Use Case: Price Transparency for Patients Using PACES

One of the goals of the PACES Center for Value in Healthcare is to provide patient-facing tools to aid in making care decisions that will lead to higher value care. The Patient-Centered Episode System (PACES), which is at the core of the PACES Center, can provide highly specific estimates of what services and costs will be associated with providing care for a patient with a given set of characteristics. These estimates will provide a much clearer, more complete, and we believe more accurate picture of what the patient could reasonably expect their care to cost, than will alternative proposals such as publishing lists of gross or negotiated charges for single services.

For price information to be meaningful for patients, it must be both comprehensive and easy to understand. PACES looks at a patient's concurrent care issues and medical history and uses that information to inform which clinically relevant services are likely during a clinically meaningful episode of care. This information is used to create a more accurate estimation of what they might expect, both in terms of services provided and their total cost. This information can be further broken down by hospitals to allow for comparison.

Example: Comparing Colectomy Services

A colectomy episode consisting of a particular set of services provided by a facility and several types of clinicians, including pre-op services, operating room, imaging, surgery, anesthesia, and so forth can be summarized as in the table below.

Table 1: Illustration of PACES Service and Price Comparison

	Column A	Column B	Column C	Column D
Colectomy Services	**Medicare Prices**		**Median Provider Prices**	
	25th percentile	**75th percentile**	**Medicare**	**Commercial**
Preoperative				
Pre-Surgical E/M	$ 175	$ 316	$ 233	$ 350
Pre-Surgical Imaging/Lab	$ 218	$ 202	$ 201	$ 543
Pre-Surgical Other	$ 309	$ 209	$ 312	$ 780
Subtotal	$ 702	$ 727	$ 746	$ 1,673
Operative Stay				
Facility	$ 17,384	$ 22,818	$ 17,516	$ 40,286
Operating Clinician	$ 1,900	$ 1,725	$ 1,821	$ 5,463
Anesthesia	$ 549	$ 339	$ 478	$ 1,912
Imaging/Lab Professional Fee	$ 125	$ 139	$ 167	$ 668
Other Professional	$ 58	$ 58	$ 45	$ 79
Subtotal	$ 20,016	$ 25,079	$ 20,027	$ 48,408
Post-Discharge				
Readmissions	$ 649	$ 888	$ 715	$ 1,573
PAC-SNF/IRF/LTAC	$ 556	$ 669	$ 602	$ 1,144
Sequelae	$ 1,402	$ 1,511	$ 1,454	$ 3,490
PAC Other	$ 2,361	$ 2,578	$ 2,494	$ 4,988
Subtotal	$ 4,968	$ 5,646	$ 5,265	$ 11,195
TOTAL	**$ 25,686**	**$ 31,452**	**$ 26,038**	**$ 61,276**
	Service Profiles		***Price Differentials***	

Columns A and B contrast service profiles for two hospitals in a particular geographic area in 2014, which reflect the 25th percentile and 75th percentile total Medicare spending for Colectomy. The substantial difference in average Medicare spend for Colectomy patients in the two hospitals reflects differences in rates of services during pre-op, the index stay, and post-acute phases of care, as well as sequelae or complications. Such comparisons ideally would reflect recent data and adjustments for differences in comorbidities and relative complexity.

Columns C and D contrast the same hospital (i.e., the median provider in the same area in total Medicare spend for Colectomy) for differential payment amounts between Medicare and commercial payors. Information about the episode in its entirety is important for decision-making, not simply the respective prices for individual service items such as the surgeon's fee, a diagnostic test, or a day in the hospital.

Combining Efforts

The example above represents a first step. Actual cost to patients also typically requires information specific to insurance coverage. Thus, the episode framework can be expanded more generally to inform data exchanges between payors, physicians, and patients. A hospital or clinician could query the insurance plan about a particular patient's benefit design; i.e., estimated out-of-pocket for that individual for an episode in order to inform decision-making and avoid 'surprises.' Similarly, patients could query their own payors about differential prices from local hospitals and physicians based on the standard taxonomy for episodes as the clinically meaningful units of pricing.

An optimal system could be reached through staged implementation of available technology. With an accessible open-source standard, all providers and payors could organize their reporting in a consistent and comparable fashion to reflect a patient's full experience for the acute event and its post-acute aftermath. This framework could work well also for treatment of a diagnosed condition, such as colon cancer, where the reporting might be sub-categorized into a procedural cost and a chemotherapy cost.

With services grouped logically and consistently for any number of episode types, many types of information can be produced to inform decision-making. Service profiles by facility could use Medicare allowed payments to inform differences related to efficiency with respect to standard services for that episode, as well as costs attributable to complications. Alternatively, holding constant a common set of services related to a particular type of episode, facilities could report total cost of care first using Medicare allowed payments, and then by negotiated commercial payment amounts. Most importantly, when coupled with meaningful information on patient experience and outcomes, this price information can be used to form a true picture of the value of care.