NATIONAL ASSOCIATION OF
Community Health Centers

Administrative and Regulatory Policy Developments Affecting Health Centers

NACHC Staff Report to the Health Policy Committee

August 18, 2018

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This report highlights policy developments between the March 2018 Policy & Issues Forum in Washington DC and August 15. Some issues may have evolved further since that time; please check www.nachc.org and related links for the most current updates.

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Cross-Cutting Issues

NACHC developing comprehensive policy agenda for State and Federal levels; please complete Policy Poll to share your priorities*[1]

NACHC policy staff are currently developing a comprehensive policy agenda to support the wide-ranging needs of Health Centers and their patients at both the federal and state levels. The goal is to create an inclusive policy vision that lays out a variety of opportunities for policymakers to support the future of the health center program, at both the Federal and state levels, as well as in the legislative and regulatory arenas. The agenda is expected to focus on eight key policy areas: Federal and State Funding; Medicaid; Medicare; Non-public coverage; Special Populations; Integrated Care; 340B; and Workforce. NACHC's goal is to have a final document ready by the time that the new Congress arrives in early 2019.

As the agenda is being developed, NACHC is reaching out to health centers, PCAs, HCCNs, and NCAs to solicit their input on the policies and public resources that will be necessary to enable health centers to continue to thrive in the future. We are also asking all members to provide input into the process by completing the Policy Poll. This can be directly done from the CHI app; on the event page, look in the lower-right corner and click "…More" Scroll down and click on Policy Poll. The poll takes less than 5 minutes.

PCA State Environment Assessment and Chartbook

Each year NACHC's State Affairs team fields a comprehensive questionnaire covering various high-priority issues for health centers at the state level, including Medicaid, FQHC PPS/APM implementation, telehealth, and state funding. For the year 2018, the questionnaire was significantly revised to take into consideration feedback received from stakeholders at the PCAs and within NACHC. The data will inform technical assistance, and advocacy and policy initiatives at both the federal and state levels throughout the year.

As a new offering, planning is well underway to produce a growing body of charts, tables, and publications (like our recent telehealth fact sheet) to more cogently present some of this information in the aggregate. NACHC is providing a new chartbook (to be called the "Health Center & State Environment Chartbook") containing an assortment of visualizations (e.g., tables and maps) with brief narratives where appropriate to present the data in more effective ways. This work is part of an overall effort to make our data more accessible.

Medicare

CMS Issues Physician Fee Schedule, Includes FQHC Specific Provisions

As in years past, in its annual Physician Fee Schedule Notice of Proposed Rule Making, CMS has included several provisions related to Medicare and FQHCs. This year's proposed rule has received a lot of attention as CMS is proposing to make major changes to the way Medicare reimburses providers via the Physician Fee Schedule.

Specific to FQHCs, CMS proposed to update the Chronic Care Management (CCM) payment to FQHCs, to reflect a new CPT code being used for CCM by providers paid via the Physician Fee Schedule. The proposed rule also include a provision to reimburse FQHCs for "communication technology based services" and "remote evaluation services" as long as those services are not in direct relation to a previous visit (within the last 7 days) or lead to a visit within 24 hours (or at the next soonest appointment). While this does not allow for the provision of full

[1] An asterisk indicates a section that has been added or significantly revised since the 8/18/18 version of this report.

telehealth services at health centers, it is important because in order to allow for FQHCs to provide these services, CMS has waived the face to face requirement typically required to trigger a payment. Comments are due September 10, 2018 and NACHC will be commenting on this proposed rule and encourages health centers and PCAs to submit as well. NACHC staff will continue to update health centers and PCAs when this rule is finalized.

Proposed Changes to CMS's Medicare ACO Program Released

In August, CMS released a proposed rule that would transform the Medicare Shared Savings Program (MSSP), ultimately pushing participating accountable care organizations (or ACOs) to take on increasing levels of financial risk. The transformed program, which CMS has dubbed "Pathways to Success", consolidates track options to two - the basic and enhanced tracks – both of which incorporate some level of two-sided risk. NACHC is in the process of reviewing the proposed rule and plans to submit comments. To share feedback on your experience with the MSSP, or for more information about the proposed rule, please contact state@nachc.org.

Medicaid

NACHC Launches Workgroup with NAMD

In June 2018, NACHC launched a workgroup with the National Association of Medicaid Directors (NAMD) focused on fostering strong relationships between Medicaid programs and community health centers, and identify opportunities to collaborate around shared priorities. The workgroup membership includes State Medicaid Directors and PCA CEOs from Colorado, Connecticut, Hawaii, Kansas, and North Carolina. NACHC staff will provide regular updates as the workgroup's efforts progress.

NACHC Continues to Clarify Details on Capitated FQHC APMs

In July 2018, NACHC staff met with officials at HHS to address concerns CMS recently raised regarding Colorado's proposal to implement a capitated (per member per month) FQHC alternative payment methodology in a fee-for-service environment. The HHS officials were receptive to information shared by NACHC and Colorado Community Health Network (CCHN) on how capitated FQHC APMs can serve as a key tool to advancing value-based health care, and offered to look into CMS' reluctance to approve the proposal. NACHC continues to work closely with the CCHN as the PCA coordinates the state response to CMS and future payment reform strategies, and to refine a legal argument and policy strategy supporting health center-driven efforts to engage in capitated FQHC-APMs.

