Federal Health Update

FEB. 28, 2014

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

EXECUTIVE AND CONGRESSIONAL NEWS

- **On Feb. 26, 2014, President Obama announced his intent to nominate:**
  - Lisa S. Disbrow to be the next assistant secretary of the Air Force for Financial Management. Disbrow is a member of the Senior Executive Service and a retired Air Force Reserve Colonel. Currently, she serves as the vice director for Force Structure, Resources, and Assessment of the Joint Staff's J8 Directorate, a position she has held since 2009. From 2007 to 2009, she served as the principal deputy for Force Management. She has served in the J8 Directorate since 1995. On active duty, Disbrow served in multiple capacities as an operational planner, electronic intelligence analyst, and programming officer. Disbrow received a B.A. from the University of Virginia, an M.A. from The George Washington University, and an M.A. from the National War College.
  - Laura Junor to be the next principal deputy under secretary of Defense for Personnel and Readiness. Junor is the deputy assistant secretary of Defense for Readiness at the Department of Defense (DoD), a position she has held since 2011. Previously, Junor supported DoD's program and budget process as the chief of staff for the Director of Cost Assessment and Program Evaluation from 2009 to 2011. From 2007 to 2009, Junor was the president and owner of Readiness Logic, LLC. Junor served as the analytic advisor and director of the Defense Readiness Reporting System Interagency in the Office of the Under Secretary of Defense for Personnel and Readiness from 2003 to 2007. Junor received a B.A. from Goucher College and an M.A. and a Ph.D. from George Mason University.

MILITARY HEALTH CARE NEWS

- **Secretary of Defense Chuck Hagel announced today that President has nominated Army Col. Robert D. Tenhet, for appointment to the rank of brigadier general.** Tenhet is currently serving as executive officer to the surgeon general, Office of the Surgeon General, Falls Church, Va.

- **Defense Secretary Chuck Hagel on Monday outlined in great detail the President's 2015 defense budget.**

  Among the proposal is to simplify and modernize the TRICARE health insurance program by consolidating plans and adjusting deductibles and co-pays in ways that encourage members to use the most affordable means of care — such as military treatment facilities, preferred providers, and generic prescriptions.

  Under the budget recommendation, the average military retiree would go from paying 8 percent of health care costs out of pocket to paying 11 percent. Retirees old enough to use Medicare and who choose to have TRICARE as well, eventually would be asked to pay a little bit more to enroll in TRICARE.

  The approach encourages retirees to use free military facilities if they are close to home, which provide outstanding care and are often underused.

  The compensation proposals do not recommend any changes to the military retirement benefits for those now in the services. DoD is waiting the results of the Military Compensation and Retirement Modernization Commission, which is expected to present its report in February 2015, before pursuing reforms in this area.

VETERANS AFFAIRS NEWS

- **The Department of Veterans Affairs (VA) has initiated a multi-faceted approach to reduce the use of opioids among America's veterans using VA health care.**

  The Opioid Safety Initiative (OSI) is a comprehensive effort to improve the quality of life for the hundreds of thousands of Veterans suffering from chronic pain. Launched in October 2013 in Minneapolis, Minnesota, OSI is already demonstrating success in lowering dependency on this class of drugs. At eight sites of care in Minnesota, OSI practices have decreased high-dose opioid use by more than 50 percent.

  OSI incorporates the team approach with the goal of reducing opioid use by alleviating a Veterans' pain using non-prescription methods. There is an emphasis on patient education, close patient monitoring with frequent feedback and Complementary and Alternative Medicine practices like acupuncture.

  The initiative faces the challenge of opioid dependency with an innovative and comprehensive plan that closely monitors VA's dispensing practices system-wide and coordinates pain management to include patient and provider education, testing and tapering programs, and alternative therapies like acupuncture and behavior therapy. Veterans enrolled in the VA health care system suffer from high rates of chronic pain. Each VA facility employs personnel including Interdisciplinary Pain Medicine Specialty Teams and Consult Services, Facility Pain Committees, Pharmacy staff and Primary Care/PACT, and other professionals to accomplish the goals and objectives of the OSI.

