VCHA CFO Workgroup

The CFOs Playbook: Financial Sustainability, Revenue Optimization & Strategic Readiness

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Conversation Roadmap

Financial sustainability, revenue optimization & strategic readiness

1. The CFO Challenge: Financial Sustainability in an Era of Change
2. Building a High-Performance Reporting Framework
3. Revenue Optimization: Finding the Money Already in the System
4. Medicare, Policy & Regulatory Updates
5. Strategic Growth Drivers: Pharmacy, Productivity & Value-Based Care
6. CFO Leadership Roundtables and Peer Insights & Discussion
7. The 2027 CFO Action Plan

Section 1

The CFO Challenge: Financial Sustainability in an Era of Change

A sustainability conversation, not just a reimbursement update.

July CFO Work Group Carryforward

NEW SUMMARY

A management framework connecting near-term performance improvement with long-term strategic resilience

1 Revenue Optimization

- Strengthen front-, middle-, and back-office workflows
- Reduce denials, charge lag, and aged accounts receivable
- Capture Medicare, Medicaid, PPS, 340B, and contract opportunities

2 Cost & Workforce Management

- Align staffing, job design, compensation, and accountability
- Map costs by program, location, funding source, and revenue stream
- Protect liquidity while managing capital and integration costs

3 Data, Technology & AI

- Use clear KPIs, benchmarks, and dashboards to drive action
- Automate patient access, coding, billing, and follow-up workflows
- Invest in analytics and AI that improve operational visibility

4 Partnerships & Long-Term Sustainability

- Evaluate shared services, alliances, joint ventures, and consolidation
- Define partnership criteria before financial pressure becomes urgent
- Balance mission, governance, community trust, risk, and financial value

Main Takeaways for CFOs and Executive Teams

NEW SUMMARY

The leadership agenda is to improve today's performance while preserving options for tomorrow

CENTRAL MESSAGE

Sustainability requires disciplined execution now and strategic choices before a crisis.

Executive implication

Treat revenue cycle, workforce, technology, compliance, and partnerships as one integrated sustainability agenda.

01 **Know the score**

Track a focused set of financial and operating KPIs. Tailor reporting to management and the board and connect every metric to action.

02 **Fix the fundamentals**

Improve revenue cycle discipline, cost mapping, productivity, and cash management before relying on growth or one-time funding.

03 **Build enabling infrastructure**

Strengthen leadership, culture, compliance, analytics, automation, and AI so teams can act earlier and operate consistently.

04 **Preserve strategic options**

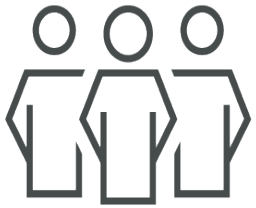
Assess partnership models, HRSA and reimbursement implications, integration costs, capital needs, and cultural alignment before urgency limits choices.

Leadership question: Are we improving the current model while preparing for the next one?

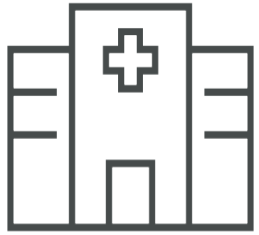
Challenges & Opportunities 2026, 2027, & Beyond

Eroding Margins

Regulatory Compliance



Staffing & Productivity



Competition

Payment Reform

Inflation | Payor Mix Erosion | Grant Dependency | Revenue Cycle Opportunities

Aging Population | 340B Reform | Federal Scrutiny | Recruitment

Productivity | Provider Contracting Strategies | Upstream Competition | Consolidation

Partnership Strategies | Value-Based Reimbursement | Alternative Payment Models

AI | HR1

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The sustainability model: four revenue pillars

The first three pillars are under pressure; value-based care is the emerging fourth pillar.

PILLAR 1 GRANT AND CONTRIBUTION REVENUE

Supports mission funding, uninsured care, enabling services, outreach, and innovation.

CFO TAKEAWAY

Protect this pillar, and separate recurring from nonrecurring funding.

PILLAR 2 BILLABLE PATIENT SERVICE REVENUE

Remains the operating engine but is pressured by payor mix, workforce costs, productivity constraints, denials, and reimbursement friction.

CFO TAKEAWAY

Protect this pillar.

PILLAR 3 340B PHARMACY SAVINGS REVENUE

Can fund access but faces manufacturer restrictions, payor and PBM dynamics, compliance burden, and savings volatility.

CFO TAKEAWAY

Protect this pillar.

PILLAR 4 VALUE-BASED CARE REVENUE

Creates opportunity through quality incentives, PMPM care management, shared savings, analytics, and population health performance.

CFO TAKEAWAY

Build the capabilities to capture this pillar.

CFO takeaways: protect the first three pillars, build capabilities for the fourth, and separate recurring from nonrecurring funding.

Grants management

Controls, documentation, and revenue recognition - including the October 2024 / 25 updates.

POLICIES AND PROCEDURES

Review policies and procedures related to grants management and be sure to incorporate any updates.

VENDOR EXCLUSION CHECKS

Check the OIG vendor exclusion list (sam.gov and LEIE database) before making purchases with federal funds. Current vendors and contractors should be checked at least every 6 months.

TIME AND EFFORT REPORTING

Ensure you have a system of internal control that supports time and effort reporting. Best practice is to incorporate time and effort reporting into your payroll system so that employees are responsible for allocating their time and effort on their timesheet.

REVENUE RECOGNITION - ASC 958-605

Evaluate all award letters, contracts, and agreements in accordance with ASC 958-605. Revenue for restricted grants can only be used for the restricted purpose and recognized when the expense has been incurred or the requirement has been met.

CONDITIONAL GRANTS

Conditional grants should not be recorded in the financial statements until the condition is met. If cash is received in advance, it is recorded as deferred revenue until the condition is met, then can be recognized as revenue.

GENERAL LEDGER AND DOCUMENTATION

Record all expenses related to grants directly in the general ledger with a grant specific code. Document! Document! Document!

CFO takeaway: exclusion screening, time and effort support, and grant specific coding are what make grant revenue defensible.

What high-performing health centers do differently

They pair mission clarity with business discipline.

Leadership & culture

- Tone at the top
- Open communication between departments
- A culture of accountability
- Constructive criticism is welcomed

Innovative – AI efficiency

Us vs. Them

Management mindset

- Innovative – AI efficiency
- Understand the importance of revenue cycle
- Finance provides the right information to the right individuals
- Administration works well with providers

Decision discipline

- Balance mission and business impact
- Avoid penny-wise, pound-foolish decisions
- Use data to select priorities
- Innovation is deliberate

Section 2

Building a High-Performance Reporting Framework

Measure what matters, then let the numbers drive action — including where AI can help.

Detailed Findings

Dashboard Reporting

- Key Performance Indicators (KPIs) should be on the Board, CEO, and C-suite dashboards
- Revenue Cycle Managers should have a set of KPIs to review regularly to identify issues with charges, coding, timeliness, denials and others as appropriate
  - Leading vs. lagging indicators
- Consider these metrics when trending month-to-month, quarter-to-quarter and/or year-to-year comparisons to FQHC/Physician Practice benchmarks and defined targets

Benchmarking discipline

Use external definitions, internal trends, and peer context

Benchmarks are helpful only when definitions and data sources are consistent.

1

Define the metric

- Use a standardized definition, data source, inclusion/exclusion logic, and calculation owner.

CFO management question: *If the metric misses target, what action is required and who owns it?*

2

Trend internally

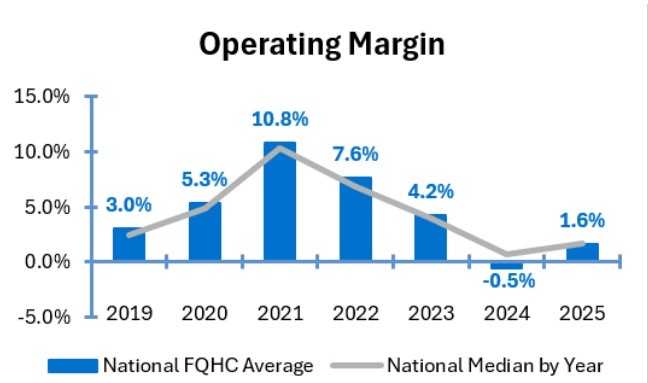
- Compare current month to rolling 3-, 6-, and 12-month trends. Separate one-time vs. recurring drivers.

