NATIONAL ASSOCIATION OF Community Health Centers

MEMO

To: NACHC Leadership, Board of Directors, Committees, Members, Advocates and Partners
From: NACHC Policy Staff
Date: December 5, 2016

Re: The 2016 election, the outlook for legislative action in 2017 and the implications for Community Health Centers

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Introduction

The election of Donald J. Trump as President, combined with the reduced but still substantial majorities held by Republicans in both the House and Senate, carries major implications for health care policy as a whole, and for community health centers specifically (See **Attachment A** for key election outcomes.) In addition to the challenges we have been anticipating and extensively planning for (primarily the next "funding cliff" in the fall of 2017), the election means that many more large policy questions will now be a part of the discussion. Action is expected quickly, though as with all things in health policy, major changes quickly become complicated and divisive.

We must remember two things, even as these results bring new uncertainty to the road ahead for health centers. First, we are better positioned to succeed in this new environment than virtually any other federal health program or provider type – with a track record of bipartisan support, a wealth of data and evidence demonstrating our effectiveness, and a local connection to nearly every Member of Congress. Second, success in the debates to come will require every leader, staff member, clinician, board member, patient, partner and advocate in the Health Center movement to be engaged, active, flexible and dedicated to our advocacy agenda.

This memo lays out the specific legislative items we expect to be "on the table" in the new year, and to which NACHC will be devoting significant resources, time and energy. Following the legislative section are a roundup of top-line election results as well as our current intelligence regarding key committee chairs in the new Congress and other key members of the transition team.

Primary Care Funding Cliff 2.0

Since 2010, a portion of all funding for the Community Health Centers (CHCs) program, as well as all funding for the National Health Service Corps (NHSC) and the Teaching Health Centers Graduate Medical Education (THCGME) Program, has come via so-called "mandatory" appropriations. These funds, originally authorized for five years in the Affordable Care Act, were originally set to expire in 2015, when Congress extended them for an additional two years as part of the bipartisan Medicare and CHIP Reauthorization Act (MACRA) of 2015. That two-year extension is set to expire at the end of the current Federal Fiscal Year – September 30th of 2017. These mandatory funds make up approximately 70% of all

funding for the Health Centers program. Congressional action is required to extend this funding further into the future.

NACHC has an extensive legislative and advocacy strategy in place to address this next "primary care cliff," which would still have been necessary (and still a major challenge, given the cost – roughly $4 billion annually) under a Democratic administration. While achieving a cliff fix will be difficult, we still believe there are several structural advantages over our effort in 2015. First, Members on both sides of the aisle have now voted in favor of CHC mandatory funding. Second, funding streams and key policies affecting a number of other high-profile and bipartisan programs, notably the Children's Health Insurance Program (CHIP), also expire at the same time. NACHC recently joined more than 20 national groups in a letter to Congress urging swift action on these items.

While there has been much discussion of repeal of the Affordable Care Act, a complete repeal is unlikely in 2017 (more on this below). The funding for CHCs, the NHSC, and THCGME would not automatically be eliminated under the most likely scenario for partial repeal of the ACA – passage of a "budget reconciliation" bill through House and Senate. Still, the funding cliff facing these programs must be addressed, coupled with protecting Medicaid, and doing both will be NACHC's top priority in the new Congress.

Affordable Care Act

President-elect Trump and the House and Senate majorities ran on a platform of repealing—and replacing—the Affordable Care Act (ACA). Based on public statements since the election, it is likely that Congress will move quickly with action on repeal. The desire for speed means that they are likely to utilize the Budget Reconciliation process to pass a bill, which allows passage of certain legislation with only 51 votes in the Senate, versus the 60 votes required on most legislation to overcome a filibuster. This process – which was used to pass parts of the ACA itself – includes limits on the kinds of provisions that can be passed or repealed under that 51-vote threshold.

This is why only certain provisions of the ACA can be repealed using this mechanism. In early 2016, Republican majorities in both House and Senate passed H.R. 3762, budget reconciliation legislation that would have repealed major parts of the ACA. As expected, this legislation was vetoed by President Obama, but it is expected to form the blueprint of any partial-repeal legislation once the new President is sworn in.

