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The RAND Corporation released a report on August 12, which concludes that divergent views on the purpose of the program and program expansion under the Affordable Care Act (ACA) have created uncertainly for safety net providers and drug manufacturers. **Read below**

310,000 Enrollees To Lose Healthcare Coverage If Citizenship Not Verified

CMS announced that the federally facilitated exchange has informed approximately more than 300,000 individuals with data inconsistencies related to citizenship or immigration status on their healthcare coverage applications that they may face coverage termination at the end of September if they do not submit proper documentation by September 5. **Read below**

CMS Releases Potential Innovative Oncology Payment Model

The US Oncology Network has been actively engaged with the Center for Medicare and Medicaid Innovation (Innovation Center) payment and service delivery models over the past few years. The Innovation Center is interested in developing specialty practitioner-focused payment and delivery models that would be designed to improve the effectiveness and efficiency of specialty care. Among the specialty practitioner-focused models under development, the Innovation Center is developing an oncology care management model that would include two forms of payment in addition to Medicare fee for service (FFS) payments:

- a monthly per-beneficiary care management payment for Medicare FFS beneficiaries to offer participating practices financial resources to aid in effectively managing and coordinating care;
- a retrospective performance-based payment to incentivize participating practices to lower the total cost of care and improve care for beneficiaries over the 6-month episode period.

The Innovation Center has not finalized an oncology model or any of particular aspects of the model. However, given the level of interest in an oncology model test, they posted the provisional design elements of the model. The design paper below provides an explanation of target oncology patients and providers, as well as the anticipated structure of the payments. If CMS decides to move forward with an oncology model, the Innovation Center will publish the final model with additional detail regarding participation in the model, and will post a Request for Applications on the Innovation Center website.

To view the CMS preliminary design for an oncology-focused model CLICK HERE.

New Veteran Affairs Bill Expands Private Practice Services to Veterans

On August 7, President Barack Obama signed a $16.3 billion bill – The Veterans Access, Choice and Accountability Act of 2014 Highlights – to overhaul the U.S. Department of Veterans Affairs, including a provision to allow veterans to seek private care outside VA facilities. The bill also provides money for the VA to hire more physicians and healthcare professionals.

The legislation allows veterans to obtain a card – known as a Veterans Choice Card – which provides them with an option to seek care from non-VA healthcare providers if they have waited more than 30 days for an appointment or if they live more than 40 miles from a VA medical center.

The law also caps all new contracts at Medicare rates for non-VA providers for newly eligible veterans who seek non-VA care if the patient is unable to secure an appointment at a VA facility within a 30-day window. This cap could result in some rate changes among oncology practices due to the lower reimbursement rates. There is concern that the low reimbursement rates may discourage some providers from opting to be non-VA providers.

The bill, however, does allow the VA to pay above Medicare reimbursement rates in instances where a provider is serving a highly rural area, which the law defines as residing more than 40 miles away from the nearest VA medical facility, with certain exceptions.

The VA has 90 days to set their regulations around the legislation.

To read a summary of the bill, CLICK HERE.

Physician Groups Concerned Open Payments Dispute Process Flawed

As part of the Sunshine Act, manufacturers of pharmaceutical drugs and devices, as well as group purchasing organizations, are required to report payments made to physicians and teaching hospitals. CMS hopes this process will create greater transparency around the financial relationships of manufacturers, physicians, and teaching hospitals, under a program known as Open Payments.

The American Medical Association, Alliance of Specialty Medicine and other state specialty societies have voiced concern that the dispute resolution process for the Open Payment's program does not offer adequate protections

for physicians and permits manufacturers to dismiss unresolved disputes with physicians or hospitals.

In a July 28 letter to CMS Administer Marilyn Tavenner, the Alliance of Specialty Medicine warned, "we are concerned that the lack of adequate notice before the beginning of registration periods has handicapped providers that hope to participate in the program in a meaningful manner. This concern is magnified by the lengthy registration process and the obstacles it poses."

CMS has indicated that it will not resolve disputes, but errors can be reported to manufacturers through the Open Payments System or directly through Open Payments contacts listed on most manufacturer websites.

The Alliance further writes, "Our members are concerned that this approach does not provide a sufficient means of challenging false information or miscalculations, which can have a significant impact on a physician's credibility and practice…In the absence of a well-defined reconciliation process, the Alliance believes that CMS should safeguard the mission of the Open Payments program by taking steps to limit the publication of false information that can impact patient decision-making."

In an effort to simplify the process, the AMA has created a 3 important steps physicians need to take in 2014 guide to meet the requirements of the Physician Payments Sunshine Act, a process that has been called "cumbersome and complicated." The steps include:

- **Step 1:** Complete CMS e-verification process today.
- **Step 2:** Register with CMS' Open Payments system. Once physicians have completed Step 1 and gained access to EIDM, physicians can move onto phase two and register in CMS' Open Payments System via EIDM. Access detailed instructions at AMA Wire.
- **Step 3:** Review and dispute data by Aug. 27. Physicians can request their individual report, review it and flag disputes after completing Step 2.

Due to complications with the website last week, the Open Payments site was temporarily down to physicians and teaching hospitals wanting to check data about payments they've received from drug and device manufacturers. According to CMS, the original deadline of August 27 to verify or dispute data before it was set to be published on September 30 will be pushed back due to the website delays.

RAND Analysis Recommends Review of 340B Program Processes

The RAND Corporation released a report on August 12, "The 340B Prescription Drug Discount Program: Origins, Implementation, and Post-Reform Future," concludes that divergent views on the purpose of the program and program expansion under the Affordable Care Act (ACA) have created uncertainly for safety net providers and drug manufacturers.

Researchers suggest that policymakers need to clarify the purpose and scope of the program, which allows for billions of dollars in drug discounts to safety net providers each year who care for underserved and vulnerable patient populations. According to RAND's report, eligibility rules for the 340B drug discount program need to be better defined and methods for calculating discounts should be more transparent.

Nationally, 7,800 entities are eligible for participation in the program, which could double under provisions in the ACA.

Specific issues identified by RAND for policymakers to consider as changes are made include:

- Whether to keep eligibility based on characteristics of healthcare facilities or make only certain patients eligible for discount drugs
- Exclusion of expensive orphan drugs from the program
- More transparency about how the program's discounts are calculated

The report's lead author and policy research at RAND Andrew Mulcahy said, "Policymakers need a clear, objective description of the 340B program and he challenges it faces on the road ahead. There are increasingly divergent views on the program's purpose and the role it should play in supporting safety net providers."

To view the Rand study, click here.

To view the Rand press release, click here.

310,000 Enrollees To Lose Healthcare Coverage If Citizenship Not Verified

On August 12, the Centers for Medicare and Medicaid Services (CMS) announced that the federally facilitated exchange has informed approximately more than 300,000 individuals with data inconsistencies related to citizenship or immigration status on their healthcare coverage applications that they may face

coverage termination at the end of September if they do not submit proper documentation by September 5.

The cases identified by CMS apply to individuals who have inconsistencies in the information they provided when they initially enrolled in a healthcare plan. CMS has been contacting the affected individuals for several months via email, phone calls and letters, in both English and Spanish.

The 310,000 cases identified by CMS only include individuals who enrolled in federal or partnership marketplaces. The policies at question were not issued by the marketplaces of the 14 states that have implemented their own healthcare exchanges as they have separate data specific to their state's enrollees.