MEDI-CAL FEDERALLY QUALIFIED HEALTH CENTER ALTERNATIVE PAYMENT METHODOLOGY PROGRAM GUIDE

October 16, 2024

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I. Introduction to the FQHC APM

The California Department of Health Care Services (DHCS) is developing the State's new Alternative Payment Model (APM) for participating Federally Qualified Health Centers (FQHCs) in a manner to incentivize delivery system and practice transformation through the flexibilities available under a fully capitated reimbursement model on a per member per month (PMPM) basis. FQHCs participating in this APM would be able to move away from the volume based, per visit payment to a front-loaded reimbursement methodology that more closely aligns with evolving practice needs and the effective delivery of health care services.

The APM will be developed by leveraging base year FQHC utilization data and managed care membership data. Each participating FQHC will receive monthly payments equivalent to their projected prospective payment systems (PPS) payment entitlement in the form of an APM PMPM rate, paid across all assigned members for each managed care plan (MCP) the participating FQHC has contracted. Adjustments for data quality and unassigned member outlier claims will be made to the APM PMPM. Upon implementation, DHCS will be including APM PMPM rates in monthly capitation paid to MCPs. MCPs will then be expected to remit appropriate APM PMPM payments to participating FQHCs for assigned members.

DHCS will be implementing safeguards to ensure FQHCs in the APM with MCP contracts will be paid their APM PMPM based on assigned member months, regardless of whether assigned patients receive services in a particular month and FQHCs under the APM without MCP contracts receive their full PPS entitlement for encounters rendered. On an annual basis, the State will verify and reconcile payments made to participating FQHCs are sufficient and comply with all APM requirements, and participating FQHCs did not experience increases in utilization. In the event the PMPM payments are determined to be inadequate during reconciliation, DHCS will pay the participating FQHC the difference between the total PMPM amount paid and the amount the entity would have received under the traditional PPS rate methodology.

To incent enhanced health care access and quality for Medi-Cal members, the new APM methodology will be linked to specific quality metrics that must be satisfied by the participating FQHC as a condition of continued participation in the APM program.

Legislative Background on the FQHC APM

Under the Benefits Improvement and Protection Act (BIPA) of 2000, section 702, California was required to adopt a PPS for FQHCs for federally defined encounters by qualified practitioners. Under that legislation, the State also has the option of developing an APM.

APM Purpose

The purpose of the APM is to create a value-based payment arrangement where reimbursement is no longer volume-based. FQHCs will be paid a monthly PMPM. Care teams (including non-billable providers under the PPS) will serve clients and some traditional visits by physicians will be converted to new modes of care (e.g., email, group visits). The APM PMPM will be based on historic utilization under the PPS and, as traditional encounters decrease as care is transformed, the PMPM may exceed the PPS reimbursement. FQHCs may retain the entire PMPM as long as they meet quality and access metrics. The State will ensure FQHCs are paid at least as much under the APM as they would have been paid under PPS.

Intended Use of Program Guide

The FQHC APM is a significant change to the traditional payment model and a high priority for DHCS to achieve practice transformation. DHCS recognizes the work California MCPs and FQHCs will be doing to operationalize the APM among other new initiatives under California Advancing and Innovating Medi-Cal (CalAIM) and to transition reimbursement smoothly as quality of care improves.

Throughout 2023 and 2024, DHCS has offered a range of technical assistance and support including detailed implementation requirements and guidance presented in this Program Guide. In addition, DHCS will post available materials on the DHCS website, host webinars, and provide other opportunities for discussion to support the implementation of the APM and other CalAIM initiatives. All information provided in this program guide is preliminary and subject to change. This program guide is for informational purposes and is not intended to replace future guidance and State and/or federal requirements.

For specific questions about the FQHC APM, please submit to: FQHCAPM@dhcs.ca.gov.

A Frequently Asked Questions document, which provides up-to-date information about the FQHC APM implementation, will be updated regularly and is available from the *FQHC APM Resource Directory*.

II. What are the Goals of the FQHC APM Program?

Introduction

CalAIM is a new initiative by DHCS to improve the quality of life and health outcomes of Medi-Cal members by implementing broad delivery system, programmatic, and payment system reforms. CalAIM establishes a framework to address social determinants of health (SDOH) and to improve health equity statewide. A key feature of CalAIM is the introduction of value-based purchasing for FQHCs through the APM. For more information about CalAIM, see DHCS' revised CalAIM proposal released on January 8, 2021. [1]

The FQHC APM will require significant new investments in care management capabilities, infrastructure, information technology (IT) and data exchange, and workforce capacity at both the MCP and FQHC levels. FQHCs' will be permitted to retain "Pay for Transformation Payment" or "the wedge", which refers to the difference in reimbursement an FQHC would receive under an APM PMPM and what the FQHC would have received under PPS, assuming traditional PPS-reimbursable encounters decline. FQHCs' retention of "Pay for Transformation" ("the wedge") will be a critical component of CalAIM to promote MCP and provider participation in and capacity building for the APM.

DHCS has designed a payment approach with input from stakeholders with the goal of capitation payments to MCPs including the APM.

Listed below are the goals and design principles of the program.

Overview of the APM

As authorized in Section 1902(bb)(6) of the Social Security Act (SSA), California will establish an APM for FQHCs for members and services under managed care. The APM will reimburse participating FQHCs on a PMPM basis. The APM was first launched in July 1, 2024, and is only available to FQHCs participating under managed care contracts. Any FQHC may elect to participate in the APM if the clinic submits an application and is approved to participate by the State. Ongoing participation of individual FQHCs is contingent upon meeting minimum access and quality thresholds (Gate) and maintaining quality metric performance as described below. FQHCs electing not to participate in the APM or are not eligible/approved to participate in the APM will

[1] https://www.dhcs.ca.gov/calaim, January 2021.

continue to be reimbursed in accordance with the PPS State Plan methodology. If not approved to participate initially, FQHCs may continue to improve their processes and infrastructure and reapply in subsequent years. All services provided to fee-for-service (FFS) members or services not included in the managed care contract will also continue to be reimbursed in accordance with the approved State Plan methodology for FQHC PPS reimbursement. Dual-eligible members will be excluded from the APM PMPM.

The APM is intended to allow innovative payment reform and quality of care improvement. With the flexibility of payment reform, FQHCs will provide and/or expand upon the innovative forms of care which are not reimbursed under traditional volume-based PPS.

Centers for Medicare & Medicaid Services (CMS) allows the "Pay for Transformation Payment" or "the wedge" that exceeds the current utilization multiplied by the current PPS rate to be "at risk" (i.e., excess revenues above PPS, also known as "the wedge"). Under the APM, FQHCs will increasingly take on some level of risk in excess of the PPS over time.

The Pay for Transformation Payment will equal the historic encounter utilization priced at the current PPS minus the current encounter utilization priced at the current PPS, where an encounter meets the State's statutory and regulatory definitions of an encounter.

An FQHC can increase the size of the pay-for-transformation funding by improving its efficiency while maintaining access and improving the quality of care for its members. The size of the pay-for-transformation funding is unrelated to the Alternative Encounters provided.

Requirements for FQHC Participation in the FQHC APM

Pursuant to the approved State Plan, FQHCs and FQHC look-alikes may voluntarily apply to participate in the APM. However, FQHCs must first obtain State approval of readiness to participate by demonstrating all the requirements under the APM will be met. The application process and FQHC eligibility is explained further below.

Once approved by DHCS, the FQHC will be added to the APM program and posted on the DHCS website as a State-approved FQHC APM participant. While FQHC participation is voluntary, MCPs and their delegates must participate in the APM for any FQHC APM participant providing care for an MCP member, whether or not the MCP has a contract with the APM-participating FQHC. The first round of FQHC APM applicants that elected to participate implemented the APM program on July 1, 2024. Additional FQHC APM participants will be added to the APM program January 1, 2026, with an annual application and enrollment process occurring on a 12-month cadence thereafter.

Federal Requirements: Federal law allows a Medicaid State Agency to pay FQHCs using an APM as long as:
It is voluntarily agreed to by the state and the individual FQHC
It "results in payment to the center or clinic of an amount which is at least equal to the amounts otherwise required to be paid to the center or clinic" under PPS *(An FQHC attestation of receipt of PPS is not sufficient, the FQHC must be able to document receipt of at least PPS)*
It does not exceed what would be paid under the applicable upper payment limit provisions.

Federal Requirements for the APM

According to Section 1902(bb)(6) of the SSA, when the state implements an APM, there are two federal statutory requirements; first, the APM must be agreed to by the state and the individual FQHC, and second the APM must result in payments to the FQHC that are at least equal to what the FQHC would have received under PPS. In addition, the alternative payments cannot exceed what would be paid under the applicable upper payment limit provisions.[2] California State Legislative updates were made as part of Senate Bill 184 (Ch. 47, Stats. 2022).

CMS has stated that the state may not implement an APM if an FQHC agrees to the APM that results in a payment amount lower than the amount the FQHC would receive under the Medicaid PPS.. If a state chooses to adopt an APM, it must prove every year

[2] *Source: Benefits Improvement and Protection Act (BIPA) of 2000,section 702, Prospective Payment System for FQHCs and RHCs Affected FQHCs and RHCs Q's and A's, 2001*

that each FQHC's APM payments are equal to or more than that FQHC's payments under the PPS. The state must develop a process comparing what the PPS-based reimbursement would be to their reimbursement under the APM.[3]

Goals of the FQHC APM

The APM is intended to align with and support the DHCS' quality strategy including:

- Eliminating health disparities through anti-racism and community-based partnerships.
- Data driven improvements that address the whole person.
- Transparency, accountability, and member involvement.

Under the APM, FQHCs from across the State and across various managed care models are expected to develop transformation plans to transition to a reformed payment model and delivery system leading to higher quality of care to members. Members will experience improvements in access to and quality of care, and health disparities will be reduced. Prospective, predictable payments, and flexible use of resources will enable and drive care delivery transformation for clinics. Provider care teams will be more satisfied in their practice and workforce retention in FQHCs will increase.

The goals and performance metrics under the FQHC APM are consistent with CalAIM quality strategy goals to engage members as owners of their own care, to keep families and communities healthy via prevention, to provide early interventions for rising risk populations and patient-centered chronic disease management, and to provide whole person care for high-risk populations, addressing drivers of health. Over time, DHCS expects the quality outcomes of FQHC-served managed care members to improve.

The APM Guiding Principles obligate the payment modernization to support:

- Patient-centered care, allowing members to receive needed services conveniently (e.g., via a broader range of care team providers)
- Alignment of measures in CalAIM, Medi-Cal managed care, and pay-for-performance (P4P) programs to ensure greatest impact in quality targets
- Data informed innovation that encourages deeper health information exchange between MCPs and FQHCs
- Care of the whole person, including the integration of physical, behavioral, and oral health services, in addition to long-term services and supports

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[3] *Source: Benefits Improvement and Protection Act (BIPA) of 2000,section 702, Prospective Payment System for FQHCs and RHCs Affected FQHCs and RHCs Q's and A's, 2001*

- Delivery reform that focuses on value and outcomes, and acknowledgement that investment in early intervention and primary care can result in per capita cost decreases to the larger Medi-Cal program
- Reduction in disparities by allowing FQHCs more flexibility to address member needs, including SDOH
- FQHC experience as providers in Medi-Cal by reducing administrative burden and providing consistent and timely payment that helps to ensure a strong and resilient safety net in California

As part of the foundation for the FQHC APM, DHCS will work with participating FQHCs to build capacity and create a foundation for delivery system transformation and payment reform. DHCS will create a standard set of requirements across MCPs, including readiness standards for coding/data capture/reporting. DHCS will also set fundamental outcome and access measures for the APM with minimum performance levels and improvement targets. There will be penalties for participating FQHCs if thresholds and benchmarks are not met (e.g., removal from APM, return of a portion of the transformation payment exceeding PPS, etc.).

To support FQHCs to regularly review and improve performance in the APM framework, the industry will convene a learning and improvement community for participating FQHCs through the "FQHC Quality Collaborative".

DHCS will convene an advisory group to recommend options for State decision on the APM The Post-implementation Advisory Group will recommend options for State decision on the APM program with two distinct subcommittees; one for quality and one for policy and reimbursement. The advisory group and its subcommittees will be convened and coordinated by DHCS to provide a venue for shared discussion, feedback, and input into APM program considerations, including metrics, and alignment with other programs with DHCS final decision-making.

APM Federal Authority

DHCS' authority to implement the APM will stem from a State Plan Amendment (SPA) approved by CMS. The SPA will document how the APM will adhere to the APM Federal and State requirements including the voluntary nature of the FQHC participation in the APM and the requirement that the APM is as at least what the FQHC would have otherwise received under PPS (attestations are not sufficient).

As authorized in Section 1902(bb)(6) of the Social Security Act and under its approved SPA, the State of California shall reimburse participating FQHCs contracting with MCPs in this APM in order to facilitate and incentivize delivery system and practice

transformation. Participating FQHCs in this APM will receive reimbursement for APM Enrollees from Medi-Cal MCPs on the basis of a unique, PMPM payment that, in the aggregate for each FQHC, is verified annually to be at least equivalent to the amount the participating FQHC would receive under the applicable PPS rate if it were paid on a per-encounter basis for billable visits defined in subdivision (g) of section 14132.100 in accordance with the California State Plan and the Program Guide Section VIII. FQHC APM – Annual Reconciliation.

- The APM is only available to FQHCs operating in the State of California that are assigned Medi-Cal Members for services through a contract with a Medi-Cal MCP, which are selected by DHCS in accordance with the criteria set forth in Section III – Application and Eligibility.
- This alternative payment methodology is voluntary. FQHCs who apply and meet the criteria in Section III – Application and Eligibility may participate, but are not required to. FQHCs that do opt to participate for a calendar year must do so for the entirety of that year.
- Nothing in the APM relieves FQHCs of the responsibility to operate in accordance with all applicable state and federal laws, regulations, and guidance, including those including those regarding, licensure, and scope of practice. This includes, but is not limited to requirements imposed by CDPH, DCA, and boards of healing arts.

Roles

Each partner in the APM has a crucial role to ensure success of the program. These roles are described in detail below:

- DHCS provides oversight and accountability for the APM. DHCS will fund the APM by ensuring the entire PPS is in the capitation rate as it relates to managed care covered services. In addition, DHCS will work with the State's actuary to develop the APM PMPMs to be paid to FQHCs. DHCS will continue to set each PPS rate and to determine any change in scope of service request (CSOSR). DHCS will annually reconcile to ensure FQHCs receive the minimum PPS rates across the FQHC program and will provide additional funding to the FQHCs when the annual reconciliation demonstrates that utilization necessitates additional PPS payments. DHCS will ensure the MCPs in Medi Cal are contractually required to pay the APM or PPS rates even when not contracting with FQHCs participating in the APM. Through the contract amendment, DHCS will ensure dispute resolution processes exist between MCPs and FQHCs for payment, encounter, and quality

data disputes. DHCS will also develop the SPA, develop guidance to MCPs, develop policies and procedures for participation of plans, FQHCs, and delegated entities (when applicable), and select/determine the readiness of any FQHC willing to participate in the APM.

- MCPs will ensure FQHCs are paid the full State-established APM PMPM (at least equal to projected PPS) for assigned members. MCPs are responsible for reimbursing APM participating FQHCs at the FQHC PPS rate for non-contracted unassigned visits. MCPs are responsible to share complete FQHC encounter data with DHCS and provide data dashboards with performance metrics, encounter data, and assigned lives back with participating FQHCs. MCPs will provide a dispute resolution process for reimbursement and data correction with FQHCs, as well as review and reconcile quality data issues with FQHCs including accepting encounter data for Alternative Encounters and unassigned members from participating FQHCs. MCPs must assign members to FQHCs and other primary care providers and review and reconcile member assignment roster with FQHCs as needed. MCPs must assign members to the FQHC National Provider Identifier (NPI) or site and work with providers to accurately maintain assignment, per the DHCS assignment letter. MCPs may request additional data or elements from their contracted clinics participating in the APM unrelated to the APM. The MCPs will not impose mandatory reporting requirements as a precondition of an FQHC participating in the APM that differ from or are additional to those required for encounter and supplemental reporting under the APM by DHCS. The MCPs, as a contractor and designee of DHCS, will be responsible for implementing all FQHC APM Corrective Action Plans (CAP) in collaboration with other contracting MCPs for each FQHC.
    - MCP readiness: Medi-Cal MCPs will be required to amend contracts with participating network FQHCs to incorporate the specific provisions and requirements of the proposed APM. FQHCs may elect to include all or some of their PPS rates/sites. If a PPS site is selected and there are intermittent sites and/or mobile units affiliated with that PPS site, then those intermittent/mobile locations must be included in the APM. Medi-Cal MCPs and FQHCs under the APM should negotiate updates to contracts to incorporate the specific provisions and requirements of the proposed APM during the readiness process prior to go-live. Contract negotiations should incorporate provisions (i.e., memorandums of understanding [MOUs]) so funds flow is not affected by delay of fully executed contracts. DHCS will give MCPs six months to update their

contracts with FQHCs with the contracts being required to have a retroactive date back to the start date. Medi-Cal MCPs and FQHCs under the APM should negotiate updates to contracts to incorporate the specific provisions and requirements of the proposed APM during the readiness process prior to go-live. Contract negotiations should incorporate provisions (i.e., MOUs) so funds flow is not affected by delay of fully executed contracts.

- FQHCs participating in the APM must develop and implement practice transformation plans, provide complete encounter data to the MCPs, meet quality, and access metrics, and submit data required for MCPs to calculate performance metrics as outlined by DHCS to the MCPs. Annually, the participating FQHCs must provide documentation to verify it receives the full State-established APM PMPM (equal to the projected PPS) for assigned contracted MCP members, as well as the PPS for member encounters from non-contracted MCPs, and cooperate with any State reconciliation processes.
- Delegated entities must ensure FQHCs are paid the full State-established APM PMPM (equal to the projected PPS) for assigned members, ensure there is a member assignment roster assigning each member to an FQHC, ensure data is submitted to MCPs consistent with MCP requirements, and perform other functions delegated by the MCPs.
    - The State of California does not have a contractual relationship with delegated entities or subcontractor networks. DHCS respects the relationships and continues to enforce All Plan Letter (APL)23 006 but does not mandate any particular delegate structure with FQHCs and MCPs, which can vary. Contractual relationships between delegated entities, FQHCs, and MCPs vary and are not mandated; therefore, each delegated entity, MCP, and FQHC will need to interpret this program guide as applicable for its unique contract (if any). It is the responsibility of the MCP and FQHC to ensure the delegated entity providing services to either party complies with any portion of the applicable program guide. In all instances, the MCP and FQHCs should ensure the delegated entity and its services comply with the APM requirements including:
        - Recognizing infrastructure and IT investments may be built at the delegated entity on behalf of the MCPs or FQHCs and therefore must comply with all APM requirements.
        - Recognizing FQHCs may contract directly with an MCP or indirectly through a delegated entity.

