



January 4, 2019

Physician-Focused Payment Model Technical Advisory Committee (PTAC)
c/o U.S. Asst. Sec. of Planning and Evaluation Office of Health Policy
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: The “Medical Neighborhood” Advanced Alternative Payment Model (AAPM) Proposal from the American College of Physicians (ACP) and the National Committee for Quality Assurance (NCQA)

Dear PTAC Members:

RadNet appreciates the opportunity to comment on the “Medical Neighborhood” AAPM from ACP and NCQA. The ACP/NCQA model includes several objectives with respect to care coordination involving medical imaging. We agree that the coordination of imaging care can be improved and recommend that the model encourage electronic ordering and interoperability for radiology studies.

RadNet, Inc., with a network of over 340 imaging centers and 750 radiologists in six states, 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. In addition, RadNet provides radiology information technology solutions, teleradiology professional services, and other related products and services to customers in the diagnostic imaging industry.

The Medical Neighborhood APM (MNM), as described by ACP and NCQA, is a multi-payer model that focuses on specialists that: a) receive referrals from primary care providers in the Centers for Medicare & Medicaid Services’ (CMS’) Comprehensive Primary Care Plus (CPC+) model and b) have achieved a set of robust clinical transformation standards such as NCQA’s MACRA-recognized Patient Centered Specialty Practice (PCSP) Recognition Program. ACP/NCQA APM is intended to solve two problems: (1) the poor coordination between primary care clinicians and specialists and (2) the lack of APMs for most specialists. We agree and commend ACP and NCQA on both counts.

Electronic Ordering of Imaging Studies

Radiology is an integral part of the patient care continuum. But, diagnostic imaging can fail to meet its full potential in terms of disease and injury detection and diagnosis because of poorly coordinated patient care. The consequences of this failing include repeat imaging, delayed care, unnecessary radiation exposure (if applicable), and higher costs to the patient and the health system overall.

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The proposed model calls for the tracking of imaging tests from order to the receiving results. We believe tracking is a step in the right direction; so, too, with flagging abnormal findings.¹ However, it is our experience that a significant percentage of orders for imaging studies involve some form of paper and manual processing (e.g., fax, paper scrips, phone calls). Without automation, an order tracking and flagging workflow to accommodate this manual process is going to be labor intensive and costly.

On the other hand, electronic ordering of imaging studies would facilitate the process of tracking orders while also reducing its burden and cost. Time stamps can be used to track the order's progress from inception to report receipt. Electronic ordering also lessens imaging non-compliance issues (e.g., lost scrips, patient no-shows), permits follow-up and re-orders as needed, and eases data collection and reporting in support of process and care improvement. This is good for the imaging provider too because manual entry of order information (e.g., patient name, study, referring clinician, reason for exam) is avoided and patient adherence to imaging appointments will improve. Healthcare is moving in the direction of electronic and digital health; supporting legacy manual and paper-based systems seems counter-productive.

Interoperability

Multidirectional interoperability between primary care practitioners, specialists, and radiology can deliver the efficient management of imaging orders and results which is essential to care coordination. ACP and NQCA are correct in including imaging coordination objectives in their proposed model. For example, the APM proposal calls for: (1) electronically record[ing] more than 30 percent of radiology orders in the patient record,² (2) electronically integrating results and imaging in the host medical record system and not a separate one,³ (3) using resources judiciously; understanding redundant imaging or lab tests,⁴ and (4) being informed and up-to-date on referrals from primary care to specialists and the associated exchange of information and coordination of care, changes in medications and lab or imaging results.⁵ All of these objectives can be achieved readily through interoperability. Interfaces can be created between clinicians to electronically order imaging studies, report results, and share images. Thus, the costs and burden associated with tracking studies, scanning documents, importing images from CD-ROMs, etc. can be avoided. Moreover, this exchange of imaging information would reduce repeat exams, avoid unnecessary radiation exposure (if applicable), and lower costs. Finally, requiring interoperability would align the APM proposal with the goals of the Centers for Medicare & Medicaid Services (CMS).

¹ Medical Neighborhood" Advanced Alternative Payment Model (AAPM) Proposal, Page 21

² *Id* (PCSP 5: Track and Coordinate Care, page 73)

³ *Id* (PCSP 5: Track and Coordinate Care, page 74)

⁴ *Id* (PCSP 6: Measure and Improve Performance, page 84)

⁵ *Id* (PCSP 6: Measure and Improve Performance, page 86)

The interfaces that permit electronic ordering and the exchange of imaging health data can be costly for the ordering professional and the imaging provider. This expense can be significant and vary widely according to the IT systems affected and size and complexity of the participating providers. First, there is a cost for modifying the ordering professional’s EHR system and, similarly, for the imaging provider’s radiology information system (RIS) to create the initial interface to send and receive information. Second, vendors charge an annual maintenance fee for servicing the interface. Third, a “per click” transaction fee is imposed by some vendors. The imaging provider should not be required to incur all of these costs for both ends of the interface; each participant should be responsible for their respective expenses. Moreover, in light of these costs, the proposed model should incentivize interoperability interfaces. We recommend that the proposed monthly coordination fee include the costs associated with interoperability interfaces for participating ordering professionals. Imaging providers can be incentivized through performance measures in the Merit-based Incentive Payment System (MIPS) or APM bonus payments.

“Flagging” Critical Findings

The ACP/NCQA model proposal to flag abnormal findings is a good idea; but, should be expanded to other circumstances warranting attention and tracking. In addition to abnormal findings, a radiology report may also include recommendations for follow-up imaging or tests. This is often the case with oncology patients, screening scenarios, and monitoring disease or treatment progress. In addition, it is increasingly common for radiology reports to include an assessment of a patient’s risk factor(s) for disease (e.g., breast cancer). We believe that recommendations for follow-up imaging, either per standard guidelines (e.g., BIRADS, LungRADS) or clinical indication, and patient risk assessments should be flagged as well. Performance measures can be built around the capture and evaluation of these flagged events.

E-Consults

The e-consultation concept is unclear with respect to its applicability to radiology consultations. The ACP/NCQA APM model calls for the creation of an e-consult consisting of communication between the CPC+ practice and MNM specialist using various means to discuss a variety of issues related to a specific patient’s care.⁶ While idea of promoting primary care and specialist communication is good and appropriate, consultations between primary care, specialists, and radiologists over imaging studies and their results take place and typically do not require a face-to-face visit. We request clarification with how the e-consult applies radiologists.

⁶ *Id*, page 13



In closing, RadNet appreciates PTAC giving us the opportunity to comment on the “Medical Neighborhood” AAPM from ACP and NCQA. If questions or the need additional information arises, please contact Michael Mabry, RadNet’s Director of Public Policy and Economic Analysis at 443.810.4798 or Michael.Mabry@RadNet.com.

Sincerely,

A handwritten signature in blue ink that reads "Susan Hollabaugh".

Susan Hollabaugh
Vice President, Regulatory Analysis and Conformance

cc: Ranjan Jayanathan, RadNet
Michael Mabry, RadNet