North Carolina Medicaid Alternative Payment Methodology: **What will you do with what you know now?**

David Fields, CPA, CMA, CFM, June 5, 2026

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Meet the Presenter

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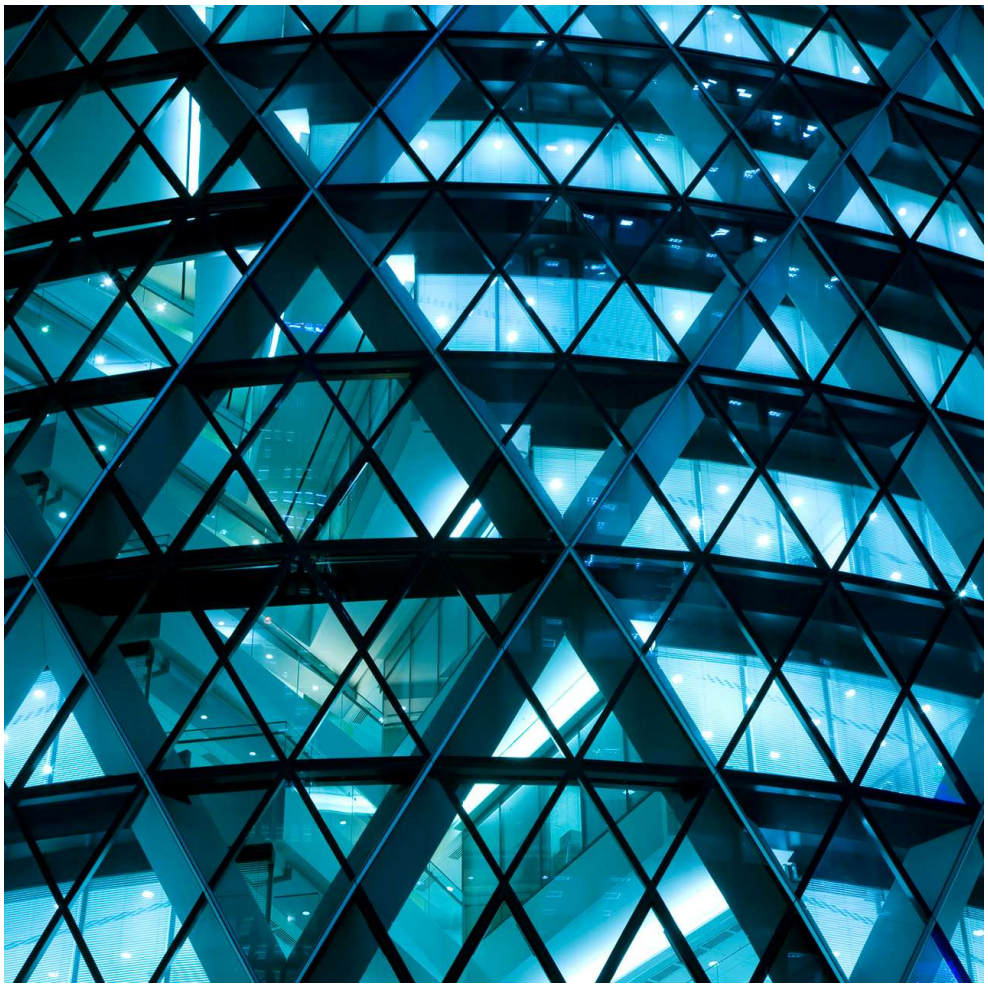
Agenda

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
- Medicaid AND Medicaid Managed Care
  - Medical, dental and pharmacy
- Certainty and predictability…well sort of
- There are still future cost reports to be filed – every 3 years:
  - 2027, 2030… NC Medicaid
- New normal of Cash flows improvements
- It is time to get strategic!

Medicaid & Medicaid Managed Care
The New Normal

- Many were waiting for “the catch”
- We now understand how it is going to work…now let’s make it work for us
- Everyone is PPS, but you all have your own unique PPS rate
  - Real-time wraps…anecdotally this is working and working well
  - There are some old cost reports pending, state hopes to resolve in the next year now that the rebasing process is coming to a close for this cycle
  - There will NOT be cost settlements for 7/1/23 DOS forward
  - There is one PPS rate for all services
- 7/1/26 PPS rates are based on 2024 cost reports 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
  - Examine your Medicaid patients for those at risk of losing Medicaid
  - Understand the work requirements, patient ages, gender, life stage, etc.
- 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
- 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 2027 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 2026
    - For a 3/31/27 fiscal period that begins 4/1/26
    - If you were surprised this cycle, do NOT be surprised next cycle!
  - Your 2024 and next your 2027 cost reports set your unique PPS rate
    - Based on your cost, dental/medical mix, etc.
    - No 2026 or 2028 NC Medicaid cost reports – still have Medicare

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

- All wraps (except dental) are done and resolved
  - If someone is aware of something let NCCHCA and myself know for support
- 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 – process seems to be in rhythm now

