NATIONAL ASSOCIATION OF
Community Health Centers

FEDERAL POLICY UPDATE

New Mexico Primary Care Association
Annual Conference
June 14, 2018

Joe Gallegos, MBA
Senior Vice President Western Operations
National Association of Community Health Centers

Today We'll Cover:

The Latest on Capitol Hill – Cliff Fix and Beyond

What to Expect in 2018

Staying Involved with Health Center Advocacy

The Cliff is Finally Fixed!

How We Got Here: Path to the Cliff Fix

START HERE!

290 Representatives sign Bilirakis-Green letter

61 Senators sign Stabenow-Wicker letter

House E&C Subcommittee on Health holds hearing

H.R. 3770, Bipartisan CHIME Act is introduced in the House;

70 Senators sign onto bipartisan letter

S. 1899, Bipartisan CHIME Act is introduced in the Senate;

September 28, 2017

House E&C Committee markup of newly introduced H.R. 3922

passes CHAMPION Act 28-23

153 House Representatives sig onto bipartisan letter

CHAMPIONING Healthy Kids Act passes the House, 242-174 –

Congress passes HRes 670 as "short term patch"

Rep. Stefanik leads House R letter to Speaker Ryan

105 cosigners

Senators Blunt and Stabenow are joined by 65 colleagues

RED ALERT FOR CHCs

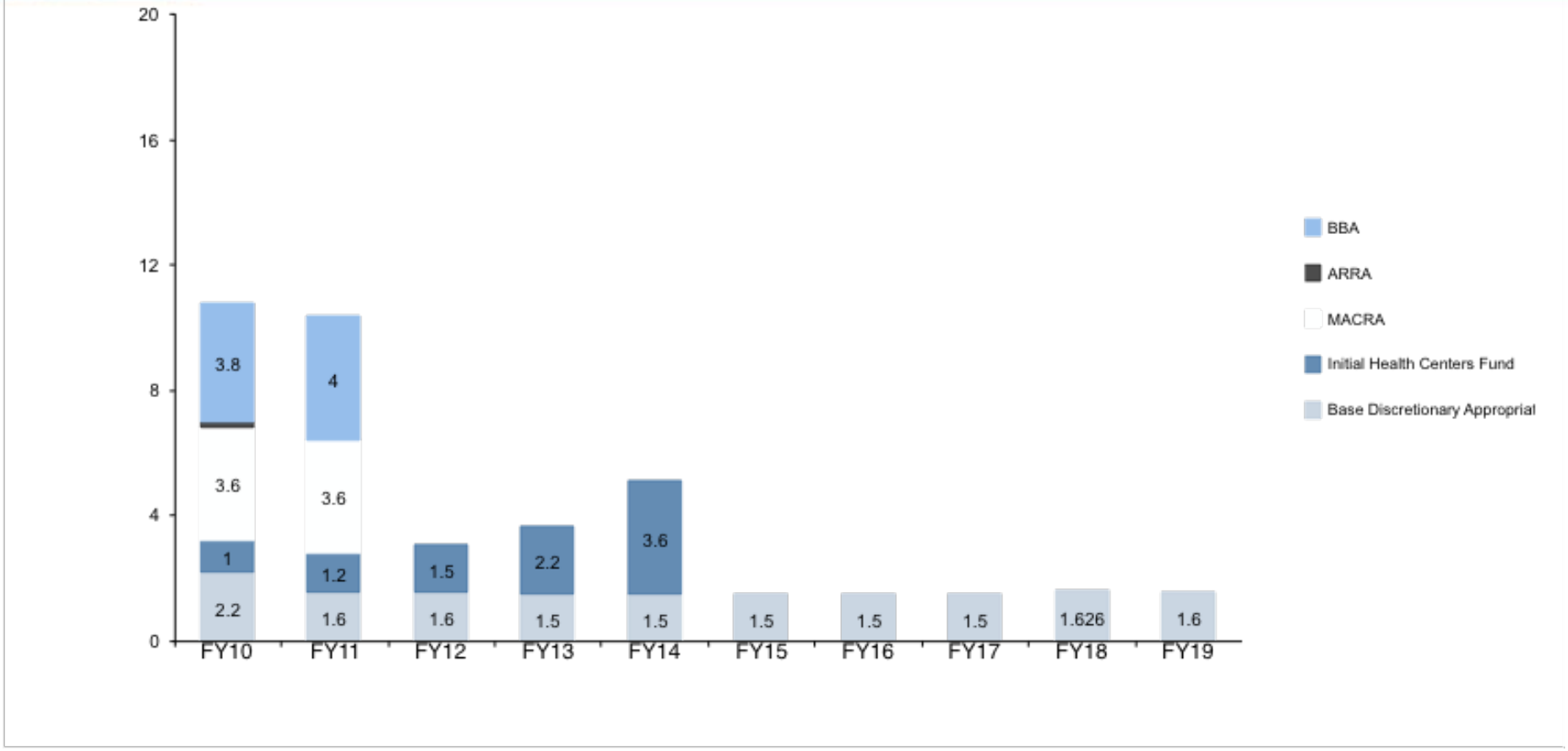
February 9, 2018

House and Senate pass Bipartisan Budget Act extending 2 years of CHC funding

Health Care Extenders – What was in the Budget Deal?

- **Community Health Centers Fund (CHCF)** – 2 year extension w/ increased funding ($3.8B in FY18 and $4.0B in FY19)
- **National Health Service Corps (NHSC)** – 2 year extension of level funding ($310M/yr)