That legislation includes several major components:

1) A complete repeal of the ACA's Medicaid expansion
2) Repeal of the ACA's cost-sharing and premium subsidies for marketplace plans
3) Repeal of the ACA's individual and employer mandates
4) Repeal of a number of the tax provisions (on medical devices, high-value health plans, Medicare, etc) that formed the financing basis of the ACA.

In many ways, this legislation would form an "effective" repeal of the ACA, but wouldn't repeal every provision of the law. In addition to the mechanism allowing for mandatory funding for Health Centers, ACA provisions that created the new FQHC Medicare PPS, ACA changes to 340B, and other ACA-passed items are not currently being considered as part of the Budget Reconciliation plan.

Some 22 million people have gained coverage through the ACA – 12 million through the Medicaid expansion and another 10 million through the Marketplaces. One current unknown is whether the Republican majorities in Congress will feel comfortable passing "repeal" legislation stand-alone, or whether there will be a political imperative that they then also demonstrate a viable plan to "replace" those core tenets of the law. In the days following the election, public statements by the President-elect and individual Members of Congress have only added additional uncertainty to this question. In recent weeks, consensus appears to be building around a strategy known as "repeal and delay" – in other words, passage of an effective repeal through budget reconciliation, but with a delay in the effective date for several years, in order to allow time for a replacement plan to take shape.

Earlier this year, House Republicans released their health care plan, entitled "A Better Way," and indications are that that plan will form the basis of their "replace" agenda. Because the plan is a white paper, not a piece of legislation, many details are yet to be fleshed out. Still, the plan does call for changes to how Medicaid is financed (more below), changes to how insurance is regulated, and a form of tax credits that would assist certain individuals in purchasing coverage. Squaring these proposals with some of the more popular ACA provisions (e.g. the ban on discrimination based on pre-existing conditions) remains a major challenge.

Obviously there are many, many unknowns still to be seen in terms of the future of the ACA. Yet it is widely expected that passage of the "repeal" reconciliation legislation will be one of the first items enacted by a new Congress, given the work that's already been done and the need to demonstrate quick action on a long-time campaign promise.

Medicaid

Medicaid changes are high on the list of stated health care priorities for the House, Senate, and President-elect. Three major areas under consideration will be: the elimination of the Medicaid expansions authorized and incentivized under the Affordable Care Act, significant structural reforms to the way Medicaid is financed by the federal government, and additional flexibility for State governments when it comes to the design of individual State Medicaid programs.

A complete rollback of the ACA's Medicaid expansion was included in the budget reconciliation legislation passed in early 2016. This legislation, as already noted, is subject only to a 51-vote majority threshold for Senate passage and, while vetoed earlier this year by President Obama, is widely seen as a roadmap for action in the new Congress once President-elect Trump takes office. There are several challenges to overcome in implementing such a proposal, given that Medicaid expansion has been taken up by 31 states and used to cover roughly 12 million Americans. Several expansion states are headed by Republican Governors who may be concerned about the impact this would have on their budgets and their citizens. It is not yet known whether a plan to repeal Medicaid expansions would include a transition time to figure out alternative options for those who gained Medicaid coverage under the expansion, though that is being discussed as a possibility.

Details on what larger structural changes to Medicaid might be considered next year are slim, but one major indicator is the House Republican vision for healthcare policy, "A Better Way." One of the major components of the proposal is a plan to limit federal Medicaid funding and increase state flexibility by offering states an option to finance their programs through either a per capita cap or a block grant. Either approach would fundamentally change Medicaid from an entitlement program to one in which

states would receive a set amount of financing from the federal government to support their programs while retaining wide discretion to use those dollars to cover categories of people and types of benefits as they see fit. During the campaign, then-candidate Trump repeatedly expressed support for a block grant approach. Earlier this year, as part of the Partnership for Medicaid, NACHC expressed concern that this kind of shift could exacerbate the existing strain on Medicaid, shifting more of the program's costs onto state and local governments, providers, and patients. Cuts to provider and plan payments, elimination of benefits, changes to eligibility and reduced access to care are serious threats under this type of proposal.

