

# Federal Health Update

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

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*Best Wishes for a Happy Veterans Day!*

## EXECUTIVE AND CONGRESSIONAL NEWS

▪ **On Nov. 8, 2017, the House passed .R.4173, the *Veterans Crisis Line Study Act of 2017*.**

This bill directs the Department of Veterans Affairs (VA) to conduct a study on the outcomes and the efficacy of the Veterans Crisis Line during the five-year period beginning Jan. 1, 2014, based on an analysis of national suicide data and data collected from the line.

Such study shall address: the efficacy of the line in leading veterans to sustained mental health regimens and suicide prevention; the line's visibility; the role of the line as part of the VA's mental health care services; and whether receiving sustained mental health care affects suicidality, including among veterans who are at high risk for suicide.

▪ **On Nov. 8, 2017, the House passed H.R.1066, *VA Management Alignment Act of 2017*.**

This bill requires the Department of Veterans Affairs (VA) to submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report (including recommendations for appropriate legislation) regarding the roles, responsibility and accountability of elements and individuals of the VA.

In creating such report, the VA shall utilize the results of:

- The Independent Assessment of the Health Care Delivery Systems and Management

Process of the VA established by the Veterans Access, Choice, and Accountability Act of 2014;

- Any study or report by the Commission on Care established by such Act; and
- Other studies or reports, including a report titled "Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health," dated February 28, 2015.

The VA shall also specify clearly delineated roles and responsibilities to optimize the organizational effectiveness and accountability of each:

- Administration, staff office, or staff organization and each subordinate organization thereof; and
- Key leader of the VA in relation to any Administration, staff office, or staff organization, Veteran Integrated Service Network, or medical facility.

## MILITARY HEALTH CARE NEWS

- **Doctors at the U.S. Army Institute of Surgical Research Burn Center at Joint Base San Antonio-Fort Sam Houston are using a novel method of administering pain medication to burn patients in the burn intensive care unit in hopes to mitigate opioid addiction and other complications associated with burn care.**

The pain medication is managed with the placement of an intrathecal catheter and infusion of preservative-free morphine. The concept is similar to epidural anesthesia used during labor for pain relief, except the catheter resides in the intrathecal space where the cerebrospinal fluid resides instead of the epidural space.

The catheter used is exactly like an epidural catheter used for laboring women.

It's an FDA-cleared device for a procedure that a lot of anesthesiologists have done for other reasons. However, it had never been done on burn patients. The Burn Center leadership agreed to try this initiative.

Dr. Clayne Benson, an Air Force Reserve lieutenant colonel, got the idea of using this technique in the intensive care unit while taking care of polytrauma soldiers at Landstuhl Regional Medical Center in Germany from 2009-2012. Benson said he is excited about the potential of this new pain management for burn patients.

"The results are amazing," he said. "The best thing about it is that it only uses one-one hundredth of the amount of pain medication used with the traditional [intravenous] method."

Intrathecal medication is delivered straight to where it is effective, the spinal cord, thereby minimizing systemic complications of IV medications.

Intravenous medication disperses pain medication throughout the entire body and only a tiny percentage of it gets to where it is needed. This is especially beneficial for burn patients who require numerous painful operations and traditionally require being placed on a ventilator, with one of the reasons being pain control.

Longer ventilator times lead to complications like deconditioning, delirium and pneumonia, which all impact quality of life and time in the Burn Intensive Care Unit. Also, the majority patients who are mechanically ventilated are diagnosed with delirium and are likely to have increased length of hospitalization, increased ventilator days and higher rates of long-term cognitive dysfunction.

Delirium is another complication burn patients experience with exposure to sedatives and pain medications.

Members of the USAISR Burn Center Intensive Care Unit will present the data of the initiative at the 2018 American Burn Association meeting in April 2018. The presentation will describe a patient who sustained 45 percent burns to her body and had her pain and sedation managed with the placement of the intrathecal catheter.

Benson's goal is to apply this type of pain management to patients with polytrauma to reduce pain and the amount of pain medication, which could potentially lessen addictions to pain medication.

"It's a new approach and I hope that eventually it becomes the main mode of pain control for burn and polytrauma patients," Benson said. "It has been a good team effort with the burn staff and their 'can do' attitude. I'm looking forward to where this leads. I believe it will change pain management as well as help to prevent opioid addiction in patients who have suffered from polytrauma and burns."

- **On Jan. 1, 2018, there are a number of changes coming to your TRICARE benefit. This includes a change to the current TRICARE regions.**

The current three regions (North, South and West) will become two regions (East and West). There will be [new regional contractors](#) for the new East and West regions.