- **Teaching Health Centers Graduate Medical Education (THCGME)** – 2 year extension w/ increased funding ($126.5M/yr)
- **Children's Health Insurance Program (CHIP) funding** – Additional 4 year extension (for a total of 10 years through FY27!)
- **Cuts to Medicaid Disproportionate Share Hospital (DSH) Payments** – 2 year delay
- **Maternal Infant Early Childhood Home Visiting (MIECHV)** – 5 year extension ($400M/yr)
- **Medicare Therapy Caps** – Permanent repeal
- **Special Diabetes Program** – 2 year extension at current funding levels
- **Puerto Rico/ U.S. Virgin islands Medicaid** – 2 year increase to Medicaid caps
- **Opioid Funding** – $6B over two years through state grants
- **Disaster Relief** – $90B in total, incl. $60M for CHCs in affected areas (renovation, equipment, etc.)

Community Health Center Funding



Cliff Fix FAQs

- **What does "2 years of CHC funding" really mean?**

The two years of funding is retroactive to the day it expired, covering the period from October 1, 2017 through September 30, 2019.

- **What will the additional $600 million in funding be used for?**

We don't know yet. HRSA will determine how to distribute those dollars. Expect to see grants with quick turnaround times (e.g. Quality Improvement) in FY18; possible service expansions/NAPs in FY19

- **What do I say to my Members who voted NO on the Bipartisan Budget Act?**

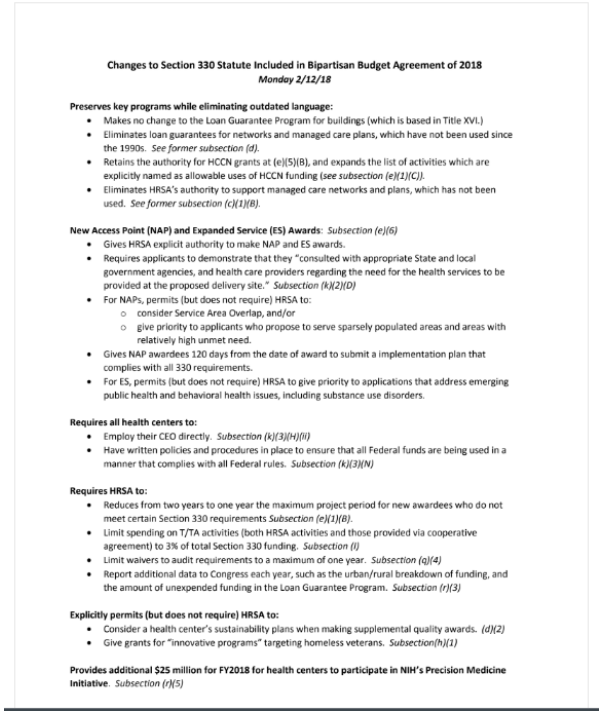
We recommend you look at their support over the course of the year, and not just one vote. Hopefully there is still much to thank them for and build from.

