POLICY & PRACTICE

Binge Drinking Mapped

The highest rates of underage binge drinking in the United States occurred in the northeast region of North Dakota in 2002-2004, with the lowest rates reported in the District of Columbia's Ward 7, according to a report from the Substance Abuse and Mental Health Services Agency. The report, based on the results of the National Survey on Drug Use and Health, presented rates of binge drinking (consuming five or more drinks on the same occasion) in 340 substate areas among individuals aged 12-20 years. The lowest rate of binge drinking was 10.4% of the 12- to 20-year-old population. The highest rate was 36.1%, according to the SAMHSA report. "We have made real progress in convincing young people to abstain from drug use. Now we need to have the same positive results with alcohol abuse and dependence," Eric B. Broderick, assistant surgeon general and acting administrator of SAMHSA, said in a statement. "We are working with states and communities to provide information and resources needed to mobilize against underage drinking." The full report is available at www.oas.samhsa.gov/substate2k6/substate.pdf.

Citizenship Documentation Regs

Officials at the Centers for Medicare and Medicaid Services should ease citizenship documentation requirements for Medicaid recipients and applicants, the National Association of Psychiatric Health Systems said in comments to the agency last month. CMS published an interim final rule that outlined requirements for citizenship documentation in the Federal Register on July 12. NAPHS called on CMS officials to change the phrase "incapacity of mind," which is used in the regulation, to something that better describes individuals who, "due to a physical or mental condition," cannot meet the documentation requirements. NAPHS also urged CMS officials to stop the delay in accessing benefits for new Medicaid applicants who have otherwise met eligibility requirements but are waiting for the required citizenship documentation.

Eating Disorder Prevention

An Internet-based prevention program can help certain college-aged women who are at risk of developing an eating disorder, according to the results of a study sponsored by the National Institutes of Health. The findings, which were published in the August issue of the Archives of General Psychiatry, show that there was no overall drop in the onset of eating disorders among women aged 18-30 years who were at high risk for developing an eating disorder. Participation in the intervention, however, was associated with a decline in the onset of eating disorders among women with baseline behaviors such as self-induced vomiting and laxative use and among women with a baseline body mass index of 25 or more. The intervention included an 8-week cognitive-behavioral intervention called "Student Bodies." Participants were asked to read materials online, keep an online body image journal, and participate in an online discussion group. "This is the first study to show that eating disorders can be prevented among high-risk groups," Dr. C. Barr Taylor, the lead study author, said in a statement.

HIV Treatment Adherence

Educational programs can be effective at improving adherence to HIV drug regimens when the programs are one-on-one and provide practical medication management strategies, according to a review of 19 randomized, controlled trials. The literature review, which was published in the Cochrane Library in July, also noted that interventions tended to be successful if they were conducted for longer periods of time, usually 12 weeks or more. Interventions that were performed on a one-on-one basis were successful in improving adherence to medication in 10 out of 15 such studies (67%). In the four studies conducted in group settings, none was successful in improving adherence. The 19 studies reviewed included 2,159 patients. The reviewers did not find evidence to support the use of more "complex psychological constructs" such as self-efficacy, stress management, and motivation.

Drug Code Directory Incomplete

The Department of Health and Human Services' Office of Inspector General has found that the Food and Drug Administration's National Drug Code Directory is incomplete and inaccurate, largely as a result of drug companies' failure to submit required data, though the FDA shares some blame. The NDC Directory is supposed to be a current compendium of marketed drug products. The FDA relies on internal reports and on submissions from pharmaceutical manufacturers, which must report when a new product is introduced or withdrawn. The OIG report is a snapshot of the NDC directory as of February 2005. At that time, there were 123,856 products with unique NDCs. The OIG found that the FDA's listing left off just more than 9,000 drug products. For about 16%, the drug maker either had not submitted required forms or the agency had not appropriately processed them. Listings for about 5,100 products had been held up because the companies had failed to provide needed information. Finally, the OIG found that 34,000 products listed were either no longer marketed or their entries contained erroneous information, mostly because drug makers had not told the FDA that the products were discontinued. In a comment submitted with the report, the FDA acknowledged many of the failures, but also said there was a decrease in the percentage of missing products since 1990.

—Mary Ellen Schneider

CMS Proposes 5.1% Pay Cut

Physician *from page 1*

Michael McAdoo, a family physician in Milan, Tenn., who works in a four-physician practice, stopped taking new Medicare patients about 3 years ago. "We saw this coming," he said.