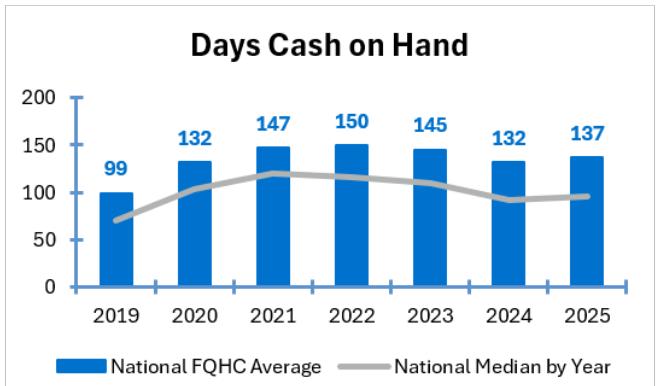
3

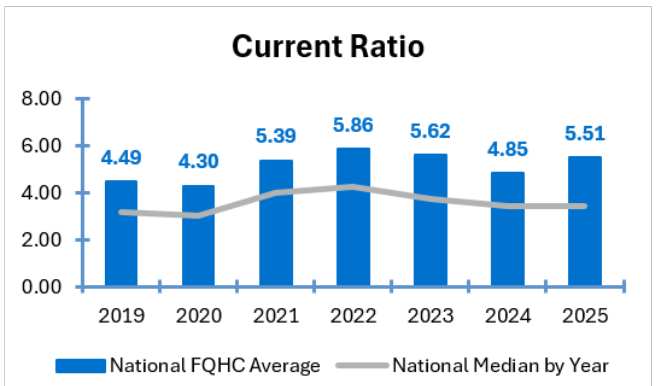
Compare externally

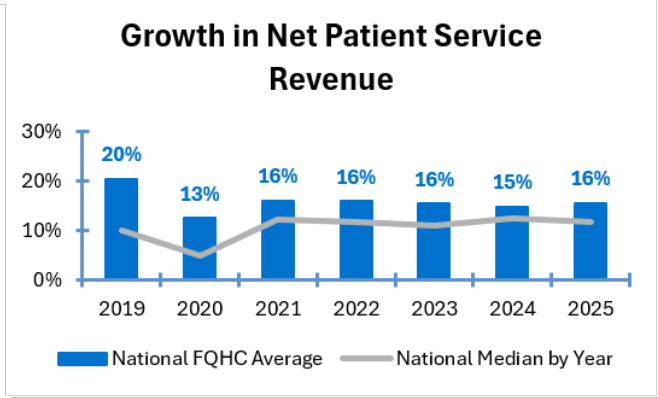
- Use credible benchmarking sources where available but verify applicability to FQHC operations and payor mix.

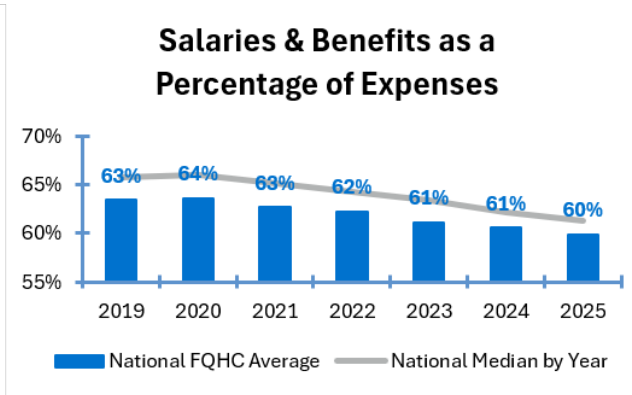
2025 National FQHCs – Financial Comparisons

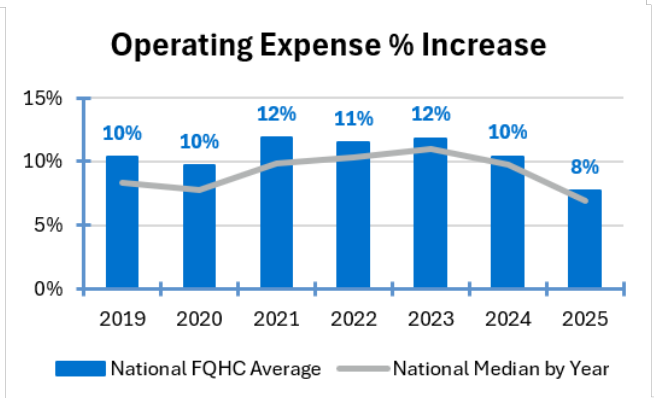


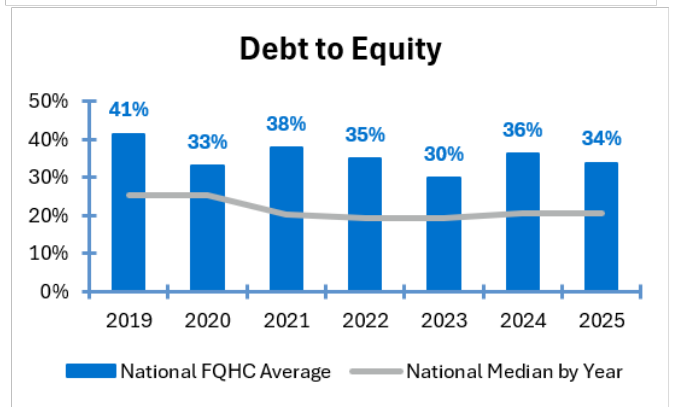


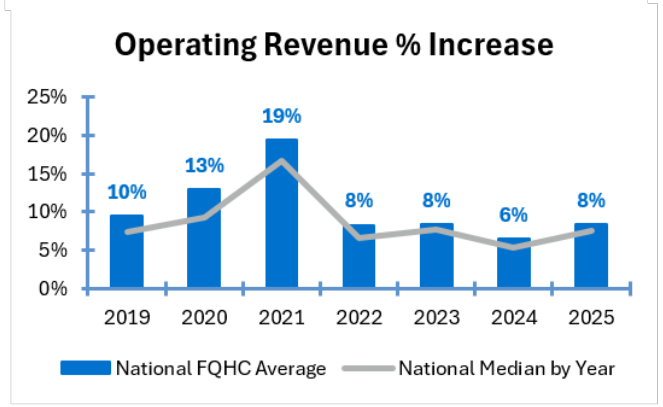


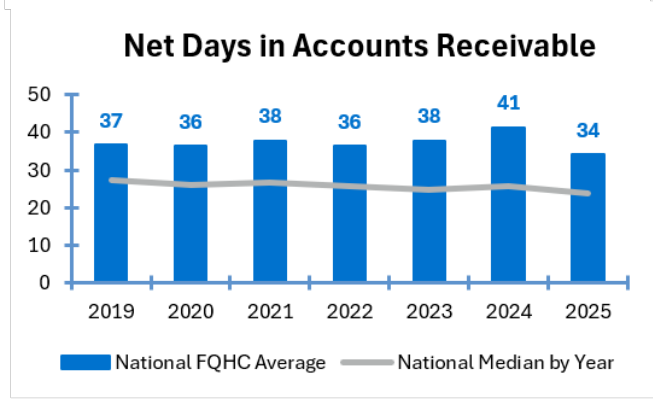












2025 National FQHCs – Financial Comparisons

2025 National Financial Update as of August 2026

Source: Audited Financial Statements

	National FQHC Average							2025 National Comparisons - 883 FQHCs		
Key Financial Metrics	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2025 FQHCs 25th Percentile**	**2025 FQHCs Median**	**2025 FQHCs75th Percentile**
Operating Margin	3.0%	5.3%	10.8%	7.6%	4.2%	-0.5%	1.6%	-3.6%	1.7%	6.9%
Days Cash on Hand	99	132	147	150	145	132	137	45	96	173
Current Ratio	4.49	4.30	5.39	5.86	5.62	4.85	5.51	1.97	3.44	6.12
Growth in Net Patient Service Revenue	20%	13%	16%	16%	16%	15%	16%	4%	12%	22%
Salaries & Benefits as a Percentage of Expenses	63%	64%	63%	62%	61%	61%	60%	67%	61%	55%
Operating Expense % Increase	10%	10%	12%	11%	12%	10%	8%	13%	7%	2%
Debt to Equity	41%	33%	38%	35%	30%	36%	34%	47%	21%	9%
Operating Revenue % Increase	10%	13%	19%	8%	8%	6%	8%	-1%	8%	17%
Net Days in Accounts Receivable	37	36	38	36	38	41	34	34	24	17

Financial reporting that changes behavior

Management reporting should tell the story quickly and direct attention to what matters.

