Hospitals, Doctors and Costs

By Tom Schuman

Hospital Ratings Vary – a Lot

For many years, a lack of information about health care quality was a primary challenge. Today, four different national ratings services that rarely agree on the top hospitals are "likely to cause confusion and information overload rather than driving patients to higher quality, safer care."

A *Health Affairs* article earlier this year had the breakdown and analysis. The services and what they evaluate are:

- *U.S. News & World Report* – care for serious conditions with scores from 1 to 100 in 16 specialties
- *Consumer Reports* – a safety score on a 100-point scale based on infections, readmissions and other measures
- Leapfrog Group – also safety focused (keeping patients from "preventable harm and medical errors") with A through F letter grades
- Healthgrades – top 50 and top 100 rankings for performance on patient outcomes as measured by mortality and complication rates

According to the article, 27 hospitals received high marks from at least one service while being graded among the poorest performers in another ranking. Of the 844 hospitals touted in the various ratings, just 10% were identified by more than one service.

A Vanderbilt University professor who was a co-author of the *Health Affairs* study maintains that more information, rather than less, remains vital but that a term such as "best hospitals" is simply too vague.

Coalition Targets Physician Quality

The Indiana Employers Quality Health Alliance (IEQHA) is a coalition that has been dedicated to improving health care and reducing employer costs since its inception in 1994. A current focus is establishment of a Physician and Employer Quality Health Alliance.

The community-based, not-for-profit would, according to IEQHA, "provide an independent, conflict-free, cost-effective approach to health reform and cost containment."

Ralph Alexander, a managed health care executive for more than 30 years, is co-developer and now director of the Physician Self-Management for Quality & Efficiency Improvement process. He notes, "The most direct route to improved quality is reducing the outrageous variation in medical practice patterns among physicians of the same specialty in the same geographic area treating patients of similar medical conditions."

Dr. Ned Lamkin, IEQHA president, says that physicians will only change their medical practice patterns if they believe there is a better (and practical) approach to diagnosis and/or treatment. He adds that physicians are most likely to accept and respond to quality standards defined by clinical leadership in their own specialties.

Lamkin and IEQHA are seeking additional coalition members to "convince the provider community that employers want these changes to occur."

IEQHA, which includes a variety of employers and organizations primarily in Central Indiana, has played a role in previous improvement efforts. These include the Indiana Health Information Exchange (which has lowered operational costs for hospitals) and Leapfrog (a tool for evaluating hospital performance).

RESOURCE: Indiana Employers Quality Health Alliance at www.qualityhealthalliance.org

Reference Pricing Still in Development

What is reference pricing and will you or your organization benefit from its potential growth? Part one can be clearly answered; the jury is still out on its impacts, according to industry analysts.

Kaiser Health News provides this explanation of reference pricing. Insurers or employers survey what providers are charging for a specific treatment. A cap is then set to mark the maximum that will be paid for that service. Employees/patients can still use a hospital or provider that charges more than the reference price, but the individual will pay the difference in cost.

In May 2014, the federal government gave the green light to large or self-insured employers to use reference pricing in designing health plan benefits. *Kaiser* notes, "Reference pricing can save money for employers when applied to high-cost services where there are big pricing variations and consumers have the time and information to shop for the best option."

The National Institute for Health Care Reform completed an in-depth review, focusing on the reference pricing model used for inpatient knee and hip replacements by the California Public Employees' Retirement System. It reports that overall potential savings are "modest" because "shoppable services only account for about a third of total spending and reference pricing only directly affects prices at the high end of the price distribution."

A *Health Affairs* posting on the subject acknowledges the appeal of the concept but advocates for a "go slow approach and more careful regulation."