Humana Military will manage the East Region. The East Region is a merger of the North and South Regions and includes: Alabama, Arkansas, Connecticut, Delaware, the District of Columbia, Florida, Georgia, Illinois, Indiana, Iowa (Rock Island area), Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri (St. Louis area), New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas (excluding El Paso area), Vermont, Virginia, West Virginia, and Wisconsin.

Health Net Federal Services, LLC will manage the West region. The West region includes: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa (excludes Rock Island arsenal area), Kansas, Minnesota, Missouri (except St. Louis area), Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas (southwestern corner including El Paso), Utah, Washington and Wyoming.

In preparation for this change, enrollments in TRICARE health plans will be delayed while beneficiary files are transferred to the incoming regional contractors. The delay period, or an enrollment freeze, will begin on Dec. 1, 2017 and last approximately three weeks, or until the data transfer is complete.

If you would like to switch to a different TRICARE health plan, or enroll in a plan for the first time, take action before Nov. 20, 2017. You can enroll in certain TRICARE plans online, by phone or by mail. Learn about how to [enroll in or purchase a health plan](#) on the TRICARE website.

You don't have to enroll in [TRICARE Select](#) if you're a TRICARE Standard beneficiary as of Nov. 30, 2017. You'll be automatically converted to TRICARE Select on Jan. 1, 2018, as long as you're registered in the [Defense Enrollment Eligibility Reporting System](#) (DEERS) and are [eligible for TRICARE](#). Learn more about [TRICARE Select](#), which replaces TRICARE Standard and TRICARE Extra next year.

Beginning Nov. 20, 2017, you will not be able to use the [Beneficiary Web Enrollment](#) (BWE) website to enroll in or dis-enroll from TRICARE Prime options and select or change primary care managers. Additionally, eligible beneficiaries will not be able to use BWE to enroll in TRICARE Young Adult (TYA) or TRICARE dental options. While the BWE website is unavailable, regional contractors will accept enrollment applications through other communications channels (for example, phone and mail). Regional contractors will process these applications once the freeze is complete.

Visit [www.tricare.mil/changes/enroll](http://www.tricare.mil/changes/enroll) to find instructions on how to submit TRICARE enrollment forms during the enrollment freeze.

You'll still have access to care during the enrollment freeze. Save your pharmacy and other health care receipts while your enrollment is pending, so that you can get reimbursed for TRICARE covered expenses once the freeze is complete and your enrollment is processed. If you have a problem accessing care while your enrollment is pending, [contact your regional contractor](#). If you have a problem getting your medications while your enrollment is pending, contact [Express Scripts](#).

- **The final version of National Defense Authorization Act for fiscal year 2018 includes a measure to raise pharmacy co-pays for TRICARE beneficiaries, according to *Military.com***

The proposal would raise out-of-pocket costs for beneficiaries each year until 2026.

Currently, non-active-duty TRICARE users under 65 have no co-pays for 90-day prescriptions of generic drugs through Express Scripts, TRICARE's mail order program. Non-generic prescriptions cost \$20 for a 90-day supply. Prescriptions filled at an in-network retail pharmacy carry a cost of \$10 for a 30-day supply of a generic drug or \$24 for a 30-day supply of a brand-name drug.

Beginning in 2018, generic prescriptions will cost \$10 for a 90-day supply, and \$28 for non-generic drugs through the mail-order program. Generic prescriptions filled at in-network retail pharmacies will cost of \$10 for a 30-day supply and brand-name prescriptions will cost \$28.

The bill proposes beneficiaries' copays will increase over the next several years, resulting in a 30-day supply of a generic at a retail pharmacy and a 90-day supply by mail will cost \$14, and a 30-day supply of a non-generic at a retail pharmacy or a 90-day supply by mail will cost \$45.

The proposal keeps prescriptions filled at military pharmacies free.

The Department of Defense estimates these increases will save \$2.1 billion by 2022.

The bill still needs to pass both the House and the Senate and be signed the president.

## VETERANS AFFAIRS NEWS

- **The Department of Veterans Affairs (VA) announced it is making changes to its Inbox Notifications system, a messaging system intended to communicate important clinical information, such as test results, referrals, medication refills or high-priority messages, but has become bogged down with non-urgent, unimportant information.**

The change will give VA's primary care physicians, in particular, more time to devote to patient care.

"The public never sees the excessive amount of e-mails and alerts that take up a doctor's time," said VA Secretary Dr. David J. Shulkin. "Some of it is necessary, but other emails do nothing to advance patient care and can, in fact, pose a major safety hazard because of lesser important emails. We want our doctors to have the right information they need to provide quality health care to Veterans, and this is a step in the right direction."

