the media, they will continue to use you as source of information and be more open to telling your story.

- 90 percent of journalists have a Twitter handle. See what they tweet about. Do they have a blog? If they mention health related topics, make sure you provide your medical perspective and respond to what they report.
- 40 percent of journalists prefer to receive tips via Twitter. When you have a success on your issue, tweet it to your local media.

How to handle pushback

Engaging the media can be daunting but always do your best to stay on message, no matter where they try to lead the discussion. Do not lose your cool, regardless of how frustrating the situation is. Always remember, nothing you say is ever really “off the record,” so think before you speak. Also, be sure to turn questions into an opportunity to share your message.

Understanding Radiation Oncology: Talking Points

Who am I?

- I am a radiation oncologist, a doctor who is part of a team of highly skilled, caring professionals treating cancer patients in your state.
- I treat [insert # of] patients each year using radiation therapy – the careful and precise use of radiation to kill fast-growing cancer cells while minimizing damage to the body and limiting the side effects of treatment.

What is radiation oncology?

- Radiation oncology is an important treatment option for cancer patients.
- Radiation oncology, or radiation therapy, has been used to treat cancer patients for more than 100 years. More than 1 million cancer patients receive radiation therapy every year. It is most often used to treat breast, prostate and lung cancer.
- Thanks to remarkable advances in radiation oncology and technology, we can treat breast cancer without removing the breast and brain tumors without having to open a person's skull.
- Radiation therapy can be delivered externally, by using advanced technology to beam high-energy radiation at the cancer, or internally, by delivering an intravenous injection or inserting radioactive "seeds" directly into the tumor.
- Radiation therapy alone can cure cancer and relieve pain. Radiation therapy is often used in combination with surgery and/or chemotherapy. For example, patients may be treated with radiation before surgery to help shrink the cancer, allowing a less extensive surgery than would otherwise be needed. Radiation oncology may be used after surgery to reduce likelihood of recurrence. Radiation also is used with chemotherapy to improve cancer control while preserving organ function and quality of life.
- Radiation therapy is targeted and is less invasive than other cancer treatments, making it a good treatment option for men and women who want to maintain their lifestyles and jobs while receiving treatments.

Self-Referral in Radiation Oncology

Background

Physician self-referral is the practice of a physician ordering a service for a patient that is performed either by that individual physician or by a facility from which they derive a financial benefit for the referral. Due to the inherent financial incentive to self-refer, the Stark Law was passed to place some restrictions on the practice of physician self-referral. Added to the Stark Law in the early 1990s, the in-office ancillary services (IOAS) exception allows physicians to bill Medicare for the self-referral of certain services. This exception was originally intended to facilitate the rapid diagnoses and initiation of treatment during a patient's office visit. Over the years however, abuse of the IOAS exception has substantially broadened the exception, making it much easier for physicians to avoid the law's prohibitions by structuring arrangements to meet the technical

requirements, but not the intent of the exception. For example, the most common arrangement occurs when a group of urologists pool resources to open a free-standing radiation therapy center as part of their large urology practice. However, the radiation therapy services are not truly integrated with the physician organization because they will typically be set up in a geographic location separate from the urology practice. The radiation oncologist and his/her technical staff will function apart from the group on a day-to-day basis with little or no integration of the physicians, staff, locations or services.

For patients with localized prostate cancer, there are four courses of treatment considered “clinically equivalent” according to a 2008 report by the federal Agency for Healthcare Research and Quality: (1) external beam radiation therapy, (2) radioactive seeds (brachytherapy), (3) prostate surgery and (4) active surveillance. The report noted that because the treatments have varying side effects, individual patient preferences are an important factor in determining a management strategy. The National Comprehensive Cancer Network clinical guideline states that a patient with clinically localized prostate cancer should be informed about the commonly accepted interventions, and a discussion of the anticipated benefits and risks of each intervention should occur with the patient.

Determining the most appropriate prostate cancer treatment option is an involved process that depends on the patient’s preferences, age, concerns, co-morbidities and physiology. Data shows that when referring urologists own radiation therapy facilities, they are so heavily incentivized to refer their patients for external beam radiation therapy services that their clinical decision-making becomes biased and likely leads to overutilization of radiation therapy. Specifically, these models channel referrals to a particular radiation therapy, called intensity modulated radiation therapy (IMRT). IMRT is particularly of interest because of the technical fees that are billed by the owner of the linear accelerator. In January 2009, the Institute for Clinical and Economic Review produced a report comparing the clinical benefit and costs of the various treatments for low-risk prostate cancer. The report concluded that the rates of survival and tumor recurrence are similar among the most common treatment approaches, although costs can vary considerably, with surgery and brachytherapy costing significantly less than IMRT.

