NAMD
National Association of Medicaid Directors

February 24, 2014

Secretary Kathleen Sebelius
U.S. Department of Health and Human Services
Hubert H Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius:

We write today on behalf of the National Association of Medicaid Directors (NAMD) to advance proposals that we believe are necessary to improve the relationship between and ensure the long-term sustainability of the Medicaid and the federally qualified health center (FQHC) and rural health clinic (RHC) programs. NAMD and our members have had constructive discussions with our partners at the Centers for Medicaid and CHIP Services as well as with the Health Resources and Services Agency (HRSA) and state and national-level representatives for FQHCs/RHCs. Still, we believe that the cross-cutting nature of these issues requires engagement at the highest levels within the Department of Health and Human Services (HHS).

Over the last decade, multiple Congresses and Administrations have rightly placed a high priority on building the infrastructure for and further investing in existing FQHCs/RHCs. In addition, the Affordable Care Act established a dedicated $11 billion Trust Fund to continue to grow the health center program. As a result, your Department has made important funding opportunities available to FQHCs/RHCs across the country so that they may improve access to quality, effective primary care services.

In many ways these opportunities align with the fundamental responsibility of state Medicaid programs to provide clients with appropriate access to services. States are incorporating expanded FQHC/RHC organizational capacity in their broader strategic plans for meeting the diverse needs of a growing Medicaid population. In fact, states and the FQHCs/RHCs project that many of the newly enrolled Medicaid clients will be previously uninsured clinic patients. Preserving this link is a critically important goal of Medicaid Directors.

Equally important is the duty of states to ensure the efficiency and quality of services for

Medicaid enrollees. Similar to modernization efforts underway with other Medicaid providers, states have offered unqualified support for the efforts to transform the clinical practice models at FQHCs/RHCs throughout the country, including adoption of patient-centered medical home designations and electronic health records, among other initiatives. States have embraced FQHCs/RHCs' enhanced role in meeting the physical, behavioral and supportive health care needs for the millions of low-income individuals and families we expect to newly enroll in Medicaid as well as our current clients.

As you know, the FQHCs/RHCs' quality and effectiveness improvements are occurring alongside state initiatives to modernize their health care systems, including aligning the delivery and payment mechanisms in Medicaid. One key resource facilitating these efforts is the Department's State Innovation Model (SIM) program administered by HHS' Center for Medicare and Medicaid Innovation. Both SIM and non-SIM grantee states are actively exploring and testing payment and delivery system models that will advance greater alignment across multiple payers on contracting and payment strategies that promote value over volume, greater consistency in quality, cost and patient experience, and expanded primary care. These payment models may also give a competitive advantage to groups offering better outcomes to Medicaid and its beneficiaries.

In the context of ongoing state innovation and learning, it is an appropriate time to determine whether the rules and operations of the FQHC/RHC program comport with our shared goals and ongoing management and oversight responsibilities in Medicaid. States have long-standing partnerships with FQHCs/RHCs and are using the currently available tools to include clinics in Medicaid's comprehensive delivery reforms and value-based purchasing initiatives. However, the historical rules in combination with regulatory conflicts between the two programs can limit what Medicaid can do today. Further, existing regulatory and administrative disconnects could impede states and FQHCs/RHCs as they try to keep pace with the necessary transformations that are taking place across private and other public payers for all other provider types and settings.

We believe the Administration can facilitate additional value in the Medicaid program and maximize the positive impact FQHCs/RHCs can have for low-income individuals and families. To do so, we encourage the Department to examine the statutory, regulatory and on-the-ground relationship between Medicaid and the FQHC/RHC programs and the evolution of coverage, delivery systems and payment mechanisms that is already underway.

The enclosed paper identifies and provides context for overarching policy and operational issues that impact Medicaid and the FQHC/RHC programs. These issues can present challenges for the next phase of state delivery system and payment improvement initiatives as well as ongoing management and oversight. We are also providing our

recommendations for concrete action steps that will begin to mitigate the barriers some states face in seeking to include FQHCs/RHC in system-wide modernizations now and in the future. Three overarching themes run throughout our paper:

- The FQHC/RHC's unique payment methodology does not always promote efficiency and value and increasingly impedes some states' evolving delivery system and payment transformations.
- States are frequently stymied by the lack of or inconsistent federal policy and regulations that seemingly operate independently for Medicaid and FQHCs/RHCs.
- Additional collaboration is needed between the multiple federal agencies with authority for the Medicaid and FQHC/RHC programs as well as between those federal agencies and the state Medicaid and public health agencies that administer and interface with the programs.

