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 are in recess until after the mid-term elections.

- On Oct. 24, 2018, the president signed into law: H.R. 6, the “Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act.” This law is designed to address the opioid crisis by reducing access to and the supply of opioids and by expanding access to prevention, treatment, and recovery services.

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**MILITARY HEALTH CARE NEWS**

- On November 27, 2018, the DoD/VA Interagency Program Office (IPO) will facilitate the 7th DoD/VA Industry Interoperability Roundtable.

  The theme for this year is “The Journey of Interoperability”. Speakers from the DoD and VA will discuss project updates, and industry discussion will revolve around interoperability influences and lessons learned on delivering quality patient care. We will facilitate the Roundtable in an effective and efficient manner, welcoming participants who possess relevant broad-based knowledge and experience. This event is open to the public.

  High-level agenda topics include:
The U.S. Department of Veterans Affairs (VA) recently completed a significant modernization effort in which more than 7.8 million paper files were removed from 60 locations in fewer than 22 months, enabling rapid scanning into VA’s electronic claims processing system by multiple third-party vendors. This will lead to faster claims decisions for veterans.

This milestone was part of a long VA effort to improve the veteran experience and streamline claims processes.

In 2013, VA began removing paper records from its regional offices to save space and taxpayer money.

- The effort expanded in 2016 when the agency launched the File Bank Extraction initiative.
- This initiative removed more than 1.7 million paper claims files across 59 VA locations and contributed to reduced claims processing time by establishing more electronic records.

Additionally, in Nov. 2017, VA began extracting nearly 6.1 million paper records held within the Records Control Division (RCD) of the Records Management Center (RMC) in St. Louis.

- VA is currently working with the General Services Administration (GSA), which owns the Goodfellow Federal Center complex that houses the RMC, to return the RCD’s leased warehouse space back to GSA. As a result, VA will save nearly $1.8 million per year.
- The other areas of the RMC remain open and operational.
- The 6.1 million paper records extracted from the RCD are temporarily stored in a secure facility certified by the National Archives and Records Administration where they are inventoried, prioritized and sent to multiple VA vendors for rapid scanning into VA’s Veterans Benefits Management System (VBMS).
- Records removed during File Bank Extraction will also be scanned and uploaded to VBMS.

VA continues to take steps to operate in a digital environment and modernize the way it processes compensation and pension claims — moving from a cumbersome, paper-intensive process to an efficient, electronic process — resulting in a faster, more accurate and transparent claims process.

For more information about VA benefits, visit [https://benefits.va.gov/benefits/](https://benefits.va.gov/benefits/).
The U.S. Departments of the Treasury, Health and Human Services, and Labor issued a proposed regulation that expands the usability of health reimbursement arrangements (HRAs) in Oct. 23, 2018.

HRAs are designed to give working Americans and their families greater control over their healthcare by providing an additional way for employers to finance quality, affordable health insurance. This proposed regulation is intended to benefit hundreds of thousands of businesses and millions of workers and their families in the coming years.

HRAs allow employers to reimburse their employees for medical expenses in a tax-favored way. Current regulations, issued by the previous administration, prohibit employers from using HRAs to reimburse employees for the cost of individual health insurance coverage. Undoing that prohibition, the proposed regulation would permit HRAs to reimburse employees for the cost of individual health insurance coverage, subject to certain conditions. These conditions mitigate the risk that health-based discrimination could increase adverse selection in the individual market, and include a disclosure provision to ensure employees understand the benefit.

Because medical expense reimbursements from HRAs are tax-preferred, HRAs provide the same tax advantage enjoyed by traditional employer-sponsored coverage. The proposed regulation would not alter the tax treatment of traditional employer-sponsored coverage. It would merely create a new tax-preferred option for employers of any size to use when funding employee health coverage. While the employer would fund the cost of individual health insurance coverage, the employee would own the coverage, allowing the employee to keep the coverage even if he or she left the employer and was no longer covered by the HRA.

In the near term, the proposed regulation, if finalized, would provide opportunities to employers, especially small and mid-size employers who have struggled to offer coverage, to fund the cost of individual health insurance coverage on a tax-preferred basis.

In the long term, the proposed regulation, if finalized, has the potential to spur a truly competitive, value-driven health insurance market that empowers people to shop for their own health plans and, by virtue of consumer choice, drive health plans to deliver higher quality coverage at lower cost. The proposed regulation holds the potential of transformative impact on the health insurance landscape in the coming years.

Separately, in addition to allowing HRAs to reimburse the cost of individual health insurance coverage, the proposed regulation would allow employers offering traditional employer-sponsored coverage to offer an HRA of up to $1,800 per year (indexed annually for inflation) to reimburse an employee for certain qualified medical expenses, including premiums for short-term, limited-duration insurance plans.

The proposed regulation can be found here, and a fact sheet can be found here.

Comments on the proposed regulation are requested by December 28, 2018. The regulation, if finalized, is proposed to be effective for plan years beginning on and after January 1, 2020.

The Centers for Medicare & Medicaid Services (CMS) announced the Maternal Opioid Misuse (MOM) model, an important step in advancing the agency’s multi-pronged strategy to combat the nation’s opioid crisis.