- Including the readiness attestation of the delegated entity in the FQHC or MCP checklist to the extent the FQHC or MCP relies on a delegated entity for one of the services outlined. FQHCs and MCPs completing a readiness attestation checklist must identify the service/function provided by the delegated entity and attest to the delegated entity's readiness.
- Updating contract references between MCPs and FQHCs includes updating contracts with delegated entities for APM specific services as needed, particularly in markets where contracts between MCPs and FQHCs only exist through the delegated entities.
- Complying with any APM requirements for services or functions delegated by MCPs or FQHCs under the APM including any quality improvement activities, data capabilities, assignment of medical homes at the NPI level, acceptance and complete transmission of encounter data, and reconciliation of member rosters.
- Including a description in any APM application by an FQHC of how data is submitted to each primary MCP with a contract directly with DHCS including any delegated entity services or functions that occur during that process. Any application to the APM by an FQHC must include a description of the processes that FQHC will use to internally track data for all APM quality metrics (e.g., using data from electronic medical record [EMR] Health Practice Management tools such as I2I and Arcadia) and the FQHC's ability to interface with various portals. Any application to the APM by an FQHC must include a description of how the FQHC will transmit encounter data as specified in the prime MCP provider contract with DHCS. If there is a delegated entity with services or functions related to transmitting encounter data, the FQHC should include a description of those services/functions.
- Ensuring auditable payment information is provided to the MCP through encounter data when required by DHCS so it is available to DHCS as needed.
- Interpreting the APM Program Guide to include any delegated tasks. The Program Guide is written by DHCS for its prime

contractor (MCPs) and the providers (FQHCs) with direct contact with members who are entitled to PPS payments under federal statute. The MCP must ensure that it oversees and holds accountable any functions and responsibilities that it delegates to any subcontractor. The subcontract does not terminate the legal responsibility of the MCP to assure all activities under the Medi-Cal contract are carried out. The MCP is not relieved of its contractual responsibility to DHCS by shifting that responsibility to a delegated entity. In the same way through delegation, the FQHC is not relieved of its duties to demonstrate to DHCS that it has received the full PPS/APM payments through encounter data.

- to demonstrate to DHCS that it has received the full PPS/APM payments through encounter data.

FQHC APM Implementation Timeline

The FQHC APM was launched for approved FQHCs beginning July 1, 2024. All MCPs must implement the FQHC APM at this time and pay participating FQHCs consistent with the APM whether or not the MCP and its delegates assign members to the APM or not (either paying the APM PMPM for assigned members or paying the PPS when there are no assigned members but an MCP member visits a participating FQHC).

Definitions

- APM Enrollee — a Medi-Cal member who is assigned by a Medi-Cal MCP or subcontracting payer to a participating FQHC site for primary care services and who is under the APM. All FFS beneficiaries and any MCP members who are in a dual eligible category of aid (COA) are excluded from the APM.
- APM Service — a service within the scope of services for a participating FQHC for which it is entitled to receive a per-encounter rate under PPS but only to the extent that it is covered under the MCP contract and not excluded from the APM. Dental services, Community-Based Adult Services and benefits available in managed care but not under the State Plan, such as enhanced care management (ECM), are excluded from the APM.
- FQHC - means any community or public “federally qualified health center,” as defined in Section 1396d(l)(2)(B) of Title 42 of the United States Code and providing services as defined in Section 1396d(a)(2)(C) of Title 42 of the United States Code.. Qualifying tribal entities such as Urban Indian Health Organizations

must meet this definition and may participate in the FQHC APM only if they: (1) Affirmatively obtain FQHC status; and (2) Are reimbursed via a PPS rate at the time of their requested participation in the APM. Tribal entities reimbursed under the IHS rate are not included in this definition. Rural Health Clinics are excluded from this definition.

- Gap — refers to the difference between the participating FQHC's end of prior-program year (PY) performance and the current PYs high performance benchmark. A participating FQHCs' performance rate and final target shall be rounded to the same number of decimal places as the measure's benchmark.
- Medi-Cal managed care plan (MCP) – the Medi-Cal managed care plan defined under subdivision (j) of WIC Section 14184.101
- Parent Site — means an FQHC site with or without associated Intermittent Site/Mobile Units (identified by NPI number). An FQHC may identify the Parent Site through any billing NPI when it applies for the APM, but must include all Intermittent Site/Mobile Units and mobile units/sites associated with that billing NPI under the APM.
- Intermittent Site/Mobile Unit means: (1) an FQHC site that is open for 40 or fewer hours per week, is exempt from licensure, and that bills Medi-Cal under an associated Parent Site billing NPI number OR (2) a mobile unit shares a rate with the Parent Site. Intermittent Sites/Mobile Units must be included on the HRSA scope and Notice of Award, approved by the department to be included on the Parent Site's provider master file with DHCS, consistent with DHCS policy, and, except when the Parent Site is license exempt, included on the Parent Site's license. Intermittent Sites/Mobile Units must be included in the APM application.
- Traditional Wrap-around Payment (wrap) — the supplemental payments payable to an FQHC in absence of the APM project with respect to services provided to Medi-Cal managed care enrollees, which are made by the department pursuant to subdivision (e) of WIC Section 14087.325 and subdivision (h) of WIC Section 14132.100.

III. FQHC APM – Application and Eligibility

Application Forms

Check the APM website https://www.dhcs.ca.gov/services/Pages/FQHC_APM.aspx for the latest updates and versions of the following APM documents.

FQHC Application

FQHC Application for January 1 2026

CY 2026 FQHC Application Instructions

FQHC APM CY 24-25 Timeline

CY 2026 Health Plan Roster and Assessment

Overview

Federally Qualified Health Centers (FQHCs) will apply to the State of California Department of Health Care Services (DHCS) to participate in the Alternative Payment Model (APM). Interested FQHCs must self-identify, begin working with Managed Care Plans (MCPs) to obtain member rosters consistent with DHCS requirements, and submit all necessary forms outlined in the application. FQHCs must submit all materials for consideration for a January 1 implementation date by December 16, twelve months preceding the implementation date (e.g., for FQHC APM participation effective January 1, 2026, the application due date is December 16, 2024). MCPs must submit rosters for the FQHC National Provider Identifiers (NPIs) no later than that date as well. DHCS (finance and quality) will vet applications based on criteria and minimum readiness standards. DHCS will review applications to ensure the FQHC as an organization, appears committed to transformation. While the APM is voluntary and FQHCs may select the sites which apply, under the prospective payment systems (PPS), all affected sites under each PPS rate in the APM must participate, including intermittent and mobile sites. DHCS anticipates releasing applications for the APM every year, year-over-year.

Contact Information

FQHC APM Capitated Rates Development Division MS

4413 151 Capitol Ave, Sacramento, CA 95814

Email: FQHCAPM@dhcs.ca.gov

Internet Address: https://www.dhcs.ca.gov/services/Pages/Federally-Qualified-Health-Centers-Alternative-Payment-Methodology.aspx

Eligibility to Apply to Participate

FQHCs, FQHC "look a-likes", and qualifying tribal entities may apply to participate in the APM. FQHC "look a-likes" must meet the requirements in California Welfare and Institutions Code (WIC) 14138.1(i)(B)(iii) and (iv) below. Qualifying tribal entities such as Urban Indian Health Organizations must meet the requirement in WIC 14138.1(i)(B) (iv) below and may participate in the new FQHC APM only if they; (1) Affirmatively obtain FQHC status, and (2) Are reimbursed via a PPS rate at the time of their requested participation in the APM.

The definition at WIC 14138.1(i) states a "FQHC" means any community or public "federally qualified health center," as defined in Section 1396d(l)(2)(B) of Title 42 of the United States Code and providing services as defined in Section 1396d(a)(2)(C) of Title 42 of the United States Code) and refers to the federal definition of FQHC at 42 U.S.C. § 1396d(l)(2)(B) which includes the following references to FQHC "look a-likes" and tribal entities in (iii) and (iv) below:

"(B) The term "Federally-qualified health center" means an entity which

(i) is receiving a grant under section 254b of this title,

(ii) (I) is receiving funding from such a grant under a contract with the recipient of such a grant, and

(II) meets the requirements to receive a grant under section 254b of this title,

(iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant, including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity, or

(iv) was treated by the Secretary, for purposes of part B of subchapter XVIII, as a comprehensive Federally funded health center as of January 1, 1990; and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) [25 U.S.C. 5321 et seq.] or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act [25 U.S.C. 1651 et seq.] for the provision of primary health services. In applying clause (ii),3 the Secretary may waive any requirement referred to in such clause for up to 2 years for good cause shown".

FQHC Selection/Readiness to Participate

On September 23, 2024, the State will open an annual application process for interested FQHCs to apply to participate in the APM for the implementation date of January 1, 2026. DHCS' intended participation goal is to have a variety of FQHCs participate including a blend of urban, rural, large, and small facilities. FQHCs will apply to DHCS to participate in the APM. All sites under each PPS in a participating FQHC must participate including mobile units/sites and intermittent [4] sites associated with the billing NPI PPS rate, even if that intermittent clinic or mobile unit/site is independently licensed (if applicable). Once selected, the FQHCs may not modify the parent, intermittent, and mobile unit/site structure associated with the APM NPI after applying to get into the APM without specific adjustment to the capitated rate. To have actuarially sound managed care rates, there must be sufficient data for the actuary to match the baseline data to the APM structure (i.e., intermittent sites and mobile units/sites in the baseline year should be associated with the same parent billing NPI under the APM).

Application — DHCS will attempt to ensure interested applicants are notified of deadlines with sufficient time to complete the application, which is continuously posted on the DHCS website. DHCS will vet applications based on criteria described below, minimum readiness standards, and an interview process to clarify FQHC responses. While the APM is voluntary, all affected sites under each PPS rate must participate or not participate conjointly. DHCS will review applications to ensure the FQHC as an organization appears committed to transformation. To be considered for participation in the APM, the site must submit a complete application with all required elements and must be deemed to have complete, responsive narratives on all of the criteria listed below and, in the State's, approved State Plan Amendment with Centers for Medicare & Medicaid Services (CMS).

In its sole discretion, DHCS shall select FQHCs that have applied for participation in the APM program for a particular calendar year (CY) based following standards, which demonstrate operational, clinical, data, and financial readiness to participate in the APM in the following manner:

- Complete application and commitment to APM — The FQHC has submitted a complete, written application, including a letter of support from the applying FQHC's Chief Executive Officer (CEO) or designees attesting to the following:

[4] All mobile units are included in references to intermittent sites and vice versa throughout this Program Guide.

    - Commitment to the APM Care Transformation strategy
    - Willingness to commit staff participation in quality collaborative/learning communities
    - Organizational commitment to creating and maintaining an effective quality improvement infrastructure
    - Organizational commitment to redesigning the FQHC's Care team to improve quality of care outcomes
- Encounter Data/Fee-For-Service (FFS) Wrap Claim Match and Percentage of Assigned Encounter Data — FQHC's data must meet a minimum benchmark of at least 66% of wrap records having a corresponding encounter record to determine the data viability for participation in the APM. Only FQHCs with a match rate exceeding this threshold are admitted into the APM.
    - DHCS is currently working on a public facing dashboard that would allow FQHCs to determine their Wrap Claim Match percentage ahead of an application period. That dashboard will not be ready in time for this round of applications. Instead, an FQHC can send an email request to DHCS at FQHCAPM@dhcs.ca.gov and request the Wrap Claim Match percentage. Response time may vary depending on the number of requests. Requests must include the following information:
        - Clinic name
        - NPI
        - Identification as a Parent or Intermittent Clinic
- Assigned Utilization — FQHCs must have at least 50% of reported MCP encounters incurred by assigned APM enrollees demonstrating a commitment to medical home models of care and ensuring an actuarially sound MCP capitated rate can be calculated by the State's actuary for the MCPs with APM contracted FQHCs. DHCS may increase the minimum benchmarks in 2025 and thereafter.
- Data Capabilities — The FQHC has appropriate data capabilities including the ability to submit complete, timely, and compliant encounter data including data reflecting non PPS eligible services addressing health related social needs. In addition, the FQHC demonstrates an ability to internally track data for all APM quality metrics and to interface with various portals thereby enabling the sharing of quality data to health plans.
- Capacity for Care Transformation: APM Strategy — The FQHC has outlined at least a 5-year strategy for participation in the APM to transform its care delivery model and improve quality and health equity and envisions expanding the APM to all sites.

- Capacity for Care Transformation — Experience with strategic practice transformation. The FQHC has documented at least three goals for strategic practice transformation and outlined how participation on the APM will help the FQHC achieve those goals. The FQHC has documented previous experiences and successes with strategic practice transformation.
- Staffing Capacity to Enact Transformation — The FQHC has documented and justified its current care team model and staffing ratios. The FQHC has outlined a plan to modify its care team model and staffing ratios in the next five years to achieve APM Practice Transformation strategic goals. The FQHC has identified potential challenges in achieving the necessary staffing and how it will overcome those challenges.
- Quality Improvement Infrastructure — The FQHC or system has a formal quality improvement infrastructure to improve Healthcare Effectiveness Data and Information Set (HEDIS)/Uniform Data System (UDS) or other quality measures including; clinical staff, methods used, data integration methods, and evaluation of the quality improvement infrastructure. The FQHC has a formal plan for meeting the quality improvement targets and its three top care transformation goals including lessons learned from past relevant successes. The FQHC has identified potential challenges in achieving continuous quality improvement.
- Collaboration and Care Coordination with MCPs — The FQHC has identified specific methods of collaborating with its current MCP contractors to achieve the APM strategic goal and care transformation and to improve patient health.
- Financial and Administrative Capacity to Undertake Payment Reform — The FQHC has the ability and a planned strategy for maintaining financial health while undertaking practice and care delivery transformation efforts including financial resources supporting the Staffing outlined in Staffing Plan.
- Operational Considerations — MCPs contracting with the FQHC report that the FQHC demonstrates operational and data readiness and is in good standing. The FQHC organization demonstrates a commitment to the APM, in part evidenced by the proportion of sites committed to the APM.
- The FQHC is in good standing with State and Federal regulators.
- If a participating FQHC reassigns an Intermittent Site/Mobile Unit(s) to a different Parent Site's NPI subsequent to the base data period, the NPIs of both Parent Sites shall be excluded.
- In order to be eligible to participate in the APM, an FQHC must agree to forgo reassignment of Intermittent Sites/Mobile Units under the APM PMPM during an active APM PMPM rating period (e.g., from the point that the APM PMPM is set

to the end of the annual rating period). Any change in structure must be identified at least 180 days in advance of the next rating period. Data associated with an intermittent site/mobile unit must be identifiable to remove the utilization from the old Parent Site and match to the new structure effective with the beginning of the next rating year.

- A participating FQHC may choose to remove a particular NPI from the APM so long as notice is provided to DHCS no less than 180 days before the beginning of the next managed care rating period.
- In its sole discretion, DHCS may exclude FQHCs for which actuarially appropriate rates cannot be calculated in accordance with the SPA.
- DHCS may choose to remove the NPI from participation in the APM for a participating FQHC in the event DHCS cannot establish a unique APM PMPM for a Parent Site or an actuarially sound capitation rate for the MCP any reasons, including but not limited to:
    - The utilization data in the base year from Intermittent Sites/Mobile Units no longer in the NPI cannot be accurately identified and isolated;
    - The utilization data in the base year from an Intermittent Site/Mobile Unit added to the NPI cannot be accurately removed from another Parent Site NPI or cannot be accurately added to the participating Parent Site's NPI; or
    - The historic claims of an Intermittent Site/Mobile Unit were not submitted to the MCP or DHCS and the base year does not reflect the utilization data of an existing on-going Intermittent Site/Mobile Unit.
- Selected and participating FQHCs, as well as the MCPs with which they contract, must supply DHCS with sufficient information for the development of actuarially sound Medi Cal MCP rates. At a minimum, participating FQHCs and MCPs must submit the following information to DHCS for the development of a unique APM PMPM in the timing and manner determined by DHCS:
    - Identification and documentation of the participating FQHC's contracts for Medi Cal program services with MCP(s)
    - A reasonable estimate of the number of enrollees assigned to the participating FQHC by each contracted Medi-Cal MCP (by NPI number) with MCPs submitting the actual member rosters for the base year data for the participating FQHCs to DHCS
    - The PPS rate for the participating FQHC (by NPI number) and
- Any decision to exclude or remove an FQHC, NPI, or Intermittent Site/Mobile unit from participation in the APM or APM PMPM rate development shall require DHCS to notify the FQHC. If this notification occurs after the APM withdrawal

deadline, the FQHC will have 30 days from the date of notification to withdraw from the APM.

- If information for rate development is unavailable and DHCS is unable to establish a unique APM PMPM rate for a particular NPI associated with a participating FQHC, then such NPI will be excluded from participating in the APM. For an NPI to participate in the APM, the participating FQHC and its contracted MCP(s) must supply DHCS with following the information in the time and manner determined by DHCS and available in the DHCS data warehouse:
  - The data must meet data quality standards of at least a 66% matching rate between managed care encounters and T1015 wrap payments and have at least 50% of encounters from assigned APM enrollees [5]
  - The NPI must have clean base year utilization data for the site sufficient to be able to set an APM PMPM rate and the associated MCP capitation rate (i.e., the structure of the Parent Site and its Intermittent Sites/Mobile Units must match the proposal under the APM)
  - The NPI cannot have any change in the licensure structure of the parent or its Intermittent Sites/Mobile Units after the application through the end of the APM year. Any change in structure must be called out in the application or at least 180 days in advance and must include the specific changes to be made and the data must be identifiable to be able to be moved to match the new structure effective with the beginning of the next CY; and
  - These conditions do not preclude a Parent Site from establishing a new Intermittent Site/Mobile Unit starting with no base year utilization so long as the FQHC provides enough utilization information for the State's actuary to set actuarially sound rates.

Ability of an FQHC to Leave the APM

Prior to the first year of participation, FQHCs may withdraw from the APM by submitting a signed letter from the FQHC CEO to DHCS and MCPs at FQHCAPM@dhcs.ca.gov notifying contracted MCPs and DHCS no later than September 1 of the year prior to the

[5] DHCS may increase the minimum benchmarks in 2025 and thereafter.

start date of the contract year. Subsequently, annual opt-out for FQHCs must occur with at least 180-days prior to the start of the next CY (July 1). If an FQHC withdraws or is removed from the APM, the State will develop criteria for the FQHC to become reenrolled. If the FQHC withdraws and changes staff, Audits and Investigations Division (A&I) will be notified and will review with the FQHC regarding whether or not a mandatory Controlled Substance Ordering System (CSOSR) should be filed. State statute requires an FQHC file a CSOSR if the clinic experiences a decrease in the scope of services provided that results in a lower per-visit rate in excess of 2.5%. If services are impacted due to removal or withdrawal from the APM, a CSOSR may be required.

This section will provide additional detail to clarify the selection and participation criteria outlined in Section III. FQHC APM — Application and Eligibility. FQHCs are eligible to apply with DHCS to participate in the APM. DHCS anticipates releasing applications for the APM every year, year-over-year. In the future, DHCS will review applications to ensure the FQHC as an organization, appears committed to transformation, in part, evidenced by the number of sites committed to the APM. While the APM is voluntary and FQHCs may select the parent NPIs to participate in the APM, all affected sites under each parent NPI's PPS rate in the APM must participate, including intermittent and mobile units/sites.

Readiness Checklist

The following inventory of key activities are part of a readiness checklist that FQHCs and MCPs will each respectively complete and attest to prior to the implementation date. The attestation that the organization has successfully completed the full checklist and is ready for participation in the Alternative Payment Methodology Program will be submitted by FQHCs and MCPs with at least 30 days prior to go-live date.

Prior to go live, MCPs and FQHCs should be working together through a collaborative process to improve data quality. The data quality workgroup will continue to work through issues related to data quality, but each MCP-FQHC pair should be actively working to resolve data issues even prior to DHCS's workgroup discussions.

