

Federal Health Update

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ktheroux@federalhealthcarenews.com

EXECUTIVE AND CONGRESSIONAL NEWS

- **On Oct. 29, 2015, the House elected Representative Paul Ryan to be the 54th Speaker of the House.**
- **On Oct. 28, 2015, the House voted (266-167) to approve a budget deal that raises the nation's debt ceiling through March 2017, potentially avoiding a fiscal crisis that could have ensued if the nation defaulted on its loans.**

The budget deal increases federal spending on defense and domestic programs over \$80 billion for the next two years and suspends the nation's debt limit through March 2017.

The focus now turns to the Senate, where Sen. Rand Paul has promised to filibuster the legislation, but Senate Republican leaders were "confident" they could push the measure to Obama's desk. Senate Majority Leader Mitch McConnell has also built in enough time to the debate to overcome Paul's maneuvers.

To pay for the higher levels, Boehner and congressional leaders used a mix of reforms to entitlement programs, including the Social disability insurance program and Medicare. They also raised some money from the sale of public airwaves to telecommunications companies and the sale of oil from the strategic petroleum reserve.

Congress still needs to pass the omnibus funding bill in December.

MILITARY HEALTH CARE NEWS

- **The premiums for TRICARE Young Adult (TYA) program will increase on Jan. 1, 2016 to \$306 per month for TYA Prime, and \$228 per month for TYA Standard.**

The TYA program provides health benefits for “adult children between 21 and 26 years old of TRICARE beneficiary.

The increase is due to the requirement in the National Defense Authorization Act of 2011 that TRICARE set TYA premiums to cover the full cost of health care received by the program’s beneficiaries. Previous years’ premiums were lower because TRICARE did not yet have sufficient cost data to set annual premiums. This coming year marks the first time TRICARE has had enough actual cost data to set the premiums based on actual costs rather than predicted cost.

The monthly fees for Tricare Young Adult will be \$306 for Tricare Young Adult Prime and \$228 for Tricare Young Adult Standard starting January 1, 2016. The current fees for 2015 are \$181 for Standard and \$208 for Prime.

Other health care options for young adult beneficiaries include:

- Purchasing TYA Standard – lower premiums, higher cost shares – instead of TYA Prime
- Enrolling in a parent’s civilian health insurance plan, if available
- Purchasing coverage through the college or university, if enrolled
- Purchasing a plan offered through the Health Insurance Marketplace at www.healthcare.gov.

Lower cost plans may be available depending on income and residence, and assistance paying premiums may be available if beneficiaries qualify for government subsidies through commercial plans.

Visit www.tricare.mil/TYA for more information.

- **TRICARE announced that more than 2 million TRICARE beneficiaries have gotten a free flu vaccine under the TRICARE Retail Vaccination program since it began in 2010.**

Getting the flu vaccine every year is the most effective way to lower your chances of getting the flu. The Centers for Disease Control and Prevention (CDC) recommends that everyone six months and older get a flu vaccine every year. Serious cases of the flu can lead to hospitalization and even death. The elderly, young children, and people with serious health issues are at a higher risk for getting the flu.

TRICARE covers two forms of the flu vaccine, the flu shot and Flu Mist. The CDC recommends a normal flu shot for everyone aged 6 months to 64 years of age. There is a high dose version for those older than 65. Flu Mist is for those between the ages of 2 and 49 years old, but not pregnant women.

If you choose to get your flu vaccine in a retail pharmacy, you must make sure to get it from the pharmacist. Some retail pharmacies now include medical clinics, but if someone other than a pharmacist (like a nurse, doctor or physician’s assistant) administers the vaccine, TRICARE may not cover it.

TRICARE also covers vaccines when you get them from your primary care doctor. Depending on your TRICARE plan, you may have to pay a copay for the office visit. Active duty service members need to follow their Service policy for getting and reporting vaccines.

For more information, go to www.tricare.mil/flu.

