

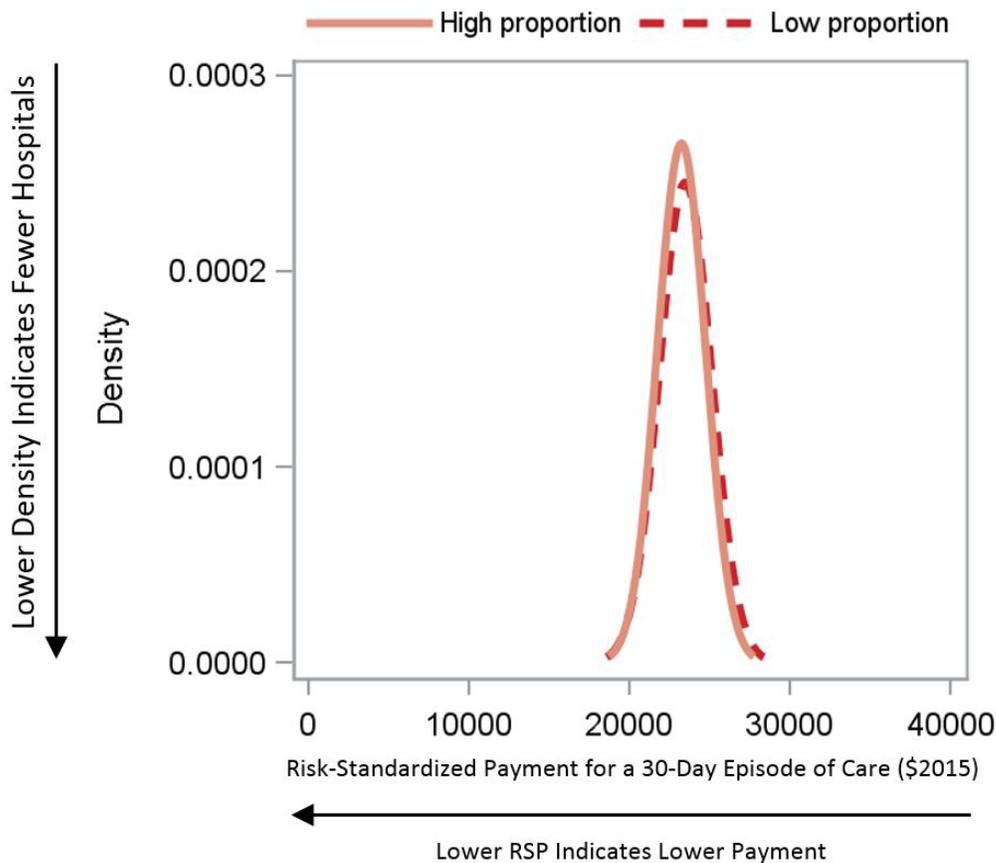
► **Risk-standardized payments across hospitals for a 30-day episode of care following admission for acute myocardial infarction:** Hospitals that serve high and low proportions of Medicaid patients.

The Centers for Medicare & Medicaid Services (CMS) evaluates hospital performance in relation to the proportion of Medicaid patients served in order to monitor patterns, changes, and potential unintended consequences in the measure results. This information allows CMS to better understand the current state of care within U.S. hospitals.

The acute myocardial infarction (AMI) payment measure includes admissions for Medicare fee-for-service (FFS) beneficiaries aged 65 or older and captures payments across multiple care settings, services, and supplies (this includes inpatient, outpatient, skilled nursing facility, home health, hospice, physician/clinical laboratory/ambulance services, and durable medical equipment, prosthetics/orthotics, and supplies) [1]. To isolate payment variation that reflects practice patterns rather than factors unrelated to clinical care, geographic differences and policy adjustments in payment rates for individual services are removed from the total payment for that service [1]. Standardizing the payment in this way allows for comparison across hospitals based solely on payments for decisions related to clinical care. However, it's important to note that the AMI payment measure results alone are not an indication of quality.

