

## **CARE FAQs**

### **Questions (and Answers) About the Consistency, Accuracy, Responsibility and Excellence (CARE) in Medical Imaging and Radiation Therapy Bill**

#### **1. What will the CARE bill do?**

The CARE bill will amend and enforce the Consumer-Patient Radiation Health & Safety Act of 1981 (42 USC 10001, et seq.), and charge the Secretary of the Department of Health & Human Services (HHS) to promulgate updated regulations specifying the education and credentialing requirements for persons who perform medical imaging examinations and who plan and deliver radiation therapy treatments.

#### **2. Why isn't the 1981 CPRHSA unenforceable?**

The Consumer-Patient Radiation Health & Safety Act of 1981 was lobbied by the ASRT for more than 10 years. When the bill was on the Senate floor for the final vote a political bargain was struck to ensure the bill's passage and the enforcement mechanism was stripped out in an amendment. This law directed HHS to develop regulations specifying the education and credentialing of radiographers, radiation therapists, dental radiographers, sonographers and nuclear medicine technologists, but there are no legally enforceable penalties for states which chose not to comply by adopting the education and credentialing standards. In 1985 ASRT initiated legal action requiring HHS promulgate regulations (42 CFR 75), however states face no penalty for not meeting the HHS regulations and they are now considered to be "federally-recommended guidelines" for states to follow.

#### **3. If there are Federal standards in place why don't states follow them?**

Some states have chosen to follow the Federal standards and have put state laws or regulations into place specifying the education and credentials for medical imaging and radiation therapy personnel; many state laws set standards significantly lower than the federal recommendations. States that have not followed the Federal guidelines cite many reasons including impasses in the state legislative bodies, lack of evidence supporting a benefit, states-rights and the non-applicability of 20 year-old standards in today's health care environment.

#### **4. How will the CARE Bill make the 1981 CPRHSA enforceable?**

Looking at the bill it may appear that there isn't much meat" on it specifying educational and credentialing standards. This is because the bill amends the 1981 CPRHSA to make the law enforceable. The CARE bill makes it a condition of payment under all federal health insurance programs (Medicaid and Medicare) that medical imaging and radiation therapy personnel working in facilities receiving Medicaid/Medicare payments or working for physicians receiving Medicaid/Medicare payments must meet the federal education and credentialing requirements or the insurance claim for imaging or therapy services will not be paid. The end result is that medical imaging and radiation therapy professionals will have to meet the Federal education and credentialing standards set by HHS.

#### **5. Will Medical imaging and radiation therapy professionals be required to get a Federal license to practice?**

No. Medical imaging and radiation therapy professionals will either have to get a state license to practice (and all states that license personnel will have to issue licenses based on the Federal education and credentialing standards) or medical imaging and radiation therapy professionals will have to meet the Federal standards in order to have their services paid for by Medicaid/Medicare. There will be no federal license to practice, at most only a state license.

#### **6. Why don't we write standards into the bill/law?**

Writing education and credentialing standards into the CARE bill and ultimately into the 1981 CPRHSA would require us to start from scratch. The CARE bill builds on the existing law and enhances it. Writing standards into law would require a complete rewrite of the 1981 CPRHSA. It is politically more feasible to just amend the portion of the CPRHSA regarding enforcement and to keep the regulations specifying the education and credentialing standards under the authority of HHS. HHS is more knowledgeable about the specific educational and credentialing guidelines for medical professionals than the 535 voting members of Congress.

### **7. If we don't write the standards in to the bill/law, how will we get what we want?**

As evidenced by the 1981 CPRHSA, many times political bargains are struck and we don't always get the perfect" outcome. However by developing strategic alliances, developing materials in advance, rather than leaving them to someone else to write, and engaging professional representation on Capitol Hill and for our work with HHS were prepared to get as close to perfect" as we can. Even by writing the standards into the bill/law, it's uncertain as to what will come out of Congress or even if the bill will be passed into law, but with the standards written into the bill, they will most likely not be what we want.

