Statement of the American College of Surgeons
To the Committee on Ways and Means
United States House of Representatives
RE: Health Care Price Transparency: A Patient's Right to Know
May 16, 2023

facs.org

CHICAGO HEADQUARTERS
633 N. Saint Clair Street
Chicago, IL 60611-3295
T 312-202-5000
F 312-202-5001
E-mail: postmaster@facs.org

WASHINGTON OFFICE
20 F Street NW, Suite 1000
Washington, DC 20001
T 202-337-2701
F 202-337-4271
E-mail: ahp@facs.org

The American College of Surgeons (ACS) welcomes the growing focus on transparency, and we agree that the current environment makes it difficult for patients to find useful, actionable information when it comes to their health. This lack of transparency extends beyond price to include a lack of actionable data on quality, which is equally necessary for patients to make choices based on value. As a scientific and educational association dedicated to improving the quality of care for the surgical patient, we have more than a century of experience in developing more meaningful quality measures. Through this experience we have learned that safe, high-quality care can often be more affordable care as well. Improved price transparency, coupled with meaningful measures of quality, will help to prove this and help patients find care aligned with their goals and values. Price information in the absence of quality information is not sufficient for patients to make informed decisions and could lead to higher prices for patients and higher overall costs for purchasers.

Achieving meaningful price transparency for complex care will be tricky. Current efforts are in essence attempting to make available perfect information, with accurate pricing for each individual billed service, provided by every physician or facility, with the exact price paid by each payer. Achieving this might make it possible for a savvy patient with a simple, non-urgent health need to compare options for a consultation, a test, or an imaging study. However, for more complex care such as a major surgical procedure, care for a chronic condition, or cancer treatment, producing a perfect up-front estimate would be akin to shopping for a car piece by piece without knowing exactly what parts you need. For example, if a patient recently diagnosed with breast cancer were to request a good faith estimate (GFE) from his or her physician or wished to compare prices for different hospitals through a shoppable services portal, it would be nearly impossible to provide estimates that encompasses the full course of treatment without additional guidance on how to meet this congressional goal. There would be a great deal of uncertainty as the care pathway has multiple decision points which can lead to drastically different prognoses and care requirements. Even if the exact care pathway could be determined at the time of scheduling care, it is still unlikely that the full team of ancillary providers involved would be known. The uncertainty of this pathway furthermore might require different or additional team members with significantly higher or lower cost than originally foreseen.

Align and Streamline Data Sources

There is a wealth of information becoming available as hospitals post charges and shoppable services online and as insurer machine-readable files (MRFs) are released, creating the potential for valuable insights. However, this information is currently difficult to decipher even for sophisticated researchers. Furthermore, the multitude of competing requirements for price measurement and reporting across transparency efforts and payment programs runs the risk of adding unwelcome and unnecessary confusion. Hospital Price Transparency, Transparency in Coverage, and requirements for GFEs and advanced explanations of benefits (AEOBs) are all intended to improve price transparency but lack uniformity in what information is made available. A unified strategy with standardized definitions for price information conversely has the potential to reduce some of the complexity and mystery often experienced by patients shopping for or undergoing care.

Furthermore, a unified strategy would be less burdensome to implement than having different requirements and definitions for each application.

There have been several positive developments recently that represent incremental steps toward better transparency. These include the announcement from the Centers for Medicare & Medicaid services that they would be stepping up enforcement on hospitals out of compliance, as well as the introduction of bipartisan legislation in the House of Representatives to expand price data availability, accessibility, and utility. If successful, the amount of useful price information available to consumers and researchers would be greatly expanded. However, truly meaningful price transparency will remain elusive for many with complex care requirements unless additional action is taken to allow convenient analysis of care the way that it is actually experienced by patients. Specifically, standard definitions of episodes of care should be adopted that allow for real charges to be grouped and analyzed, and a comprehensive patient specific estimate produced.

Price Estimates for Complex Care

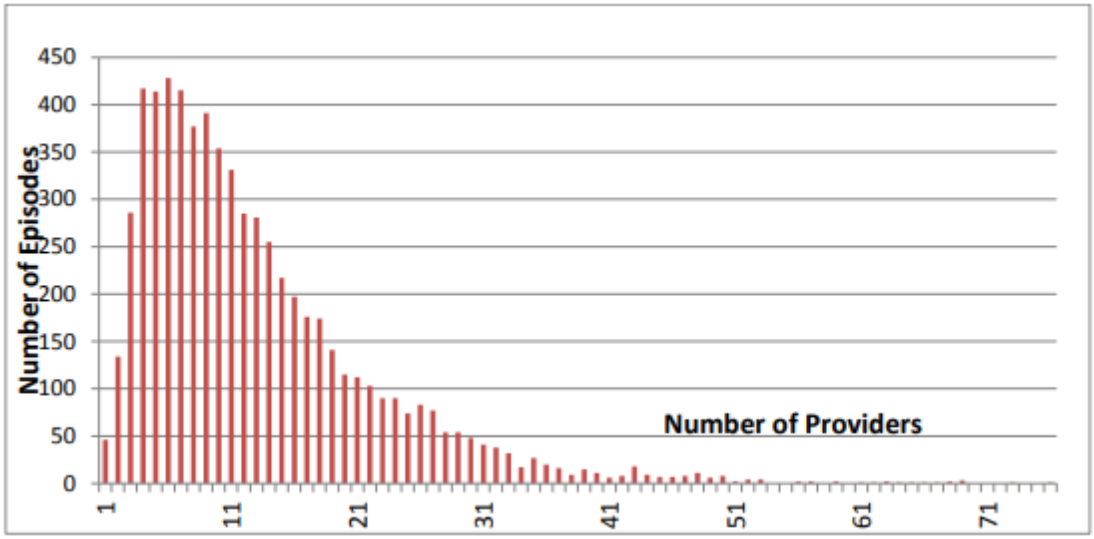
To understand the shortcoming of current transparency efforts, consider the example of requirements for GFEs for uninsured patients. Upon scheduling an item or service to be furnished, the No Surprises Act requires that providers and facilities compile a GFE with the expected billing and diagnostic codes for the patient including the expected charges for furnishing such item or service along with *any item or service that is reasonably expected to be provided in conjunction with such scheduled or requested item or service or reasonably expected to be so provided by another provider or facility*. This requirement for including the price of services reasonably expected to be provided with the core service is both vitally important and nearly impossible to meaningfully implement in the fee-for-service (FFS) environment without first settling on definitions for what constitutes the episode of care and having the ability to group services using such definitions.