START WITH AUDIENCE

Effective reporting starts with audience: what, who, how often, and why.

BOARD-LEVEL REPORTING

Board-level reporting should emphasize graphical and easy-to-understand information.

WHAT KPIs SHOULD ANSWER

KPIs should answer whether the organization is trending, comparing, and achieving goals.

WHEN A KPI TRENDS POORLY

If a KPI is trending poorly, management should know what action it will take next.

CFO takeaways: tailor detail by audience, use reporting to prompt action, and track ownership for every major indicator.

CFO dashboard: priority indicators

Suggested dashboard categories for discussion.

	Trend	Risk signal	Management action
Financial stability	Cash, margin, days cash, operating loss trends	Declining margin or cash burn	Reforecast, expense action, revenue acceleration
Access and productivity	Visits, days available, scheduling capacity, no-shows	Provider capacity unused or demand unmet	Panel access, schedule redesign, productivity review
Revenue cycle	Denials, A/R, cash collections, charge lag	Cash leakage or workflow friction	Root-cause workgroups, payor escalation, training
Strategic revenue	340B, Medicare, grants, VBC, payor contracts	Overreliance or underdeveloped opportunity	12-month revenue opportunity plan

Forecasting scenario modules

Use simple scenarios first, then add complexity as data reliability improves.

Base case

Current volume, current payor mix, current rates, expected staffing and standard cash lag.

Downside case

Lower visits, delayed collections, higher denial rate, lower wrap timing, or expense pressure.

Upside case

MA wrap setup, Medicaid reconciliation improvement, better clean claim rate, productivity gain, targeted payor corrections.

Sensitivity toggles

Rate change, payor mix, provider productivity, no-show rate, denial rate, AR days, staffing model, wrap approval delays.

Why CFOs should care about AI

AI is not a separate strategy; it is a tool for better financial and operational execution.

WHAT AI CAN DO

AI can help summarize activity, structure unstructured information, draft analytics narratives, and accelerate recurring reporting.

HIGHEST-VALUE CFO APPLICATIONS

For CFOs, the highest-value applications are often workflow acceleration, exception identification, documentation support, and management communication.

HOW IT MUST BE GOVERNED

AI should be governed with clear data, privacy, legal, compliance, and quality controls.

AI will not replace you but the person who embraces and uses AI may.

CFO takeaways: start with low-risk use cases, keep humans accountable, and document governance and review.

AI use cases for a CFO workgroup

Frame AI in practical, finance-adjacent use cases.

Revenue cycle

- Denial trend summarization
- Payor issue packets
- A/R narrative drafts

Finance analytics

- Monthly variance narratives
- Dashboard interpretation
- Board-ready summaries

Operations

- Meeting recap and action items
- Policy comparison support
- Training content drafts

Section 3

Revenue Optimization: Finding the Money Already in the System

Revenue cycle, reimbursement opportunities, and fee schedule strategy.

What constitutes a visit, patient, member

Use this slide as the “reimbursement foundation” before strategy.

Visit – one encounter, three different counts

HRSA REPORTING

UDS countable visit

A documented, individualized service delivered by a licensed or credentialed provider exercising independent professional judgment, in person or virtual.

All components must be met. Services in different categories on the same day each count.

REIMBURSEMENT

Medicare cost report

Form CMS-224-14

The billable PPS encounter. One all-inclusive rate per qualifying visit.

Multiple medical visits with the same provider on the same day generally collapse into one.

REVENUE RECOGNITION

Financial statement

ASC 606

Revenue is recognized when the performance obligation is satisfied – **at date of service, net of implicit price concessions.**

Not when the claim is billed or paid.

Who you are counting

Patient

An individual with at least one countable visit during the calendar year, counted once regardless of how many visits. **Unduplicated for UDS reporting.**

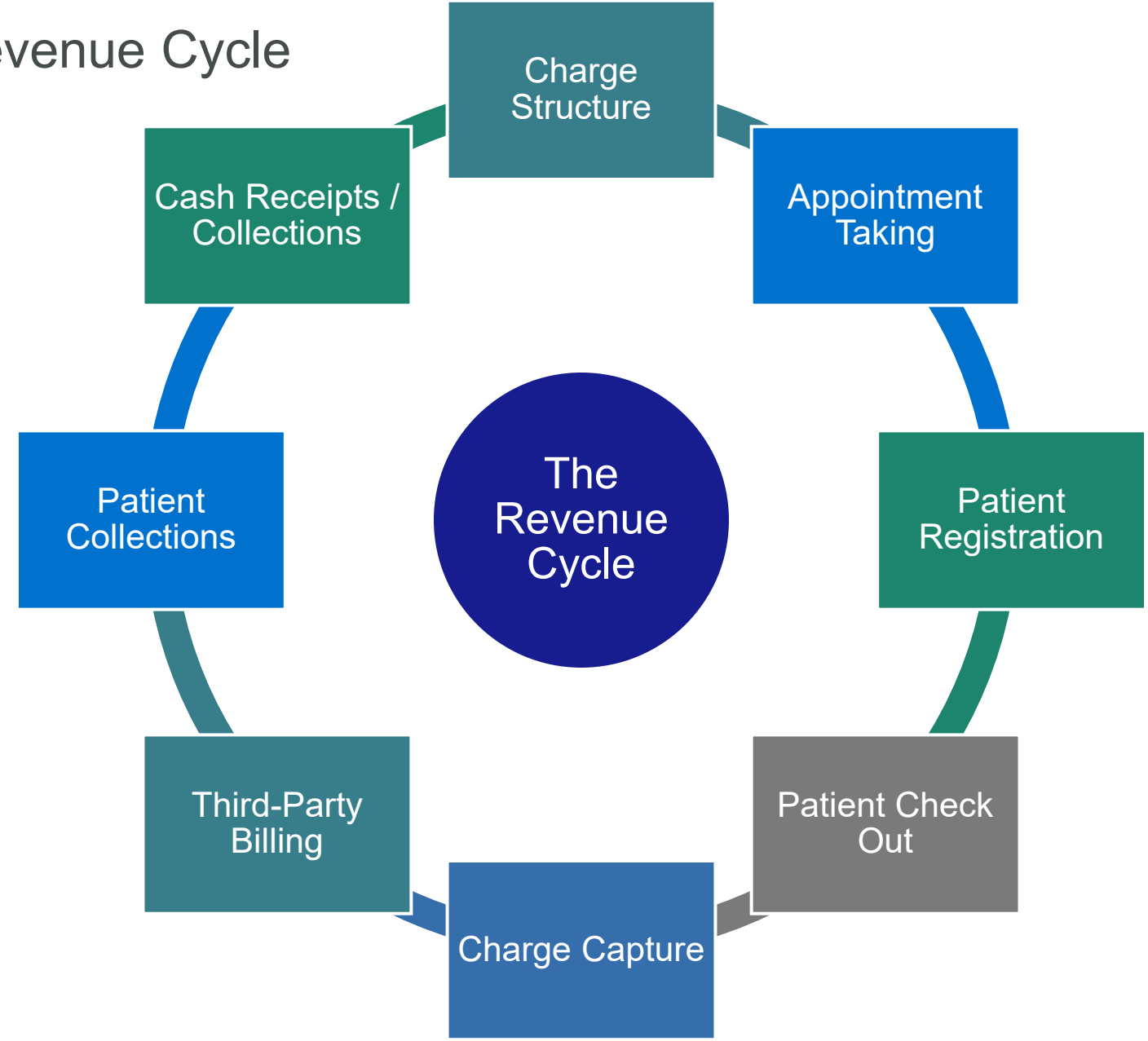
Member

An individual enrolled in a health plan and attributed to the health center. **Members generate capitation whether or not they are seen;** a member becomes a patient only after a countable visit.

