Federal Health Update

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EXECUTIVE AND CONGRESSIONAL NEWS

- **On Sept. 14, 2016, the House passed H.R. 5620, the VA Accountability First and Appeals Modernization Act.** This legislation amends title 38, United States Code, to provide for the removal or demotion of employees of the Department of Veterans Affairs based on performance or misconduct, and for other purposes.

- **According to The Hill, the House and Senate are working separately on two bills that would keep the federal government running until Dec. 9, 2016.**

  Each chamber's bill has partisan riders that risk its passing.

  The Senate measure includes a GOP rider that would prevent the $80 million in funding to fight the Zika virus to go to health care providers that provide abortions. It also includes a Republican-sponsored proposal to loosen regulatory restrictions on the use of pesticides against mosquitoes, the main carriers of the virus and one that would block the administration from relinquishing the Department of Commerce's oversight of the internet.

  Democrat Senators (with some Republican support have proposed a rider that would change the quorum rules at the Export-Import Bank to allow it to finance transactions bigger than $10 million.

  The House's legislation also includes partisan measures that may make it difficult to pass through the chamber.

  One rider would halt the Syrian refugee resettlement program until the government can assure

no terrorists or radicals will be admitted to the U.S. A second would block money from going to Planned Parenthood clinics. The third blocks President Obama's internet transition plan, which is scheduled to go into effect at month's end.

There are 14 days left.

MILITARY HEALTH CARE NEWS

- **The Department of Defense announced today the induction of three new members to the Defense Advisory Committee on Women in the Services.**

  DACOWITS, established during the Korean War in 1951 by Secretary of Defense George C. Marshall, is an independent advisory committee that provides the department with advice and recommendations on matters and policies relating to the recruitment and retention, treatment, employment, integration and well-being of highly-qualified professional women in the armed forces.

  Previously comprised of 16 members, the DACOWITS charter authorizes a total of 20 committee members.

  The incoming members are as follows:

  - Retired Army Reserve Command Sergeant Major Michele Jones, Jacksonville, Florida;
  - Navy Veteran Ms. Janie Mines, Fort Mill, South Carolina;
  - Retired Navy Fleet Master Chief Jo Ann Ortloff, San Diego, California.

  DACOWITS members include prominent civilian women and men representing a distribution of demography, academia, industry, public service and other professions. They are selected based on military experience or woman-related workforce issues.

  Members are selected for a four-year term, without compensation, to perform a variety of duties, including visiting military installations each year, conducting a review and evaluation of current research on military women, and developing an annual report with recommendations on these issues for service leadership and the secretary of defense.

  More information about DACOWITS can be found at http://dacowits.defense.gov/

- **The next Uniform Formulary Beneficiary Advisory Panel will be held on Sept. 22, 2016, from 9:00 a.m. to 12:00 p.m. in Washington D.C. The Panel will review the following items:**

  - Topical Acne and Rosacea Agents
  - Migraine Agents—Triptans Agents
  - Alcohol Deterrents; Narcotic Antagonists
  - Over-The-Counter Program
  - Designated Newly FDA Approved Drugs
  - Pertinent Utilization Management Issues

  For more information, please visit http://www.health.mil/About-MHS/Other-MHS-Organizations/Beneficiary-Advisory-Panel.

- **Madigan Army Medical Center is now offering in-house training to civilian nurses to specialize as perioperative and emergency nurses.**

  In August, a civilian nurse began training with Madigan's Consolidated Education Division in a course which previously only trained military nurses. Opening up the existing perioperative, or operating room, course to civilians and developing a new ER training course for civilians allows Madigan to invest in its civilian employees, which comprises nearly 68 percent of the hospital staff. Many nurses may see a grade increase after specializing as well.

  "One of goals is to help us find talented people for hard-to-fill positions and grow our own. We think investing in them here will make them more dedicated employees, and will help us to retain our best people," said Army Col. John Groves, Madigan's chief nursing officer.

  Before now, civilian nurses who wanted to specialize in these areas often left federal service to get training in the civilian workforce. Groves believes that offering specialized training here will also serve as a recruiting tool as it enhances nurses' professional development.

  The OR course lasts 16 weeks and the ER course is scheduled to take 12 weeks; both offer a combination of self-study, classroom and clinical teaching. Madigan is ensuring the ER self-study program uses the "gold standard" of a program already accredited by the Emergency Nurses Association, said Groves. After graduating from the courses, employees enter orientation programs in the specialty areas. Offering the clinical training alongside of nurses already in these fields also allows leadership to better evaluate the trainees before hiring them.

  While the OR course has already had its first civilian student, the ER course is predicted to start this fall. The ER course is being developed by Army Lt. Col. Katherine Frost, the unit's clinical nurse officer-in-charge, and by Michelle Darcy, a trauma nurse educator with the Consolidated Education Division.

