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

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The Update will not be published on Aug 24 and 31, 2018.

EXECUTIVE AND CONGRESSIONAL NEWS

- The House is in recess until Sept. 4, 2018.

- The White House announced the president intends to nominate James B. Lockhart III to be a member of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, a member of the Board of Trustees of the Federal Hospital Insurance Trust Fund, a member of the Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund, and a member of the Board of Trustees of the Federal Disability Insurance Trust Fund. Each has four-year term.

  During the George W. Bush Administration, Mr. James B. Lockhart served as the principal deputy commissioner of the Social Security Administration, secretary to the Trustees of Social Security, and member of the President's Management Council. Lockhart also led the Office of Federal Housing Enterprise Oversight, Federal Housing Finance Agency, Pension Benefit Guaranty Corporation and Benefit Guaranty Corporation. Additionally, he served on the Troubled Asset Relief Program Oversight Board. During his time in the private sector, he held senior financial positions in oil, insurance, and banking firms.

  Mr. Lockhart is a graduate of Yale University and Harvard Business School.
MILITARY HEALTH CARE NEWS

- TRICARE announced emergency procedures are in place due to wildfires in California until Aug. 17, 2018. The counties affected include Lake, Riverside, Shasta, Mendocino and Napa.

  TRICARE beneficiaries in those counties can get an emergency refill of their prescription by taking their prescription bottle to any TRICARE retail network pharmacy. To find a network pharmacy, call Express Scripts at 1-877-363-1303 or search the network pharmacy locator. If possible, TRICARE suggests beneficiaries visit the pharmacy where the prescription was originally filled.

  If the beneficiary uses a retail chain, they can fill your prescription at another store in that chain. If their provider is available, he or she may call in a new prescription to any network pharmacy.

VETERANS AFFAIRS NEWS

- The Department of Veterans Affairs (VA) released the Spanish version of the application for health benefits, as part of VA’s effort to simplify and improve the health care enrollment process for veterans.

  The new language version implements the VA Advisory Committee on Minority Veterans’ recommendation to provide Spanish versions of the application and instructions.

  According to the National Center for Veterans Analysis and Statistics, the number of living veterans who identify as being Hispanic or Latino, as of Sept. 30, 2017, is nearly 1.5 million people. More than half a million veterans already enrolled in the VA health care system self-identify as Hispanic or Latino.

  The form is available at VA medical facilities and online at https://vaww.va.gov/vaforms/medical/pdf/10-10EZ_Spanish.pdf

- On Aug. 6, 2018, Secretary of Veterans Affairs Robert Wilkie visited the Washington DC VA Medical Center (VAMC), where he met with facility and regional leaders and received updates on recent progress in veterans’ care and plans for further improvements at the facility.

  Of the 25 recommendations made to the facility in a recent Inspector General report, the facility announced it has addressed or resolved six, and is working to resolve the remaining 19.

  The DC VAMC has now put in place changes/improvements in six broad areas:
  
  o Bringing in skilled leaders in quality improvement, purchasing, a new deputy chief of staff and others;
  
  o Assuring reliable availability and sterilization of instruments for surgical procedures;
  
  o Establishing and maintaining an electronic inventory to identify needed equipment rapidly and in a timely fashion;
  
  o Implementing financial controls for purchasing supplies to maximize use of taxpayer dollars;
o Building and maintaining effective systems that facilitate audit of current and future progress;
o Assuring timely access to veteran appointments, particularly in prosthetics.

VA has identified a new permanent director for the facility, who will be announced and begin serving there in the near future. In the interim, VA announced that, beginning in two weeks, DC VAMC Chief of Staff Charles Faselis will serve as acting director of the facility. The current acting director, Adam M. Robinson Jr., will return to his previous position as director of the VA Maryland Health Care System.

GENERAL HEALTH CARE NEWS

- The Department of Health and Human Services announced that Medicare Advantage plans will be able to use tools employed by private-sector insurers to negotiate lower prescription drug prices for patients.

The Centers for Medicare & Medicaid Services is rescinding a policy regarding Medicare Part B drugs that discouraged Medicare Advantage plans from using tools that are widely used in private insurance plans to negotiate lower prices from pharmaceutical companies.

Specifically, patients will now be able to choose Medicare Advantage plans that require enrollees to try certain more cost-effective drugs first (known as “step therapy”). Plans will also be able to cross-manage between the drugs covered by different parts of Medicare, allowing them to pay for the most appropriate, most affordable drugs, regardless of whether patients receive them in a doctor’s office (Part B) or at a pharmacy (Part D).

These negotiating tools will offer plans the same power that private-sector insurers have to drive down the price of prescription drugs and force manufacturers to compete on price, while maintaining patients’ rights to appeal decisions, choose another plan, or enroll in Medicare fee-for-service instead.

More than 20 million Americans are enrolled in Medicare Advantage plans, representing 33 percent of Medicare enrollees. In 2017, Medicare Advantage plans spent $11.9 billion on Medicare Part B drugs, the category where plans will now have more power to drive down prices.