VETERANS AFFAIRS NEWS

- **A new report from the Government Accountability Office (GAO) reports the Department of Veterans Affairs is still struggling to manage patients' schedules, at least in the mental health care arena where some veterans have waited nine months for evaluations.**

The GAO reviewed 100 patient cases and found that while 86 patients seeking an initial mental health evaluation generally were seen within an average four days of scheduling an appointment, they actually waited an average of 26 days from their first request for mental health treatment to get that appointment — and some waited up to 279 days.

GAO also found that at one medical center, schedulers were not using the VA's appointment system and were managing appointments manually — a practice that sidesteps oversight and, in the scandal that exploded last year, drew allegations of scheduling failures and use of "secret wait lists."

The GAO report said VA has conflicting policies on allowable wait times, which can cause confusion in assessing whether schedulers are meeting standards. The Veterans Health Administration, for example, sets the standard for mental health appointments at 14 days, while legislation requires VA to refer veterans to private care if they have to wait 30 days or more.

The GAO report also noted that some patients still wait as long as 57 days after their first comprehensive mental health appointment to begin treatment.

The GAO recommended that VA clarify its policies on wait times, issue guidance for calculating wait times and reiterate its policies on maintaining schedules, to include using the VA's official system.

VA hired 5300 mental health clinicians and administrative staff from 2012 to 2013 and increased mental health staffing by a fourth from 2010 to 2014. VA also has hired more than 900 peer specialists — veterans who are trained to work with veterans seeking counseling and mental health services — and is on track to meet the 30-day requirement for accessing care across services by March 2016.

GENERAL HEALTH CARE NEWS

- **A new Department of Health and Human Services report finds that consumers who reenrolled in the Health Insurance Marketplace last year and who switched to a plan with the same level of coverage saved nearly \$33 per month after tax credits, or almost \$400 annually, relative to what they would have paid had they remained in the same plan as in 2014.**

Those who also switched issuers within the same level of coverage were able to save \$41 per month, or over \$490 annually after tax credits.

The report shows Marketplace consumers were active shoppers last year, with about one third (31 percent) of re-enrollees from 2014 switching to a new plan for 2015.

During Open Enrollment in the Marketplace this coming year, if all consumers switched from their current plan to the lowest-cost premium plan in the same metal level, consumers could save an average of \$610 annually before tax credits and the total savings - to consumers and taxpayers (in premiums and tax credits) - would be more than \$4 billion. For 2016, more than 8 in 10 current Marketplace enrollees can find a lower premium plan in the same metal level before tax credits by returning to shop.

Last year, HHS projected that if all returning consumers who bought a silver plan in 2014 switched to

the lowest-cost silver plan in 2015, they would have saved an average of \$492 annually. If all returning consumers had switched to the lowest-cost plan within their metal level, across all metal levels, the total savings in premiums would have been over \$2 billion before tax credits.

The findings underscore that the Marketplace offers a competitive insurance market from which consumers can choose affordable health plans based on their specific needs and budget. It also shows that consumers using HealthCare.gov are smart shoppers, who pay close attention to plan costs when making selections.

According to the report, historical estimates of plan switching among enrollees in employer sponsored insurance (2.8 percent), the Federal Employee Health Benefits Program (12 percent) and Medicare Drug Plans (13 percent) are low compared to Marketplace consumers.

The report also finds that more consumers switched issuers than metal level, suggesting they preferred to keep the same level of coverage. Specifically, 57 percent of switchers changed issuers in 2015, while only 38 percent changed metal level. Among reenrolling consumers with 2014 silver level plans, the majority (91 percent) stayed in silver plans in 2015. Enrollment in silver level plans is much higher than other metal level plans—69 percent of enrollees chose a silver plan in 2014. (Health insurance plans on the Marketplace are classified by metal level, which range from bronze, with the lowest premiums but the highest deductibles and co-pays, to platinum with the highest premiums and lowest deductibles and co-pays.)

HealthCare.gov offers detailed information about each health insurance plan sold in an area, including out-of-pocket costs, customer service and more. Consumers can visit the [2016 health insurance plans and prices](#) tool on HealthCare.gov and use the new total yearly out-of-pocket cost estimator to learn more about their specific costs.