The readiness attestation of any delegated entity should be included in the FQHC or MCP checklist to the extent that the FQHC or MCP relies on a delegated entity for one of the services outlined. FQHCs and MCPs completing a readiness attestation checklist

must identify the service/function provided by the delegated entity and attest to the delegated entity's readiness.[6]

Readiness Attestation Form Content

The purpose of this Alternative Payment Methodology (APM) Program attestation is to provide Medi-Cal Managed Care Plan (MCP) Partners and Federally Qualified Health Centers (FQHC) with an inventory of key activities that must be completed prior to going live. The readiness attestation of any delegated entity should be included in the FQHC or MCP checklist to the extent that the FQHC or MCP relies on a delegated entity for one of the services outlined. FQHCs and MCPs completing a readiness attestation checklist must identify the service/function provided by the delegated entity and attest to the delegated entity's readiness. The State does not have a relationship with the delegated entities. MCPs and FQHCs may decide on a data flow that best meets their needs in an efficient manner. This may include delegated entities at MCP/FQHC option.

MCPs and FQHCs must complete their respective portion of this document and submit the document to DHCS to fqhcapm@dhcs.ca.gov. Policies and procedures in the checklist do not have to be discrete individual documents; an organization can group APM-related policies and procedures within a single document when appropriate. Questions regarding this checklist can be sent to fqhcapm@dhcs.ca.gov.

Entity	Readiness Activity	Completion
FQHC	A policy and procedure to document that the FQHC has been paid the full State-established APM PMPM for each assigned member.	☐ Y ☐ N
FQHC	A policy and procedure to bill uncontracted MCPs the State-established PPS for any member who receives services from the participating FQHC.	☐ Y ☐ N
FQHC	A policy and procedure to submit complete FQHC encounter data to the MCP. DHCS encourages FQHCs that have significant concerns about encounter data submission processes to delay participation until those concerns have been resolved.	☐ Y ☐ N

[6] The State does not have a relationship with the delegated entities. The MCP and FQHCs may decide on a data flow that best meets its needs in an efficient manner. This may include delegated entities at MCP/FQHC option.

Entity	Readiness Activity	Completion
FQHC	A policy and procedure to compare data submitted to the MCP to data received from the MCP including performance metrics, encounter data, and assigned lives. This policy and procedure will be utilized to identify differences between the FQHC submitted data and the MCP shared data.	☐ Y ☐ N
FQHC	A policy and procedure to utilize the MCP dispute resolution process to address variances in reimbursement, encounter data, quality data issues, and assigned lives.	☐ Y ☐ N
FQHC	Programming of all alternative encounters coding into the FQHC's Electronic Health Record and claim or encounter submittal system and a policy and procedure outlining the ability and protocols to submit all claims or encounters including alternative encounter data.	☐ Y ☐ N
FQHC	A policy to receive member assignment information from the MCPs and reconcile member assignment roster with MCPs as needed.	☐ Y ☐ N
FQHC	FQHCs must be able to document they received the APM PMPM for assigned MCP members as well as the PPS rate for unassigned, non- contracted MCP members through encounter data using the coding guidance provided by DHCS. Attestation of receipt will not suffice as	☐ Y ☐ N

FQHC/Provider Group Primary Contact

☐ This documentation serves as attestation that the organization has successfully completed the full checklist and is ready for participation in the APM Program. If the FQHC cannot attest to completion of all the above items, the FQHC cannot elect [the proposed] participation date. Please give a description (in the box below) of the plan to address outstanding items and/or assistance required from MCPs or DHCS.

_____

FQHC signature and date: _____

Additional explanation of Readiness Review guidelines for FQHC from above:

- A policy and procedure (P&P)[7] to document the FQHC has been paid the full State-established APM PMPM (at least equal to projected PPS) for each assigned member.
- A P&P to bill uncontracted MCPs the State-established PPS for any member who receives services from the participating FQHC.
- A P&P to submit complete FQHC encounter data to the MCP.[8] The FQHC should approach the MCP if there are any concerns about encounter data submission process to an MCP.
- A P&P to compare data submitted to the MCP to data received from the MCP including data dashboards with performance metrics, encounter data, and assigned lives. This P&P will be utilized to identify disparities in data between the FQHC submitted data and the MCP shared data.[9]
- A P&P to utilize the MCP data dispute resolution process to address disparities in reimbursement, encounter data, quality data issues, and assigned lives.[10]
- Programming of all Alternative Encounters coding into FQHCs Electronic Health Record and encounter data submittal system and a P&P outlining the ability and procedures to submit all encounters including alternative care service data as outlined in Section XV.[11] The State does not have a relationship with the delegated entities. It is up to the MCP and FQHCs to decide on a data flow that best meets its needs in an efficient manner. This may include delegated entities at MCP/FQHC option.

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[7] It is anticipated that FQHCs will amend their P&P over time to reflect new practices needed over time. Each FQHC should utilize the format required by its governing board for P&P - some require separate policies from procedures, and some have combined P&Ps. Policies and procedures in the checklist do not have to be discrete individual documents; an organization can group APM-related policies and procedures as appropriate.

[8] FQHCs should seek technical assistance from MCPs to ensure that complete encounter data is submitted consistent with the MCP contract. .

[9] FQHCs should not submit data directly to DHCS unless requested. Data discrepancies should be resolved between the MCPs and FQHCs. FQHCs should seek technical assistance from MCPs to ensure that complete encounter data is submitted consistent with the MCP contract. DHCS will not give FQHCs technical assistance on individual contract provisions with MCPs.

[10] FQHCs should work with MCPs to resolve any contractual issues. If an MCP is not working collaboratively with an FQHC, please notify DHCS staff regarding the communication issues.

[11] The FQHCs should ensure that all codes in Section XV are programmed into the Electronic Health Record (EHR) and that there is a P&P to submit that data. The ability to submit alternative care service encounter data was a condition of acceptance into the APM and all FQHCs have stated that they can accomplish this task. 30 days prior to go live, all FQHCs must have a P&P outlining the ability and procedures to submit all required encounters including alternative care service data. Note, Alternative care service data will be coded with a Q2 modifier.

- A policy to receive member assignment information from the MCPs and reconcile member assignment roster with MCPs as needed.[12]
- FQHCs must be able to document they received the APM PMPM for assigned members and the PPS rate for unassigned, non-contracted MCP members (attestation is not sufficient). The FQHC will provide auditable documentation that it has received the APM PMPM for each assigned member for each MCP. FQHCs must create and maintain auditable accounting records linked to the general ledger of the FQHC, to track the APM PMPM revenue received. Finally, the FQHC must systematically submit or validate, in a form and manner specified by DHCS, information documenting payments for each member assigned by the MCPs and the amount received from the MCPs. Historically documented P4P amounts/calculations are outside of the FQHCs APM PMPM. DHCS will utilize encounter data and member rosters to validate payment to FQHCs for unassigned, non-contracted MCP members, as needed.

Entity	Readiness Activity	Completion
MCP	A policy to ensure that the FQHCs participating in the APM and under contract with the MCP are paid the full State-established APM PMPM for assigned members.	☐ Y ☐ N
MCP	A policy to ensure that the FQHCs participating in the APM and not under contract with the MCP are paid the State-established PPS for any member who receives services from the participating FQHC.	☐ Y ☐ N

[12] All FQHCs should already be able to receive member assignment information from the MCPs and reconcile their member assignment roster with MCPs as needed. This will need to be addressed by the FQHC and MCP. FQHCs should work with MCPs to resolve any contractual issues. FQHCs should seek guidance from their EHR vendor, as necessary.

Entity	Readiness Activity	Completion
MCP	A policy and procedure to share complete FQHC encounter data with DHCS and provide data on performance metrics, encounters, and assigned lives to participating FQHCs. The State may not mandate the exact data elements that are expected to be shared but participation under the APM will require FQHCs receive regular member rosters, performance metric results, and encounter data extracts submitted to DHCS from the MCPs. Section 9 of the Program Guide outlines minimum data sharing requirements. MCPs must provide, at a minimum, the following information to all FQHCs participating in the APM: a. Physical, behavioral, administrative, and information indicating member SDOH needs, as specified on previously submitted claims encounters or identified through other data sources (e.g., HMIS) for assigned members. b. Reports of performance on quality measures and/or metrics, as requested. c. MCPs are required to use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with FQHCs and with DHCS.	☐ Y ☐ N
MCP	A policy and procedure for a dispute resolution process for reimbursement and data correction with FQHCs, as well as to review and reconcile quality data issues with FQHCs including accepting encounter data for alternative encounters and unassigned members from participating FQHCs.	☐ Y ☐ N
MCP	Programming of all alternative encounter services coding into the MCP's encounter data system; alternative care encounters data will be coded with a Q2 modifier.	☐ Y ☐ N

Entity	Readiness Activity	Completion
MCP	The ability and procedure to accept all claims or encounters from APM participating FQHCs including alternative encounters data (following all billing guidance).	☐ Y ☐ N
MCP	A policy to assign members to FQHCs and other primary care providers and review and reconcile member assignment rosters with FQHCs as needed.	☐ Y ☐ N

☐ This documentation serves as attestation that the MCP has successfully completed the full checklist and is ready for participation in the Alternative Payment Methodology Program. If the MCP cannot attest to completion of all the above items, please give a description (in the box below) of the plan to address outstanding items by December 1, 2025 for Cohort 2/ 2026.

_____

Plan signature and date: _____

Additional explanation of MCP readiness items listed above:

- The MCPs must ensure all codes in Section XV are programmed into the data warehouse and there is a P&P to accept that data from the FQHCs, including delegated entities operating on the MCPs behalf. Thirty days prior to go live, all MCPs must have a P&P outlining the ability and procedures to receive all required encounters including alternative care service data. [13]
- A policy to ensure the FQHCs participating in the APM and under contract with the MCP are paid the full State-established APM PMPM for assigned members.
- A policy to ensure the FQHCs participating in the APM and not under contract with the MCP are paid the State-established PPS for any member who receives services from the participating FQHC.
- A P&P to share complete FQHC encounter data with DHCS and provide data dashboards with performance metrics, encounter data, and assigned lives back with participating FQHCs. The State is not anticipating mandating the exact data elements that are expected to be shared but participation under the APM will require FQHCs receive regular member rosters, performance metric results, and

[13] Alternative care service data will be coded with a Q2 modifier.

encounter data extracts submitted to DHCS from the MCPs; Section 9 outlines minimum data sharing requirements. To support the FQHC APM, MCPs must provide, at a minimum, the following information to all FQHCs participating in the APM:
    - Physical, behavioral, social, and administrative data, and information indicating member SDOH needs, as specified on previously submitted claims encounters or identified through other data sources (e.g., Homeless Management Information System) for assigned members.
    - Reports of performance on quality measures and/or metrics, as requested.
    - MCPs are required to use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with FQHCs and with DHCS.
- A P&P for a dispute resolution process for reimbursement and data correction with FQHCs, as well as to review and reconcile quality data issues with FQHCs including accepting encounter data for Alternative Encounters and unassigned MCP members from participating FQHCs.
- Programming of all alternative care service coding into the MCPs encounter data system. Alternative care service data will be coded with a Q2 modifier.
- The ability and procedure to accept all encounters from APM participating FQHCs including alternative care service data. [14] The State does not have a relationship with the delegated entities. It is up to the MCP and FQHCs to decide on a data flow that best meets its needs in an efficient manner. This may include delegated entities at MCP/FQHC option.
- A policy to assign members to FQHCs and other primary care providers and review and reconcile member assignment roster with FQHCs as needed. Any services or functions delegated to delegated entities must comply with the requirements under the APM including assignment of medical homes at the NPI level, complete transmission of encounter data, and reconciliation of member rosters.

[14] If the Medi-Cal beneficiary is not a member of the health plan, it is expected that the health plan reject the claim and will not reimburse the FQHC for a PPS eligible encounter. MCPs are not required to reimburse APM FQHCs PPS rates for non-PPS eligible visits coded with a Q2 modifier. Note: claims for members who are excluded populations such as dual eligible or services that are excluded under the APM such as dental should follow the regular FQHC claiming procedures under the MCP contract with the State for non-APM FQHCs.

- A P&P to calculate the APM performance metrics at the "parent" NPI level for participating FQHCs in the APM and to submit those metrics to DHCS as requested.
- A procedure to submit complete monthly rosters to DHCS twice a year for FQHCs participating in the APM following the procedures outlined by DHCS (in June and in December).
- A procedure to submit supplemental data requests under the APM to DHCS. The supplemental data requests mentioned here are related to actuarial requests linked to the MCPs financial reports and encounter data which must include auditable information recording payments. The MCP will need to ensure FQHCs receive the APM PMPM for all members. The Health Plan must be able to create and maintain an auditable accounting record linked to the general ledger of the MCP that demonstrates the FQHC received the full APM PMPM.

IV. Provider Enrollment, Credentialing, and Vetting Requirements

This section will provide additional detail to clarify the selection and participation criteria outlined in Section III. FQHC APM – Application and Eligibility. FQHCs are eligible to apply with DHCS to participate in the APM. DHCS anticipates releasing applications for the APM every year, year-over-year. In the future, DHCS will review applications to ensure the FQHC as an organization, appears committed to transformation, in part, evidenced by the number of sites committed to the APM. While the APM is voluntary and FQHCs may select the parent NPIs to participate in the APM, all affected sites under each parent NPI's PPS rate in the APM must participate, including intermittent and mobile units/sites.

Encounter Data/Wrap Payments Have 66% Managed Care Match and 50% of Encounters from Assigned APM Enrollees

As reconciliation will utilize only encounter data, APM FQHCs must have complete, credible, and accurate data. DHCS will examine the level of match between health plan submitted encounter data and the FQHC wrap claims submitted to DHCS. DHCS will compare encounter data to wrap records to ensure that encounter data volume is sufficient for the FQHC on-going participation to ensure validity of reconciliation.

Under the APM, there will be an access threshold (Gate) requiring FHQCs to maintain a minimum floor of PPS visits and Alternative Encounters. Since encounter data will be the sole source of tracking these services, DHCS considers the minimum benchmark of at least 66% of wrap records having a corresponding managed care encounter record as the minimum benchmark to determine the data viability for participation in the APM. Only FQHCs with a match rate exceeding this threshold are admitted into the APM. In addition, FQHCs must have at least 50% of encounters from assigned APM enrollees to participate. DHCS will proportionally adjust the utilization for any FQHC so that no more than 30% of the utilization is attributable to unassigned members to ensure no adverse incentive for avoiding assignment exists. [15]

DHCS recognizes there may be many reasons why data mismatches occur and systems issues can contribute greatly to data mismatches. Where significant discrepancies exist, FQHCs, MCPs, and any applicable delegated entities should coordinate to investigate

[15] DHCS may increase the minimum benchmarks in 2025 and thereafter.

the cause(s) of the mismatches. DHCS recognizes data improvement is a complex and time consuming effort and is evaluating how DHCS can best support such efforts.

The data matching includes the following:

Analysis Description

Using a set list of NPIs for FQHCs who apply to participate in the January 1, 2026 Cohort 2/ 2026 APM, DHCS/Mercer will create a database of several data fields from FFS T1015 claims submitted from FQHCs and compared to encounter data submitted by MCPs with two primary metrics/fields:

1. MC-paid encounters — Visits are counted based on unique AKA_CIN, SVC_FROM_DT, and PROV_NBR. We include and count all visits from encounters submitted by providers on the list of NPIs [16] (DHCS/Mercer do not limit solely to visits identified through the FQHC category of service [COS] logic).
2. T1015 FFS Wrap visits — Identified on claims paid for by FFS (PGM_CD="09") with PROC_CD="T1015" and procedure code modifier = "SE" (TOOTH_OR_MODFIER_1, TOOTH_OR_MODFIER_2, TOOTH_OR_MODFIER_3, TOOTH_OR_MODFIER_4). Similarly, visits are counted based on unique AKA_CIN, SVC_FROM_DT, and PROV_NBR. Similarly, DHCS/Mercer include and count all visits from encounters submitted by providers on the list of NPIs (see footnote 4) (we do not limit solely to visits identified through the FQHC COS logic).

Data Parameters and Restrictions

1. Included only members enrolled with an MCP (where PLAN_CD is not '000')
2. Included only encounters paid for by managed care (PGM_CD="02")
3. Included only non-duals (excluded full-duals and partial duals based on values in the MC_STAT_A, MC_STAT_B, and MC_STAT_D fields)
4. Included only managed care covered services, derived from the DHCS Services carved in and out of Medi-Cal Managed Care document and exclude dental claims.
5. Pulled encounter data with dates of services (SVC_FROM_DT) from January 2021 through June 2024, but most of the analysis focuses on a state fiscal year (SFY)
6. 2023–2024 snapshot.

[16] Parent NPI — There is a master list of NPIs, based on applications provided by the FQHCs/providers, but each one crosswalks to a Parent NPI (i.e., some NPIs are for intermittent site that roll up to a parent NPI). See attached crosswalk.

DHCS/Mercer Measure a Level of "Match" Between MC-paid Encounters and T1015 Wrap Visits Using the Following Methodology:

1. After limiting the data by the parameters above, we look for an FFS wrap "match" using the same unique AKA_CIN, Parent NPI (based off of billing NPI – PROV_NBR), and SVC_FROM_DT.
2. There should be a high degree of match with FFS wrap visits (referenced above as T1015 FFS wrap visits). As in, FQHCs submit an initial claim to the health plan, and then send a corresponding T1015 wrap claim to the state.
3. There is not a perfect correlation, as there are some exceptions where an encounter would not necessarily have a corresponding wrap (and vice versa), but the majority of them should align.

Application Content

For FQHCs not already participating in the APM (Cohort 1A or 1B/Cohort 2024-2025), the FQHC will need to complete all sections of the application.

For FQHCs already participating in the APM (Cohort 1A or 1B/Cohort 2024-2025), the FQHC will only need to complete the portions of the application where there is a note for existing (Cohort 1A or 1B/ Cohort 2024-2025) FQHCs to include additional NPIs participate or change NPI structure effective January 1 of the forthcoming calendar year.

Section 1 – Spreadsheet Attachment (Existing APM FQHCs [Cohort 1A and 1B/Cohort 2024-2025] submit additional NPIs or NPI changes and new Cohort 2026 FQHCs submit in entirely)

The FQHC should attach a spreadsheet to the Application (a sample is attached to these instructions) with each of the following for each FQHC address included in the APM. All intermittent sites/mobile units under a PPS rate must be included and clearly linked to a Parent Site NPI and PPS rate.

Below are clarifications regarding the Excel spreadsheet:

- The base year will be SFY 2023–2024 (July 1, 2023 through June 30, 2024). The clinics should report SFY 2023–2024. Assigned lives in the Excel spreadsheet should align with this base year.

