CONGRESS MOVES TO PERMANENTLY REPEAL VEXATIOUS SGR - BILL REMOVES BARRIERS TO HOSPITAL-PHYSICIAN “GAINSHARING” PROGRAMS

SUMMARY OF THE BILL
The United States House of Representatives overwhelmingly approved a measure this week to repeal the Sustainable Grow Rate ("SGR"), which has been used to determine Medicare physician payment rates for more than a decade. The SGR was established as part of the Balanced Budget Act of 1997 as a method for limiting growth in physician services' spending through a formula that automatically reduces physician reimbursement when health care spending exceeds a certain targeted growth rate. Since adoption of the SGR, Congress has passed 17 bills, known as "doc fixes" or "patches," to prevent the pay cuts from going into effect. These patches have often occurred in the eleventh hour at the urging of physicians threatened with loss of Medicare revenues vital to their practices. If Congress had not acted by the end of March, physicians would have faced a 21.2 percent cut in Medicare payments.

The House approved the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2) on Thursday, March 26. While the Senate was unable to take up the legislation before leaving for a two-week Easter recess, it is expected to pass the measure shortly after lawmakers return, and President Obama has already indicated he will sign it into law. CMS will administratively hold physician payments during that two-week period so the cuts will not go into effect.

H.R. 2 permanently repeals the SGR making the doc fix a thing of the past. It would implement a new payment policy that is designed to reward quality instead of volume. The bill would provide fee increases of 0.5 percent in each of the next four years. Payment rates would then hold flat for six years. After that, Medicare physicians would see annual 0.25 percent payment increases. H.R. 2 is also the first Medicare entitlement reform in almost two decades, and its overwhelming approval in the House marked a rare display of bipartisanship. The legislation offsets $70 billion of the roughly $210 billion cost of permanent SGR repeal through a number of cost-cutting measures and reforms including:

- Adjustments to inpatient hospital and physician payment rates;
- Market basket reductions for long-term care hospitals, inpatient rehabilitation facilities, home health agencies, skilled nursing facilities and hospices; and
- "Structural Reforms" to the Medicare program.

Notwithstanding proposed cuts to hospital payments, the American Hospital Association endorsed H.R. 2, stating that it "strikes a careful balance in the way it funds the SGR repeal."

H.R. 2 is notable for its continuation of a number of important programs including the Children’s Health Insurance Program (through September 30, 2015) and the Medicare-dependent Hospital Program (through September 30, 2016) and for another partial enforcement delay of Medicare’s controversial two-midnight rule (through September 30, 2015).

H.R. 2 is also notable for what it left out, including: (i) reductions to outpatient hospital services payments to match payments for identical services provided in other lower intensity settings such as ASCs (site-neutral payment); (ii) reductions to Medicare bad debt payments; and (iii) changes to laws affecting physician-owned specialty hospitals.

GAINSHARING PROVISION
One particularly welcome and noteworthy provision included in H.R. 2 is the elimination of the statutory barrier to "gainsharing programs." Gainsharing programs allow hospitals and physicians to collaborate and improve patient quality of care and reduce unnecessary and wasteful spending in hospital services, sharing among themselves the savings realized from the efficiency measures implemented by these programs.

Currently, the Civil Monetary Penalties Law ("CMP") prohibits a hospital or critical access hospital from "knowingly making a payment,
directly or indirectly, to a physician as an inducement to reduce or limit services* for Medicare/Medicaid beneficiaries. Penalties under the CMP are $2,000 per violation and thus have had a chilling effect on otherwise properly structured gainsharing programs for fear that the government would view the programs as violative of the CMP.

In recent years, the Office of the Inspector General (“OIG”) has issued a number of favorable advisory opinions on gainsharing programs that incorporate a number of safety factors designed to protect federal health care program beneficiaries. Nonetheless, OIG advisory opinions are binding only on the requesting parties, and the existence of the CMP and its current interpretation has discouraged full-scale gainsharing partnerships between hospitals and their medical staffs.

H.R. 2 amends the CMP by adding the clause “medically necessary” after “reduce or limit” so that the CMP will explicitly state that penalties will inure only when payments are made to induce physicians to reduce or limit medically necessary services. This will then clear the way for gainsharing programs, which serve to reduce unnecessary costs without compromising patient care.

Rep. Charles Boustany, M.D. (R-LA), a retired cardiovascular surgeon who understands the structure and value of an appropriate gainsharing program, authored language in the bill that requires the secretary and OIG to submit to Congress a report with options for amending existing fraud and abuse laws to permit gainsharing arrangements that otherwise would be subject to the CMP in order to improve patient care while reducing waste and increasing efficiency. Specifically, the report should: (i) consider whether such provisions should apply to ownership interests, compensation arrangements or other relationships; (ii) describe how the recommendations address accountability, transparency and quality, including how best to limit inducements to stint on care, discharge patients prematurely or otherwise reduce or limit medically necessary care; and (iii) consider whether a portion of any savings generated by such arrangements should accrue to the Medicare program.

**PRACTICAL TAKEAWAYS**

Permanent repeal of the SGR is long overdue, and the gainsharing provision will provide a clear path forward for hospitals and physicians to develop innovative programs that reduce costs and ultimately benefit Medicare beneficiaries. The possibility that gainsharing programs would have to share some of the earned savings with the Medicare program is an interesting twist on the concept and one that likens gainsharing programs to the Medicare Shared Savings Program. Further updates on H.R. 2 and an in-depth analysis on other aspects of the bill will be forthcoming.

If you have any questions or would like additional information about this topic, please contact:

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2. Id.