The 10 states with the highest annual savings from switching were: Florida, Texas, North Carolina, New Jersey, Pennsylvania, Wisconsin, Louisiana, Arizona, Indiana and Georgia.

Open Enrollment in the Health Insurance Marketplace starts on Nov. 1, 2015 and runs through Jan. 31, 2016. Sign up by Dec. 15 to have coverage that starts Jan. 1.

To read the report and to see state by state information on consumer choices visit: http://aspe.hhs.gov/sites/default/files/pdf/134556/Consumer_decisions_10282015.pdf.

- **The U.S. Food and Drug Administration expanded the approved use of Yervoy (ipilimumab) to include a new use as adjuvant therapy for patients with stage III melanoma, to lower the risk that the melanoma will return following surgery.**

Melanoma, the most aggressive type of skin cancer, is the leading cause of death from skin cancer. Melanoma is more likely to spread to other parts of the body than other forms of skin cancer and has been on the rise over the past several decades, according to the National Cancer Institute, with an estimated 73,870 new cases and 9,940 deaths from the disease this year. In stage III melanoma, the cancer has reached one or more lymph nodes. Patients with stage III melanoma are generally treated by surgery to remove the melanoma skin lesions and the nearby lymph nodes.

Yervoy, administered intravenously, was originally approved in 2011 to treat late-stage melanoma that cannot be removed by surgery. Yervoy is a monoclonal antibody that blocks a molecule known as CTLA-4 (cytotoxic T-lymphocyte antigen). CTLA-4 may play a role in slowing down or turning off the body's immune system, and affects its ability to fight off cancerous cells. Yervoy may work by allowing the body's immune system to recognize, target and attack cells in melanoma tumors.

Due to the potential for fatal immune-mediated adverse reactions and unusual severe side effects with Yervoy, the label includes a Boxed Warning. A Medication Guide will also be provided to patients to inform them about the therapy's potential side effects.

Yervoy is manufactured by Bristol-Myers Squibb in Princeton, New Jersey.

- **The Centers for Medicare & Medicaid Services (CMS) has proposed to revise the discharge planning requirements that hospitals, including long-term care hospitals and inpatient rehabilitation facilities, critical access hospitals, and home health agencies, must meet in order to participate in the Medicare and Medicaid programs.**

The proposed changes would modernize the discharge planning requirements by: bringing them into closer alignment with current practice; helping to improve patient quality of care and outcomes; and reducing avoidable complications, adverse events, and readmissions.

The proposed rule would also implement the discharge planning requirements of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), which will improve consumer transparency and beneficiary experience during the discharge planning process. The IMPACT Act requires hospitals, critical access hospitals, and certain post-acute care providers to use data on both quality and resource use measures to assist patients during the discharge planning process, while taking into account the patient's goals of care and treatment preferences.

As called for in the IMPACT Act, hospitals, including inpatient rehabilitation facilities and long-term care hospitals, critical access hospitals, and home health agencies would be required to develop a discharge plan based on the goals, preferences, and needs of each applicable patient

Under the proposed rule, hospitals and critical access hospitals would be required to develop a discharge plan within 24 hours of admission or registration and complete a discharge plan before the patient is discharged home or transferred to another facility. This would apply to all inpatients and certain types of outpatients, including patients receiving observation services, patients who are undergoing surgery or other same-day procedures where anesthesia or moderate sedation is used, and emergency department patients who have been identified by a practitioner as needing a discharge plan. In addition, hospitals, critical access hospitals, and home health agencies would have to:

- Provide discharge instructions to patients who are discharged home (proposed for hospitals and critical access hospitals only);
- Have a medication reconciliation process with the goal of improving patient safety by enhancing medication management (proposed for hospitals and critical access hospitals only);
- For patients who are transferred to another facility, send specific medical information to the receiving facility; and
- Establish a post-discharge follow-up process (proposed for hospitals and critical access hospitals only).

Hospitals and critical access hospitals would be required to consider several factors when evaluating a patient's discharge needs, including but not limited to the availability of non-health care services and community-based providers that may be available to patients post-discharge.

