Federal Health Matters

TRICARE Standard Drops Nonavailability Statements

As of December 28, 2003, TRICARE Standard beneficiaries no longer need a nonavailability statement (NAS) to receive most types of inpatient care at civilian hospitals. This change was built into the 2002 National Defense Authorization Act and has one major exception: inpatient mental health care. Beneficiaries who use TRICARE Standard or Extra, who are not eligible for Medicare, and who have no other primary health insurance still must obtain an NAS before seeking nonemergency inpatient mental health care from civilian facilities.

Military medical treatment facilities (MTFs) may request a departmental waiver to continue the NAS requirement in specific, limited circumstances. Waivers are not permitted, however, for maternity services—unless the beneficiary's first prenatal visit was prior to December 28, 2003. If a waiver is granted, the Federal Register must have the exempt procedures documented and beneficiaries must be notified by the TRICARE Management Activity.

"With this change in policy, beneficiaries now have the freedom to choose a military treatment facility or a civilian facility, without any extra paperwork," said Assistant Secretary of Defense for Health Affairs William Winkenwerder, Jr. He encouraged beneficiaries to compare current MTF services to those offered in civilian facilities before making a decision, citing frequent changes in MTF staffing levels and capabilities, as well as such new initiatives as the Family-Centered Care program.

CARES Commission Reports Findings to VA Secretary

After a year of reviewing the VA's plans for adjusting infrastructure to improve veterans' access to care, the independent Capital Asset Realignment for Enhanced Services (CARES) Commission submitted its recommendations to VA Secretary Anthony J. Principi on February 13. As well as examining the Draft National CARES Plan (DNCP) submitted by Principi in August, the commission made 81 site visits to VA and DoD facilities and solicited input from veterans and other stakeholders.

> The commission...agreed with many, but not all, of the proposals.... It strongly recommended that the VA reexamine the justifying data before approving any proposed changes requiring significant capital investment.

Overall, the commission supported the CARES process as one that "advances [the] VA's efforts to ensure the continued availability of quality health care for the veterans it serves." It agreed with many, but not all, of the proposals set forth in the DNCP. First, due to unresolved concerns with the model used to estimate VA enrollment, utilization, and costs, it strongly recommended that the VA reexamine the justifying data before approving any proposed changes requiring significant capital investment.

Other notable areas in which the commission's views differed from those expressed in the DNCP included: the construction of certain new facilities (advising the VA not to build a new Las Vegas, NV facility but to consider one to replace the four current facilities in Boston, MA), the realignment of services at certain existing facilities (suggesting, for example, that the closing of all acute inpatient services at the Altoona, PA facility not be delayed until 2012), the centrally controlled prioritization system for establishing new community-based outpatient clinics (arguing that more local control over these decisions would best serve the needs of veterans), the methods

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for assessing mental health and long-term care needs (pointing out flaws in each), and the ways in which the VA planned to reduce the amount of vacant space it maintains (suggesting avenues not yet explored by the VA). The commission concurred, however, with many other construction and realignment proposals, as well as the VA's plan to enhance care by contracting for services in the community.

On other topics the commission identified as being of national importance, it made several additional recommendations. For example, it advised that the VA move quickly to secure funding to correct structural deficiencies in some facilities. In the realm of provider education, the commission suggested that educational programs be revised to reflect the VA's increased focus on outpatient care, and that the VA work to establish affiliations with nursing schools (and those for other health professionals) that reflect the types of affiliations established with medical schools. There was also a call for better coordination of special disability programs between veterans integrated service networks and the development of more outpatient blind rehabilitation services. Finally, the commission recommended that collaboration between the VA and DoD be a primary consideration when addressing local health care needs, suggesting that incentives be offered to managers who promote VA-DoD sharing.

The commission made many other recommendations for changes on both the national and local levels. The report can be accessed in its entirety online at the commission's web site (www.carescommission.va.gov).

Bush Submits FY 2005 Budgets to Congress

President Bush is requesting increases in the VA, DoD, and IHS budgets for fiscal year (FY) 2005. Of the $401.7 billion in discretionary funding proposed for the DoD, $25.1 billion would be earmarked for the defense health program, direct medical personnel, and medical construction. An additional $10.3 billion would go into the Medicare-eligible retiree health care fund to finance the future benefits of current active duty personnel.

> The new budget would eliminate all copayments for former prisoners of war.... On the other hand, veterans in categories 7 and 8...would have their pharmacy copayments bumped up from $7 to $15 and would be charged a $250 annual user fee.

The VA budget for FY 2005 was submitted at $67.7 billion, with about $29.5 billion slated for health care (including $2.4 billion collected from third party insurance and beneficiary copayments). This amount represents a 4% increase over the 2004 budget. The new budget would eliminate all copayments for former prisoners of war and pharmacy copayments for veterans in priority categories 2 through 5 whose incomes are between $9,894 and $16,509.

On the other hand, veterans in categories 7 and 8 (those who receive no service-connected disability payments and have higher incomes) would have their pharmacy copayments bumped up from $7 to $15 and would be charged a $250 annual user fee. Other changes would include VA coverage of emergency or urgent care at non-VA facilities and the dissolution of hospice copayments. At $524 million, the Capital Asset Realignment for Enhanced Services program funding would more than double.

Among the uses for the $3 billion budget proposed for the IHS in FY 2005 are enhancement of preventive services, hiring of new staff, and construction of new health care facilities. Five outpatient centers are scheduled to open this year and two others are under construction. The proposed budget also would allow the IHS to cover pay raises for employees of federal and tribal facilities, recruit 30 community health aides and practitioners to help serve Alaska Natives in isolated communities, and add three or four epidemiology centers to the existing seven. In addition to supporting rural areas, the budget designates $32 million for 34 urban Indian health organizations. ●

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