Regardless of whether Congress enacts a change to the financing structure of Medicaid, it is now far more likely that Congress will also pursue changes to the law to give states additional flexibility in program implementation. This could include changes to—or elimination of—currently required benefits, changes to cost-sharing for beneficiaries, and significant changes to provider payments, all without the need for federal approval from CMS. Even without underlying legislative change, it is widely expected that States will find CMS far more receptive to requests to waive certain requirements under Medicaid. Under these kinds of changes, the statutorily protected FQHC Medicaid PPS would be at significant risk, and NACHC has already begun discussion of a range of different scenarios to preserve that protection.

340B

While the fate of the pending HRSA Mega-Guidance is uncertain given the change in administration, Congress is now more likely to legislate on the 340B program than had the election resulted in divided government. We expect legislation to be introduced, with the support of the manufacturer community (PhRMA, BIO) giving HRSA authority to regulate the program, and calling for significant additional restrictions on *hospital* use of 340B. Additional transparency and accountability measures may also be applied to all covered entities. NACHC will be evaluating all proposals, and we expect to play an active role in any negotiations over the program.

While there is certainly a strong desire among the manufacturers and some on the Hill to make changes to 340B, the issue does not break down evenly along party lines – positions on the program often depend on the presence or absence of large safety net hospitals in a particular state or district. Additionally, unless 340B changes can be shown to generate significant savings to the federal taxpayer, there may be little appetite/incentive to add 340B legislation to an already crowded health care agenda.

Advocacy

Given the multitude of the challenges ahead, the best and most effective requirement for success is our grassroots advocacy. With that in mind, there is no time to waste. We have to strengthen and expand our advocacy to include EVERY part of the health center community. Every single health center employee and board member and as many patients and community allies as possible will be needed as never before. We will need Health Center Key Contacts, increased Advocacy Capacity Building via the ACE (Advocacy Centers of Excellence) Program, and the data and stories to effectively tell the Health Center story in both human and factual terms. Advocacy action items and priorities for the remainder of 2016 and early 2017 are included in **Attachment B**.

ATTACHMENT A – Key Federal and State Election Outcomes, Congressional Leadership and Committee Posts and President-Elect Trump's Transition Team and Key Cabinet Picks

Presidency

Electoral College

- Donald Trump (R)- **306**
- Hillary Clinton (D)- 232

Popular Vote

- Hillary Clinton (D) - **48.2%**
- Donald Trump (R) - 46.2%

Congress

Senate

- Democrats- 48 (+2)
- Republicans- 52 (-2) *note: Louisiana has runoff election in December, Republican candidate is favored*
- New Senators- 6 (5 D, 1 R)
    - Kamala Harris (D-CA), Tammy Duckworth (D-IL), Todd Young (R-IN), Chris Van Hollen (D-MD), Maggie Hassan (D-NH), Catherine Cortez Masto (D-NV)
    - 2 seats flipped from R to D - Duckworth (IL) and Hassan (NH)

House

- Democrats- 194 (+6)
- Republicans- 238 (-6)
- New members - 53 (27 R, 26 D)
- 13 seats flipped
    - 9 R to D
    - 3 D to R (doesn't include Puerto Rico flips from D to R)

Governorships and State Legislatures

State Governors

- 12 seats up for reelection
    - R to D - likely NC
    - D to R - MO, NH, VT
- Democrats- 16 (includes NC)
- Republicans- 33
- Independents- 1
- Territories – 2 D, 2R, 1I

State Legislatures

- Of 99 State Legislative chambers – 68 R, 30 D, 1 Tied
- Control of both Chambers: 32 R, 13 D, 3 Split
- 3 Chambers switched D to R; 4 Chambers switched R to D

Key Leadership and Committee Posts in the 115th Congress

Congressional Leadership

	Republican (Majority)	Democratic (Minority)
Senate	Majority Leader: McConnell (KY) Majority Whip: Cornyn (TX)	Minority Leader: Schumer (NY) Minority Whip: Durbin (IL) Assistant Dem Leader: Murray (WA)
House	Speaker: Ryan (WI) Majority Leader: McCarthy (CA) Majority Whip: Scalise (LA) Conference Chair: McMorris Rodgers (WA)	Minority Leader: Pelosi (CA) Minority Whip: Hoyer (MD) Caucus Chair: Clyburn (SC)

Committee Chairs

- **Senate Health Education Labor and Pensions**- Sen. Lamar Alexander (R-TN) will stay as Chair, and Patty Murray (D-WA) will keep the Ranking Member slot.