CFO takeaways

- Verify operational understanding of each count before benchmarking.
- Train coders and providers together, not separately.
- Review same-day visit scenarios across medical, dental and behavioral health.
- Reconcile visit counts across all three definitions before the board sees them.

Optimizing the Revenue Cycle



Revenue cycle best practices: front, middle and back end

Revenue leakage often originates upstream, before the billing team ever touches the claim.

No one department owns the whole result. CFO governance should make cross-functional dependencies visible.

Front end: patient access

- Scheduling capacity
- Accurate demographics
- Insurance verification and benefits
- Authorizations
- SFDS/financial screening
- POS collections
- Clear patient responsibility communication

Middle: documentation & claims

- Timely note completion
- Coding accuracy
- Claim edits
- Charge capture
- Clearinghouse edits
- Use of PMS rules
- Avoiding unnecessary 100% manual review where edits can do the work

Back end: payment posting, AR & denials

- Payment posting automation
- Denial routing
- Payor follow-up
- Resubmissions
- Credit balances
- Write-off policy
- Consistent collections routines

Denials and AR: CFO playbook

Turn AR and denial performance into a weekly operating rhythm.

Root cause

Classify denials by eligibility, authorization, coding, documentation, payor rule, credentialing, timely filing, or system issue.

Prioritize

Work by value and aging bucket, not just claim count. Escalate recurring issues to process owners.

Prevent

Fix upstream controls: verification, authorization, templates, coding education, claim edits, payor rules.

Report

Track denial rate, dollars at risk, status, recoveries, write-offs, and owner action.

Recommended cadence: weekly AR/denial huddle, monthly executive dashboard, quarterly payor trend review.

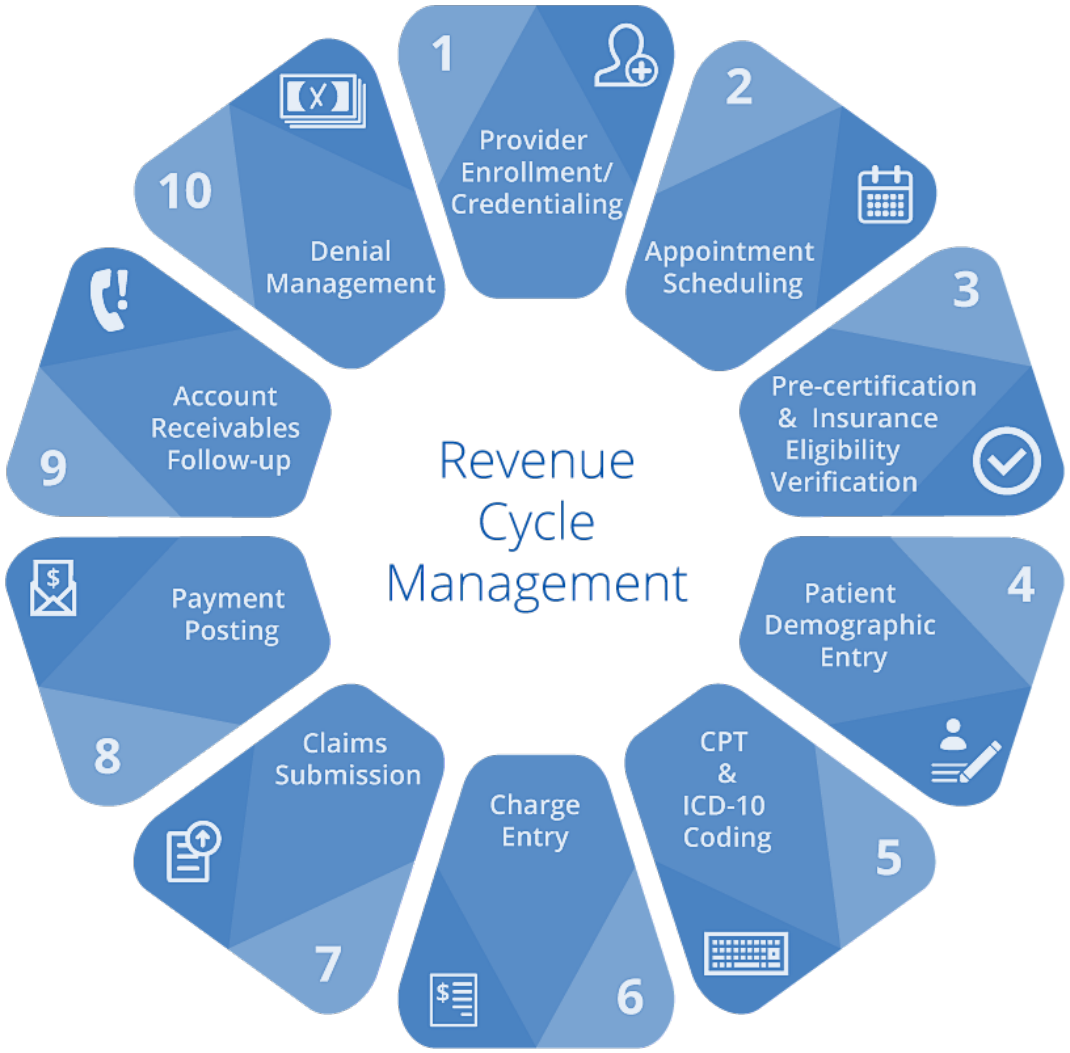
Revenue cycle: the whole organization owns the result

Overview of the revenue cycle

High-performing CFOs make revenue cycle an organization-wide operating discipline.

CFO takeaways

- Do not isolate RCM as billing only.
- Map accountability across front, middle, and back end.
- Tie workflow fixes to financial impact.



From reimbursement challenges to money on the table

Convert common challenges into discrete, actionable CFO opportunities.

Common challenges facing CHCs

PAYMENT ENVIRONMENT

- Changing payor mix

PAYOR CONTRACTS

- Fragmented methodologies
- PPS, FFS, and capitation complexity

OPERATIONAL FRICTION

- Credentialing and enrollment delays
- High denial rates
- Payors downcoding claims

FINANCIAL PRESSURE POINTS

- Low commercial payment rates
- Missed revenue and MA Wrap
- Increasing accounts receivable

Money on the table: opportunity inventory

CORE REIMBURSEMENT STREAMS

Medicare Advantage wraparound, fee schedule, Sliding Fee Discount Program, and FQHC services paid fee-for-service.

SERVICE LINE FOCUS AREAS

Preventive vaccines, care coordination services, medical telehealth, point-of-care labs, and technical components.

ALSO ON THE INVENTORY

Documenting and coding, commercial payors, Medicare bad debt, cost report, Medicare Part D, Medicaid scope change, quality incentives, 340B, and philanthropy.

CFO takeaways

Every challenge on the left has a named opportunity on the right.

- Create a prioritized opportunity register.
- Estimate financial scale and ease of execution.
- Assign an owner and timing.

Prioritization filter for revenue opportunities

Rank each opportunity by financial impact and execution complexity.

	Low	Medium	High
Near-term cash	Adjust reporting, monitor denials	Payor follow-up routines	MA wrap setup, fee schedule refresh
Compliance / risk	Policy review	SFDS utilization analysis	Charge setting governance
Strategic upside	Medicare care coordination	VBC upside-only contracts	PHMI infrastructure and payor alignment
Operational lift	Training refresh	Workflow observation	Practice management setup redesign

Fee schedule analytics: what matters to the CFO

The analytical work should identify underpriced, overpriced, and poorly supported services.

Pricing analytics: what to test

UNDERPRICED CODES

Analyze codes with charges below Medicare allowed amounts, minimum thresholds, private payor allowed amounts, or cost per service.

OVERPRICED CODES

Review codes above maximum thresholds when pricing appears excessive relative to strategy.

POORLY SUPPORTED SERVICES

Flag codes where the charge is not supported by cost, by benchmarks, or by a documented pricing rationale.

