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'SGR Fix' Law Adds Program-Integrity Tools, Exempts Gainsharing From Penalties

CMS was given more tools to reduce overpayments and fraud in the 2015 Medicare Access and CHIP Reauthorization Act (H.R. 2), which passed the Senate on April 14 and was signed into law by President Obama on April 16. Although the legislation was primarily designed to repeal the sustainable growth rate (SGR) formula for physician reimbursement, it also contains significant program-integrity provisions, echoing the fraud and abuse mandates in the Affordable Care Act, which are still being rolled out.

This time around, however, the "SGR fix" legislation also gives hospitals some breathing room in certain physician relationships and audits. Congress exempted "gainsharing" from the civil monetary penalty law and extended through Sept. 30 the audit moratorium on most patient-status reviews under the Medicare two-midnight rule.

"This is a strong message from Congress that the focus on fraud and abuse is here to stay," says Troy Barsky, former director of the CMS Division of Technical Payment Policy. "The bill was supposed to focus on physician payments, but then you have as part of that a huge number of fraud and abuse provisions. Having a strong compliance program is vitally important if you continue to operate in this space."

Law Adds Program-Integrity Tools

The Medicare Access and CHIP Reauthorization Act was first approved by the House of Representatives on March 26, and, after six amendments failed in the Senate, it embraced an identical version. The heart of the law is the replacement of the SGR, which was a cap on physician payments designed to control Medicare spending, but over time, that meant sharp cuts, which Congress kept averting with an annual SGR patch. If last year's SGR patch expired, physicians faced a 21% payment cut on March 31, although CMS said it could hold the claims for two weeks. Under the new payment system, physicians will receive annual 0.5% payment updates every year for five years, and in 2019, Medicare will shift physician payments partly to a value-based purchasing system. Twenty-five percent of their reimbursement will be linked to performance targets.

It's remarkable how much the legislation tackles fraud, waste and abuse. "It's a piling on with the Affordable Care Act," says Austin, Texas, attorney Brian Flood, who is with Husch Blackwell. "The big picture here for providers is no one on the Hill will back off enforcement and no one in the agencies will back off regulatory activities."

Of particular interest in compliance circles is the legislation's temporary ban on certain audits of patient status — inpatient admissions vs. outpatient services — under the two-midnight rule through Sept. 30. "The Secretary of Health and Human Services shall not conduct patient status reviews (as described in such notice) on a post-payment review basis through recovery audit contractors … for inpatient claims with dates of admission October 1, 2013, through March 31, 2015, unless there is evidence of systematic gaming, fraud, abuse, or delays in the provision of care by a provider of services," the legislation says. Medicare administrative contractors (MACs) operate under similar constraints, but they can continue the probe and educate program. CMS, however, has only committed to probe and educate through April 30.

Two-Midnight Rule Remains in Limbo

The extension of the audit moratorium keeps the two-midnight rule in limbo, says Barsky, who is with Crowell & Moring in Washington, D.C. "It is still the law of the land," but it puts hospitals "in the challenging position where they are required to comply, yet the enforcement teeth aren't there." They probably will be in the future, but it's an odd dynamic, Barsky says. "You have a payment policy and you know CMS won't enforce it," although on the upside it gives hospitals breathing room to improve their compliance before enforcement kicks in, he says.

Congress also got rid of civil monetary penalties for "certain inducements to physicians to limit services that are not medically necessary." This is an allusion to hospital gainsharing programs, which are designed to distribute a percentage of cost savings to physicians based on

efficiencies (e.g., using only one type of cardiac device) and/or quality improvement. Gainsharing is considered essential to furthering new models of delivery systems, such as accountable care organizations (ACOs), and payment methodologies, such as bundled payments. The SGR fix legislation also requires HHS to publish a report within the year describing the best way to set up a permanent physician-hospital gainsharing program.

Relief from Gainsharing Fines is 'Welcome'

The gainsharing provisions "are very welcome" and "helpful," Barsky says. Currently, providers can be liable for civil money penalties "even when limiting nonmedically necessary services," and OIG had no discretion depending on the nature of the inducements. But there's a glitch, even with the new law: "You still have anti-kickback and Stark law problems when entering gainsharing programs," he says.

The legislation has a fairly extensive section on "reducing improper payments." It requires MACs to establish an "improper payment outreach and education program." Every quarter, MACs must give CMS a list of the most common, expensive payment errors, instructions on how to fix them and other information. MACs also will prioritize audits of items and services that have the highest rates of overpayment, waste the most money, and "are due to clear misapplication or misinterpretation of Medicare policies" and/or common clerical/administrative errors or other preventable errors.

All this will be paid for without the benefit of the usual $195 million a year CMS gets to support this part of the program-integrity infrastructure, Flood says. Instead, CMS will fund many of its activities with money it retains from a portion of RAC recoveries, he says. That worries Flood because he thinks it may perpetuate the bounty-hunter mentality that's been the source of complaints about the RACs. "CMS can take up to 15% of what RACs collect and use it to fund all these new requirements," he said.

There are many more provisions in the legislation designed to combat fraud, waste and abuse *(RMC 3/30/15, p. 6)*. For example, RACs will hunt down and recoup erroneous Medicare payments for incarcerated, dead and not lawfully present people, with the HHS Office of Inspector General keeping tabs on their progress.

In some good news for providers, Congress extended the exceptions process for medically necessary outpatient physical, occupational and speech therapy that exceeds the annual per-beneficiary Medicare payment cap *(RMC 4/6/15, p. 8)*.

And whether it is good news or bad news depends on where providers fall on this issue, but Congress did not interfere with the Oct. 1, 2015, implementation deadline for ICD-10 coding systems.

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