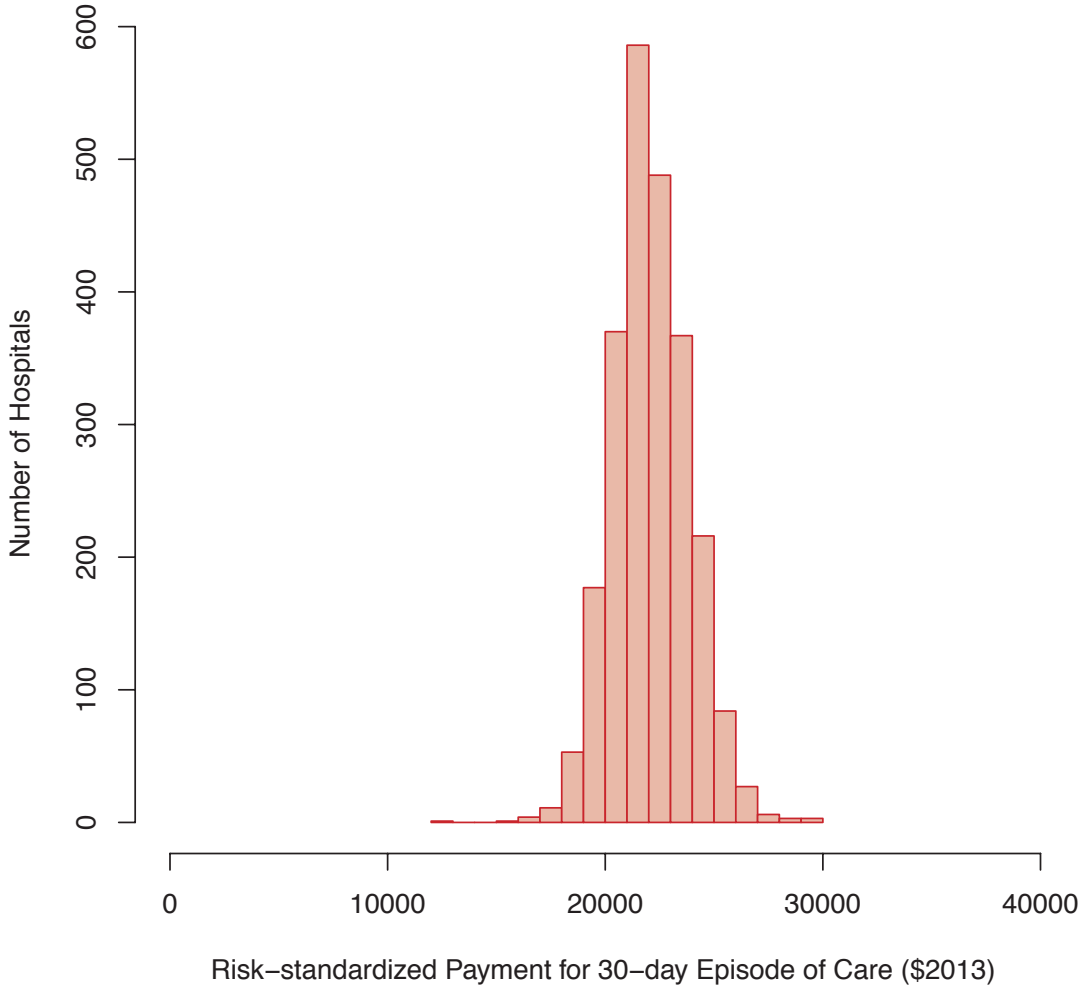
PAYMENT

Variation in risk-standardized payments across hospitals for a 30-day episode of care following admission for acute myocardial infarction.

In 2014, the Centers for Medicare & Medicaid Services (CMS) began publicly reporting the following payment measure on Hospital Compare: hospital-level risk-standardized payment (RSP) associated with a 30-day episode of care for acute myocardial infarction (AMI) [1]. The AMI payment measure includes admissions for Medicare fee-for-service (FFS) beneficiaries aged 65 or older [2]. The AMI payment measure 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 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.

FIGURE I *Distribution of hospital RSPs ($2013) for AMI, July 2011-June 2014.*



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 both at the hospital and after they leave. Wider distributions suggest more variation in payments, and narrower distributions suggest less variation in payments. To determine the extent of variation present in the AMI payment measure, we examined hospital RSPs for the July 2011 – June 2014 reporting period. To ensure accurate assessment of each hospital, the measure uses 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 [2]. Additionally, all payments were inflation-adjusted to 2013 dollars.

TABLE I *Distribution of hospital RSPs ($2013) for AMI, July 2011-June 2014.*

	Distribution of AMI RSPs ($2013)
Maximum	29,802
90%	24,380
75%	23,234
Median (50%)	21,996
25%	20,959
10%	19,964
Minimum	12,862

Hospital RSPs for AMI were normally distributed and centered at $21,996. The hospitals that were at the 25th and 75th percentiles had a $2,275 difference in RSP. The absolute difference between the 10th and 90th percentiles was $4,416. Figure 1 and Table 1 display the distribution of this variation for hospitals with 25 or more qualifying admissions.

While half of hospitals had RSPs within a $2,275 range around the median hospital's RSP, the absolute difference in RSPs across all hospitals was $16,940, indicating variation in payments for AMI episodes of care.

1. "Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals, Final Rule." Federal Register / 22 August 2014; http://federalregister.gov/a/2014-18545. Accessed 16 June 2015.

2. Kim N, Ott L, Hsieh A, et al. 2015 Condition-Specific Measure Updates and Specifications Report Hospital-Level 30-Day Risk-Standardized Payment Measures: Acute Myocardial Infarction – Version 4.0, Heart Failure – Version 2.0, Pneumonia – Version 2.0; https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228774267858. Accessed 26 June 2015.