North Carolina Medicaid Alternative Payment Methodology: **Reminders for FQHCs and RHCs**

David Fields, CPA, CMA, CFM, June 5, 2025

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Meet the Presenter

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Agenda

1. Reminders
2. Medicaid and Medicaid Managed Care – Status Update
    1. What to do for your health center?
    2. What is pending for payments to your health center?
3. Foundational Policy Matters
4. Questions and Answers

Why does it matter?

- Single biggest payer for all (or maybe almost all of you)
  - If not by volume, then in dollars
- This impacts direct Medicaid AND Medicaid Managed Care
- This has created more certainty and is expected to be the last State Plan Amendment (SPA)…at least for many years
- There are still future cost reports to be filed – every 3 years:
  - 2024, 2027, 2030… NC Medicaid
- Cash flows improvements – how is real time wraps going?
- Why should you care what I have to say about all of this? Post implementation

Medicaid & Medicaid Managed Care
What is happening?

- The current SPA was retroactively effective July 1, 2023
- Everyone is PPS, but you all have your own unique PPS rate
  - What is going on with wrap payments now versus real-time wraps?
  - There will NOT be cost settlements for 7/1/23 DOS forward
  - There will still be “some” cost reports during and after the transition
  - There is one PPS rate for all services
- Everyone will be utilizing their 2021 rebased PPS rates + 13% + inflation
- Pharmacy will be paid fee schedule – not in PPS or the cost report

Medicaid & Medicaid Managed Care
What to do?

- Keep seeing patients, serving your communities and providing great care!
- Help qualifying patients gets enrolled in Medicaid / Managed Care
  - Medicaid expansion execution on your part – even if that changes
- Keep fighting for payment and making sure you work denied claims
  - This does not protect you if the MCO never pays the claim – get paid!
  - Know your PPS rate and monitor claims payments
- Keep track of the Managed Care encounters paid – August 1, 2024 and before
  - Compare this to your wrap payments and/or your cost report historically
- Budget and plan with more certainty - set PPS rate with no settlement

Medicaid & Medicaid Managed Care
What to do?

- Take your cost reporting process very seriously – rebasing is a game changer
  - Remember FQHC Medicare cost report is foundational
  - Your 2024 cost report has set your next PPS rate – effective July 1, 2026
    - If you didn't budget and plan strategically for 2024, focus on 2027
    - Use your FQHC Medicare cost reports to track and plan in 2025
    - For a 3/31/27 fiscal period that begins 4/1/26
  - Your 2021 and your 2024 cost reports set your unique PPS rate
    - Based on your cost, dental/medical mix, etc.
    - No 2025 or 2026 NC Medicaid cost reports – still have Medicare

Medicaid & Medicaid Managed Care
What is the current environment?

- Prospective Payment System (“PPS”) continues to be in effect
- There is no settlement for claims moving forward
  - Medicaid Managed Care claims paid at PPS rates “real time” wraps…8/1/24
  - Direct Medicaid – think NCTracks paid at PPS rates 5/1/24
  - Dental is the only exception with some ongoing wraps – see next slide
- There continue to be disruptions and transitional challenges, but progress…
  - See ongoing items on the subsequent slides
- The state is focusing on obtaining the 2024 cost reports, processing them, and establishing the rates for 7/1/26 so that rates are communicated early – date TBD

Medicaid & Medicaid Managed Care
Wraps – What is still pending?

- Direct Medicaid (NCTracks) wrap settlement
  - 5th quarter wrap for 4/30/24 and before dates of service paid Spring of 2025
- Dental wraps will continue
  - Wraps are run 45 to 50 days after quarter end and then it takes another couple of weeks before the wraps are paid – the 9/30/24 Dental wrap was paid 11/5/24
- Medicaid Managed Care claims for 7/31/24 and prior – Tailored plans later
  - Quarterly wraps have been paid, but NO 5th quarter wraps have been paid
  - Claims paid after the last wrap report was run through the final report run date will be wrapped to the PPS rate – thinking maybe late summer 2025?