Physicians, especially those who are in a position to refer patients for radiation therapy services, have realized that if the provision of these services and the related billing of the technical fees for the equipment can be “captured,” financial gain can be achieved based upon the referral decisions. This business dynamic has been identified, packaged, and is being marketed to physician groups, particularly within the urology community, by for-profit companies that specialize in fueling the enthusiasm about lucrative joint ventures with financially aggressive physicians.

Message Points

- ASTRO is very concerned that new forms of physician business arrangements that have exploited the in-office ancillary services exception to the Stark Law have led to a skewed system of referral decisions driven by profits instead of what is best for the patient. The patient often is not aware that the referring physician is deriving a financial benefit from the referral. More importantly, the patient may not be fairly offered and advised about the choice of therapies available.
- Under these arrangements, the quality of cancer care suffers.
 - Practices steer patients toward the services they wish to offer, rather than those that might be best for the patient.
 - Given the financial return that a urology group can realize on some radiation therapy treatments, there is considerable risk that “active surveillance,” surgery or brachytherapy will not be thoroughly presented to the patient as viable treatment options. Therefore, patients who may not need treatment could be treated, putting them at unnecessary risk for side effects.
- *The Wall Street Journal* investigated several group practices in 2010 that have used the self-referral exception to bring radiation therapy services into their offices. The article revealed two major findings:
 - Urology groups that brought a radiation therapy machine into their practices had utilization rates well above national norms for IMRT treatment for prostate cancer. Moreover, the practice patterns for these groups showed dramatic utilization increases from before they owned the machines to after.
 - These practices treated a higher than average number of men over the age of 80 with IMRT for their low-risk prostate cancer. Experts agree that in most instances, 80+ year old men with low-risk prostate cancer do not need aggressive treatment.
- In 2011, *The Washington Post* also featured a story that exposed self-referral abuses in radiation oncology. The article quotes world-renowned Johns Hopkins urologist, Dr. Patrick Walsh, as criticizing the “for-profit motive” that is affecting treatment decisions for some physicians involved in self-referral arrangements.
- A *Baltimore Sun* article in 2012 described how a Maryland urology clinic’s prostate cancer referrals for IMRT tripled after they purchased a radiation therapy machine. As the article states, “The more patients the Baltimore-area urologists referred for that expensive therapy alternative, the more revenue and profits they would generate.”
 - The Maryland data is part of a national study by Georgetown University coming in mid-2012. It is expected to show that urology practices across the country drastically increased expensive IMRT referrals after they acquired a radiation therapy machine.
- By setting up a business model that tends to drive patient referrals to the most expensive treatment option, many cancer patients are denied the independent clinical judgment and choice they need and deserve.
- In addition, a published survey of radiation oncology residency program directors across the country revealed that 27 percent of residency programs in communities with this type of business arrangements reported a negative impact on residency training as a result of decreased referrals to

their centers. While this is a small survey sample, it foreshadows large quality problems in the future if residents do not see enough patients to develop the expertise needed to treat prostate cancer patients.

- ASTRO is actively working to end these abuses by closing the loophole that allows for these arrangements. ASTRO is working to limit the use of the exception so that only robust, integrated and truly collaborative multi-specialty group practices can offer radiation therapy services through the exception.
- There's still a chance to stop this abusive activity before it gets out of control, and lawmakers must act soon. Not only do we need to protect these patients, but this is undoubtedly resulting in unnecessary Medicare spending at a time when everyone wants to control health care costs, reduce the deficit and help sustain the Medicare program.



ASTRO Media Guide

Speaking with the media is a great way to promote your work and your facility while helping ensure that people in your area are aware of the lifesaving treatments you and your colleagues provide. It is also a great way to promote our specialty.

To assist you in preparing for interviews, we have put together the following pointers. This information can also help you convey your message to elected officials and regulators.

ASTRO Talking Points

Since 2003, ASTRO has been conducting surveys to better understand the public's knowledge of and attitude toward radiation therapy. When you speak with the public or the media, please try to keep this information in mind.