- **Where do we go from here?**

We need long-term stability. That work is already starting, and we are going to need your help.

Minor Section 330 Changes

- Cliff fix included technical changes and "statutory clean up"
- Requested by Senate HELP staff as part of CHCF extension
  - Negotiated between NACHC and bipartisan House, Senate committee staff
  - Significant technical input from HRSA and Feldesman-Tucker
- **<u>KEY TAKEAWAY</u>: Nothing of serious concern included**
- Additional information available – <u>http://blog.nachc.org/the-cliff-is-fixed-congress-passes-bipartisan-budget-package-with-health-center-funding/</u>



Changes to Section 330 Statute Included in Bipartisan Budget Agreement of 2018
Monday 2/12/18

Preserves key programs while eliminating outdated language:

- Makes no change to the Loan Guarantee Program for buildings (which is based in Title XVI.)
- Eliminates loan guarantees for networks and managed care plans, which have not been used since the 1990s. *See former subsection (d).*
- Retains the authority for HCCN grants at (e)(5)(B), and expands the list of activities which are explicitly named as allowable uses of HCCN funding (*see subsection (e)(1)(C)).*
- Eliminates HRSA's authority to support managed care networks and plans, which has not been used. *See former subsection (c)(1)(B).*

New Access Point (NAP) and Expanded Service (ES) Awards: *Subsection (e)(6)*

- Gives HRSA explicit authority to make NAP and ES awards.
- Requires applicants to demonstrate that they "consulted with appropriate State and local government agencies, and health care providers regarding the need for the health services to be provided at the proposed delivery site." *Subsection (k)(2)(D)*
- For NAPs, permits (but does not require) HRSA to:
  - consider Service Area Overlap, and/or
  - give priority to applicants who propose to serve sparsely populated areas and areas with relatively high unmet need.
- Gives NAP awardees 120 days from the date of award to submit a implementation plan that complies with all 330 requirements.
- For ES, permits (but does not require) HRSA to give priority to applications that address emerging public health and behavioral health issues, including substance use disorders.

Requires all health centers to:

- Employ their CEO directly. *Subsection (k)(3)(H)(ii)*
- Have written policies and procedures in place to ensure that all Federal funds are being used in a manner that complies with all Federal rules. *Subsection (k)(3)(N)*

Requires HRSA to:

- Reduces from two years to one year the maximum project period for new awardees who do not meet certain Section 330 requirements *Subsection (e)(1)(B).*
- Limit spending on T/TA activities (both HRSA activities and those provided via cooperative agreement) to 3% of total Section 330 funding. *Subsection (i)*
- Limit waivers to audit requirements to a maximum of one year. *Subsection (q)(4)*
- Report additional data to Congress each year, such as the urban/rural breakdown of funding, and the amount of unexpended funding in the Loan Guarantee Program. *Subsection (r)(3)*

Explicitly permits (but does not require) HRSA to:

- Consider a health center's sustainability plans when making supplemental quality awards. *(d)(2)*
- Give grants for "innovative programs" targeting homeless veterans. *Subsection(h)(1)*

Provides additional $25 million for FY2018 for health centers to participate in NIH's Precision Medicine Initiative. *Subsection (r)(5)*

What's Up Next for Congress?

- DACA expiration/Immigration reform
- FY19 Appropriations
- Opioid epidemic response
- "Welfare Reform"?
- Market stabilization?
- Infrastructure?
- Drug pricing?