- **Senate Finance**- Sen. Orrin Hatch (R-UT) stays as Chair, Sen. Ron Wyden (D-OR) stays as Ranking Member

- **Senate Appropriations** – Sen. Thad Cochran (R-MS) likely to continue as Chair, Sen. Pat Leahy (D-VT) will take over as Ranking Member of Full Committee. Labor-HHS Subcommittee will remain chaired by Sen. Roy Blunt (R-MO) with Senator Murray (D-WA) staying on as Ranking Member.

- **House Energy and Commerce –** Rep. Greg Walden (R-OR) won a hotly contested race for Chair. Congressman Frank Pallone (D-NJ) as ranking member of the full Committee. The Health Subcommittee will have a new chairman because Rep. Joe Pitts (R-PA) is retiring. Rep. Brett Guthrie (R-KY) is the vice chairman of the subcommittee and one likely replacement as Chair of Health, though Representative Michael Burgess (R-TX) and Representative Tim Murphy (R-PA) have also been mentioned. Rep. Gene Green (D-TX) is likely to continue as Ranking Member on the Health Subcommittee, though may face a challenge.

- **House Appropriations:** Rep. Rodney Freylinghuysen (R-NJ) will ascend to full committee chair, with Rep. Nita Lowey (D-NY) likely to stay on as Ranking Member. The Labor-HHS Subcommittee is likely to remain chaired by Rep. Tom Cole (R-OK) with Rep. Rosa DeLauro (D-CT) staying on as Ranking Member.

- **House Ways and Means**- Kevin Brady (R-TX) expected to remain chairman of full committee, Rep. Pat Tiberi (R-OH) expected to remain chairman of health subcommittee. Democrats have named Rep. Richard Neal (D-MA) as the new full committee ranking member. Rep. Lloyd Doggett (D-TX) expected to take over as ranking member on health subcommittee.

Trump Transition Team and Possible Cabinet Picks

Department of Health and Human Services

- **Congressman Tom Price** (R-GA), current Chair of the House Budget Committee has been nominated as the HHS Secretary. Congressman Price, an orthopedic surgeon, has a long track record working on health policy, and introduced a full ACA replacement bill in the current Congress.

- **Seema Verma**, a health care consultant from Indiana who is the architect of the Indiana Medicaid expansion program has been nominated as the CMS Administrator.

Transition Team

- Vice President-elect **Mike Pence** has been tapped to lead the transition team, and the Trump campaign has named **Rick Dearborn**, Chief of Staff to Senator Jeff Sessions (R-AL) as Executive Director. The transition has an executive committee comprised of several sitting Members of Congress, the President-elect's children Ivanka Trump, Donald Trump Jr. and Eric Trump, and additional supporters and campaign advisors.

- Several names have been mentioned as the key players on the health care transition team:

    - **Paula Stannard,** a lawyer at Alston & Bird who was deputy general counsel and acting general counsel of HHS, has been tasked with health care reform.

    - **Andrew Bremberg,** who worked at HHS under President George W. Bush and more recently has been an adviser to Senate Majority Leader Mitch McConnell and Wisconsin Gov. Scott Walker's fleeting presidential bid, is leading the HHS agency review.

    - **Paul Winfree,** who is at the Heritage foundation and has written extensively on ACA repeal and critically about Medicaid

    - **Scott Gottlieb,** a former FDA and CMS official and prominent Republican health policy thinker at the American Enterprise Institute

    - **Eric Hargan,** a health care lawyer with Greenberg Traurig who served as HHS chief operating officer under President George W. Bush

    - **Nina Owcharenko,** head of the Heritage Foundation's Center for Health Policy Studies. Owcharenko co-authored recommendations encouraging GOP to immediately repeal Obamacare through reconciliation and work toward a replacement that could be implemented in 2018.

