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ISSUES RELATED TO A PHYSICIAN QAAP

by

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EXECUTIVE SUMMARY

The Senate Appropriations Subcommittee on the Department of Community Health budget held a hearing on the proposed physician quality assurance assessment program (QAAP) on October 20, 2009. This hearing followed passage of House Bill 5386 by the Michigan House of Representatives on October 6, 2009. House Bill 5386 would have established a physician QAAP in Michigan. On October 28, 2009, the Michigan Senate defeated the bill, ending any further consideration of that version of the QAAP. Another version of the physician QAAP legislation, Senate Bill 854, has been referred to the Senate Appropriations Committee.

This paper provides an overview of the issues surrounding the proposed physician QAAP. Among the key issues raised in this paper are the following:

- The physician QAAP bill passed by the Michigan House would have established a 3.0% tax on reimbursement for physician services, which would have raised an estimated \$321.4 million in revenue. It would have allowed the State to retain \$116.3 million. Of the revenue, \$191.0 million would have been used, combined with \$523.6 million in Federal Medicaid match, to increase Medicaid physician reimbursement rates to Medicare levels.
- The net increase to physician services as a whole, the Medicaid increase less the tax collected, would have been \$393.1 million.
- While there would be a net increase, various hospitals, clinics, and practices would have been net losers under House Bill 5386 if they do not take Medicaid or have a low Medicaid volume.
- The break-even point for a practice, where the increase from Medicaid equaled the tax paid, would occur when 4.1% of the practice's pre-QAAP revenue came from Medicaid physician services payments.
- A practice's cost structure and overhead would have no impact on the effects of the QAAP. The tax would be on reimbursement and the rate increase would be made to a practice's Medicaid reimbursement. Costs, whether overhead or other expenses, would have no impact on the net effect of the QAAP.
- The various versions of the proposed QAAP do not represent an increase in the personal income tax paid by physicians. The physician QAAP would be a tax on the party receiving reimbursement for physician services, whether that is a hospital, a clinic, or an individual or group practice.
- The perception that the only way a practice could make up the revenue loss from the QAAP would be to see more patients is generally incorrect. The easiest way to make up some or all of the revenue loss from the QAAP tax paid would be to accept Medicaid patients and receive the increase in Medicaid reimbursement rates to Medicare levels.
- Physician practices with a large Medicaid volume, such as obstetrics/gynecology practices, would see an increase in net income. Physician practices with no or low Medicaid volume would see up to a 3.0% decrease in net income.
- The reduction in the Federal match rate in fiscal year (FY) 2010-11 to roughly 68% will lead to one or more of the following: a higher QAAP tax rate, a lower amount of State

gainsharing, or the reduction of the enhanced Medicaid physician services rates below Medicare levels.

- The inclusion of in-office pharmaceutical reimbursement in the QAAP tax base could cause major problems for certain physician practices, in particular oncologists who provide infusion services.
- The State would see increased costs from the requirement to pick up the 20% coinsurance costs for Medicare/Medicaid dual eligible physician services.
- Federally Qualified Health Centers (FQHCs), which receive reimbursement at cost, could see a reduction in revenue due to the tax.
- The Medicare Upper Payment Limit applies only to institutional providers. Providers such as physicians could be reimbursed for Medicaid services at rates exceeding Medicare.
- No information on the potential costs of compliance with a physician QAAP has been made available yet.

INTRODUCTION

On October 6, 2009, the Michigan House of Representatives passed House Bill 5386, a quality assurance assessment program for physician services. The bill would have imposed a 3.0% tax on gross physician services revenue. This tax would have applied to reimbursement payments made to billing entities for services rendered. Examples of such entities include an individual physician's practice, a clinic or hospital that employs physicians, and a group practice.

On October 30, 2009, the Michigan Senate defeated House Bill 5386 and defeated a motion to reconsider the bill, thus ending consideration of that version of the physician QAAP. Senate Bill 854, which would impose a 4.0% provider tax on reimbursements for physician services, has been referred to the Senate Appropriations Committee. It is not clear when or whether action will be taken by the Senate on Senate Bill 854.