Office of National Coordinator Promotes PRAPARE with State Medicaid Agencies and HIEs

The Office of the National Coordinator (ONC) is interested in promoting PRAPARE as the standardized social determinants of health screening tool to be used across state Medicaid agencies and state Health Information Exchanges. To that end, ONC tasked the Urban Institute to work with NACHC and a group of states to determine what stakeholders, planning steps, and infrastructure are needed for Medicaid provider organizations to use PRAPARE in their Health Information Exchanges. The NACHC Research and State Affairs departments (collaborating with the Urban Institute) will be working with the PCAs and state Medicaid agencies in Oregon, Colorado, and Washington to host stakeholder meetings to discuss key readiness areas, map out plans to move forward, and identify opportunities to use the 90/10 HITECH Federal Match to help fund this work. Key outcomes for this work are case studies, guiding toolkits, and webinars based on the lessons learned from these specific state-based planning processes that other states can customize to start standardized social determinant of health work in their own states.

CMS Issues Proposed Rule on Medicaid Access Plan Exemptions

Just after the Policy and Issues Forum, CMS issued a proposed rule "*Methods for Assuring Access to Covered Medicaid Services-Exemptions for States With High Managed Care Penetration Rates and Rate Reduction Threshold*," allowing states with high Medicaid managed care populations and those making "nominal" rate reductions to be exempt from the Access Monitor Review Plans (AMRPs), which were established in 2015 to ensure access to core Medicaid services. NACHC commented on this proposed rule, raising questions about the impact of these exemptions on those beneficiaries that remain in traditional Medicaid, along with questions about the methodology used to determine the exemption thresholds. We also joined in with 16 other groups on the Partnership for Medicaid to submit comments on behalf of the Partnership. NACHC appreciates those PCAs and health centers that submitted their own comments and will provide updates if and when this rule is finalized.

NACHC Responds to Proposed Rule Regarding the Medicaid EHR Incentive Program

Earlier this summer, CMS released a proposed rule that would revise some of the requirements around the Medicaid EHR Incentive Program. In particular, it would allow providers participating in the program to report on a continuous 90-day period instead of a full year as was previously proposed. It also confirmed that providers would be required to use the 2015 Health IT Certification Criteria, using EHR systems that include API functionality, export capability, and patient access to data via email, and other updated technology. CMS is also requested information around how to update Medicaid and Medicare conditions of participation to compel providers to share data across the system and facilitate health record sharing with their patients. NACHC submitted comments to CMS which supported CMS's increasing focus on interoperability of EHR systems among providers while encouraging CMS to reduce unnecessary burden on FQHC providers. You can access NACHC's comments here.

Medicaid Expansion Efforts and Ballot Initiatives

To date, 33 states and Washington, D.C., have expanded Medicaid. In May 2018, Virginia's legislature y approved the expansion of Medicaid, albeit with conditions that will require a waiver application. Maine's voters demanded that the state expand Medicaid, but the implementation had been stalled due to resistance from the state's governor citing insufficient state appropriations to support the program. Despite intervention from the courts, Maine's governor further stalled the expansion efforts by vetoing the budget, which was sustained by state lawmakers. A lawsuit is still pending to enforce the will of the voters in the state.

Despite stumbling blocks for Maine and possible uncertainty around work requirements that may impact Virginia's expansion efforts, ballot initiatives are still underway in other states. See the following list of ballot measures underway in other states:

- **Idaho** voters will see Medicaid expansion on the ballot in November of 2018, as the state determined that enough signatures from enough areas had been collected. If the state expands Medicaid, 69,000 people could gain coverage.
- **Utah** voters will see Medicaid expansion on the ballot in November of 2018. If the state expands Medicaid, approximately 76,000 people could gain coverage.
- **Nebraska** voters may see Medicaid expansion on the ballot in November of 2018. Signatures were still being validated by the state as of the date of this report. If expanded, approximately 45,000 people could gain coverage.
- **Montana** voters will decide on whether to extend the Medicaid expansion program as the measure will be on the ballot in November of 2018. The measure would raise taxes on tobacco products to fund the state's Medicaid expansion and other health programs. The measure would help 100,000 people retain Medicaid coverage.

Medicaid expansion ballot initiatives are being tracked by NACHC's State Affairs staff working collaboratively with PCAs and other national organizations.

Section 1115 Medicaid Waivers

NACHC staff continues to closely monitor, analyze and provide support to the state PCAs on Medicaid waivers, paying particular attention to those proposals which seek to implement significant reforms to state Medicaid programs. For the PCAs and community health centers, the primary concern with any of these proposals continues to be the need to ensure that the programs they implement improve, rather than restrict, access to care for their patient populations.

There are a little over 20 Section 1115 Medicaid waiver applications pending at CMS. While all are being tracked, three of the waivers being closely monitored are:

- **Mississippi**: The federal comments period was reopened until August 18 for a revised application submitted by the state. Although the state now proposes to provide 12 additional months of coverage for individuals who continue to participate in work-related requirements, exceeding the income limit may still result in people losing coverage.
- **Kentucky:** A favorable decision was issued on June 29, 2018 by the judge in the US District Court (DC) for the plaintiffs (Medicaid beneficiaries) suing to prevent the state from implementing its controversial Kentucky HEALTH waiver which included work requirements. CMS has announced that a new federal comment period on the proposed waiver would be open until August 18. Some have perceived the new comment period as an attempt to collect comments in support of the administration's continued efforts to implement work requirements.
- **Arkansas:** In June, Arkansas became the first state where Medicaid work requirements took effect. On August 14, Advocacy groups filed a lawsuit challenging the decision by the Trump Administration's decision to allow Arkansas to impose work requirements on Medicaid recipients in the state. The lawsuit, which is similar to Kentucky's and filed against the U.S. Department of Health and Human Services in federal court in Washington on behalf of three Medicaid recipients in the state, claims that the federal Medicaid law does not allow the administration to approve work requirements. The National Health Law Program will be supporting and representing Arkansas Medicaid beneficiaries in the lawsuit and was also the leader against Kentucky's waiver.

