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The Honorable Bill Cassidy, M.D.
United States Senate
520 Hart Senate Office Building
Washington, DC 20510

The Honorable Michael Bennet
United States Senate
261 Russell Senate Office Building
Washington, DC 20510

The Honorable Charles Grassley
United States Senate
135 Hart Senate Office Building
Washington, DC 20510

The Honorable Tom Carper
United States Senate
513 Hart Senate Office Building
Washington, DC 20510

The Honorable Todd Young
United States Senate
400 Russell Senate Office Building
Washington, DC 20510

The Honorable Claire McCaskill
United States Senate
503 Hart Senate Office Building
Washington, DC 20510

Dear Senator Cassidy, Senator Bennet, Senator Grassley, Senator Carper, Senator Young, and Senator McCaskill:

On behalf of the Association of American Medical Colleges (AAMC), thank you for your outreach to stakeholders to gain information on how health care price and information transparency can potentially empower patients, improve the quality of health care, and lower health care costs. As you know, this is a complex topic due to the fragmented nature of our health care system that will require all parties – including providers, patients, and third parties – to work together in order to achieve meaningful outcomes. The AAMC strongly supports your ultimate goal of bending the health care cost curve and curbing unnecessary health care spending.

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 151 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

AAMC Recommendations:

- Broaden the conversation about price transparency to include appropriate contextual information, including risk-adjusted quality metrics and longer periods of time to account for a complete episode of care to allow patients to accurately assess the quality and cost of their treatment;
- Engage with a variety of stakeholders, including patients, pharmaceutical manufacturers, and others to ensure broad consensus and buy-in from the healthcare industry. Importantly, engage with insurers who are the most appropriate party to provide a patient's out-of-pocket cost responsibility and encourage educational efforts to ensure that patients have a basic understanding of health insurance concepts, vocabulary, and health literacy;
- Make comprehensive claims data available to all providers; and
- Take into account the unique costs of teaching hospitals, as these institutions serve a disproportionate number of the nation's most vulnerable and complex patients while simultaneously training the next generation of physicians and serving as the sites for cutting-edge research.

To Present an Accurate Representation of Cost, We Must Broaden the Discussion

In order to be meaningful to the patient, costs must be reported with appropriate contextual information that allows the patient to accurately assess the quality and price of a service. This includes providing patients with information such as quality metrics. According to a 2011 report by the Government Accountability Office (GAO), "some researchers argue that consumers can then use this information to choose providers with the highest quality and the lowest price – thereby obtaining the greatest value when purchasing care."[1] Studies have also shown that presenting cost data in conjunction with quality information that is easy to understand improves the possibility that consumers will choose high-value care options.[2] As discussed below, however, to be meaningful, quality data must reflect the circumstances of the patient population.

In addition, it is critical that we remain dedicated to increasing patient education about the context in which cost and quality information is provided. As an example, researchers have posited, "The extent to which consumers will accurately understand the meaning of data on costs and resource use – and be able to use the information in decision making – is unclear…When it comes to the amount of care, consumers tend to think longer is better. They might not understand, for example, that longer lengths-of-stay are undesirable and often avoidable."[3] This example clearly illustrates the need for providing appropriate context to patients when examining cost and quality reporting.

[1] GAO. "Health Care Price Transparency: Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care." September 2011. Available at: https://www.gao.gov/assets/590/585400.pdf.
[2] Hibbard, Judith H. et. al. "An Experiment Shows that a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Care." HealthAffairs. March 2012. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.1168. Last accessed April 5, 2018.
[3] Ibid.

Another key decision is how best to report the pricing data. We believe that both the patient and the provider will benefit most from pricing data that encompasses an entire episode of care over an expanded period of time which extends beyond the inpatient admission. For example, data only showing that an inpatient admission is especially costly could be misleading if that admission resulted in lower outpatient rehabilitation and other costs which would ultimately result in low total episode costs. This is the foundation of Centers for Medicare and Medicaid Services' (CMS) bundled payment program, and it would help patients understand that there are many costs associated with the treatment of an illness or injury beyond the time spent in a hospital. As you know, CMS provides very detailed claims data for their various bundled payments programs. This type of patient-specific and episode of care data would be ideal to share with all providers, both hospitals and physicians, to provide greater detail and further establish price transparency.

