

Federal Health Update

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EXECUTIVE AND CONGRESSIONAL NEWS

- **On Jan. 3, 2013, President Obama signed into law H.R. 4310, the "National Defense Authorization Act for Fiscal Year 2013."**

The \$633.3 billion bill blocks the Administration's proposed increases in TRICARE health insurance fees. In a statement, President Obama enumerated his concerns with the legislation despite signing it into law.

To read his statement, please visit: <http://www.whitehouse.gov/the-press-office/2013/01/03/statement-president-hr-4310>.

- **On Jan. 3, 2013, President Obama signed into law H.R. 8, the "American Taxpayer Relief Act of 2012."**

This legislation makes permanent the temporary rates on taxable income at or below \$400,000 for individual filers and \$450,000 for married individuals filing jointly; permanently indexes the Alternative Minimum Tax exemption amount to the Consumer Price Index; extends emergency unemployment compensation benefits and federal funding for extended benefits for unemployed workers for one year; continues current law Medicare payment rates for physicians' services furnished through Dec. 31, 2013; extends farm bill policies and programs through Sept. 30, 2013; and provides a postponement of the Budget Control Act's sequester for two months.

MILITARY HEALTH CARE NEWS

- **According to the *Military Update*, the National Defense Authorization Act of 2013, signed by President Obama on Jan. 3, includes a provision increasing co-pays for TRICARE's pharmacy program.**

The fee increases, scheduled to take effect Feb. 1, includes a requirement that beneficiaries 65 and older have all maintenance drugs for chronic conditions refilled, for at least one year, through TRICARE mail order or at base pharmacies, rather than through retail outlets where the cost to TRICARE is a third higher.

According to the article, TRICARE likely will need to publish a draft regulation, solicit public comment and launch an education effort for elderly beneficiaries before it begins to enforce home delivery for seniors. That could delay starting that portion of the pharmacy plan until April or later.

The new law increases formulary brand name drug copays at TRICARE retail outlets from \$12 to \$17. The \$25 co-pay for non-formulary drugs will rise to \$44. The co-pay for generic drugs at retail will remain \$5. There will be no fees for drugs obtained at military pharmacies.

For mail order, the current \$9 co-pay for brand names on TRICARE's formulary will be \$13. The \$25 co-pay for non-formulary brand names will increase to \$43. Generic drugs will continue to be dispensed by mail at no cost.

For fiscal 2014 and beyond, the plan directs that drug fees be raised annually by the same percentage as retiree cost-of-living adjustments. In years when a COLA increase applied to pharmacy fees would total less than a dollar, it will be delayed a year and combined with the next adjustment. So that drug fee increases, when executed, are always a dollar or more.

VETERANS AFFAIRS NEWS

- **The Office of Inspector General (OIG) released a report of an audit assessing whether the Veterans Health Administration (VHA) had an effective methodology for determining physician staffing levels for specialty care services.**

The audit revealed that VHA did not have an effective staffing methodology to ensure appropriate physician staffing levels for specialty care services. Specifically, OIG reported that VHA did not establish productivity standards for 31 of 33 specialty care services reviewed, and VA medical facility management did not develop staffing plans. These conditions occurred because of a lack of agreement within VHA about which methodology to use to measure productivity, and current VHA policy does not provide sufficient guidance on developing medical facility staffing plans.

As a result, VHA's lack of productivity standards and staffing plans limit the ability of medical facility officials to make informed business decisions on the appropriate number of specialty physicians to meet patient care needs, such as access and quality of care.

OIG recommends that VHA develop an effective staffing methodology for specialty care services. Specifically, VHA establish productivity standards for all specialties and focus on the benefits of discovering medical facilities that might have a best practice, identifying practices that should be changed or eliminated. This would maximize the use of physician resources, while increasing access and quality of care to more veterans.

To read the full report, please visit: <http://www.va.gov/oig/pubs/VAOIG-11-01827-36.pdf>.

GENERAL HEALTH CARE NEWS

- **Health and Human Services (HHS) Secretary Kathleen Sebelius announced that California, Hawaii, Idaho, Nevada, New Mexico, Vermont and Utah are conditionally approved to operate a state-based Exchange, and Arkansas is conditionally approved to operate a State Partnership Exchange.**

These conditional approvals follow those issued previously granted to Colorado, Connecticut, the District of Columbia, Kentucky, Massachusetts, Maryland, Minnesota, New York, Oregon, Rhode Island and Washington to operate state-based Exchanges and to Delaware to operate a State Partnership Exchange. To date, 20 states including DC have been conditionally approved to partially or fully run their marketplaces – with the remaining states having until Feb. 15, 2013, to apply for a State Partnership Exchange.

