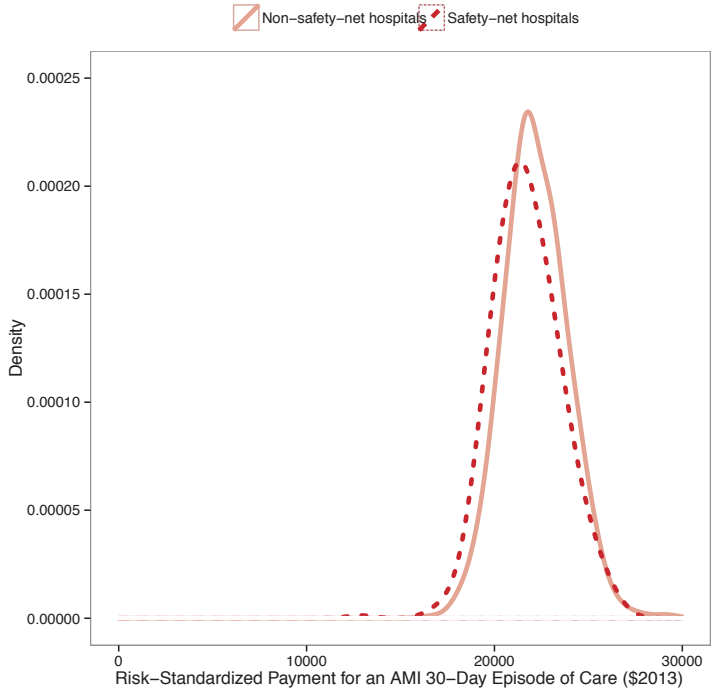
Results from the acute myocardial infarction payment measure by hospital characteristics: **safety-net status, teaching status, and urban or rural location.**

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 *Distributions of hospital RSPs ($2013) for AMI by safety-net status, July 2011-June 2014.*



Variation in AMI RSPs reflects differences 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 the impact of hospital safety-net status, teaching status, and urban or rural location, we examined payments among hospitals with these characteristics with 25 or more qualifying admissions. Therefore, we evaluated the RSPs for a 30-day episode of AMI care for a total of 2,374 hospitals by comparing 429 safety net hospitals against 1,945 non-safety-net hospitals, 950 teaching hospitals against 1,424 non-teaching hospitals, and 2,261 urban hospitals against 113 rural hospitals.

Safety-net hospitals are defined as those committed to caring for populations without stable access to care, specifically public hospitals or private hospitals with a Medicaid caseload greater than one standard deviation above their respective state's mean private hospital Medicaid caseload [3]. Teaching Hospitals provide post-graduate education for physicians completing residency and fellowship [3].

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 [2]. Additionally, all payments were inflation-adjusted to 2013 dollars.

FIGURE 2 *Distributions of hospital RSPs ($2013) for AMI by teaching status, July 2011-June 2014.*

