

Federal Health Update

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Welcome to Federal Health Update. This newsletter is a compilation of the latest news in the federal health care sector.

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EXECUTIVE AND CONGRESSIONAL NEWS

- **The House and Senate will be back in session on Jan. 9, 2018.**

MILITARY HEALTH CARE NEWS

- **On Feb 1, 2018, copayments for prescription drugs at TRICARE Pharmacy Home Delivery and retail pharmacies will increase. These changes are required by law and affect TRICARE beneficiaries who are not active duty service members.**

While retail pharmacy and home delivery copayments will increase, prescriptions filled at [military pharmacies](#) remain available at no cost.

Using home delivery, the copayments for a 90-day supply of generic formulary drugs will increase from \$0 to \$7. For brand-name formulary drugs, copayments will increase from \$20 to \$24. Non-formulary drug copayments will increase from \$49 to \$53.

At a retail network pharmacy, copayments for a 30-day supply of generic formulary drugs will increase from \$10 to \$11 and from \$24 to \$28 for brand-name formulary drugs.

In some cases, survivors of active duty service members may be eligible for lower cost-sharing amounts.

TRICARE groups pharmacy drugs into three categories: generic formulary, brand name formulary and non-formulary. You pay the least for generic formulary drugs and the most for non-

formulary drugs, regardless of whether you get them from home delivery or a retail pharmacy.

To see the new TRICARE pharmacy copayments, visit www.tricare.mil/pharmacycosts. To learn more about the TRICARE Pharmacy Program, or move your prescriptions to home delivery, visit www.tricare.mil/pharmacy.

- **On Jan. 1, 2018, the Defense Health Agency established a preferred-provider network (PPN) in the Philippines, marking the end of the Philippine Demonstration.**

Any provider currently approved in the Philippine Demonstration will be available as part of the PPN.

The Philippine Demonstration began Jan. 1, 2013 as a way to offer high-quality health care for eligible TRICARE Overseas Program (TOP) Standard beneficiaries who live in the Philippines and receive care in designated demonstration areas. The demonstration project concluded at midnight on Dec. 31, 2017.

As of Jan. 1, 2018, copayments, cost-shares deductibles and catastrophic caps will be the same as those enrolled in the [TRICARE Select health plan](#). Out-of-pocket costs may be lower when using a preferred provider.

Beneficiaries who live or travel in the Philippines, will be required to see a certified provider for care. However, they are encouraged to see a preferred provider. Visit the [TOP website](#) to find a network provider.

Choosing a provider that isn't TRICARE certified or preferred, may result in significant delays in processing a claim. A claim may also be denied if the provider declines or can't be certified by TRICARE.

Learn more about how to get care in the Philippines on the [TOP website](#). For the costs, visit www.tricare.mil/costs.

VETERANS AFFAIRS NEWS

- **The U.S. Department of Veterans Affairs (VA) announced a series of immediate actions to improve the timeliness of payments to community providers.**

The actions will address the issue of delayed payments head-on and produce sustainable fixes that solve ongoing payment issues that affect Veterans, community providers and other VA partners.

VA will immediately take the following short and long-term actions to improve payments to community providers. Short-term actions include:

- Publish a list the week of Jan 8, identifying providers with high dollar value of unpaid claims, on the following website: <https://www.va.gov/COMMUNITYCARE/providers/>
- Create rapid response teams to work with these providers to reach financial settlement within 90 days.
- Increase the number of claims processed by vendors by 300 percent in January 2018 and by 600 percent in April 2018 with a goal of 90 percent clean claims processed in less than 30 days.
- Establish multiple entry points for providers to check the status of their claim, including a dedicated customer service team and VA's Vendor Inquiry System (VIS) located at <https://www.vis.fsc.va.gov>.

In addition, long-term actions include:

- Deploy multiple IT improvements within the first six months of 2018 that streamline the claims submission and payment process to reduce time for payments significantly.
- Align concurrent performance improvement goals with VA's existing third-party administrators to improve multiple aspects of their performance to ensure veterans have continued uninterrupted access to care.
- Award four new contracts in 2018 to establish the new Community Care Network that includes elements designed to ensure prompt payment of claims. These contracts will be implemented in 2019.
- Work with Congress to consolidate and simplify all VA community care programs, including provisions for prompt payment of claims.
- Ensure transparency of VA's claims processing performance by publishing VA's claims processing timeliness on a monthly basis.

