DOWNLOAD PDF VETERANS HEALTH PROGRAMS IMPROVEMENT ACT OF 1992

Chapter 1 : TOPN: Women Veterans Health Programs Act of | US Law | LII / Legal Information Institute

Veterans Health Programs Improvement Act of report of the Committee on Veterans' Affairs, United States Senate to accompany S. Item Preview.

It required pharmaceutical manufacturers to provide rebates for medication purchases, based on sales to Medicaid beneficiaries, as a condition of having their products covered by Medicaid. According to a detailed study of the most widely used outpatient drugs at five public hospitals, hospital costs for the previously discounted drugs increased, on average, by 32 percent, far in excess of the historical 5 to 9 percent annual increases in drug prices experienced by public hospitals. The steep rise reflected the size of the discounts previously offered, and the dramatic shift once "best prices" were imposed in place of voluntary discounts. Previously, hospitals had to register only those sites at separate addresses that received direct shipments of B drugs. OPA is charged with designing and implementing necessary policies and procedures to enforce agency objectives and assess program risk. There are also ten categories of non-hospital covered entities that are eligible based on receiving federal funding. Once enrolled, covered entities are assigned a B identification number that vendors must verify before allowing an organization to purchase discounted drugs. Failure to recertify will result in removal from the B program. Policymakers have used the DSH adjustment percentage as an indicator of how much uncompensated care hospitals are providing patients without receiving payment. Expansion[edit] Covered Entity Eligibility: Not all patients that seek care from a covered entity are qualified to receive outpatient prescription drugs at B discounted prices. Likewise hospitals participating in the B program are not required under the statute to provide B-discounted medications to patients in need. Only "outpatients" are eligible to receive prescription drugs at B discounted prices because the program is an outpatient program. Hospitals are exempt from this third requirement. In HRSA also issued guidance allowing covered entities that did not have an in-house pharmacy to contract with a single outside pharmacy. In April , HRSA began allowing all B covered entities to contract with multiple pharmacies, instead of just one. Contract Pharmacy Arrangements[edit] Covered entities that participate in the B program may contract with pharmacies to dispense drugs purchased through the program on their behalf. Although the majority of covered entities do not use contract pharmacies, their use has increased rapidly over the past few years. The Department of Health and Human Services Office of Inspector General conducted this study to learn about how participating covered entities operate and oversee their contract pharmacy arrangements, and what steps they may or may not take to effectively prevent diversion and duplicate discounts in contract pharmacy arrangements. Moreover, the number of unique pharmacies serving as B contract pharmacies has grown by percent, and the total number of contract pharmacy arrangements has grown by 1, percent. The covered entities reviewed in the study reported different methods of identifying B eligible prescriptions to prevent diversion in their contract pharmacy arrangements. In some cases, these different methods lead to differing determinations of B eligibility from one covered entity to another for similar types of prescriptions. As a result, there is inconsistency within the B Program as to which prescriptions filled at contract pharmacies are treated as B eligible. Most covered entities in the study prevent duplicate discounts by not dispensing B purchased drugs to Medicaid beneficiaries through their contract pharmacies. However, some covered entities that do dispense B purchased drugs to Medicaid beneficiaries through their contract pharmacies did not report a method to avoid duplicate discounts. Although almost all covered entities reported monitoring their contract pharmacy arrangements, the extent of such monitoring varies. Few covered entities reported retaining independent auditors for their contract pharmacy arrangements as recommended in HRSA guidance. Thirteen of the 29 covered entities GAO interviewed reported that they generated B program revenue that exceeded drug-related costs, which includes the costs of purchasing and dispensing drugs. Of those remaining, 10 did not generate enough revenue to exceed drug-related costs, and six did not report enough information for GAO to determine the extent to which revenue was generated. Several factors affected B revenue generation,