CMS began publicly reporting risk-standardized payments (RSPs) associated with a 30-day episode of care for AMI in 2014 [2]. Publicly reported measure results are updated annually on the [Hospital Compare](#) website. The AMI payment measure will be included in the Hospital Value-Based Purchasing (HVBP) Program beginning in 2021 [3, 4].

**FIGURE I.** Distributions of AMI RSPs (\$2015) for hospitals with low and high proportions of Medicaid admissions, July 2013-June 2016.



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## SOCIAL RISK FACTORS

Variation in AMI RSPs reflects different patterns in care decisions and resource utilization (for example, treatment, supplies, or services) among hospitals for a hospital's patients during and after the hospital stay. To understand how caring for high or low proportions of Medicaid patients might impact a hospital's resource utilization, we examined RSPs among hospitals with high and low proportions of Medicaid patients. We compared the AMI RSP for a 30-day episode of care for the 232 hospitals with  $\leq 9.8\%$  Medicaid admissions to the 231 hospitals with  $\geq 32.6\%$  Medicaid admissions. We defined hospitals with low and high proportions of Medicaid admissions as those that fall within the lowest and highest deciles of all hospitals with 25 or more qualifying admissions (N= 2,313). The proportion of Medicaid admissions for each hospital was determined using the American Hospital Association (AHA) Annual Survey Database Fiscal Year 2015 [5]. To ensure accurate assessment of each hospital, the AMI payment measure uses a statistical model to adjust for key differences in patient risk factors that are clinically relevant and that have a strong relationship with the payment outcome [1]. Additionally, all payments were inflation-adjusted to 2015 dollars.

**TABLE I.** Distributions of AMI RSPs (\$2015) for hospitals with low and high proportions of Medicaid admissions, July 2013-June 2016.

	AMI RSP (\$2015)	
	Hospitals with low proportions ( $\leq 9.8\%$ ) of Medicaid admissions n = 232	Hospitals with high proportions ( $\geq 32.6\%$ ) of Medicaid admissions n = 231
Maximum	28,416	27,247
90%	25,539	25,044
75%	24,660	24,262
Median (50%)	23,335	23,350
25%	22,439	22,288
10%	21,571	21,152
Minimum	19,339	19,738

The median AMI RSP for hospitals with low proportions of Medicaid admissions was \$23,335 (interquartile range [IQR]: \$22,439 - \$24,660; Figure 1 and Table 1). The median AMI RSP for hospitals with high proportions of Medicaid admissions was \$23,350 (IQR: \$22,288 - \$24,262; Figure 1 and Table 1).

Hospitals with low proportions of Medicaid admissions had a median AMI RSP that was \$15 lower than hospitals with high proportions.

1. Jaymie Simoes, Jacqueline N. Grady, Jo DeBuhr, et al. 2017 Measure Updates and Specifications Report Hospital-Level Risk-Standardized Payment Measures: Acute Myocardial Infarction – Version 6.0 Heart Failure – Version 4.0 Pneumonia – Version 4.0 Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) – Version 3.0. <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228774267858>. Available as of April 4, 2017.

2. Hospital Inpatient Quality Reporting (IQR) Program Overview. QualityNet website. <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1138115987129>. Accessed March 1, 2017.

3. Hospital Value-Based Purchasing Overview. QualityNet website. <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772039937>. Accessed March 1, 2017.

4. Centers for Medicare and Medicaid Services. Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals, Final Rule Fiscal Year 2017. 81 FR 56761. Federal Register website. <https://www.federalregister.gov/d/2016-18476>. Published August 22, 2016. Effective October 1, 2016. Accessed March 1, 2017.

5. AHA Annual Survey Database Fiscal Year 2015; <http://www.ahadataviewer.com/book-cd-products/AHA-Survey/>. Accessed March 2, 2017.

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