For the purposes of this paper, the focus will be on the QAAP proposed by the House-passed version of House Bill 5386. This particular version of the QAAP was the subject of extensive discussions in the Legislature, in the media, and at the Senate Subcommittee hearing on October 20, 2009. These discussions provide a jumping-off point for a more extensive exploration of the proposed physician QAAP and the issues raised by such a proposal.

House Bill 5386 would have required that revenue from the physician QAAP, originally estimated at \$300.0 million, be used to support the Medicaid program. The bill directed that 13.2% of the Federal match revenue gained from the tax, roughly \$109.0 million, be retained by the State to offset General Fund/General Purpose (GF/GP) funding. The remaining QAAP tax revenue, \$191.0 million, was to be used, in combination with the Federal match, to increase Medicaid fee-for-service and managed care payment rates for physicians.

Given the enhanced 73.27% Federal match rate in place for FY 2009-10, this rate increase would have meant a gross increase in Medicaid physician reimbursement of about \$714.6 million. That increase would have been sufficient to raise Medicaid reimbursement rates for physician services to rates paid by the Federal Medicare program.

As one might expect, the House-passed bill was the subject of significant controversy. The two largest physician organizations in Michigan, the Michigan State Medical Society and the Michigan Osteopathic Association, came out in opposition to the bill. Other physician groups, such as the Michigan College of Emergency Physicians, endorsed the bill.

The purpose of this paper is to provide background on the proposed QAAP, to address some misunderstandings about the proposal, and to note other possible physician QAAP issues that have not yet been discussed generally. The Senate Fiscal Agency serves as the nonpartisan fiscal advisor to the Senate and does not take a position for or against the idea of a physician QAAP. It is important, however, if discussions continue, that all interested parties have a full understanding of the issues involved, and this paper represents an attempt to focus attention on the actual issues.

BACKGROUND ON QAAPs

In 2007, the Senate Fiscal Agency published a background article on the various existing QAAP programs, "A Summary of Quality Assurance Assessment Programs". The article can be found at:

<http://www.senate.michigan.gov/sfa/Publications/Notes/2007Notes/NotesJulAug07df.pdf>

As noted in the article, a QAAP is a tax on a provider group. A portion of the revenue is retained by the State to offset GF/GP funding. The remaining funding is used, combined with the Federal Medicaid match, to increase Medicaid payment rates to the provider group in question. Because of the Federal match, the gross rate increase greatly exceeds the amount of the tax, leading to a net increase in funding for the provider group as a whole.

This does not mean that every provider sees a net gain. A provider that does not take Medicaid would pay the tax but would not see any benefit from the increased Medicaid rates. A provider that has a low Medicaid volume would pay the tax but would not receive enough of an increase in Medicaid payments to offset the tax. Over the entire provider group, however, there are enough "winners" to more than offset the "losers" and the provider group, as a whole, sees an increase in revenue.

The hospital and nursing home QAAPs have been in place since early in this decade and have resulted in significant provider funding increases without costing the State any additional GF/GP dollars. The QAAP mechanism has enabled hospitals and nursing homes to receive increased funding from Medicaid during a period when other Medicaid payment rates have stayed flat or have been cut. For instance, the net annual benefit to Michigan hospitals, the rate increase less the tax paid due to the hospital QAAP, is \$688.3 million. The net annual benefit to Michigan nursing homes is \$282.0 million.

The Federal government has fairly tight rules for QAAPs. The tax must be broad-based. That means the tax cannot be structured in such a way as to protect the potential net losers from losing money. The easiest way to comply with this requirement is to have a flat tax. Other more complicated tiered taxes may be allowed if the Federal government determines they meet certain statistical tests. The tax may not exceed 5.5%. The tax may be applied only to certain provider groups specified in Federal statute and rules. Obviously, hospital services and long-term care services are among these, but so are physician services, outpatient prescription drugs, and dental services.

The proposed physician QAAP is similar in nature to the existing hospital and nursing home QAAPs. A provider group would be taxed, with the State retaining 13.2% of the Federal gain, with the rest of the revenue being used to increase Medicaid payment rates.