- If a clinic has sites going through PPS rate setting or rate setting final determination, the clinic should use the rate that is in effect and approved for January 1, 2025.
- The FQHC can select any billing NPI (i.e., Parent Site) to apply for the APM, but must include all intermittent sites and mobile units/sites associated with that billing NPI under the APM. After the application is submitted, the parent, mobile unit/site and intermittent sites cannot be modified under the APM prior to the implementation for the next CY. Note, the parent and intermittent site PPS rates must match in the base year for the APM. APM Parent Sites may not modify the intermittent sites associated with the APM NPI after applying to get into the APM without specific adjustment to the capitated rate. For further discussion, please see the application and participation criteria in Section III. FQHC APM — Application and Eligibility or discuss with DHCS and Mercer.
- If any clinics (Parent Sites or Intermittent Clinics) have any structural changes after July 1, 2023, then pending ownership changes must be processed and approved to the master provider file by DHCS no later than May 30, 2025. In addition, the NPI that the site utilized to bill for all dates must be clearly noted (e.g., from
- July 1, 2023–August 8, 2023 the Baker Street site utilized NPI #123456789 and from August 9, 2023 to December 31, 2023, the Baker street site utilized NPI #234567890, after December 31, 2023, all claims were held until ownership changes are processed).
- A new Parent Site with an interim rate is treated like a regular FQHC site for the purposes of the APM.
- MCPs must assign members by NPI or PPS site if they do not already do so.
- Please report the average monthly assigned Medi-Cal managed care member months (non dual eligibles) for the 12-month period of SFY 2023–2024 in the Excel spreadsheet.

FQHC Provider Name	Corporate NPI	FQHC Site Name	Address of FQHC Site	Billing NPIs	Approved January 1, 2024 PPS Rate	Is This an Intermittent or Parent Site?	If This is an Intermittent Site, what is the Site NPI?	If This is an Intermittent Site, what is the NPI of the Parent Site?	County	Number of Medi-Cal Lives Assigned to Site in SFY 23–24
FQHC A	1234567890	Sample Site 1	101 E First St, LA	1234567891	$200	Parent	N/A	N/A	LA	10,000
FQHC A	1234567890	Sample Site 2	202 W, 10th St, LA	1234567891	$200	Intermittent	1234567892	1234567891	LA	2,000
FQHC A	1234567890	Sample Site 3	303 N, 100th St, LA	1234567891	$200	Intermittent	1234567893	1234567891	LA	All lives for this site are assigned to the Parent

Section 2 – Data Capabilities (Cohort 2/2026 Only) Encounter Data Quality Requirements and Standards (Cohort 2/2026 only)

The FQHC should attach a narrative to the application that addresses each of the following issues: [17]

1. Please describe how encounter data is submitted to the State, independent (individual) practice association (IPA), and/or MCP in accordance with state and federal Medicaid monitoring and reporting requirements. If there are multiple contracted MCPs and delegated entities, please describe monitoring and reporting relationship for each entity. In your response, please address if applicable:
    a. Encounter data submission functionality in electronic health record (EHR) or via clearinghouses or services (e.g., Office Ally)
    b. Use of national standard file formats and coding structures for managed care encounter data submissions (e.g., ASC X12N EDI)
    c. Required data elements reported, including but not limited to Encounter Date/Time (including for all Alternative Encounters), Line of Business, Provider NPI or license, Provider specialty, procedure, and diagnosis (ICD-10) codes, CVX Codes, and Place of Service code, and Patient Demographics
    d. Reporting frequency
    e. Please address how you evaluate data prior to submission for completeness and accuracy and maintain timeliness standards.
2. Include a description of how the FQHC will be able to submit encounter data to MCPs for services using the coding for Alternative Encounters outlined by DHCS in the attachment, including electronic visits, case manager contacts, telehealth visits and face-to-face encounters by non-billable providers (e.g., nurse visits, pharmacy visits). Any application to the APM by an FQHC must include a description of how data is submitted to each primary MCP with a contract directly with DHCS including any delegated entity services or functions that occur during that process. Please describe if applicable:
    a. Encounter data submission functionality in EHR or via clearinghouses or services (e.g., Office Ally)

[17] The FQHC should specifically address all three areas in the Application Instructions in sufficient detail to determine if the FQHC was prepared for APM participation.

b. Use of national standard file formats and coding structures for managed care encounter data submissions (e.g., ASC X12N EDI)
c. Required data elements reported, including but not limited to Encounter Date/Time (including for all Alternative Encounters), Line of Business, Provider NPI or license, Provider specialty, procedure, and diagnosis (ICD-10) codes, CVX Codes, and Place of Service code, and Patient Demographics.
d. Reporting frequency

3. Include a description of the processes FQHC will use to internally track data for all APM quality metrics (e.g., using data from EHR Health Practice Management tools such as I2I and Arcadia) and the FQHC's ability to interface with various portals thereby enabling the sharing of quality data to MCPs (e.g., Qualified Health Information Organizations (QHIOs) under DxF Framework, Health Information Exchanges, Pharmacy Third-Party Administrators, claims clearing houses, and/or contractors). Any application to the APM by an FQHC must include a description of the processes that FQHC will use to internally track data for all APM quality metrics (e.g., using data from EHR Health Practice Management tools such as I2I and Arcadia) and the FQHC's ability to interface with various portals. FQHCs in LA County may include a description of Cozeva. In your response, please address if applicable:
    a. Quality data extraction/calculation functionality in EHR or via other programs
    b. Collection of data elements that support reporting of quality metric data, including but not limited to Encounter data, Line of Business, Provider NPI or license, Provider specialty, procedure, and diagnosis (ICD-10) codes, CVX Codes, and Place of Service code, and Patient Demographics. Please address ability to report quality data stratified by patient demographics for health equity measurement.
    c. Reporting frequency

Please check the item below that relays your ability to collect and submit encounter data that complies with department requirements. This will include data for alternative patient contacts (electronic, case manager, telehealth, and face-to-face encounters by non billable providers [e.g., nurse visits, pharmacy visits]). The box below should not be marked if the FQHC cannot submit alternative care service utilization data through encounter data using the CPT and Healthcare Common Procedure Coding System (HCPCS) codes outlined by DHCS or if the FQHC cannot submit all data including any

hybrid data required for all APM metrics for which the FQHC has utilization meeting the minimum size standards to report the metric.

☐ Able to transmit encounter data as specified in provider contract with MCP(s) or the delegated entity contract as required by the MCP. Any application to the APM by an FQHC must include a description of how the FQHC will transmit encounter data as specified in the prime MCP provider contract with DHCS. If there is a delegated entity with services or functions related to transmitting encounter data, the FQHC should include a description of those services/functions.

Please mark the box only if the FQHC is transmitting encounter data to the MCP as outlined in the provider contract with the MCP and the FQHC can submit alternative care service patient contacts via encounter data in the future with a Q2 modifier. Do not mark the box if alternative care service data cannot be submitted in the future with a Q2 modifier or if there are significant gaps in the encounter data and wraparound T1015 claims (e.g., more than 30% of plan encounter data and T1015 claims are not matching).

The codes include office visit codes billed with a telehealth modifier, which are then mapped to different domains — communication and telehealth. It also includes psychotherapy codes. The intent for the Alternative Encounters codes where practitioner types and locations may include non-PPS billable providers (e.g., pharmacy, RN, LPCs who cannot generate PPS encounters).

Section 3 – Additional Items for Submission (Cohort 2/2026 only)

☐ Please check here if you have an MCP/FQHC contract in place that allows for data sharing.

The applicant health center should check the box if there is a contract in place that allows the MCP to receive FQHC data sharing even if through an IPA. However, if the MCP is not permitted to directly send data to the FQHC and vice versa, please do not mark. The FQHC is being asked if the MCP is or is not permitted to directly send data to the FQHC and vice versa for any reason.

Please do not include the data sharing agreement with the application package.

The APM will use managed care encounter data for all reconciliation under the APM. DHCS is holding internal and external sub-workgroup conversations to determine how best to support data sharing and improvement efforts between FQHCs and MCPs while balancing administrative burden to DHCS, MCPs, and FQHCs.

☐ Attestation that all participating sites are in "good standing" with relevant State and federal authorities [18]

The attestation should confirm the FQHC is not under sanction or corrective action plan from any State or federal governmental or quasi-governmental authority and is current in all reconciliation documentation owed to DHCS including A&I, HRSA, and Medicare at a minimum.

Section 4 – APM Strategy (Cohort 2/2026 only)

Describe (in 250 words or less) how you envision participation in the APM to transform your care delivery model and improve quality and health equity. What specifically will be different in the FQHC five years from now compared to today and how do you envision expanding the APM to all sites (if applicable)? Answers to subsequent questions should focus on specific changes aligned with this vision.

Section 5 – Experience with Strategic Practice Transformation (Cohort 2/2026 only)

Describe (in 250 words or less) your top three goals for strategic practice transformation under this APM (e.g., implementing new team-based care models, launching a community health worker [CHW] program, advancing value-based payment models etc.). How does APM participation help you achieve these goals and what previous experiences/successes will you leverage to achieve them?

Section 6 – Additional Items for Submission (Cohort 2/2026 only)

☐ Any certification (or certification in progress) by a nationally recognized accrediting organization for patient-centered medical home (National Committee for Quality Assurance [NCQA] or The Joint Commission)

☐ A list of local and/or federal initiatives you have participated in that supported care transformation (e.g., performance improvement/care re-design efforts facilitated by organizations like the Center for Care Innovations, CMS Innovation Center, private foundations, or via engagement with performance improvement consultants) — indicate which initiatives were local, state-level, or national/international.

[18] Good standing is defined as no corrective action plan with any of the following: State Medicaid Program (DHCS); Bureau of Primary Health Care, 330 Grant Program; and Medi-Cal MCP(s).

Section 7 – Staffing Capacity (Cohort 2/2026 only)

Describe (in 250 words or less), your current FQHC care team model/staffing ratios and how you envision them changing in the next five years to meet the APM/Practice Transformation strategic goals (changes in ratios, changes in types of staff/classifications hired, etc.). Include any challenges you foresee in achieving the necessary staffing, financial, recruitment-related, or otherwise.

Section 8 – Quality Improvement Infrastructure (Cohort 2/2026 only)

Describe (in 250 words or less), your clinic's (or system's) current quality improvement infrastructure to improve Healthcare Effectiveness Data and Information Set/Uniform Data System or other quality measures — including who leads qualified individual activities (dedicated staff, clinical staff, etc.), what methods they use, how they integrate data (dashboards, process measures, data warehouse, and analytic capability), and how effective this approach has been. Specifically describe how you envision being able to meet the quality improvement targets described in the APM, in your three specific goals above, and past relevant successes. Include any challenges you see in continuous quality improvement.

Section 9 – Collaboration with MCPs (Cohort 2/2026 only)

Describe (in 250 words or less) how you currently collaborate with MCPs and the type of relationship you envision having to achieve the APM strategy. Any application to the APM by an FQHC may include a description of a relevant delegated entity service or function in collaborating with the MCP holding the primary contract with DHCS. Specifically, how do you envision collaborating to improve patient health (e.g., sharing pharmacy data, sharing enrollment/member data, sharing emergency department/hospitalization data, receiving regular performance reports from MCPs, regular Joint Operating meetings, or meetings with MCP quality staff, etc.)? Please explain how the FQHC has historically worked on the assignment and reassignment process (both internally and with contracted MCPs) in order to enhance the member rosters and medical health some relationships at the site level?

Section 10 – Attachments (Cohort 1A and 1B/Cohort 2024-2025 submit for additional NPIs or changes in NPIs and Cohort 2/2026 submits for all NPIs)

☐ Attach Health Plan Roster and Assessment Forms from all primary DHCS MCPs you are contracted with, unless previously submitted

- Please include one form letter for each MCP you are contracted with.
- The Health Plan Roster and Assessment Form for an FQHC not directly contracted with the primary DHCS MCP (i.e., they are participating with the MCP through an IPA affiliation) should be obtained from the plan/IPA that has the closest relationship/contract with the FQHC with a signature by the health plan with a contract with DHCS as noted on the form.
- Note the following clarifications:
    - There is already a signature line for both the IPA and MCP to sign. Each MCP with a DHCS contract must have a Health Plan Roster and Assessment form sign off/signature by an MCP contractor administrator, even if the IPA partially completes the form. If there is an IPA, it can be checked.
    - Signature of the Prime health plan contracted with DHCS.
    - If the signature above is not the prime health plan directly contracted with DHCS, then prior to the submittal of the form, the prime health plan must receive and review this form. The prime health plan will sign below that the plan can affirm it has received and reviewed this Health Assessment Form and is not aware of material information that directly contradicts the information provided herein.

      _____
    - Please sign below if the Prime health plan is aware of material information that directly contradicts the information provided herein:

      _____
    - The IPA should complete the Health Plan Assessment Form as much as possible and send to the MCP. There is no need to document what questions the IPA answered and what questions the MCP answered. There is already a signature line for both the IPA and MCP.
    - Any continuing MCP should complete the Health Plan Assessment Form.
    - In the Health Plan Assessment Form, sufficient is defined consistent with the accessibility requirements in your contract with the MCP. Same day appointment or urgent care appointment should be the same consistent with the accessibility requirements in the MCP contract.
    - On item "#4" of the Health Plan Assessment Form for 'Are there any significant issues with the FQHC quality achievement scores? If the FQHC is participating with the plan, are there any significant issues meaning any FQHC that is performing under the 25th percentile or 50th percentile of all Medicaid plan performance.

- On the Health Plan Assessment Form, "If the county is the 330 grantee and the clinic is a subrecipient of the grant but is a separate entity from the county, the question about CAPs includes CAPs applied by HRSA/Bureau of Primary Health Care/330 to the county if the FQHC and the entity holding the 330 grants are contractually related.
- The presence of a corrective action plan is not automatically disqualifying. Please let us know of any corrective action plan, what correcting is needed, and if there is a missed due date. Additionally, if the MCP administers any quality reporting program for their providers, indicate whether the FQHC is having difficulty participating or reporting.

Section 11 – Financial Standing (Cohort 2/2026 only)

Describe (in 250 words or less), your clinic's (or system's) financial health, anticipated ability, and strategies for maintain financial health while undertaking practice and care delivery transformation efforts, and any recent history (within the last 12 months) of financial sanctions or penalties imposed by relevant State and federal authorities.[19]

A financial standing narrative is required. Please attach a document with the requested narrative information. The financial reports and narratives should:

1. Describe FQHC/System financial health including sufficient cash or other funding mechanism to fund changes outlined in the APM Strategy
2. Describe FQHCs anticipated ability and strategies for maintaining financial health while undertaking practice and care delivery transformation efforts including financial resources supporting the Staffing outlined in Staffing Plan
3. List any recent history (within the past 12 months) of financial sanctions or penalties imposed by relevant State and federal authorities

Section 12 – Additional Items for Submission (Cohort 2/2026 only)

☐ Copy of letters or other communication from relevant State and federal authorities imposing financial sanctions or penalties

☐ Most recent audited financial statements

[19] Relevant State and federal authorities include the following: State Medicaid Program (DHCS); Bureau of Primary Health Care, 330 Grant Program; and Medi-Cal MCP(s). Financial adjustments due to routine reconciliations or other routine activities are not considered financial sanctions and penalties.

The FQHC can submit a separate document with answers to any supplemental questions answered. The most 'most recent audited financial statements' should not be sent as an attachment.

Section 13 – Organizational Commitment to Transforming Primary Care Practices (Cohort 2/2026 only)

As evidenced by a letter of support signed by clinic leadership committing to the APM Strategy, Learning Community Participation, Quality Improvement Infrastructure, and Care Team Redesign.

☐ *Attach letter of support from CEO or CEO designee attesting to these items*

The letter should be addressed to the generic email box, FQHCAPM@dhcs.ca.gov. "To whom it may concern" or "DHCS" would be acceptable.

At a minimum, the letter should address commitment to the APM Strategy, Learning Community Participation, Quality Improvement Infrastructure, and Care Team Redesign. At a minimum the Letter of Support from CEO or designees must attest to:

- APM strategy
- Learning Community Participation
- Quality Improvement Infrastructure
- Care Team Redesign

There are no specific guidelines outlined; however, the letter of support should demonstrate the CEO understands the purpose of and activities involved with the FQHC APM program, indicates their full support of their clinic's participation, and indicates they will provide resources to ensure the success of their clinic in the program.

V. FQHC APM – Calculation of the APM PMPM

The base year for clinics that entered the APM in 2024 for their PMPM rate was SFY 21–22 informed by past utilization (e.g., CY 2019). For future years, the actuary will be looking at utilization from prior to the base year to determine the adjustments necessary. FQHCs participating in the APM will receive a detailed APM PMPM calculation exhibit that details the various adjustments, including COA case mix used to calculate each FQHCs specific APM PMPM, as well as any annual updates thereafter.

Calculation of the APM

DHCS shall establish)h a unique APM PMPM for a participating FQHC Parent Site (by billing NPI), based on historical utilization and other trend and utilization adjustments as appropriate to reflect the level of reimbursement that is projected to have been received by the participating FQHCs in the absence of the APM project.

The resulting PMPMs calculated on a COA basis is combined into a single PMPM for the Parent Site. Specifically, the data source used for calculating the APM PMPM shall be either: (i) the volume of PPS encounters based on a utilization base year, to be determined on the basis of the most recent, complete and appropriate utilization data covering the past three years of the FQHC's operation in the county, which may be stratified by MCP, or (ii) an average of the two most recent years of available data for a participating FQHC. DHCS and its actuary shall have sole discretion to determine the best available data source and may concurrently rely upon data associated with other existing FQHCs with characteristics similar to the participating FQHC.

Two APM PMPMs will be calculated annually for each Parent Site to correspond with the time-periods of each PPS rate as annually adjusted by the Medicare Economic Index (MEI) index (January–September) and (October–December). A third APM PMPM may be calculated based on an updated PPS if the FQHC has a change in scope effective with the beginning of its fiscal year end (FYE). In the case of a change in scope, the PPS would be updated effective with the beginning of its fiscal year (FY). The prospective APM would be calculated based upon the interim CSOSR attestation if a change in scope has not yet been determined in accordance with standard CSOSR procedures. The prospective APM based on the final CSOSR or interim CSOSR would be reconciled after the fact, based on the APM PMPM calculated using the final PPS compared to the APM calculated using the interim CSOSR, if any.

For the 2024 period, the APM PMPM formula for each Parent Site billing NPI=

Count of SFY 21-22 Medi-Cal FFS PPS encounters for managed care members (including unassigned walk-in utilization) for APM services x Participating FQHC's PPS for the current year / SFY 21-22 APM Enrollee Medi-Cal Managed Care Member Months

DHCS shall calculate an applicable APM PMPM rate for the participating FQHC's Parent Site. MCPs without members assigned to a participating FQHC, must reimburse the participating FQHC its PPS rate for any PPS-eligible APM service encounters by the MCP's enrollees.

DHCS will adjust the numerator of the equations in paragraphs (d) and (e) for any FQHC so that no more than 30% of the numerator is attributable to unassigned members to ensure no adverse incentive for avoiding assignment exists. *Note: DHCS may increase the minimum benchmarks in 2025 and thereafter*.

Medi-Cal MCPs shall reimburse a participating FQHC no less than the determined APM PMPM rate for each APM Enrollee on a monthly basis. MCPs may make such payment in multiple payments per month so long as total reimbursement is no less than the APM PMPM amount. MCPs and participating FQHCs must adequately document and verify payment disbursement and receipt, respectively, for APM PMPM reimbursement. Attestation, alone, is not sufficient.

DHCS annually shall verify that MCPs made required APM PMPM payments to participating FQHCs in accordance with this APM.

Medi-Cal MCPs are required to reimburse participating FQHC sites (or ensure that participating FQHCs receive) at least the APM PMPM rate for each MCP assigned member on a monthly basis, even if in multiple payments on behalf of the MCP. Unassigned walk-ins are defined under the APM as, "MCP members who visit the APM participating FQHC but who are not assigned to the APM participating FQHC by the MCP."

