SCHIP's Fate Unclear as Congress, President Clash

BY ALICIA AULT
Associate Editor, Practice Trends

With the end of the year drawing near—and Congress past due to adjourn—the fate of the reauthorization of the State Children's Health Insurance Plan was unclear.

SCHIP received one reprieve in October when Congress approved a continuing resolution to keep the government operating through at least mid-November. The resolution kept funding at current levels for all government programs. As that November deadline approached at press time, the House had come up with another continuing resolution, which it attached to next year's defense spending bill, but the Senate had not taken up the legislation.

The continuing resolutions at least kept SCHIP operating. But without funding increases—as were promised under a reauthorization—many states were slated to start cutting enrollment as early as January.

About 6 million children are currently enrolled in SCHIP. The congressional proposal under consideration would increase funding by about $7 billion a year, adding as many as 4 million children to the SCHIP rolls.

What had seemed like a foregone conclusion early this year—that no one would question SCHIP's success and it would be easily refunded for 5 more years—was a distant memory by the time House and Senate negotiators sat down last month to discuss how to avert a second White House veto.

House Republicans vowed to ensure that only low-income children would receive benefits, and that the program wouldn't extend to illegal immigrants.

President Bush's first veto came in October. Soon thereafter, the House voted 273-156 to override the veto; that tally was 10 votes short of the needed two-thirds majority. The vote was split down party lines, with 229 Democrats and 44 Republicans voting in favor of override, and 154 Republicans and 2 Democrats voting against.

With that failure, the House took up a new SCHIP package on Oct. 25, voting 265-142 in favor. However, there were no new Republican converts, making it doubtful that the bill would survive another presidential veto. The Senate approved the same package by a vote of 64-30.

House and Senate leaders delayed sending the bill to the president, hoping to work out a compromise in conference that would withstand White House scrutiny.

Negotiators from the Bush administration were intent on making sure that at least 500,000 children who are currently eligible for SCHIP but not receiving benefits would be enrolled, according to a White House statement. "If enrolling these children requires more than the 20% funding increase proposed by the President, we will work with Congress to find the necessary money," the statement noted.

House Republicans said they also would work to ensure that only low-income children would receive SCHIP benefits, and that the program would not extend benefits to illegal immigrants.

At press time, negotiators were deep in discussions over how to ensure that those requirements might be met, said Ron Pollack, executive director of the advocacy group Families USA, in an interview.

The goal of covering 10 million children and financing the program through an increase in the tobacco tax was not at issue among congressional negotiators, said Mr. Pollack. The Bush administration, however, has said it is adamantly opposed to a tobacco tax increase.

Children's advocates and physician organizations continue to be perplexed by the White House stance. After the initial veto, Dr. Jay E. Berkelhamer, president of the American Academy of Pediatrics, said in a written statement that "the rhetoric of those who opposed the legislation to reauthorize SCHIP demonstrated a fundamental misunderstanding of the bill."

He noted that the first package passed by Congress would have blocked the enrollment of many adults and children that the White House considered not eligible, "while still providing states flexibility and financial support for enrollment of up to 4 million low-income eligible children." ■

Permanent Changes Unlikely, for Now

Medicare *from page 1*

ered, said Dr. Roenigk. "In addition, dermatologists are doing more skin cancer surgery due to the rapidly increasing incidence of BCC/SCC. Reimbursement rates for the treatment of skin cancer and medical skin disease will go down but volumes will go up."

Dr. Brett Coldiron offered a different view. "This will continue the slow death of medical dermatology," he suggested. "It just doesn't pay very well [for us] to deal with the most difficult patients—lupus, blisters, and severe acne—who take much more time. This is terribly unfair but not easily corrected."

Dermatologists that treat the sickest and neediest patients will be hurt the most by this pay cut, added Dr. Coldiron, chariman of the health care finance committee of the American Academy of Dermatology.

The 10.1% cut is a direct result of Congress failing to come up with an alternative to the Sustainable Growth Rate (SGR), the formula that sets physician payment rates partly on the growth in the gross domestic product. For the last 5 years, Congress has at the last minute disregarded the SGR and legislated temporary 1- or 2-year adjustments in payments. Last fall, legislators froze 2007 payment rates at 2006 levels, averting a slated 5% cut, but setting the stage for a 10% cut in 2008 because, by law, the 5% had to be accounted for at some point.