Inputs to the analysis

CLINICAL AND COST DATA

Utilization, modifiers, cost data, and relative value units for each code under review.

MARKET BENCHMARKS

Private payor allowed amounts and local prevailing rates, alongside Medicare allowed amounts.

HOW TO USE THEM

Compare every code against these benchmarks so findings rest on claims data rather than anecdotes.

CFO takeaways

Fee schedule analytics is where underpriced services and charge governance gaps surface.

- Look for revenue capture and compliance signals.
- Use claims data, not anecdotes.
- Tie findings to charge governance.
- Prioritize the codes with the largest volume and variance.
- Revisit the schedule on a defined cycle, not ad hoc – every 2-3 years

Sliding Fee Discount Program: design, controls, and review

What the program requires, where risk shows up, and what the CFO should do about it.

Program design and controls

STRUCTURE

Uses current Federal Poverty Levels, applies up to 200% FPL, includes a minimum of three categories, and uses income gradation.

NOMINAL CATEGORY

Nominal category payment must be less than the 101% FPL category; a nominal fee is optional for patients at or below 100% FPL.

DISCOUNT METHOD

Flat rate, percent of charge except nominal, or a hybrid approach.

REQUIRED CONTROLS

Board-approved policy, waiver, payment plan, prompt pay, utilization analysis, signage in patient common areas, and assessing all patients.

HRSA Compliance Manual Chapter 9

	Key question	Common risk	CFO action
Policy	Does the policy match HRSA expectations?	Policy not updated or not followed	Board review and policy refresh; link board policy to actual practice.
Schedule	Do categories and nominal amounts work?	Category above nominal pays less than nominal	Test payment logic and revise the schedule.
Operations	Are all patients assessed consistently?	Inconsistent screening or signage	Workflow training and monitoring; review waiver and prompt-pay usage.
Analytics	What do volume and collections show by category and service area?	Unexpected category distribution or collection percentages	Analyze collections by category and build repeatable monitoring so the center can self-evaluate.

CFO takeaway: the sliding fee schedule is a compliance requirement and a financial operating model — test policy against practice with data, not assumptions.

Revenue cycle projects CFOs can sponsor

Use projects to move from discussion to execution. The projects below all appear in the Revenue Strategy source deck.

ASSESSMENTS

Revenue cycle assessment, fee schedule assessment, and Sliding Fee Discount Program review.

PAYOR AND POLICY WORK

Medicare Advantage wraparound setup, payor contract review, and policy review.

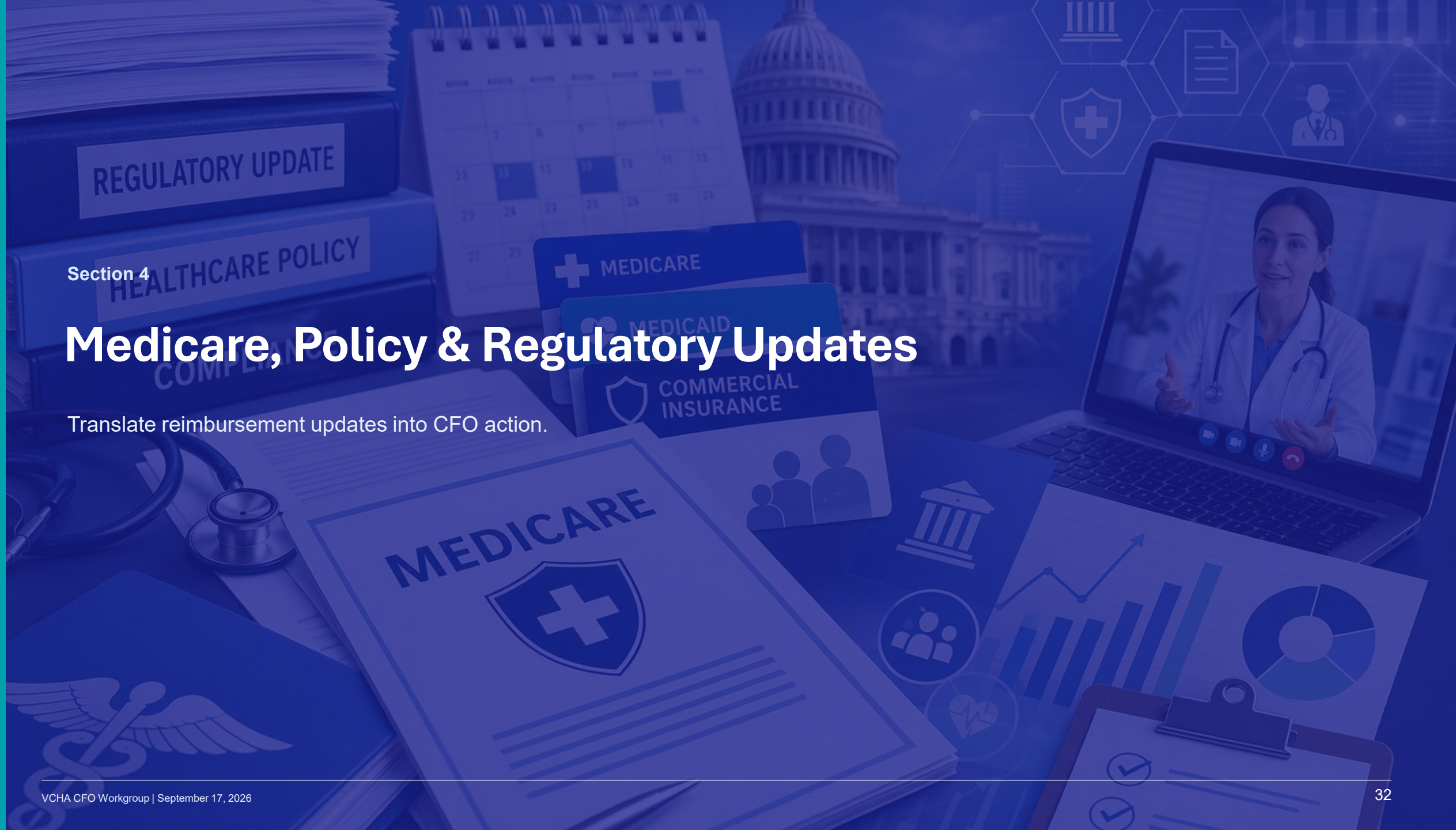
PEOPLE AND OPERATIONS

Credentialing and enrollment, billing support, and training.

HOW TO DESIGN THE PROJECT

Project design should combine data analysis, workflow review, policy review, and staff interviews.

CFO takeaways: sponsor projects with specific outcomes, define baseline, owner, and target metric, and avoid “review” without implementation follow-through.



Section 4

Medicare, Policy & Regulatory Updates

Translate reimbursement updates into CFO action.

CY 2027 MPFS proposed rule: payment highlights

Issued July 14, 2026, with policies effective for services on or after January 1, 2027.

Rates and conversion factors

TWO CONVERSION FACTORS

Separate factors continue for qualifying APM participants and non-qualifying practitioners, with statutory updates of +0.75% and +0.25% respectively.

PROPOSED CY 2027 AMOUNTS

Qualifying APM factor of $33.17, down $0.40 (-1.19%); non-qualifying factor of $32.84, down $0.56 (-1.68%).

WHY THEY FALL

The one-year 2.50% statutory increase for CY 2026 expires, requiring a 2.50% reduction that offsets the updates and an estimated +0.53% work RVU adjustment.

Payment policy changes

COMPLEXITY ADD-ON

G2211 would convert to a modifier that raises the associated visit payment 16%, with a second voluntary modifier raising it 32% for Shared Savings Program ACO and LEAD Model participants.

REMOTE MONITORING

RTM limited to established patients, a separately billable initiating visit required, and payment only when clinical staff employed by the practice furnish the service.

Valuation and cost data

PRACTICE EXPENSE REFORM

CMS continues moving from survey data toward objective, auditable cost data and would phase out the step anchoring practice expense RVUs to 2007-or-earlier data, replaced by a practice expense stabilizer.

SITE OF SERVICE

Indirect practice expense would be adjusted for visits during a Part A SNF stay, with comment sought on whether the facility and non-facility differential is still appropriate.

