On July 1, the Centers for Medicare & Medicaid Services (CMS) issued its proposed physician pay rule for 2012. The proposed rule was published in the July 19 Federal Register, and comments will be accepted until August 30.

Because of the Sustainable Growth Rate (SGR) formula currently in existence, the rule has a steep (29.5%) cut in pay, but CMS has pledged to work with Congress to reform the SGR formula. In its proposal, CMS pointed out that “by law we are required to make these reductions.” The agency added, “While the Congress has provided temporary relief from these reductions for every year since 2003, a long-term solution is critical. We are committed to working with the Congress to permanently reform the SGR methodology for Medicare physician fee schedule updates.”

The reason the proposal does not address the SGR, according to CMS, is that the reduction can only be averted through a change in law. The agency noted that President Obama’s budget submission for FY 2012 would extend current payment rates through December 31, 2013. Meanwhile, Congress has been holding hearings in an attempt to find a solution to the SGR.

The proposal also includes measures that would be used in establishing a new value-based modifier that would reward physicians for providing higher quality and more efficient care. In discussing the new modifier, the proposal explains that the Patient Protection and Affordable Care Act requires CMS to begin making payment adjustments to certain physicians and physician groups as of 2015, and to all physicians by 2017. “We believe that this provision requires the [Health and Human Services secretary] to establish a differential payment under the physician fee schedule to reflect ‘value;’ for example, the quality of care compared to cost.”

CMS is planning to use 2013 as the initial performance year for adjusting payments in 2015. The agency expects that information obtained from Physician Feedback reports, along with its efforts to learn from and build upon the best transparent practices and methodologies developed in the private sector, and its continued and sustained dialogue with physician and patient communities will yield significant improvements to the development of the value modifier.

The proposed rule also touches upon: the physician quality reporting system; the electronic prescribing (eRx) incentive program; the physician resource-use feedback program; electronic health records; durable medical equipment, and payments for Medicare Part B drugs. In addition, the proposed rule would significantly expand the potentially misvalued code initiative, in an attempt to ensure that the effort looks broadly at all services, not just those performed by specific specialties.

SAMHSA Reports Increase in ED Visits for Drug-Related Suicide Attempts

According to two recent reports from the Substance Abuse and Mental Health Services Administration (SAMHSA), the number of ED visits for drug-related suicide attempts from 2005 to 2009 (the most recent year with available figures) increased substantially. The reports, broken down by gender and age group, show a 49% increase in such visits by women ages 50 and older – from 11,235 visits in 2005 to 16,757 visits in 2009 – and a 55% increase in such visits by men ages 21 to 34 – from 19,024 visits in 2005 to 29,407 visits in 2009. Based on data from the 2005-2009 Drug Abuse Warning Network (DAWN) reports, both SAMHSA reports include statistics for other age groups with respect to the misuse of specific drugs. The studies for both reports focused on cases where a determination was made by hospital ED staff that the admission was an intentional drug-related suicide attempt, rather than an unintentional overdose.

The DAWN Report: Trends in Emergency Department Visits for Drug-Related Suicide Attempts among Females: 2005 and 2009, notes that the 49% increase cited above reflects the overall population growth of women in that age group. The report also shows that, while overall rates for such ED visits by women of all ages remained relatively stable throughout the 2005-2009 period, visits for particular pharmaceuticals increased. For example, ED visits by women of all ages for suicide attempts involving drugs to treat anxiety and insomnia increased 56% during this period – from 32,425 in 2005 to 50,548 in 2009 – and the number of ED visits by women of all ages for suicide attempts involving pain relievers rose more than 30% from 36,563 in 2005 to 47,838 in 2009. Moreover, the rise in the number of ED visits for drug-related suicide attempts involving the misuse of two specific narcotic pain relievers, hydrocodone and oxycodone, was particularly steep. The number of cases involving hydrocodone increased by 67%—from 4,613 in 2005 to 7,715 in 2009 – and the number of cases involving oxycodone increased by 210% – from 1,895 in 2005 to 5,895 in 2009.

The corresponding report on men, The DAWN Report: Trends in Emergency Department Visits for Drug-Related Suicide Attempts among Males: 2005 and 2009, notes that the total number of ED visits by men of all ages for drug-related suicide attempts in 2009 was 77,971. With respect to such visits involving particular pharmaceuticals, the period 2005-2009 saw considerable increases. The number of ED visits by men ages 21 to 34 for suicide attempts involving antidepressants increased by 155% – from 1,519 in 2005 to 3,876 in 2009 – and the number of such visits involving anti-anxiety and insomnia medications increased by 93.4%. Furthermore, the number of such visits by men ages 35 to 49 involving narcotic pain relievers nearly doubled and, for men ages 50 and older, the number almost tripled.

Referring to the women’s report, SAMHSA Administrator Pamela Hyde said, “The steep rise in abuse of narcotic pain relievers by women is extremely dangerous and we are now seeing the result of this public health crisis in our emergency rooms. Emergency rooms should not be the frontline in our efforts to intervene. Friends, family and all members of the community must do everything possible to help identify women who may be in crisis and do everything possible to reach out and get them needed help.” As for the men’s report, Director of SAMHSA’s Center for Behavioral Health Statistics and Quality Peter Delaney said it highlights the growing problem of prescription drug abuse of painkillers, antidepressants, anti-anxiety drugs, and sleep aids. He added, “These drugs are effective, important treatments for pain, insomnia, and/or depression, so we don’t want to throw the baby out with the bath water. Instead, to prevent the medications from falling into the wrong hands, he said, “We need to restrict access to prescription drugs, and keep them in safe, restricted places in homes.”