We look forward to working together in a meaningful way with our federal partners and, as appropriate, with other key stakeholders to improve the value and quality of Medicaid services for consumers and taxpayers.

Sincerely,

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TennCare Director
Department of Finance and Administration
State of Tennessee
President, NAMD

Thomas J. Betlach
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Containment System Director
State of Arizona
Vice-President, NAMD

Enclosure:
Medicaid and the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Programs: Alignment and Modernization Opportunities

Cc:
House Energy and Commerce Committee Chair and Ranking Member
House Oversight and Government Reform Committee Chair and Ranking Member
Senate Health, Education, Labor and Pensions Committee Chair and Ranking Member
Senate Finance Committee Chair and Ranking Member
Senate Homeland Security and Governmental Affairs Committee Chair and Ranking Member

NAMD Informational Brief

Medicaid and the Federally Qualified Health Center and Rural Health Clinic Programs: Alignment and Modernization Opportunities

INTRODUCTION

This brief provides background and context for issues intersecting the Medicaid and FQHC/RHC programs. NAMD's enclosed recommendations were developed by state Medicaid Directors. The requests to HHS are intended to improve alignment and coordination between Medicaid and the FQHC/RHC programs. In addition, this brief speaks to the need to ensure states are able to meet the full scope of their responsibilities for program management and oversight of the Medicaid program when these duties overlap with the FQHC/RHC programs.

NAMD GOALS

- *Clarify existing policies and facilitate new approaches to Medicaid reimbursement for FQHCs/RHCs.*
- *Improve consistency of quality measurement across programs operated by the Centers for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA).*
- *Establish streamlined vehicles to allow states to provide meaningful information that could help inform HRSA's existing selection process as well as a process whereby HRSA notifies Medicaid agencies of FQHC/RHC approvals.*
- *Insert meaningful, objective state-level information into the new access point (NAP), change in scope and affiliation review process.*
- *Establish a process whereby states can request and obtain HHS assistance to resolve inconsistencies between federal Medicaid and FQHC/RHC requirements and policy.*

BACKGROUND

I. Changes Impacting Federally Mandated Medicaid Reimbursement Programs

Over several decades federal and state policymakers have identified instances where it is appropriate to acknowledge the value and unique role of certain types of safety net providers. For example, the Medicaid statute requires states to make disproportionate share hospital (DSH) payments to financially disadvantaged hospitals treating large numbers of low-income patients. Similarly, policymakers have historically recognized the ongoing value of FQHCs/RHCs by funding expansions of the health center program and establishing a special payment methodology known as the prospective payment system (PPS) that provides enhanced revenue for serving Medicaid clients.

In a limited set of situations federal policymakers have also modified programs to reflect new realities of the marketplace and to advance the goals of delivering high quality, cost effective services in the most appropriate setting. For example, the Affordable Care Act (ACA) reduces the aggregate funding level for the DSH program to recognize that hospitals would see some increase in the number of insured patients whose costs would be covered beginning in 2014.[1]

In the case of FQHCs/RHCs, as health care coverage expands beginning in 2014, health centers in many states will begin to transition their uninsured patient population to Medicaid and health insurance exchanges.[2] However, states have limited guidance and tools should they wish to make appropriate corresponding modifications to the federally-mandated FQHC/RHC payment methodology to reflect projected changes in the status and type of insurance for patients served by the health centers.

II. The PPS Reimbursement Approach and State Medicaid Options

The PPS system emerged when Congress repealed FQHCs' right to cost-based

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[1] See discussion of "Medicaid Program; State Disproportionate Share Hospital Allotment Reductions," a rule by the Centers for Medicare & Medicaid Services, September 18, 2013, https://www.federalregister.gov/articles/2013/09/18/2013-22686/medicaid-program-state-disproportionate-share-hospital-allotment-reductions

[2] Center for Studying Health System Change, "A Long and Winding Road: Federally Qualified Health Centers, Community Variation and Prospects Under Reform," HSC Research Brief No. 21, November 2011 http://www.hschange.com/CONTENT/1257/

reimbursement in the 1997 Balanced Budget Act, and each FQHC/RHC's original PPS rate derived from its *then*-cost calculated rate. The Medicaid PPS specified in statute is determined separately for each individual FQHC/RHC, calculated on a per-visit basis.[3]