Others recent and important waivers pending at CMS include:

- Work Requirements: Arizona, Kansas, Kentucky (on remand), Maine, Mississippi, Ohio, Utah, Wisconsin
- Expansion: Utah (Note: If Virginia continues with work requirements as planned, the state will have to file a waiver.)
- Eligibility and Enrollment Restrictions (varied): Arizona, Florida, Maine, New Mexico, Texas, Utah, Wisconsin
- Benefit Restrictions (varied): Maine, Mass., Utah, New Mexico, Texas, Wisconsin

CMS Rejects Kansas' Proposal to Apply Lifetime Limits in Medicaid

On May 7, 2018, CMS rejected the state's proposal to impose a 36-month lifetime limit on individuals' subject to the state's work requirements. The proposal to implement work requirements is still pending in this non-expansion state, a scenario which would raises serious concerns that this waiver would be particularly detrimental to the working poor in the state. However, the PCA informed NACHC staff that through state coalition efforts, the state legislature passed language as part of their budget package that permits the Governor

to negotiate a waiver with CMS but bars implementation until the legislature affirmatively approves it during their 2019 legislative session. The PCA further informs that the legislature is very likely to reject implementation of any waiver that seeks to impose work requirements. NACHC staff will continue to monitor the Kansas developments carefully, as the legislature continues to debate expansion.

NACHC Comments on State Waiver Proposals at Federal Level

NACHC continues to engage with national stakeholders during the federal public notice and comment periods. With the consent of health center and PCA partners, NACHC has submitted or signed onto coalition letters or submitted its own letter commenting on the following state waiver proposals:

- **Arizona** – AHCCCS Works
- **Arizona** - Retroactive Eligibility
- **Indiana** – Healthy Indiana Plan (HIP) 2.0
- **Kansas** – KanCare Renewal
- **Kentucky** – KY HEALTH
- **Maine** – MaineCare
- **Mississippi** – Workforce Training Initiative
- **New Hampshire** – Health Protection Program Premium Assistance
- **Wisconsin** – BadgerCare
- **Texas** – Health Texas Women
- **Utah** – Primary Care Network

NACHC Provides Support on Medicaid Waivers and State Plan Amendments
NACHC staff continues to provide resources, direct technical assistance, and trainings to support to health centers and Primary Care Associations in navigating the waiver and state plan amendment (SPA) development, approval and implementation processes. NACHC worked in consultation with the PCA Leadership Committee to develop a set of Medicaid waiver principles that: 1) support the mission of health centers, 2) ensures patient access to high-quality, affordable care for underserved and vulnerable populations, and 3) can be adopted and tailored by state and regional PCAs and health centers to suit specific needs. The *NACHC Medicaid Waiver Principles* have been released as planned and can be found at http://www.nachc.org/policy-matters/states/1115-waivers/.

NACHC also partnered with the American Academy of Family Physicians (AAFP) to co-develop a resource for the primary care field. On May 9, 2018, NACHC and the AAFP co-hosted *"Medicaid and 1115 Waivers: Informing the Conversation from the Primary Care Perspective,"* a webinar for primary care advocates interested in staying informed and equipped to engage in the changing landscape of Medicaid policy. Experts Sara Rosenbaum, JD, of GWU, Cristal Gary of Leavitt Partners, and Dr. Felix Valbuena, Jr. of CHASS Center in Michigan, shared their knowledge and experiences on how ongoing changes to Medicaid may impact patients and the practice of primary care.

Payment & Delivery Reform

Center for Medicaid and Medicaid Innovation Gets New Leadership

In April 2018, Seema Verma announced that Adam Boehler, the former CEO of Landmark Health, a home-based medical care company, would become the head of the Center for Medicare and Medicaid Innovation (CMMI). Earlier this year, CMS published a Request for Information (RFI) on a "new direction" for CMMI, to "promote greater flexibility and patient engagement." NACHC staff will continue to monitor developments from CMMI, and work to engage health centers in any conversations, as appropriate.

NACHC Responds to CMS RFI on Direct Primary Care

Recently NACHC provided comments in response to the Center for Medicare and Medicaid Innovation (CMMI)'s request for information on a direct provider contracting (DPC) model. The model, also known as direct primary care, would allow CMS to test payment arrangements whereby Medicare and Medicaid could pay participating providers a direct per-beneficiary-per-month (PBPM) payment to manage a patient's primary care. NACHC's comments highlighted how health centers can be key players in a DPC model and have already demonstrated success in various value-based payment models, but that a successful DPC model would recognize the critical role of PPS in sustaining the unique health center model. See NACHC's full comments.

NACHC Releases New Case Study on Washington's Capitated FQHC APM

The new case study gives a detailed overview of Washington's APM4, a capitated FQHC APM that pays health centers on a per member per month basis and ties a portion of their payment to performance metrics. Washington is the second state in the country to implement a capitated FQHC APM - Oregon implemented a similar model in 2013 - and the first to integrate performance metrics that are tied to a portion of the rate. NACHC continues to work with the Washington Association of Community & Migrant Health Centers to monitor best practices and lessons learned from the Washington health centers participating in the new payment model.

Delta Center, NACHC and Partners Award Grants to 13 States

NACHC and the National Council for Behavioral Health were selected by the Robert Wood Johnson Foundation to partner with the *Delta Center for a Thriving Safety Net*. The goal of the Delta Center is to promote the diffusion of value-based payment arrangements among their provider partners by building capacity within PCAs and state behavioral health associations. As part of the partnership, NACHC worked with the Delta Center to guide the selection funding awards to PCAs and behavioral health state associations through a competitive application process. The grantees were announced in May and represent 13 states, 9 of which are joint awards that are shared between the PCA and state behavioral health association.