… All of which will be heavily influenced

President's FY19 Budget Released

- Continued Support for Community Health Centers, NHSC, THCGME

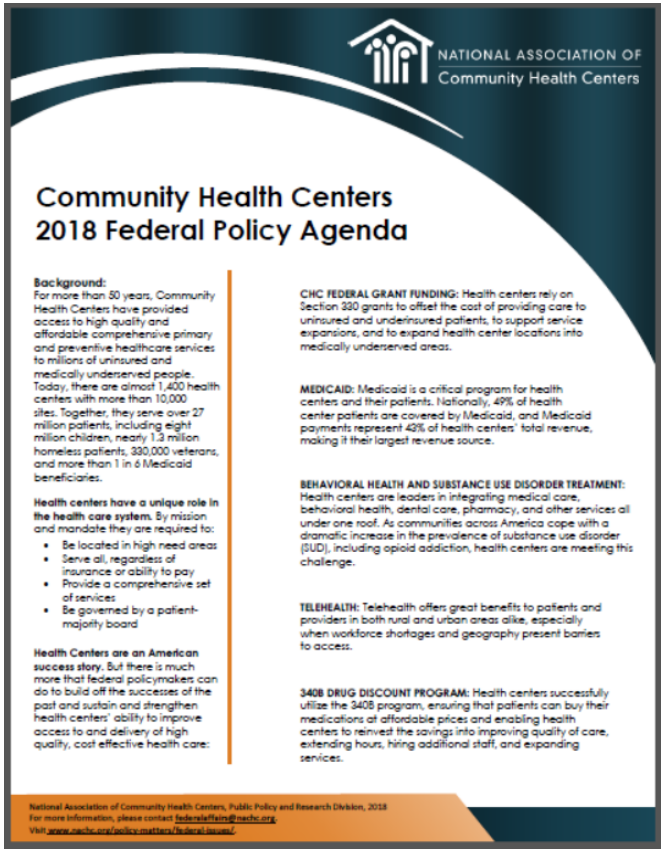
Provides $10 billion to combat opioid epidemic, incl. $400 million directed specifically to health centers

Made 21% cut to HHS's overall budget (loss of $17.9 billion) – including large cuts to HRSA and CDC

Included Graham-Cassidy ACA repeal and replace legislation (incl. Medicaid block grant)

- **Unlikely to shape Congressional action**

NACHC's 2018 Legislative Agenda – 5 Key Areas



NATIONAL ASSOCIATION OF Community Health Centers

Community Health Centers 2018 Federal Policy Agenda

Background:
For more than 50 years, Community Health Centers have provided access to high quality and affordable comprehensive primary and preventive healthcare services to millions of uninsured and medically underserved people. Today, there are almost 1,400 health centers with more than 10,000 sites. Together, they serve over 27 million patients, including eight million children, nearly 1.3 million homeless patients, 330,000 veterans, and more than 1 in 6 Medicaid beneficiaries.

Health centers have a unique role in the health care system. By mission and mandate they are required to:

- Be located in high need areas
- Serve all, regardless of insurance or ability to pay
- Provide a comprehensive set of services
- Be governed by a patient-majority board

Health Centers are an American success story. But there is much more that federal policymakers can do to build off the successes of the past and sustain and strengthen health centers' ability to improve access to and delivery of high quality, cost effective health care:

CHC FEDERAL GRANT FUNDING: Health centers rely on Section 330 grants to offset the cost of providing care to uninsured and underinsured patients, to support service expansions, and to expand health center locations into medically underserved areas.

MEDICAID: Medicaid is a critical program for health centers and their patients. Nationally, 49% of health center patients are covered by Medicaid, and Medicaid payments represent 42% of health centers' total revenue, making it their largest revenue source.

BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT: Health centers are leaders in integrating medical care, behavioral health, dental care, pharmacy, and other services all under one roof. As communities across America cope with a dramatic increase in the prevalence of substance use disorder (SUD), including opioid addiction, health centers are meeting this challenge.

TELEHEALTH: Telehealth offers great benefits to patients and providers in both rural and urban areas alike, especially when workforce shortages and geography present barriers to access.