It is estimated that doctors spend two hours on administrative work for every hour they spend with patients. That time-consuming activity leads to fatigue and burnout, and is a top frustration for all doctors, including VA's.

The system was revamped to decrease the volume of low-value emails and experts trained

clinicians to optimally process their inbox.

Early results show the system is working: Clinicians now spend an hour and a half less on emails per week, opening up more time for more meaningful work and more time with veterans.

- **The Department of Veterans Affairs (VA) appointed four new members to its Advisory Committee on Minority Veterans.**

Initially chartered on Nov. 2, 1994, the committee advises the VA Secretary on the needs of the nation's 4.7 million minority veterans regarding compensation, health care, rehabilitation, outreach and other benefits and programs administered by VA.

Minority veterans comprise nearly 21 percent of the total veteran population in the United States and its territories, while minority women veterans represent about 33 percent of the women veteran population.

The new committee members are:

- Phillip L. Billy, an Air Force veteran from Lindsay, Oklahoma, who is the director of the Chickasaw Nation Veterans Services and has collaborated with the Oklahoma VA to serve Chickasaw veterans and their families. Billy oversees the services to be provided at the new 15,000-square-foot Veterans Lodge, which is in the final stages of construction.
- Robert V. McDonald, a Navy veteran from Anaheim, California, who was recently re-appointed to the Orange County Veterans Advisory Council, where he is now chairman of the council. McDonald is president and executive director of the Black Chamber of Commerce of Orange County and is leading the organization into its 30th year. Under his leadership, the chamber has partnered consistently with minority business associations, local chambers and legislators to provide support and advocate for the county's many small-business owners.
- Raul E. Rosas, a retired Navy petty officer first class and a disabled/combat veteran from Columbia, Maryland. Rosas is the founder and executive director of LIFT A VET, a Maryland-Puerto Rico nonprofit assisting Veterans. He serves as a commissioner with the Maryland Veterans Commission, a governor-appointed position, advising the Maryland VA Secretary on issues impacting Iraq/Afghanistan veterans. He also advises on the development of initiatives and strategies to further the Maryland VA outreach, advocacy and awareness to over 450,000 veterans residing in Maryland.
- Dr. Glenda L. Wrenn Gordon, a 1999 West Point graduate and recipient of the Distinguished Cadet Award from Decatur, Georgia. Gordon is a board certified psychiatrist and director of the Kennedy-Satcher Center for Mental Health Equity at the Morehouse School of Medicine, where she is also an associate professor of Psychiatry and Behavioral Sciences. Currently, she works clinically with women veterans at the Women's Center of Excellence for Specialty Care Education at the Atlanta VA.

Committee members are appointed to two- or three-year terms.

## GENERAL HEALTH CARE NEWS

- **The U.S. Food and Drug Administration cleared a complete blood cell count (CBC) test that, based on its categorization, can be run in more health care settings, including physicians' offices, clinics or other types of health care facilities, by a wider range of personnel (e.g. support staff). This broadened test access will allow for faster availability of results.**

A CBC is one of the most common physician-ordered tests used to evaluate a patient's blood levels, determine if an infection is present and if immediate intervention is needed. However, in the current health care setting, non-hospitalized patients who require a CBC can experience at least a 24-hour wait for test results, if not longer, when the test is performed by an off-site laboratory.

This waiting period may be detrimental to the health of patients whose care depends on quick results to rule out conditions that may require immediate medical intervention. With this new device, processing time may now be reduced by making testing available in these additional settings.

The XW-100 Automated Hematology Analyzer is intended for use in patients 2 years of age and older who require a whole blood cell count and white blood cell differential. Test results can be used with other clinical and laboratory findings to provide early alerts of patients with serious conditions such as severe anemia (low red blood cell or hemoglobin count) and agranulocytosis (low white blood cell count), who require additional testing. However, it is not intended to diagnose or monitor patients with primary and/or secondary hematologic diseases, including oncology and critically ill patients. The device works by using a blood sample to classify and quantify 12 different blood characteristics (hematology parameters), which provides patients with a blood component profile as part of their overall health assessment.

The XW-100 Automated Hematology Analyzer was granted a waiver under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The CLIA waiver for this device allows it to be used by a variety of non-traditional laboratory sites, including physicians' offices, clinics or other types of health care facilities with a CLIA Certificate of Waiver (CLIA-waived settings).

