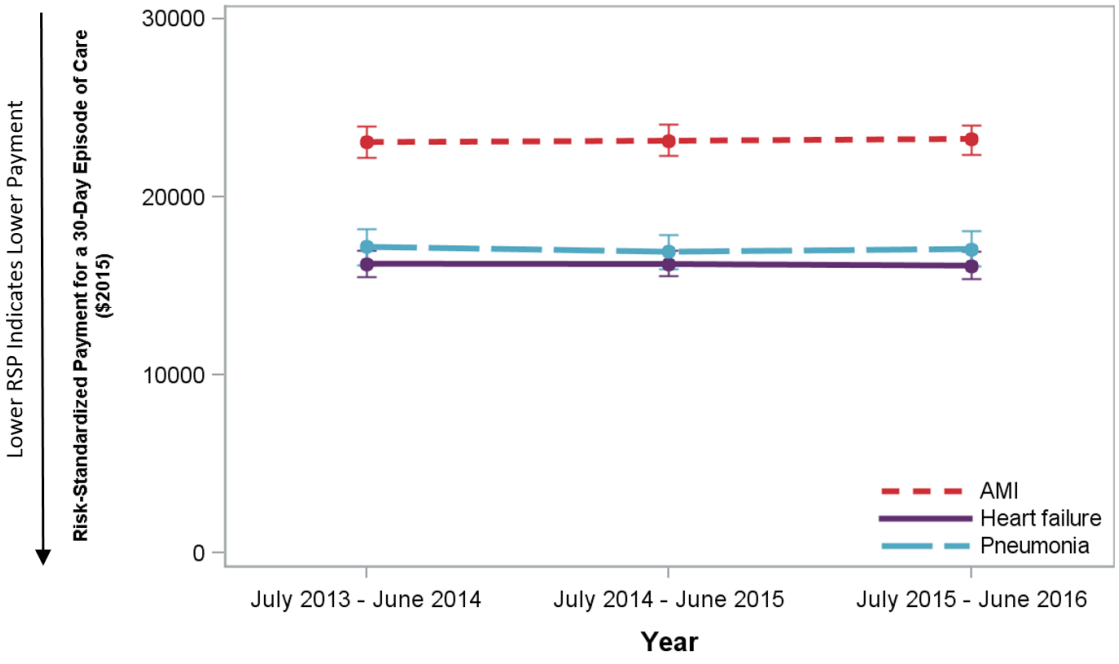
▶ Trends in risk-standardized payments across hospitals for a 30-day episode of care following admission for acute myocardial infarction, heart failure, and pneumonia.

The Centers for Medicare & Medicaid Services (CMS) evaluates the trends in measure results over time 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 payment measures assess 30-day episode-of-care payments that begin with an index admission for acute myocardial infarction (AMI), heart failure, and pneumonia. The measures include admissions for Medicare fee-for-service (FFS) beneficiaries aged 65 or older [1]. These measures capture payments across multiple care settings, services, and supplies (this includes inpatient, outpatient, skilled nursing facility, home health, hospice, physician/clinical laboratory/ambulance services, durable medical equipment, prosthetics/orthotics, and supplies). 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. It is important to note that the AMI, heart failure, and pneumonia 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; and for heart failure and pneumonia in 2015 [2]. Publicly reported measure results are updated annually on the *Hospital Compare* website. The AMI and heart failure payment measures will be included in the Hospital Value-Based Purchasing (HVBP) Program beginning in 2021 [3, 4].

FIGURE I. *Trends in the median hospital RSPs ($2015) for AMI, heart failure, and pneumonia, July 2013-June 2016.*



Examining trends in hospital results for the condition-specific payment measures provides insight into whether there is variation from year to year in care decisions and resource utilization (for example, treatment, supplies, or services). To determine the trends in national results for these measures, we examined hospitals' RSPs for each year of the July 2013-June 2016 reporting period. We included hospitals with 25 or more qualifying cases. To ensure accurate assessment of each hospital, the measures use a statistical model to adjust for key differences in patient risk factors that are clinically relevant and that have strong relationships with the payment outcome [1]. Additionally, for this reporting period, all payments were inflation-adjusted to 2015 dollars.

TABLE I. *Trends in the median hospital RSPs ($2015) for AMI, heart failure, and pneumonia, July 2013-June 2016.*

	Median (IQR) of Hospital RSPs ($2015)		
	July 2013-June 2014	July 2014-June 2015	July 2015-June 2016
AMI	23,058 (22,177, 23,974) (1674 hospitals)	23,132 (22,288, 24,069) (1695 hospitals)	23,238 (22,355, 24,020) (1666 hospitals)
Heart Failure	16,226 (15,485, 16,967) (2610 hospitals)	16,210 (15,557, 16,993) (2585 hospitals)	16,119 (15,400, 16,928) (2520 hospitals)
Pneumonia	17,176 (16,138, 18,197) (3314 hospitals)	16,901 (15,960, 17,845) (3346 hospitals)	17,053 (16,124, 18,070) (3201 hospitals)

The median hospital RSP for AMI increased by $180 between June 2014 and June 2016 (Figure 1 and Table 1). Over this three-year period, the median hospital RSP for heart failure decreased by $107, and the median hospital RSP for pneumonia decreased by $275 between June 2014 and June 2015, and increased by $152 by June 2016 (Figure 1 and Table 1). The bars on the graph in Figure 1 represent the interquartile range (IQR).

Hospital RSPs for an AMI episode of care increased by $180 between June 2014 and June 2016, hospital RSPs for a heart failure episode of care decreased by $107, and hospital RSPs for a pneumonia episode of care decreased by $275 between June 2014 and June 2015, and increased by $152 by June 2016.

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.