There are two key differences: First, the hospital and nursing home QAAPs were and are supported by the main provider groups, while the largest physician groups oppose the proposed physician QAAP. Second, there were very good data on how the hospital and nursing home QAAPs would affect individual hospitals and nursing homes. Because hospitals and nursing homes report institutional cost data to the State, it was relatively easy to show the trade groups as well as individual institutions how much they would pay in tax and how much of a Medicaid reimbursement increase they would receive. Physician practices do not report such information to the State, so there is no way to set up a global spreadsheet showing the net impact of the QAAP on all practices. Certainly one can show the impact on a given practice if provided the relevant data, but a global view is impossible to create.

HOW A PHYSICIAN QAAP WOULD WORK

As noted above, House Bill 5386 would have imposed a 3.0% tax on reimbursements for physician services. The entity paying the tax would be the entity that receives reimbursement for the services provided. In many cases, this would be a hospital or clinic that employs physicians, does billing, and receives reimbursement for the billing. In other cases, the taxed entity would be a group or individual physician practice. In any case, the physician QAAP would not be a tax on the physician's income; and it would not represent an increase in the physician's State income tax rate. It would be a tax on reimbursement paid to the entity that bills for physician services provided by its employees.

The tax was projected to increase State revenue by an estimated \$300.0 million. Some of that money, equal to 13.2% of the Federal gain or \$109.0 million, would have been used to offset GF/GP support as "gainsharing" revenue. The 13.2% figure was chosen because that is the statutory gainsharing rate used in the hospital and nursing home QAAPs. The remaining \$191.0 million, combined with \$523.6 million in Medicaid match, would have been used to increase Medicaid physician reimbursement rates by \$714.6 million, making Medicaid payment rates equal to the rates paid by Medicare.

According to supporters of the proposed QAAP, increasing Medicaid payment rates to the Medicare level would encourage more physicians and physician practices to take Medicaid and thus would increase access to health care for Medicaid clients. Opponents contend that taxing physician services reimbursements to help support the Medicaid program would lead to doctors leaving the State and thus would reduce access.

IMPACT OF A PHYSICIAN QAAP ON A PRACTICE

Many interested parties have expressed concern about the impact of a provider tax on physicians.

The simplest way to explore the impact is to provide an example, using round numbers. Table 1 illustrates the net increase in physician services reimbursement that would have occurred under House Bill 5386. Table 2 depicts the impact of the proposed QAAP on a hypothetical individual practice.

Table 1

Physician Quality Assurance Assessment Program (QAAP) Scenarios		House Bill 5386
1.	Total pre-QAAP statewide physician services reimbursement (tax base)	\$10,000,000,000
2.	Physician services tax rate	3.0%
3.	Tax revenue used to increase Medicaid physician services rates	\$191,000,000
4.	FMAP for FY 2009-10 (Federal match rate)	73.27%
5.	Gross increase to Medicaid physician reimbursement rates	\$714,552,937
6.	Revised physician services reimbursement tax base (line 1 plus line 5)	\$10,714,552,937
7.	Revenue from tax (3.0% times line 6)	\$321,436,588
8.	Federal gain due to tax revenue (line 7 divided by 26.73% x 73.27%)	\$881,094,606
9.	Gainshare (amount retained by State) (13.2% of line 8)	\$116,304,488
10.	Tax revenue used to increase Medicaid rates	\$191,000,000
11.	Remaining undedicated revenue (line 7 minus lines 9 and 10)	\$14,132,100
12.	Estimated current Medicaid physician reimbursement	\$950,000,000
13.	Percentage increase in Medicaid reimbursement rates	75.2%
14.	Net increase in physician services reimbursement (line 5 less line 7)	\$393,116,349

Table 1 reflects the following assumptions, with numbers corresponding to rows above:

1) That the original physician services reimbursement (tax base) is \$10.0 billion. 2) That the physician services tax rate is 3.0% as is stated in the bill. 3) That the revenue used to increase Medicaid rates would be \$191.0 million. 4) That the Federal Match Assistance Percentage (FMAP) for FY 2009-10 is 73.27% (meaning the State match rate is 100% minus 73.27% or 26.73%). 5) That the gross increase that could be provided by spending \$191.0 million in State funds is \$714.6 million (\$191.0 million divided by the State match rate of 26.73%). 6) That the actual tax base would be the original \$10.0 billion plus the Medicaid rate increase, or just over \$10.7 billion. 7) That the revenue from the tax would be 3.0% times the revised tax base, or \$321.4 million. 8) That the Federal gain associated with the tax revenue would be \$321.4 million divided by the State match rate of 26.73% and multiplied by the Federal match rate of 73.27%, or \$881.1 million. 9) That the gainshare implied by the bill's provisions (13.2% of the \$881.1 million in Federal revenue gained) is \$116.3 million. 10) That the tax revenue used to increase Medicaid rates is \$191.0 million (see line 3). 11) That there is just over \$14.1 million that is not allocated based on House Bill 5386's provisions (see explanation below). 12) That the current total reimbursement to physicians for Medicaid services is \$950.0 million. 13) That the percentage increase in physician reimbursement rates thus would be 75.2% (\$714.6 million divided by \$950.0 million). 14) That the net increase in reimbursement for physician services would be the increase in Medicaid physician reimbursement less the tax (\$714.6 million minus \$321.4 million) or \$393.1 million.

One of the quirks of calculating the effects of this proposed tax is the impact of the Medicaid rate increase on the tax base. Without a QAAP, the tax base (total physician reimbursement) is around \$10.0 billion. Due to the \$714.6 million Medicaid rate increase, actual total physician reimbursement would be over \$10.7 billion. Thus, the actual tax revenue collected would be \$321.4 million rather than \$300.0 million and the gainshare would go from \$109.0 million to \$116.3 million, for a net increase in revenue from the assumptions in the House bill of \$14.1 million.

In the case of a hypothetical individual practice, Table 2 illustrates how one would determine the break-even point for a practice.

Table 2

Effect of the QAAP on a Hypothetical Physician Practice	
15. Practice's original reimbursement revenue	\$1,000,000
16. Medicaid rate increase necessary to offset tax	\$30,928
17. Total reimbursement, original plus Medicaid rate increase (tax base)	\$1,030,928
18. Tax paid (3.0% of total reimbursement revenue)	\$30,928
19. Percentage increase in Medicaid reimbursement (line 12)	75.2%
20. Original Medicaid revenue necessary to offset tax (line 18/line 19)	\$41,119
21. Original Medicaid revenue as percent of total revenue (line 20/line 15)	4.11%

Table 2 reflects the following assumptions:

15) That the practice's reimbursement revenue (the tax base) is \$1.0 million. 16) That the Gross Medicaid rate increase necessary to exactly offset the tax is \$30,928 (\$30,000 divided by 97%). 17) That the total tax base thus is \$1,000,000 plus the Medicaid rate increase, \$30,928, for a total of \$1,030,928. 18) That the tax collected is 3.0% of \$1,030,928, or \$30,928, which exactly offsets the Medicaid rate increase. 19) That the percentage increase in Medicaid reimbursement rates would be 75.2% (see calculation for line 12 above). 20) That the original pre-QAAP Medicaid revenue necessary to lead to a \$30,928 Medicaid reimbursement increase would be \$30,928 divided by 75.2% or \$41,119. 21) That \$41,119, the break-even Medicaid revenue point, represents 4.11% of total practice revenue.

As such, the practice would break even in terms of its bottom line. It would pay \$30,928 in QAAP taxes and receive a benefit of \$30,928 in additional Medicaid revenue. Again, as noted in the global example (lines 1 through 14), the fact that the increase in Medicaid payments would increase the tax base means one cannot simply multiply \$1.0 million by 3.0% to calculate the revenue. (Technically speaking, one must divide \$1.0 million by 97.0% to get the tax base, which is a slightly different calculation.)

CLARIFYING HOW THE QAAP TAX WOULD BE APPLIED

Based on statements and testimony, there appears to be considerable confusion as to how the proposed QAAP tax would be applied and how a provider could make up the revenue lost to the tax.