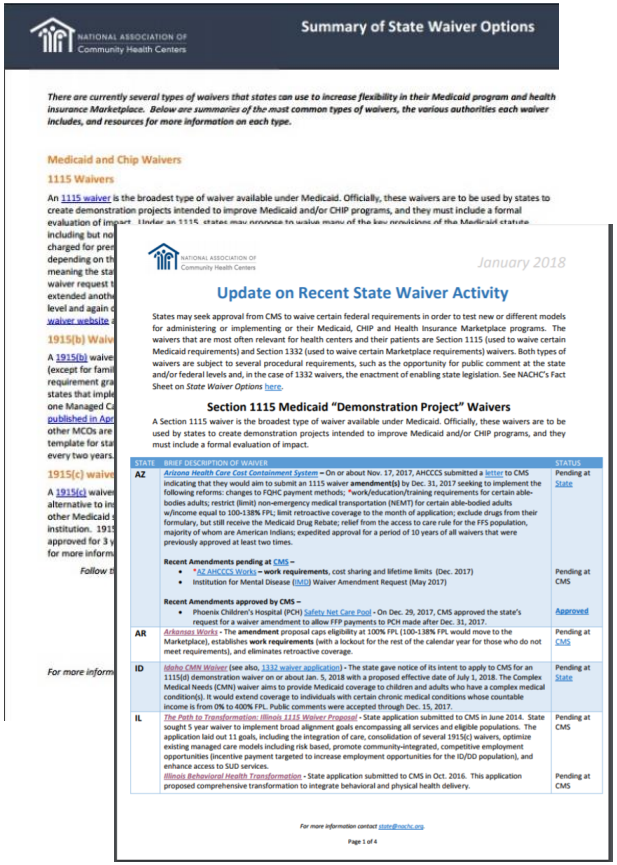
340B DRUG DISCOUNT PROGRAM: Health centers successfully utilize the 340B program, ensuring that patients can buy their medications at affordable prices and enabling health centers to reinvest the savings into improving quality of care, extending hours, hiring additional staff, and expanding services.

National Association of Community Health Centers, Public Policy and Research Division, 2018
For more information, please contact federalaffairs@nachc.org.
Visit www.nachc.org/policy-matters/federal-issues/.

- **Federal Grant Funding**
  - FY19 Appropriations; Long term stability for cliff
- **Medicaid**
  - State-federal connection; Protections for program at-large and FQHC PPS specifically
- **Behavioral Health/SUD Treatment**
  - Targeted grant funding; Adding billable providers
- **340B Drug Pricing Program**
  - Maintaining health center access
- **Telehealth**
  - Reimbursing CHCs as distant and originating sites

Workforce issues included throughout agenda

Medicaid



NATIONAL ASSOCIATION OF Community Health Centers

Summary of State Waiver Options

There are currently several types of waivers that states can use to increase flexibility in their Medicaid program and health insurance Marketplace. Below are summaries of the most common types of waivers, the various authorities each waiver includes, and resources for more information on each type.

Medicaid and Chip Waivers

1115 Waivers

An 1115 waiver is the broadest type of waiver available under Medicaid. Officially, these waivers are to be used by states to create demonstration projects intended to improve Medicaid and/or CHIP programs, and they must include a formal evaluation of impact. Under an 1115, states may propose to waive many of the key provisions of the Medicaid statute including but no charged for pren depending on th meaning the sta waiver request t extended anothe level and again waiver website

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1915(c) waive

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NATIONAL ASSOCIATION OF Community Health Centers

January 2018

Update on Recent State Waiver Activity

States may seek approval from CMS to waive certain federal requirements in order to test new or different models for administering or implementing or their Medicaid, CHIP and Health Insurance Marketplace programs. The waivers that are most often relevant for health centers and their patients are Section 1115 (used to waive certain Medicaid requirements) and Section 1332 (used to waive certain Marketplace requirements) waivers. Both types of waivers are subject to several procedural requirements, such as the opportunity for public comment at the state and/or federal levels and, in the case of 1332 waivers, the enactment of enabling state legislation. See NACHC's Fact Sheet on *State Waiver Options* here.

Section 1115 Medicaid "Demonstration Project" Waivers

A Section 1115 waiver is the broadest type of waiver available under Medicaid. Officially, these waivers are to be used by states to create demonstration projects intended to improve Medicaid and/or CHIP programs, and they must include a formal evaluation of impact.