Similarly, when utilizing quality metrics or other performance measures to assess providers, we urge you to include risk-adjustment that adequately accounts for differences in patient populations. As you may be aware, numerous outcome measures, such as readmissions, mortality, episode payments, etc., are greatly influenced by conditions that occur outside of the provider's control. For example, a patient who is discharged from a hospital and does not have access to a pharmacy, or lacks family to ensure that an appropriate care plan is followed, is far more likely to return to the hospital than a patient who has these support structures in place. Teaching hospitals historically have been unfairly penalized by performance measures that do not contain risk adjustments for factors such as severity of illness (SOI) and socio-demographic status (SDS). Often, these measures do not account for the complexity of care provided and do not allow for the proper assessment of providers who treat sicker and more vulnerable patients, such as teaching hospitals. As you move forward, we strongly urge you to ensure that hospital quality measures are appropriately adjusted to account for the SDS of patients to ensure that teaching hospitals who treat the nation's sickest and most vulnerable patients are not inappropriately penalized.

Price Transparency Efforts Must Engage a Variety of Stakeholders, Including Providers, Patients, Insurers, and Others

Part of the difficulty in achieving price transparency in health care has centered on the complexity of health care costs and the fragmented nature of the health care system. The cost of performing a service in a hospital may depend not only on the hospital's costs, but also on the cost of medications set by a pharmaceutical company and the cost of medical supplies set by a manufacturer. There are times when hospitals are able to negotiate costs, but in many instances, a pharmaceutical company or another supplier sets a price which the hospital must pay. In order to have true transparency, all health care entities must engage with Congress.

In addition, ultimately, the cost or number that may be most important to the patient is the out-of-pocket cost they will face at the end of the procedure, a number that is often dictated by the patient's insurance company and the terms of the plan itself. This is especially true for individuals with high deductible health plans. According to a Kaiser Family Foundation survey, 28 percent of individuals are enrolled in a high-deductible plan – an increase of 9 percentage

points since 2012.[4] Given this rise, and the corresponding rise in out-of-pocket spending, it is likely that the desire for comprehensive price transparency will also increase. Engaging insurers, who are the most appropriate party to provide the out-of-pocket estimate, is imperative to moving forward with price transparency efforts.

Additionally, discussions of price transparency must start with a shared vocabulary. According to a study by Saurabh Bhargava, 71% of individuals could not identify fundamental cost-sharing features of health plans.[5] Additional studies have found that a majority of Americans could not correctly identify their out-of-pocket costs, even with the terms of the plan readily available to them.[6] These metrics show that even with a shared vocabulary, discussions about "price" are extremely complex. As such, we encourage you to consider ways of ensuring that proper patient education takes place to work towards a basic standard of health care literacy.

To Achieve Price Transparency, Comprehensive Data Must be Made Available to Providers

Comprehensive data sharing is critical to price transparency initiatives. The AAMC strongly supports and echoes the comments of our colleagues from the Society of Thoracic Surgeons, "[c]ombining clinical data with robust quality information…is the key to value-based payment."[7] As you know, under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the Centers for Medicare and Medicaid Services (CMS) is required to provide Qualified Clinical Data Registries (QCDRs) with access to Medicare claims data that may then be used to perform quality reports and ultimately support quality improvement or patient safety. However, to date, this provision has not been fully implemented.

The accessibility of private, non-federal claims data is also important in price transparency efforts. The growing momentum behind All-Payer Claims Databases (APCDs) has been linked to efforts to increase price transparency. Currently, 18 states have or are actively creating APCDs and 22 states have expressed strong interest in ACPDs.[8] The Agency for Healthcare Research and Quality (AHRQ) is examining the use of APCDs and has found one distinct advantage in these datasets is that they "include information on care for patients across care sites, rather than just hospitalizations and emergency department visits reported as part of discharge data systems."[9] Additionally, these data sets may be risk-adjusted, allowing for an appropriate