  Although each program may initially train one to two nurses in the first course, the programs may train four to six students a year depending on the need of each specialty area.

  The training helps prepare nurses for future national board-certified tests as well. Madigan nurses who want to apply for this specialized training should work through their chains of command and annotate this goal in their individualized development plans.

VETERANS AFFAIRS NEWS

- **The Department of Veterans Affairs (VA) has published proposed regulations to establish presumptions for the service connection of eight diseases affecting military members exposed to contaminants in the water supply at Camp Lejeune, N.C.**

  The presumptive illnesses apply to active duty, reserve and National Guard members who served for no less than 30 days at Camp Lejeune between Aug. 1, 1953 and Dec. 31, 1987, and are diagnosed with the following conditions:

  - adult leukemia
  - aplastic anemia and other myelodysplastic syndromes
  - bladder cancer
  - kidney cancer
  - liver cancer
  - multiple myeloma
  - non-Hodgkin’s lymphoma
  - Parkinson’s disease

Environmental health experts on VA's Technical Workgroup conducted comprehensive reviews of scientific evidence, which included analysis and research done by the Department of Health and Human Service's Agency for Toxic Substances and Disease Registry (ATSDR), Environmental Protection Agency, the International Agency for Research on Cancer, the National Toxicology Program, and the National Academies of Science.

Military members with records of service showing no less than 30 days of service, either concurrent or cumulative, at Camp Lejeune during the contamination period can already be granted Veteran status for medical benefits, following passage of the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012.

In the early 1980s, volatile organic compounds, trichloroethylene (TCE), a metal degreaser, and perchloroethylene, a dry cleaning agent (PCE), as well as benzene, and vinyl chloride were discovered in two on-base water supply systems at Camp Lejeune. These systems served the housing, administrative, and recreational facilities, as well as the base hospital. The contaminated wells supplying the water systems were shut down in February 1985.

VA acknowledges that current science establishes a link between exposure to certain chemicals found in the water supply at Camp Lejeune and later development of one of the proposed presumptive conditions. However, VA experts agree that there is no scientific underpinning to support a specific minimum exposure level for any of the conditions. Therefore, VA welcomes comments on the 30-day minimum exposure requirement and will consider other practical alternatives when drafting the final rule. VA also notes that the proposed 30-day requirement serves to establish eligibility for service connection on a presumptive basis; nothing in this proposed regulation prohibits consideration of service connection on a non-presumptive basis.

The 30-day public comment period on the proposed rule is open until Oct.10, 2016.

- **Veterans receiving care at Department of Veterans Affairs' (VA) Medical Centers will now be able to schedule routine ear and eye appointments at local VA Audiology and Optometry clinics without a primary care referral – a move that eliminates multiple steps and gets Veterans into appointments quicker.**

Before now, veterans seeking appointments with audiologists or optometrists had to first make an appointment with a primary care physician for a referral for a routine clinic consult visit. A clinic representative would contact the patient to set up the consult appointment, which could result in a several weeks'-long lag between the appointment and when the veteran was actually seen. The new process, the Audiology and Optometry Direct Scheduling Initiative, which began as a successful pilot at three sites in 2015, is being expanded to all VA Medical Centers.

The Audiology and Optometry Direct Scheduling Initiative is one of a number of efforts underway at VA to improve veterans' access to care and wait times. Among those recent accomplishments:

VA and Choice contractors created more than 3.1 million authorizations for veterans to receive care in the private sector from May 1, 2015 through Apr. 30, 2016. This represents an 8 percent increase in authorizations when compared to the same period in 2014/2015.

- In FY 2015, 12 percent of all veterans enrolled for VA care received telehealth-based care. This includes more than 2 million telehealth visits touching 677,000 Veterans; 45 percent of these veterans live in rural areas.
- In FY 2015, more than 6,300 veterans accessed VA care through live interactive video telehealth from home.
- VA has activated over 3.9 million square feet of space in the past two years.
- We've increased authorizations for care in the community 46% in the past two years.
- Clinic production is up 10 percent as measured by the same productivity standard used

by many private-sector healthcare systems. This increase translates into roughly 20 million additional hours of care for veterans.

- As we improve access to care, more and more veterans are choosing VA care — for the quality, for the convenience, or for the cost-savings so even though we're completing millions more appointments, we continue to have more work to do.

VA has increased salaries for physicians and dentists to close the pay gap with the private sector and to make VA an employer of choice. With more competitive salaries, VA will be better positioned to retain and hire more health care providers to care for veterans.

The Audiology and Optometry Direct Scheduling Initiative is expected to be fully operational within all VA Medical Centers by the end of 2016.