PCAs

- Arizona Alliance of Community Health Centers
- Colorado Community Health Network
- Iowa Primary Care Association
- Maine Primary Care Association*
- New Mexico Primary Care Association*
- Missouri Primary Care Association*
- North Carolina Community Health Center Association*

*Indicates grantee included state behavioral health association as partner

State Behavioral Health Associations

- Association of Oregon Community Mental Health Programs*
- Community Mental Health Association of Michigan*
- Massachusetts League of Community Health Centers*
- New York State Council for Community Behavioral Healthcare*
- Texas Council of Community Centers
- Washington Council for Behavioral Health*

*Indicates grantee included PCA as partner

Behavioral Health & Substance Use Disorder Integration

New Report on Health Centers and the Opioid Epidemic

In July 2018, Kaiser Family Foundation released a new report entitled "The Role of Community Health Centers in Addressing the Opioid Epidemic," which is based on a survey of health centers conducted in early 2018. The report finds that health centers have significantly expanded services to meet the growing need for opioid use disorder treatment in their communities, while continuing to face a variety of challenges related to provider training, capacity, and reimbursement, particularly in states which have not expanded their Medicaid programs.
NACHC Conducts Environmental Policy Scan to Build Up Policy Agenda
NACHC State and Federal Affairs departments have been working with Dr. Kima Taylor on a policy scan to enhance our policy agenda. The scan is now complete, and NACHC is finalizing the report and snapshot now. Through the policy scan, NACHC was able to elicit rich feedback from health center and PCA leaders on a range of policy barriers and opportunities around the integration of behavioral health and SUD. Through this careful assessment, NACHC is working to clarify policy-level opportunities to advance the integration of behavioral health and SUD treatment services into primary care. NACHC looks forward to sharing the report and snapshot in August 2018.

NACHC State and Federal Affairs staff also presented findings from the environmental scan via a webinar on July 10, 2018. Dr. Taylor joined NACHC staff for updates to the field, as well as panelists from the Ohio Association of Community Health Centers and a Valley Health Systems, Inc. (West Virginia) who presented on their first-hand experiences and perspectives on efforts to integrate SUD treatment services in primary care. The recording of this presentation is available on the State Affairs website.

NASHP Launching State Substance Use Disorder (SUD) Policy Institute

In July, the National Academy for State Health Policy (NASHP) announced that it was inviting states to apply to participate in its "State Substance Use Disorder (SUD) Policy Institute: Leveraging Federally Qualified Health Centers (FQHCs) to Address SUD." Continuing to build upon our collaborative relationship with NASHP, NACHC State Affairs staff is working to inform the curriculum and ensure alignment with other SUD and behavioral health policy initiatives.

Health Insurance Marketplaces

Final Rule Issued on Marketplace Benefit and Payment Parameters for 2019

The *HHS Notice of Benefit and Payment Parameters for 2019* final rule was released on April 9, 2018. The final rule includes CMS standards for issuers and Exchanges, generally for plan years beginning on or after January 1, 2019. As per the press release, this year's final rule sought "to advance the Administration's goals for increasing flexibility, improving affordability, strengthening program integrity, empowering consumers, promoting stability, and reducing unnecessary regulatory burdens…" In short, the rule: allows for plans to be sold in states that do not offer the ACA-mandated essential health benefits; softens the medical loss ratio regulatory burdens by reducing the quality improvement reporting requirements; expanded the hardship exemption to people in counties with 0-1 issuer; increases the scrutiny of income verification for the advance premium tax credits; gives states significantly more options for designing their benchmark plans; and lets states oversee whether qualified health plans meet network adequacy standards.

Steep Cuts to Navigator Funding

CMS recently announced the current Funding Opportunity for Navigator programs in Federally-Facilitated Exchange States. For the upcoming sixth open-enrollment period, groups operating Navigator programs will have to compete for awards from a funding pool that has been reduced from $36 million to $10 million. This follows severe cuts made last year that reduced the funding pool from $62.5 million for Navigator programs around the country. The latest funding announcement also reiterates the changes previously finalized that remove the requirement that each Exchange have at least two Navigator entities. Further, CMS' announcement made clear that Navigators are expected to inform consumers of non-ACA compliant plans. Funding for states has been grouped in tiers with the greatest amounts available to states that have the most people without coverage. As expected, these are states that have not expanded Medicaid under the ACA.

NACHC staff has been working closely with a group of directly funded PCAs and one health center which are impacted by this change to provide support and guidance. Decisions are currently being made by grantees on whether to pursue the Navigator funding opportunity, as the grant award amounts may not be enough to staff a Navigator program. It should be noted that some PCAs have been working closely with their state counterparts to advocate for sufficient and sustainable funding, as well as fair assessments of their performance on the grants.

CMS Halted and then Restarted Risk Adjustment Payments to Insurers

In the span of about a month and as insurers were working on setting their 2019 rates, CMS first announced that it would put "on hold" over $10 billion of risk adjustment payments due to insurers for Marketplace plans for the 2017 coverage year. CMS attributed its decision to uncertainty caused by a US District Court (NM) decision ruling in favor of a smaller insurer that challenged a flawed formula to calculate the payments. As expected, CMS' decision was perceived as disruptive to the market and, after pressure from the industry, the agency reversed course by issuing a final rule on July 24 to resume payments to insurers. The impact on premiums and availability of Marketplace options in states is yet to be seen, but the decision by CMS is expected to keep some insurers from withdrawing from the market.