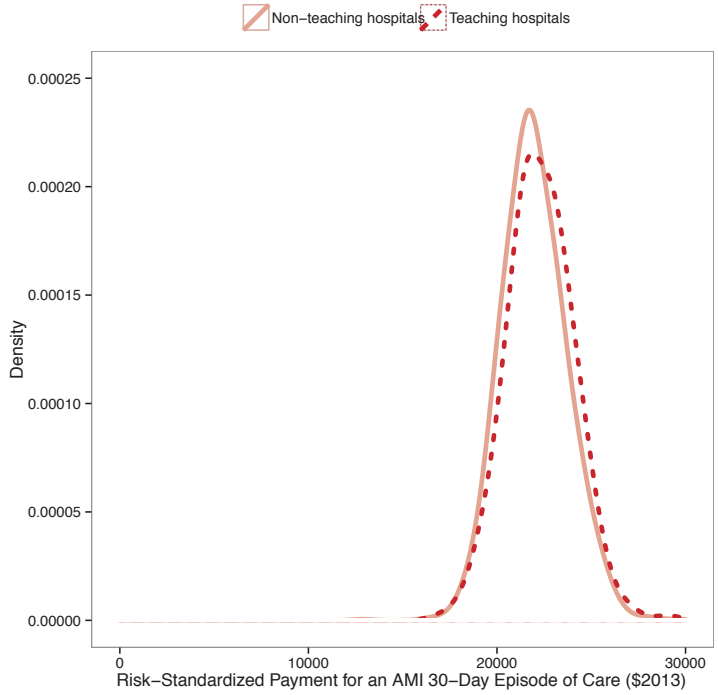
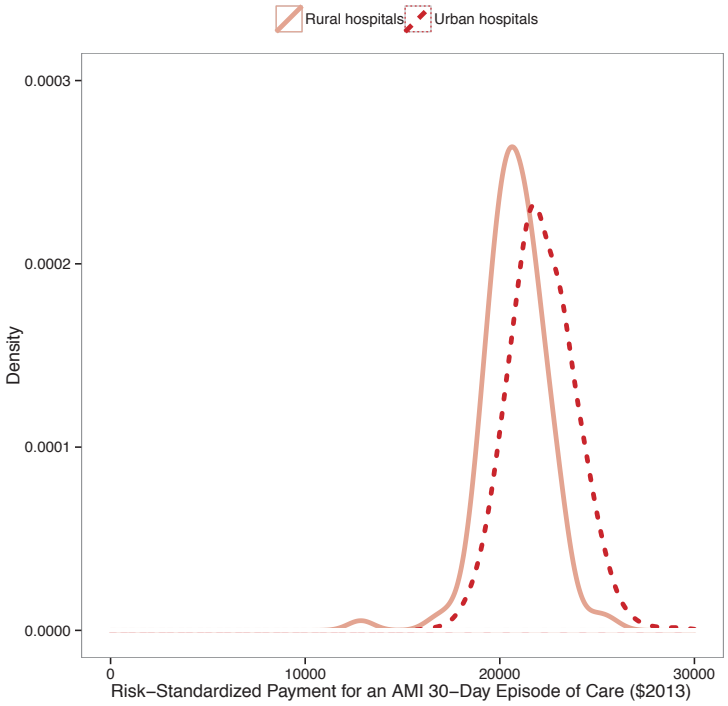


TABLE I *Distributions of hospital RSPs ($2013) for AMI overall, by safety-net status, teaching status, and urban or rural location, July 2011-June 2014.*

	AMI RSP ($2013)						
	Overall; n=2374	Safety-net hospitals; n=429	Non-safety-net hospitals; n=1945	Teaching hospitals; n=950	Non-teaching hospitals; n=1424	Urban hospitals; n=2261	Rural hospitals; n=113
Maximum	29,802	26,604	29,802	29,316	29,801	29,802	25,563
90%	24,373	24,087	24,414	24,532	24,250	24,414	22,678
75%	23,234	22,893	23,301	23,456	23,062	23,295	21,732
Median (50%)	21,994	21,573	22,076	22,242	21,865	22,059	20,775
25%	20,955	20,474	21,084	21,138	20,806	21,033	20,030
10%	19,964	19,577	20,120	20,152	19,889	20,040	19,206
Minimum	12,862	12,862	16,196	16,638	12,862	16,196	12,862

The median AMI RSP for all hospitals was $21,994 (interquartile range [IQR]: $20,955-$23,234; Table 1). The median AMI RSP for safety-net hospitals was $21,573 (IQR: $20,474-$22,893) and for non-safety-net hospitals was $22,076 (IQR: $21,084-$23,301; Figure 1 and Table 1). The median AMI RSP for teaching hospitals was $22,242 (IQR: $21,138-$23,456) and for non-teaching hospitals was $21,865 (IQR: $20,806-$23,062; Figure 2 and Table 1). The median AMI RSP for urban hospitals was $22,059 (IQR: $21,033-$23,295) and for rural hospitals was $20,775 (IQR: $20,030-$21,732; Figure 3 and Table 1).

FIGURE 3 *Distributions of hospital RSPs ($2013) for AMI by urban or rural location, July 2011-June 2014.*



Safety-net hospitals had a median AMI RSP that was $503 less than non-safety-net hospitals, teaching hospitals had a median AMI RSP that was $377 greater than non-teaching hospitals, and urban hospitals had a median AMI RSP that was $1,284 greater than rural hospitals. Payment results alone are not an indication of quality.

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.

3. AHA Annual Survey Database Fiscal Year 2013; http://www.ahadataviewer.com/book-cd-products/aha-survey/. Accessed 26 June 2015.