Now, with potentially deeper cuts on the horizon, he is considering stopping his hospital coverage and has begun limiting the number of Medicare patients he sees each day. In Milan, a town of about 10,000, there is only one physician in the community who is still accepting new Medicare patients. "I anticipate this will probably get worse," Dr. McAdoo said.

Over time, there will likely be access to care problems in rheumatology as well, said Dr. Michael Schweitz, vice president of the Coalition of State Rheumatology Organizations and a rheumatologist in West Palm Beach, Fla. He has already started to hear about physicians who are not accepting new Medicare patients, though the practice is not widespread, he said.

AMA officials estimate that without a change to the current payment formula, Medicare payments will be reduced 37% over the next 9 years.

And for physicians who care for a large number of Medicare patients and aren't willing to limit access, the cut will mean a significant drop in their take-home pay, Dr. Schweitz said.

The cuts are especially tough on general internists and other primary care physicians who already face difficulty in recruiting young physicians to their practices, said Dr. Yul Ejnes, an internist in Cranston, R.I., and chair of the board of governors of the American College of Physicians.

Many physicians have been willing to continue to see Medicare patients despite the falling reimbursement rates, Dr. Ejnes said, but lawmakers can't count on that indefinitely.

In his practice, about 20%-30% of his patients are Medicare beneficiaries, so Dr. Ejnes said he expects to see an impact on his bottom line due to the projected cuts. The impact could be greater if private insurance companies that tie their payments rates to Medicare choose to lower their payments at the same time.

The cuts are also likely to result in access issues beyond Medicare beneficiaries, he said. For example, if a physician has to cut back on staff because of Medicare payment cuts, that will affect all patients. And if a physician chooses to retire early, that affects thousands of patients who have to seek care elsewhere. "The impact is on the system as a whole," Dr. Ejnes said.

The proposed cut comes just a few weeks after CMS officials announced plans to change the way Medicare pays for evaluation and management services, with physicians who provide more cognitive services getting a bigger piece of the Medicare pie. But those increases to primary care physicians are likely to be nearly wiped out by the projected payment cuts based on the sustainable growth rate (SGR) formula.

And for specialties in which physicians are expected to experience cuts based on the proposed changes to the way Medicare pays for evaluation and management services, the latest SGR cut compounds the problem.

For example, Medicare payments to cardiologists could drop by about 7% next year, due to the 5.1% proposed fee schedule cut plus a proposed 1% decrease in work and practice expense relative value units for 2007, and a 1% decrease based on the implementation of imaging provisions in the Deficit Reduction Act of 2005 (DRA).

While the impact will vary among individual cardiologists based on the mix of services provided, practices with a high volume of imaging services are likely to see overall payment cuts of more than 7%, according to the American College of Cardiology.

The AMA called on Congress to stop proposed 2007 payment cut and begin to reimburse physicians based on the actual cost of providing care. AMA officials estimate that without a change to the current payment formula, Medicare payments will be cut 37% over the next 9 years, while at the same time practice costs will rise 22%.

Medicare physician payment rates are set annually based on a statutory formula. That formula adjusts the Medicare Economic Index based on how actual medical expenditures compare to a target rate—the SGR. The SGR is based in part on medical inflation, the projected growth in the domestic economy, and projected changes in the number of Medicare beneficiaries.

While there has been legislation introduced in Congress this year aimed at changing the formula that calculates physician payments under Medicare, a permanent fix to the payment problem is unlikely this year, said Dr. Larry Fields, president of the American Academy of Family Physicians.

The AAFP is pushing for a positive update of between 2% and 5% for 2007 and real engagement to permanently fix the problem next year, he said. Officials at the AAFP have commissioned a health care consulting firm, the Lewin Group, to examine alternative payment mechanisms that would not involve the use of the SGR formula, he said. They hope to use that information to work with Congress on a permanent solution next year, Dr. Fields said.

In addition to the 5.1% payment cut, the CMS proposal also seeks to expand coverage for some preventive services.

For example, the proposed rule would implement the provisions of the DRA that call for making abdominal aortic aneurysm screening a Medicare-covered preventive service. The benefit would include a one-time ultrasound screening for beneficiaries who seek the "Welcome to Medicare" physical, along with education, counseling, and referral services. The CMS proposed rule would also implement other provisions of the DRA that call for exempting colorectal cancer screening from the Part B Medicare deductible. ■