Although the revenue from Marketplace coverage for health centers varies greatly from state to state and is not as great as the Medicaid revenues, NACHC considers this an access issue and will continue to monitor it closely to provide support to the PCAs and health centers as needed.
Section 1332 ACA Marketplace Waivers
Over the last couple of months, activity increased again in the area of Section 1332 Marketplace waivers. As a reminder, Section 1332 waivers allows states to waive certain ACA requirements in order to make changes in their individual and small group insurance markets. Also as a reminder, last year CMS issued specific guidance to help streamline the process for states to apply for these waivers. However, as recent as July 27, governors in several states still appear to take issue with the existing guidance on 1332 waivers citing a continued lack of flexibility in the approval process and timeline.

Nevertheless, the list of recent waiver activity is as follows:

- **Maryland** - On July 5, 2018, CMS determined that the state's waiver application seeking to implement a reinsurance program was complete. The public comment is open through August 4, 2018. If the application is approved within 180 days, plans will file new rates. Right now the rates have increased almost 90%+ in the state.
- **New Jersey** - On July 13, 2018, CMS determined that the state's waiver application seeking to implement a reinsurance program was complete.

- **Ohio** – The waiver application filed on March 30, 2018, proposing to eliminate the individual mandate, was *rejected* (denied) by CMS in May 2018.

The list of approved Section 1332 waivers has grown as of July 30, 2018:

- **Maine** (approved July 30, 2018) - In May, the state submitted a waiver application to CMS seeking funding to reinstate a state-based reinsurance program. On July 30, CMS approved that request and the program will take effect in 2019. It is projected that premiums will drop by 9% as a result of the waiver, saving the federal government about $33 million that would have been used for insurance subsidies but will instead go towards funding the reinsurance program.
- **Wisconsin** (approved July 29, 2018) - In May, CMS had determined that the state's application submitted on April 18, 2018 was complete. On July 29, CMS announced that it approved Wisconsin's request to create a reinsurance program set to take effect in 2019. The state's reinsurance program is expected to result in premiums decreasing by approximately 10.6% from what they would have been without the waiver. This will reportedly save the federal government $166 million that would have been used for insurance subsidies but will instead go towards funding the reinsurance program.
- **Alaska** (approved 2017)
- **Oregon** (approved 2017)
- **Minnesota** (approved 2017)
- **Hawaii** (approved 2016)

Section 330 – Bureau of Primary Health Care (BPHC)

BPHC provides more details on expanded compliance structure

On a July 31, 2018, webinar, BPHC provided additional details about how it will implement the new compliance requirements added to the Section 330 statute as part of the Bipartisan Budget Act of 2018:

- Starting in September 2018, BPHC will begin assessing compliance with the new requirement that Health Centers must direct employ their CEOs.
- Starting with FY19 SACs and Look-Alike redesignation (RD) applications:
  - All applications from existing health centers will be independently assessed for compliance by a BPHC reviewer who is not their Project Officer.
  - All first-time awardees (both SAC and LAL) will receive a one-year project period.
  - All awardees that have one or more conditions at the time of the award will receive a one-year project period. These conditions could predate the application, or be placed during the application review.
- Awardees that receive one-year project periods:
  - Will receive an OSV within two to four months of their project period start date.
  - Must submit an overall plan for achieving compliance within 120 days of the award. (This plan is in addition to the specific actions required to lift the condition.)
- Starting with FY19 SACs – and only for those Service Areas where the existing health center is the only applicant -- there will be a 14-day period during which the HRSA reviewer may communicate with the applicant, and offer them an opportunity to submit additional information to demonstrate compliance. This communication may take place only through the EHB External Correspondence Management module.
- Health centers are strongly encourage to resolve all outstanding conditions by the time that they submit their SAC/RD applications, as any opportunity to have a condition lifted after that time -- and before it results in a one-year project period – will be very limited.

BPHC provides further details on new options for measuring "need" within a service area; all options will address Service Area Overlap; may be used for potential FY19 NAP cycle

In early August 2018, BPHC held a webinar for all health center stakeholders, to present their preliminary work on a new system to measure "need" within a service area. This system – to be called the Service Area Needs Assessment Measure or SANAM -- will replace the Need for Assistance scores currently used in NAP applications. BHPC has contracted with a statistical analysis firm, which has done a comprehensive review of measures of need, and identified four potential models for calculating SANAM scores. While each model contains a different set of measure, they all incorporate four "core" measures: ratio of population to providers; percent of population below 200% FPL; percent uninsured; and health center penetration (measured as percent of population below 200% FPL that are currently served by health centers.) This last measure is intended to address concerns around service area overlap. BPHC will continue to test the various models, to determine the most appropriate measure. If BPHC offers NAPs in FY19, it is possible -- but not definite – that they will apply the final SANAM methodology to these applications.

All health centers required to have Policy and Procedures (P&Ps) in place documenting compliance with all restrictions on Federal grant funds; NACHC drafts sample P&Ps

Starting this year, all health centers will be required to demonstrate that they have P&Ps in place that document their compliance with all Federal restrictions on the use of Section 330 grant funds. Most health centers will be asked to show these P&Ps as part of their annual single Federal audit; those whose Section 330 program is not subject to the single audit (either because they receive less than $750,000 in Section 330 funds, or because Section 330 is not considered a "major" program" for their organization) were asked to send these P&Ps directly to HRSA's Office of Federal Assistance Management (OFAM) this spring. To assist health centers in complying with this requirement, NACHC worked with Feldesman-Tucker to develop a sample P&P that health centers can adapt to address compliance with these restrictions.

