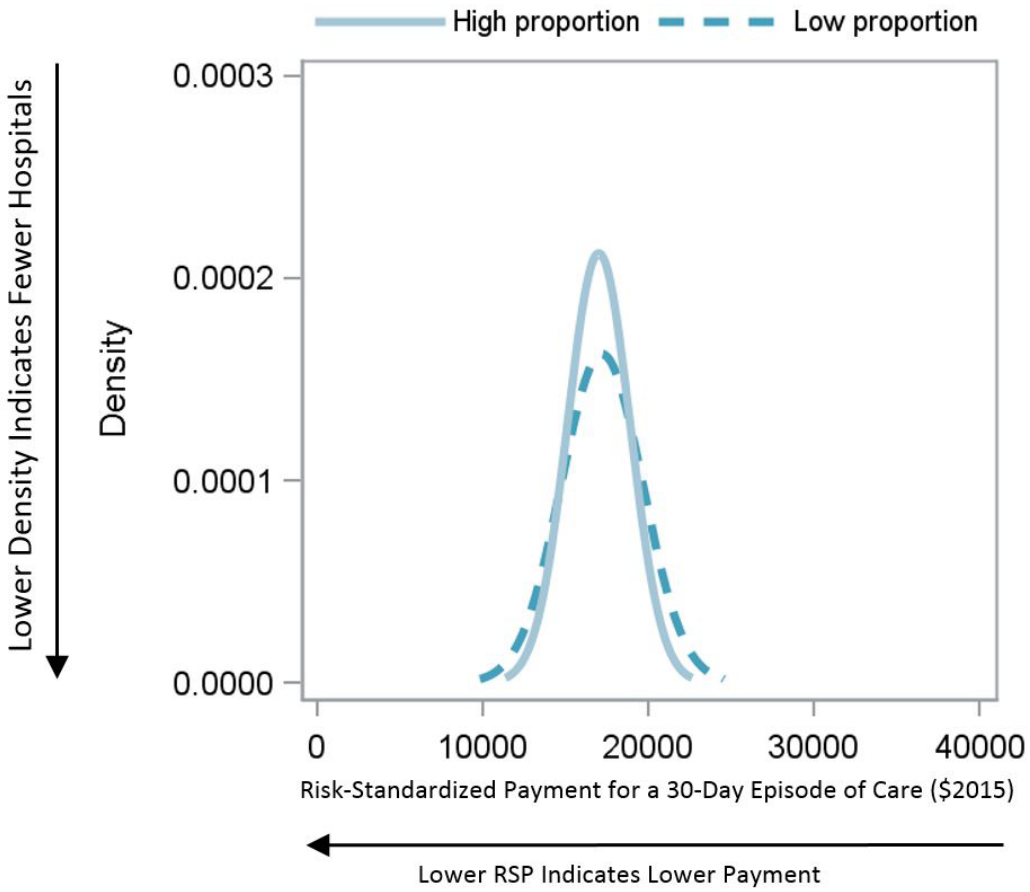
▶ Risk-standardized payments across hospitals for a 30-day episode of care following admission for pneumonia: Hospitals that serve high and low proportions of Medicaid patients.

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 pneumonia 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. 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 pneumonia payment measure results alone are not an indication of quality. For 2017 public reporting, the pneumonia payment measure cohort has been expanded to include aspiration pneumonia and non-severe sepsis patients.

CMS began publicly reporting risk-standardized payments (RSPs) associated with a 30-day episode of care for pneumonia in 2015 [2]. Publicly reported measure results are updated annually on the *Hospital Compare* website.

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



SOCIAL RISK FACTORS

Variation in pneumonia RSPs reflects different patterns in care decisions and resource utilization (for example, treatment, supplies, or services) among hospitals for a hospital's patients both at the hospital and after they leave. 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 pneumonia RSP for a 30-day episode of care for the 411 hospitals with ≤6.1% Medicaid admissions to the 411 hospitals with ≥31.3% 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= 4,109). The proportion of Medicaid admissions for each hospital was determined using the American Hospital Association (AHA) Annual Survey Database Fiscal Year 2015 [3]. To ensure accurate assessment of each hospital, the pneumonia 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 pneumonia RSPs ($2015) for hospitals with low and high proportions of Medicaid admissions, July 2013-June 2016.*

	Pneumonia RSP ($2015)	
	Hospitals with low proportions (≤ 6.1%) of Medicaid admissions n = 411	Hospitals with high proportions (≥ 31.3%) of Medicaid admissions n = 411
Maximum	26,301	25,169
90%	20,454	19,372
75%	18,462	18,202
Median (50%)	17,137	16,892
25%	15,714	15,766
10%	14,224	14,689
Minimum	10,778	11,768

The median pneumonia RSP for hospitals with low proportions of Medicaid admissions was $17,137 (interquartile range [IQR]: $15,714 -$18,462; Figure 1 and Table 1). The median pneumonia RSP for hospitals with high proportions of Medicaid admissions was $16,892 (IQR: $15,766 -$18,202; Figure 1 and Table 1).

Hospitals with low proportions of Medicaid admissions had a median pneumonia RSP that was $245 higher than hospitals with high proportions. Payment results alone are not an indication of quality.

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%2F-Page%2FQnetTier2&cid=1138115987129. Accessed March 1, 2017.

3. AHA Annual Survey Database Fiscal Year 2014; http://www.ahadataviewer.com/book-cd-products/AHA-Survey/. Accessed March 2, 2017.