GLOBAL SURGERY

CMS proposes pausing MACRA post-operative visit data collection after several years of data showing paid post-op visits are not occurring, and seeks revaluation strategies.

CFO takeaway: Based on the proposed information consider modeling the conversion factor decline now, then test how the complexity modifier and remote monitoring rules change realized rates per encounter.

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CY 2027 MPFS proposed rule: health center and compliance impacts

The provisions with the most direct effect on FQHC and RHC operations, coding, and reporting.

RHC and FQHC provisions

NEW STAND-ALONE VISITS

Diabetes self-management training and medical nutrition therapy would be recognized as qualified preventive services paid at the all-inclusive rate as stand-alone billable visits.

BEHAVIORAL HEALTH ACCESS

In-person visit requirements for mental health visits would not apply through December 31, 2027 under CAA 2026.

TELECOMMUNICATION PAYMENT

Payment for non-behavioral-health visits furnished through telecommunication technology is extended through December 31, 2027.

Coding and care model

SHARED MEDICAL APPOINTMENTS

CMS proposes separate coding and payment for shared medical appointments, which have no HCPCS code today, citing that three in four adults have at least one chronic condition.

BEHAVIORAL HEALTH CODES

Smoking and tobacco cessation and SBIRT services would be added to the final year of the timed behavioral health code work RVU transition.

ADVANCE CARE PLANNING

Two new codes would cover planning furnished by clinical staff under direct supervision, while existing CPT codes are limited to the billing practitioner's own time.

Compliance and reporting

340B CLAIMS REPORTING

Covered entities are expected to submit specified claim data elements for Part D 340B drugs to the Medicare Part D Claims Data 340B Repository for dates of service on or after January 1, 2027.

LABORATORY PAYMENT

Clinical laboratory fee schedule reductions phase in beginning CY 2027 at up to 15% per year through CY 2029, with the next reporting period May 1 to July 31, 2026.

COVERAGE ELIGIBILITY

Medicare eligibility is expected to be limited to four status categories, with new termination procedures, appeal rights, and re-enrollment options.

CFO takeaway: the health center upside sits in new billable visits and extended telehealth flexibility, but the reporting and eligibility changes carry hard January 1, 2027 deadlines.

Medicare program: the puzzle pieces

CFOs need a portfolio view of Medicare, not a single reimbursement lane.

PART A

Institutional provider reimbursement.

PART B

Outpatient and physician professional services.

PART C

Medicare Advantage.

PART D

Prescription drug coverage.

WHO ADMINISTERS IT

The program is administered by regional Medicare Administrative Contractors.

WHAT A STRATEGY MUST COVER

A strategy should address enrollment, billing, reimbursement, pharmacy, and care coordination opportunities.

CFO takeaways: map each Medicare lane, identify who owns it, and review whether billing systems support each opportunity.

Medicare Telehealth: what is extended, and how to bill it

The flexibilities to plan around, and the coding changes that come with them.

CAA 2026 SECTION 6209

Through December 31, 2027: geographic requirements removed, originating sites expanded, eligible practitioners expanded, FQHC and RHC telehealth extended, and audio-only services allowed.

BEHAVIORAL HEALTH IN-PERSON RULE

In-person requirements for mental health services furnished via telehealth are delayed to services on or after January 1, 2028.

MODIFIER REQUIREMENT

Modifiers will be required for telehealth services in certain instances not later than January 1, 2027.

EFFECTIVE OCTOBER 1, 2026

Per CMS MM14468, submit the individual CPT/HCPC code rendered according to the CMS list of telehealth services along with the appropriate modifier.

REVENUE CODE AND MODIFIERS

Report the appropriate revenue code with modifier 93 for synchronous audio-only service, or modifier 95 for synchronous audio and video service.

WHO CAN FURNISH, AND WHERE

Practitioners may furnish distant site services within their scope of practice, from any location, while working for the RHC or FQHC.

CFO takeaway: build the model only on flexibilities that are actually extended, and confirm billing and modifier readiness before each effective date.

Medicare Telehealth: how it gets paid

Payment rates, patient liability, and the classification rule that changes the rate.

NON-BEHAVIORAL HEALTH RATE

Payment amounts updated annually and based on the volume-weighted average of all Physician Fee Schedule telehealth list services, with no adjustment for geographic locality.

BEHAVIORAL HEALTH RATE

Since January 1, 2022, behavioral health services furnished through interactive telecommunications technology are paid at the encounter rate. Include the appropriate modifier for audio-only or audio-video services.

PATIENT LIABILITY

Coinsurance and deductible apply to RHC services and coinsurance applies to FQHC services, based on the lesser of the payment rate or submitted charges. Preventive services patient financial responsibility is waived.

A CLASSIFICATION TRAP

A visit with a psychiatrist or psychiatric nurse practitioner for medication management, or where that provider bills an E/M code, is a medical visit and not a behavioral health visit.

CFO takeaway: the rate follows how the visit is classified, so treat visit type accuracy as a revenue integrity control.

Medicare Advantage Wraparound

MA wraparound is a high-value process issue when it is not set up correctly.

WHAT THE WRAPAROUND IS

For FQHCs under contract with MA organizations, supplemental wraparound payment is intended to address the difference between MA plan payment and the amount the FQHC would otherwise be entitled to receive if reimbursed by traditional Medicare.

WHY CENTERS MISS IT

Confusion around enrollment and payment setup is cited as a reason for not setting up the wraparound rate.

WHAT SETUP REQUIRES

Successful setup requires payor contract review, payment analysis, and claims system configuration.

CFO ACTIONS

Inventory active MA contracts. Identify the current payment methodology. Confirm eligibility for wrap rates. Reconcile payments by payor.

CFO takeaway: **Setup, enrollment, contracting, or system-configuration gaps may contribute to missed wraparound revenue.**

Medicare preventive vaccines

What is covered, how it is paid, and how it is billed and reconciled. Effective July 1, 2025.

WHAT IS COVERED, AND WHEN

Pneumococcal, influenza, hepatitis B, and COVID-19 vaccines and their administration, furnished at time of service, with or without a qualifying visit.

PAYMENT

Vaccine products are paid at 95% of AWP. Vaccine administration is paid according to the National Fee Schedule for Medicare Part B vaccine administration.

BILLING

Report G0008, G0009, G0010, 90480, and M0201 on the UB04 / 837I claim form.

IN-HOME ADDITIONAL PAYMENT

M0201 provides an in-home additional payment for Part B preventive vaccine administration only if the home visit meets all necessary requirements of 42 CFR 405 Subpart X and 42 CFR 410.152(h)(3)(iii).

ANNUAL RECONCILIATION

Annually reconcile payments received with actual vaccine and administration costs on the cost report, including in-home additional costs nly if the data is reflected in the PS&R.

WHY IT MATTERS TO THE CFO

Vaccine payment is only as accurate as the cost report reconciliation behind it, so the PS&R data dependency is the control point.

CFO takeaway: confirm the codes and claim form are configured correctly, then verify the annual cost report reconciliation actually happens.

Medicare non-FQHC services

Services billed outside the FQHC benefit, and the reimbursement rule that applies to them.

SERVICE CATEGORIES

Durable medical equipment, ambulance, prosthetic devices, laboratory, and hospital services.

TECHNICAL COMPONENT OF DIAGNOSTIC TESTS

For example, EKG, EEG, ECG, and radiology.

TECHNICAL COMPONENT OF PREVENTIVE SERVICES

Screening pap smears (Q0191), screening pelvic and clinical breast exam (G0101), prostate cancer screenings (G0102), colorectal cancer screening tests, screening mammography, bone mass measurements, and glaucoma screening (G0117 and G0118).

HOW TO BILL AND HOW IT PAYS

Submit on the 1500 / 837P. Fee-for-service reimbursement is based on applicable Medicare fee schedules without regard to the health center's cost of providing such services, with Medicare payment based on the lesser of actual charge or the Medicare fee schedule.

CFO takeaway: these services do not carry cost-based protection, so margin depends on charge setup and fee schedule accuracy rather than the encounter rate.

Section 5

Strategic Growth Drivers: Pharmacy, Productivity, Value-Based Care, and M&A

Pharmacy margin, provider capacity, the move toward value, & M&A.

