Federal Health Update

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EXECUTIVE AND CONGRESSIONAL NEWS

- **The House and Senate will be back in session on Jan. 12, 2018.**

- **On Jan. 3, 2018, the Senate passed S. 925, the *Veterans E-Health and Telemedicine Support Act of 2017*.** This legislation allows a licensed health care professional of the Department of Veterans Affairs to practice his or her profession using telemedicine at any location in any state, regardless of where the professional or patient is located.

MILITARY HEALTH CARE NEWS

- **The Defense Health Agency released results from its 2017 Joint Outpatient Experience Survey (JOES), which finds soldiers, retirees and family members reported very high overall satisfaction with their experience at Army medical treatment facilities.**

  The survey found 93 percent of participants were satisfied with Army medical facilities; 83 percent said access to Army providers was positive; and 78 percent rated Army pharmacies positively.

  Overall satisfaction rates increased 2 percent, compared with 2016 results.

  About 2.7 million surveys go out annually to about 10 percent of patients who have visited a

military health facility in a random selection process.

Another finding from the survey was that some patients experience frustration during their initial call to schedule an appointment, with some being told to call back because there were no appointments. Some military health facilities are now retraining clerks who take the calls to get the appointments set up without the patient having to call back.

The U.S. Army Medical Command is working to stand up a website that will better help military health facilities to share their ideas and further elevate patient experience and survey scores.

- **Federal News Radio reports TRICARE Select beneficiaries who joined the military before 2018 will have lower than expected copays for primary care, specialty care, urgent care, emergency room visits and ambulance services. The Defense Health Agency recalculated the rates.**

Active-duty military families will see copays drop from $27 to $21 and retirees will see costs go down from $35 to $28.

TRICARE Select replaces TRICARE Standard and TRICARE Extra. TRICARE Select lets patients use any authorized medical provider, but cost shares are lower when beneficiaries see in-network providers.

Under Select, beneficiaries will pay a fixed, per-visit rate for in-network providers that varies according to the type of medical care they're receiving.

VETERANS AFFAIRS NEWS

- **On Jan. 11, 2018, The Department of Veterans Affairs announced it has begun publicly posting information on opioids dispensed from VA pharmacies, along with VA's strategies to prescribe these pain medications appropriately and safely.**

With this announcement, VA becomes the only health-care system in the country to post information on its opioid-prescribing rates.

The disclosure is part of VA's promise of transparency to veterans and the American people, and builds on VA's strong record of transparency disclosures — including on wait times, accountability actions, employee settlements and the Secretary's travel,

The interactive map shows data over a five-year period (2012-2017) and does not include veterans' personal information. The posted information shows opioid-dispensing rates for each facility and how much those rates have changed over time.

Highlights from the data include:

- A 41-percent drop in opioid-prescribing rates across VA between 2012 and 2017
- Ninety-nine percent of facilities decreased their prescribing rates.
- San Juan, Puerto Rico, and Cleveland, Ohio, top the list of medical centers with the lowest prescribing rates, at 3 percent.
- El Paso, Texas, and Fayetteville, North Carolina, are most improved, and decreased prescribing rates by more than 60 percent since 2012. El Paso's prescribing rate decreased by 66 percent, and Fayetteville's decreased by 65 percent.

It is important to note that because the needs and conditions of veterans may be different at each facility, rates may also be different for that reason, and cannot be compared directly.

The prescribing rate information will be updated semi-annually, on January 15 and July 15 of each year.

As a learning health system using the current best evidence to learn and improve, VA continually develops and refines best practices for the care of Veterans. Releasing this data will facilitate the sharing of best practices in pain management and opioid prescribing among doctors and medical center directors.

VA currently uses a multi-faceted approach to reduce the need for the use of opioids among Veterans. Since 2012, the Opioid Safety Initiative has focused on the safe use and slow and steady decrease in VA opioid dispensing. VA also uses other therapies, including physical therapy and complementary and integrative health alternatives, such as meditation, yoga and cognitive-behavioral therapy.

Information about the VA Opioid Safety Initiative may be found here. A link to the interactive map on VA's opioid use across the nation may be found here.

- **The U.S. Department of Veterans Affairs (VA) published a notice in the Federal Register, revising its regulations concerning payment or reimbursement for emergency treatment for non-service connected conditions at non-VA facilities.**

VA will begin processing claims for reimbursement of reasonable costs that were only partially paid by the veteran's other health insurance (OHI). Those costs may include hospital charges, professional fees and emergency transportation, such as ambulances.

