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Birmingham Medical News: 2016 Health Care Year in Review

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Since I began writing this year-end review in 2013, there have been some common themes - a shift to pay for quality and away from fee-for-service, much of which has been brought about by the Affordable Care Act (ACA): efforts to combat fraud and abuse in the health care system; provider consolidation; Alabama Medicaid's ongoing struggle to cover the cost of health care for our most needy citizens; and increased regulations for the health care industry.

2016 has been no different, but with the election of Donald Trump, change is definitely coming. With Congress under Republican control, a full (or at least a meaningful) repeal of the ACA is expected. We can also anticipate Medicaid and insurance reform.

I have a feeling that my 2017 year-end review will be very interesting. For now, however, the following are my top ten 2016 health care events for Alabama providers.

10. Hospital Payment Reforms Continue. In 2016 we continued to see CMS pursue various incentive programs for hospitals, all designed to move at least 50 percent of Medicare payments to quality or value-based programs by 2018. CMS launched a series of pilot programs through its Bundled Payment for Care Improvement initiative, including bundled payments in the areas of oncology, joint replacement and cardiac care. A bundled payment combines multiple services into a single payment to providers for a defined condition or course of treatment including follow-up services, also known as an episode of care. Other payment reform programs

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include the Hospital Value-Based Purchasing Program, which rewards acute care hospitals with incentive payments for the quality of care they provide to Medicare beneficiaries. Another program, the Hospital Readmission Reduction Program, provides financial incentives to hospitals to reduce unnecessary hospital readmissions.

9. Fraud and Abuse Initiatives. According to the HHS Office of Inspector General (OIG) Semiannual Report to Congress, from October 1, 2015 to March 31, 2016, fraud and abuse recoveries exceeded $2.77 billion, which is a significant increase from the $1.8 billion during the same period last year. The OIG reported 428 criminal actions against individuals or entities and 383 civil actions. In addition, 1,662 individuals and entities were excluded from participation in federal health care programs. To increase its fraud and abuse enforcement powers, on March 1, 2016 CMS issued a proposed rule which, if adopted, would allow CMS to deny or revoke Medicare enrollment to health care providers affiliated with entities or individuals that pose an undue risk of fraud, waste, or abuse. Under the proposed rule, providers would be required to disclose any affiliations with entities or individuals who currently have: (a) Medicare, Medicaid, or Children's Health Insurance Program (CHIP) debts; (b) are the subject of a payment suspension or exclusion from federal health care programs; or (c) have had their enrollment in Medicare, Medicaid, or CHIP revoked or denied. In keeping with its enforcement efforts, in June a Medicare Fraud Strike Force action in 36 different cities resulted in criminal and civil charges against 301 individuals for their alleged participation in health care fraud schemes causing approximately $900 million in false billings.

To read the remaining list, download "2016 Health Care Year in Review."