STATE	BRIEF DESCRIPTION OF WAIVER	STATUS
AZ	*Arizona Health Care Cost Containment System* – On or about Nov. 17, 2017, AHCCCS submitted a letter to CMS indicating that they would aim to submit an 1115 waiver **amendment(s)** by Dec. 31, 2017 seeking to implement the following reforms: changes to FQHC payment methods; *work/education/training requirements for certain able-bodies adults; restrict (limit) non-emergency medical transportation (NEMT) for certain able-bodied adults w/income equal to 100-138% FPL; limit retroactive coverage to the month of application; exclude drugs from their formulary, but still receive the Medicaid Drug Rebate; relief from the access to care rule for the FFS population, majority of whom are American Indians; expedited approval for a period of 10 years of all waivers that were previously approved at least two times. **Recent Amendments pending at CMS –** • *AZ AHCCCS Works – **work requirements**, cost sharing and lifetime limits (Dec. 2017) • Institution for Mental Disease (IMD) Waiver Amendment Request (May 2017) **Recent Amendments approved by CMS –** • Phoenix Children's Hospital (PCH) Safety Net Care Pool - On Dec. 29, 2017, CMS approved the state's request for a waiver amendment to allow FFP payments to PCH made after Dec. 31, 2017.	Pending at State Pending at CMS Approved
AR	*Arkansas Works* - The **amendment** proposal caps eligibility at 100% FPL (100-138% FPL would move to the Marketplace), establishes **work requirements** (with a lockout for the rest of the calendar year for those who do not meet requirements), and eliminates retroactive coverage.	Pending at CMS
ID	*Idaho CMN Waiver* (see also, 1332 waiver application) - The state gave notice of its intent to apply to CMS for an 1115(d) demonstration waiver on or about Jan. 5, 2018 with a proposed effective date of July 1, 2018. The Complex Medical Needs (CMN) waiver aims to provide Medicaid coverage to children and adults who have a complex medical condition(s). It would extend coverage to individuals with certain chronic medical conditions whose countable income is from 0% to 400% FPL. Public comments were accepted through Dec. 15, 2017.	Pending at State
IL	*The Path to Transformation: Illinois 1115 Waiver Proposal* - State application submitted to CMS in June 2014. State sought 5 year waiver to implement broad alignment goals encompassing all services and eligible populations. The application laid out 11 goals, including the integration of care, consolidation of several 1915(c) waivers, optimize existing managed care models including risk based, promote community-integrated, competitive employment opportunities (incentive payment targeted to increase employment opportunities for the ID/DD population), and enhance access to SUD services. *Illinois Behavioral Health Transformation* - State application submitted to CMS in Oct. 2016. This application proposed comprehensive transformation to integrate behavioral and physical health delivery.	Pending at CMS Pending at CMS

For more information contact state@nachc.org.

Page 1 of 4

- Large scale, structural changes to Medicaid unlikely to pass Congress
- Focus will be on the states, particularly as CMS has expressed interest in "fast tracking" waivers that include provisions already approved
  - Work requirements, premiums, lockouts, co-pays, lifetime caps, etc.
  - FQHC PPS protections
- **More important than ever for health centers to work with their PCAs and Networks to ensure thoughtful, coordinated responses to complex proposals**

340B – What's the Latest?

- Flurry of 340B bills introduced in last few months (primarily hospital focused):

  Early November - **H.R. 4392; McKinley (R-WV) & Thompson (D-CA)**
  Blocks CMS cuts to Medicare Part B Payments to Hospitals

  Late December: **H.R. 4710 aka PAUSE ACT; Bucshon (R-IN) & Peters (D-CA)**
  Two-year moratorium on new DSH hospitals and new reporting requirements

  Mid-January: **S. 2312 aka HELP Act; Cassidy (R-LA)**
  Similar to PAUSE ACT, two-year moratorium on new DSH hospitals and new reporting requirements (beyond those included in PAUSE ACT)

- E&C Committee conducted 2-year review of 340B program, including 3 Congressional hearings, stakeholder meetings and document requests
  Report highlights strong bipartisan support for the program, also areas of concern

340B Continued

More to come?

- E&C Chairman Walden: “Will bring up additional 340B-related legislation as soon as February”
- GAO Report on Contract Pharmacy
- Senator Hatch letter to HHS RE: moving program from HRSA to CMS
- Additional Hearings?

What should health centers be doing?

- *Be able to demonstrate how 340B benefits your patients (savings)*
- Ensure compliance (diversion, duplicate discounts, contract pharmacies)