  VA has developed patient management initiatives, including:

- Pain Coach, which is a pain management app available for download by patients receiving pain management treatments
- Veterans' Health Library, including a Patient/Family Management Toolkit
- Resources for Pain Management on My HealtheVet.

All of these applications allow veterans to better manage their pain without the use of opioids. VA's measurement-based pain care includes the "Pain Scale," which reduces uncertainty and helps veterans by discussing the potential benefits of a medication and possible side-effects.

- **For the fourth consecutive year, the Department of Veterans Affairs (VA) Consolidated Mail Outpatient Pharmacy receives the highest customer satisfaction score among the nation's public and private mail-order pharmacies, according to a respected, independent study.**

  The 2013 independent study was conducted by J.D. Power. Veterans were asked to rate VA on cost competitiveness, delivery, ordering process and customer service experience. Out of 1,000 possible points, VA scored 871. This was the highest score among participating mail-order pharmacies. The score matched the same industry-high score received by the Department in 2012. VA also led the industry nationwide in 2010 and 2011.

  VA participates in this annual survey as a way to compare itself against industry leaders and to ensure VA health care meets the highest standards. With over 8 million veterans enrolled, VA operates the largest integrated health care delivery system in the United States. Veterans who wish to learn about the mail-order pharmacy and other health benefits can find information at www.va.gov/healthbenefits/

- **The Department of Veterans Affairs (VA) announced the phased roll out of newly designed, more secure Veteran Health Identification Cards.**

  The new cards are distinguished by additional security features and will have a different look and feel. In addition to being more secure, the card has been transformed into a Veterans Health Identification Card (VHIC). Similar to a typical health insurance card, the VHIC displays the veteran's Member ID, a new unique identifier, as well as a Plan ID, reflecting the veteran's enrollment in VA health care.

  The VHIC is personalized to display the emblem of the veteran's branch of service. It also provides features that make it easier to use, such as the addition of "VA" in Braille to help visually impaired Veterans, and the printing of VA phone numbers and emergency care instructions on the cards. The card replaces the Veteran Identification Card (VIC), which was introduced in 2004. As part of a phased rollout, starting this month, the card will only be offered to newly enrolled and other veterans who have not been issued a VIC. Then, in early April, VA will begin a three month effort to automatically issue the more secure VHIC to current VIC cardholders. VA recommends veterans safeguard their VIC as they would a credit card, and cut up or shred the card once it is replaced. While not required to receive VA health care, all enrolled veterans are encouraged to get a VHIC.

  Enrolled veterans can get more information about the VHIC by visiting their VA medical facility enrollment coordinator or the website www.va.gov/healthbenefits/vhic.

GENERAL HEALTH CARE NEWS

- **The latest CDC obesity data show a significant decline in obesity among children aged 2 to 5 years.**

  Obesity prevalence for this age group went from nearly 14 percent in 2003-2004 to just over 8 percent in 2011-2012 – a decline of 43 percent – based on CDC's National Health and Nutrition Examination Survey (NHANES) data. Although the *JAMA* study does not specifically compare 2009-2010 with 2011-2012, NHANES data does show a decline in the 2 to 5 year old age group during that time period – from just over 12 percent in 2009-2010 to just over 8 percent in 2011-2012.

  While the precise reasons for the decline in obesity among 2 to 5 year olds are not clear, many child care centers have started to improve their nutrition and physical activity standards over the past few years. In addition, CDC data show decreases in consumption of sugar-sweetened beverages among youth in recent years. Another possible factor might be the improvement in breastfeeding rates in the United States, which is beneficial to staving off obesity in breastfed children.

  Overall, CDC's latest NHANES obesity data published in this week's issue of the *Journal of the American Medical Association* indicates there have been no significant changes in obesity prevalence among 2-19 year olds or adults in the United States between 2003-2004 and 2011-2012.

- **The Food and Drug Administration (FDA) is proposing several changes to the nutrition labels you see on packaged foods and beverages.**

  If approved, the new labels would place a bigger emphasis on total calories, added sugars and certain nutrients, such as Vitamin D and potassium.