A practice's costs, including its overhead, have nothing to do with how a QAAP tax would affect the practice. There are only two factors determining how the practice would be affected in terms of reimbursement: the tax paid and the increase in Medicaid reimbursement.

The calculation of the net cost/benefit of the proposed QAAP is not influenced at all by how much overhead a practice has. The tax would be on reimbursement, not costs. The "break-even" practice with \$1.0 million in reimbursement cited in the example above could have \$800,000 in overhead costs or \$300,000 in overhead costs. In either case, it would pay \$30,928 in tax and it would receive a \$30,928 increase in Medicaid reimbursement.

There appears to be some fundamental confusion among some about the tax, which has led to a number of mistaken interpretations. The proposal would not place a 3.0% income tax surcharge on physicians. If the tax applied just to physician incomes rather than to practice revenue, then the

overhead issue would be legitimate, because the tax paid would be only on a portion of the office's revenue base, namely the portion that goes to the physician. That is not the case, however.

Instead, the tax would be on gross physician services revenue, that is, the reimbursement from the insurer or individual for the physician services provided. House Bill 5386 itself states, "The quality assurance assessment is imposed at a rate of 3% of the gross **revenue** of the physician or entity related to a physician" (emphasis added). The term "revenue" is distinct from the term "income".

Even those who apparently understand that the tax would apply to gross revenue do not appear to understand how a practice would generate enough revenue to make up for the cost of the tax. Several who provided testimony at the October 20, 2009, Senate Subcommittee hearing calculated that they would have to do X more procedures per year to cover the cost of the tax. For instance, one administrator stated that an ob/gyn office would have to do over 2,000 more office calls to make up for the costs of the tax.

Certainly a practice could increase revenue by seeing more patients. On the other hand, any practice that took (or subsequently chose to take) Medicaid would see increased revenue from the Medicaid rate increase. Any practice receiving more than 4.1% of its revenue from Medicaid before the rate increase (quite common for an ob/gyn office) would see a net gain without doing any more procedures. The gain would not be from doing more procedures; it would be from receiving increased reimbursement for any Medicaid procedures.

There was one other major concern expressed by interested parties, one that has significantly more validity, at least for certain practices. It appears that the definition of "physician services" would include infusion and other pharmaceutical services provided in the physician's office, which are pass-through costs. This could have a significant impact on providers because the Medicaid rate increase would apply only to physician services, not the pharmaceutical services provided in the physician's office.

The following example illustrates the potential impact: Assume that an oncology practice has \$10.0 million in gross revenue. Assume that 40.0% of its revenue, \$4.0 million, is from infusion and other pharmaceutical services. Leaving aside any adjustment for the expanded tax base for simplicity's sake, the practice would pay \$300,000 or 3.0% in QAAP tax. Assume that 5.0% of its revenue, \$500,000, is from Medicaid and that 40.0% of that, \$200,000, is from infusion, with the other \$300,000 being reimbursement for physician billings. The Medicaid physician services rate increase would apply only to the \$300,000 in reimbursement; thus, the increase would be 75.0% of \$300,000 or \$225,000, which would be less than the \$300,000 in QAAP tax paid. Even though the practice had 5.0% Medicaid revenue, the practice would be a net loser because the pharmaceutical portion of its revenue would not be subject to the rate increase.

The House of Representatives attempted to address this issue by passing a companion piece of legislation providing a tax credit under the Michigan Business Tax Act. The difficulty with this approach is that the Federal government would likely express great concern over any effort to shield potential losers in any QAAP arrangement. Another approach would be to define "physician services" in a way that would exclude pharmaceutical services such as infusion provided in the physician's office.

As Table 3 below demonstrates, the net effect of a QAAP on a physician practice would be linearly linked to Medicaid revenue as a percentage of total revenue. If a \$1.0 million physician practice does not take Medicaid, then the net impact would be a loss of \$30,000 or 3.0%. If the practice's reimbursement revenue is 2.0% Medicaid, the net impact would be a loss of just over \$15,000 or

1.5%. If the practice's reimbursement revenue is 10% Medicaid, the net impact would be a gain of about \$43,000 or 4.3%. If the practice's reimbursement revenue is 25.0% Medicaid, the net impact would be a gain of over \$152,000 or a 15.2% increase in total revenue.