For participating FQHCs that furnish services under the MCP contract to members enrolled in managed care, the State will verify annually that the payments are made in accordance with the APM, no increases in utilization over the utilization in the APM PMPM were experienced by the FQHCs, and all FQHCs receive at least what they would have received under PPS. MCPs and FQHCs must be able to document that they paid and received at least the APM PMPM (attestation is not sufficient). The APM PMPM would then fulfill the requirement the State ensures the MCPs pay at least PPS and no additional wrap-around supplemental payment will be made by DHCS during the contract year for managed care populations and service under the APM. The receipt of

the full APM PMPM must be documented from the MCP down to the FQHC including any third parties making payments on behalf of the MCP. DHCS will reconcile the APM PMPM to the PPS rate on an annual basis described below. Any reconciliations will require that the FQHC verify it received the full APM PMPM for all assigned members. *As noted in Section XI, excluded populations such as dual eligibles and excluded services such as dental and non-managed care services such as specialty mental health will continue to be paid outside of the APM.*

FQHCs will participate in traditional DHCS A&I reconciliations for populations and services outside of the APM.

For FQHCs joining the APM after 2024, DHCS shall establish a unique APM PMPM for a participating FQHC Parent Site billing NPI, utilizing the volume of encounters based on a utilization base year, to be determined on the basis of the most recent, complete and appropriate utilization data covering the past three years of the FQHC's operation. Alternatively, DHCS may utilize an average of the two most recent years of available data for a participating FQHC and may concurrently rely upon data associated with other existing FQHCs with characteristics similar to the new, participating FQHC. The actuaries will use the best available data as the base year to ensure actuarial soundness.

For FQHCs that are chosen and elect to participate in this APM in years after CY 2024, the data source shall be consistent with this Paragraph and the APM PMPM formula for each Parent Site billing NPI =

(Count of Base Year Medi-Cal PPS encounters for Medi-Cal managed care members [including unassigned walk-in utilization with adjustments] for APM services) x (Participating FQHC's PPS for the upcoming calendar year) / (Base Year Annual Assigned Medi-Cal APM enrollee Managed Care Members [Member Months])

APM PMPM Calculation will be Based on MCP Members, not Patients

The State's actuary will calculate the APM PMPM using assigned members only in the denominator. Projected MCP member utilization, including unassigned member walk-ins adjusted for outliers, will be in the numerator. Unassigned member walk-ins are defined under the APM as, "MCP members who visit the FQHC site participating in the APM but who are not assigned to that APM FQHC site by the MCP".

The utilization component used in the APM PMPM calculation is meant to reflect the utilization of PPS in absence of the APM, and not meant to forecast actual utilization under the APM. This is in contrast to traditional actuarial rate setting, where

assumptions reflect expectations of actual future utilization. Under the APM FQHCs may pursue alternative delivery of care, therefore the APM utilization assumption is not designed to align with actual PPS-eligible utilization during the rating period.

Regardless, the base period utilization is subject to appropriate prospective adjustments to align with the July 1,2024 period for the covered populations. The following adjustments were applied to the SFY 21–22 base utilization, and are further described in the following sections:

1. Unassigned Member Utilization
2. Public Health Emergency Acuity Adjustment
3. Mental Health Utilization Trend
4. COA Case Mix

Unassigned Member Walk-in Utilization

APM PMPM payments will be issued for assigned members but will include unassigned member funding.

- MCPs historically may have denied claims/encounters from an FQHC for unassigned walk-in claims where the member was not assigned or subcapitated to that FQHC. Under the APM, MCPs (and all MCP subcontractors/delegated entities) will be required to ensure all encounters for covered services from a participating FQHC are accepted. FQHCs will be compensated for unassigned walk-in claims through the APM methodology.
    - If an MCP does not have a contract with an FQHC participating in the APM, the MCP must reimburse the FQHC its PPS rate. If an MCP has a contract with an FQHC participating in the APM, the MCP must reimburse the FQHC at least its APM PMPM on a monthly basis. During annual reconciliation, if the actual utilization multiplied by the PPS exceeds the APM PMPM payments, then the FQHC will be compensated for the amount by which the calculated PPS payment exceeds the APM PMPM
- MCP capitated rates will build in the historic claims and the PPS/wrap payment paid FFS to each participating FQHC for each MCP's members (not just those members assigned to the FQHC).
- MCP member unassigned walk-ins will be included in the numerator of the calculation for each FQHC's MCP specific APM PMPM.
- The State will monitor the number of MCP members who have walked into the FQHC without assignment (unassigned walk-in) relative to the number of MCP

members assigned to the clinic to determine if an adjustment is necessary for utilization beyond the control of the FQHC.

- Each FQHC will receive at least their PPS x utilization.
- The MCP will be fully funded to pay each FQHC an APM PMPM calculated as all assigned and unassigned members' utilization multiplied by PPS and divided by the member months assigned to that FQHC. In other words, the APM PMPM would then include all historic managed care and FFS PPS/wrap payment for each FQHC even if the MCP had historically denied unassigned walk-in claims to FQHCs where the member was not assigned. The PMPM rates will include funding for unassigned member utilization but be paid only based on assigned members. The total utilization multiplied by PPS will include assigned MCP members and those MCP members who are unassigned walk-ins and are not assigned to the FQHC.
- This will ensure that even if the MCPs deny claims for unassigned members, the FQHCs are paid for those visits. Any MCP or subcontractor, including delegated entities, must accept encounter data for unassigned members making visits to an APM participating FQHC in order to ensure that encounter data is complete.
- Operationally, plans will need to accept encounters for unassigned patient visits so there are no issues with reconciliation and to ensure the FQHC receives at least PPS. [20] DHCS will provide guidance to plans that unassigned patient visits at APM FQHCs need to be accepted encounters. Plans have requested guidance be issued six months prior to implementation.

Advantages of Unassigned Walk-in Inclusion in the Numerator

- Much less data is needed to calculate the capitation rate and APM PMPM.
- MCPs and their subcontractors do not need to change their processes to pay for previously denied claims for contracted APM clinics. However, MCPs and their subcontractors will need to create a process for reimbursing non-contracted/participating APM clinics.
- FQHCs are paid up front for all historic PPS encounters and adjustments are made for changes for non-assigned patient encounters, scope changes, and case

[20] If the Medi-Cal beneficiary is not a member of the health plan, it is expected that the health plan reject the claim and will not reimburse the FQHC for a PPS eligible encounter. MCPs are not required to reimburse APM FQHCs PPS rates for non-PPS eligible visits coded with a Q2 modifier. Note: claims for members who are excluded populations such as dual eligible or services that are excluded under the APM such as dental should follow the regular FQHC claiming procedures under the MCP contract with the State for non-APM FQHCs.

mix (i.e., population) changes. Actuarial adjustments may differ from year-to-year based on actual data and will be explained each year.

Annual Updates to the Clinic-Specific APM PMPM

At the conclusion of each CY of participation in the APM, DHCS will update a participating FQHC Parent Site's APM PMPM based on any material changes in the average beneficiary COA mix, the participating FQHC's PPS rate applicable for the coming CY, and any approved changes in scope. DHCS shall monitor the number of Medi-Cal managed care beneficiaries who have been treated by the participating FQHC without assignment (i.e., walk-ins) relative to the number of Medi-Cal managed care beneficiaries assigned to the participating FQHC to determine if utilization beyond the control of the FQHC warrants a utilization based adjustment to the participating FQHC's APM PMPM reimbursement.

For FQHCs in years subsequent to their initial year of participation in the APM, the APM PMPM formula for each Parent Site billing NPI =

(Base Year Medi-Cal FFS PPS encounters for APM services for managed care members including unassigned walk-in Utilization with adjustments) x (Participating FQHC's PPS for upcoming CY) / (Base Year Annual Assigned Medi-Cal APM enrollee Managed Care Members [Member Months])

DHCS will adjust the numerator for any FQHC so that no more than 30% of the numerator is attributable to unassigned members to ensure no adverse incentive for avoiding assignment exists. *Note: DHCS may increase the minimum benchmarks in 2025 and thereafter*.

DHCS may prospectively adjust a participating FQHC's APM PMPM on an annual basis to account for changes in the scope of services that are anticipated to trigger an update to a participating FQHC's PPS rate in accordance with the interim CSOSR process described in Section VII. The prospective adjustment to the APM PMPM may only reflect an increase to the FQHC's existing PPS rate of between 2.5 and 10 percent. Such adjustments to the APM PMPM shall be on an interim basis and will be reconciled to the participating FQHC's actual PPS rate calculated in accordance with the regular CSOSR process. Final payments under this provision will be based on the APM PMPM calculated using the actual PPS rate under State Law. Calculation of the APM PMPM Rate remains subject to an Annual Reconciliation in accordance with Section VIII – FQHC APM – Annual Reconciliation.

On an on-going basis, DHCS anticipates that final updated APM PMPMs including MEI will be announced in November of each year for the upcoming CY. The deadline for withdrawal by an already participating APM site is July 1 of the preceding year. The rates are expected to go into effect on January 1 of the immediate next CY. Each FQHC participating in the APM will receive two rates (January 1–September 30; October 1–December 31).

At the conclusion of each CY, DHCS will update the APM PMPM based on any changes in the member COA member mix, upcoming PPS, and any approved changes in scope. The State will monitor the number of MCP members who have walked into the FQHC without assignment (unassigned walk-in) relative to the number of MCP members assigned to the clinic to determine if an adjustment is necessary for utilization beyond the control of the FQHC. The APM PMPM will not be updated for actual utilization in order to preserve the Pay for Transformation Payment/wedge. The actuary will monitor for assignment/unassignment or COA mix changes and adjust as needed to ensure the FQHC receives sufficient funding through the APM to not require reconciliation based on PPS utilization at a minimum. Utilization above historic utilization will be investigated but alone is not a cause for rebasing the PMPM.

APM PMPM =

([SFY 21-22 Encounters, including unassigned walk-in utilization, by MCP members to the FQHC updated by recent COA mix] x upcoming PPS for the FQHC0 / (SFY 21-22 MCP members assigned [member months] to the FQHC)

Once the on-going PPS rate is set, any changes in scope for FQHCs participating in the PPS may use the proposed interim CSOSR process. DHCS will update the interim PPS encounter rate, and subsequently the APM PMPM rate, if the FQHC attests that it will experience or have experienced a valid CSOSR of service. In all cases, DHCS will utilize the traditional retrospective CSOSR process to reconcile the actual PPS, which is finalized, to any APM PMPM set using an interim PPS.

For changes in scope that occur during the CY, the FQHC will attest to the change following the criteria outline in Section VII, upon which the interim PPS will be set for the upcoming CY. The interim PPS for the CSOSR will be the basis of the APM PMPM. Once the FQHC has completed the full FY in which the qualifying event occurred, the FQHC must then submit the required CSOSR to the State. The triggering event for an interim CSOSR must meet all timelines for the regular CSOSR requirements as outlined in Section VII of this guide. The State will evaluate the CSOSR filing to ensure it meets the requirements under state statute. If the CSOSR is accepted for processing, the State will

review the CSOSR and set a final PPS rate using the standard PPS methodology. The final rate will take effect on the first day of the following FY in which the change occurred. For example, if an FQHC filed a CSOSR for FYE June 30, 2024, the new PPS rate is effective July 1, 2024 with a MEI increase applied October 1, 2024. DHCS will reconcile any APM PMPM payments resulting from a CSOSR from past CYs once the final PPS rate is set. Future APM PMPMs will be set using the final PPS rate and historic utilization under the APM PMPM.

MCPs will have multiple APM PMPM rates to load each CY. There will be at least two APM PMPMs the Health Plans receive each year (January–September; October–December). If there is an interim CSOSR, there will be a third APM PMPM finalized for the FQHC related to the application of the interim change in scope-of-service request (ICSOSR) effective with the FQHCs FYE.

Annual Case Mix Adjustment to APM PMPM

The APM PMPM will be adjusted annually for COA case mix changes to account for projected population changes. The update will occur once updated member rosters reflecting changes in COA and encounter data from FQHCs are available from the MCPs which would be after July of each year and released with the October MEI updates for the next year. Case mix adjustments that Mercer will make will be prospective. The case mix changes will not remove the Pay for Transformation. The case mix changes will be compared against base year and made using an updated member list. There is no threshold to adjust utilization during the initial year. Actuarial adjustments may differ from year-to-year based on actual data and will be explained each year on a clinic-by-clinic basis in rate sheets presented to participating FQHCs.

Annual Update: PPS Inflation

Annual Updates to the APM PMPM will include the MEI change in PPS, COA mix, assigned versus unassigned walk-in changes, and scope changes. Under PPS, rates are inflated annually by the MEI in October. The APM PMPM will also be inflated by MEI for the applicable time period (January–September) and (October–December).

The base equation will include:

- Expected visits based on historical utilization x PPS rate with annual MEI inflation
- The APM PMPM Formula would increase annually
- APM PMPM x Annual MEI inflation

One APM PMPM per Site/PPS Rate Including all Intermittent/Mobile Units/Sites for that PPS

There will be one APM PMPM per PPS rate. If a clinic has sites going through PPS rate setting or rate setting final determination, the State will use the rate that is in effect and approved in October annually to set the APM PMPM rate.

The FQHC can select any billing NPI (e.g., Parent Site) to apply for the APM, but all intermittent/mobile units/sites associated with that billing NPI will be included under the APM. APM Parent Sites may not modify the intermittent sites associated with the APM NPI after applying to get into the APM without specific adjustment to the capitated rate. The base year of the Parent Site must be reflective of the intermittent-Parent Site relationship in order for actuarially sound rates to be set under capitation.

A new Parent Site with an interim rate is treated like a regular FQHC site for the purposes of the APM. After the application is submitted, the parent and its intermittent sites and mobile units/sites cannot be modified under the APM prior to the implementation for the next CY.

MCPs are required to assign members to the parent NPI or intermittent NPI/site if they do not already do so for APM-participating FQHCs (i.e., cannot be assigned to a practitioner or to the provider agency).

Each PPS Rate will have its Own APM PMPM

Each FQHC will have at least one APM PMPM per PPS to reflect the utilization under that MCP. In the future, there may be as many as one APM PMPM per NPI per county per plan depending upon the quality and volume of data from FQHCs participating in the program. All intermittent sites and mobile units/sites under that PPS rate will be included in the APM. If an FQHC is contracted with a county organized health system (COHS) and has 10 sites with 10 different PPS rates, that FQHC will have 10 different APM PMPM rates. If an FQHC has contracts with both plans in a two-plan county and has four sites with four different PPS rates, that FQHC would have at least four different APM PMPM rates at the beginning of the APM.

In the example below, the APM PMPM includes both assigned and unassigned member utilization in the numerator. The math example is part of the learning framework to illustrate how DHCS would like to monitor what portion of utilization over time is derived from assigned versus unassigned members.

FQHC APM Rate Development MCP to FQHC – APM PMPM Example

- FQHC #1 has 170 assigned members from "MCP A" who produced 2,040 member months (170 x 12) Note, this is an example only. Actual calculations will utilize actual member months.

Historical Base Costs

$100,000 historically paid to the FQHC (MCP + Wrap = PPS = 500 encounters x $200) for assigned managed care members for MCP A

- $10,000 historically paid to the FQHC (Wrap = PPS = 50 encounters x $200) for unassigned walk-ins managed care members for MCP A
- **$110,000 total cost historically paid for all MCP A members served at the FQHC (550 encounters x $200 PPS)**

APM PMPM

$110,000 (total historical revenue = 550 encounters x $200 PPS) divided by 2,040 (assigned member months) = **$53.92 APM PMPM**

- $100,000/2,040 = $49.02 — PMPM for assigned MCP A managed care members
- $10,000/2,040 = $4.90 — PMPM to account for unassigned walk-ins MCP A managed care members

APM PMPM =

(Encounters by MCP members to FQHC x PPS) / (Assigned MCP Members)

Any intermittent site, including mobile units, must be included in the APM if the overall PPS rate Parent Site is included in the APM PMPM.

How Will Payment to the MCP Occur?

The State will pay MCPs a capitation rate including consideration for the APM PMPMs based on PPS-equivalent amounts for all MCP members seeking care at FQHCs participating in the APM and adjusted as outlined by the actuary each year. The capitated payment will be aid category specific. There will be a single APM PMPM for each participating FQHC PPS**. However, the APM will be paid to MCPs through separate capitated rate cells with federally eligible and in-eligible components.**

The MCP is responsible for ensuring the FQHC participating in the APM receives the APM PMPM calculated for each FQHC by the State and its actuary. Only MCP members

and covered services in managed care will be included in the APM PMPM to comply with actuarial soundness and Medicaid claiming regulations. There are no revenue withholds by the MCP.

Annual Changes in the APM PMPM will be Applied Prospectively

Adjustments based on inflation and changes in scope are generally applied prospectively. DHCS will update the APM PMPM based on changes in the average member COA experience, PPS based on annual updates to the MEI (applied to PPS rates the following October), and any changes in scope that A&I has approved (either on an interim basis or using the traditional CSOSR process). The State will monitor the number of MCP members who have walked into the FQHC without assignment (unassigned walk-ins) relative to the number of MCP members assigned to the clinic.

- PPS is inflated by the MEI annually in October.
- FQHCs are permitted to request changes to PPS through CSOSR if they meet the criteria as defined in State statute. A change in the cost of a service is not considered in and of itself a change in the scope of services. [21]
- The interim CSOSR process is voluntary; however, all CSOSR must follow the current retrospective process.
- Productivity thresholds will be applied in the PPS/APM consistent with current policy.
- FQHCs will file CSOSR under the current traditional process consistent with State's existing timelines.

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[21] 14132.100 (3) A change in costs is not, in and of itself, a scope-of-service change, unless all the following apply:
(A) The increase or decrease in cost is attributable to an increase or decrease in the scope of services defined in subdivisions (a) and (b), as applicable.
(B) The cost is allowable under Medicare reasonable cost principles set forth in Part 413 (commencing with Section 413) of Subchapter B of Chapter 4 of Title 42 of the Code of Federal Regulations, or its successor.
(C) The change in the scope of services is a change in the type, intensity, duration, or amount of services, or any combination thereof.
(D) The net change in the FQHC's or RHC's rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs and RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75-percent threshold shall be applied to the average per-visit rate of all sites for the purposes of calculating the cost associated with a scope-of-service change. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular FY.

Annual Case Mix Change Case Mix Adjustment to FQHC APM Payment in Future Years

On an annual basis, the PMPM will be reweighted to account for an FQHC's changes to case mix defined as the number of assigned members in each aid category. The purpose is to account for projected population changes, especially because the Medi-Cal adult population is expected to age into a more "seniors and people with disabilities" population (SPD) in future years. To make COA mix adjustments, FQHC-specific utilization patterns by COA by MCP will be used. The case mix will be annually analyzed to determine if a change is needed. The State will not set a minimum change threshold at this time. The example below is for a single MCP and shows only two COAs, but all four COA would be used in making adjustments to future rates.