Medicaid & Medicaid Managed Care
Cost Report Settlements

- Medicaid Managed Care become effective 7/1/21
- Emergency state plan amendment effective 7/1/21 to 6/30/22
  - This functioned under the COVID emergency SPA – some PPS & some cost
  - PPS is finalized as they were wrapped to the individual CHC PPS rate
  - Cost settled has been tentative settled, but pending MCO claims cost settlement
- SPA effective 7/1/22 to 6/30/23 – everyone is cost settled
  - Direct Medicaid claims were tentatively cost settled – final pending
  - The MCO claims are still pending tentative and final settlement at cost
- 7/1/23 and forward is PPS – see the preceding wrap slide

Medicaid & Medicaid Managed Care
SPA Quick Summary

- On March 28, CMS approved NC's Medicaid State Plan Amendment to establish a new FQHC Alternative Payment Methodology
- Reminder: This Prospective APM establishes:
  - A new prospective, cost-based encounter rate that is rebased every three years and enhanced by 13% above allowable cost (carving pharmacy out),
  - Real-time managed care wrap payments, and
  - Quarterly dental supplemental payments, among other changes:
- How long is the cost plus 13% effective? Renewed bi-annually with the budget
  - Advocacy to maintain the cost plus 13%

Medicaid APM Reminder

Brendan Riley

VP of Government Relations & External Affairs, NCCHCA

Originally presented on April 12, 2024 NCCHCA Task Force Meeting. Revised as of 4/19/24

Design Features of New Medicaid Alternative Payment Methodology for FQHCs and RHCs (UPDATED as of April 2, 2024)

Enhanced Cost-Based Prospective Alternative Payment Methodology

How is each FQHC's unique encounter rate calculated? How is the encounter rate adjusted over time?

Prospective Cost-Based APM:	Initial Rate Development:	Rate Enhancement:	Rebase Every Three Years:	Annual Inflationary Adjustments:	Other Adjustments:
Replace cost-settled APM with new prospective cost-based APM encounter rate, eliminating annual settlements.[1]	Allowable cost per encounter calculated from FQHC's FY2021 Cost Report, excluding Pharmacy and hospital-based physician services	FQHC allowable cost-per-encounter rates increased by 13% during each rebase cycle.	Encounter rate rebased every three years using full Medicaid FQHC cost report submission. Effective dates of FQHC rates will follow State Fiscal Year (July thru June).	Between rebasing, inflate encounter rate by the greater of the FQHC Market Basket or the medical component of Consumer Price Index.	Between rebasing, rates may be adjusted prospectively due to a change in scope of services request submitted by Feb. 28 to be effective July 1.

Encounter Definition & Claims Adjudication

Which services are eligible for encounter rate reimbursement? How are FQHCs reimbursed for services they currently bill fee-for-service?

Eligible Billing Codes for Encounter Rate	Dental	Pharmacy	Ancillary Services:
T1015 99381EP-99385EP 99391EP-99395EP Dental: Not code-specific; one dental encounter per beneficiary per day regardless of volume of services.	Claims initially adjudicate at fee schedule as they do today. Medicaid will pay a quarterly wraparound payment to make FQHCs whole to encounter rate.[2]	Carved out of encounter rate. Billed & reimbursed separately according to State Plan (i.e. acquisition cost and dispensing fee).	No separate reimbursement; costs are built into encounter rate. Claims adjudicate at $0. Like pharmacy services, hospital-based physician services and diagnostic lab services are excluded from APM & paid separately FFS.

Initial Claims Adjudication & Supplemental Wraparound Payments

How are claims reimbursed under Managed Care vs. Medicaid Direct? How and how often are FQHCs made whole to encounter rate?
How are the costs of FQHC services included in PHP capitation rates?

Encounter Claims Adjudication		Process for Wraparound Payments	Frequency of Wraparound	PHP Capitation
Medicaid Direct (i.e. Fee-for-Service): Reimbursed at the encounter rate. (Dental excepted, per above)	***Managed Care:*** PHPs reimburse at interim rates of $117.32 for T1015 and fee schedule rates for Health Checks.	PHPs pay wraparound payments to make FQHCs whole to APM encounter rate. DHHS reimburses PHPs directly outside of capitation. Quarterly wraparound process eliminated.	Starting July 2024, PHPs will make real-time wraparound payments. DHHS makes payments to reconcile FQHC claims dating back to July 2023.	Capitation payments to PHPs would be lowered due to market-based initial encounter rates for FQHCs compared to status quo.