As a result, to this day PPS rates reflect the trended-forward cost of uncompensated care each FQHC/RHC provided to uninsured patients well over a decade ago. States may use an Alternative Payment Methodology (APM) agreed upon with the FQHC/RHC, but it must result in a payment to the FQHC/RHC that is *at least equal to* the amount to which it is entitled under the PPS.[4] This does allow states to design performance incentive payments *above* the PPS minimum benchmark. Several states are collaborating with FQHCs/RHCs on this incentive based approach, and have begun to see improvements towards shared goals.

However, in the case of health centers and clinics, the statute does *not* allow states to pay underperforming FQHCs/RHCs a rate *less than* the calculated PPS minimum and states possess a limited set of tools to address consistently underperforming FQHCs/RHCs. This is in contrast to the policies and processes states can employ with all other provider types and networks and health plans. It also conflicts with general statutory requirements for Medicaid payments to be consistent with efficiency, economy, and quality of care.

There has been insufficient policy guidance from the Department of Health and Human Services. This has and could further limit Medicaid's options and opportunities for driving value in the overall health care system.

III. FQHCs/RHCs and State Delivery System and Payment Improvements

The special Medicaid financing requirements for FQHCs/RHCs have implications for their role and participation in delivery system and payment transformations many states have underway with other Medicaid providers, as well as with other payers.[5] States are taking different paths to achieve their goals of improving value and outcomes. Some

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[3] SHO#10-004/CHIPRA#15, Center for Medicaid and State Operations, CMS, February 4, 2010: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO10004.pdf

[4] Ibid.

[5] "Payment and Delivery System Reform in Medicaid: Progress, Challenges, and Opportunities to Move Forward," February 5, 2013: http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/payment_and_delivery_system_reform_in_medicaid_-_progress_challenges_and_opportunities_to_move_forward.pdf

have articulated their goals and plans in their applications for the federal State Innovation Model (SIM) Initiative.[6] A common theme across their proposals is transformation that leads to integrated care delivery models, payment alignment among key health care payers, and value-based purchasing and unified quality outcomes. Outside of the SIM program, other states are pursuing similar objectives using analogous or targeted state approaches.

As an incentive for quality and efficient service delivery or as a disincentive for uncontrolled costs and ineffective care, states are examining a range of delivery system and payment models that will give a competitive advantage to groups offering better outcomes for all consumers, including Medicaid enrollees. These payments can be specific to provider or beneficiary, or based on benchmarks of performance generalized across a population. Paired with these initiatives is an increase in policy solutions that support accountability at every level in the outcomes for beneficiaries, rather than just the delivery of discrete services. Regardless of the state's timetable for delivery system transformation or the specific approach, states –like most public and private insurers including Medicare – are at least beginning to move away from predominance of fee-for-service (FFS) and most cost-based types of arrangements like the PPS and APM for FQHCs/RHCs.

Medicaid is a major component of these initiatives, with many states pursuing new or more sophisticated models to increase organizational coordination and financial alignment, including episodic payments, bundled payments, coordinated or managed care programs, and accountable care organizations (ACOs) to name a few. In some cases FQHCs/RHCs *do* participate in state-driven system transformations that are expected to lower the total cost of care. Some states are finding that certain FQHCs/RHCs are producing excellent outcomes and hold the promise for lowering total cost of care. Still, these are often limited to a subset of FQHCs/RHCs in a state and represent the first phase in the transformations that states may want to pursue.

The PPS rate-setting approach for health centers ultimately may not reflect states' delivery system and payment improvement initiatives in 2014 and beyond. Despite the engagement and innovation underway with other providers, Medicaid still reimburses health centers on a per visit basis that is ultimately based on each individual center's *historical* costs. Further, in some situations it remains difficult for states to drive efficiencies among individual FQHCs/RHCs. This may perpetuate an inequity between FQHCs/RHCs and other providers that could grow over time. Ultimately this inequity

[6] State Innovation Models Initiative: General Information, Centers for Medicare and Medicaid Innovation: http://innovation.cms.gov/initiatives/state-innovations/

could undermine the drive for overall system change.