Plans will be required to pass on to patients more than half of the savings generated from tougher negotiation. Savings can be realized for enrollees through lower coinsurance amounts and through rewards programs, which provide patients with benefits such as gift cards.

Beginning in 2020, plans will be able to pass on savings to patients through lower premiums. (Premiums have already been set for 2019 Medicare Advantage plans.)

Medicare Advantage plans can begin using these tools as part of their 2019 policies, meaning savings could be generated and passed on to patients as soon as next year. Plans have limited time to implement the tools for next year, however, and it is expected that more plans will adopt the tools over time.

Each year, beneficiaries have the opportunity to choose which Medicare Advantage plan is right for them, or whether they would prefer Medicare fee-for-service, which covers all medically necessary drugs at a fixed price. Plans will be allowed only to apply step therapy to new prescriptions or prescriptions where the patient is not actively receiving the affected medication. On top of that, for the first time in 2019, beneficiaries will be able to change their Medicare Advantage plan or switch to fee-for-service through March 31.

If a beneficiary chooses a plan that incorporates step therapy and needs a drug subject to it, but feels they need access to it without trying an alternative drug, they can ask their plan for an exception, which will be reviewed as expeditiously as the beneficiary’s health condition requires (generally within 72 hours).
Medicare Advantage plans will be required to couple Part B step therapy with patient-centered care coordination services for beneficiaries as part of a drug management care coordination program. Care coordination must include discussing medication options with beneficiaries, providing beneficiaries with educational material and information about their medications, and implementing adherence strategies to their medication regimen.


- The number of pregnant women with opioid use disorder (OUD) at labor and delivery more than quadrupled from 1999 to 2014, according to a new analysis by the Centers for Disease Control and Prevention (CDC).

This first-ever multi-state analysis of trends reveals significant increases in the 28 states with available data.

People with OUD have a problematic pattern of opioid use that can result in health problems, disability or failure to meet major responsibilities at work, school or home. OUD during pregnancy has been associated with a range of negative health outcomes for both mothers and their babies, including maternal death, preterm birth, stillbirth, and neonatal abstinence syndrome (NAS).

Using data from the Agency for Healthcare Research and Quality's (AHRQ) Healthcare Cost and Utilization Project (HCUP) National Inpatient Sample, researchers found that the national prevalence rate of OUD increased from 1.5 per 1,000 delivery hospitalizations in 1999 to 6.5 in 2014. On average, the national prevalence rate grew by 0.39 cases per 1,000 each year.

Analysis of data from the AHRQ's HCUP State Inpatient Databases found significant increases in all of the 28 states with at least three years of data available for analysis. Over the study period, the average annual rate increases were lowest in California and Hawaii (growth of less than 0.1 cases per 1,000 each year) and highest in Maine, New Mexico, Vermont, and West Virginia (all with growth of more than 2.5 cases per 1,000 each year).

The state-level analysis found that the OUD rates varied by state, from the lowest rates in D.C. (0.7 cases/1,000 hospital births) and Nebraska (1.2) to the highest rates in West Virginia (32.1) and Vermont (48.6). The report notes that while variability by state may reflect differences in opioid prescribing rates or the prevalence of illicit drug use, it could also reflect improved screening, diagnosis, and treatment of OUD and NAS.

Reducing the burden of OUD on pregnant women and infants is a key component of CDC's response. The agency is supporting state-based perinatal quality collaboratives (PQCs). These state or multi-state networks of teams are working to better identify women with OUD during pregnancy and to standardize care for mothers and NAS-affected infants.

To read the report, please visit: https://www.cdc.gov/mmwr/volumes/67/wr/mm6731a1.htm?s_cid=mm6731a1_w

- According to the Centers for Disease Control and Prevention (CDC) about 1 in 7 babies now 1 year or older who were born to women with Zika virus infection during pregnancy had one or more health problems possibly caused by exposure to the virus before birth.

About 4,800 pregnancies from areas with Zika (Puerto Rico, American Samoa, U.S. Virgin Islands, Federated States of Micronesia, Republic of Marshall Islands) in the U.S. Zika Pregnancy and Infant Registry (USZPIR) had a laboratory result showing possible or confirmed Zika virus infection between 2016 and 2018. From these pregnancies, 1,450 babies were at least 1 year old by February 1, 2018, and had any follow-up care reported to the USZPIR. Many of these babies did not receive all the recommended screenings for health problems potentially
related to Zika virus. Careful monitoring and evaluation of these children is essential to ensure early detection of possible disabilities and referral to early intervention services.

**Follow-up evaluation of babies born to women with Zika virus infection during pregnancy**

CDC recommends that all babies born to mothers with Zika virus infection during pregnancy receive a variety of screenings and care even if they appear healthy at birth. CDC scientists analyzed the most current data reported to the USZPIR to examine the follow-up care of these babies.

Data reported for Puerto Rico, American Samoa, U.S. Virgin Islands, Federated States of Micronesia, and Republic of the Marshall Islands showed opportunities for improvement in the screening and care these babies receive. For example, among the 1,450 babies included in the analysis, while 95 percent were reported to have had at least one physical examination after two weeks of age, only 36 percent were reported to have received the recommended eye exam by an eye specialist. Following the recommended screenings and care for these babies is important for more complete identification of health problems and timely referral to services.