1. **Do not assume that the public understands what you do or how you do it.** In general, the public is not well-versed on radiation therapy or radiation oncology. Be sure to explain that you are a radiation oncologist — a doctor who specializes in delivering high doses of radiation to specific parts of the body to treat cancer and other diseases. You may also need to explain that you are not a radiologist — a doctor who uses radiation to diagnose disease and detect other health problems.
2. **When explaining a procedure, be sure to explain in the most basic terms what each treatment does and how it differs from the others.** Although you know the differences between the various types of treatments (external beam, IMRT, brachytherapy, etc.), reporters and the public usually don't understand the differences.
3. **The public likes the concept of a team approach with a strong leader (a radiation oncologist) at the helm.** Talk about the extensive training you have undergone to become a radiation oncologist as well as the combined expertise of the other members of the treatment team.
4. **The public wants to know that a physician is in charge of their treatment, not a machine.** When you are talking about equipment and technique, be sure to discuss them in terms of how the doctor and the team use them to improve treatment. Avoid the impression that the machine and software do all the work and planning.
5. **It is important to emphasize that radiation therapy is a safe and effective cancer treatment.** The public needs to know that this is not a new treatment, rather it has been used safely and effectively for more than 100 years.
6. **The public likes the concept that the body naturally eliminates the cancer cells after the radiation therapy damages them.** The idea of the body working with the cancer treatment is a powerful image.
7. **People like that radiation therapy spares healthy tissue.** Also mention that any healthy cells affected can repair themselves naturally in a way cancer cells cannot.
8. **Be sure to differentiate how these treatments impact the body. Most people believe that hair loss, nausea, weakness and weight loss are automatically side effects of all cancer treatments.** To the public, the side effects of chemotherapy and radiation therapy are the same.
9. **Many people are afraid radiation hurts.** Be sure to emphasize that radiation therapy treatments themselves are painless and noninvasive, much like getting an X-ray.
10. **Emphasize that radiation therapy is effective in curing cancer, sometimes alone or in combination with other treatments.** Radiation is sometimes perceived as a treatment of last resort — something that is used after all other treatments have failed.

Radiation may initially conjure up some negative images, but the public is receptive to learning more about radiation therapy. Emphasizing these points will help the public feel more positive toward radiation therapy and the specialists that use it.

General Media Tips

So a reporter has just asked to interview you. Say yes! Then don't panic! Just follow these simple tips and you will do fine.

1. **Do your homework.** If a reporter calls you for a story, find out as much as you can about what the story is about. For example, is it a general article on Breast Cancer Awareness Month? Has a public figure been diagnosed with prostate cancer? Is the article about a new technology? Once you find this out, ask the reporter for five minutes to collect your thoughts and then call him or her back. Be sure to actually call the reporter back in five minutes like you promised. Never keep a reporter waiting if you can help it.
2. **Learn about the medium and audience.** There are thousands of media outlets in existence – daily and weekly newspapers and monthly magazines (both in print and online), Internet health sites, online publications, blogs, social media sites, and radio and television stations. Find out what type of media outlet it is so you can phrase your answers for the audience. ASTRO can help by providing photos or b-roll video footage to help illustrate the specialty. Call ASTRO's Communications Department at 1-800-962-7876 for help gathering the appropriate materials.
3. **Keep it short.** Once you know the topic and type of media outlet, think about what your answers will be and develop short take-home message points. Jotting down your messages first will help you stay on track during the interview and help keep you from becoming flustered. ASTRO can also help you create your message points.
4. **Practice your thoughts.** No matter what the media outlet, it's important to have short sound bites that are easy to put into a story. Practice ahead of time so you are able to say your main message in a few seconds.
5. **Don't be afraid to correct a reporter.** If the reporter misunderstands you, don't hesitate to correct them. If you do not, you risk incorrect information running in the article.
6. **Bridge your message.** During the interview, the reporter may drift off topic. Be able to "bridge" your message back to the subject you want to talk about. If you sense you are getting off track, refer to your notes to find a way to get back to your main message.
7. **Keep it simple.** Radiation therapy is a very complicated specialty so try to avoid using technical terms. If the terms are important to the story, work hard to explain them in language the public can understand.
8. **Avoid distractions.** It's important to focus on the interviewer to avoid distractions. If you are interviewed in person, try to maintain eye contact with the interviewer. If you are interviewed over the phone, standing during the interview may help you stay focused. Always use the handset for a phone interview – never use a speakerphone. For television interviews, don't look at the camera unless instructed. Be sure to silence your pager or cell phone so they do not distract you during your interview.
9. **Dress conservatively.** If you are going to be interviewed in person, dress conservatively and avoid flashy jewelry. If you look professional, the interviewer is more likely to focus on what you are saying.
10. **Don't Guess.** If you don't know the answer to a question, answer honestly. It is always okay to say, "I don't know." This gives you credibility.
11. **There is no such thing as "off the record."** It can be easy to lapse into being more open with a reporter that you might be otherwise if you go off the record. Unfortunately, there is no guarantee that the information you provide won't end up in the story later.

If you have a question about an interview, call ASTRO's Communications Department at 1-800-962-7876. They will be happy to help you prepare.