NAMD has for some time been engaged with our federal partners at CMS to explore potential options for states to work through the issues we believe dampen our collective success. Based on this work, we believe the statutory language governing the FQHC/RHC and Medicaid programs establishes a static relationship between the two programs and does not allow states to employ the full panoply of payment methodologies for FQHCs/RHCs that can evolve over time. While states appreciate that they can pursue an alternative payment methodology, unfortunately the floor for such payments remains a PPS calculated based on the per-visit baseline payment rate equal to 100 percent of a center's average costs per visit dating back to 1999 and 2000.

These federal legislative limitations in combination with other administrative challenges can limit how state Medicaid agencies may incorporate FQHCs/RHCs in their broader state delivery system and payment improvements. There are other payment strategies that states use with other provider types that maintain the principles of assuring efficiency, quality, and flexibility, all the while maintaining the principle of actuarial soundness. Federal policy changes and guidance should be advanced to make clear states can similarly employ these strategies with FQHCs/RHCs.

IV. Evolving Needs and Definitions with Respect to "Access"

In states that have already or expect to substantially lower their uninsured populations, location is no longer a sufficient measure of whether FQHCs/RHC are providing new or expanded access to services and providers. Instead, the definition of access with respect to FQHCs/RHCs should evolve to reflect recent trends and forthcoming changes in insurance coverage. Further, it must align and be compatible with expectations and any new requirements that result from HHS' Assistant Secretary for Planning and Evaluation's (ASPE) report, "Recommendations for Monitoring Access to Care among Medicaid Beneficiaries at the State-level."

One complicating issue is that the Medicaid program has historically categorized services according to provider type, rather than type of service. FQHC's were created as a provider type specifically to assure access to health care for persons who are uninsured and underinsured. In states that have substantially minimized these problems, having FQHCs as a distinct provider type with a unique reimbursement methodology will make less sense over time.

Underlying these challenges is the fact that there is no clear pathway for state Medicaid agencies to provide input into HRSA's existing processes for funding/approving clinics,

changes in scope, and affiliations. This has been a particular challenge in some states that have observed that an approved service area expansion for FQHCs/RHCs does not necessarily improve access for Medicaid clients. In some instances these approvals are also not necessarily consistent with the state's own plans to expand access. This concerning trend is occurring in part because the FQHCs/RHCs with approved service expansion areas hire previously-independent physicians to join the FQHC/RHC, paying the physician an above-market salary partly subsidized by PPS rates and the avoidance of liability insurance costs due to federal tort protections.

Further, HRSA does not have processes in place to notify state Medicaid agencies of these approvals. This can be problematic for states because HRSA's decisions establish the health center's right to claim Medicaid reimbursement. The lack of timely notification from HRSA or the FQHC/RHC can create challenges for state Medicaid agencies from a budgeting and programmatic planning perspective.

V. Federal, State and Stakeholder Discussions

In 2012, NAMD initiated conversations with the Center for Medicaid and CHIP Services (CMCS) and the Health Resources and Services Administration (HRSA) concerning intersecting issues between Medicaid and the FQHC program. Participants in these discussions expanded to include the Association for State and Territorial Health Officials (ASTHO) and Primary Care Office (PCO) representatives. The conversations focused on FQHC-related policy and operational issues and delved into the need to adapt the health center program in the context of several concurrent marketplace changes.

These conversations shed light on policies and other aspects of the FQHC program which can impede progress towards some states' health care transformation goals and ongoing management and oversight of the programs. Generally the challenges include the following:

- Historical payment methodology unique to health centers which is based on quantity of care and an outdated cost basis, which increasingly may impede states' ability to incorporate FQHCs/RHCs in their system-wide value based purchasing initiatives.
- Inconsistent or conflicting federal policy and regulations.
- Insufficient coordination between the multiple federal agencies with authority for the FQHC/RHC and Medicaid programs as well as insufficient collaboration between those federal agencies and the state Medicaid and public health agencies that administer and interface with the programs.

NAMD continues to welcome opportunities to engage with our federal partners and, as

appropriate, other stakeholders to develop workable solutions to these delivery system improvements and program management issues. Included here is further explanation of the issues important to Medicaid Directors and policy recommendations we hope that the Administration will pursue with states and other interested stakeholders, as appropriate.

STATE REQUESTS TO HHS

Issue 1: Barriers to State-driven Medicaid Delivery and Payment Improvement

The PPS rate-setting approach for health centers is not sufficiently aligned with the present and future realities in states' delivery system and payment improvement initiatives. HHS must begin to bridge the gaps and disconnects between the Medicaid and FQHC/RHC programs in the area of delivery system and payment improvements.