### **8. How can we ensure that HHS will write "good" standards?**

Once the CARE Bill is passed, HHS is required by the Federal Administrative Procedures Act to publish in the *Federal Register* a notice called a Notice of Proposed Rulemaking (NPRM)." This is an opportunity for the public to comment on what they think should be included in the education and credentialing standards. AAPM and ACMP, along with the Alliance for Quality Medical Imaging & Radiation Therapy, has been working on a comprehensive draft of updated education and credentialing guidelines to provide to HHS when the rulemaking process begins. This document will most likely be the document upon which HHS will base their education and credentialing standards. Other organizations may also make comments, but the majority of organizations who would normally make public comments on proposed education and credentialing regulations have already been working on the Alliance draft.

### **9. If we get "good" standards, how can we make sure they won't arbitrarily be changed by HHS in the future?**

HHS must follow the Administrative Procedures Act before any regulatory changes can be made. This means that ASRT and the Alliance will have the opportunity during the public comment period to bring any bad" standards or inconsistencies to HHS attention before they are finalized. Also, if HHS does not publish good standards and the imaging and radiation therapy community feels strongly about it there are legal remedies that can be pursued.

### **10. Why are we updating the 1985 HHS educational and credentialing standards?**

In the 20 years since these standards were published there have been vast changes in the imaging and radiation therapy sciences. New technologies and professions such as MRI and medical dosimetry have emerged. Medical physics is playing a larger role in patient care and radiologic technologists' duties have changed substantially. New educational accreditation methods need to be recognized along with expanded competencies, credentialing requirements and credentialing organizations. Ideally, we should look at the federal educational and credentialing standards every 10 years and ensure they are still applicable to the profession and the practice environment.

### **11. Will the CARE bills exacerbate the personnel shortage?**

Even though medical imaging and radiation therapy professionals are in short supply in some areas, the CARE bill will not exacerbate the shortage. The CARE bill will ensure that all medical imaging and radiation therapy professionals meet educational and credentialing standards and specify a generous timeframe for states, employers and individuals to comply. Additionally, the CARE legislation gives the Secretary of Health and Human Services some latitude to issue alternative regulations based on defined criteria if needed to preserve patients' access to care. As a historical perspective, a 1976 study conducted by the American Society of Radiologic Technologists and the American College of Radiology showed that mandatory state licensure had no significant effect upon technologist manpower in terms of recruitment, availability or compensation.

### **12. What is the Alliance for Quality Imaging & Radiation Therapy?**

The Alliance is a coalition of 20 organizations supporting the need for federal educational and credentialing standards for medical imaging and radiation therapy professionals. Founding members of the Alliance are the American Society of Radiologic Technologists (ASRT) and Society of Nuclear Medicine-Technologist Section (SNMTS). Other members of the Alliance are the American Association of Medical Assistants (AAMA), American Association of Medical Dosimetrists (AAMD), American Association of Physicists in Medicine (AAPM), American College of Medical Physics (ACMP), American

Registry of Radiologic Technologists (ARRT), Association of Educators in the Imaging and Radiologic Sciences (AEIRS), Association of Vascular and Interventional Radiographers (AVIR), Cardiovascular Credentialing International (CCI), Joint Review Committee on Education in Cardiovascular Technology (JRCCVT), Joint Review Committee on Education in Radiologic Technology (JRCERT), Joint Review Committee on Educational Programs in Nuclear Medicine Technology (JRCNMT), Nuclear Medicine Technology Certification Board (NMTCB), Section for Magnetic Resonance Technologists (SMRT), Society of Diagnostic Medical Sonographers (SDMS), Society for Radiation Oncology Administrators (SROA) and the Society of Invasive Cardiac Professionals (SICP). Other organizations supporting the Alliance and attending Alliance meetings are the Conference of Radiation Control Program Directors (CRCPD), American College of Radiology (ACR) and American Society for Therapeutic Radiation Oncology (ASTRO).

