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The Cost of Equalization: New HHS Rules Increase Medicaid Pay to Doctors and Cut Medicare Pay

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Providing a poignant example of the tension between reducing federal debt and providing high quality healthcare, **HHS** proposed three new rules on November 1, 2012. One such rule increased **Medicaid** reimbursements to certain physicians. Another rule, which will likely be overturned, proposed 26.5% cuts to Medicare reimbursements to over one million physicians.

The Medicaid rule, CMS-2370-F, is focused on executing an **Affordable Care Act ("ACA")** provision that required equalizing Medicare and Medicaid reimbursement rates to physicians specializing in: primary care, general internal medicine, pediatric medicine and other related specialties. Generally, physicians are reimbursed at a much lower rate for treating patients on Medicaid. Because the reimbursement rates are so low, many physicians are hesitant to treat patients receiving Medicaid. Partly in an effort to reduce this problem, the ACA raised the Medicaid reimbursement rates. However, equalization may be costly.

Another HHS rule, CMS-1590-FC, released simultaneously, called for reducing Medicare rates paid to more than one million physicians by more than 25 percent. This reduction in Medicare reimbursements is required by the Balanced Budget Act of 1997. However, the Center for Medicare and Medicaid Services maintains that these cuts are unlikely to occur. Congress has overruled this same reduction annually since 2003. Additionally, the Medicare rule established reimbursement rates for physicians managing the care of patients recently released from hospitals or nursing facilities. This measure is aimed at increasing quality of patient care and reducing hospital readmission rates, which will, in turn, theoretically reduce costs.

While aspects of these rules aim to repair some serious issues in the Medicare and Medicaid programs, the potential cost increases are tangible and the potential cost offsets are intangible. There is certainly potential for cost offsetting in reducing unnecessary readmissions to hospitals, but the cost savings are difficult to quantify and may take time. These rules, viewed together, can serve as a case study of the tension between providing high quality and potentially high cost healthcare programs and mounting federal government debt.

As an aside, last month I reviewed the penalties recently imposed on hospitals with high patient readmission rates. The new Medicare rule, which provides a funding source for physicians coordinating the care of patients recently released from hospitals, can be utilized by hospitals aiming

to reduce high readmission rates and potentially avoiding penalties.

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