One of the restrictions on the use of Federal grant funds is that such funds may not be used to pay for health insurance benefits for health center employees, if such benefits included coverage for elective abortions. This restriction is discussed in further detail in the section in this report entitled "Women's Reproductive Health Services."

BPHC issues updated Compliance Manual and OSV Protocol reflecting recent statutory changes: new Protocol will be used for all OSVs occurring after Thursday September 6*

On August 21, BPHC published updated versions of the **Health Center Compliance Manual** and **Operational Site Visit (OSV) Protocol**. Both documents have been revised to reflect the new requirements, changing terminology, and increased emphasis on compliance which Congress enacted when it reauthorized Health Center funding this past February. The new Protocol will be used for OSVs occurring after Thursday, September 6, 2018. BPHC has also published a comprehensive list of all changes to the Compliance Manual.

Loan Guarantee Program replenished; over $700 million in additional loans guaranteed

In the Omnibus spending bill passed in late March, Congress added $20 million to the Loan Guarantee Program (LGP) for health centers. This funding will enable BPHC to guarantee up to $743.5 million in additional loans to health centers for construction and renovation activities. Prior to this action, the LGP fund was almost exhausted, creating concerns that BPHC would be unable to guarantee any new loans until existing loans are paid off.

NACHC submits comments on ways BPHC can reduce burden on grantees

In early July 2018, in response to a request from the agency, NACHC submitted formal comments to HRSA on ways that they can reduce administrative burden on grantees. NACHC recommendations included:

- opening access to the UDS reporting environment earlier than January 1.
- providing health centers with the option -- but <u>not a requirement</u> -- to transfer UDS data directly from their EHRs to BPHC
- expending the process of reviewing and approving carry-over requests.
- more clearly indicating in NOFOs which review criteria should be addressed in which section of the Project Narrative.

Auto-HPSAs

Initial estimates of updated auto-HPSA scores to be released in September; final scores expected in spring 2019; some health centers may see major changes

In September 2018, HRSA's Bureau of Health Workforce (BHW) is expected to send all health centers the ***initial estimate*** of their updated Auto-HPSA scores. It is important to note that these scores will be for informational use only, and are ***subject to change*** between now and spring 2019, when HRSA plans to finalize and update all auto-HPSA scores nationally. Between September and the national update, HRSA and State Primary Care Offices will continue to refine their systems and/or data, and HRSA will provide health centers with additional estimates to reflect these refinements. Some health centers may see significant changes in their scores – particularly those whose auto-HPSA scores have not been updated since 2002 or 2003.

BHW has been working collaboratively with NACHC, PCA, and health center representatives for over two years to prepare for the national update, and BHW has been responsive to much of our input. Nonetheless, NACHC's Auto-HPSA workgroup is concerned about one aspect of the new system, which could have large potential impacts on the new auto-HPSA scores.

Health Centers and PCAs concerned about accuracy of provider data underlying new auto-HPSA scores; Workgroup plans to request additional information on this data and on preliminary impact analyses*

A critical factor in calculating all HPSA scores is the number of providers in an area who treat Medicaid and/or sliding fee scale patients (measured in FTEs.) This data impacts up to 15 points out of a total of 25 (26 for dental HPSAs.) Under the new HPSA system, BHW relies on state PCOs to provide this FTE information. Specifically, the new system contains a data file on each provider in the country, based on where BHW thinks (based on CMS data) they are practicing. PCOs are required to open the file for each provider in their state, and (along with other steps) indicate that percent of their FTE that is spent caring for Medicaid/ SFS patients. This process is called "validating" the provider data.

When BHW initially populated SDMS' provider data files, it put a default of zero in the field for Medicaid/ SFS FTE. As a result, if a provider file currently has a zero in the FTE field, it could be either a "true zero" – meaning the PCO has verified that the provider does not care for any Medicaid/ SFS patients – or a "default zero" – meaning that the PCO never verified the actual FTE level, and simply left the default number in place.

A failure to distinguish between "true zeroes" and "default zeroes" can lead to bias in auto-HPSA scores. This is because the more zeroes in a facility's service area, the higher the facility's auto-HPSA score. (E.g., if <u>all</u> the providers in a facility's service area have a zero FTE, the facility would likely receive the maximum 15 points.) Therefore, ***facilities with a large number of "default zeroes" in their service area receive artificially high scores, which disadvantages other facilities whose provider data has been more thoroughly validated.***

Unfortunately, the BHW system is unable to distinguish between true zeroes and default zeroes. As a result, health centers who PCOs have validated all their provider data are concerned that they will be disadvantaged, relative to those whose PCOs have not updated their data.

NACHC's auto-HPSA workgroup is meeting with Dr. Padilla on Friday afternoon (immediately prior to the Health Policy Committee meeting) to share these concerns and make requests regarding access to the data and the timing of when individual auto-HPSA scores will be released.

340B and Drug Pricing

CVS-Caremark reducing reimbursement for brand-name drugs dispensed by health centers' in-house, closed-door pharmacies – potentially to rates below health centers' costs

**** Please note that this is an evolving issue, and there may be significant updates by the time of the committee meeting. **** In late July 2018, health centers in at least seven states who operate in-house, closed-door pharmacies (meaning pharmacies owned by a health center that serve only health center patients) received letters from CVS-Caremark, the Pharmacy Benefits Manager (PBM) that cover approximately one-third of outpatient prescriptions dispensed nationally. These letters stated that effective September 1, CVS-Caremark will dramatically reduce its reimbursement for brand-name drugs (except those covered under Medicare Part D) to Average Wholesale Price (AWP) <u>minus</u> 30%, with a 50-cent dispensing fee. Health centers are required to either accept these lower rates, or withdraw from all CVS-Caremark plans.