### **13. What other groups support the CARE bill?**

Patient groups, social advocacy organizations and radiology industry support the CARE bill. Some of the supports of the CARE bill include: American Cancer Society, American Heart Association Council on Cardiovascular Radiology, American Organization of Nurse Executives, American Osteopathic College of Radiology, Cancer Research Foundation of America, Conference of Radiation Control Program Directors, Help Disabled War Veterans, Help Hospitalized Veterans, Imatron, Inc., International Society of Radiographers and Radiological Technologists, National Coalition of Cancer Survivorship, Medical Imaging Consultants, Inc. and Philips Medical Systems, Inc.

### **14. Why don't all professional/certification/accreditation organizations participate in the Alliance?**

Many organizations, such as the American Healthcare Radiology Administrators (AHRA) and Joint Review Committee on Education in Diagnostic Medical Sonography participate in the Alliance as observer organizations" and may become full Alliance members. All interested parties are encouraged to participate in Alliance discussions.

### **15. When did ASRT and the Alliance start working on the CARE bill? How long has this been going on?**

The Alliance has been working on the CARE bill since 1998. The first CARE Bill was introduced in 2000 in the last days of the 106th Congress by Rep. Rick Lazio (R-NY) as H.R. 5624. It was reintroduced in the 107th Congress in 2001 by Rep. Heather Wilson (R-NM) as H.R. 1011, and introduced again in the 108th Congress in 2003 by Rep. Wilson as H.R. 1214. The Senate CARE bill (called the RadCARE bill) was introduced in 2003 by Senator Mike Enzi (R-WY) as S. 1197. The CARE and RadCARE bills were reintroduced in the 109th Congress as H.R. 1426 by Rep. Chip Pickering (R-MS) and S. 2322 by Senator Mike Enzi (R-WY). The CARE bill will be reintroduced in the 110th Congress when it convenes in 2007.

### **16. Why does the CARE bill include ultrasound?**

When we first started working on the CARE bill the proposal required each state to license imaging and therapy personnel. Ultrasound organizations had determined that state licensure is not an appropriate regulatory approach for sonography, asked to be exempted from the legislation and chose to pursue sonography-specific educational and credentialing standards that did not require state licensure. Ultrasound is now included in the CARE bill at the request of sonography professional organizations. Magnetic resonance imaging (also a nonionizing form of radiation used for medical imaging) organizations participate in the Alliance and MR is a discipline that is included in the CARE bill.

### **17. When will the CARE bill be passed and enacted?**

ASRT and the Alliance feel that the CARE bills are important pieces of patient quality care legislation and are committed to seeing them enacted. We came very close in the 109th Congress when the bill was passed in the Senate and missed passing the House by mere hours before Congress adjourned. We are hopeful that the bills will be acted on in the 110th Congress.

### **18. Isn't the CARE bill just another MQSA?**

MQSA (the Mammography Quality Standards Act) was comprehensive legislation that tied federal standards for the performance of mammography procedures to federal reimbursement. While MQSA has been shown to increase the safety and efficacy of mammography, the MQSA standards covered personnel qualifications, facility inspections, quality control and physician assessment of mammograms. The CARE bill speaks only to personnel qualifications through evidence of education and credentialing for medical imaging and radiation therapy professionals.

### **19. You state that the CARE bill will help the federal government save money. How?**

The CARE bill will reduce health care costs by lowering the number of medical imaging examinations that must be repeated due to improper positioning or poor technique by requiring that personnel who perform medical imaging examinations meet educational and credentialing standards. Repeated imaging examinations cost the U.S. health care system millions of dollars annually in needless medical bills. According to the Radiologic Sciences of North America (RSNA) journal *Radiology*, approximately 130 million diagnostic radiology procedures are performed on 30 million Medicare enrollees a year<sup>1</sup>. Approximately \$9.3 billion was spent by Medicare on medical imaging in 2003 (according to the Medicare Payment Advisory Commission MedPAC)<sup>2</sup>. If the national repeat examination rate is between 4% and 7%, averaging 5.5%, and the CARE bill can lower the repeat rate from 5.5% to 4.5%, enacting education and credentialing standards could save Medicare nearly \$92 million a year.