The two reports are available at http://www.oas.samhsa.gov.
AHRQ Releases Data on ED Visits in Rural and Non-Rural Hospitals

In a comprehensive Statistical Brief (#116) entitled *Emergency Department Visits in Rural and Non-Rural Community Hospitals, 2008*, the Agency for Healthcare Research and Quality (AHRQ) presents detailed data on the use of EDs in rural areas with a focus on patient and hospital characteristics of both rural and non-rural ED visits in the United States in 2008. The estimated percentages in the brief with respect to overall ED visits, hospital characteristics, patient characteristics, and most frequent first-listed conditions for ED visits for both adults and children are based upon data from AHRQ’s *Healthcare Cost and Utilization Project 2008 Nationwide Emergency Department Sample*. The percentages for each of these categories are broken down further in a series of four tables.

A summary of the findings follows:

- Only 1.8% of EDs in rural areas were located in teaching hospitals while 40.4% of non-rural EDs were in teaching hospitals.
- Patients who visited EDs in rural areas more often reside in ZIP Codes with the lowest median household income – 56.2% of rural ED patients lived in the lowest income areas compared with 30.1% of non-rural ED patients.
- The most frequently treated conditions among adults (ages 18 and older) in EDs in rural areas were sprains and strains, contusions, abdominal pain, headache, and back problems. These were similar to those treated in non-rural EDs with the exception of headaches, which ranked lower, and chest pain, which ranked higher.
- Upper respiratory infections, contusions, ear infections, sprains and strains, and open wounds were the leading conditions among children visiting EDs in rural areas. Similar rankings existed among non-rural EDs for the top three pediatric conditions, while open wounds ranked 4th and fever ranked 5th in this population.

The complete brief can be found at [http://www.hcup-us.ahrq.gov/reports/statbriefs/sb116.jsp](http://www.hcup-us.ahrq.gov/reports/statbriefs/sb116.jsp).
Senate Bill Would Require Doctor Training to Fight Prescription Drug Abuse

A bill co-sponsored by Senators Chuck Schumer (D-NY) and Jay Rockefeller (D-WV) – S. 507 – would require doctors to receive training for prescribing opiate-based narcotics. The training would cover clinical standards on safe management of pain, help doctors better identify patients who are vulnerable to addiction, and provide information on alternatives to opiate narcotics for pain management. Under current law, the Drug Enforcement Administration does not require doctors, dentists and other authorized prescribers to undergo training in order to obtain a license to dispense opioids.

The Prescription Drug Abuse Prevention and Treatment Act of 2011 also would increase sentences for robbing pharmacies of controlled substances, as well as for stealing medical products and transporting and storing them. Under the bill, the penalty for committing a prescription drug-related crime would jump from 10 years to 20 years in prison. The bill also would provide $25 million for states to create or upgrade prescription drug monitoring systems.

In April, the White House Office of National Drug Control Policy announced a new government strategy to cut the use of prescription painkillers by 15% in five years. The plan includes doctor training, promoting prescription databases in all states and increased focus on rooting out illegal ‘pill mill’ clinics.

Representative Nick Rahall (D-WV) introduced a companion bill – H.R. 1925 – in the House.

North Carolina Legislators Override Medical Malpractice Veto

On July 26, 2011, North Carolina lawmakers approved changes that make it harder for patients to sue ED doctors and cap the amount juries can award for most medical injuries. The House voted 74-42 to override a veto by Governor Bev Perdue (D). The bill won support from eight House Democrats, who crossed party lines to support the GOP-penned reform. The Senate voted to trump the veto last week.

The measure would limit victim’s awards for pain and suffering to $500,000. It also increases the legal standard needed to prove that ED physicians were negligent. Republicans said the bill will drive down frivolous lawsuits that increase the cost of practicing medicine.

House Speaker Tom Tillis (R-Mecklenburg) stated “This bill will provide North Carolinians with more access to affordable health care, while at the same time safeguarding the rights of injured people to have their day in court.”

But opponents said the cap on non-economic damages goes too far. They argued that it would undermine a person’s legal rights and jeopardize public safety. "The most severely injured patients are not protected by this bill," said House Minority Leader Joe Hackney (D-Orange). "It discriminates against them, children, stay-at-home mothers and the elderly – people who in the tough, tough parlance of the courtroom have no economic value."

West Virginia High Court Upholds Cap

The West Virginia Supreme Court of Appeals ruled June 22 that a West Virginia law limiting noneconomic damages awards in medical malpractice cases does not violate the state constitution. By doing so, the court upheld W. Va. Code §55-7B-8, which provides a $250,000 limit on the amount recoverable for a noneconomic loss in a medical professional liability action and extends the limitation to $500,000 in certain cases. The court held that the law does not violate the right to a jury trial, right to equal protection, or the doctrine ensuring separation of powers. It also does not violate the “special legislation” or “certain remedy” provisions of the state constitution, the court added.