[4] Kaiser Family Foundation. Employer Health Benefits: 2017 Summary of Findings. Available at: http://files.kff.org/attachment/Summary-of-Findings-Employer-Health-Benefits-2017.
[5] Bhargava, Saurabh, George Lowenstein and Justin Sydnor. "Do Individuals Make Sensible Health Insurance Decisions? Evidence from a Menu with Dominated Options." May 2015. Available at: http://www.nber.org/papers/w21160.pdf
[6] Lowenstein et.al. "Consumers' misunderstanding of health insurance." Journal of Health Economics. Volume 32, Issue 5, September 2013. Available at: https://www.sciencedirect.com/science/article/abs/pii/S0167629613000532
[7] Society of Thoracic Surgeons. Comments re: Health Care Price Transparency Efforts. March 20, 2018. Available at: https://www.sts.org/sites/default/files/content/On%20the%20Record/STS_Response_Price_Transparency_Updated.pdf
[8] Finison, Karl et. al. "Risk-adjustment methods for all-payer comparative performance reporting in Vermont." Jan. 19, 2017. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5248440/
[9] AHRQ, "Overview of All-Payer Claims Databases." Available at: https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/apcd/index.html. Last accessed April 4, 2018.

comparison of providers as previously noted. We encourage you to continue examining the appropriate use of APCDs, and how best to appropriately incentivize states to use these databases.

The Unique Role of Teaching Hospitals

Finally, as you continue your examination of health care price and information transparency, we urge you to consider the unique role that teaching hospitals play in the delivery of our nation's health care and how the required program and infrastructure investment impacts prices. Teaching hospitals are committed to their core missions of providing critical health care services, serving vulnerable populations, educating the next generation of physicians, and conducting groundbreaking research. However, these missions carry heavy expenses that tend to be underpaid by insurers and the government and often must be absorbed by the hospitals themselves. In recognition of the differences in patient care costs between teaching and non-teaching hospitals, and the additional costs incurred by teaching hospitals, the Medicare program provides a special Indirect Medical Education (IME) payment adjustment in its inpatient prospective payment system (IPPS).

Additionally, although the Affordable Care Act (ACA) reduced the number of uninsured in this country, safety net hospitals continue to rely on Medicare Disproportionate Share Hospital (DSH) funding to provide uncompensated care for the large numbers of patients who are still uninsured and underinsured. With shrinking clinical margins, maintaining these payments is essential if teaching hospitals are to continue to support their teaching, research, and clinical care missions. As you move forward, it is critical to ensure that any price transparency initiative not disadvantage teaching hospitals because of these higher policy payments, as the distinctive capabilities and unique services of teaching hospitals benefit patients throughout the nation.

As you know, medical schools and teaching hospitals also sustain an environment where basic, clinical, and health services research can flourish alongside clinical care and training. These institutions share a commitment to providing education and graduate training to future physicians, biomedical scientists, and other health care providers and professionals; conducting biomedical and clinical research; and advancing medical knowledge, therapies, and technologies to prevent disease, alleviate suffering, and improve quality of life.

While AAMC member teaching hospitals represent only five percent of all hospitals, they account for a much larger share of care delivered nationally – including 23% of all hospital inpatient days, 20% of all Medicare inpatient days, and 24% of all Medicaid hospitalizations – and disproportionately care for the nation's underinsured and uninsured patients, providing approximately 33% of all charity care. Compared to other hospitals, major teaching hospitals care for patients that are sicker, poorer, and more likely to be disabled and non-white.

Additionally, AAMC-member teaching hospitals maintain the vast majority of the country's critical standby units, including trauma centers, burn units, and neonatal and pediatric ICUs. As a result, these institutions serve as regional referral centers for the most complex patients. The infrastructure afforded by AAMC member teaching hospitals strengthens the ability of the nation's health care system to respond expeditiously to novel threats. However, the ability to

respond to these catastrophic events requires a robust and continuing investment in standby costs for resources needed to ensure that, at a moment's notice, a hospital can respond to an unanticipated event. Unfortunately, federal investment in maintaining this infrastructure has not kept pace with demand, causing teaching hospitals to repurpose existing investments and strain already scarce resources.

In conclusion, America's teaching hospitals are working to redesign care delivery systems and reduce costs, but these goals must be balanced with our nation's goal to provide access to high-quality and appropriate patient care. As the institutions that train the next generation of physicians, we remain dedicated to educating these individuals about the importance of considering cost when determining the most appropriate course of care and treatment. We stand ready to assist in your efforts. If you have questions, or would like additional information, please contact Len Marquez, AAMC Senior Director of Government Relations and Legislative Advocacy, at lmarquez@aamc.org or (202)828-0412.

Sincerely,

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