This change comes on the heels of an earlier announcement that VA was taking immediate action to address delayed payments to community providers, found here.

Effective Jan. 9, VA updated a portion of its regulations in response to an April 2016 U.S. Court of Appeals for Veterans Claims decision that stated VA could no longer deny reimbursement when OHI pays a portion of the treatment expenses.

VA will apply the updated regulations to claims pending with VA on or after April 8, 2016, and to new claims. By law, VA still may not reimburse Veterans for the costs of copayments, cost shares and deductibles required by their OHI.

VA will work directly with community providers to get additional information needed to review and process these claims. Previous claims do not have to be resubmitted unless requested by VA.

More information on the amended regulation along with guidance may be found here.

- **On Jan. 8, 2018, President Trump signed Executive Order, "Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life."**

This Executive Order directs the Departments of Defense, Veterans Affairs and Homeland Security to develop a plan to ensure that all new veterans receive mental health care for at least one year following their separation from service.

The three departments will work together and develop a Joint Action Plan to ensure that the 60 percent of new veterans who currently do not qualify for enrollment in healthcare will receive treatment and access to services for mental health care for one year following their separation from service.

The Department of Defense, Veterans Affairs and Homeland Security will work to expand mental health programs and other resources to new veterans to the year following departure from uniformed service, including eliminating prior time limits and:

- Expanding peer community outreach and group sessions in the VA Whole Health initiative from 18 Whole Health Flagship facilities to all facilities. Whole Health includes wellness and establishing individual health goals.
- Extending the Department of Defense's "Be There Peer Support Call and Outreach Center" services to provide peer support for veterans in the year following separation from the uniformed service.
- Expanding the Department of Defense's Military One Source (MOS), which offers resources to active duty members, to include services to separating service members to one year beyond service separation.

GENERAL HEALTH CARE NEWS

- **The Centers for Disease Control and Prevention (CDC) released new data in its Antibiotic Resistance (AR) Investment Map, which shows early progress by states to combat AR.**

  This year's AR Investment Map features more than 170 state-reported successes—like rapidly identifying and containing rare and concerning resistant germs to protect communities. Each state reported multiple successes. These are the first comprehensive reports on state progress made following the first year of Congress' unprecedented investment in CDC's Antibiotic Resistance Solutions Initiative.

  The AR Investment Map displays CDC's AR activities in printable state- and city-specific fact sheets, providing a comprehensive view of CDC's resources to protect Americans from antibiotic-resistant infections. Antibiotic resistance occurs when germs no longer respond to the drugs designed to kill them. Some germs already have become resistant to all available antibiotics, making some completely untreatable.

  In fiscal year 2016, CDC made investments in all 50 states, six large cities, and Puerto Rico to enhance laboratory and epidemiology expertise and grow public health innovations to fight antibiotic resistance across healthcare settings, food, and communities.

  These investments helped states like Oklahoma and Connecticut each successfully identify and contain a single case of *Candida auris,* a multidrug-resistant fungus that can cause deadly infections.

  In its mission to protect people, a significant portion of CDC's AR investments goes to enhancing infrastructure in health departments nationwide. Since 2016, CDC has provided $144 million to 56 state and local health departments and Puerto Rico to address this threat. CDC has also invested more than $76 million in more than 60 universities and healthcare partners to find and implement innovative ways to prevent resistant infections and contain their spread.

  The updated AR Investment Map reflects fiscal year 2017 extramural funding and highlights CDC's collaborations that protect people worldwide. CDC continues to partner with health departments; academia; and the healthcare, veterinary, and agriculture industries to advance the science and implement strategies that protect Americans from antibiotic resistance.

  Learn more about CDC's AR Solutions Initiative and ongoing work to combat AR at www.cdc.gov/DrugResistance.

- **There are about 3,500 sleep-related deaths among U.S. babies each year, including sudden infant death syndrome (SIDS), accidental suffocation, and deaths from unknown causes.**

In the 1990s, there were sharp declines in sleep-related deaths following the national “Back to Sleep” safe sleep campaign. However, the declines have slowed since the late 1990s – and data from a new Vital Signs report from the U.S. Centers for Disease Control and Prevention shows the risk for babies persists.

