

Physician Tax Plan Prompts Debate in Michigan

BY JOYCE FRIEDEN

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Michigan physicians are divided over efforts by Gov. Jennifer Granholm (D) to pass a physician tax that would help increase payments to Medicaid providers in the state.

Under the governor's proposal, a 2.28% gross receipts tax would be levied on all physicians in the state. The tax would raise \$96 million, which would then be put into the Medicaid program and would increase the amount of matching funds the program received from the federal government.

"In that scenario, the state keeps \$40 million, and then the \$56 million left would be paired with Medicaid matching dollars, so we can return \$125 million to providers, bringing up to Medicare rates our physicians who've long complained that Medicaid [reimbursement] rates were too low," said T.J. Bucholz, spokesman for the Michigan Department of Community Health in Lansing.

In the case of physicians who have at least 3.5% of their practice revenue coming from Medicaid, "they will get more back in terms of Medicaid reimbursement" than they paid into the system in taxes, he noted.

But the Michigan State Medical Society (MSMS) isn't buying it. "Inherent in that is an underlying current of a lot of trust, and for those of us who have paid attention to legislative and gubernatorial activities in the state over the last decade, a track record of trust is one that needs to be earned. People have a lot of questions

about that," said Gregory Forzley, M.D., who is a member of the society's board of directors.

For instance, "when they introduced the state lottery, it was going to benefit K-12 education programs and colleges in the state, but it appears they used the lottery money in place of other governmental funding," said Dr. Forzley, a family physician in Grand Rapids. "So when they come with a similar-sounding proposal in a system already fraught with cutbacks and underfunding, most people say, 'I don't believe you when you say you are going to put safeguards in.'"

But Stephen DeSilva, M.D., president of Michigan Doctors Making a Difference, said that some of these problems could be overcome. For example, the law could be written so that "when the federal matching funds go away, the tax would automatically sunset," he said.

Dr. DeSilva, an orthopedic surgeon, noted that similar tax assessments in the state have worked very well for hospitals, pharmacies, and nursing homes. "It would work well for physicians, but it's difficult to overcome the knee-jerk reaction to taxes as well as the paranoia about how the state will use the money."

He acknowledged that his own 750-member practice group at Wayne State University in Detroit would have a lot to gain if the proposal became law, since about 20% of the group's patients are on Medicaid.

"In Michigan, Medicaid pays \$22 per work unit, and Medicare pays almost \$38 per work unit, so you can see it's a big increase," Dr. DeSilva said. "For our group,

it would mean an extra \$30 million to our bottom line."

But the main reason to support the program is that it would improve access for Medicaid patients, Dr. DeSilva said. "Right now, they either go without or use the emergency room for primary care, because very few physicians are willing to see patients at that very low reimbursement rate," he said. "If you look in the 50 states, there is a direct correlation between access to physician office practices and the ratio of Medicare to Medicaid reimbursement. In states where the ratio approaches [1:1], access is usually good, but as rates fall, access usually falls as well. In New York and New Jersey, which are near the bottom, almost no physician will see a Medicaid patient."

Like Dr. DeSilva, Dr. Forzley said he thinks the Michigan Medicaid program needs fixing, but he doesn't think a physician tax is the way to do it. "There are some areas where we can get more creative," he said. For example, "a long time ago, a lot of studies showed that if you provide people with transportation to their physician, they stay out of the hospital. It's worth it to look at those experiments out there and see how we can make a broader effort to touch rural and urban populations most effectively."

"We're willing to work with the governor on trying to create a solution, and we don't think a tax is the best solution," he added. That may mean using a Band-Aid approach—such as the cut in Medicaid rates currently in place in the state—while all parties work on a long-term fix, he said.

Michigan is not the only state to have

considered provider taxes. Outgoing Washington Gov. Gary Locke (D) also proposed such a tax in January, but Christine Gregoire (D), the current governor, did not include it in her budget proposal, nor has the state legislature moved to implement it.

Physician concerns about taxing providers actually reflect issues revolving around Medicaid copayments, said Diana Ewert, senior manager for state government relations at the American Academy of Family Physicians. These are proposals in which "if you contract with the state to provide Medicaid services ... they would require you to take the patient, whether or not the patient pays the copay, and the state will still deduct the copay on other end because you should have collected it," she explained. "That makes the losing proposition of taking Medicaid patients even more critical, which we believe will impact the safety net and result in less access."

Ms. Ewert expressed concern regarding states enacting legislation such as provider taxes to increase federal Medicaid matching funds—a strategy known as intergovernmental transfers (IGTs)—for the coming fiscal year. She noted that the federally chartered commission on Medicaid will be looking at all financing mechanisms, including IGTs, in a preliminary report due to Congress on Sept. 1. The goal is to cut \$10 billion from Medicaid over the next 5 years.

"If states are depending upon IGTs to offset Medicaid costs and for some reason that doesn't come through, that may put states in an untenable situation," she said. ■

Governors Propose Strategies to Reform Medicaid Program

BY ALICIA AULT

Contributing Writer

The Bush administration has focused on overhauling the Social Security program, but the nation's governors and health providers say the real crisis is in Medicaid.

The National Governors Association (NGA) has offered a reform proposal to Congress, which has begun considering what can be done to sustain the program that provides health care for some 53 million impoverished and disabled Americans.

In July, the administration named 13 voting members and 15 nonvoting members to its commission on Medicaid reform. By law, the commission has until Sept. 1 to outline recommendations for cutting \$10 billion from the Medicaid program; a report on long-term solutions for the program is due at year's end.

Tennessee Gov. Don Sundquist (R) will chair the commission and former Maine Gov. Angus King (I) will serve as vice chair, the Health and Human Services department announced.

Both the state and federal governments are feeling the squeeze. The program will likely hit \$350 billion overall in 2005.

Medicaid represents 22% of the average state budget, according to testimony giv-

en to Congress by Mark Warner, Democratic governor of Virginia and chairman of the NGA. The problem: a skyrocketing caseload over the last 5 years, combined with rising health care costs, and an increasing number of sicker patients, Gov. Warner said.

The number of enrollees has grown by 40% in that period—at a time when eligibility has often been restricted, except for pregnant women and children, who have made up some of the growth. But there has also been a huge increase in the number of seriously disabled and severely and chronically ill recipients. Though they make up only 25% of the total number of Medicaid recipients, the elderly and disabled account for more than 70% of the budget.

That lopsided spending is seen when the per capita annual expense for various recipients is broken out. According to the Kaiser Family Foundation, Medicaid spends an average of \$1,700 per child, \$1,900 per nondisabled adult under 65 years, \$12,300 per disabled recipient, and \$12,800 per elderly recipient. So-called dual eligibles—those who receive both Medicaid and Medicare—also are an increasing burden, said Diane Rowland, executive vice president of the Kaiser Family Foundation.

Speaking at the Medicaid Managed Care

Conference in Baltimore in June, Ms. Rowland said dual eligibles make up 14% of the Medicaid population but account for 42% of its costs. Medicaid covers prescription drugs, long-term care, acute care, and Medicare premiums for this group.

States have been using a variety of tactics to reduce spending. Forty-eight states

now have drug cost controls, 50 have reduced payments to providers, and 21 have begun restricting eligibility and benefits, Ms. Rowland said. And states have increasingly looked to managed care to decrease costs and improve health, she said, adding that 13 states have 75% of Medicaid recipients in a managed care plan. ■