ATTACHMENT B – Grassroots Advocacy and Member Outreach Schedule and Priority Actions

Below are several actions and communications to look out for in the next month, as well as key action steps every health center advocate can take now to begin advocacy work for the year. Please keep a close eye on NACHC's weekly Washington Update for more information.

- **Message to the Field - 12/5** Communication from NACHC CEO Tom Van Coverden to advocates about NACHC strategy and urgent advocacy actions they can and should be taking for the remainder of 2016 to prepare for the challenges and opportunities ahead.

- **State Legislative Coordinator Call - 12/7:** Call with SLCs to apprise them of communications and outreach plan with Key Contacts and the field through the remainder of 2016. Will also discuss SLC meeting agenda and targeted Fly-In slated for January.

- **Key Contacts Call – 12/12:** National call with all current Health Center Key Contacts to discuss election outcome and outlook – as best known – their role in strategic advocacy for the remainder of 2016 and the year ahead.

- **National Policy & Advocacy Webinar – 12/14, 3:30 PM:** Deep-dive webinar with advocates to update on election results by the numbers, likely committee and leadership assignments, refresher education on the Primary Care Funding Cliff and Medicaid, advocacy marching orders and action steps. First in a monthly series.

- **Advocacy Year Ender Communication- 12/19:** Review of all that was accomplished and outcomes of 2016 as well as general forecast for needed advocacy work in 2017 announcing monthly Policy/Advocacy Webinars.

- **Target Call with SLCs and Key Contacts: 1/2** Prep call with Health Center Key Contacts and corresponding SLCs with priority Republican MOCs in advance of the Fly-In to discuss their specific role, messaging, and priorities.

- **In Person SLC Meeting – 1/9:** In person convening of SLCs (State Legislative Coordinators) in DC to walk through policy and advocacy strategy for 2017, discuss tactics, resources and workplan, and allow peer to peer discussion around state based policy/advocacy strategy and best practices.

- **Targeted Fly In – 1/10 & 1/11:** Convening of select Health Center Key Contacts to arrange meetings with target Members of Congress across key committees, leadership and champions to begin driving the Health Center Policy Agenda, action plan and to establish work track for 2017.

- **Follow up Policy/Advocacy Webinar Briefings: 1/18, 2/22, 3/21, all at 3:30 PM EST**

- **NACHC Policy and Issues Forum – March 29 - April 1, 2017.**

Immediate Action Steps for Capacity Building, Foundational Advocacy Education and Assessment:

1. **Schedule In-Person Meetings At Home with Members of Congress:** Whether it is a brand new or veteran Member of Congress, scheduling in person meetings at home much in advance of their arrival in DC in January must be an absolute priority. These meetings will provide opportunity to establish foundational knowledge of Health Centers (particularly for new MOCs), layout what sets Health Centers apart from other providers, and discuss what is at stake in the year ahead in the context of both the Primary Care Funding Cliff and Medicaid. These conversations should also convey in clear terms advocate expectations of the actions they are asking their MOCs to take upon arriving in DC in January.

2. **Complete a Health Center Data Analysis:** Part of being able to tell the Health Center story must include data – what are the implications of the funding cliff on Health Center operations, patients, services and the community at large? Relative to Medicaid – how many patients are being served in each FPL bracket under Medicaid? How much of Health Center revenue derives from Medicaid? What is the financial impact of Medicaid cuts/changes to the Health Center in the context of operations, services, patients etc? Gathering and analyzing Health Center level data now so that advocates can effectively tell their story through both a human and figure based lens.

3. **Prioritize and Begin Building Advocacy Capacity:** Whether it be at the federal, state or local level, without question ALL will demand organized, effective and consistent advocacy response to ensure continued support, resources and protection for Health Centers and their patients. The first step must be to establish advocacy infrastructure at the Health Center (and PCA) by engaging and educating board, staff, patients and partners about what is at stake and their role in advocating to support, protect and preserve the Health Center. Building advocacy capacity will be best accomplished at the Health Center and PCA level through the ACE (Advocacy Centers of Excellence) Program which lays out a simple framework to build advocacy infrastructure, create a culture of advocacy, and establish protocols and benchmarks for engagement and effective response.