  The FDA is also proposing changes to serving size requirements in an effort to more accurately reflect what people usually eat or drink. For example, if you buy a 20-ounce soda, you're probably not going to stop drinking at the 8-ounce mark. The new rules would require that entire soda bottle to be one serving size -- making calorie counting simpler.

  This is the first overhaul for nutrition labels since the FDA began requiring them more than 20 years ago. There has been a shift in shoppers' priorities as nutrition is better understood and people learn what they should watch for on a label, administration officials said.

  The proposed labels would remove the "calories from fat" line you currently see on labels, focusing instead on total calories found in each serving. Nutritionists have come to understand that the type of fat you're eating matters more than the calories from fat. As such, the breakdown of total fat vs. saturated and trans fat would remain.

  The proposed labels would also note how much added sugar is in a product. Right now, it's hard to know what is naturally-occurring sugar and what has been added by the manufacturer.

  The FDA also plans to update the daily values for certain nutrients such as sodium, dietary fiber and Vitamin D. For instance, the daily limit for sodium was 2,400 milligrams. If the new rules take effect, the daily value will be 2,300 milligrams, administration officials said.

  Food and beverage companies would also be required to declare the amount of Vitamin D and potassium in a product, as well as calcium and iron. Research shows Americans tend not to consume enough Vitamin D for good bone health. And potassium is essential in keeping your blood pressure in check.

  Administration officials said about 17% of current serving size requirements will be

changing, and the FDA is adding 25 categories for products that weren't commonly around 20 years ago (think pot stickers, sesame oil and sun-dried tomatoes).

Most of the required serving sizes will be going up; no one eats just half a cup of ice cream, for instance. Others, like yogurt, will be going down.

With this announcement, the FDA has opened a 90-day comment period, during which experts and members of the public can provide input on the proposed rules. The FDA will then issue a final rule. Officials said they hope to complete the process this year.

Manufacturing companies will have two years to implement the changes.

- **Attorney General Eric Holder and HHS Secretary Kathleen Sebelius released the annual Health Care Fraud and Abuse Control (HCFAC) Program report showing that for every dollar spent on health care-related fraud and abuse investigations through this and other programs in the last three years, the government recovered $8.10 billion.**

  This is the highest three-year average return on investment in the 17-year history of the HCFAC Program.

  The government's health care fraud prevention and enforcement efforts recovered a record-breaking $4.3 billion in taxpayer dollars in fiscal year (FY) 2013, up from $4.2 billion in FY 2012, from individuals and companies who attempted to defraud federal health programs serving seniors or who sought payments from taxpayers to which they were not entitled. Over the last five years, the administration's enforcement efforts have recovered $19.2 billion, an increase of $9.8 billion over the prior five-year period. Since the inception of the program in1997, the HCFAC Program has returned more than $25.9 billion to the Medicare Trust Funds and treasury.

  The success of this joint Department of Justice and HHS effort was made possible in part by the Health Care Fraud Prevention and Enforcement Action Team (HEAT), created in 2009 to prevent fraud, waste and abuse in Medicare and Medicaid and to crack down on individuals and entities that are abusing the system and costing American taxpayers billions of dollars.

  In FY 2013, the strike force secured records in the number of cases filed (137), individuals charged (345), guilty pleas secured (234) and jury trial convictions (46). Beyond these remarkable results, the defendants who were charged and sentenced are facing significant time in prison – an average of 52 months in prison for those sentenced in FY 2013, and an average of 47 months in prison for those sentenced since 2007.

  In addition, the Justice Department opened 1,013 new criminal health care fraud investigations involving 1,910 potential defendants, and a total of 718 defendants were convicted of health care fraud-related crimes during the year. The department also opened 1,083 new civil health care fraud investigations.

  To read the report visit http://oig.hhs.gov/publications/docs/hcfac/FY2013-hcfac.pdf

- **The HHS Office of the National Coordinator for Health Information Technology (ONC) today issued proposals for the next edition (the "2015 Edition") of electronic health record (EHR) technology certification criteria.**

  This proposed rule marks the first time ONC has proposed an edition of certification criteria separate from the Centers for Medicare & Medicaid Services' "meaningful use" regulations. The proposals represent ONC's new regulatory approach that includes more incremental and frequent rulemaking. This approach allows ONC to update certification criteria more often to

reference improved standards, continually improve regulatory clarity, and solicit comments on potential proposals as a way to signal ONC's interest in a particular topic area.