Assessments and Observations – 340B Pharmacy Program

- Health centers that monitor capture rate and are operating at or near 65% seem to have a high degree of success.
  - Management should work with all of its operating personnel to discuss ways to help increase the capture rate. Forward-facing patient personnel can communicate the availability of the internal pharmacy, while preserving the patient's choice. Ultimately, it is the patient’s decision what pharmacy to use, but the patient should be **fully informed** of the internal pharmacy option
  - Build clinics around pharmacy
- Top 50%-75% of savings generated from small portion of your drugs
- Review 340B missed opportunity by provider
- It is also important to have a good tracking system to determine:
  - Number of scripts per day with the in-house pharmacy
  - Gross Receipts
  - All costs associated with the pharmacy to include staffing, operations, cost of pharmaceuticals and facility costs
  - Net Pharmacy revenue
- Review contract pharmacy financial statements – Opportunities to change formulary if Health Center has an in-house pharmacy

Legislative Update

340B Impacts

Proposed Legislation

- SUSTAIN 340B Act – Senate
- SECURE 340B Act – House
- Senator Bill Cassidy Discussion Draft

MFP Rebate Logic: PBM Payment vs. Manufacturer Rebate

1) Same prescription, two linked but separate financial streams

PBM / Part D Plan Payment	MTF / Manufacturer MFP Rebate
Claim reimbursement stream • Claim adjudicates through PBM / Part D sponsor • Pharmacy reimbursed through normal claim payment process	**Cost recovery / rebate stream** • Claim data supports MFP refund determination • Manufacturer determines whether refund is owed • Rebate is separate from claim reimbursement

Key point: The PBM payment and MFP rebate are tied to the same dispense, but they are not the same payment.

2) 340B / MFP price comparison logic

If 340B Price Is Lower Than MFP	If MFP Is Lower Than 340B Price
340B is the better price • Covered entity should not receive additional MFP value on top of 340B • No double benefit • No incremental MFP rebate expected Example: WAC $1,000 | MFP $700 | 340B $400 Better price = 340B	MFP is the better price • Pharmacy may receive MFP rebate • Refund helps bring effective cost down toward MFP • Potential incremental MFP value exists Example: WAC $1,000 | 340B $700 | MFP $500 Better price = MFP

Pharmacy Operations

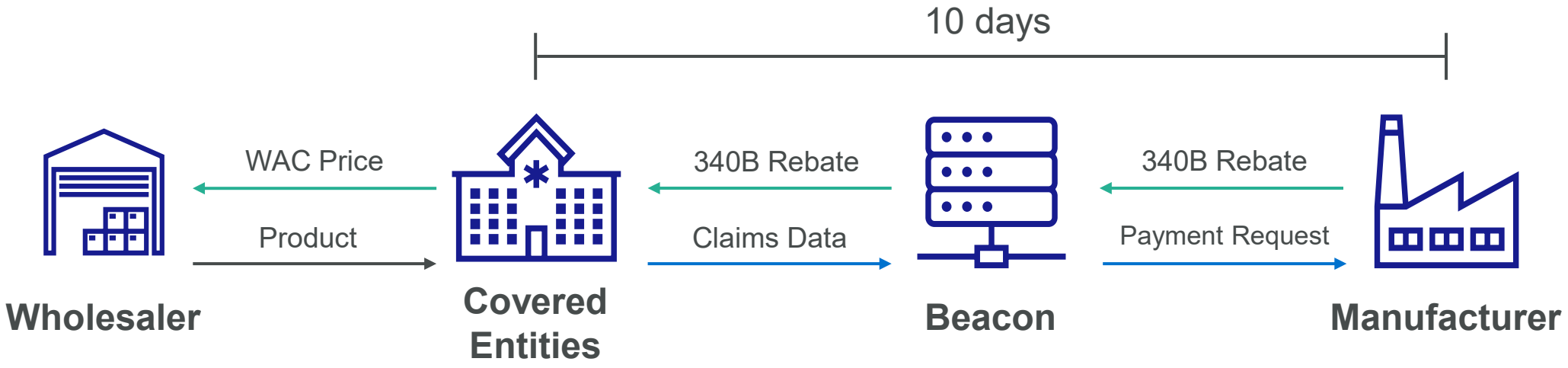
Medicare Drug Price Negotiation Program

One MFP Rebate requires a minimum of six platforms

Legislative Outlook: MFP Rebate Timeline

340B Rebate: Overview

- January 1, 2027
  - Includes 2026 and 2027 drug list
- All purchasing will continue to take place on 340B accounts with **WAC pricing** loaded
- Manufacturer plans due August 24, 2026
  - HRSA approval of plans expected September 24, 2026



Legislative Outlook: How to Prepare
340B Rebate: Preparing Your Entity

Assess the Impact

Determine your volume of rebate-eligible dispensations and administrations. Estimate the WAC and 340B cost differential to understand cash flow changes.

Ongoing Education

The program is being developed in real time. Attend webinars, monitor news releases, and engage with Beacon's provided resources. Always defer to HRSA guidance if discrepancies arise.

Develop Processes

Engage with TPAs and pharmacy platforms to understand reporting capabilities. Request data specs for all reports (utilization, HL7 feeds, dispensing data, etc.).

Track Time Spent

The program is intended to be at "no-cost" to covered entities. Track your time and resources spent to support future comments on the program's success.

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Legislative Outlook: MTF & Beacon Platforms

340B Rebate: Software Management

Medicare Transaction Facilitator (MTF)

- **Mandatory enrollment for Part D participants**
- Facilitates the effectuation of MFPs to dispensing entities
- Data is received from plan sponsors
- Payments are made via the MTF Payment Module (manufacturer dependent)
- Dispensing entities are the intended user

Beacon MFP Platform

- **Optional participation**
  - MFP rebates will process via the MTF automatically
- View MFP rebate information including status & resolutions
- Data is ingested via the MTF
- No payment facilitation
- Pharmacies are the intended user

Beacon Rebate Platform

- **Necessary to ensure 340B pricing on eligible claims**
- Submit claims data, monitor approvals & payment status
- Data must be uploaded by CE
- Beacon facilitates payment of rebate amounts
- Covered entities are the intended user

Note: Each platform is distinct and requires a unique registration.

Legislative Outlook: 2026 Negotiated Drug List

340B Rebate & IRA: 2026 Drug List (Medicare Part D)

Manufacturer	Drug Name	Conditions Treated
AbbVie	Imbruvica	Blood Cancers
Amgen	Enbrel	Rheumatoid Arthritis, Psoriasis, Psoriatic Arthritis
AstraZeneca	Farxiga	Diabetes, Heart Failure, Kidney Disease
Boehringer Ingelheim	Jardiance	Diabetes, Heart Failure, Kidney Disease
Bristol Myers Squibb	Eliquis	Prevention & Treatment of Blood Clots
Janssen (J&J)	Stelara	Psoriasis, Psoriatic Arthritis, Crohn's Disease, UC
Janssen (J&J)	Xarelto	Prevention & Treatment of Blood Clots, Stroke Reduction
Merck	Januvia	Diabetes
Novartis	Entresto	Heart Failure
Novo Nordisk	Fiasp, NovoLog	Diabetes

Legislative Outlook: 2027 Negotiated Drug List

340B Rebate & IRA: 2027 Drug List (Medicare Part D)

Manufacturer	Drug Name	Conditions Treated
AbbVie	Linzess; Vraylar	IBS; Schizophrenia/Bipolar Disorder
Amgen	Otezla, Otezla XR	Psoriasis, Psoriatic Arthritis
Astellas	Xtandi	Prostate Cancer
AstraZeneca	Calquence	Leukemia/Lymphoma
Boehringer Ingelheim	Ofev; Tradjenta	Pulmonary Fibrosis; Diabetes
Bristol Myers Squibb	Pomalyst	Multiple Myeloma
GlaxoSmithKline	Breo Ellipta, Trelegy Ellipta	COPD/Asthma
Merck & Co.	Janumet, Janumet XR	Diabetes
Novo Nordisk	Ozempic, Rybelsus, Wegovy	Diabetes, Weight Loss
Pfizer	Ibrance	Breast Cancer
Salix Pharmaceuticals	Xifaxan	Hepatic Encephalopathy
Teva	Austedo, Austedo XR	Tardive Dyskinesia

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340B governance framework

Use CFO oversight to connect compliance, finance, and access.