GENERAL HEALTH CARE NEWS

- **The Department of Health and Human Services highlighted findings from a few new studies that show Americans are experiencing slower growth in health care premiums, increased access to coverage, and higher quality of care.**

  More Affordable: The average premium for families with employer-sponsored health plans grew just 3.4 percent in 2016, according to the Kaiser Family Foundation and Health Research and Educational Trust survey, extending a period of unusually slow growth since 2010. The White House Council of Economic Advisers calculates that the average family premium is $3,600 lower in 2016 than if premiums had grown at the same rate as the pre-ACA decade.

  - The independent analysis released this morning by the Kaiser Family Foundation finds that the average family premium for the 150 million Americans with employer-sponsored health plans increased by only 3.4 percent in 2016. Since 2010, the average family premium has increased an average of 4.7 percent per year, compared to 7.9 percent from 2000 to 2010 – a 40 percent reduction in growth. That slowdown is saving American families $3,600 in 2016, compared to if premium growth had continued at pre-ACA rates.
  - Workers' contributions to premiums have also increased an average of 4.7 percent per year since 2010, compared to 9.5 percent during the previous decade. Meanwhile, another Kaiser study found that total enrollee cost sharing (counting deductibles, coinsurance, and copayments) increased an average of 4.1 percent per year from 2010-2014, compared to 7.1 percent from 2004-2010.

- **Greater Access**: New Census data show that the uninsured rate dropped in every state in the country between 2013 and 2015. In total, 20 million Americans have gained coverage thanks to provisions of the ACA, and the uninsured rate is at its lowest level ever - PDF.

  - Last week, new data - PDF showed that the national uninsured rate fell to a record low of 8.6 percent in the first quarter of 2016, following the Health Insurance Marketplace's third open enrollment season. Yesterday, the Census Bureau released its first detailed data on how the ACA's coverage expansions impacted insurance coverage in 2015, including data on trends in insurance coverage in every state in the country. The Census' national data confirmed earlier estimates that rapid gains in insurance coverage continued in 2015. Notably, the new Census data show that the uninsured rate fell in every state in the country from 2013 to 2015.

- **Better Quality**: Hospital readmissions dropped 8 percent between 2010 and 2015. In 2015, that drop translated into about 100,000 times Medicare beneficiaries avoided an unnecessary return to the hospital. Cumulatively since 2010, Medicare beneficiaries have avoided 565,000 readmissions.

- According to CMS data, hospital readmissions dropped in 49 states plus the District of Columbia since 2010. That means that Medicare beneficiaries avoided about 100,000 readmissions just in 2015, compared to if readmissions had stayed constant at 2010 rates.

- **A Centers for Disease Control and Prevention (CDC) study finds about 5 million Medicare Part D enrollees age 65 and older are not taking their blood pressure medicine properly, increasing their risk of heart disease, stroke, kidney disease, and death.**

  Seven out of ten U.S. adults ages 65 and older have high blood pressure (140/90mmHg or higher), but nearly half do not have their blood pressure under control. The report outlines the dangers of high blood pressure and the important role health care systems play in helping patients take blood pressure medicines as directed.

  The report analyzes data from more than 18.5 million people enrolled in Medicare Advantage or Original Medicare with Medicare Part D prescription drug coverage during 2014. CDC and the Centers for Medicare & Medicaid Services (CMS) researchers looked at disparities in beneficiary adherence rates based on factors including geography, race/ethnicity, gender, income status, and medication class.

  Key findings in the report include:

  - About 5 million Medicare Part D enrollees ages 65 or older are not taking their blood pressure medicine as directed. This means they may skip doses or stop taking it altogether.
  - The percentage of Medicare Part D enrollees not taking their blood pressure medicine is higher among certain racial/ethnic groups (American Indian/Alaska Native, Black, Hispanic). This contributes to these groups' higher risk of heart attack, stroke, kidney disease, and death.
  - There are also geographic differences. Southern U.S. states, Puerto Rico, and the U.S. Virgin Islands have the highest overall rates of not taking blood-pressure medicines as directed. North Dakota, Wisconsin, and Minnesota have the highest rates of people who do take their medicine as directed.

  To learn more about heart disease and stroke, visit https://www.cdc.gov/heartdisease(https://www.cdc.gov/heartdisease/) and https://www.cdc.gov/stroke(https://www.cdc.gov/stroke/).

  For more information on high blood pressure, visit https://www.cdc.gov/bloodpressure(https://www.cdc.gov/bloodpressure/).

- **The U.S. Food and Drug Administration approved the VisuMax Femtosecond Laser to reduce or eliminate nearsightedness in certain patients 22 years of age or older.**

  Not all patients are candidates for the procedure and individuals should carefully review the patient labeling and discuss their expectations with their eye care professional.