Compliance with the 2015 Edition would be voluntary – EHR developers that have certified EHR technology to the 2014 Edition would not need to recertify to the 2015 Edition for customers to participate in the Medicare and Medicaid EHR Incentive Programs. Similarly, health care providers eligible to participate in the Medicare and Medicaid EHR Incentive Programs would not need to "upgrade" to EHR technology certified to 2015 Edition to have EHR technology that meets the Certified EHR Technology definition.

The proposed rule was published in the *Federal Register* on Feb. 26, 2014. ONC will accept comments on the proposed rule through April 28, 2014. The final rule is expected to be issued in summer 2014.

- **The Centers for Medicare & Medicaid Services (CMS) proposed some new policies to improve payment accuracy for Medicare Advantage (Part C) for 2015.**

  The proposed changes for 2015 are smaller than those implemented in 2014 – a year in which CMS expects to exceed its 5 percent enrollment growth projection in Medicare Advantage for 2014.

  Since the Affordable Care Act was passed in 2010, Medicare Advantage premiums have fallen by 10 percent and enrollment has increased by nearly 33 percent to an all-time high of approximately 15 million beneficiaries. Today, nearly 30 percent of Medicare beneficiaries are enrolled in a Medicare Advantage plan. Furthermore, enrollees are benefiting from greater quality as over half of enrollees are now in plans with 4 or more stars, a significant increase from 37 percent of enrollees in such plans in 2013.

  Proposed guidance in today's Advance Notice and draft Call Letter increases value and protections for beneficiaries:

  - **Lower Out-of-Pocket Drug Spending:** Beneficiaries in the Part D prescription drug coverage gap, or "donut hole," will benefit from greater savings on prescription drugs. As a result of the Affordable Care Act, in 2015, enrollees with liability in the donut hole will receive coverage and discounts of 55 percent on covered brand name drugs and 35 percent on covered generic drugs, an increase from 52.5 percent and 28 percent, respectively, in 2014.
  - **Improved Notification for Beneficiaries Regarding Changes in Medicare Advantage Plan Networks:** The call letter identifies as a best practice greater notification to enrollees regarding any changes to provider networks and indicates CMS' intention to consider rulemaking that would broaden its authority to limit such changes to certain times during the year.
  - **Greater Protection for Beneficiaries:** CMS intends to again use its authority, provided by the health care law, to protect Medicare Advantage enrollees from significant increases in costs or cuts in benefits, and, for the 2015 contract year, proposes reducing the permissible amount of increase in total beneficiary cost to $32 per member per month (down from $34 per member per month for the 2014 contract year). CMS proposes to maintain existing limits on beneficiaries' out-of-pocket spending, but clarifies existing guidance that enrollees' dollar contributions towards these limits are transferable when they move to any plan, regardless of plan type, offered by the same organization. CMS also continues to require plans to refine their offerings so that beneficiaries can easily identify the differences between their options.
  - **Improving Access to Preferred Cost-Sharing:** CMS may request that Part D plans increase the number of pharmacies offering preferred, or lower, cost sharing as we are

concerned that some plans that offer preferred cost sharing do not provide beneficiaries with sufficient access to the lower cost sharing at select network pharmacies. The intent of this policy will be to ensure that beneficiaries are not misled into enrolling in a plan only to discover that they do not have meaningful access to the advertised lower cost sharing.

- **Improved Coordination of Care:** CMS intends to expand plans' ability to use technologies that enable health care providers to deliver care to beneficiaries in remote locations. The use of remote access technologies as a care delivery option for Medicare Advantage enrollees may improve access to and timeliness of needed care, increase communications between providers and beneficiaries, and enhance care coordination.

To read more about the proposals, please visit: Advance Notice and draft Call Letter may be viewed through: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/ and selecting "Announcements and Documents."