VA's current third-party administrators, Health Net Federal Services and TriWest Healthcare Alliance are committed to working with VA to improve the timeliness of payments to community providers. Health Net and TriWest manage VA's community care networks and process payments to community providers.

Improving timeliness of payments to community providers is a critical element in VA's goal of building a community care program that is easy to understand, simple to administer, and meets the needs of veterans and their families, community providers and VA staff.

To view resources for community care providers, please visit:

<https://www.va.gov/COMMUNITYCARE/providers/resources.asp>.

- **The U.S. Department of Veterans Affairs (VA) appointed of a new chair and four new members to the Advisory Committee on Women Veterans, an expert panel that advises the VA Secretary on issues and programs of importance to women veterans, their families and caregivers.**

Established in 1983, the committee provides policy and legislative recommendations to the Secretary.

Current member Octavia Harris, a retired U.S. Navy command master chief petty officer from San Antonio, Texas, is appointed as the new chair of the committee. The following are new members of the Advisory Committee on Women Veterans:

- Moses McIntosh, of Hephzibah, Georgia, is a retired U.S. Army chief warrant officer and immediate past national commander of the Disabled American Veterans, where he served as the official spokesperson and provided leadership to the National Executive Committee.
- Yareli Mendoza, of Iowa City, Iowa, is a U.S. Air Force veteran. She is pursuing a doctorate of philosophy degree in higher education and student affairs, with a specialization in higher education administration and policy.
- Keronica Richardson, of Gaithersburg, Maryland, is a U.S. Army veteran with deployments in support of operations Enduring Freedom and Iraqi Freedom. She serves as the assistant director for Women and Minority Veterans Outreach at the American Legion.
- Wanda Wright, of Tempe, Arizona, is a retired U.S. Air Force colonel, currently serving as the director of the Arizona Department of Veterans Services, where she is a state cabinet member, providing leadership and direction for administering benefits and services to veterans and their dependents.

In addition, committee members Dr. Kailyn Bobb, a U.S. Air Force veteran, from Plumas Lake, California, and Commander Janet West, of the U.S. Navy, are reappointed for an additional term.

For information about VA's benefits and services for women veterans, visit www.va.gov/womenvet or contact the Women Veterans Call Center at 855-829-6636.

GENERAL HEALTH CARE NEWS

- **The American Cancer Society released its annual statistics of U.S. death rates from cancer on Jan. 4, 2018.**

As of 2015, the cancer death rate for men and women combined had fallen 26 percent from its peak in 1991. This decline translates to nearly 2.4 million deaths averted during this time period.

During the most recent decade of available data, the rate of new cancer diagnoses decreased by about 2 percent per year in men and stayed about the same in women.

“*Cancer Statistics, 2018*,” published in the American Cancer Society’s journal *CA: A Cancer Journal for Clinicians*, estimates a total of 1,735,350 new cancer cases and 609,640 deaths from cancer are projected to occur in the U.S. in 2018.

The drop in cancer mortality is mostly due to steady reductions in smoking and advances in early detection and treatment. The overall drop in cancer death rates is largely due to decreasing death rates for lung, breast, prostate, and colorectal cancers.

- Lung cancer death rates declined 45 percent from 1990 to 2015 among men and 19 percent from 2002 to 2015 among women. From 2005 to 2014, the rates of new lung cancer cases dropped by 2.5 percent per year in men and 1.2 percent per year in women. The differences reflect historical patterns in tobacco use, where women began smoking in large numbers many years later than men, and were slower to quit.
- Breast cancer death rates declined 39 percent from 1989 to 2015 among women. The progress is attributed to improvements in early detection.
- Prostate cancer death rates declined 52 percent from 1993 to 2015 among men. Routine screening with the PSA blood test is no longer recommended because of concerns about high rates of over-diagnosis (finding cancers that would never need to be treated). Therefore, fewer cases of prostate cancer are now being detected.
- Colorectal cancer death rates declined 52 percent from 1970 to 2015 among men and women because of increased screening and improvements in treatment. However, between 2006 and 2015, the death rate among adults younger than 55 increased by 1 percent per year.

The rates of new cancer cases and cancer deaths vary quite a bit among racial and ethnic groups, with rates generally highest among African Americans and lowest for Asian Americans. The cancer death rate in 2015 was 14 percent higher in blacks than in whites. That gap has narrowed from a peak of 33 percent in 1993. However, the racial gap was much larger for those younger than 65 than it was for those 65 or older, likely in part due to universal health care access for seniors through Medicare.

