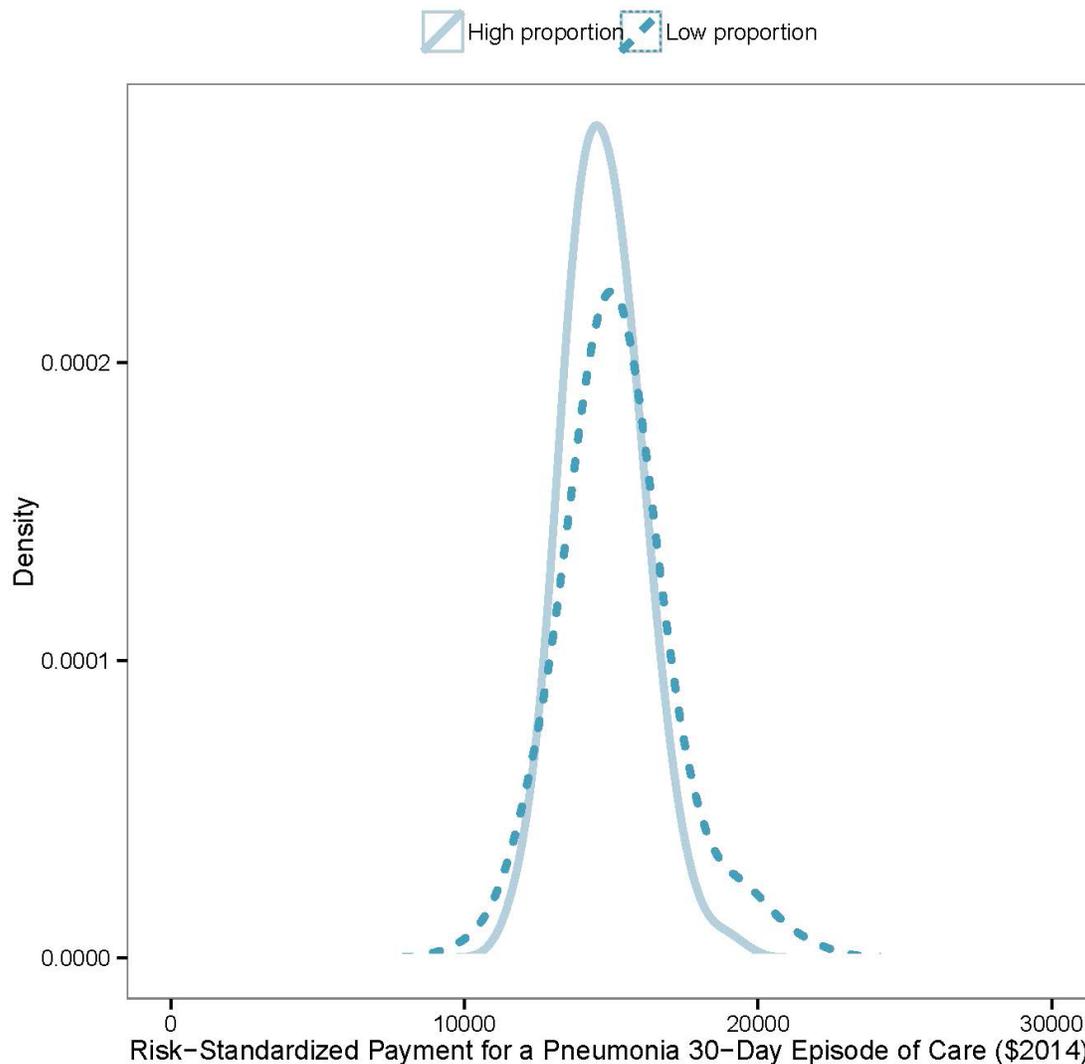


► **Risk-standardized payments across hospitals for a 30-day episode of care following admission for pneumonia:** Hospitals that serve high and low proportions of Medicaid patients.

The Centers for Medicare & Medicaid Services (CMS) periodically investigates select hospital practices that may impact a hospital's results on the following payment measure: hospital-level risk-standardized payment (RSP) associated with a 30-day episode of care for pneumonia [1]. 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) [2]. 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 [2]. 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 2016 public reporting, the pneumonia payment measure does not reflect the cohort change of the pneumonia mortality and readmission measures [2]. The pneumonia payment measure has been publicly reported on [Hospital Compare](#) since 2015 [3].

FIGURE I. Distributions of pneumonia RSPs (\$2014) for hospitals with the lowest and highest proportions of Medicaid admissions, July 2012-June 2015.



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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 412 hospitals with the lowest overall proportion of Medicaid admissions ($\leq 5.8\%$ of a hospital's admissions) to the 412 hospitals with the highest overall proportion of Medicaid admissions ($\geq 28.7\%$ of a hospital's admissions). We defined hospitals with the lowest and highest proportions of Medicaid admissions as those that fall within the lowest and highest deciles of all hospitals with 25 or more qualifying admissions, respectively. The proportion of Medicaid admissions for each hospital was determined using the American Hospital Association (AHA) Annual Survey Database Fiscal Year 2014 [4]. 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 [2]. Additionally, all payments were inflation-adjusted to 2014 dollars.

TABLE I. Distributions of pneumonia RSPs (\$2014) for hospitals with the lowest and highest proportions of Medicaid admissions, July 2012-June 2015.

	Pneumonia RSP (\$2014)	
	Lowest proportion ($\leq 5.8\%$) Medicaid admissions; n=412	Highest proportion ($\geq 28.7\%$) Medicaid admissions; n=412
Maximum	22,369	19,281
90%	17,526	16,417
75%	16,142	15,529
Median (50%)	15,075	14,635
25%	14,020	13,816
10%	12,940	13,223
Minimum	9,502	11,467

The median pneumonia RSP for hospitals with the lowest proportion of Medicaid admissions was \$15,075 (interquartile range [IQR]: \$14,020 - \$16,142; Figure 1 and Table 1). The median pneumonia RSP for hospitals with the highest proportion of Medicaid admissions was \$14,635 (IQR: \$13,816 - \$15,529; Figure 1 and Table 1).

Hospitals with the lowest proportion of Medicaid admissions had a median pneumonia RSP that was \$440 higher than hospitals with the highest proportion. Payment results alone are not an indication of quality.

1. 2015 Medicare Hospital Quality Chartbook. Prepared by Yale New Haven Health Services Corporation Center for Outcomes Research and Evaluation for the Centers for Medicare and Medicaid Services. <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/outcomemeasures.html>. Accessed March 1, 2016.
2. Ott, L.S., Kim, N., Hsieh, A., et al. 2016 Measure Updates and Specifications Report Hospital-Level Risk-Standardized Payment Measures: Acute Myocardial Infarction – Version 5.0, Heart Failure – Version 3.0, Pneumonia – Version 3.0, Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) – Version 2.0. <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228774267858>. Accessed May 9, 2016.
3. 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 4, 2016.
4. American Hospital Association (AHA) Annual Survey Database Fiscal Year 2014. <http://www.ahadataviewer.com/book-cd-products/aha-survey/>. Accessed March 2, 2016.

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