Update on the 2017 health care legislative and regulatory agenda

Health Care Compliance Association – Orange County Regional Conference
June 16, 2017

Today’s discussion

1. 2017 regulatory and legislative calendar
2. Repeal and replace: the American Health Care Act (AHCA)
4. Aligning regulations: Medicaid Managed Care final rule
A race against the calendar

Providers in 2017 face significant deadlines, while watching to see how the Trump Administration and Congress will respond to a series of action-forcing deadlines.

Fall: Time frame projected by the Congressional Budget Office for Congress to need to raise the debt limit to avoid default on the federal debt.

<table>
<thead>
<tr>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
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<td><strong>Jun 21:</strong></td>
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<td>• Deadline for plans to file products with CMS for federally-facilitated Exchanges</td>
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<td><strong>Jul 1:</strong></td>
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<td>• Date for CMS to begin providing feedback on quality and cost under Merit-based Incentive Payment System (MIPS)</td>
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<td>• Compliance date for new Medicaid managed care provisions</td>
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<td><strong>Jul 28:</strong></td>
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<td>• Target date for Senate and House to adjourn for August recess</td>
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<td><strong>Sep 30:</strong></td>
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<td>•Expiration date of FY 2017 federal funding</td>
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<td>•Expiration of authorization for Children’s Health Insurance Program (CHIP)</td>
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<td>•Expiration of FDA user fee agreements</td>
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<td><strong>Oct 1:</strong></td>
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<td>• Beginning date for at-risk bundled payments for Comprehensive Care for Joint Replacements (CJR)</td>
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<td><strong>Oct 2:</strong></td>
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<td>• Last day for clinicians to begin collecting data to report for MIPS for 2017 performance year</td>
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<td><strong>Nov 1:</strong></td>
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<td>•Beginning of open enrollment in Affordable Care Act (ACA) Exchanges for benefit year 2018</td>
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<td><strong>Dec 31:</strong></td>
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<td>•Expiration of moratoria for health insurer fee for 2017</td>
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<td>•Expiration of two-year moratoria on medical device excise tax</td>
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<td>•Expiration of Medicare extender provisions authorized MACRA</td>
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Source: Deloitte Risk and Financial Advisory Regulatory Services for Life Sciences and Health Care

‘Repeal and Replace’: the AHCA

The House passed the AHCA on May 4, 2017. A 13-member Senate working group is working on the next iteration of the bill.

Tax credits
Based primarily on age, rather than income

Medicaid
• Higher federal funding for ACA Medicaid expansion repealed after 2019
• Per capita cap beginning in 2020
• Alternatively, states could opt to receive block grant funding with certain restrictions

Taxes and fees
• Nullifies tax penalties under individual and employer mandates.
• Repeals ACA health industry taxes and fees; tax increases on higher income individuals
• Delays Cadillac tax

State pooling and funding
• New Patient and State Stability Fund
• Options to shore up the nongroup market
• Default reinsurance program run by CMS
• Federal Invisible Risk Sharing Program
• State waivers for essential health benefits, age rating, community rating

Source: American Health Care Act, H.R. 1628

Update on the health care legislative and regulatory agenda

Update on the health care legislative and regulatory agenda
‘Repeal and replace’: projected impact on the federal budget
The Senate is expected to make significant changes to the House bill, but procedural rules will require the same amount of deficit reduction.

<table>
<thead>
<tr>
<th>Net effects of AHCA* on federal budget deficit, 2017-2026 (billions of dollars)</th>
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<tbody>
<tr>
<td>Medicaid</td>
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<tr>
<td>$-834</td>
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<tr>
<td>Tax credits and select coverage provisions</td>
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<tr>
<td>$-276</td>
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<tr>
<td>Patient and State Stability Fund grants</td>
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<td>$500</td>
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<tr>
<td>Penalty payments</td>
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<tr>
<td>$210</td>
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<td>Noncoverage provisions</td>
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<tr>
<td>$900</td>
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<tr>
<td>Impact on the deficit</td>
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<td>$113 (on budget)</td>
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</table>

Source: Congressional Budget Office, staff of the Joint Committee on Taxation.
*As passed by the House of Representatives, May 4, 2017.

Repeal and replace: projected change in the uninsured
Overall, the AHCA is expected to increase the number of uninsured individuals by 23 million by 2026. Lower-income people ages 50-64 would account for the biggest increases.

Share of uninsured adults ages 19-64 under the ACA and the AHCA*

<table>
<thead>
<tr>
<th>Income below 200% of the federal poverty level</th>
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<tbody>
<tr>
<td>Age 19-29</td>
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<tr>
<td>ACA</td>
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<tr>
<td>33.9%</td>
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<td>17.6%</td>
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<table>
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<tr>
<th>Income above 200% of the federal poverty level</th>
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<tr>
<td>Age 19-29</td>
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<tr>
<td>ACA</td>
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<tr>
<td>15.5%</td>
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</tbody>
</table>

Source: Congressional Budget Office, staff of the Joint Committee on Taxation.
*As passed by the House of Representatives, May 4, 2017.
Payment and delivery reform: MACRA

MACRA is a game changer...the law will drive the future of health care payment and delivery system reform for clinicians, providers, and plans across their payer mix.

With the repeal of the Sustainable Growth Rate (SGR) formula, MACRA sets updates to the Medicare Physician Fee Schedule (PFS) and for the first time evaluates clinicians’ performance at an individual level. MACRA offers significant financial incentives for health care professionals to participate in risk-bearing, coordinated care models and to move away from the traditional fee for service system. MACRA is poised to drive increased participation in risk-bearing coordinated care models across all payers, not just Medicare.