a. *Radiology 2005; 234:824-832, Sunshine and Bhargavan, Utilization of Radiology Services in the United States: Levels and Trends in Modalities, Regions and Populations.*"

b. *Statement of Mark Miller, Executive Director, Medicare Payment Advisory Commission, Testimony Before the Subcommittee on Health of the House Committee on Ways and Means, March 17, 2005.*

### **20. In a nutshell, what are the standards?**

The disciplines included and a synopsis of the Alliance-recommended standards are:

- **Radiographer** Completion of a JRCERT or equivalent radiography program and certification and ongoing registration in radiography by the ARRT.

- **Cardiovascular-interventional, Cardiac-interventional or Vascular interventional Radiographer** ARRT certification and ongoing registration in radiography and CV, CI or VI radiography.

- **Radiation Therapist** Completion of a JRCERT or equivalent radiation therapy program and certification and ongoing registration in radiation therapy by the ARRT.

- **Nuclear Medicine Technologist** Completion of a JRCNMT or equivalent nuclear medicine technology program and certification and ongoing registration in nuclear medicine by the ARRT or NMTCB.

- **Magnetic Resonance Technologist** Completion of a JRCERT or equivalent magnetic resonance program or documented supervised clinical experience making the applicant certification-eligible, and certification and ongoing registration in magnetic resonance by the ARRT.

- **Cardiovascular Invasive Specialist** Completion of a JRCCVT or equivalent program in cardiovascular technology or documented supervised clinical experience making the applicant certification-eligible, and certification and ongoing registration as a registered cardiovascular invasive specialist by CCI.

- **Medical Dosimetrist** Completion of a JRCERT or equivalent medical dosimetry program or documented supervised clinical experience making the applicant certification-eligible, and certification and ongoing registration as a registered medical dosimetrist by the Medical Dosimetry Certification Board (MDCB).

- **Medical Physicist** Masters or doctoral degree from an accredited college or university in physics, medical physics, biophysics, radiological physics, medical health physics or equivalent courses making the applicant board-eligible; two years of supervised clinical practice and board certification by the American Board of Radiology, American Board of Medical Physics, American Board of Science in Nuclear Medicine or Canadian College of Physics in Medicine.

- **Radiologist Assistant** Certification and ongoing registration as a radiographer and radiologist assistant by ARRT.
- **Sonographer** - Completion of a Joint Review Committee on Education in Diagnostic Medical Sonography (JRCEDMS) or equivalent program in sonography or active certification as a sonographer by the American Registry of Diagnostic Medical Sonographers (ARDMS), ARRT or CCI.
- **Limited X-ray Machine Operator** These standards apply only in states that expressly license limited x-ray machine operators. Any state that licenses LXMOs must have standards that mandate completion of a LXMO educational program that meets the curriculum content specified in the ASRT LXMO Curriculum or completion of a medical assistant program that meets the curriculum content specified in the ASRT LXMO Curriculum and successful completion of an examination that meets the federal standard. LXMOs are limited to radiography of the chest and thorax, cranium, extremity, podiatric and vertebral column and are prohibited from performing procedures involving contrast media, fluoroscopy and computed tomography.
- **Bone Density Equipment Operator** These standards apply only in states that expressly license bone density equipment operators. Any state that licenses BDEOs must have standards that mandate completion of a BDEO educational program that meets the curriculum content specified in the ASRT BDEO Curriculum and successful completion of an examination that meets the specified federal standard.

## **21. The CARE bill used to be known as the Consumer Assurance of Radiologic Excellence (CARE) bill. Why the name change?**

Many of the imaging disciplines included in the CARE legislation are not directly related to radiology and some cross over into other medical fields such as cardiology and obstetrics. To more accurately reflect medical imaging's move to the front lines of medicine, the Alliance changed the name of the legislation to the Consistency, Accuracy, Responsibility and Excellence (CARE) in Medical Imaging and Radiation Therapy" bill.