Goal: *Clarify existing policies and facilitate new approaches to Medicaid reimbursement for FQHCs/RHCs.*

Action Steps:

1) We request that HHS work with states to issue guidance about the federal agencies' expectations and allowable parameters for incorporating FQHCs/RHCs in state-driven delivery and payment improvements. Ultimately, the federal agencies should provide clear, coordinated communication about the options and vehicles available to state Medicaid programs. The guidance should address the levers states may employ to facilitate and/or require FQHCs/RHCs to participate in state-driven delivery and payment reforms.

2) We request that HHS approve demonstration waivers that allow alternate payment methodologies when mutually agreed to by the state and the majority of that state's FQHCs. This could help to align the FQHC/RHC payment approach with objectives of value-based purchasing programs. For example, a template could create a pathway to establish quality withholds and/or incentive payments for FQHCs/RHCs, consistent with the state's payment methodology for other types of providers. Some of the initiatives already underway in states like Oregon and Minnesota– and policies that were pursued but not permitted – could serve as a good starting point.

3) We request that the Secretary direct CMS and HRSA to collaborate to provide a clear, consistent interpretation of the FQHC/RHC alternative payment methodology (APM) to the PPS. The lack of guidance and clarity continues to generate confusion and tension between states and the clinics, and in some instances has led to costly litigation for all involved.

4) Federal policymakers should focus additional federal resources on building FQHC/RHC capacity to participate in risk-based programs, including Medicaid managed care. This work should address state wrap-around payments to clinics in managed care programs which have been a source of tension and confusion between states, plans, and providers. This work should also provide guidelines for development of Medicaid managed care rates to FQHCs/RHCs that include the cost of federal FQHC/RHC requirements unique to FQHC/RHC providers. Medicaid managed care programs are becoming a dominant delivery system and payment model and the FQHC/RHC program, the clinics themselves and health plans must adapt to this.

5) We request that the Secretary direct CMS and HRSA to issue coordinated federal guidance directing FQHCs/RHCs to comply with the single state Medicaid agency's data requests. This would help inform more accurate, state-driven quality, payment and delivery system initiatives. Without cooperation from FQHCs/RHCs, it can be difficult for states to provide the full picture of information about beneficiary health outcomes, quality improvement and program management, including financing.

6) HHS should advance innovative proposals or opportunities that would facilitate FQHCs/RHCs' progress towards our shared goals, including enhanced business acumen. For example, data analytics training for clinics and investment in data systems for clinics can help drive overall system efficiencies and improvement in quality. Further, FQHCs/RHCs may benefit from resources that allow them to develop capacity to work in a risk-based contracting system.

Issue 2: Variation in Medicaid-FQHC Quality Measures and Expectations

Federal and state governments cannot compare information from different programs, even when such programs have the same or similar goals.

Goal: *Improve consistency of quality measurement across programs operated by HRSA and CMS.*

Action Steps:

1) We request that HHS crosswalk quality measures in Medicaid and public health to identify those with common ends but conflicting methodologies/inputs. The federal agencies, states and other interested stakeholders could use this information to consolidate measures and prioritize measures that meet shared priorities and goals.

2) HHS should work with states and key stakeholders to identify solutions that would allow state and federal agencies to aggregate data in a useable format with the downstream goal of employing this information in a payment methodology that is based on high performance.

Issue 3: Insufficient Inputs for FQHC/RHC Access Criteria

The definition of access with respect to FQHCs/RHCs is not currently designed to reflect recent trends and forthcoming changes in insurance coverage. Further, there is no clear pathway for state Medicaid agencies to provide input to HRSA and similarly for HRSA to communicate with states about funding/approving clinics, changes in scope, and affiliations.

Goals: *Establish streamlined vehicles to allow states to provide meaningful information that could help inform HRSA's existing selection process as well as process whereby HRSA notifies Medicaid agencies of approvals. Further, states are seeking the flexibility to determine the services Medicaid covers without regard to the type of provider covering them. States are not seeking carte blanche approval or denial for FQHC/RHC applicants, expansions or affiliations.*

Action Steps:

1) We request that HHS develop a process whereby states are notified in advance of approvals for FQHC/RHC applications, expansions or affiliation agreements.