Table 3
IMPACT OF QAAP ON PHYSICIAN PRACTICES
WITH VARYING LEVELS OF MEDICAID
Hypothetical \$1.0 million Physician Practice

House Bill 5386							
<u>% Original Revenue Medicaid</u>	<u>Revenue</u>	<u>Medicaid Revenue</u>	<u>Medicaid Rate Increase 75.2%</u>	<u>Total Tax Base</u>	<u>Tax Paid (3.0% of Base)</u>	<u>Net Gain/(Loss) to Practice</u>	<u>% Increase/Decrease in Practice Revenue</u>
0%	\$1,000,000	\$0	\$0	\$1,000,000	\$30,000	\$(30,000)	-3.0%
1%	1,000,000	10,000	7,522	1,007,522	30,226	(22,704)	-2.3%
2%	1,000,000	20,000	15,043	1,015,043	30,451	(15,408)	-1.5%
3%	1,000,000	30,000	22,565	1,022,565	30,677	(8,112)	-0.8%
4%	1,000,000	40,000	30,086	1,030,086	30,903	(816)	-0.1%
5%	1,000,000	50,000	37,608	1,037,608	31,128	6,480	0.6%
6%	1,000,000	60,000	45,130	1,045,130	31,354	13,776	1.4%
8%	1,000,000	80,000	60,173	1,060,173	31,805	28,368	2.8%
10%	1,000,000	100,000	75,216	1,075,216	32,256	42,960	4.3%
15%	1,000,000	150,000	112,824	1,112,824	33,385	79,439	7.9%
20%	1,000,000	200,000	150,432	1,150,432	34,513	115,919	11.6%
25%	1,000,000	250,000	188,040	1,188,040	35,641	152,399	15.2%

OTHER RELEVANT ISSUES

A number of important issues related to the proposed QAAP were not fully discussed at the October 20, 2009, Senate Subcommittee hearing. These are addressed below.

Changes in the Federal Match Rate

One reason why the QAAP could be set at a 3.0% rate with a \$116.3 million State gainshare and an increase to Medicare rates is that the Federal match rate (FMAP) for FY 2009-10 will be 73.27%. Therefore, the amount of State revenue necessary to provide a \$714.6 million rate increase (the amount of State revenue necessary to increase Medicaid reimbursement rates to Medicare levels) is just \$191.0 million. The remaining \$523.6 million is Federal match.

However, the enhanced FMAP rate provided through the American Recovery and Reinvestment Act (ARRA) will expire on December 31, 2010. The blended match rate for FY 2010-11 is expected to be about 68.36%. This would be the weighted average of a 76.05% match rate in the first quarter and a 65.79% match rate for the remaining three quarters. While there is no preliminary information on the FY 2011-12 match rate, there is little doubt that Michigan's match rate will continue to increase, likely up to the 68.0% range. For the purposes of this discussion, a 68.0% match rate for FY 2010-11 and FY 2011-12 is assumed.

If the match rate drops from 73.27% to roughly 68.0% for FY 2010-11 and FY 2011-12, then the amount of State revenue necessary to increase Medicaid reimbursement rates to Medicare levels will increase. Instead of needing \$191.0 million State revenue to increase rates by \$716.0 million gross, the State would need about \$229.0 million, an increase of \$38.0 million.

This money would come either from a reduction in the gainsharing from \$116.3 million to \$78.3 million or from an increase in the tax rate to 3.38%. If the first option were chosen, the State would have to come up with \$38.0 million in GF/GP funding to supplant the lost gainsharing revenue. If the second option were chosen, the tax would be increased and the break-even point for providers would rise from 4.1% to 4.5%. As this would be an issue less than a year from now, it is important that the issue be explored fully in any discussion of the concept.

Medicare Dual Eligible Costs

Individuals who are dually eligible for Medicare and Medicaid have Medicare as their primary insurance. For physician services, Medicare reimburses 80.0% of the Medicare fee screen, with the client and his or her secondary insurance covering the other 20.0%.

