Does your insurance card matter when you have a heart attack?

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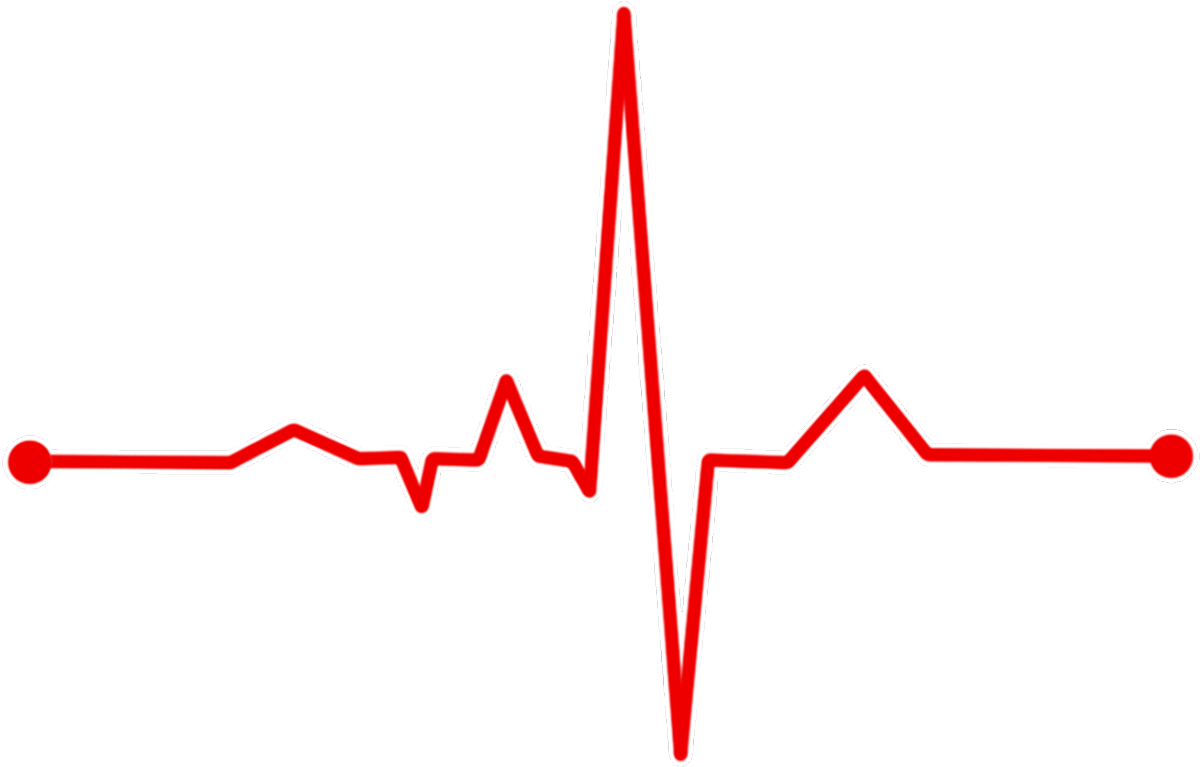

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Medicaid reimbursement to health care facilities on ST-elevation

myocardial management—or STEMI, a serious form of a heart attack—is often lower when compared with the reimbursement rate of private insurance, according to a study published in the journal *Circulation: Cardiovascular Quality and Outcomes*. The findings were made by a team of cardiovascular researchers at the University of Alabama at Birmingham.

Utilizing the largest in-patient database—the National Inpatient Sample—investigators from UAB summarized the impact of the reimbursement gap between Medicaid and private insurance on management and in-hospital outcomes among patients admitted for STEMI.

"We conducted a retrospective study to examine the differences in management and outcomes between Medicaid beneficiaries versus privately insured STEMI hospitalizations as a proxy for understanding the impact of reimbursement gap across the two insurance groups,"said first author Nirav Patel, M.D.

Patel designed and conducted the analyses for the study.

"As expansion of Medicaid has significantly improved health care access but often lowered payments to hospitals and providers," Patel said, "we wanted to explore the possible unintended consequences of the differences in reimbursement rates on emergent medical conditions such as STEMI in Medicaid beneficiaries as compared with privately insured individuals."

Medicaid is the largest federally funded health insurance program in the United States, covering nearly 73 million people. Implementation of the Affordable Care Act and expansion of Medicaid has allowed more than 15 million previously uninsured individuals to gain health care coverage. However, Medicaid reimbursement to the health care facilities is often

lower as compared with private insurance. Researchers say that, in principle, the reimbursement rates should have no effect on health care outcomes, especially to those requiring immediate assistance such as with a heart attack, where there is abrupt blockage of a heart artery with changes on the electrocardiogram.

In this nationwide retrospective study from January 2012 through September 2015, researchers found that Medicaid beneficiaries with STEMI had significantly lower rates of coronary revascularization and higher rates of in-hospital mortality compared with the privately insured. Medicaid beneficiaries with STEMI were more likely to receive bare metal stents, while those with private insurance were more likely to receive drug eluting stents for coronary revascularization.

Additionally, the rates of coronary angiography and utilization of thrombolysis were also significantly lower in Medicaid beneficiaries compared with privately insured with STEMI. The rates of invasive hemodynamic support and median length of stay were similar between Medicaid beneficiaries and privately insured with STEMI. However, the cost of STEMI hospitalization was higher among Medicaid beneficiaries compared with privately insured.

"The finding of disparities in management and in-hospital outcomes by insurance status can be explained by Medicaid's complex payment system—base plus supplemental payments and reimbursement rates," said senior author Pankaj Arora M.D., an assistant professor in UAB's Division of Cardiovascular Disease. "Historically, Medicaid pays roughly 90 percent of the cost incurred to the hospitals, whereas private insurances typically remunerate roughly 144 percent of the cost of the service provided by the hospital. After the execution of the Affordable Care Act, hospitals are getting a higher number of Medicaid beneficiaries, which has distorted the hospital payer mix—pooled Medicaid and private insurance payment basket."

Additionally, Arora said mandated federal spending cuts through the Tax Cuts and Jobs Act of 2017 may further exacerbate the disparities in quality of health care for Medicaid beneficiaries. He cautioned that there can be bias, or residual confounding, in an observational study, but he said that their findings of disparities by insurance status in treatment of heart attack are intriguing and underscore the importance of additional research to identify and understand the reasons behind these disparities.

Authors emphasized the need to dedicate efforts to customize health care reforms by increasing transparency on policymaking decisions and the overall process, restructuring reimbursement policies for life-threating conditions and lifesaving procedures independently, increasing the supplemental payments to solidify Medicaid reimbursement, and timeliness of supplemental payments to hospitals and health care providers to avoid distorting the payer mix as possible solutions to improve the disparities.

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