2) We request that HHS work with state Medicaid agencies to clarify the expectation (and definition as needed) of access for purposes of determining the value-add of FQHCs/RHCs for the Medicaid population. We seek to ensure that FQHC/RHC grant criteria with respect to access is aligned with Medicaid goals and initiatives and modifications are made where needed.

3) Consistent with these expectations, HHS should add and refine criteria for new access points (NAP), change in scope, and affiliation agreements to ensure that

clinics are truly expanding access for low-income individuals in a cost-efficient manner. For example, HRSA's review process should examine price and value as part of the clinic's application and/or renewal for funding if the health center is going to receive Medicaid reimbursement.

4) We request that the Secretary direct HRSA to incorporate new tools in its review and approval processes concerning FQHC/RHC submissions. Specifically, HRSA should consider those tools currently used by single state Medicaid agencies to monitor access to services and network adequacy in risk-based and FFS programs.

Issue 4: Misalignment between FQHC/RHC Criteria and Accountability and State Medicaid Goals and Statutory Responsibilities

The criteria used for approving FQHCs/RHCs participation in the Medicaid program do not always align with the oversight and management responsibilities of the state Medicaid agency.

Goal: *Insert meaningful, objective state-level information into the FQHC/RHC NAP, change in scope and affiliation review process to ensure the efficient, effective operation of the Medicaid program.*

Action Steps:

1) We request that HHS work with NAMD and its members to identify Medicaid-related information that must be included in HRSA's NAP, change in scope, and affiliation applications and refine the FQHC/RHC criteria accordingly. For example, HRSA's objective criteria for FQHCs/RHCs should include the following additional information along with other issues that may be identified by the federal-state workgroup:
    - Information from the state regarding FQHC/RHC participation in the community health needs assessment process (e.g., ACA Section 5007, which requires all nonprofit hospitals to identify community needs, and work to address those needs as a condition of federal tax exemption);
    - The IRS 990 form, specifically the information on health center salaries and margins;
    - Open investigations of existing center;
    - Open cost reports; and
    - Pending litigation.

2) We request that HHS work with NAMD and its members to identify additional information that Medicaid directors may provide that would be included in HRSA's review processes.

3) We request that HHS also examine the evolving relationship between the FQHC/RHC site and its providers. States are increasingly identifying situations where clinics are incorporating providers that are beyond a reasonable geographic distance from the clinic and are receiving the above market PPS rate. The federal agencies should work with states to develop reasonable policies to address inappropriate or inefficient contracting relationships.

5) We request that HHS amend the service expansion application to allow HRSA to collect and consider data on FQHCs/RHCs contracting practices with managed care organizations (MCOs). This would allow HRSA to consider whether FQHCs/RHCs are engaged in selective contracting practices in whole or in part based on their ownership interest in a particular MCO. Likewise, we request that HHS collect and consider data on managed care plans' contracting practices with providers of the same services as FQHCs/RHCs. This would allow HHS to consider whether MCOs are engaged in selective contracting practices in whole or in part based on their interest in avoiding providers serving high cost chronically ill persons and the underinsured and underinsured.

6) Building on the previous recommendation, we request that HHS evaluate FQHC/RHC-related market dynamics that create challenges for improving access or providing quality care in a cost effective manner. For example, HHS should engage the Office of the Assistant Secretary for Planning and Evaluation (ASPE) to examine the impact of relationships between FQHCs/RHCs, managed care plans and private providers.

Issue 5: Policy and Operational Inconsistencies between the Medicaid and FQHC/RHC Programs

The Medicaid and FQHC/RHC programs are governed by distinct statutory authorities and are administered by separate agencies within HHS. However, the siloed approach to federal policy making and federal oversight of the Medicaid and FQHC/RHC programs has led to a range of challenges for many state Medicaid agencies as they have sought to fulfill their fiduciary and programmatic responsibilities for the Medicaid program, including requirements that Medicaid payments be consistent with efficiency, economy

and quality of care.

Goal: *Establish a process whereby states can request and obtain HHS assistance to resolve inconsistencies between federal Medicaid and FQHC/RHC requirements and policy.*

Action Steps:

1) We request that HHS develop a formal process whereby states may seek HHS engagement to resolve Medicaid-FQHC/RHC policy. States would like to work more closely with HHS to avert costly litigation concerning FQHCs/RHCs, which can stem from ambiguity or conflicts in federal policy and guidance.