EPILEPSY FOUNDATION®

NATIONAL OFFICE

4351 GARDEN CITY DRIVE
LANDOVER. MD 20785-7223

January 25, 2006

Medicaid Commission Members
Health and Human Services Medicaid Commission
C/O Nancy Barnes, Executive Secretary
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: Comments to Medicaid Commission

Dear Governor Sundquist, Governor King, and Members of the Commission:

Thank you for the opportunity to provide comments to the Commission as it grapples to reshape the Medicaid program for the 21st century. First, let me tell you a little about my background. I am a neurologist who specializes in the practice of epilepsy and clinical neurophysiology at Henry Ford Hospital in Detroit, Michigan as a salaried staff physician and researcher of the Henry Ford Medical Group. About 40% of health care provided by our medical group is given to members of Health Alliance Plan (HAP), a non-profit HMO owned by our parent organization, the Henry Ford Health System. About 11% of our patients are covered by Medicaid. In addition, our health system provides about $120 million in uncompensated care annually. One of my duties for the health system is to chair the HAP Ambulatory Pharmacy and Therapeutics Committee where we review medications and make recommendations for use on the formulary, step-therapy, prior authorization, and decisions on medication co-payment tiers. I am also active in health economics issues for several national neurology organizations including the American Academy of Neurology which, by way of disclosure, is represented in Washington D.C. by Commission member John D. Kemp's firm, Powers, Pyles, Sutter, and Verville, PC. I am here today as a member of the Board of Directors of the Epilepsy Foundation. I have no other disclosures to make.

Last night, HHS Secretary Michael O. Leavitt spoke to you about the unsustainable costs of the current Medicaid program and urged you to "think out of the box" to come up with innovative ideas to change the system in your final report. In that spirit, I have modified my comments from points I made in a letter to this commission of November 1, 2005. I was going to speak on how important that patients with epilepsy should have access to all anticonvulsant drugs including benzodiazepines and barbiturates which have been excluded from coverage in Medicare Part D. I was also going to speak about how tiered therapy is often de facto denial of therapy to our most vulnerable patients to whom even a $1 co-payment creates a burden and give you some personal examples. Instead, I want to talk about the more global issues that you debated last night. I could not agree more with remarks Secretary Leavitt and others made about the unsustainable state of American health care since Detroit is at the center of the implosion of

our current health care financing. General Motors, which provides health care for about 1% of all Americans recently announced layoffs of 30,000 employees. On Monday, Ford Motor Company announced layoffs of another 30,000 workers, nearly one quarter of its workforce, and Daimler Chrysler announced layoffs of 6,000 employees. While there are many factors for these layoffs, one fact that can't be ignored is that the costs of providing a generous health care package to each of its workers, retirees, and their families has placed them at a competitive disadvantage. The health care plans of the Big Three have been the envy of workers across the country but the costs of health care has saddled these manufacturers with a cost disadvantage of more than $1000 per vehicle it manufactures compared with cars built by foreign companies whose American workers are decades younger on average and who have few retirees.

Our American health system has both too much competition and too little competition. Our insurance companies compete to insure those patients and their families who are healthy and who do not need health insurance and spend vast amounts of money avoiding the small percentage of truly ill individuals who consume most of the costs. Those adversely selected individuals are increasingly aggregated in the Medicaid program either because of illness or because they are disabled or elderly and need long term care. Yet there is too little competition in the area of health care delivery, with no rewards for, or even financial penalties, for quality care and efficiency of operation.

There are several things that can be done about this. The first is the bold step of realizing that until you place all Americans under a single comprehensive health care financing plan, that talk of reform is merely rearranging the deck chairs on the Titanic because Medicaid will always be the provider of last resort. This Commission needs to provide politicians with the political coverage they need to join every other advanced country in the world and provide a single payor national health care plan. A well designed health care plan would take several features of what has been learned from well run HMOs and the best features of health care in Europe, Japan, Australia, and Canada and combine them with competition in the efficient delivery of quality care. All of these countries spend a lower percentage of their GDP than the US to cover 100% of their population whereas our complicated system leaves 40 million Americans without any coverage at all. The best of these plans have a combination of national standards with regional administration which could be at the state level in this country. A single payor would permit the redirection of the vast sums of money spent administrating eligibility requirements, free employers to compete on a more equal manner in the global marketplace, and free employees frozen in jobs for fear of losing insurance coverage.

