April 3, 2020

The Honorable Donald Rucker, MD
National Coordinator
Office of the National Coordinator for
Health Information Technology
Mail Stop: 7033A
Mary E. Switzer Building
330 C Street, S.W.
Washington, DC 20201

Attn: Draft ONC 2020-2025 Federal Health IT Strategic Plan

Dear Dr. Rucker:

RadNet appreciates the opportunity to comment on Office of the National Coordinator for Health Information Technology's (ONC) draft 2020-2025 Federal Health IT Strategic Plan.

RadNet, Inc. is the leading national provider of freestanding, fixed-site diagnostic imaging services in the United States based on the number of locations and annual imaging revenue. Our goal is to deliver high-quality, conveniently accessible care in the most cost-effective manner possible -- all of which makes us the alternative to the higher-priced hospital and health system-based or owned imaging provider. RadNet has a network of more than 340 owned and/or operated outpatient imaging centers. RadNet's markets include California, Maryland, Florida, Delaware, New Jersey, and New York. Our over 340 imaging centers, nearly 800 radiologists, and approximately 8,500 employees perform an estimated eight million procedures annually. In addition, RadNet provides radiology information technology solutions, teleradiology professional services, and other related products and services to customers in the diagnostic imaging industry.

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The Strategic Plan through its four overarching goals and their associated objectives intends to improve the health of individuals, families, and communities. The second goal, "Enhance the Delivery and Experience of Care," includes objectives to "Foster competition, transparency, and affordability in healthcare"(2B) and "Reduce regulatory and administrative burden on providers" (2C). RadNet agrees with the ONC that federal health IT initiatives aimed at fostering competition and reducing provider burden can enhance care and, ultimately, improve health.

However, missing from the Strategic Plan is how health IT can decrease burden, increase efficiency, and lower costs associated with healthcare administration. According to a recent article in the Annals of Internal Medicine, U.S. insurers and providers spent $812 billion or $2,497 per capita on healthcare administration.[1] For example, RadNet spends several millions of dollars annually dealing with the prior-authorization process

[1] Himmelstein DU, Campbell T, Woolhandler S. Health Care Administrative Costs in the United States and Canada, 2017. Ann Intern Med. 2020;172:134–142. [Epub ahead of print 7 January 2020]. doi: https://doi.org/10.7326/M19-2818

alone. We believe that the following strategies, if added to the Strategic Plan, would reduce administrative costs and burden while contributing to the objectives and overarching goals of the Strategic Plan:

1. Improve the 270/271 Transaction Standard While Providing for the Transition to FHIR.

Health plans and provider exchange standardized transaction messages: (1) 270 Transaction Set (Eligibility Request) is used to transmit healthcare eligibility benefit inquiries from healthcare providers, insurers, clearinghouses, and other health care adjudication processors and (2) 271 Transaction Set (Eligibility Response) is the corresponding response mechanism from insurers for healthcare eligibility benefit inquiries.

While the 270/271 transaction standard provides the means for insurers and providers to communicate with respect to eligibility, it is not without several major shortcomings:

- The current version (V5010) is approximately 15 years old and changes can take upwards of five years to implement. This limits the flexibility and usefulness of the standard. For example, providers would be in a better position of informing their patients of their expected out-of-pocket costs for upcoming health services if unused fields in the 271 message could be re-purposed to contain this information.
- Not all insurers issue 271 messages despite being required.
- There is significant variability in how insurers define the fields in the 271 message which serves to add confusion on the part of providers. Also, this variability can lead to the benefit information in the 271 response message to be inaccurate. (Based on our experience, 271 messages often contain faulty information.) Perhaps the greatest source of variability and inaccurate benefit information has to do with the use of "Service Type Codes (STCs)." STCs classify services or benefits in the 270/271 transaction. Their use can vary widely between payors and even between plans administered by the same payor. As a consequence, multiple STCs have to be tested individually and in combination and then compared to the payor portal for validation in order to get accurate benefit information. For instance, if establishing a benefit transaction for magnetic resonance imaging (MRI) services, all of the below Service Type Codes need to be tested to determine which provides the most accurate combination:
  - Diagnostic X-Ray (STC = 4)**:** Diagnostic x-ray provided by a healthcare provider
  - Plan Coverage and General Benefits (STC = 30)**:** Plan coverage and general benefits for the member's policy or contract.
  - MRI Scan (STC = 62): Diagnostic MRI (magnetic resonance imaging) services.
  - Diagnostic Medical (STC = 73)**:** Services required to determine the diagnose to treat a medical condition, illness, or injury

  The programming and testing for this process is resource intensive. These efforts may need to be repeated as payors change or add new plans. Standards around the use of STCs would improve the responses providers receive from payors. When accurate benefit information is received in the 271 response, providers can compare those benefits to their payor contracts and provide patients with accurate cost sharing estimates.

2. Support Real-Time Claims Adjudication

Billing-related and insurance-related costs account for about 15 percent of medical spending.[2] Real-time claims adjudication (processing) can reduce these expenses significantly and provide patients more timely estimates of their out-of-pocket costs. The goal of real-time claims adjudication (RTA) is for medical claims to be submitted by the provider to the insurer and settled within moments at the patient's point of care.

RTA has underperformed relative to its promise for two reasons: (1) slow uptake by insurers and practice management vendors and (2) revenue cycle workflow processes. Insurers and vendors want to know there is a market for RTA before investing time and resources. Support of RTA in the Strategic Plan would encourage more RTA solutions and wider adoption. The revenue cycle process involves multiple workflows such as coding, review of reports/notes, charge posting, etc. which can slow progress. RTA adoption could be furthered if applied to claims where the revenue cycle process is straightforward with little variability. Screening services could lend themselves to RTA. For example, screening mammography is a good candidate for RTA because the coding and indications are well-established and, in most instances, there is no out-of-pocket cost for patients. As additional technologies such as machine learning for medical coding advance in the marketplace, more RTA will be possible.

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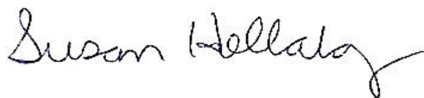
RadNet appreciates the opportunity to provide the ONC with our comments on the draft Strategic Plan for Federal Health IT. As always, we stand prepared to meet with the Departments to discuss our concerns and comments directly. If you have any questions or need additional information, please contact Michael Mabry, RadNet's Director of Public Policy and Economic Analysis at 443.810.4798 or Michael.Mabry@RadNet.com.

Respectfully submitted,



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[2] David Cutler, JAMA Forum: Practical Steps to Make Health Care Better, April 18, 2019, https://newsatjama.jama.com/2019/04/18/jama-forum-practical-steps-to-make-health-care-better/, accessed 03/04/2020.