[1] Cost report submissions will be required only once every three years for future APM rate rebasing; no reconciliation or cost settlement will take place.
[2] FQHCs will not be placed into repayment scenarios due to dental wraparound. If fee schedule payments exceed encounter rate, FQHCs will not owe back to NC Medicaid.

Alternative Payment Model (APM)
Issue Addressed: Simplification - Reduced Administration Burden

- Narrows gap between “active” PPS rate and cost
  - **Carve out - Pharmacy**
    - Pharmacy will be carved out of the PPS rate; reducing complexity of cost reporting and adverse financial impact
  - **Less frequent cost reporting**
    - Every three years to support tri-annual rebasing
  - **One specific rate per Health Center**
  - **Alignment of rate setting timeline with State Fiscal Year (SFY)**
    - PHPs update rates once per year

FQHC Reimbursement Methodology:
What was the impact?

While the overall structure for the proposed FQHC reimbursement methodology significantly differs from the existing approach, many key components are consistent with the current methodology.

Methodology Component	Differs from Current Approach	Aligns with Current Approach
Rate Methodology & Treatment Pharmacy	• Prospective cost-based rate, rather than retrospective cost-settled rate • Encounter rate of approximately 113% of allowable costs, rather than 100% (i.e., 13% rate increase) • Pharmacy carved *out* of encounter rate	• Use of FQHC cost reports to develop FQHC-specific encounter rate • Inclusion of both medical and dental costs in encounter rate development • Ability to request a change in scope of services to adjust the encounter rate
Encounters & Claims Adjudication	• FQHCs receive full encounter rate for all eligible encounters to ease administrative burden and support predictable FQHC cash flow *(funds flow process differs in managed care vs. FFS; see slide slides 9-10)*	• Definition of an encounter (i.e., which billing codes "trigger" an encounter payment)
PHP Capitation Rate Development	• Prospective PHP capitation rate would be lowered to reflect "market-based" initial rate	
Payment Timing & Reconciliation	• No annual reconciliation required	

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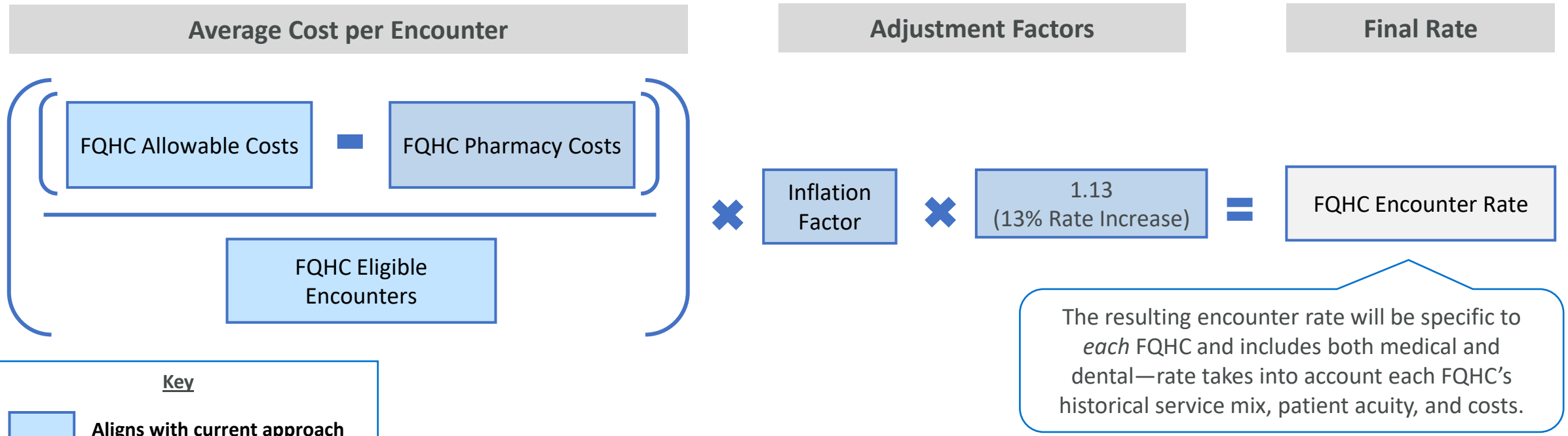
Reminder:

Calculating the Prospective, Cost-Based Encounter Rate

DHHS will calculate each FQHC's prospective cost-based encounter rate every three years, taking into account FQHC-specific costs and service mix. Due to the 13% rate increase above cost, per-encounter rate is likely to exceed payment under current state.