CLIA, a program run by the Centers for Medicare & Medicaid Services (CMS), oversees all U.S. laboratory testing (except for laboratory testing for research purposes) performed on human specimens. The type of CLIA certificate a laboratory obtains depends upon the complexity of the tests it performs. CLIA regulations describe three levels of test complexity: waived tests, moderate complexity tests and high complexity tests. Although CMS oversees the CLIA program, the FDA is responsible for categorizing the complexity of tests. According to CMS, more than 180,000 laboratories are certified to perform waived testing. These CLIA-waived laboratories are not the same as clinical laboratories accredited to perform more complex testing.

The FDA granted premarket clearance and a CLIA waiver for the XW-100 Automated Hematology Analyzer to Sysmex America, Inc.

## REPORTS/POLICIES

- **The GAO published “*Transitioning Veterans: DoD Needs to Improve Performance Reporting and Monitoring for the Transition Assistance Program,*” (GAO-18-23) on Nov. 8, 2017.** This report examines, among other questions: the extent of transparency in DOD's public performance reporting, TAP participation levels and attainment of Career Readiness Standards or referrals for additional services, and DoD's TAP monitoring and performance measures. <https://www.gao.gov/assets/690/688203.pdf>
- **The GAO published “*Prescription Opioids: Medicare Needs to Expand Oversight Efforts to Reduce the Risk of Harm,*” on Nov. 6, 2017.** This report examines CMS oversight of beneficiaries who receive opioid prescriptions under Part D, and CMS oversight of providers who prescribe opioids to Medicare Part D beneficiaries. <https://www.gao.gov/assets/690/687629.pdf>

## HILL HEARINGS

- The Senate Armed Services Committee will hold a hearing on **Nov. 14, 2017**, to examine the nominations of Anthony Kurta, to be a principal deputy under secretary, and James E. McPherson to be General Counsel of the Department of the Army, both of the Department of Defense.
- The Senate Armed Services Committee will hold a hearing on **Nov. 16, 2017**, to examine the nominations of John C. Rood to be under secretary for policy, and Randall G. Schriver to be an assistant secretary, both of the Department of Defense.

## LEGISLATION

- **H.R.2123** (introduced Nov. 8, 2017): VETS Act of 2017 was referred to the Committee on Veterans' Affairs. Sponsor: Representative Glenn Thompson [R-PA-5]
- **S.1015** (introduced Nov.8, 2017): National Suicide Hotline Improvement Act of 2017 was referred to the Committee on Energy and Commerce and the Committee on Veterans' Affairs. Sponsor: Senator Orrin G. Hatch [R-UT]
- **S.2076** (introduced Nov. 8, 2017): A bill to amend the Public Health Service Act to authorize the expansion of activities related to Alzheimer's disease, cognitive decline, and brain health under the Alzheimer's Disease and Healthy Aging Program, and for other purposes was referred to the Committee on Health, Education, Labor, and Pensions. Sponsor: Senator Susan M. Collins [R-ME]
- **H.R.918** (introduced Nov. 7, 2017): Veteran Urgent Access to Mental Healthcare Act was referred to the Committee on Veterans' Affairs. Sponsor: Representative Mike Coffman [R-CO-6]:
- **H.R.4245** (introduced Nov. 3, 2017): Veterans' Electronic Health Record Modernization Oversight Act of 2017, was referred to the House Committee on Veterans' Affairs. Sponsor: Representative Timothy J. Walz [D-MN-1]
- **H.R.4243** (introduced Nov. 3, 2017): To establish a commission for the purpose of making recommendations regarding the modernization or realignment of facilities of the Veterans Health Administration; to improve construction and management leases of the Department of Veterans Affairs; to amend and appropriate funds for the Veterans Choice Program, and for other purposes was referred to the Committee on Veterans' Affairs, and the Committee on Rules, and Appropriations. Sponsor: Representative David P. Roe [R-TN-1]
- **H.R.1133** (introduced Nov. 3, 2017): To amend the Veterans Access, Choice, and Accountability Act of 2014 to authorize the Secretary of Veterans Affairs to provide for an operation on a live donor for purposes of conducting a transplant procedure for a veteran, and for other purposes was referred to the Committee on Veterans' Affairs. Sponsor: Representative John R. Carter [R-TX-31]

## MEETINGS

- The 2017 AMSUS Annual Continuing Education Meeting will be held on **Nov. 27- Dec. 1, 2017**, at the Gaylord National Harbor, Md. <http://www.amsus.org/annual-meeting/>
- HIMSS 2018 Annual Conference will be held on **March 5-9, 2018**, in Las Vegas Nev. <http://www.himssconference.org/>
- The 8th Annual Traumatic Brain Injury Conference will be held on **May 16-17, 2018**, in Washington DC. <http://tbiconference.com/home/>

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