Due to the complexity of drug pricing, there is no standard way to compare these new reimbursement rates to health centers' actual costs; such comparisons must be done on a case-by-case basis. However, health centers report that these lower rates significantly reduce their ability to retain 340B savings, and can result in reimbursement that is less than actual costs.

NACHC staff are working with PCAs and legal counsel to determine how best to respond to this development. Also, there will be a meeting of the 340B/ Pharmacy Access Workgroup at 4:45 – 5:45 Sunday August 26 (immediately after the Opening Session) in room ???, to discuss this and related issues. Members of the Health Policy Committee are welcome to attend.

Secretary Azar states intentions to reduce 340B savings for drugs covered under Medicare and Medicaid drugs, but does not specifically name health centers

At the Summer 2018 340B Coalition conference (which was attended by roughly 360 health center representatives), HHS Secretary Alex Azar stated that there should be less of a difference between the price a 340B provider pays for a drug, and the amount that Medicaid or Medicare reimburses them for it. Last winter, HHS largely eliminated hospitals' ability to retain 340B savings for many drugs covered by Medicare, and last month HHS proposed expanding this policy to cover almost all Medicare drugs dispensed by 340B hospitals. To date, HHS has yet to take any actions to reduce health centers' ability to retain 340B savings for drugs covered under either Medicare or Medicaid managed care. (All provider types – including health centers -- lost the ability to earn 340B savings on Medicaid fee-for-service drugs in July 2017). Also, while Secretary Azar has expressed explicit concerns about some hospitals' participation in 340B, and stated his intention to reduce their ability to retain 340B savings, he has made no public statements about health centers and 340B.

NACHC submits comments on HHS Blueprint to Lower Drug Prices, stressing key points about 340B program

In July 2018, NACHC submitted comments in response to the HHS Blueprint to Lower Drug Prices. Our comments focused on the 340B program, and included the following:

- Contrary to some claims, 340B helps to reduce drug prices nationally by creating a financial disincentive for manufacturers to raise prices faster than inflation.
- Estimates of "savings" attributed to 340B are overstated.
- Any changes to which prescriptions are eligible for 340B should take into account the unique roles and requirements that apply to health centers.
- Contract pharmacies are critical to Health Centers' ability to provide their patients with affordable medications at accessible locations and times.

Numerous PCAs and Health Centers submitted their own comments echoing NACHC's.

For the fifth time, HRSA delays effective date of regulation on penny pricing and manufacturer penalties

The Administration has again delayed the effective date of a regulation that would formalize "penny pricing" and authorize HRSA to impose fines on manufacturers who knowingly overcharge for 340B drug; the most recent delay will last until July 2019. HRSA also continues to delay the release of its ceiling database, which would enable health centers to ensure that they are not being overcharged. HRSA further suggests that they plan to issue a revised version of this regulation, rather than allowing the Obama-era version to go into effect.

Immigration and Public Charge

Administration seeking to dramatically expand the definition of "public charge", making it harder for legal immigrants to become Lawful Permanent Residents (LPRs) if they or family members use any means-tested public benefit

The Trump Administration is drafting a proposed regulation that, if finalized as predicted, would mean that legal immigrants' ability to become a Lawful Permanent Resident (LPR) would be negatively impacted if they -- or a dependent family member -- receives a publicly-funded benefit, such as (but not limited to) Medicaid, CHIP, SNAP, WIC, TANF, the Earned Income Tax Credit (EITC), or subsidized health insurance through the ACA.

While the Administration has yet to officially publish a proposed rule, two working drafts have been ***leaked*** to the press. Under the most recent leaked version:

- Simply receiving, or being likely to receive, any means-tested government assistance could negatively impact an immigrant's ability to get a Green Card.
- State, local, and tribal benefits will be considered in Green Card decisions (not just Federal benefits).
- The definition of "dependents" is significantly expanded to include anyone who resides in the same house and in any way depends on the immigrant for financial support. Thus, if any of these individuals receives any means-tested public benefit, it could negatively impact the immigrant's ability to get a Green Card.

While the proposed rule is still being reviewed by OMB, health care providers across the country are very concerned about the "chilling effect" of these and related proposals on immigrants' willingness to seek health care and other public benefits to which they are entitled.

The regulation was sent to OMB for final review in late March, and is still there. In late June, staff from NACHC, CA PCA, and AAPCHO met with officials from OMB and the Department of Homeland Security to express our concerns about the proposal. We also provided a list of four detailed analyses that the Administration is legally obligated to prepare and publish at the same as the proposed rule (e.g., impacts on state and local government, small businesses, and child safety.)

As the proposed rule could be published any day, NACHC also continues to collaborate with CA PCA and AAPCHO to prepare PCAs and health centers to respond when it is published.

NACHC collaborating with CA PCA and AAPCHO to respond public charge proposals; working to educate health centers and raise concerns with OMB

To coordinate our responses to the anticipated public charge proposal, NACHC has collaborated with the California PCA and AAPCHO to form a National Health Center Immigration Workgroup. The Workgroup -- which is open to all interested health center, PCA, HCCN, and Cooperative Agreement staff -- aims to share information and resources about this topic, and to align the health center message.