Calculation in Rebasing Year



The resulting encounter rate will be specific to *each* FQHC and includes both medical and dental—rate takes into account each FQHC's historical service mix, patient acuity, and costs.

Reminder:

Calculating the Prospective, Cost-Based Encounter Rate (continued)

Between “rebasing” years, FQHCs will benefit from inflationary increases and can request change in scope of services, if needed. Since this builds on the prior year’s encounter rate, the 13% rate increase is already applied.

Adjustments Between Rebasing Years

Prior Year FQHC Encounter Rate *(includes 13% rate increase)* ✖ Inflation Factor = FQHC Encounter Rate

Key

- **Aligns with current approach**
- **Differs from current approach**

Same as current state, qualifying events for a change in scope of service include changes in type, duration, or amount of services and Medicaid patients served. Unlike current methodology, change in scope would be applied prospectively to following year’s rate (there would not be retrospective adjustments).

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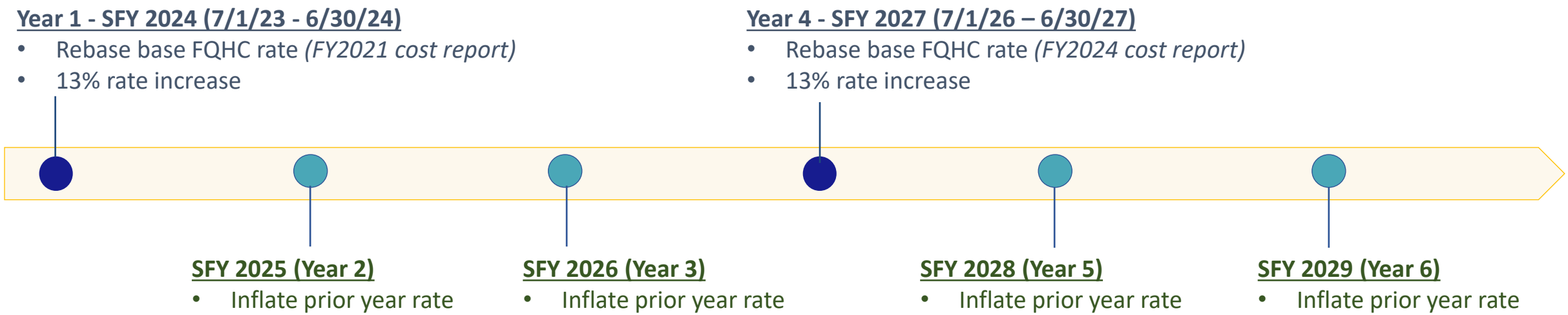
Timeline:
Rebasing and Non-Rebasing Years

The below timeline illustrates how FQHC encounter rates are updated on an annual basis. As noted, between rebasing years, FQHCs can request an adjustment to their encounter rate for a change in scope of services.



Change in scope policy applicable during "non-rebasing" years.

Notes of Interest in Rate Development Timeline

Rates Aligned with State Fiscal Year (July thru June)

All FQHCs' rates will be aligned with the SFY instead of FQHC fiscal year – for effective dates

But FQHC fiscal year is still the rate-setting year for future rebases – for calculating rates

Inflationary adjustments

Rates adjusted each SFY by factor = greater of FQHC Market Basket Adjustment less Productivity Adjustment or CPI Medical Care

If FQHC FY does not align with SFY, the adjustment will be compounded based on month of FQHC FYE relative to SFY start

Change in Scope of Services opportunities

Outside of rebase years (FY2021, FY24, FY27, etc.), FQHC can submit once a year by March 31 for prospective adjustments to be made to rate by beginning of SFY (July)

Our View:
Key Benefits

- Improve cash flow – are you all feeling the improved cash flows?
- Remove barriers to FQHC success in value-based arrangements
- Remove incentives for PHPs to steer patients away from FQHCs
- Simplify and streamline Medicaid reimbursement methodology for FQHCs
- Continually update rates with more recent costs thru regular rebasing based on allowable cost
- Enhance rates 13% above cost – pending continued funding approval
- Remove volatility of pharmacy reimbursement
- Eliminate/reduce risks of paybacks and reprocessed claims

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