For the Vital Signs report, CDC analyzed Pregnancy Risk Assessment Monitoring System (PRAMS) data to describe sleep practices for babies. PRAMS, a state-based surveillance system, has monitored self-reported behaviors and experiences before, during, and after pregnancy among women with a recent U.S. live birth since the late 1980s.

CDC examined 2015 data reported by mothers about unsafe sleep positioning, any bed sharing, and use of soft bedding from states with available data. Unsafe sleep positioning means placing the baby on his or her side or stomach to sleep. Soft bedding includes pillows, blankets, bumper pads, stuffed toys, and sleep positioners.

In 2015, within states included in the analysis:

- About 1 in 5 mothers (21.6 percent) reported placing their baby to sleep on their side or stomach, more than half of mothers (61.4 percent) reported any bed sharing with their baby, and 2 in 5 mothers (38.5 percent) reported using any soft bedding in the baby’s sleep area
- The percentage of mothers who reported placing their baby on his or her side or stomach to sleep varied by state, ranging from 12.2 percent in Wisconsin to 33.8 percent in Louisiana.
- Placing babies on their side or stomach to sleep was more common among mothers who were non-Hispanic black, younger than 25, or had 12 or fewer years of education.

In recent years, state public health agencies have worked with partners to promote safe sleep. These efforts include communication campaigns, messages shared during visits through WIC and through home-visiting programs, safe sleep policies, and quality-improvement initiatives in hospitals and childcare centers.

To read the entire *Vital Signs* report, visit: www.cdc.gov/vitalsigns/safesleep.

- **The Centers for Medicare and Medicaid Services (CMS) announced new guidance that will support state efforts to improve Medicaid enrollee health outcomes by incentivizing community engagement among able-bodied, working-age Medicaid beneficiaries.**

The policy responds to numerous state requests to test programs through Medicaid demonstration projects under which work or participation in other community engagement activities – including skills training, education, job search, volunteering or caregiving – would be a condition for Medicaid eligibility for able-bodied, working-age adults. This would exclude individuals eligible for Medicaid due to a disability, elderly beneficiaries, children, and pregnant women.

The new policy guidance sent to states is intended to help them design demonstration projects that promote the objectives of the Medicaid program and are consistent with federal statutory requirements. To achieve the objectives of Medicaid, state programs should be designed to promote better physical and mental health.

To date, CMS has received demonstration project proposals from 10 states that include employment and community engagement initiatives: Arizona, Arkansas, Indiana, Kansas, Kentucky, Maine, New Hampshire, North Carolina, Utah and Wisconsin.

CMS has identified a number of issues for states to consider in the development of proposals to promote work and other community engagement among working-age, non-pregnant Medicaid beneficiaries not eligible for Medicaid on the basis of a disability.

Meeting work and community engagement requirements should take into consideration areas of high unemployment or caregiving for young children or elderly family members. States will therefore be required to describe strategies to assist eligible individuals in meeting work and community engagement requirements and to link individuals to additional resources for job training, provided they do not use federal Medicaid funding to finance these services.

CMS will support state efforts to align Medicaid work and community engagement requirements with SNAP or TANF requirements, where appropriate, as part of this demonstration opportunity. Aligning requirements across these programs may streamline eligibility and reduce the burden on both states and beneficiaries and help beneficiaries succeed in meeting their work and community engagement responsibilities.

States must also fully comply with federal disability and civil rights laws and ensure that all individuals with disabilities have the necessary protections to ensure that they are not inappropriately denied coverage. States will be required to offer reasonable modifications to individuals with disabilities, and will be required to exempt individuals determined to be medically frail or who have an acute condition that a medical professional has determined will prevent them from complying with the requirements.

To view a copy of the SMD letter # 18-002, please click here.

REPORTS/POLICIES

- **The Congressional Budget Office (CBO) published *"Extending Funding for the Children's Health Insurance Program for 10 Years,"* on Jan. 11, 2017.** In this report, the CBO and the staff of the Joint Committee on Taxation (JCT) released preliminary estimate of the budgetary effects of extending funding for the Children's Health Insurance Program (CHIP) for 10 years. https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/extendingfundingforthechildrenshealthinsuranceprogramfor10years.pdf

HILL HEARINGS

- The Senate Veterans Affairs Committee will hold a hearing on **Jan. 17, 2017**, to examine the state of the Department of Veterans Affairs, focusing on a progress report on implementing 2017 Department of Veterans Affairs reform legislation.

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/

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