**Zika is still a threat**

Zika virus is still a risk for pregnant women and their babies. In addition to the 4,800 pregnancies in the U.S. territories and freely associated states, nearly 2,500 pregnancies in U.S. states Zika virus infection; most infections occurred during travel.

Zika virus can be transmitted from the bite of an infected mosquito, from a pregnant woman to her developing baby, through sex, and through blood transfusion. Most of the cases in the U.S. states resulted from mosquito bites during travel to areas with risk of Zika. There are currently no areas with local mosquito-borne Zika virus transmission in the continental United States. Though transmission has declined around the world, Zika virus continues to spread at low levels in many areas, and nearly 100 countries and territories are areas with risk of Zika. For this reason, CDC continues to urge pregnant women not to travel to areas with risk of Zika and recommends that men and women who travel to an area with risk of Zika wait before trying to conceive.

**CDC releases updated guidance for timing of pregnancy after Zika exposure**

This issue of CDC’s *Morbidity Mortality Weekly Report* also includes updated CDC guidance for couples planning to become pregnant after possible exposure to Zika virus.

CDC now recommends that men with possible Zika virus exposure who are planning to conceive with their partner wait at least 3 months after symptoms or possible exposure (travel to or residence in an area with risk of Zika). This shortened timeframe also applies for men who are not planning to conceive with their partners but who want to prevent passing of Zika virus through sex. These updated recommendations are based on emerging data, which suggest that risk of infectious Zika virus in semen appears to decline substantially during the 3 months after onset of symptoms.

For more information about Zika virus and pregnancy visit https://www.cdc.gov/pregnancy/zika/.

For more information about CDC’s guidance on care of infants and children born to mothers with possible Zika virus infections during pregnancy visit https://www.cdc.gov/pregnancy/zika/testing-follow-up/infants-children.html. For resources and tools to help track your child’s development visit https://www.cdc.gov/ncbddd/actearly/milestones/.

- **On August 9, 2018, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would set a new direction for the Medicare Shared Savings Program (Shared Savings Program).**
  - The proposed rule would redesign the participation options available under the program to encourage Accountable Care Organizations (ACOs) to transition to two-sided models (in which
they may share in savings and are accountable for repaying shared losses), increase savings for the Trust Funds and mitigate losses, reduce gaming opportunity and increase program integrity and promote regulatory flexibility and free-market principles.

- This proposed rule would also strengthen beneficiary engagement, ensure rigorous benchmarking and help improve care for Medicare beneficiaries, with an emphasis on combatting opioid addiction and expanding the use of interoperable electronic health record technology among ACO providers/suppliers.

- The proposed policies also include changes to address the additional tools and flexibilities for ACOs established by the Bipartisan Budget Act of 2018 (BBA of 2018), specifically in the areas of new beneficiary incentives, telehealth services, choice of beneficiary assignment methodology and voluntary alignment refinements.

Currently, 561 Shared Savings Program ACOs serve over 10.5 million Medicare fee-for-service (FFS) beneficiaries. ACOs are an important tool for moving CMS’s payment systems away from paying for volume and towards paying for value and outcomes, as ACOs are held accountable for the total cost of care (spending in relation to a historical benchmark) and quality outcomes for the assigned beneficiary patient population they serve.

In connection with the proposed program redesign, CMS would delay the 2019 agreement period start until July 2019.

This would provide ACOs time to review new policies, make business and investment decisions, obtain buy-in from their governing bodies and executives, and complete and submit a Shared Savings Program application for a performance year beginning July 1, 2019. CMS would resume the usual annual application cycle for the performance year starting on January 1, 2020 and subsequent years.

There will be a 60-day public comment period on this proposed rule. CMS encourages all interested members of the public, including ACOs, providers, suppliers, and Medicare beneficiaries to submit comments so that CMS can consider them as we develop the final rule. The 60-day comment period closes on October 16, 2018. Comments can be submitted at: https://www.regulations.gov/ (in commenting please refer to file code CMS-1701-P).

REPORTS/POLICIES

- The GAO published “Military Personnel: DoD Needs to Improve Funding Process for Morale, Welfare, and Recreation Programs,” (GAO-18-424) August 8, 2018. This report assesses the extent the services have met DoD’s established funding targets for each category of MWR programs and DoD has comprehensively evaluated the relevance of its targets; and DoD has oversight structures and performance measures that include measurable goals, including those for cost-effectiveness, by which to review MWR programs. https://www.gao.gov/assets/700/693813.pdf

HILL HEARINGS

- There are no health-related hearings scheduled next week.

LEGISLATION
**LIST**


**MEETINGS**


- The 2018 AMSUS Annual Continuing Education Meeting will be held on **Nov. 26-30, 2018**, at the Gaylord National Harbor, Md. [http://www.amsusmeetings.org/home-2/](http://www.amsusmeetings.org/home-2/)

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