Possible Addition of a Third Hospital Peer Group to Hospital Provider Peer Grouping Analysis

What Is The Issue?

In the total care report released confidentially to hospitals in April 2013, hospitals were compared within two peer groups: Critical Access Hospitals (CAHs) and Prospective Payment System (PPS) hospitals. This is consistent with recommendations from the 2009 PPG Advisory Group that advised creating broad groups to ease hospital comparisons for consumers.

Some stakeholders have argued that hospitals delivering high-level trauma care, providing significant medical education and producing relatively high volumes of uncompensated care are potentially disadvantaged in cost comparisons. They argue payments in support of these services create an underlying costs structure that does not lend itself well to a comparison with facilities that do not provide such services.

These stakeholders argue one solution would be to create a third peer group in which to compare hospitals that are distinguished by one or more of the aforementioned characteristics.

Considerations

In considering this issue, the advisory committee should balance two concerns:

- **What is useful to consumers and purchasers?** Results from the PPG analysis are intended to inform consumers’ health care purchasing decisions by providing transparency of cost and quality. (1) As consumers make comparisons between all hospitals in a geographic region, is the cognitive task made more difficult by creating a sub-category for hospitals because of underlying costs? (2) In their decision making would consumers care about policy reasons underlying cost differentials, given that they would have to pay a portion of these higher costs?

- **What is fair to the hospitals being compared?** The hospitals being compared argue that cost comparisons to other facilities with different underlying costs are inherently unfair and might cause them to be penalized for providing these benefits to the community. (1) In comparing risk-adjusted costs per discharge, would it be fairer to compare cost performance among a smaller group of hospitals with similar teaching, trauma and uncompensated care characteristics? (2) What factors should MDH consider in designing a third peer group?

In resolving the tension between the two concerns, are there strong alternatives to creating a third peer group, for instance providing contextual information to consumers in public reporting? What contextual information would be potentially of value to consumers as they consider differential performance among hospitals in costs of inpatient care?

Staff Recommendation

Staff recommends retaining the structure of two peer groups to enable easier comparison of hospitals by consumers.
However, staff also recommends that public reports include the opportunity for hospitals to provide brief contextual information that may explain variations in cost related to the mix of services provided beyond what was accounted for in risk adjustment.