Racial and ethnic disparities in the cancer burden are a reflection of several factors related to socioeconomic status. According to the US Census Bureau, in 2016, 22 percent of blacks and 19 percent of Hispanics/Latinos lived below the poverty line, compared to 9 percent of whites and 10 percent of Asians.

People with lower socioeconomic status are less likely to have health insurance. In 2016, 11 percent of blacks and 16 percent of Hispanics/Latinos were uninsured, compared to 6 percent of

whites and 8 percent of Asians. Even when other factors are equal, studies show that racial and ethnic minorities tend to receive lower-quality health care than whites.

Cancer is the second most common cause of death among children ages 1 to 14 years in the US, after accidents. In 2018, an estimated 10,590 children in this age group will be diagnosed with cancer and 1,180 will die from it. Leukemia accounts for almost a third (29 percent) of all childhood cancers, followed by brain and other nervous system tumors (26 percent).

Cancer incidence rates increased in children and adolescents by 0.6 percent per year since 1975. However, death rates have declined continuously. The 5-year relative survival rate for all cancer sites combined improved from 58 percent for children diagnosed during 1975 to 1977 to 83 percent for those diagnosed during 2007 to 2013.

To read more details, please visit: [Cancer Facts and Figures 2018](#).

- **On Jan. 2, 2018, the Centers for Medicare & Medicaid Services (CMS) announced that doctors and other eligible clinicians participating in the Quality Payment Program can begin submitting their 2017 performance data using a new system on the Quality Payment Program website (qpp.cms.gov).**

The data submission system is an improvement from the former systems under the CMS legacy programs, which required clinicians to submit data on multiple websites. Now, eligible clinicians will use the new system to submit their 2017 performance data for the Quality Payment Program during the 2017 submission period, which runs from Jan. 2, 2018 to March 31, 2018, except for groups using the CMS Web Interface whose submission period is Jan. 22, 2018 to March 16, 2018.

Eligible clinicians will be required to log into the system, which will connect each eligible clinician to the Taxpayer Identification Number (TIN) associated with their National Provider Identifier (NPI). Eligible clinicians will report data either as an individual or as a group.

There are multiple data submission options, including Qualified Clinical Data Registries (QCDRs), qualified registries, attestation, or the CMS Web Interface. Eligible clinicians can also submit data using a Health IT Vendor, which extracts data from certified EHR technology. Eligible clinicians can generate a non-certified report in either the new Quality Payment Program file format or QRDA III file format and manually upload the file into the submission system.

As data is entered into the system, eligible clinicians will see real-time initial scoring within each of the Merit-based Incentive Payment System (MIPS) performance categories based on their submissions. This scoring may change if new data is reported or quality measures that have not yet been benchmarked are used. Additionally, the performance category score will not initially take into account the user's Alternative Payment Model (APM) status, Qualifying APM Participant (QP) status, or other special status that may apply to clinicians.

Eligible clinicians are encouraged to log-in early and often to familiarize themselves with the system. Data can be updated at any time during the submission period. Once the submission period closes on March 31, 2018 (with the exception of the CMS Web Interface, which ends on March 16, 2018), we will calculate your payment adjustment based on your last submission or submission update.

Eligible clinicians who need assistance with the data submission system may contact the Quality Payment Program by email at qpp@cms.hhs.gov or toll free at 1-866-288-8292. Eligible clinicians have until March 31, 2018 to submit data for the 2017 transition year, unless they are part of a group reporting via the CMS Web Interface.

For a fact sheet on the Quality Payment Program data submission system, including more information for clinicians participating in APMs, please visit: <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-2017->

REPORTS/POLICIES

- There were no relevant reports published this week.

HILL HEARINGS

- There are no health-related hearings scheduled yet in 2018.

LEGISLATION

- There was no legislation introduced this week.

MEETINGS

- HIMSS 2018 Annual Conference will be held on **March 5-9, 2018**, in Las Vegas Nev. <http://www.himssconference.org/>
- The 8th Annual Traumatic Brain Injury Conference will be held on **May 16-17, 2018**, in Washington DC. <http://tbiconference.com/home/>

If you need further information on any item in the *Federal Health Update*, please contact Kate Theroux at (703) 447-3257 or by e-mail at katetheroux@federalhealthcarenews.com.