  Nearsightedness, or myopia, is a common vision condition in which close objects are seen clearly, but objects farther away are blurred. It occurs when the eye focuses light in front of the retina. This can be due to the shape of the cornea being too steep and/or the length of the eyeball being too long.

  The VisuMax Femtosecond Laser removes a small amount of eye tissue to permanently reshape the cornea. A femtosecond (very fast, short-pulsed) laser makes cuts within the cornea, creating

a disc-shaped piece of tissue that is removed by the surgeon through a small incision in the surface of the cornea. This tissue removal causes the shape of the cornea to change, which corrects the nearsightedness.

A clinical study of the safety and effectiveness of the device to correct nearsightedness found the procedure resulted in stable vision correction at six months. Of the 328 participants evaluated at six months, all but one had uncorrected (without glasses or contacts) visual acuity of 20/40 or better, and 88 percent had uncorrected visual acuity of 20/20 or better.

The VisuMax Femtosecond Laser is manufactured by Carl Zeiss Meditec Inc., of Dublin, California.

REPORTS/POLICIES

- **The GAO published *"Health Care: Results of Recent Undercover Testing for Patient Protection and Affordable Care Act Coverage, and Review of Market Concentration in the Private Insurance Markets,"* (GAO-16-882T) on Sept. 14, 2016.** This report examines enrollment controls for health-care coverage obtained through the health-insurance marketplaces, and private health-insurance market concentration. http://www.gao.gov/assets/680/679729.pdf

- **The GAO published *"Patient Protection and Affordable Care Act: Most Enrollees Reported Satisfaction with Their Health Plans, Although Some Concerns Exist,"* (GAO-16-761) on Sept. 12, 2016.** This report describes what is known about enrollee experiences with QHPs obtained through the exchanges during the first years of exchange operation, and how CMS and selected states have monitored the post-enrollment experiences of those who obtained their QHPs through the exchanges. http://www.gao.gov/assets/680/679673.pdf

- **The GAO published *"Patient Protection and Affordable Care Act: Results of Undercover Enrollment Testing for the Federal Marketplace and a Selected State Marketplace for the 2016 Coverage Year,"* (GAO-16-784) on Sept. 12, 2016.** This report provides results of GAO undercover testing of potential vulnerabilities to fraud in the application, enrollment, and eligibility-verification of the federal Marketplace and one selected state marketplace. http://www.gao.gov/assets/680/679671.pdf

HILL HEARINGS

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

LEGISLATION

- **H.R.6027** (introduced Sept. 14, 2016): To amend section 9010 of the Patient Protection and Affordable Care Act to provide health insurance fairness for Puerto Rico was referred to House Energy and Commerce.

Sponsor: Representative Patrick D. Murphy [D-FL-18]

- **H.R.6023** (introduced Sept. 14, 2016): To exempt health insurance of residents of United States territories from the annual fee on health insurance providers was referred to House Energy and Commerce.
Sponsor: Representative Curbelo, Carlos [R-FL-26]:

- **S.3331** (introduced Sept. 14, 2016): A bill to exempt health insurance of residents of the United States territories from the annual fee on health insurance providers was referred to the Committee on Finance.
Sponsor: Senator Marco, Marco [R-FL]

- **S.3326** (introduced Sept. 14, 2016): A bill to give States the authority to provide temporary access to affordable private health insurance options outside of Obamacare exchanges.
Sponsor: Senator Lamar Alexander [R-TN]

- **S.3322** (introduced Sept. 14, 2016): A bill to provide an exemption to the individual mandate to maintain health coverage for certain individuals residing in service areas with no health insurance issuers offering plans on an Exchange was referred to the Committee on Finance.
Sponsor: Senator Jeff Flake [R-AZ]

- **H.R.6018** (introduced Sept. 13, 2016): Ensuring Health Care Opportunities Act was referred to the House Committee on Energy and Commerce.
Sponsor: Representative Don Young [R-AK-At Large]

- **H.R.6011**: (introduced 09/13/2016): ACA Premium Payment Verification Act was referred to House Ways and Means was referred to the House Committee on Energy and Commerce.
Sponsor: Representative Gus M. Bilirakis [R-FL-12]

- **H.R.6005** (introduced Sept. 13, 2016): Lead by Example Act of 2016 was referred to House Veterans' Affairs
Sponsor: Representative Warren Davidson [R-OH-8]

MEETINGS

- The AUSA 2016 Annual Meeting & Exposition will be held **Oct. 3-5, 2016**, in Washington DC. http://ausameetings.org/2016annualmeeting/
- 2016 AMSUS Annual Continuing Education Meeting will be held on **Nov. 29- Dec. 2, 2016**, at the Gaylord National Harbor, Md. http://www.amsusmeetings.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.