AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

March 23, 2018

Senator Bill Cassidy
520 Hart Senate Office Building
Washington, D.C. 20510

Senator Michael Bennet
261 Russell Senate Office Building
Washington, DC 20510

Senator Chuck Grassley
135 Hart Senate Office Building
Washington, D.C. 20510

Senator Tom Carper
513 Hart Senate Office Building
Washington, DC 20510

Senator Todd Young
400 Russell Senate Office Building
Washington, DC 20510

Senator Claire McCaskill
503 Hart Senate Office Building
Washington, D.C. 20510

Re: Health Care Price Transparency Initiative

Dear Senators Cassidy, Bennet, Grassley, Carper, Young, and McCaskill,

On behalf of over 34,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), we appreciate the opportunity to comment on this initiative to bring price and information transparency to the healthcare system. AAOS recognizes that the growth in healthcare costs represents a challenge for the long-term sustainability of the system overall and for the federal healthcare programs Congress and the agencies oversee. Healthcare spending has grown at a considerable pace over the past ten years alone, and according to the Centers for Medicare & Medicaid Services (CMS), health spending is projected to grow 1% faster than national GDP per year between 2017 and 2026. AAOS understands and welcomes meaningful proposals to address this challenge.

Context and Quality

As the Medicare Access and CHIP Reauthorization Act (MACRA) envisioned, healthcare in the United States should be oriented toward delivery of high quality and value-based care. Giving patients more information on their healthcare is an important step toward that goal. Yet transparency alone – and relying on the patient to make those decisions alone – will never be enough in the absence of comprehensive work from all stakeholders to move toward value-based care. Relatedly, providing pricing information alone does not help patients understand that information nor does it take into account other measures of patient satisfaction. Equally important is preserving the value of physicians' services for their patients.

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One complication to providing greater transparency in healthcare pricing is the unique nature of assessing the quality of healthcare services for many patients. In fact, a study in the *New England Journal of Medicine* has explained that, "Timely and salient comparative quality information is often unavailable, so patients may rely on cost as a proxy for quality. The belief that higher-cost care must be better is so strongly held that higher price tags have been shown to improve patients' responses to treatments through the placebo effect."[1]

In addition to the tendency to equate higher cost with higher quality products in other transactions, many patients are often insulated from paying the full cost of a given procedure or service, removing another incentive to seek out lower-cost care or confirm prices beforehand. To counteract this, one price transparency intervention program[2] proposed several key elements that would be valuable for non-urgent procedures, such as elective joint replacements. Among its solutions were providing relevant, customized information to consumers; emphasizing quality along with price; certifying all data was up to date and accurate; and ensuring the timeliness of providing the data to patients. Any program designed to help patients make more informed choices must recognize that more information on cost in the absence of greater context will not move our current system toward greater openness, efficiency, and accountability.

Lastly, we would also like to emphasize another impairment to full transparency. Many physicians have multiple contracts with carriers where the actual price for a procedure is unknown as providers will only supply the surgeon with a sample of the twenty most common procedures. In these circumstances, many surgeons do not actually know what price will be paid for a specific procedure for a specific patient's health plan. This arrangement is by some carriers' design so that one particular surgeon group does not know what another is being paid in a specific region, and it can serve to prevent price-setting. AAOS would ask Congress to remain cognizant of such gaps in providers' price knowledge as it works to craft solutions, and recognize the need for an all-inclusive plan that involves participation by all stakeholders.

Site Neutrality

Traditionally, Medicare uses different payment systems depending on the location where a beneficiary receives services (e.g., inpatient, outpatient, Ambulatory Surgical Center (ASC), emergency department, physician office). Having payments that vary by facility site derives from the idea of payment based on total resources used in provision of healthcare services, something that has long been a part of Medicare and Medicaid payments, and remains the central part of payment systems like the Physician Fee Schedule. However, significant variation is all too common in the Medicare payment system and has resulted in inefficient care and increased costs

[1] "Increased Price Transparency in Health Care — Challenges and Potential Effects," *The New England Journal of Medicine,* Anna D. Sinaiko, PhD, et. al., 891-894 (March 10, 2011).
[2] "Price Transparency For MRIs Increased Use Of Less Costly Providers And Triggered Provider Competition," *Health Affairs,* 33, NO. 8 (2014): 1391–1398.

to Medicare patients who face higher co-pays for hospital outpatient services compared to services provided in an office setting.

Recently, CMS and Congress have explored eliminating this approach in favor of site-neutral payments. AAOS is generally supportive of efforts to reduce payment differentials by site for the same services and has consistently commented to CMS and Congress that we believe significant differences in payments by site creates economic inefficiencies that result in unnecessary expenditures by payers like Medicare and Medicaid. We have been supportive of making payments for services furnished in the physician office or the ASC equal to payments in the hospital outpatient setting. However, we have consistently recommended seeking this equilibrium not by bluntly reducing the outpatient payments to equal ASC or office payments but by also increasing payments in those settings toward a more middle ground. Expanding the site-neutral payment policy – and, in particular, equalizing rates for office visits and in-office procedures as well as ASC procedures – will allow patients to receive the same care for the same out-of-pocket cost, regardless of the facility site. This will also do away with various Medicare reimbursement complexities surrounding inpatient versus outpatient/observation status for patients, thereby reducing burden for both providers and patients.

All Payer Claims Databases

One idea that the bipartisan working group raised in its letter is developing all payer claims databases (APCD). AAOS welcomes any tool that would allow physicians to make better-informed decisions about what care is most suitable and cost-effective for their patients. While APCDs are one solution many states have tested to provide pricing information to patients, obstacles remain to effectively implement these databases, including accurate identification of providers,[3] and ensuring that an APCD's pricing and quality data are always timely and complete. Nevertheless, AAOS believes that APCD data can be combined with other sources of clinical data (such as that contained within registries) to expedite movement toward value-based care assessment.

Value of "Big Data"

AAOS agrees with the bipartisan working group's suggestion that our health care system can better utilize big data, including information from the Medicare, Medicaid, and other public health programs, to drive better quality outcomes at lower costs. Registries present health care stakeholders with a powerful tool to improve quality and deliver care in a transparent manner. Both classic registries and those that are deemed qualified clinical data registries (QCDR) give stakeholders access to an important reservoir of clinical data about procedure outcomes, device performance, and quality of care.

[3] "All-Payer Claims Databases: State Initiatives to Improve Health Care Transparency," Denise Love, et. al., *The Commonwealth Fund,* (2010).

To successfully fill this role, registries need to be able to validate the data submitted by providers. Under Section 105(b) of MACRA, Congress directed CMS to provide registries with real-time access to Medicare claims data. The "real-time" element is critical to ensuring that the data that registries hold provides its greatest value. Yet over two years after the passage of MACRA, CMS has yet to adequately implement this element of the law.

As "big data" become more and more important to the delivery of health care, ensuring that data repositories like registries have the access necessary to fully carry out their mission is critical. CMS has affirmed that registries will play a role in delivering high quality care by providing that QCDRs may function as one reporting option under the new Merit-based Incentive Payment System (MIPS). Any action that would ensure registries can perform their role effectively should be a priority. AAOS encourages Congress to communicate with CMS and urge the agency to quickly and fully implement Section 105(b) of the Medicare Access and CHIP Reauthorization Act.

Thank you for your time and consideration of the American Association of Orthopaedic Surgeons' suggestions to greater price and information transparency in the healthcare system. If you have any questions on our comments, please do not hesitate to contact William Shaffer, MD, AAOS Medical Director by email at shaffer@aaos.org.

Sincerely,

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President, American Association of Orthopaedic Surgeons (AAOS)

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