What are these features? The first is a realignment of incentives. The best systems all provide comprehensive risk prevention and public health measures such as vaccinations, risk modification, and preventative services. Many of these services can be delivered by nonphysician health care workers such as nurses, often at home, at work, or at other sites. These measures have a modest cost but stave off much more expensive medical care later on.

A major feature of realignment can be driven by a variety of changes in the system of billing and coding of medical care. These include the removal of the penalty for providing services for diagnostic codes in chapter 5 of the International Classification of Diseases (ICD-9) which was established by the Medicare Act of 1964. This penalty reimburses physicians at 50% of the fee

schedule for those diagnoses in the Mental Disorders chapter rather than 80% of the fee schedule for all other diagnoses.

Another major change could be driven by increasing the value of physician services for patient care and decreasing the value of physician services for procedures. In the current system a physician who does a one hour consultation of a complicated patient is reimbursed at a rate that is 1/3 to 1/4 the rates that physicians are reimbursed for the hour it takes to read 6 MRI scans or perform 3 or 4 colonoscopies. Surgeons are reimbursed about 3 times higher per hour than physicians providing direct patient care. In addition, current technical reimbursement procedures are based upon artificially low rates of equipment utilization. For example MRI technical reimbursements are set for a 40 hour work week when in most hospitals, these machines operate 12-16 hours a day or more, 7 days a week. There is a bitter battle ongoing at the AMA Relative Value Unit (RVU) Update Committee which advises CMS on reimbursement on this issue and your Commission could again provide valuable direction in advocating which aspects of care should be emphasized. The forces of the medical-industrial complex are lined up in support of the current system which rewards procedures and expensive equipment at the expense of direct patient care, especially chronic care on established patients. It is a curious system that there is a charge that is readily paid for every suture, bandage, and dressing but no reimbursement for returning a patient's phone call or for patient teaching by a nurse if a physician sees that patient the same day.

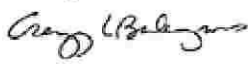
Hospital reimbursements are paid by the DRG mechanism which includes multipliers for patients in whom complications occur. Yet, if hospitals employ quality improvement efforts and reduce complications, their DRGs drop and they are paid less. There are ways to change incentives to reward for quality. Realignment of long term care services could be reorganized in a similar way, looking at stepped care strategies for home care, assisted living, adult foster care, and long term care alternatives.

Finally, the Commission can advocate the adoption of universal use of electronic medical records with instant access by physicians and patients. With proper safeguards for privacy, this data could be accessed by CMS for analysis and reporting to improve public health and eliminate disparities in care and outcomes. This data could also be used to deliver care more efficiently though competition for goods and services using standard business techniques. Another benefit of the EMR was illustrated by the problems of delivering health care in the aftermath of Hurricane Katrina.

Some of these changes, such as innovations in pharmaceutical and supply purchases, could be adopted immediately with rapid cost savings. Others would require initial investments but with a later payoff. An example is the electronic medical record (EMR). We have an EMR at the Henry Ford Health System with digital imaging developed over the last 20 years that is one of the highlights of healthcare in our system. We are currently in the midst of a complete rewrite of the system to bring enhanced features of decision-support and computer assisted physician order entry into practice. This new version is costing us approximately $15 million dollars but by the time we implement it next January, we will have spent four or five times as much on upgrades to our computer network infrastructure, servers, and PCs to run the system.

In closing, your Commission has a unique opportunity to reshape American health care for the next 50 years. I hope that you will take Secretary Leavitt's advice and boldly seize this opportunity to make the recommendations needed to improve the healthcare of all Americans on a solid, financially secure foundation. I appreciate the opportunity to present these comments on behalf of the Epilepsy Foundation. Please feel free to contact me at 313-916-3922 or Donna Meltzer, Senior Director of Government Relations, at 301-918-3764 for additional information.

Sincerely,



Gregory L. Barkley, M.D.
Board of Directors and
Immediate Past Chair, Professional Advisory Board
Epilepsy Foundation

Clinical Vice Chair
Henry Ford Hospital
Department of Neurology

Associate Professor of Neurology
Wayne State University
Detroit, Michigan