including drug reimbursement rates. Regardless of the amount of revenue generated, all covered entities reported using the program in ways consistent with its purpose. For example, all covered entities reported that program participation allowed them to maintain services and lower medication costs for patients. Entities generating B program revenue that exceeded drug-related costs were also able to serve more patients and to provide additional services. However, B stakeholders reported issues with covered entities accessing intravenous immune globulin IVIG at B prices. These restrictions happen on an ongoing basis because the IVIG is susceptible to drug shortages. Moreover, GAO said the B program has increasingly been used in settings, such as hospitals, where the risk of improper purchase of B drugs is greater, in part because they serve both B and nonB eligible patients. To ensure appropriate use of the B program, GAO recommended that HRSA take steps to strengthen oversight regarding program participation and compliance with program. HRSA began conducting such audits in HRSA reportedly is studying the matter. HRSA has issued guidance on these issues. Review of B Prices [45] Objective: To determine whether B covered entities pay more than the statutory defined B ceiling price and, if so, the potential reason for the price discrepancies. To determine 1 whether five manufacturers of 11 prescription drugs sold them to B covered entities using the correct Medicaid rebate amount; and 2 the extent of any overcharges. HRSA should require the five drug manufacturers identify the exact amounts of the overcharges for each of the affected B- covered entities and apply the overcharged amounts as offsets or credits to each entities future purchases. The study found that: Although B hospitals accounted for only 35 percent of all hospitals included in the analysis, B hospitals provided 58 percent of all uncompensated care. In addition, when taking hospital size into account and looking at uncompensated care as a percent of total patient care costs, B hospitals across all hospital sizes provided consistently high levels of uncompensated care. A higher percentage of B DSH hospitals provide public health and specialized services â€” many of which are unprofitable but essential to their communities â€” than nonB hospitals. Outpatient Prescription Dispensing Patterns Through Contract Pharmacies In [edit] A study published in the November edition of Health Affairs provided the first comparison of B prescriptions [48] and all prescriptions dispensed by retail pharmacies operating under contracts with B covered entities. The study used data from Walgreens, the national leader in B contract pharmacies. Medications used to treat chronic conditions such as diabetes, high cholesterol levels, asthma, and depression accounted for an overwhelming majority of all prescriptions dispensed at Walgreens as part of the B program. The majority of B prescriptions dispensed at Walgreens originated at tuberculosis clinics, consolidated health centers, disproportionate-share hospitals, and Ryan White clinics. And as safety-net community providers, FQHCs use the funding to benefit all patients of the community, indirectly passing savings to the state as a whole," said the report which was commissioned by the Oregon Primary Care Association. Oregon is weighing whether to require these health centers to hand over essentially all of their savings on B drugs provided to Medicaid beneficiaries. The analysis raises questions about whether the current B eligibility criteria specifically used for DSH hospitals are serving the spirit and intent of the law in that they may be overly broad and not just target those entities that serve high numbers of vulnerable, uninsured patients. Specifically, the new research shows: More than two-thirds of hospitals that receive B drug discounts provide less charity care as a percent of patient costs than the national average for all hospitals, including for-profit hospitals which do not qualify for B under current eligibility criteria. Currently, hospitals that qualify for the program claim B discounts for most outpatient prescription drugs, for both insured and uninsured patients. And while the B program lowers outpatient drug costs for qualifying hospitals on the presumption that it will help significant numbers of vulnerable, uninsured patients, participating hospitals currently see no restrictions on the way they spend the revenue generated if they charge both insured and uninsured patients higher prices than the B-discounted price. This stands in contrast to many other covered entities that participate in the B program as a result of a specific grant often referred to as "grantees" from the U. Department of Health and Human Services. According to the report, overly-broad eligibility criteria for hospitals have led to an explosion in the number of hospitals that have come into the B program. Today, one-third of all hospitals in the country participate in the B program and get

B discounts; that number is expected to grow, particularly absent an effort to tighten eligibility requirements. In its continued public relations campaign to discredit the B drug discount program, the pharmaceutical industry has financed another study that intentionally misrepresents its purpose. The B program has lived up to congressional expectations, which is why Congress chose to add several new categories of hospitals to its ranks under both Republican and Democratic administrations. Congress was clear when it established the program that eligible hospitals must serve a disproportionately high percentage of Medicaid patients, low-income seniors or be located in remote rural areas. Congress allows these hospitals to advance the real purpose of the program: The report is based on unreliable estimates of charity care that even the government refuses to use to determine uncompensated hospital expenses. In addition, hospitals are significantly underpaid by Medicaid, a fact completely omitted from the analysis. The average B hospital provides three times more uncompensated care than nonB hospitals. Private oncology practices refer their Medicare, Medicaid and uninsured patients to hospitals. Another lobbying group, the American Hospital Association issued a statement in response to the report stating: Department of Health and Human Services that analyzed potential options for modifying Medicare payment policies to improve the value of services provided in ambulatory settings by addressing the differential in the amount that Medicare pays for similar facility services in various ambulatory settings. However, the consequences are increased Medicare payments and beneficiary coinsurance, as well as additional competition for community-based practices For oncology practices, one reason cited for the growth is the opportunity to expand the patient base for drugs purchased under the B discount drug purchase plan. The program allows facilities to purchase outpatient drugs at prices below market. Because the [Outpatient Prospective Payment System] payment rates for drugs furnished to hospital outpatients are the same for all hospitals without regard to whether the drugs were purchased through the B program, hospitals have an incentive to increase margins by expanding their patient base for chemotherapy administration. At the same time, changes in Medicare payments for chemotherapy drugs furnished in [physician offices] have limited the ability of oncologists to profit on these drugs and have increased the attractiveness of affiliating with a hospital. The authors of that piece found that the acquisition of community oncology practices by hospitals with B pricing is leading to more cancer patients being treated by hospitals rather than in specialized community practices, reversing a year trend. Charlotte News Observer April Series: It is not intended to subsidize covered entities for providing inpatient services to those who are covered by private insurance, Medicare, or Medicaid. As such, I have been examining the B program. It also argues the program is saving money for federal, state, and local governments and taxpayers and attempts to refute many of the statements made by critics of the program. Instead of using the deeply discounted drugs these hospitals receive for the most vulnerable in need, the hospitals are up-selling those drugs to patients with Medicare and private insurance because those patients can pay more. The hospitals are keeping the difference. In fact, it is very likely that some version of these programs will be needed for the foreseeable future because, under the best-case scenario, the ACA will still leave millions without adequate coverage. But the Administration has an opportunity to bolster the oversight of programs like B to ensure the most vulnerable are protected and no one is abusing the program. That will make it easier when the time comes to recalibrate safety net programs for a level of services appropriate to the number of remaining uninsured. A report by an association representing the affected hospitals is not objective" [71] September 26, letters by Sen. Retrieved 17 July