The model addresses the need to better align and coordinate care of pregnant and postpartum Medicaid beneficiaries with opioid use disorder (OUD) through state-driven transformation of the delivery system surrounding this vulnerable population. By supporting the coordination of clinical care and the integration of other services critical for health, wellbeing, and recovery, the MOM model has the potential to improve quality of care and reduce expenditures for mothers and
infants.

Substance use-related illness and death is now a leading cause of maternal death. Pregnant and postpartum women who misuse substances are at high risk for poor maternal outcomes, including preterm labor and complications related to delivery; these problems are frequently exacerbated by malnourishment, interpersonal violence, and other health-related social needs. Infants exposed to opioids before birth are at greater risk for negative health outcomes such as higher risk of being born preterm, having a low birth weight, and experiencing the effects of neonatal abstinence syndrome (NAS), a group of conditions caused when an infant withdraws from certain drugs s/he is exposed to in the womb. In addition, Medicaid pays the largest portion of hospital charges for maternal substance use, as well as a majority of the $1.5 billion annual cost of NAS.

The primary goals of the model are to:

- Improve quality of care and reduce expenditures for pregnant and postpartum women with OUD as well as their infants;
- Increase access to treatment, service-delivery capacity, and infrastructure based on state-specific needs; and
- Create sustainable coverage and payment strategies that support ongoing coordination and integration of care.

The CMS Innovation Center will execute up to 12 cooperative agreements with states, whose Medicaid agencies will implement the model with one or more “care-delivery partners” in their communities. The MOM model will serve pregnant Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries with OUD who have elected to participate, during the prenatal, peripartum (i.e., surrounding labor and delivery), and postpartum periods. Awardees will be responsible for ensuring that beneficiaries participating in the model have access to a set of essential physical and behavioral health services, such as medication-assisted treatment (MAT) for OUD, maternity care, relevant primary care services, and other mental and behavioral health services beyond MAT.

The MOM model will have a five-year period of performance with different types of funding. Specifically, implementation funding, transition funding, and the opportunity for milestone funding will be provided in three distinct model periods: Pre-implementation (Year 1), Transition (Year 2), and Full Implementation (Years 3-5).

CMS anticipates releasing a Notice of Funding Opportunity (NOFO) in early 2019 to solicit cooperative agreement applications to implement the MOM model. The state Medicaid agency will be expected to complete the application, which must demonstrate that it has partnered with at least one care-delivery partner. A maximum of $64.6 million will be available across up to 12 state awardees over the course of the five-year model. The NOFO will contain all model requirements and eligibility criteria for potential applicants.


- **The Centers for Disease Control and Prevention (CDC) announced that just 37 percent of Americans received a flu vaccination last year.**

In its report, vaccination coverage among adults was 37.1 percent, a decrease of 6.2 percentage points from the previous flu season. In 2017, more than 79,000 people died, close to 1 million ended up in the hospital and 48 million people got sick. Adult flu deaths are estimated but the CDC counts every child who dies of flu. Last season, 183 children died of influenza.
The CDC found 30 million people ages 18 to 64 got sick with flu last season. Close to 12 million children ages 17 and younger got sick.

Last year’s Influenza vaccine lowered the risk of infection by about 40 percent.

- **The FDA approved the first new type of flu drug in two decades on Oct. 24, 2018.**

  Xofluza, manufactured by Roche Group and Shionogi & Co., can reduce severity and shorten duration of flu symptoms after just one dose for people ages 12 and older.

  It works about as well as Tamiflu, Roche’s older flu treatment, which is also available in cheaper generic versions. Tamiflu is taken twice daily for five days. Health officials have said an estimated 80,000 Americans died of flu and its complications last winter, the disease's highest death toll in at least four decades. The severe flu season increased demand for Tamiflu and led to spot shortages.

  In company testing on 1,064 people, Xofluza ended coughing, sneezing, and fever, or greatly reduced symptoms, in just over two days on average; a comparison group given Tamiflu fared similarly. While Xofluza didn't work faster than Tamiflu, it did reduce virus levels in patients' noses and throats more quickly. Xofluza side effects were mild—diarrhea, nausea, headaches, and bronchitis—and occurred at about the same rate as study subjects given Tamiflu or placebo pills.

### REPORTS/POLICIES

- **The GAO published “Veterans First Program: VA Needs to Address Implementation Challenges and Strengthen Oversight of Subcontracting Limitations,” (GAO-18-648) on Oct. 24, 2018.** In this report assesses the extent to which changes occurred in procurement obligations to veteran-owned small businesses from fiscal years 2014 through 2017; VA has encountered any challenges in implementing Veterans First policies; and VA has mechanisms to oversee contractor compliance with subcontracting limitations.  

- **The GAO published “Opioid Crisis: Status of Public Health Emergency Authorities,” (GAO-18-685R) Oct. 23, 2018.** This report describes: the factors HHS indicated as affecting its decision to declare and renew the public health emergency for the opioid crisis, and the public health emergency authorities the federal government has used to address the opioid crisis.  

### HILL HEARINGS

- The Senate Committee on Health Education, Labor and Pension will hold a hearing on **Nov. 28, 2018**, to examine reducing health care costs, focusing on improving affordability through innovation.
LEGISLATION

- **H.R.7079** (introduced Oct. 19, 2018): The Corrections Public Health and Community Re-entry Act of 2018 was referred to the House Committee on the Judiciary. Sponsor: Representative Ann M. Kuster [D-NH-2]

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/)

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.