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
  - New rates are set to be effective 7/1/26, so pending a problem no extra settlement anticipated
  - Dental is the only exception with some ongoing wraps – see next slide
- It was a challenging journey to get the 2024 cost reports, develop the rebasing process, and meet the deadline, but for most and hopefully all it was met
- The next cycle should go more smoothly: 2027 cost reports effective 7/1/29 PPS
- The state will be able to focus on the old cost report settlements next, hopefully resolved and settled by 7/1/27

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
  - Other than emergencies, has anyone received the MCO claims?
    - My understanding is these are still pending tentative and final settlement at cost

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%
  - Let's discuss the 3% and how things progressed regarding the 13%

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

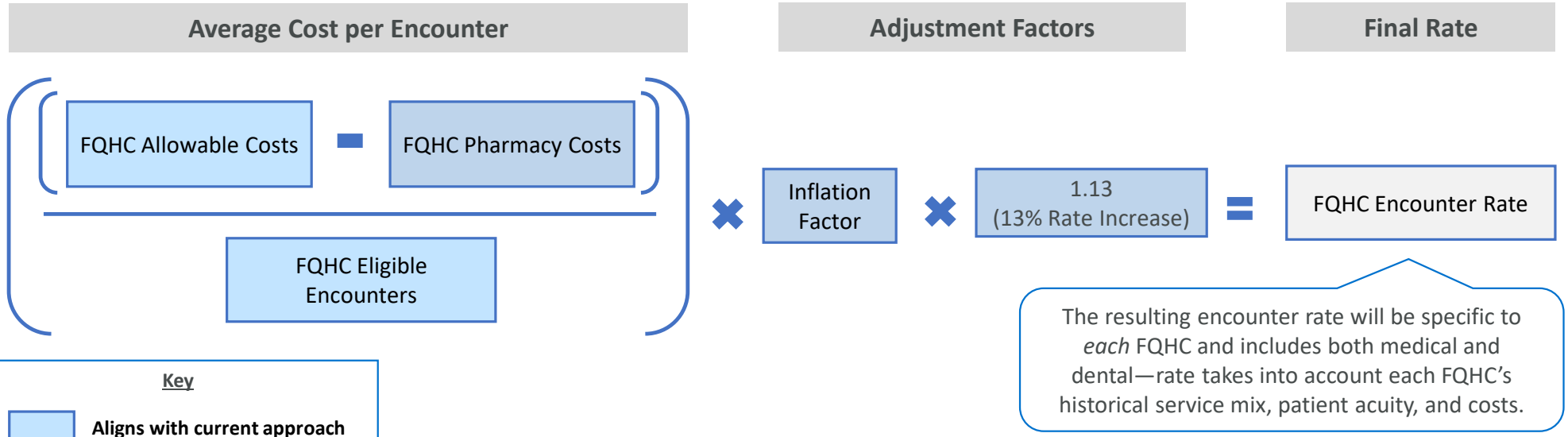
- Narrows gap between “active” PPS rate and cost
  - **Carve out - Pharmacy**
    - Pharmacy will be carved out of the PPS rate; reducing complexity of cost reporting and adverse financial impact
  - **Less frequent cost reporting**
    - Every three years to support tri-annual rebasing
  - **One specific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

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



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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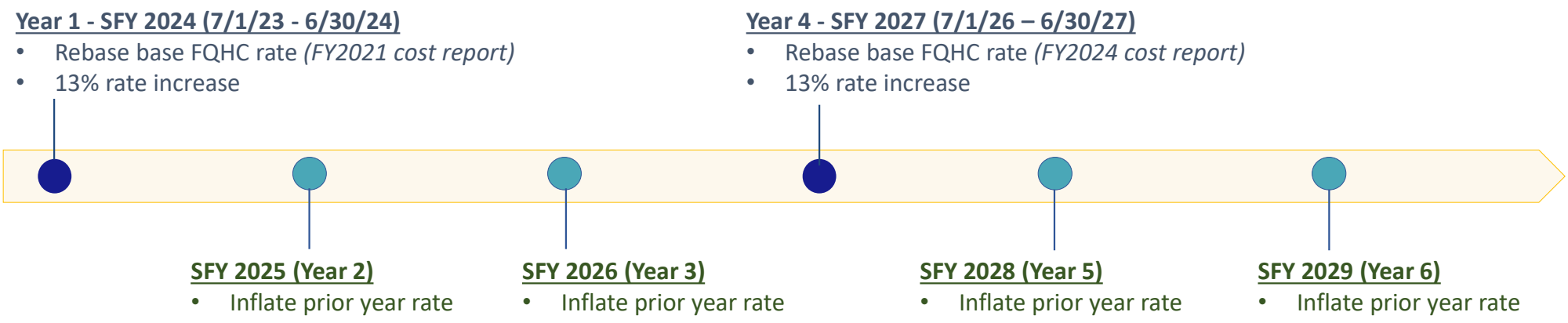
Timeline:

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)

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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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