"Congress, the President, nor the public seem to have the political will or capital to make the necessary permanent changes because health care is so complex and there are so many competing interests," commented Dr. Roenigk. "In fact, I wonder if those who want change are simply waiting for Medicare to implode, forcing change due to insolvency."

Physician organizations have sought a permanent replacement of the SGR, but that's unlikely as the congressional sessions wind down this year. Instead, the battle again will be to reverse the cuts, at least for 2 years, and to find a way to cover the payments. Congress is required to offset any new spending.

The AMA has been urging lawmakers to take that money from the Medicare Advantage program, which it says is overfunded by $54 billion. Another potential offset source is the $1.35 billion that's been set aside for the Physician Quality Reporting Initiative. Physicians who participate in PQRI are eligible for up to a 1.5% bonus. But the American College of Physicians (ACP), the AMA, and other physician organizations have said their members are less likely to have the time or resources available to participate if they are facing a 10% decline in overall pay.

"The cuts will accelerate the collapse of primary care, create access problems, and manufacture obstacles to fundamental reform of physician policies," said Dr. David C. Dale, ACP president, in a statement. He noted that an AMA survey found that more than half of physicians said they'd limit the number of new Medicare patients and two-thirds would defer purchase of information technology if the cuts go through.

The AAFP, ACP, AMA, and other organizations said they want Congress to pass legislation to provide an increase in fees for both 2008 and 2009, so that legislators do not have to revisit the issue in 2008 during the distraction of the presidential campaign, Robert Doherty, ACP senior vice president for governmental affairs and public policy, said in an interview.

And, said Dr. King, a freeze at current levels won't be enough, since expenses continue to rise. "We're getting tired of coming to Washington and begging them not to cut us, and then thanking them for freezing us."

At press time, the Senate Finance Committee was putting together a bill that would address the physician pay cuts, said ACP's Mr. Doherty. Lawmakers hoping to address the cuts—and many were motivated to do so—were facing an uphill battle against time and multiple competing legislative demands, he said. ■

Provider Collaboration Found to Curb Incidence of Pressure Ulcers

BY ALICIA AULT
Associate Editor, Practice Trends

Working together, hospitals, nursing homes, and home health agencies in New Jersey and in some other states have curbed pressure ulcer incidence and prevalence. Their efforts are likely to serve as models for providers preparing to cope with the development that beginning on October 2008, Medicare will no longer pay hospitals for ulcers that develop under their watch.

The Centers for Medicare and Medicaid Services (CMS) reported recently that 52 nursing homes in 39 states reduced the onset of pressure ulcers 69% by working together on process improvement. The project was coordinated by Qualis Health, the quality improvement organization for Washington state.

In a run-up to its new nonpayment rule, the CMS is requiring hospitals to start collecting data now on secondary diagnoses present at time of admission.

Making hospitals more accountable may cut down on the "blame game" that often occurs among providers when a patient develops an ulcer, said Theresa Edelstein, vice president of continuing care at the New Jersey Hospital Association, which has a program that is widely viewed as the pioneering effort in provider collaborations.

In the fall of 2005, the NJHA decided to bring hospitals and nursing homes together to share best practices—building on two successful collaboratives among NJHA member hospitals to reduce ventilator-associated pneumonia and central line bloodstream infections.

Forty of 80 hospitals, 60 of 350 nursing homes, and 12 of 40 home health agencies in the state eventually signed on to participate in the voluntary, 2-year NJHA Pressure Ulcer Collaborative, which involved monthly conference calls in which best practices, education programs, brochures to distribute to providers, access to a Listserv, and technical support for data collection were shared. Some joined only in the second year.

Participants were asked to hit 95% or better in three strategies: conducting head-to-toe skin assessments on every patient or resident; conducting a Braden Risk Assessment within 8 hours of initial contact; and implementing preventive actions in the first 24 hours on those identified as at risk on the Braden Scale.

In the first year, some participants collected point prevalence data, which counted how many patients had an ulcer on a particular day in the month. The second year, they assessed how many new ulcers had developed in a month.

"The data collection was a big challenge pretty much across the board," Ms. Edelstein said.

For providers who submitted data in both years, overall incidence dropped 70% from September 2005 to May 2007—from 18% to 5%. Forty-eight providers reported no new ulcers for 3 or more months. Ulcer prevalence was cut 30%. ■