Compliance discipline

- Eligible-patient workflows
- Audit readiness

- Contract pharmacy oversight

Financial discipline

- Contribution reporting
- Savings volatility monitoring

- Reinvestment planning

Access discipline

- Medication affordability
- Adherence support

- Care gap closure

Productivity: capacity, access, and revenue

Productivity is not just a provider metric; it is a capacity and access strategy.

CAPABILITY

Is everyone working to the top of their capability?

ACCESS

Do the clinic hours support the needs of the community?

PROVIDER ECONOMICS

Are the providers covering their salary with their current visit volume?

HIRING AND RETENTION

Is hiring and retention an issue? In certain departments or across the board?

SCHEDULING

Flexible work schedules?

COMPENSATION

Compensation?

CFO takeaways: track capacity and actual utilization, separate controllable from structural gaps, and balance productivity with quality and access.

Why M&A belongs in the CFO workgroup

M&A should be discussed as strategic readiness, not only as crisis response.

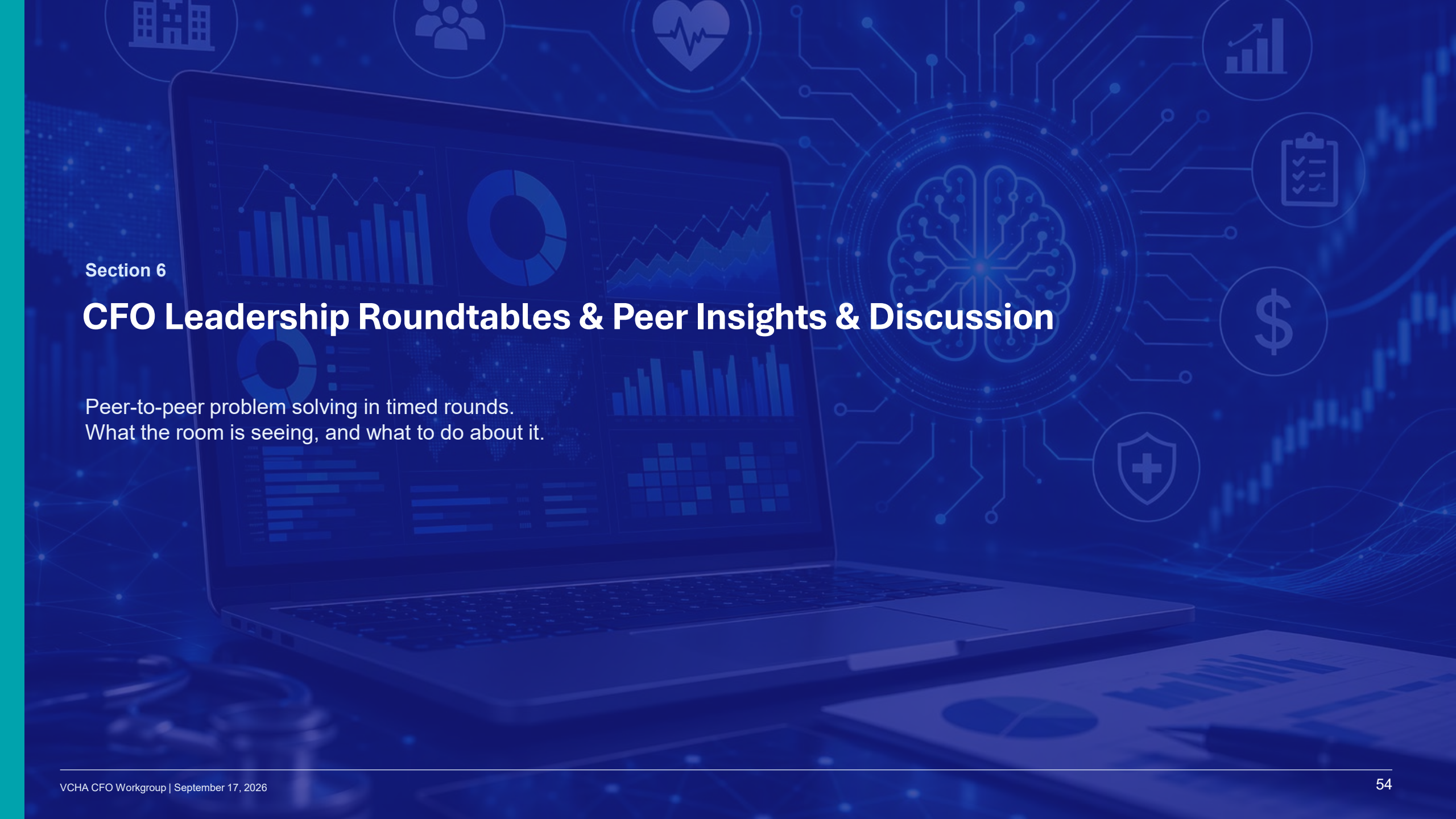
WHAT TRANSACTION-STYLE DISCUSSIONS COVER

For FQHCs, transaction-style discussions can include affiliation, consolidation, acquisition of sites, shared services, joint venture structures, and payor or pharmacy alignment.

WHAT THE CFO NEEDS TO UNDERSTAND FIRST

CFOs should understand mission, governance, reimbursement, compliance, operational, and community access implications before a transaction is active.

CFO takeaways: create an evaluation framework now, separate strategic fit from financial distress, and include reimbursement and compliance early.



Section 6

CFO Leadership Roundtables & Peer Insights & Discussion

Peer-to-peer problem solving in timed rounds.
What the room is seeing, and what to do about it.

CFO roundtable

Open the floor – member experience is the content.

- Round 1 – What is working: one change your health center made this year that measurably improved margin or cash.
- Round 2 – What is stuck: the revenue cycle, workforce, or payor problem you have not been able to solve.
- Round 3 – What is coming: the 2027 exposure you feel least prepared for – 340B rebates, HR1, payor mix, or workforce cost.
- Round 4 – What we do together: where this group can share tools, benchmarks, or negotiating position.
- Round 5 – What we commit to: one action each CFO will take before the next session.

Facilitation notes

- Two to three minutes per member.
- Capture themes, not solutions.
- Close by naming the top three shared priorities.

Discussion questions

Use these to make the workgroup practical and interactive.

- Where are Virginia CFOs seeing the most immediate revenue leakage?
- What payor issues are recurring across multiple member health centers?
- What Medicare and telehealth changes require the most education before implementation?
- Which 340B or pharmacy pressures are affecting budget planning?
- What one operational metric would improve decision-making if every member tracked it monthly?

CFO takeaways

- Capture member examples.
- Identify common workgroup follow-up topics.
- Use answers to prioritize future trainings.

Section 7

The 2027 CFO Action Plan

Strategic readiness and a 12-month execution agenda.

12-month CFO action roadmap

Close with a plan that members can adapt locally.

FIRST 30 DAYS

Identify top three revenue opportunities, assign owners, and gather baseline data.

60 TO 90 DAYS

Complete targeted reviews such as fee schedule, SFDS, payor contracts, MA wrap, or denial root causes.

6 MONTHS

Implement workflow changes, contract escalation routines, dashboards, and training.

12 MONTHS

Evaluate financial impact and update the strategy for Medicare, 340B, VBC, AI, and strategic partnerships.

CFO takeaways: make it measurable, assign executive owners, and revisit monthly.

CFO priorities for 2027

Discussion closing slide.

Protect the core

- Revenue cycle fundamentals
- Fee schedule and SFDS discipline
- Payor contracts and denials
- Productivity and access

Grow strategic revenue

- Medicare strategy
- MA wrap and care coordination
- 340B governance and reinvestment
- Value-based care capability

Build readiness

- HR1 and regulatory monitoring
- AI governance and analytics
- M&A / partnership framework
- Board-level financial storytelling

Thank you

Scott Gold, CPA, Partner
Nicole Moscatelli, CHFP, Director

Questions and discussion

CFO Workgroup

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