Telehealth

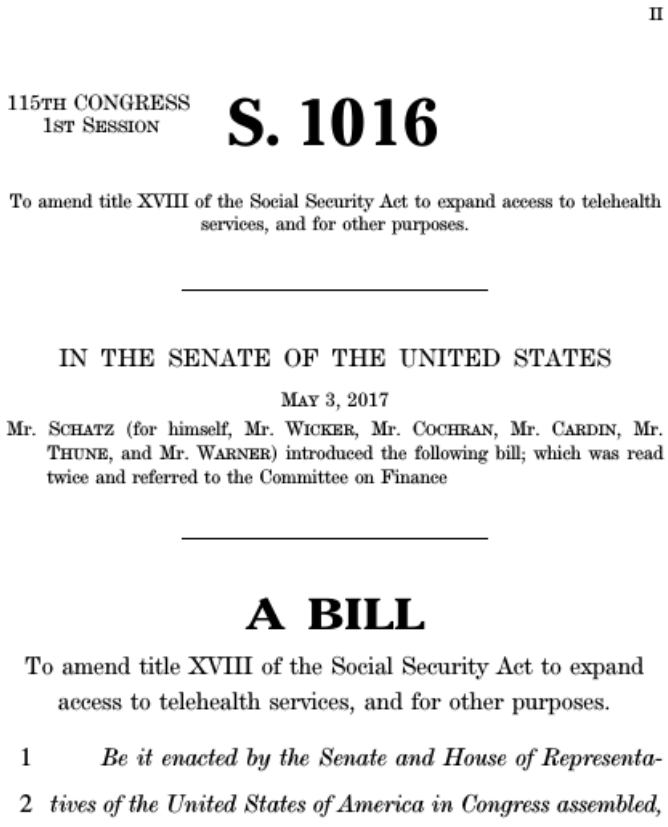
CONNECT for Health Act of 2017

S. 1016, Schatz (D-HI)/Wicker (R-MS)
H.R. 2556, Black (R-TN)/Welch (D-VT)
Co-sponsors: 19 Senate/ 24 House

For FQHCs & RHCs, CONNECT includes provisions t authorize reimbursement within Medicare for:

Distant site providers
All originating site providers
Remote Patient Monitoring (RPM) of patients with chronic conditions

Congressional telehealth caucus created last year



II

115TH CONGRESS
1ST SESSION

S. 1016

To amend title XVIII of the Social Security Act to expand access to telehealth services, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 3, 2017

Mr. SCHATZ (for himself, Mr. WICKER, Mr. COCHRAN, Mr. CARDIN, Mr. THUNE, and Mr. WARNER) introduced the following bill; which was read twice and referred to the Committee on Finance

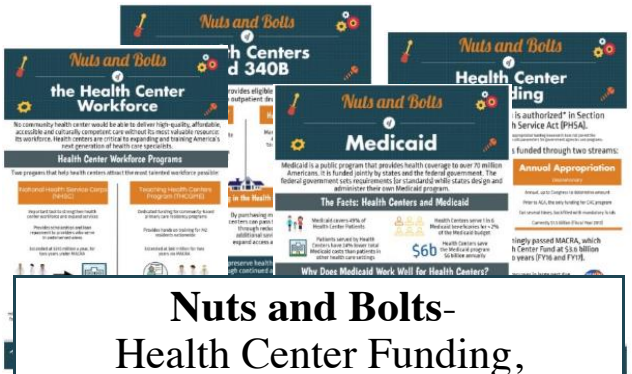
---

A BILL

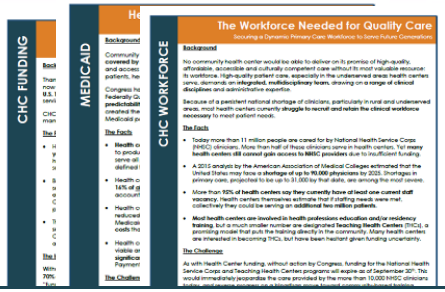
To amend title XVIII of the Social Security Act to expand access to telehealth services, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