With the repeal of the SGR formula, MACRA sets updates to the Medicare PFS for all years in the future.

Payment and delivery reform: Payment updates under MACRA

With the repeal of the SGR formula, MACRA sets updates to the Medicare PFS for all years in the future.

Under MACRA's Quality Payment Program (QPP), clinicians have two distinct paths for payments under the PFS going forward:

- **Advanced Alternative Payment Models (APMs)**
  - Risk-based, care coordination models
  - For Qualifying Participants (QPs), temporary bonuses from 2019-2024 (5% of Medicare PFS payments)
  - Increasing thresholds for QP status over time
  - All-Payer Combination Option begins in performance year 2019

- **Merit-based Incentive Payment System (MIPS)**
  - Consolidates Meaningful Use, Physician Quality Reporting System (PQRS) and Value-based Modifier
  - Budget-neutral payment adjustments based on clinician performance
  - +/-4% for 2019, progressively increasing to +/-9% for 2021 and subsequent years

Source: Public Law 114-10 (April 16, 2015)
Clinicians eligible to participate in Advanced APMs and MIPS
A broader group of clinicians initially will be eligible to participate in the Advanced APM track than will be eligible for payment adjustments under MIPS

**Advanced Alternative Payment Models (APMs)**
- Physicians*
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist
- Certified nurse-midwife
- Clinical social worker
- Clinical psychologist
- Registered dietitian or nutrition professional
- Physical or occupational therapist
- Qualified speech-language pathologist
- Qualified audiologist

**Merit-based Incentive Payment System (MIPS), 2019–2020**
- Physicians*
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist

*Physician, as defined under current law, includes: a doctor of medicine or osteopathy; a doctor of dental surgery or of dental medicine; a doctor of podiatric medicine; a doctor of optometry; and a chiropractor.

Source: Public Law 114-10 (April 16, 2015)

Participation may be expanded to other professionals paid under the Physician Fee Schedule in subsequent years.

Payment and delivery reform: the financial impact of MACRA
MACRA directly affects Medicare payments to clinicians, but the law could have a greater impact on payments to hospitals depending upon how CMS implements MACRA’s advanced APMs.

Projected impact of MACRA on Medicare payments, 2015-2030

Payment and delivery reform: CMS outreach is underway
Over the coming months, providers can expect several communications from CMS that will provide critical details for their MACRA strategic and compliance planning.

1. Advanced APM qualifying participant (QP) status
   CMS expects to complete the first round of the QP determination process for clinicians participating in advanced APMs by July/August 2017.

2. MIPS participation
   CMS in May sent letters to practices informing them which clinicians are eligible for MIPS for the 2017 performance year. A website is also available.

3. MIPS quality, cost performance reports
   CMS on July 1, 2017, is required to provide performance reports to MIPS-eligible clinicians. For the 2017 and 2018 performance years, the reports will rely on historical data.

4. MIPS data collection
   Clinicians must begin collecting data to report for MIPS no later than October 2, 2017. This is the last 90-day period of 2017 (the time period required for MIPS reporting for 2017).

Aligning regulations: Medicaid managed care rules
The May 2016 final rule sought to align rules for Medicaid managed care with Medicare Advantage and ACA Exchanges. This rule is under review by HHS.

Source: Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions to Third-Party Liability,” Final Rule, Centers for Medicare and Medicaid Services, Department of Health and Human Services, May 6, 2016.
Aligning regulations: New compliance deadline considerations

Providers could expect to see new compliance requirements for Medicaid managed care plans raised in contract negotiations.

- Limitations on marketing
- Coverage of services in alternative settings/Institutions for Mental Disease (IMD)
- Non-discrimination provisions (compliance with ACA section 1557)

2016

- Network adequacy standards
- External quality reviews
- Encounter data reporting

2018

2017

Source: Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions to Third-Party Liability,” Final Rule, Centers for Medicare and Medicaid Services, Department of Health and Human Services, May 6, 2016.

Timeline of major legislative and regulatory events: 2017–2028

Source: Deloitte Risk and Financial Advisory
Regulatory Services for Life Sciences and Health Care

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Daniel Esquibel
Senior Manager | Regulatory Services, Life Sciences & Health Care

Profile

Daniel is a Deloitte Risk and Financial Advisory Senior Manager. Building off of more than 16 years of experience in the health care industry, Daniel works with health care providers, health plans, investors, and other stakeholders to identify factors that will drive health care in the future. He helps stakeholders evaluate and plan for strategic risks and opportunities based on insights and analysis of government and private sector data, market trends, and political, legislative, and regulatory issues affecting the health care industry.

Daniel is actively monitoring the change in Administration and the legislative and regulatory agenda for health care and life sciences for 2017, including the debate over the future of the ACA and potential health care changes in tax reform. In addition, Daniel continues to track payment and delivery system reform efforts, notably through the implementation of MACRA.

Prior to joining Deloitte Risk and Financial Advisory, Daniel spent five years at a global professional services firm advising organizations on the implementation of the ACA, including issues related to eligibility for premium tax credits and Medicaid, the employer mandate, and health insurance market reforms. He authored detailed analyses of the major ACA regulations from the Department of Health and Human Services, the Department of the Treasury, the Internal Revenue Service, and the Department of Labor. Daniel's career in professional services builds off of 10 years of experience in strategic research and policy analysis at a research, technology, and consulting firm focused on the health care industry.

Daniel regularly speaks and writes on health care regulatory and legislative issues.

Education

- B.A., History - University of Pennsylvania
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