- Payment Formula for Case Mix Based on Aid Category = (PPS x Member Months x Utilization)/(Member Months)
- If PPS = $100 and MEI = 2%
- Base Payment = ($100 x 15 x 12 x 400/1,000)/(15 x 12) = $40.00 PMPM
- Adjusted Payment = ($102 x 16 x 12 x 412.50/1,000)/(16 x 12) = $42.08 APM PMPM

Population	Base Member Count	Historic Utilization Per 1,000 Members Per Month	Projected Member Count	Projected Utilization Per 1,000 Members Per Month
Adult	10	300 Visits of PPS per 1,000	10	300 Visits of PPS per 1,000
SPD	5	600 Visits of PPS per 1,000	6	600 Visits of PPS per 1,000
Total	**15**		**16**	
Case Mix		400 = (10x300+5x600)/15		412.50 = (10x30+6x600)/16

This COA adjustment will be utilized annually to account for any changes of managed care member mix at a specific FQHC billing NPI. For example, if an FQHC closes one PPS site and the utilization at another PPS site expands in a different mixture of eligibility categories, this could result in an APM PMPM COA member mix change at the different site. The adjustment would occur once encounter data from FQHCs are available from the MCPs which would be after July of each year and released with the October MEI updates for the next year.

APM PMPM Rate Setting Model Timeframe and Source of Baseline Data

The APM PMPM continues reimbursement associated with historical utilization with adjustments at the PPS rate. Under an APM, the state directs contracted MCPs to pay the FQHC the equivalent of PPS with adjustments for historically provided encounters. If in the APM, the FQHC delivers more traditional encounters, the state must make the FQHC whole to all additional PPS visits not in the APM PMPM. Under the APM PMPM, if the FQHC delivers fewer traditional encounters, the FQHC retains the full APM PMPM if the FQHC maintains access and achieves quality targets.

To set the initial APM PMPM for each participating FQHC, the State's actuary will need the following data for each PPS:

- PPS for the FQHC billing NPI site(s) — from the DHCS provider master file.
- Number of PPS-eligible encounters provided to MCP members — from FFS T1015 encounter submission to DHCS.
- Number of assigned MCP members — from MCP member rosters.

The actuary is not using the CMS' rate development guide to set APM PMPMs. The actuary is using the PPS wrap/managed care claims and assignment data initially as the source of the member encounters. DHCS will use the managed care data for reconciliation. For FQHCs joining the APM after 2024, the actuary will use managed care data if available and wrap data if it is not available to set the APM PMPM. Note, wrap data are also known as the T1015 and T1015 SE claims from the DHCS claims system. The initial cohorts (CY participation in 2024,2025, and 2026) of the APM will utilize FFS wrap data; however, it is the goal of the program to utilize managed care data if available and appropriate after the first cohorts.

VI. Billing and Payments

How will Payment to the FQHCs Occur?

Plans will ensure FQHCs receive payment at least equal to the FQHC APM PMPM for all assigned members. The APM PMPM will cover all Medi-Cal MCP covered services not specifically excluded. The APM PMPM will be prospectively set by the State's actuary.

- The plan will need to ensure FQHCs receive the APM PMPM for all members based on rosters on the rosters given to the FQHCs and submitted to DHCS (i.e., the FQHC roster should be identical to the roster shared with DHCS). The Health Plan must be able to create and maintain an auditable accounting record linked to the general ledger of the MCP that demonstrates the FQHC received the full APM PMPM for each assigned member each month.
- The FQHC will need to provide documentation it has received the APM PMPM for all members for each MCP. FQHCs must also create and maintain auditable accounting records linked to the general ledger of the FQHC, to track the APM PMPM revenue received.
- FQHCs must submit complete encounters to MCPs, as encounters will be the source for PPS reconciliation, and can be used to demonstrate what the FQHC would have otherwise received under a PPS model. DHCS does not have a contractual relationship with the delegated entity. The responsibility for complete submission of encounter data is the responsibility of the participating FQHC and any of its subcontractors. The responsibility for receipt of completed encounter data is the responsibility of MCPs and any of its delegated entities.
- The APM PMPM will include the PPS at MCP historic utilization to the FQHC participating in the APM.
- The APM PMPM will include payment for MCP members who are both assigned and unassigned to the FQHC.

The FQHC PPS-specific PMPM payment methodology will help ensure participating FQHCs receive at least what they would have under PPS, as prescribed by federal law, if the FQHC's utilization does not increase.

For unassigned patient visits in cases where the plan is not contracted with the FQHC, the plan will be responsible for paying the clinic its PPS rate. The reconciliation process will verify that MCPs pay the PPS rate for unassigned patient visits in cases where the plan is not contracted/has no assigned members with the FQHC and for non-contracted plans for unassigned patient visits.

Mapping Payment Flow

The State's actuary will build the entire PPS for the MCP APM covered services for each FQHCs' members' utilization into the capitation rate. Medi-Cal contracted MCPs must ensure that the FQHCs receive the APM PMPM rate for each MCP assigned member on a monthly basis.

- The plan receives a capitation rate from DHCS that includes service costs, historical P4P arrangements, and administrative and underwriting gain load for the plan.
- The plan then ensures the FQHC receives at least the state calculated APM PMPM for assigned members even if through multiple payments.
- P4P must be historically documented to be recognized in the MCP's rate from DHCS. This is not a statement of policy for the FQHC APM going forward. This is a requirement to ensure the MCPs are not underfunded. For calculation of the capitation rates, DHCS needs the FQHCs and MCPs to document the historical written, the actuary will need to consider all payments as PPS related. This does not mean new arrangements are prohibited. FQHCs are able to enter into new P4P arrangements after agreeing to an APM so long as they are appropriately documented.
- The MCP and its subcontractors will accept all encounter data from FQHCs participating in the APM because it is the source of reconciliation. [22]
- The MCP should ensure encounter data records the PPS payment to non-participating APM clinics. The DHCS reconciliation will verify that MCPs paid the PPS rate for unassigned patient visits in cases where the plan is not contracted with the FQHC and for non-contracted plans for unassigned patient visits.
- The MCP will provide a dispute resolution process for data and payment issues for APM participating FQHCs.

If an IPA or other subcontractor is involved, the following must occur:

[22] If the Medi-Cal beneficiary is not a member of the health plan, it is expected that the health plan reject the claim and will not reimburse the FQHC for a PPS eligible encounter. MCPs are not required to reimburse APM FQHCs PPS rates for non-PPS eligible visits coded with a Q2 modifier. Note: claims for members who are excluded populations such as dual eligible or services that are excluded under the APM such as dental should follow the regular FQHC claiming procedures under the MCP contract with the State for non-APM FQHCs.

- The MCP and IPA/subcontractor must both ensure and have documentation that the FQHC under the APM with a contract receives the APM PMPM for each MCP assigned member.
- The MCP and IPA/subcontractor must both ensure and have documentation that the FQHC participating in the APM without an MCP contract receives the full PPS for member visits.
- Contracts between MCPs and IPA/subcontractors must clarify how payments flow, specifically clarifying that all upstream contractors or third-party entities must ensure the FQHC in the APM receives the full APM PMPM amount for each assigned member under the MCP contract and that FQHCs in the APM without an MCP contract receive the PPS for each encounter.
- Subcontractors will accept all encounter data from FQHCs participating in the APM because it is the source of reconciliation.
- The FQHC must be able to document that the full amount of the APM PMPM is received for each member assigned under the MCP contract preferably through encounter data and that the PPS rate is received for any encounter from an MCP member for which there is no MCP contract.
- FQHCs must distinguish between PPS eligible encounters and PPS-ineligible encounters using the Q2 modifier to ensure over payment through the reconciliation process does not occur.
- The current FQHC PPS rates are published on the following website; FQHC and RHC Current Rates
- A list of all participating FQHCs in the APM will be listed on the Medi-Cal APM webpage; Federally Qualified Health Centers Alternative Payment Methodology Pilot (ca.gov)

Stop-Loss Risk

Participating FQHCs must be protected from risk using a PPS reconciliation as a stop-loss safeguard. FQHCs are guaranteed PPS per eligible visit. As a result, participating FQHCs will have a one-sided stop-loss protection through the PPS reconciliation process.

MCP P4P Arrangements

FQHCs may participate in P4P meeting the May 10, 2019, and June 12, 2019, criteria [23]. The P4P agreement must be in addition to the APM PMPM that MCPs must pay to each FQHC and must be historically documented. P4P, consistent with the 2019 guidance, may continue in addition to the APM PMPM.

The MCP may not place any revenues under the APM PMPM at risk for recoupment separate from the amounts under the payment transformation linked to the thresholds ("Gate") and quality metrics ("Ladder") in the APM. To be recognized as P4P, the P4P must be historically documented in the FQHC's contract. This is not a statement of policy for the FQHC APM going forward. This is a requirement to ensure the MCPs are not underfunded. For calculation of the capitation rates, DHCS needs the FQHCs and MCPs to provide historical written documentation, the actuary will need to consider all payments as PPS related. This does not mean that new arrangements are prohibited. FQHCs can enter into new P4P arrangements after agreeing to an APM so long as they are appropriately documented and meet the following criteria consistent with the 2019 letters:

- Clear objective criteria: Meet audit and claiming conditions
- Specific metrics: Written agreements prior to start
- Not less than other provider incentives to similar non-FQHC providers: Evaluated to be effective
- Policies and procedures available to DHCS, upon request
- Does not pertain to grants to add capacity or infrastructure
- Meet all state and federal requirements

For additional services (e.g., ECM and Community Supports) and population payments (e.g., Dual Eligibles) that are outside of the APM, please see Section XI.

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23 https://www.dhcs.ca.gov/dataandstats/reports/Documents/FQHCRHCFinancialIncentiveP4PPaymentPolicy.pdf
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-005.pdf

VII. FQHC APM – Interim PPS and CSOSR

The APM PMPM rate setting will use the approved PPS rate in place as of October 1st every year.

- If a site requests an interim CSOSR request before August 1, 2024 (or August 1 each year thereafter), and it is approved by A&I by October 2024 (or October 1 each year thereafter), the APM PMPM will utilize the interim PPS to calculate an interim APM that is reconciled by A&I outside of the APM once the CSOSR is finalized using the traditional approach. The final CSOSR reconciliation by A&I will include calculation of an updated APM PMPM which will then be compared to the utilization under the APM multiplied by the PPS rate. This methodology will ensure that reconciliation will not remove the "wedge"/Pay for Transformation payment.
- If the interim CSOSR is not approved by A&I by October, or if a CSOSR is received after August 1, the APM PMPM will utilize the PPS in effect as of October. If the FQHC then submits a CSOSR that is approved by A&I using the traditional approach, then the final CSOSR reconciliation by A&I will include calculation of an updated APM PMPM which will then be compared to the utilization under the APM multiplied by the PPS rate. This methodology will ensure reconciliation will not remove the "wedge"/Pay for Transformation payment.
- The interim CSOSR will not affect the PPS rate only the APM PMPM calculation. Any references to interim PPS or new PPS rate will affect only the APM PMPM calculation until the FQHC files a CSOSR application that is approved by A&I using statutory and regulatory requirements and uploaded to the provider master file. Once the new PPS is uploaded to the provider master file, A&I will conduct a reconciliation for the FQHC for that CSOSR as noted above.

What is a Scope Change?

CSOSR is defined in State and federal laws/regulations. [24] A CSOSR is defined as:

- The addition of a new FQHC service that is not incorporated in the baseline PPS rate or a deletion of an FQHC service that is incorporated in the baseline PPS rate.
- A change in service due to amended regulatory requirements or rules.
- A change in service resulting from relocating or remodeling an FQHC.

[24] Defined at Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 4, Section 14132.100(e) and evaluated in accordance with Medicare reasonable cost principles in 42 CFR Part 413.

- A change in applicable technology and medical practice.
- An increase in service intensity attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, homeless, elderly, migrant, or other special populations.
- Changes in any of the services outlined or in the provider mix of an FQHC or RHC, or one of its sites.
- Changes in operating costs attributable to capital expenditures associated with a scope change including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices.
- Indirect medical education adjustments, and direct graduate medical education costs.
- Changes in the scope of a project approved by the HRSA.

A change in the cost of a service is not considered, in and of itself, a change in the scope of services unless all of the following are met:

- Attributable to an increase or decrease in the scope of services.
- Allowable under Medicare reasonable cost principles in 42 CFR 413.
- A change in the type, intensity, duration, or amount of services, or any combination thereof.
- The net change in the FQHC's rate equals or exceeds 1.75 percent for the affected FQHC site or the average per-visit rate of all sites if calculated for multiple sites. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular FY.

Change in Scope Process – Interim Changes

DHCS has outlined an interim CSOSR process for FQHCs in the APM. The interim CSOSR will create an interim PPS for use in the APM for the upcoming year to ensure FQHCs receive sufficient cash flow to finance care transformations approved in the process. The interim CSOSR will not be utilized by the State for FFS payments and is not considered final until the FQHC submits a formal CSOSR consistent with existing rules.

The interim CSOSR process is anticipated to be an annual submission process with an August 1 deadline (i.e., not one-time only). The APM PMPM will not include utilization of non-managed care services. The definition of triggering events is not changing for CSOSR requests. Only one ICSOSR is permitted per year and every ICSOSR must be supported by an approved CSOSR following standard processes each year in order for the FQHC to retain the funds.

- On an on-going basis, the interim change must be submitted by August 1 prior to the effective date of the APM (e.g., August 1, 2024 for any change up through December 2025 consistent with CSOSRs for an FQHC FYE occurring prior to the end of the upcoming APM rating period). DHCS will require the ICSOSR attestation form to be submitted for the APM as well as the standard documentation for the CSOSR process following the standard CSOSR process. Every ICSOSR must have a CSOSR filed for the FQHC to retain the funds.
- DHCS will following statutory guidelines regarding CSOSR reviews including interim CSOSR requests.
- The projected PPS will be calculated by applying the selected interim CSOSR increase using the attestation form.
- All scope changes will be finalized and reconciled using the CSOSR process currently in place today. The definition of triggering events is not changing under the APM. If the non-APM service addition is not a triggering event in FFS, then it is not a triggering event under the APM. If the non-APM service addition is a triggering event in FFS, then it is a triggering event under the APM (e.g., addition of dental services).
- During the final CSOSR approval and reconciliation, DHCS will pay the differential due to the CSOSR outside of the APM and managed care rate. If, for example, the PPS rate increases more than expected, reconciliation to the approved PPS payment will occur outside of managed care and the APM through A&I.
- DHCS will reconcile the APM PMPM paid during the rating period with the final PPS approved using the CSOSR process in place today. FQHCs will be paid the net difference between the APM PMPM calculated under the former PPS and the APM PMPM calculated under the new PPS, for every member month during the rating period (if the new PPS is greater). For example, if the total funding of the APM PMPM was $5 million ($100 for 50,000 visits), but the FQHC would have received $5,775,000 ($105 for 55,000 visits), then A&I would ensure that the $775,000 is paid outside of the managed care process.
- The CSOSR reconciliation process will encompass all time periods until the APM PMPM incorporates the new PPS reflecting the CSOSR. The APM PMPM rate year will use PPS in place as of October from the prior year (e.g., CY 2026 rating year will use PPS in effect in October 2025).
- If encounters exceed the number used in the APM PMPM calculation, DHCS would ensure the FQHC received at least the new approved PPS rate multiplied by the actual encounters outside of the managed care rate. This scenario would be paid outside of the APM.

- A change in the mix of services or scope of services meeting all requirements under the statute to quality for a CSOSR would be addressed through the FQHC submitting a CSOSR to DHCS.

New FQHC sites will have an interim PPS rate set using the existing new FQHC site PPS rate setting process already in place. Once a site has its on-going PPS rate set, existing sites may submit any changes in scope under the PPS using the interim CSOSR process. Once the FQHC has completed the full FY in which the qualifying event occurred, the FQHC must then submit the required CSOSR to the State. The State will evaluate the CSOSR filing to ensure it meets the requirements under state statute. If the CSOSR is accepted for processing, the State will review the CSOSR and set a final PPS rate using the standard PPS methodology. The final rate will take effect on the first day of the following FY in which the change occurred. For example, if you filed a CSOSR for FYE June 30, 2025, the new PPS rate is effective July 1, 2025 with an MEI increase applied October 1, 2025. DHCS will reconcile any APM PMPM payments resulting from a CSOSR from past CYs once the final PPS rate is set. Future APM PMPMs will be set using the final PPS rate and historic utilization under the APM PMPM.

At the point of the ICSOSR review, DHCS will review the FQHC's attestation form. Clinics need to be reasonably certain the triggering event will materialize during the ICSOSR year so recoupments are not necessarily during the formal CSOSR review. The formal acceptance of the triggering event and acceptance of allowable costs will be evaluated at the time A&I receives the CSOSR after the FYE of the triggering event. If the CSOSR is accepted, the final audited rate will be used to reconcile.

The interim change for the APM CY 2025 must be submitted by August 1 prior to the effective date of the APM (e.g., August 1, 2024 for any change up through December 2025 consistent with CSOSRs for an FQHC FYE occurring prior to the end of the upcoming APM rating period as noted in the table below). An additional opportunity for a ICSOSR will be made available on August 1, 2024 for the CY2025 rating period as outlined below in conjunction with the FQHCs FYE.

FQHC FYE	Dates for which the Triggering Event is expected to occur and may be submitted by August 1 prior to the CY under the APM
January 31	Triggering event to occur before January 31 (for CY 2025, event occurs prior to January 31, 2025)
February 28	Triggering event to occur before February 28 (for CY 2025, event occurs prior to February 28, 2025)
March 31	Triggering event to occur before March 31 (for CY 2025, event occurs prior to March 31, 2025)
April 30	Triggering event to occur before April 30 (for CY 2025, event occurs prior to April 30, 2025)
May 30	Triggering event to occur before May 30 (for CY 2025, event occurs prior to May 30, 2025)
June 30	Triggering event to occur before June 30 (for CY 2025, event occurs prior to June 30, 2025)
July 31	Triggering event to occur before July 31 (for CY 2025, event occurs prior to July 31, 2025)
August 30	Triggering event to occur before August 30 (for CY 2025, event occurs prior to August 30, 2025)
September 30	Triggering event to occur before September 30 (for CY 2025, event occurs prior to September 30, 2025)
October 31	Triggering event to occur before October 31 (for CY 2025, event occurs prior to October 31, 2025)
November 30	Triggering event to occur before November 30 (for CY 2025, event occurs prior to November 30, 2025)
December 31	Triggering event to occur before December 31 (for CY 2025, event occurs prior to December 31, 2025)

Annual Process Under APM

- August: FQHC informs State of CSOSR to occur prior to and up through the FQHC's FYE falling in the CY rating period and requests Interim PPS. This is for any FYE.

- Fall: State reviews interim PPS.
- October: State applies MEI for upcoming CY to existing PPS and any approved Interim PPS for the applicable period based on the triggering event date and the FQHC's FYE. CMS announces MEI for upcoming CY.
- November: The actuary finalizes APM PMPMs for upcoming CY.
- January: MCPs pay FQHC the APM PMPM (January–September of the CY) if they have a contract with the FQHC in the APM. Otherwise, the MCP pays the non-contracting FQHC in the APM the FQHC's PPS rate.
- Throughout the year: Based on the FQHCs FYE, the actuary will set a APM PMPM reflecting the appropriate Interim PPS, MEI, and effective date to be paid by the MCP.
- Throughout the year: DHCS/A&I will review CSOSRs following the statutory CSOSR process and perform reconciliation outside of managed care for the PPS CSOSR rate differential by DHCS/A&I.
- October: The MCP pays the FQHC the APM PMPM reflecting the interim PPS and updated MEI (October–December).
- October: The State sets the PPS rate for the upcoming year October 1–September 30 (MEI) and CMS announces MEI for the following CY.
- November: The actuary will calculate two separate APM PMPMs, one APM PMPM for the PPS (to be paid during January–September) and one APM PMPM for the PPS (to be paid during October–December after then MEI is applied) the former, and the latter. An interim PPS will be utilized in the calculation of a third APM based on FYE if the FQHC submits an interim CSOSR attestation by August of each year that is approved by DHCS. Any interim PPS will be reconciled to the audited CSOSR PPS via the APM reconciliation process once documentation consistent with the current policy is received.