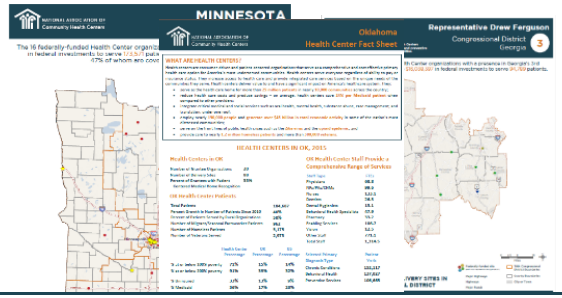
Online Policy Resources



Nuts and Bolts- Health Center Funding, Medicaid, Workforce, & 340B

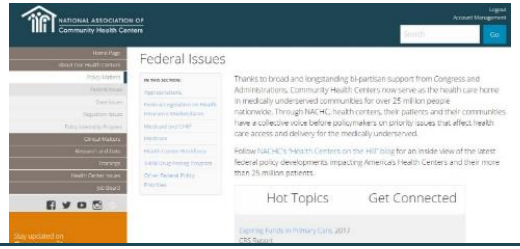


NACHC Policy Papers- Health Center Funding, Medicaid, and Workforce

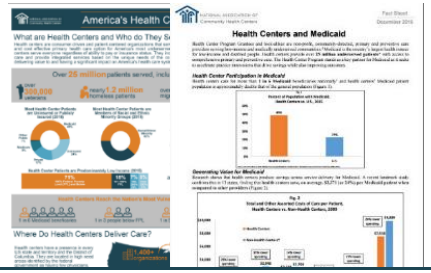


State and Congressional District Maps, State Fact Sheets

Health Centers on the Hill Blog



NACHC Federal Affairs Webpage



NACHC Fact Sheets

For these and other materials on federal, state, and regulatory issues, go to **www.nachc.org/policy-matters/.**

Building on Our Momentum

Funding Lapse For Community Health Centers Still Looms

By ANH GRAY • JAN 23, 2018

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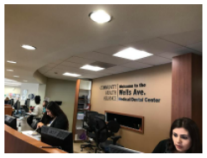

Community Health Alliance

After a brief gov
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head of one Reno-based center to learn more.

Community health centers awai funding that expired months ag

BY JESSIE HELLMANN - 01/23/18 02:38 PM EST

1,866 SHARES SHARE TWEET

Emergency aid is needed for rural, urban community health centers

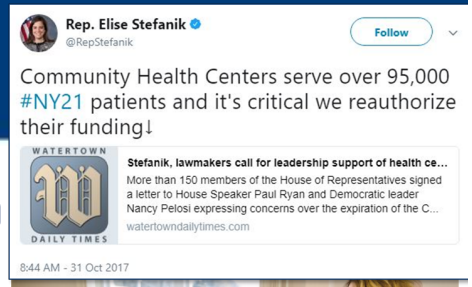
Federal funding is drying up due to ineptitude. State should step in.

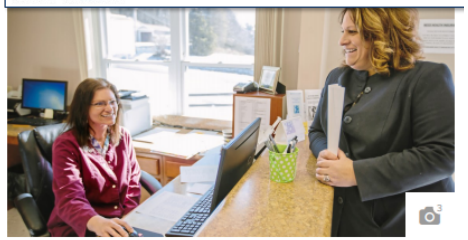
By Editorial Board Star Tribune | JANUARY 26, 2018 — 6:16PM

Funding legislative operati
lawmakers returning to the
that self-interested goal —
temporary funding to keep
network.

Legislation to extend funding for clinics serving poor and uninsured stalls in Congress

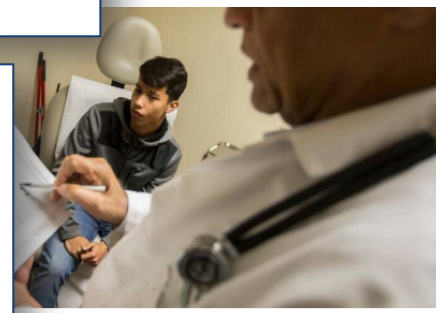
The CHIME Act isn't yet on the congressional calendar -- and f
funding is set to expire at the end of the month.





Still waiting for Congress to act, Pennsylvania community health

Clock ticking on funding for Federally Qualified Health Cent



SOAPBOX

n't leave community health centers in limbo

BY CARMELA CASTELLANO-GARCIA

Cold Shoulder Sends Shivers Through Community Health Centers

By Rachel Bluth | September 27, 2017

Before you leave today, make sure you are signed up as a Health Center Advocate!

By Joining the Health Center Advocacy Network…

- You'll have more ways to **contact Congress**
- You can easily **share alerts & calls to action** with your social media networks
- You can opt in with your mobile phone to **receive updates and alerts via text message**.

How To Sign Up:

Para recibir comunicaciones en español

Text **HCADVOCATE** to **52886**

Text **DEFENSOR** to **52886**

OR

Visit

www.hcadvocacy.org/join

Questions?

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