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Health Care Regulatory and Legislative Update

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Full Repeal of Affordable Care Act Unlikely

Despite campaign promises to fully repeal and replace the Affordable Care Act (*"ACA"*), the President-Elect recently told the Wall Street Journal that he is open to keeping some popular provisions of the ACA in place, including provisions which require insurers to provide coverage for pre-existing conditions and permit adult children to stay on a parent's plan until 26. Additionally, portions of the ACA with the ability to bend the health care cost curve, such as delivery system reform (i.e. — accountable care organizations and value-based purchasing) and enhanced fraud and abuse enforcement, may prove politically and economically difficult to abandon. The Medicare Access and CHIP Reauthorization Act of 2015 (*"MACRA"*), for example — which includes a landmark Medicare clinician payment system that replaces the sustainable growth rate methodology for physician fee-schedule updates with a value and outcomes based reimbursement system — was built on the shoulders of the ACA's value-based purchasing programs and passed on a bipartisan, bicameral basis. We will continue to closely monitor this situation and what it means for the health care industry and health care consumers.

CMS Hosting a MACRA Quality Payment Program Informational Call Tomorrow

The Centers for Medicare and Medicaid Services (*"CMS"*) is hosting an information call tomorrow, November 15 at 1:30 p.m. ET, regarding the Medicare Access and CHIP Reauthorization Act of 2015 (*"MACRA"*) final rule. During the call, CMS will provide an overview of the Merit-based

Incentive Payment System (*"MIPS"*) and Advanced Alternative Payment Model (*"APM"*) incentive payment provisions under MACRA, collectively referred to as the Quality Payment Program. For a summary of the MACRA Quality Payment Program, please see our October 17, 2016 newsletter. Although anyone may join the call, CMS lists its target audience as clinicians, office managers and administrators, state and national associations that represent health care providers, and other stakeholders. Registration will close at 12:00 p.m. ET on the day of the call or when available space has been filled. An audio recording and written transcript of the call will be posted on the CMS education outreach page approximately two weeks after the call. We will continue to the monitor the Quality Payment Program and its effect on health care provider reimbursement and care delivery.

Jury Convicts Home Health Agency Owner in $13 Million Medicare Fraud Conspiracy

On Friday, November 11, 2016, the Department of Justice (*"DOJ"*) announced that a federal jury in the Southern District of Texas had convicted the owner of Houston-based Fiango Home Healthcare Inc. (*"Fiango"*) for her role in a $13 million Medicare fraud scheme. According to the DOJ press release, the owners of Fiango received more than $13 million from Medicare for home-health services that were either not medically necessary or never provided to Medicare beneficiaries. In addition, the owners allegedly paid illegal kickbacks to (1) physicians in exchange for authorizing medically unnecessary home-health services for Medicare beneficiaries, (2) patient recruiters, and (3) Medicare beneficiaries for allowing them to bill Medicare using their Medicare information for home-health services that were not medically necessary or not provided. The Fiango co-owners are scheduled to be sentenced on February 17, 2017. This case continues the governments crack-down on fraud within the home health care industry. A review of the United States Department of Health and Human Services Office of the Inspector General website shows at least one home health care agency civil or criminal enforcement action a month since October 2015.