Once the CSOSR process is complete and a new PPS is established, A&I will perform a reconciliation on the APM PMPM paid during the rating period. FQHCs will be paid the net difference between the APM PMPM calculated under the current PPS and the APM PMPM calculated under the new PPS, for every member month during the rating period.

During the APM reconciliation, A&I will ensure that the total funding under the new APM PMPM is at least equal to what the FQHC would have received under the traditional PPS per eligible visit. The A&I reconciliation process will encompass all time periods until the APM PMPM incorporates the new PPS reflecting the CSOSR. The APM PMPM rate year will use PPS in place as of October from the prior year (e.g., CY 2026 rating year will use PPS in effect in October 2025).

The pros/cons identified for this interim PPS methodology include:

- FQHCs receive more cash up-front.
- Less/easier reconciliation is needed.
- Projected CSOSR PPS can be used if the CSOSR is processed by October. The APM PMPM will be calculated with the latest PPS available for the clinic for the time period covered under the APM PMPM. Any adjustments related to the PPS rates will be addressed through reconciliations and would be outside of managed care.
- More MCP risk.
- Interim rates will utilize the following attestation form.

Federally Qualified Health Center (FQHC) Alternative Payment Methodology (APM) Interim Change in Scope Request and Attestation Form

Name of FQHC Participating in the APM: _____

National Provider Identifier (NPI) of the Facility (of the parent FQHC):

_____

Submission Date: _____

Fiscal Year End (FYE) of the FQHC: _____

Anticipated Effective Date of the Change in Scope of Service Request (CSOSR) (no earlier than the day following the FYE of the FQHC: _____

Current Prospective Payment Systems (PPS) Rate as of July 1, 2024: $_____

Instructions: Please complete one form for each NPI participating in the APM.

1. Describe the Triggering Event anticipated to meet Statutory requirements (Table 1, Column A)
2. List and describe the statutory requirement that the Triggering Event meets and why the event meets that definition (A-I below) (Table 1, Column B)
3. Initial the attestation for a Triggering Event and the four statutorily required requirements (Table 2)
4. Select one of the three permissible interim increases requested, which will affect only APM per member per month (PMPM) rates (Table 3)
5. Initial all APM interim change in scope process attestations (Table 4)
6. The CEO of the FQHC must sign the attestation form for each NPI requesting an interim change in scope adjustment

Table 1. Describe the Triggering Event anticipated to meet Statutory requirements and describe the Statutory requirement the Triggering Event meets

Triggering Event Description (A)	Statutory Authority of the Triggering Event [25] (list A-I below and why the event meets that definition) (B)
Example: The FQHC will begin providing the following new services under the Medicaid State Plan effective January 1, 2024: CHW, Doula.	*A. The addition of a new FQHC service that is not incorporated in the baseline PPS rate or a deletion of an FQHC service that is incorporated in the baseline PPS rate.* *The FQHC will begin providing new State Plan services not previously provided.*
Narrative 1:	
Narrative 2:	
Narrative 3:	

Statutory Authority Triggering Events, subject to DHCS review per Welfare & Institutions Code Section 14132.100(e):

A. The addition of a new FQHC service that is not incorporated in the baseline PPS rate or a deletion of an FQHC service that is incorporated in the baseline PPS rate.
B. A change in service due to amended regulatory requirements or rules.
C. A change in service resulting from relocating or remodeling an FQHC.
D. A change in applicable technology and medical practice.
E. An increase in service intensity attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, homeless, elderly, migrant, or other special populations.
F. Changes in any of the services outlined or in the provider mix of an FQHC or RHC, or one of its sites.
G. Changes in operating costs attributable to capital expenditures associated with a scope change including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices.

[25] Defined at Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 4, Section 14132.100(e) and evaluated in accordance with Medicare reasonable cost principles in 42 CFR Part 413.

H. Indirect medical education adjustments, and direct graduate medical education costs.
I. Changes in the scope of a project approved by the HRSA.

APM participants must confirm that at least one triggering event (A through I) and meet all four requirements below in Table 2 are met.

Table 2: Initial the attestation related to the Statutory definition of a Triggering Event

Initial	Attestation
	1. The FQHC attests that it plans to have at least one of the triggering events listed in Table 1 above (A through I) that it believes meets the statutory requirement for a CSOSR triggering event. Additionally, the FQHC attests that the requirements set forth in Welfare and Institutions Code Section 14132.100 (e)(3)) and listed below are met: *A change in cost is not, in and of itself, a scope-of-service change, unless **all** of the following are met:* • *The increase or decrease in cost is attributable to an increase or decrease in the scope of services.* • *The cost is allowable under Medicare reasonable cost principles in 42 CFR 413.* • *The change in scope of services is a change in the type, intensity, duration, or amount of services, or any combination thereof.* • *The net change in the FQHC's rate equals or exceeds 1.75 percent for the affected FQHC site or the average per-visit rate of all sites if calculated for multiple sites. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular FY.*

Table 3: Select one of the three permissible interim increases requested, by placing an "X" in one row in the table below which will affect only APM PMPM rates:

Select one of the below rates:	Increase from the current PPS rate
	2.5%
	5%
	10%

Table 4: Initial all attestations below regarding the interim change in scope process related to the APM:

Initial	Attestation
	1. The FQHC attests that if the triggering event does not occur, it will not have to file a CSOSR package but will refund all money granted under this interim change in scope as part of the APM reconciliation.
	2. The FQHC attests that it understands that the interim rate increase listed above in Table 3, will only affect the APM PMPM and not the PPS rates of the NPI.
	3. The FQHC attests that it will file the complete CSOSR package required under State law, regulation, and policy within 150 days of their FYE. DHCS will not incorporate into the APM any changes between the signed and approved attestation and the completed CSOSR submitted within 150 days of the clinic's FYE.
	4. The FQHC attests that it understands that inclusion of the interim change in scope in the APM PMPM is not final approval of the of the requested change in scope for the PPS.

Initial	Attestation
	5. The FQHC understands that the CSOSR process will finalize the PPS rate that will be used to calculate the final APM PMPM, which will be the basis of the APM PMPM reconciliation.
	6. The FQHC attests that it will refund any amount that the CSOSR package and A&I review documents to which the FQHC is not entitled through the CSOSR and APM PMPM reconciliation processes.

This letter is a statement of confirmation that, as the Authorized Representative of the FQHC and NPI listed above, I attest that the statements above are correct and request an interim change in scope consistent with the Tables above.

I am authorized to sign this certification of an Interim Change in Scope Request on behalf of the FQHC. I understand that knowingly filing a false or fraudulent statement in support of a claim may violate the Federal False Claim act or other applicable statue and be punishable thereunder.

_____ _____

Signature E-Mail address

_____ _____

Name & Title of Authorized Signatory (CEO) Contact information

_____ _____

FQHC and NPI, addresses and locations Date

CSOSR Process

After a qualifying event (with few exceptions) that took place prior to FYE, the FQHC files the scope changes 150 days (five months) after the FQHC's FYE. The CSOSR is effective for the following FY. This process is still required under the APM for any interim CSOSR.

CSOSR Process Example (Assuming FQHC FYE June 30) [26]

Date	Event	Explanation	Rate Effective Date	Rate
		Starting Clinic Rate	October 1, 2024–September 30, 2025	$200
July 1, 2025	CSOSR Qualifying Event	A qualifying event occurs on July 1, 2025 during FYE July 1, 2025–June 30, 2026		
October 1, 2025	2025 MEI inflation (no CSOSR)	The FQHC receives October 2025–September 2026 MEI rate increase based on the rate prior to the CSOSR rebased rate (including the January 1, 2025 MEI). The October 1, 2025 MEI is applied but it is based on the old rate not the CSOSR updated rate.	October 1, 2025–September 30, 2026 Later Changed to: October 1, 2025–June 30, 2026	$205

[26] Provider elects cost report rate setting methodology with first full FY as an enrolled FQHC of June 30, 2015. Rate is updated annually on October 1. MEI automatically applied annually on October 1.

Date	Event	Explanation	Rate Effective Date	Rate
October 1, 2026	2026 MEI applied (no CSOSR) initially but later changed to CSOSR	The FQHC receives October 2026–September 2027 MEI rate increase based on the rate prior to the CSOSR rebased rate (including the January 1, 2026 MEI but old rate). • October 1, 2026 MEI rate increase applied to CSOSR rate. *The CSOSR rate has not been submitted or calculated by October 1, 2026.*	October 1, 2026–September 30, 2027	$210
November 27, 2026	Submission of CSOSR request	The FQHC sends CSOSR by November 2026		

Date	Event	Explanation	Rate Effective Date	Rate
Spring 2027	CSOSR is approved effective July 1, 2026	The new rate would be effective July 1, 2022 with reconciliation of new PPS rate and old PPS rate based on actual utilization. MEI for October 1, 2026–September 30, 2027 (using January 1, 2026 MEI) is applied on the July 1, 2026 PPS rate effective October 1, 2026. Retroactive application of CSOSR back to July 1, 2026 (beginning of FY), and CSOSR reconciliation of actual claims to the new actual PPS rate from the former PPS rate (PPS CSOSR rate differential). If provider files for CSOSR for FYE June 30, 2026, new rate effective July 1, 2026 to September 30, 2026. MEI increase for October 1, 2026 through September 30, 2027. MEI every October 1 moving forward unless they file for a CSOSR. Audit of CSOSR would be completed in early 2027, rate would be applied to July 1, 2026. *Rate does not go backwards, but CSOSR is retroactive to the beginning of the July 1, 2026 FY.* • October 1, 2026 MEI rate increase applied to CSOSR rate. *The CSOSR rate has not been calculated by October 1, 2026, but MEI will apply to the CSOSR once it is applied retroactively.*	July 1, 2026–September 30, 2026 October 1, 2026–September 30, 2027	$220 $225

Date	Event	Explanation	Rate Effective Date	Rate
October 1, 2027	2027 MEI applied	The FQHC receives October 2027–September 2028 MEI rate increase based on the rate after the CSOSR rebased rate is applied	October 1, 2027–September 30, 2028	$230

Current Process Example (Assuming FQHC FYE December 31)[27]

Date	Event	Explanation	Rate Effective Date	Rate
		Starting Clinic Rate	October 1, 2024–September 30, 2025	$200
July 1, 2025	CSOSR Qualifying Event	A qualifying event occurs on July 1, 2025 during FYE January 1, 2025–December 31, 2025		
October 1, 2025	2025 MEI inflation (no CSOSR)	The FQHC receives October 2025–September 2026 MEI rate increase based on the rate prior to the CSOSR rebased rate (including the January 1, 2025 MEI). The October 1, 2025 MEI is applied but it is based on the old rate not the CSOSR updated rate	October 1, 2025–September 20, 2026 *Later changed to October 1, 2025–December 31, 2026 because of CSOSR*	$205

[27] Provider elects cost report rate setting methodology with first full FY as an enrolled FQHC of December 31, 2015. Rate is updated annually on October 1. MEI automatically applied annually on October 1.

Date	Event	Explanation	Rate Effective Date	Rate
April 30, 2026	Submission of CSOSR request	The FQHC sends CSOSR/CSOSR by April 2026		
October 1, 2026	2026 MEI applied (no CSOSR) initially but later changed to CSOSR	The FQHC receives October 2026–September 2027 MEI rate increase based on the rate prior to the CSOSR rebased rate (including the January 1, 2026 MEI but old rate) • October 1, 2026 MEI rate increase applied to CSOSR rate if calculated. *The CSOSR rate may not be calculated by October 1, 2026*	October 1, 2026–September 30, 2027	$210

Date	Event	Explanation	Rate Effective Date	Rate
Fall 2026	CSOSR is approved effective January 1, 2026	The new rate would be effective January 1, 2026 with reconciliation of new PPS rate and old PPS rate based on actual utilization. MEI for October 1, 2026–September 30, 2027 (using January 1, 2026 MEI) is applied on the January 1, 2026 PPS rate effective October 1, 2026 Retroactive application of CSOSR back to January 1, 2026 (beginning of FY), and CSOSR reconciliation of actual claims to the new actual PPS rate from the former PPS rate (PPS CSOSR rate differential) If provider files for CSOSR for FYE December 31, 2025, new rate effective January 1, 2026 to September 30, 2026. MEI increase for October 1, 2026 through September 30, 2027. MEI every October 1 moving forward unless they file for a CSOSR. *Rate does not go backwards, but CSOSR is retroactive to the beginning of the January 1, 2026 FY.* Audit of CSOSR would be completed in early 2027, rate would be applied to January 1, 2026. • October 1, 2026 MEI rate increase applied to CSOSR rate. The CSOSR rate may not be calculated by October 1, 2026 so the MEI is applied to the retroactive CSOSR when it is calculated	January 1, 2026–September 30, 2026 October 1, 2026–September 30, 2027	$220 $225

Date	Event	Explanation	Rate Effective Date	Rate
October 1, 2027	2027 MEI applied	The FQHC receives October 2027–September 2028 MEI rate increase based on the rate after the CSOSR rebased rate is applied	October 1, 2027–September 30, 2028	$230

Historic MEI

- CY 2015=0.08%
- CY 2016=1.1%
- CY 2017=1.2%
- CY 2018=1.4%
- CY 2019=1.5%
- CY 2020=1.9%
- CY 2021=1.4%
- CY 2022=2.1%
- CY 2023=3.8%
- CY 2024 = 4.6% and will be applied October 1, 2024

Frequently Asked Questions

1. What is the ICSOSR?
   Response: DHCS has outlined an interim CSOSR process for FQHCs participating in the APM. The interim CSOSR will create an interim PPS for use in the APM for the upcoming year to ensure FQHCs receive sufficient cash flow to finance care transformations approved in the process. The ICSOSR is optional and is not required prior to or during the APM.

2. What is the acceptable time period to file for an ICSOSR?
   Response: If an FQHC participating in the APM believes it will experience a qualifying CSOSR under State law, the FQHC may apply prior to the August 1 deadline to receive an interim PPS rate for the next APM contract year.

3. What percentage of the projected ra23te will clinics receive regardless of the projected cost per visit?

Response: The projected interim rate will be set at the projected rate chosen by the FQHC on the attestation form (between 2.5 and 10%). At the end of the interim time period, all scope changes will be finalized and reconciled using the CSOSR process currently in place today. DHCS will apply the 80% cost reduction principle to the final rates.

4. What documentation do I need to submit for the ICSOSR?
   Response: The FQHC must submit a completed ICSOSR attestation form. The submission must list a permissible triggering event in the FQHC's FY that will be applicable before the end of the next APM rating period.

5. Will this process of obtaining this new rate be subject to a preliminary audit to determine cost reasonableness when establishing this rate?
   Response: No, the ICSOSR rate is only used for calculation of the PMPM and the attestation will not be audited. DHCS will not update the PPS Rate in the Provider Master File until the "actual" CSOSR is filed, accepted, and audited.

6. Will the ICSOSR be subject to productivity standards?
   Response: The ICSOSR will inflate the already approved PPS rate for calculation of the APM PMPM. The ICSOSR PPS will be based on the actual PPS methodology, including minimum productivity thresholds.

7. At what point in the ICSOSR process will the formal acceptance of the triggering event be determined?
   Response: Clinics need to be reasonably certain the triggering event will materialize during the ICSOSR year so recoupments are not necessarily during the formal CSOSR review. The formal acceptance of the triggering event and acceptance of allowable costs will be evaluated at the time A&I receives the CSOSR after the FYE of the triggering event. If the CSOSR is accepted, the final audited rate will be used to reconcile.

8. Will a home office cost report be required to file an ICSOSR?
   Response: The home office cost report is required to file a final CSOSR. When a final CSOSR is filed the home office cost report from every FQHC should be available and filed.

9. If it is determined there is a liability for the ICSOSR (because the clinic's projected costs or utilization projections did not materialize as projected), how will DHCS re-coup these monies? How will DHCS adjudicate receivables generated from the ICOSR if the FQHC is owed money?
   Response: A&I will reconcile the APM PMPM paid during the rating period with the final PPS approved using the CSOSR process in place today. FQHCs will be paid the net difference between the APM PMPM calculated under the former PPS and the APM PMPM calculated under the new PPS, for every member month during the rating period (if the new PPS is greater). The difference will be calculated via the annual APM reconciliation process. The process for recovery/payment will be the same as it is today for Reconciliation Requests. The FQHC will receive a final APM reconciliation audit report with the final settlement amount noted. The FQHC will receive a statement of account status letter from the Medi-Cal Fiscal Intermediary with instructions on the payment/recovery process.

10. What is the last date an FQHC can submit a traditional CSOSR rate change and expect it to be calculated in their APM PMPM for the following APM CY? If an FQHC submits a traditional CSOSR after this date, will and how will their APM rate be adjusted later?
    Response: After a qualifying event (with few exceptions) that took place prior to FYE, the FQHC files the scope changes 150 days after their FYE. A&I will incorporate the CSOSR in the audited PPS rate. The CSOSR is effective with the FQHC FFY. If the updated final PPS rate is complete by October, the State's actuary will incorporate the updated PPS rate into the APM PMPM for the clinic.

    - Once the CSOSR process is complete and a new PPS is established, A&I will perform a reconciliation on the APM PMPM paid during the rating period. FQHCs will be paid the net difference between the APM PMPM calculated under the current PPS and the APM PMPM calculated under the new PPS, for every member month during the rating period.
    - The FQHC will be required to file an annual Reconciliation Request as they do today within 150 days after their FYE. Additionally, the FQHC participating in the APM will have an annual APM reconciliation on a CY (within 150 days after the CY). A&I will perform a reconciliation on encounters to ensure that the total funding under the new APM PMPM at least what the FQHC would have received under the traditional PPS per eligible visit. The APM reconciliation

will be completed once per year for the FQHC's participating in the APM to incorporate the final PPS Rate (if a CSOSR is accepted) and to reconcile the APM PMPM. If the CSOSR is not fully audited, A&I will hold the APM Reconciliation and incorporate the audited rate when CSOSR is final.

- The A&I reconciliation process will encompass all time periods until the APM PMPM incorporates the new PPS reflecting the CSOSR.
- The APM PMPM rate year will use PPS in place as of October from the prior year (e.g., CY 2026 rating year will use PPS in effect in October 2025 for January–September and in October 2026 for October–December). The length of review will depend upon the completeness of the documentation submitted by the FQHC.

11. If the FQHC withdraws and changes staff, the DHCS A&I will be notified and will review with the FQHC regarding whether or not a mandatory CSOSR should be filed. How will this work?

    Response: If the FQHC maintains the same level of services and does not change its care transformation, then a CSOSR would not be required. If the FQHC withdraws from the APM and changes its care model which decreases/deletes services, a CSOSR may be required if the rate decreases by 2.5%. A change in the amount of direct care staff may have a direct impact on the PPS rate. The provider is required by statute to complete an analysis and file a CSOSR if services have decreased or deleted, and the rate is impacted by 2.5%. A&I may request verification that the provider completed the analysis if the provider reverted to the former care model and services were decreased/deleted.