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Chapter 2 : Donald Trump signs extension of veterans' choice health care bill - Washington Times

Veterans Health Programs Improvement Act of report of the Committee on Veterans' Affairs, United States Senate to accompany S.

Laws acquire popular names as they make their way through Congress. History books, newspapers, and other sources use the popular name to refer to these laws. How the US Code is built. The United States Code is meant to be an organized, logical compilation of the laws passed by Congress. At its top level, it divides the world of legislation into fifty topically-organized Titles, and each Title is further subdivided into any number of logical subtopics. In theory, any law -- or individual provisions within any law -- passed by Congress should be classifiable into one or more slots in the framework of the Code. On the other hand, legislation often contains bundles of topically unrelated provisions that collectively respond to a particular public need or problem. A farm bill, for instance, might contain provisions that affect the tax status of farmers, their management of land or treatment of the environment, a system of price limits or supports, and so on. Each of these individual provisions would, logically, belong in a different place in the Code. The process of incorporating a newly-passed piece of legislation into the Code is known as "classification" -- essentially a process of deciding where in the logical organization of the Code the various parts of the particular law belong. Sometimes classification is easy; the law could be written with the Code in mind, and might specifically amend, extend, or repeal particular chunks of the existing Code, making it no great challenge to figure out how to classify its various parts. And as we said before, a particular law might be narrow in focus, making it both simple and sensible to move it wholesale into a particular slot in the Code. But this is not normally the case, and often different provisions of the law will logically belong in different, scattered locations in the Code. As a result, often the law will not be found in one place neatly identified by its popular name. Nor will a full-text search of the Code necessarily reveal where all the pieces have been scattered. Instead, those who classify laws into the Code typically leave a note explaining how a particular law has been classified into the Code. It is usually found in the Note section attached to a relevant section of the Code, usually under a paragraph identified as the "Short Title". Our Table of Popular Names is organized alphabetically by popular name. So-called "Short Title" links, and links to particular sections of the Code, will lead you to a textual roadmap the section notes describing how the particular law was incorporated into the Code. Finally, acts may be referred to by a different name, or may have been renamed, the links will take you to the appropriate listing in the table.

Chapter 3 : Trump Signs Bill to Extend Veterans Choice Program | calendrierdelascience.com

In determining whether an agreement under subparagraph (A) meets the requirements of section B of the Public Health Service Act, the Secretary shall not take into account any amendments to such section that are enacted after the enactment of title VI of the Veterans Health Care Act of "(E) Determination of compliance.

Chapter 4 : Military Sexual Trauma | The American Legion

Nov 4, H.R. (nd). An act to amend title 38, United States Code, to revise certain pay authorities that apply to Department of Veterans Affairs nurses, to improve preventive health services for veterans, to improve health-care services for women veterans, and to enable the Department to purchase pharmaceuticals at reasonable prices, and for other purposes.

Chapter 5 : TOPN: Table of Popular Names | US Law | LII / Legal Information Institute

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Cost estimate for the bill as ordered reported by the House Committee on Veterans' Affairs on September 11, Veterans Health Programs Improvement Act of

Chapter 6 : B Drug Pricing Program - Wikipedia

Requirement tor improvement in services for veterans. Veterans Health Programs Act of be cited as the "Women Veterans Health ProÂ- grams Act of ".

Chapter 7 : President Trump Signs Veterans Choice Improvement Act

VAÂ» Office of Procurement, Acquisition and Logistics (OPAL)Â» NAC HomeÂ» FSS HomeÂ» Public Law , Veterans Health Care Act of Office of Procurement, Acquisition and Logistics (OPAL) Public Law , Veterans Health Care Act of