In addition, patients and their caregivers would be better prepared to select a high quality post-acute care provider, since hospitals, critical access hospitals, and home health agencies would be required to use and share data, including data on quality and resource use measures. This results in the meaningful involvement of patients and their caregivers in the discharge planning process.

For more information, please visit: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-27840.pdf>.

REPORTS/POLICIES

- **The GAO published “VA Mental Health: Action Needed to Improve Access Policies and Wait-Time Data,” (GAO-16-170T) on Oct. 28, 2015.** This report examines the way in which the Department of Veterans Affairs’ (VA) Veterans Health Administration (VHA) calculates veteran mental health wait times. <http://www.gao.gov/assets/680/673399.pdf>
- **The GAO published “Electronic Health Records: VA and DOD Need to Establish Goals and Metrics for Their Interoperability Efforts,” (GAO-16-184T) on Oct. 27, 2015.** This report examines the efforts taken to improve interoperability and the challenges faced. <http://www.gao.gov/assets/680/673363.pdf>

HILL HEARINGS

- The House Veterans Affairs Committee will hold a hearing on **Nov. 3, 2015**, to examine the VA’s plan to improve care in the community.
- The House Veterans Affairs Health Subcommittee will hold a legislative hearing on **Nov. 17, 2015**, to examine H.R. 1319; H.R. 1603; H.R. 1904; H.R. 2639; H.R. 3234; H.R. 3471; H.R. 3549; Draft legislation, the Promoting Responsible Opioid Management and Incorporating Medical Expertise Act; and, a VA legislative proposal, the VA Purchased Health Care Streamlining and Modernization Act.
- The House Veterans Affairs Committee will hold a hearing on **Nov. 18, 2015**, to assess VA’s plan to improve care in the community.

LEGISLATION

- **H.R.3849** (introduced Oct. 28, 2015): To amend title 10, United States Code, to ensure access to qualified acupuncturist services for military members and military dependents, to amend title 38, United States Code, to ensure access to acupuncturist services through the Department of Veterans Affairs, to amend title XVIII of the Social Security Act to provide for coverage of qualified acupuncturist services under the Medicare program; to amend the Public Health Service Act to authorize the appointment of qualified acupuncturists as officers in the commissioned Regular Corp and the Ready Reserve Corps of the Public Health Service, and for other purposes was referred to the Committee on Energy and Commerce, and in addition to the Committees on Armed Services, Veterans' Affairs, and Ways and Means.
Sponsor: Representative Judy Chu [CA-27]
- **H.R.3851** (introduced Oct. 28, 2015): the Chiropractic Membership in the Public Health Service Commissioned Corps Act of 2015 was referred to the House Committee on Energy and Commerce
Sponsor: Representative Gene Green [TX-29]
- **S.2208** (introduced Oct. 27, 2015): A bill to promote the economic security and safety of survivors of domestic violence, dating violence, sexual assault, or stalking, and for other purposes was referred to the Committee on Health, Education, Labor, and Pensions.
Sponsor: Senator Patty Murray [WA]
- **S.2210** (introduced Oct. 27, 2015): the Veteran Partners' Efforts to Enhance Reintegration Act was referred to the Committee on Veterans' Affairs.
Sponsor: Senator Richard Blumenthal [CT]

- **S.2214** (introduced Oct. 27, 2015): A bill to amend the Federal Food, Drug, and Cosmetic Act to require patient medication information to be provided with certain prescription drugs was referred to the Committee on Health, Education, Labor, and Pensions.
Sponsor: Senator Kirsten E. Gillibrand [NY]

MEETINGS

- The 31st Annual Meeting of the International Society for Traumatic Stress Studies (ISTSS) will be held **Nov.5-7, 2015**, in New Orleans, La. <http://www.istss.org/am15/home.aspx>
- The AMIA 2015 Annual Symposium will be held on **Nov. 14-16, 2015**, in San Francisco, Calif. <https://www.amia.org/amia2015>
- 2015 AMSUS Annual Continuing Education Meeting will be held **Dec. 1-4, 2015**, in San Antonio, Texas <http://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.