At present in Michigan, Medicare pays 80.0% of costs for physician services but Medicaid does not pay any of the remaining 20.0% (nor does the patient). Because Medicaid's fee screens in Michigan are well under 80.0% of the Medicare fee screens, the State's Medicaid program does not have to pay the remaining 20.0%.

The intention is that the State, under the physician QAAP, would reimburse Medicaid physician services at 100% of Medicare rates. This would change the situation on secondary reimbursement by Medicaid – the State's Medicaid program would become responsible for the remaining 20% of costs for dually eligible individuals due to the higher Medicaid fee screens.

It is estimated that this would cost the State \$40.0 million Gross or roughly \$10.0 million in GF/GP funding. This amount of money would be on top of the cost of increasing Medicaid rates to Medicare levels. It should be noted that actual QAAP revenue under the House-passed physician QAAP bill would have been about \$14.1 million greater than assumed in the original calculations, and could be used to help pay this cost. It is possible that this \$40.0 million estimate is low due to the medical costs incurred by these individuals, who are almost all elderly. If so, the \$14.1 million, combined with Federal match, may not be sufficient to cover the cost. On the other hand, the FQHC adjustment discussed below would likely offset any additional costs.

Federally Qualified Health Centers

Federally Qualified Health Centers are reimbursed at cost and thus receive far higher reimbursement for Medicaid services than other Medicaid providers receive. Under the proposed QAAP, however, they would be taxed at 3.0% of reimbursements and if their payments were not increased to accommodate this cost, they would see a net loss in revenue.

It should be noted that, due to the cost settlement process by FQHCs, the amount of funding necessary to increase rates to Medicare may be overstated by tens of millions of Gross. This would not necessarily offset the dual eligible cost noted above dollar for dollar, but it appears that these two major uncertain cost estimates could, to some degree, cancel each other out.

The Medicare Upper Payment Limit and Physician Services

Payments to institutional providers are capped by the Medicare Upper Payment Limit. A state's Medicaid program cannot reimburse institutional providers such as hospitals and nursing homes at a higher level than the Medicare program does. This limitation does not apply to services provided by individual providers such as physician services. This means that while reimbursement at Medicare rates would be a significant increase, there is nothing other than lack of funding that would prevent the State from increasing physician services reimbursement above Medicare rates.

Compliance Costs

One other issue that has not been fully addressed (and is difficult to estimate) is the cost of complying with the provisions. Physician practices, clinics, and hospitals would have to estimate and make payments to the State and reconcile those payments at the end of the year. While a simple flat rate tax such as the 3.0% envisioned in House Bill 5386 would make the calculation appear to be simple, tax and accounting costs are generally not trivial.

CONCLUSION

The intent of this article was to discuss the issues raised by the concept of a physician QAAP focusing on the provisions in House Bill 5386 because that bill, in spite of its defeat, has been the focal point of discussions. There is little doubt that this is a highly controversial subject. Some of the issues raised have limited validity, however, while others need to be discussed at greater length. In particular, the perception that a physician QAAP would impose an income tax surcharge on physicians is incorrect. It is also incorrect to claim that a practice's overhead costs would have any impact on the practice's tax base.

As is the case with other QAAPs, there is a break-even point for a physician QAAP, where the provider would receive as much from the Medicaid rate increase as it would pay in the QAAP tax. Under House Bill 5386, any physician practice which receives more than 4.1% of its reimbursement from Medicaid physician services payments would be a net winner.

Of the issues that require further discussion, perhaps the most salient is the treatment of drugs, in particular chemotherapy drugs, provided in a physician's office. While the House attempted to address this with a tax credit, it is likely that the Federal government would not be supportive of a QAAP passed simultaneously with such a provision. In all likelihood, there would need to be an attempt to exclude pass-through pharmaceutical costs from the definition of "physician services". It remains to be seen whether the Federal government would support such a definition.

There are a number of other issues, ranging from changes in the Federal match rate to compliance costs, that also merit further investigation. Given the multitude of issues as well as the strong opposition of the two largest physician organizations, it is clear that any movement toward a physician QAAP would likely require significant negotiations among all stakeholders.