HHS also provided new Partnership guidance to states considering this option.

Because of the Affordable Care Act, consumers and small businesses will have access to a new marketplace starting in 2014 where they can access quality, affordable private health insurance. These are similar to those choices that will be offered to members of Congress.

Consumers in every state will be able to buy insurance from qualified health plans directly through these marketplaces and may be eligible for tax credits to help pay for their health insurance.

To learn more about Exchange conditional approvals, visit:
<http://www.cciio.cms.gov/resources/factsheets/state-marketplaces.html>.

For more information on Exchanges, visit: <http://www.healthcare.gov/exchanges>.

To access the guidance released today, visit:
<http://cciio.cms.gov/resources/files/partnership-guidance-01-03-2013.pdf>.

- **According to a new National Institutes of Health study, working-age adults with disabilities account for a disproportionately high amount of annual emergency department visits.**

As emergency department care may not be the best to address non-urgent concerns and is higher in cost, finding a way to decrease these visits is of interest to many stakeholders.

One of the first detailed looks at this population's heightened use of urgent care, the NIH study published online in [Health Services Research](#) on Dec. 26, analyzed pooled data from the Medical Expenditure Panel Survey. Researchers found access to regular medical care, health profile complexity and disability status contributed to people with disabilities' use of the emergency department. To address this disparity, the researchers recommend enhanced communication between emergency department and primary care physicians, and tailored prevention and primary care programs.

The study found that despite representing 17 percent of the working age U.S. population, adults with disabilities accounted for 39.2 percent of total emergency room visits. Those with a severely limiting disability visited an urgent care department more often than their peers and were more likely to visit the department more than four times per year.

Emergency visits were also associated with poor access to primary medical care, which was more prevalent among adults with disabilities.

The researchers identified three nationally representative comparison groups — those without any self-reported mental or physical limitations, those with a limitation but who did not need daily living assistance, and those who did need assistance with daily living. Researchers evaluated access to medical care through self-reported survey answers to questions about attainment and delay of primary care services and prescription medications. The number of emergency department visits was also self-reported.

The report made recommendations for provider and policymaker actions to offset some of the need for emergency care by individuals with disabilities. Prevention and chronic condition management programs tailored for the functional limitations and service needs of people with disabilities may help avoid a crisis situation that would call for an urgent care visit, the report noted. The authors also endorsed wider adoption of coordinated care systems for the disabled that provide case management, integration of psychosocial care and 24/7 access to medical assistance, among other services.

When a patient is admitted to the emergency department, sharing detailed medical information between emergency room and primary care staff could prevent repeat visits. Such coordination is particularly important for disabled patients as they may have limitations that interfere with medical self-advocacy and complex conditions that demand care from various providers.

REPORTS/POLICIES

- There were no reports published this week.

HILL HEARINGS

- There are no hearings scheduled next week.

LEGISLATION

- **H.R.6719** (introduced Dec. 30, 2012): To promote and expand the application of telehealth under Medicare and other federal health care programs and for other purposes was referred to the Committees on Energy and Commerce, Ways and Means, Oversight and Government Reform, Armed Services, and Veterans' Affairs. Sponsor: Representative Mike Thompson [CA-1]

MEETINGS

- The International Meeting of Simulation in Healthcare (IMSH) 2013 will be held on **Jan. 26-30, 2013**, in Orlando, Fla. <http://ssih.org/events/imsh-2013-central>
- The 2013 Military Health System Conference will be held **Feb. 11-14, 2013**, in National Harbor, Md. <http://www.health.mil/2013MHSConference/Registration.aspx>
- Digital Health Communication Extravaganza will be held on **Feb. 20-22, 2013**, in Orlando, Fla. <http://dhcx.hhp.ufl.edu/>.
- Annual HIMSS Conference & Exhibition will be held **March 3-7, 2013**, in New Orleans, La. <http://www.himssconference.org/>
- The International Conference on Emerging Infectious Diseases 2013 (ICEID) will be held on **Feb. 15-18, 2013**, in Vienna,

Austria. www.imed.isid.org/downloads/IMED2013_FirstAnn.pdf

- The National Center for Disaster Medicine and Public Health (NCDMPH) rescheduled [Learning in Disaster Health: A Continuing Education Workshop](#) from April 2-3, 2013 to **Sept. 17-18, 2013**.
- 10th Annual World Healthcare Congress will be held **April 8-10, 2013**, in Washington DC <http://www.worldcongress.com/events/HR13000/>
- AAMA Presents: "3-in-1" Conference - Bringing Together Cardiovascular, Neuroscience & Oncology Leaders will be held on **April 10-12 2013**, in Las Vegas, Nev. <http://www.aameda.org/Conference/ACCA/ACCAMain.html>

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