To date, the Workgroup's actions have focused on two activities:

- Meeting with OMB to highlight economic impact, and analyses the Administration is required to conduct: In late June, staff from NACHC, CA PCA, and AAPCHO met with officials from OMB and the Department of Homeland Security to express our concerns about how the leaked proposal would impact patients. In addition, CPCA and AAPCHO presented data on the anticipated economic impact, and NACHC presented a list of four detailed analyses that the Administration is legally obligated to prepare and publish at the same as the proposed rule (e.g., impacts on state and local government, small businesses, and child safety.)
- Webinars to educate health center community about the proposal: To date, the Workgroup has held three webinars for interested members of the health center community. The goals have been to educate participants about the proposal, provide them with resources, answer questions, and help them prepare to respond when the proposed rule is published.

Once the proposed rule is published, the Workgroup plans to prepare draft comments that health centers, etc., can use to prepare their own comments.

Women's Reproductive Health

Hyde Amendment prohibits use of Federal grants funds for employee health benefits that cover abortion services

Feldesman-Tucker has informed NACHC that the Hyde Amendment prohibits health centers from using Section 330 grant funds from paying for Employee Health Benefits if those benefits include coverage for abortion services. When submitting their Standard Form 424A to HRSA, health centers should ensure that the Fringe Benefit line in Section B does not allocate any 330 funds for employee health benefits that include coverage for abortion services.

Administration proposes major changes to program requirements for Title X providers

In late May 2018, the Trump Administration released a draft regulation proposing to significantly revise the program requirements that apply to Title X grantees and their subrecipients. If finalized as drafted, this regulation would make several significant changes to the Title X program, including:

- Requiring strict physical, financial, and other separations (e.g., phone numbers, websites) between Title X activities and any abortion-related operations operated by a Title X grantee or subrecipient.
- Prohibiting Title X-funded family planning programs from referring their patients for abortions (except in the case of rape or incest);
- Requiring that all pregnant patients be given referrals for prenatal care and social services, and be provided assistance with setting up an appointment for prenatal care.

- Requiring all funding recipients to either provide comprehensive primary health services onsite or have a robust referral linkage with primary health providers who are in physical proximity.
- With regards to patients who are minors, requiring all funding recipients to:
  - Seek to ascertain the age of patients and their sexual partner(s), and to report any issues to the authorities, and
  - Encourage "family participation" in decisions about family planning.

NACHC responds to proposed Title X rule by educating PCAs and submitting comments
In response to the proposed rule on Title X, NACHC held a webinar to educate PCAs about its contents. We also submitted official comments expressing concern that the proposed rule could:

- interfere with the patient-provider relationship by limiting a provider's ability to give their patients comprehensive information according to evidence-based clinical guidelines;
- discourage non-Title X providers from collaborating with Title X recipients; and
- create special challenges for patients with low literacy.

For these reasons, NACHC urged HHS to withdraw the proposed rule and reconsider its course of action. Numerous PCAs and Health Centers submitted their own comments echoing NACHC's. In total, HHS received almost 200,000 comments on the proposed changes.

FCC & Telehealth

FCC Chair reverses planned cuts in subsidies to help rural providers pay for broadband access

In March 2018, the Federal Communications Commission (FCC) announced significant reductions in its subsidies to help rural providers pay for broadband access. These reductions – which ranged from 15% to 25% -- were announced 8 months into the 12-month funding year. For many health centers in highly rural and frontier areas -- especially Alaska – this is a significant financial hit, and noticeably larger than what was expected.

In response, NACHC collaborated with the Schools, Health, and Libraries Broadband Coalition to encourage the FCC to roll back these reductions. NACHC staff met with staff for all five FCC Commissioners, and formally requested in writing that the reductions be eliminated. Multiple PCAs and health centers also wrote the FCC requesting that the reductions be eliminated, using templates based on NACHC's comments. In June, the FCC reversed its position, voting to significantly increase funding for these subsidies, both for the current and future years. On June 6, the FCC Chairman signaled that he intends to significantly increase funding for these subsidies, including rescinding the cuts for the current year. While this change has not yet been finalized, this is a very positive sign.

The FCC creates $100 million program to expand telehealth to low-income populations, actively seeks health center participation*

In early August 2018, the FCC is announced the creation of a new "Connected Care Pilot Program" aimed at supporting telehealth for low-income Americans, especially those living in rural areas and veterans. The program will support a limited number of pilot projects over a two- or three-year period, and is expected to cover the cost of connectivity and perhaps some hardware and patient devices. As a first step, the FCC has issued a Notice of Inquiry (similar to a Request for Information), asking for input on program design. FCC staff have reached out directly to NACHC to indicate that they welcome health centers' input and participation in the pilot program. NACHC has submitted a general letter of support for the program, and has scheduled a call for 2:00 ET on Thursday September 6 to seek input from health centers on PCAs on how to respond to the Inquiry.

NACHC Hosts Telehealth Webinar, Issues New Telehealth Fact Sheet

In April 2018, NACHC hosted a telehealth webinar, highlighting the innovative practices of health centers in this space. Attendees heard from Mary Zelazny, CEO, of the Finger Lakes Health Centers in New York, who is using telehealth technology to provide services such as tele-psychiatry, tele-dentistry for pediatrics, tele-mental health and tele-nutrition services. Through the use of this technology they have been able to provide more comprehensive services to their patients. Attendees also heard from Kim Schwartz, CEO of Roanoke Chowan Community Health Center, Ahoskie, NC, who presented on the Remote Patient Monitoring program. Through this program, the health center has been able to reduce hospitalizations and emergency room visits among their patient population.

NACHC also released a fact sheet on telehealth, highlighting the opportunities and barriers for health centers in this space and also published a blog providing an overview of the webinar opportunity and new fact sheet. NACHC staff will continue to monitor developments on telehealth policy at both the federal and state level and will provide the latest updates to PCAs and health centers.