Physician Tax Plan Promotes 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," commented T.J. Bucholz, who is a 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., 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.

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Dr. DeSilva, who is 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," he 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, according to Dr. DeSilva.

"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 the 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.

In July, Health and Human Services Secretary Mike Leavitt announced that former Tennessee Gov. Don Sundquist (R) will chair the 13-member commission and former Maine Gov. Angus King (I) will serve as vice chair. In addition, the secretary was holding open two vacancies on the commission for current governors so that they could join after Sept. 1, when the commission begins focusing on longer-term changes.

Back in Michigan, both the state house of representatives and the state senate did not include the provider tax in their budget proposals, although it is still in the governor's budget proposal.

Dr. DeSilva is not very hopeful that the provider tax will become law this year, but he said his group would consider pushing for other ways to increase Medicaid reimbursement.

Without any fixes for the program, "we may be forced to limit access and reduce the number of Medicaid patients we're seeing," he said of his own group. "We're not in the red yet, but we're having a hard time recruiting and retaining physicians." ■

Antifraud Effort Could Help Trim Medicaid Program Costs

BY NELLIE BRISTOL
Contributing Writer

WASHINGTON — Private bounty hunters are one way to fight fraud in the Medicaid program, according to Stan Dorn, J.D., who is senior analyst at the Economic and Social Research Institute.

Successfully used by Medicare, the bounty hunter approach allows whistle-blowers to share in funds recovered through prosecutions under the False Claims Act. According to recommendations developed by Andy Schneider, J.D., Medicaid policy expert for Taxpayers Against Fraud, Congress could bolster Medicaid whistle-blower opportunities by increasing federal payments to states that enact their own False Claims Act and by offering whistle-blowers a minimum of 20% of the federal share of any recovered funds.

At a policy forum sponsored by the American Public Health Association, Mr. Dorn included enhanced fraud reduction efforts among nine budget cutting options that would trim the cost of the program without capping spending or enrollment. Congress is expected to propose Medicaid program changes this year that will result in $10 billon in reduced federal spending over 5 years.

Mr. Dorn offered other cost savings alternatives, such as improving case management for the chronically ill and implementing community-based obesity prevention strategies. The Bush administration in its fiscal year 2006 budget proposed reducing Medicaid funding by reforming the program's drug purchasing system and limiting asset transfers that qualify seniors for long-term care.

Although limits on spending and benefits are not part of any current federal budget plans, lawmakers are looking broadly at Medicaid reform proposals this year; caps could be considered as part of those, Mr. Dorn pointed out at the forum, which was cosponsored by the Joint Center for Political and Economic Studies.

Not only would caps affect Medicaid recipients, but they also could prove detrimental to the economy, Mr. Dorn said.

Since Medicaid must provide benefits to all of those eligible, the bulk of the program is economically "countercyclical," he said, meaning it expands as the economy contracts.

Not only does this ensure health benefits are available to low income individuals, but it also contributes to the flow of funds to health care providers and, in turn, other sectors of the economy.

To capitalize on Medicaid's stabilizing effects, Mr. Dorn suggested that federal matching rates could automatically rise when the economy slows. Using national and state unemployment rates as triggers, automatic adjustment would not require waiting for new federal legislation each time a recession begins and the increase would end promptly when economic conditions improved.

"It would be better timed and come into effect immediately," Mr. Dorn noted.

Congress passed a 2.95% increase in the federal matching rate for the 15 months ending on June 30, 2004. Studies show the boost allowed states to continue Medicaid benefits even though state revenues shrank. ■