REPORTS/POLICIES

- **The GAO published *"Electronic Health Records: VA and DoD Need to Support Cost and Schedule Claims, Develop Interoperability Plans, and Improve Collaboration,"* (GAO-14-302) on Feb 27, 2014.** This report describes changes to the program and evaluates the departments' current plans; and determines whether the departments are effectively collaborating on management of the program. http://www.gao.gov/assets/670/661208.pdf

- **The GAO published *"Internet Pharmacies: Most Rogue Sites Operate from Abroad, and Many Sell Counterfeit Drugs,"* (GAO-14-386T) on Feb. 27, 2014.** In this report, GAO identified how rogue sites violate federal and state laws; challenges federal agencies face in investigating and prosecuting operators; efforts to combat rogue Internet pharmacies; and efforts to educate consumers about the risks of purchasing prescription drugs online. http://www.gao.gov/assets/670/661177.pdf

- **The GAO published *"Military Health System: Sustained Senior Leadership Needed to Fully Develop Plans for Achieving Cost Savings,"* (GAO-14-396T) on Feb 26, 2014.** In this report, the GAO details the additional actions that would increase transparency and enhance accountability of DoD's reform plan. It is based primarily on GAO's November 2013 report, which assessed DoD's first two submissions of its reform plans to Congress. http://www.gao.gov/assets/670/661149.pdf

HILL HEARINGS

- The Senate Armed Services Committee will hold a hearing on **March 5, 2014**, to examine the Defense Authorization Request for Fiscal Year 2015 and the Future Years Defense Program.
- The House and Senate Veterans Affairs Committees will hold a joint hearing on **March 5, 2014,** to receive the legislative presentation of the Veterans of Foreign Wars Association.
- The House Committee on the Budget will hold a hearing on **March 5, 2014**, to examine the President's budget for FY 2015.

- The House and Senate Veterans Affairs Committees will hold a joint hearing on **March 6 and 12, 2014,** to receive the legislative presentation from various veterans services organizations.
- The House Veterans Affairs Committee will hold a hearing on **March 13, 2014**, to examine the Department of Veterans Affairs Budget Request for Fiscal Year 2015.
- The Senate Armed Services Committee will hold a hearing on **March 26, 2014**, to examine the current readiness of United States forces in review of the Defense Authorization Request for fiscal year 2015 and the Future Years Defense Program
- The Senate Armed Services Committee will hold a hearing on **March 27, 2014**, to examine the posture of the Department of the Navy in review of the Defense Authorization Request for fiscal year 2015 and the Future Years Defense Program
- The Senate Armed Services Committee will hold a hearing on **April 3, 2014**, to examine the posture of the Department of the Army in review of the Defense Authorization Request for fiscal year 2015 and the Future Years Defense Program.
- The Senate Armed Services Committee will hold a hearing on **April 10, 2014**, to examine the posture of the Department of the Air Force in review of the Defense Authorization Request for fiscal year 2015 and the Future Years Defense Program.

LEGISLATION

- **H.R.4077** (introduced Feb. 25, 2014): the *Quality Health Care Coalition Act of 2014* was referred to the House Committee on the Judiciary
  Sponsor: Representative John Conyers, Jr. [MI-13]
- **H.R.4080** (introduced Feb. 25, 2014): the *Trauma Systems and Regionalization of Emergency Care Reauthorization Act* was referred to the House Committee on Energy and Commerce
  Sponsor: Representative Michael C. Burgess [TX-26].
- **S.2046** (introduced Feb. 26, 2014): A bill to amend title XVIII of the Social Security Act to provide Medicare beneficiaries coordinated care and greater choice with regard to accessing hearing health services and benefits was referred to the Committee on Finance.
  Sponsor: Senator Sherrod Brown [OH]

MEETINGS/WEBINARS

- The ACHE Congress on Healthcare Leadership will be held on **March 24-27, 2014**, in Chicago, Ill. http://www.ache.org/congress/
- The 11th Annual World Health Care Congress will be held on **April 7-9, 2014**, in National Harbor, Md. http://www.worldcongress.com/events/HR14000/
- The Heroes of Military Medicine Awards will be held on **May 1, 2014,** in Washington, DC. http://www.hjfcp3.org

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.