The GFE for uninsured and self-pay individuals essentially requires advance knowledge not only of what services will be provided during the course of the patient's care, but also of which specific physician or provider will be delivering each service. For a care encounter such as a wellness visit, diagnostic test, or a simple procedure in the office, this might be straightforward. However, treatment for many diagnoses and conditions, such as cancer or a major surgical procedure, might involve the skill and expertise of a large team and may occur across multiple sites of service.

A retrospective look at colon resection procedures among Medicare patients shows that a surprising number of distinct parties are involved in the provision of care for a single beneficiary[1]. Typical colectomy episodes will include surgeons, anesthesiologists, pathologists, radiologists, and other consultants along with multiple locations of care such as imaging centers, lab sites, hospitals, and operating suites. While the total number of billing taxpayer identification numbers (TINs)/national provider identifiers (NPIs) for the episodes included in this analysis was typically fewer than 15, a significant number of patients experienced episodes of care involving teams of 20, 30, 40 or more.

[1] https://aspe.hhs.gov/sites/default/files/private/pdf/255906/ACSReportSecretary.pdf#page=36

Figure 1. Distribution of Providers in Colectomy Episodes



Even in the best of circumstances, care will vary from patient to patient and delivery system to delivery system based upon the unique needs of the patient and the capabilities, personnel, and resources of the system. This variation means that advance estimates for fee-for-service patients lack the level of precision necessary for them to make confident decisions about care. On top of this, each payer may have different contracted rates with each physician or facility, or even multiple rates with each depending on the insurance product.

Episodes of Care for Price Transparency

ACS agrees that price disclosure can inform and empower consumers whether they shop for items and services individually or as part of service packages (i.e., individual shoppable services, explicit or implicit items within bundles, or episodes of care), and we believe that out-of-pocket cost, in addition to total cost of care, are important types of price information for patients. ACS continues to assert that the episode of care (rather than each individual service) is the appropriate unit of comparison for complex healthcare. Further, the definition of the episode and which services are included in the analysis should be the same for purposes of price transparency, for patient cost estimates such as the GFE and AEOB, and even for assessments in payment programs such as episode-based cost measures. The use of standard definitions of what services are associated with a given diagnosis, in combination with an episode grouper, would create a groundwork for estimates and comparisons which could then be used to provide patients with a typical base price and a range of what patients with similar circumstances (such as health status and insurance plan) have actually paid for their care.

While there are multiple episode groupers available, ACS feels that the episode definitions and grouper logic maintained by the PACES Center for Value in Healthcare[2] are clinically validated, the most functional and complete for this purpose. The PACES grouper would be run on claims data to establish the complete list of services and charges associated with each episode and subcategory. This grouper was designed to count each dollar only once and to assign charges to either the most relevant episode or divide them across all concurrent episodes assigned to a patient for which that service could be plausibly provided. For the purpose of a shoppable services tool or GFE, it would be more logical to assign the full cost of the surgical procedure, the facility, anesthesia, pathology, and "any item or service reasonably expected to be provided in conjunction with the scheduled procedure" to the estimate in order to provide the most realistic price. An added benefit of using the PACES grouper to derive this estimate is that the list of items and services generated would be based on objective evidence (past claims) and therefore likely more comprehensive than lists generated on the fly by overburdened Convening Providers or Convening Facilities or by patients trying to make sense of the massive amounts of pricing data on their own.

PACES could be used with the relevant payor database or on standardized MRFs in the future to run the episode logic and its business logic to determine the overall price variability for a given condition or procedure. This information could be used to provide an expected range of estimated prices to better inform the patient of what they might expect depending on how their condition progresses. Such estimates can also be risk-stratified to better reflect what the patient might expect based on his or her underlying characteristics and comorbidities. Ultimately, providing patients with a risk-stratified range of prices based on historical, insurer and provider specific data from publicly available MRFs (including the mean and median cost) is much more actionable than trying to build a "perfect" estimate code by code.

Conclusion

The ACS thanks you for convening this important hearing on Health Care Price Transparency: A Patient's Right to Know and we look forward to being an active partner in achieving a more transparent and patient-centered heath environment. Price transparency for complex care such as surgery is different than for simple services or single encounters. Streamlining and coordinating the format and content of the different data sources related to the current price transparency programs is a critical prerequisite to achieving transparency but is not enough in isolation. Once this is accomplished, an episode grouper or similar tool can be used to generate patient-specific, risk adjusted price estimates with a range of prices as experienced by similar patients. This is far more actionable for patients than trying to "build the car from parts" by adding up the total price of each item or service related to their health care on their own. Please contact Amelia Suermann with the ACS Division of Advocacy and Health Policy at asuermann@facs.org if you would like to learn more about our efforts to increase transparency and availability of information on both price and quality of care.

[2] https://www.pacescenter.org/