If the FQHC maintains the same level of services and does not change its care transformation, then a CSOSR would not be required. However, if the FQHC withdraws from the APM and changes its care model which decreases/deletes services, a CSOSR may be required if the rate decreases by 2.5%. A change in the amount of direct care staff may have a direct impact on the PPS rate. The provider is required by statute to complete an analysis and file a CSOSR if services have decreased or deleted, and the rate is impacted by 2.5%. A&I may request verification that the provider completed the analysis if the provider reverted to the former care model and services were decreased/deleted.

In accordance with WIC Section 14132.100 and the California State Plan, if an FQHC/RHC provider decreases or deletes services that decreases the rate by 2.5% a CSOSR is required. If the provider withdraws or is removed from the APM, the provider should do an analysis to determine if a CSOSR is required.

VIII. FQHC APM – Annual Reconciliation

The State will ensure the FQHC receives at least the PPS payment if encounters exceed the number of encounters in the APM PMPM through reconciliation.

- DHCS shall annually review and reconcile the total payments made to each participating FQHC to ensure the aggregate APM PMPM amount paid by the MCP(s) in the applicable year is at least equal to the amount the FQHC would have received in the year if the FQHC had been paid its applicable PPS rate in effect for that CY including the appropriate MEI index, per PPS eligible managed care encounter for APM services. The submitted encounter data from each FQHC to the participating MCP will be the basis of the reconciliation. PPS payments for non-assigned members should also be accounted for in the FQHCs submitted data to the MCP. DHCS will ensure MCPs are reimbursed the FQHC's PPS rate for covered managed care services in their capitation rates. MCPs will ensure FQHCs are paid at least the APM PMPM on a monthly basis even if in multiple payments. The submitted encounter data from each FQHC to the participating MCP will be the basis of the reconciliation. DHCS will utilize encounter data and member rosters to validate payment to FQHCs for unassigned, non-contracted MCP members, as needed.
- P4P amounts/calculations must be historically documented in order to be outside of the FQHCs APM PMPM. To be recognized as P4P, the P4P must be historically documented in the FQHC's contract. P4P must be historically documented to be recognized in the MCP's rate from DHCS. This is not a statement of policy for the FQHC APM going forward. This is a requirement to ensure that the MCPs are not underfunded. For calculation of the capitation rates, DHCS needs the FQHCs and MCPs to document the historical written, the actuary will need to consider all payments as PPS related. This does not mean that new arrangements are prohibited. FQHCs are able to enter into new P4P arrangements after agreeing to an APM so long as they are appropriately documented.
- FQHCs must be able to document they received the APM PMPM for assigned members and the PPS rate for unassigned, non-contracted MCP members (attestation is not sufficient). The FQHC will provide auditable documentation that it has received the APM PMPM for each assigned member for each MCP. FQHCs must create and maintain auditable accounting records linked to the general ledger of the FQHC, to track the APM PMPM revenue received. Finally, the FQHC must systematically submit or validate, in a form and manner specified by DHCS, information documenting payments for each member assigned by the

MCPs and the amount received from the MCPs. Historically documented P4P amounts/calculations are outside of the FQHCs APM PMPM. DHCS will utilize encounter data and member rosters to validate payment to FQHCs for unassigned, non-contracted MCP members, as needed.

- If aggregate APM PMPM payments are less than the total amount that would have been paid under the current PPS rate methodology for each PPS eligible managed care encounter for a particular participating FQHC under the APM, DHCS shall pay the participating FQHC the difference between the amount paid by the MCP(s) and the amount the participating FQHC would have been entitled to under the PPS rate methodology for the total number of PPS eligible managed care encounters for APM services. The State will reconcile actual utilization to the APM PMPM using managed care encounter data. Any recoveries or payments will follow the State's established processes consistent with the amounts outlined in subsection Section X – On-going Measures (Ladder) Subsection Payment Linked to Quality below developed by the department with input from affected stakeholders, if the following conditions are met:
    - Actual utilization during the period is less than 70 percent of the utilization rate (based on historical PPS eligible visits) for APM enrollees as outlined in subsection Section X – Participation Threshold Measures (Gate) or
    - The FQHC fails to meet Access and Quality Standards as outlined in subsection Section X – On-going Measures (Ladder) below.
- Participating FQHCs must submit to MCPs the necessary records of all encounter claims involving that MCP by no later than 90 days after the conclusion of a CY to afford adequate time for completion of the annual reconciliation required in this subsection.
- DHCS shall base reconciliation calculations on information submitted by MCPs from APM participating FQHCs within this deadline and reserves the right to audit data upon which reimbursement is based.

How will the State Monitor that FQHCs Receive PPS and Ensure Duplicate Payment Does Not Occur?

DHCS will monitor the APM, using PPS versus the actual APM PMPM payments once all PPS CSOSR' are finalized. DHCS will monitor the actual number of PPS-eligible encounters for Medi-Cal MCP members as well as all payments on behalf of the MCP to the FQHC. The State will monitor the following for each FQHC and MCP:

- The actual versus expected number of encounters for MCP members

- The actual versus expected number of assigned MCP members with APM PMPM payments
- The actual versus expected PPS rate built into the APM PMPM if there was an interim CSOSR

To prevent duplicate payment, FQHCs should no longer submit wrap payment requests (T1015 and T1015 SE) for APM covered services for APM managed care populations except for dually eligible members who are currently excluded from the APM. APM sites providing non-APM and Non-MCP services (e.g. specialty mental health and dental) will also continue to submit the T1015 claims. See Section XI for services and populations excluded from the APM (e.g., dental, specialty mental health and dual eligibles).

APM FQHC providers will not bill 0521 T1015 SE wrap claims for any member that is eligible for receiving payment in the FQHC APM unless the service is excluded from the APM, such as dental. The wrap payment will be covered through the per-member per-month amount received for each eligible member under the APM. FQHCs will continue to bill wrap claims for non-APM eligible members such as dual eligibles. APM FQHC providers will have a new code set to use for billing Dental Managed Care wrap claims. APM FQHC providers billing for a Dental Managed Care differential will utilize 0512 T1015 SE for all claims. This new code set is currently only eligible for APM providers. APM FQHC providers billing for fee-for-service dental payments will continue to bill CA-MMIS local code 03.

Annual Reconciliation

Payments related to yearly reconciliations will be made in accordance with the two-year payment requirement at 42 CFR § 447.45 and 45 CFR § 95, Subpart A. This is a CMS requirement and begins on the date of the capitation payment for those dates of service.

Managed care encounters will be the source of data for reconciliations. All encounter claims from FQHCs participating in the APM must be received by the MCP with the prime contract no later than 90 days after the conclusion of the CY to ensure sufficient time to complete the reconciliation. DHCS will also ensure the amount paid to each FQHC that elects the APM is at least equal to the PPS rate on a per encounter basis for that FQHC for the FY as documented in encounter data. Due to the CMS timely filing requirement, DHCS will need enough time for encounters from December's dates of service to be submitted to the health plan, submitted to DHCS, and reconciled by A&I. If there are any disputes regarding data, longer filing deadlines would not allow any input from FQHCs in this process. *Note, MCPs will be held accountable through the MCP*

contract compliance process. MCPs should share data with their contracted FQHCs under the APM program. MCPs and FQHCs should working together through a collaborative process as outlined in the FQHC's application to the APM to improve data quality. The data quality workgroup will continue to work through issues surrounding these processes. There will not be a standard DHCS dispute resolution process between MCPs and FQHCs; however, it is expected that the MCP provides education to the participating APM clinic on how to file a dispute related to data.

The APM reconciliation will be performed in addition to the current annual Reconciliation Request.

IX. Data System and Data Sharing

The vision of the APM is to embrace and integrate a diversity of providers in the delivery of whole-person care, and not just traditional FQHC health care providers. DHCS acknowledges the tremendous investment required of both MCPs and FQHCs to realize this from an information technology infrastructure and data sharing perspective. To that end, listed below are high-level data system requirements for MCPs, along with data sharing requirements for MCPs and FQHCs. MCPs will be required to initiate a Corrective Action Plan on behalf of the State when needed.

Data System Requirements

MCPs are required to have an IT infrastructure and data analytic capabilities to support the APM, including Alternative Encounters and the capabilities to:

- Consume and use claims, encounter data, and supplemental data, as well as other data types listed in this guide
- Assign Members to FQHC unique sites with different billing NPIs
- Keep records of Members receiving FQHC Alternative Encounters
- Securely share data with FQHCs
- Receive, process, and send encounters and invoices from FQHCs to DHCS in accordance with DHCS standards
- Receive and process supplemental reports from FQHCs necessary for quality metrics
- Send quality metric supplemental reports to DHCS
- Open, track, and manage referrals to FQHCs as needed

Data Sharing Requirements for MCPs

The State is not mandating the exact data elements that are expected to be shared with FQHC participation under the APM will require FQHCs receive regular member rosters, performance metric results, and encounter data extracts submitted to DHCS from the MCPs. MCPs should work with FQHCs regarding the data required to be submitted under the APM.

In order to support the FQHC APM, MCPs must provide, at a minimum, the following information to all FQHCs participating in the APM:

- Physical, behavioral, administrative, and information indicating member SDOH needs, as specified on previously submitted claims encounters or identified

through other data sources (e.g., Homeless Management Information System) [28] for assigned members
- Reports of performance on quality measures and/or metrics, as requested

MCPs are required to use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with FQHCs and with DHCS.

Please note, 42 CFR 2 regarding substance use disorder (SUD) confidentiality, was proposed to be updated on December 2, 2022 to address many of these concerns and permit coordination among providers for SUD challenges while bringing Part 2 requirements into closer alignment with HIPAA, please ensure that you are relying on the current version of the regulation.

Data Sharing Requirements for FQHCs

DHCS' vision is that FQHCs will submit encounters to MCPs for transmission to DHCS. The FQHCs participating in the APM will be paid by the MCP on a capitated basis. The FQHCs are expected to generate and submit a compliant 837P encounter to MCPs or CMS 1500 claim encounters to MCPs for all services and payments. FQHCs will also need to submit all data necessary for quality measure performance calculations and reporting, including supplemental and EHR data if needed. DHCS anticipates releasing guidance surrounding this issue in the future.

MCPs must accept all encounters from participating FQHCs even for members that were not-assigned to the participating APM FQHC, payments, and Alternative Encounters.[29] FQHCs and MCPs may need to re-configure their existing systems to meet these requirements.

This manual is intended to be written from a DHCS perspective with its prime contractor (MCPs) and the providers with direct contact with members (FQHCs). The MCP must ensure it oversees and holds accountable any functions and responsibilities that it

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[28] As part of the population health management initiative of CalAIM, DHCS has issued guidance encouraging MCPs to incorporate the use of DHCS Priority SDOH Codes; please refer to APL 21-009 for more information.

[29] If the Medi-Cal beneficiary is not a member of the health plan, it is expected that the health plan reject the claim and will not reimburse the FQHC for a PPS eligible encounter. MCPs are not required to reimburse APM FQHCs PPS rates for non-PPS eligible visits coded with a Q2 modifier. Note: claims for members who are excluded populations such as dual eligible or services that are excluded under the APM such as dental should follow the regular FQHC claiming procedures under the MCP contract with the State for non-APM FQHCs.

delegates to any subcontractor. The subcontract does not terminate the legal responsibility of the MCP to assure all activities under the Medi-Cal contract are carried out. The MCP is not relieved of its contractual responsibility to DHCS by shifting responsibility to a delegated entity. The MCP and FQHC must ensure the responsibilities under the APM are met even if performed by a delegated entity.

Assignment Process

MCPs must have member assignment processes in place to assign members to primary care providers including FQHCs, using procedures that have been approved by DHCS in advance, in accordance with the MCP's current contract with DHCS.

As part of the assignment process, MCPs must document their processes, maintain clinical prior relationships and accessibility standards, including time and distance standards. In no instances should MCPs steer assignments away from FQHCs participating under the APM.

MCPs should assign at the NPI number of the location (if possible) and if not then at the NPI number of the Parent Site. Participation under the APM is predicated on assignment at the NPI site level. MCPs should not assign members to the overall FQHC organization or corporate NPI level of participating FQHCs.

Data and Coding

Under the APM, all encounter data will go through the MCP. DHCS will utilize MCP encounter data to capture all elements necessary for the calculation of administrative quality metrics and reconciliation. Alternative Encounters will be coded through CPT, HCPCS, and ICD-10 coding as noted later in this document. DHCS will require the same Z codes required in managed care. The 18 Z codes outlined for in lieu of services will be utilized for tracking SDOH. For hybrid quality metrics, DHCS' goal is to ensure the relevant data feeds are sent to the plans and for the plans to develop the necessary system capabilities to accept this data to ensure complete calculation of metrics with electronic data submission.[30] Encounter data/claims submission will be submitted to DHCS through the MCPs.

[30] Hybrid quality metrics are defined by NCQA as either hybrid or admin (claims). Generally, these are quality measures where administrative data is combined with data abstracted from member record during a medical record review. There are standard processes for hybrid measures, which can include chart review and supplemental data. The Quality and Data Subcommittee will discuss how and when hybrid data is collected.

The State would like guardrails to be implemented as DHCS implements a single source of truth and improves encounter data. DHCS will work with the MCPs and FQHCs to develop a checklist for clear standards on what is good data quality. MCPs and FQHCs will be required to work together throughout the chain of data custody to identify data issues and fix those issues. MCPs and FQHCs should ensure that any subcontractors or delegated agencies also work to fix data issues. MCPs, delegated entities, and FQHCs will work together to identify the procedures of modifying or removing incomplete, incorrect, inaccurately formatted, or repeated data in a database to improve data consistency, accuracy, and reliability. This will include examination of automated data tools, rules and protocols utilized to clean or scrub data prior to submission to the MCP.

Quality Data Dispute Resolution

MCPs and FQHCs will be required to work together to ensure encounter, claims, member, and supplemental data are accurate and complete for quality reporting. The FQHC and MCP will need to agree on how to address quality of data concerns depending upon the issues. MCPs will be required to have a dispute resolution process for FQHCs who disagree with the MCP data quality and/or in cases where the MCP is not working with the FQHC in a meaningful way to resolved data concerns or discrepancies.

X. FQHC APM Quality Component Requirements – Participation Threshold Measures (Gate) and Quality Measures Impacting Pay for Transformation (Ladder)

DHCS has selected 14 metrics across seven domains in total for the APM with 12 at risk for payment (please refer to Section XIV for the list of quality metrics). After selecting for the six required measures, FQHCs may choose any other measures of choice within the categories as noted to reach to a total of 12. However, FQHCs may not change the measures/metrics in the following year. FQHC select a set of metrics they will have linked to payment year-over-year and those metrics will not change each year. FQHCs will submit encounter and supplemental data to the primary MCPs. DHCS does not require FQHCs and MCPs to work with delegated entities. MCPs and FQHCs may choose to work with delegated entities at their option. MCPs will report all encounter data and calculate and report performance outcomes on metrics to the State. A subset of measures has been selected for stratification with the plan to outline a methodology for establishing health equity targets.

All metrics will go through the MCPs. DHCS recognizes there are discrepancies and plans/FQHCs are working through those issues; however, in order to have a single source of truth, the APM will utilize only MCP data.

DHCS has set thresholds for minimum performance on a defined set of thresholds (Gate) measuring access and quality processes and outcomes. If the FQHC does not maintain one or more of the access and quality thresholds described below, the MCPs will initiate a CAP with potential termination from the APM or financial penalty, consistent with the approved State Plan. The MCPs contracting with each participating FQHC will collaborate on all CAPs. In all cases, each FQHC participating in the APM will receive at least the PPS rate in effect for that CY on a per encounter basis, for that FQHC. To retain the APM PMPM reimbursement exceeding the PPS rate for encounters provided during the PY, the FQHCs on an annual basis must meet the access and quality measures identified by DHCS as described below.

The selected quality metrics are linked to CalAIM and the DHCS Comprehensive Quality Strategy and Health Equity Roadmap. Metrics may change after the initial implementation based on overall DHCS goals and alignment with quality programs across the department. DHCS will welcome feedback from the APM Advisory Workgroup on metrics once implemented. All decision-making will occur by DHCS.

Participation Linked to Threshold Measures (Gate)

In all cases, each FQHC participating in the APM will receive at least the current PPS rate in effect for that CY on a per encounter basis, for that FQHC.

Participating FQHCs must submit data and information to MCPs who will submit the calculated numerator and denominator of selected APM metrics to DHCS on all 12 at risk measures selected from Section XIV in a manner and timing determined by DHCS. Participating FQHCs must meet the quality standards in this Section in order to continue participation in this APM. A participating FQHC's continued participation in the APM is contingent upon satisfaction of the following minimum standards for access and quality measures.

- Access Performance Metrics (Gate): Annually, participating FQHCs must provide access to at least 70 percent of the utilization rate (based on historical PPS eligible visits) used in the calculation of the APM PMPM Rate in accordance with subsection 7 for APM enrollees. Access may also include services not recognized as a billable encounter under the state's PPS statute at subdivision (g) of Section 14132.100 of the California Welfare and Institutions Code if the service may be provided under State law, is permissible under the clinic's state license and reported by the FQHC consistent with a list of approved codes set by DHCS with input from stakeholders and updated periodically to include services recognized as improving Health-Related Social Needs but not qualifying as a PPS visit. APM PMPM reimbursement will be set consistent with Section V. FQHC APM – Calculation of the APM PMPM for APM enrollees not based upon those additional codes. The additional codes will not qualify as a visit under PPS reconciliation under the APM in Section VIII. FQHC APM - Annual Reconciliation. If a participating FQHC starts the APM on July 1st, then the measurement period for this access measure shall be a 6 month period from July 1st to January 1st of the following year with subsequent periods being on a calendar year 12 month period basis
- Quality Performance Metrics (Gate): Annually, participating FQHCs must maintain baseline performance for the following measures at a level at least equal to the performance achieved in the FQHC's last CY prior to beginning participation in the APM:
    - Well Child Visits in the first 30 months (W30+ & W30-2+)
    - Child and Adolescent Well-Care Visits (WCV)
    - Adults' Access to Preventive/Ambulatory Health Services (AAP)

- Aggregated Quality Factor Score (AQFS); calculated from all reported measures in Section XIV. FQHC APM Quality Metrics for CY 2024 below)

In other words, the FQHC must maintain a floor of its own unique baseline engagement rate for the following three measures:

1. *Adults' Access to Preventive/Ambulatory Health Services (AAP, NCQA)*
2. *Child and Adolescent Well-Care Visits (WCV, NCQA)*
3. *WCV in the first 30 months of life (W30, NCQA)*

Note, this will be a product of the future quality workgroup discussions. Quality metric baseline data or PY0 will be reported for 2023 (not the base year for APM rates) for clinics entering the APM in 2024. On an on-going basis, the quality metric baseline data or PY0 will be based on the year before the FQHC enters the APM (not the base year for the APM rates). Note that if an FQHC start the APM on July 1st, PY0 refers to the calendar year prior to starting the APM leveraging the MCP assignment data used in rate setting.

For all quality measures, MCPs should attribute members to a particular FQHC site participating in the APM using the MCP's usual attribution model (for example, including but not limited to the MCP's in-house pay-for-performance program attribution methodology). Attribution means the method of determining with members for which the FQHC site is responsible for a given quality measure (i.e. what members are in the denominator for a measure). In the future, DHCS may release a quality metric attribution method that MCPs must use. In the absence of a DHCS method, MCPs should seek to use the same attribution methodology in the quality baseline year and the CY being assessed for performance. If a change in attribution methodology year-to-year causes a large drop in performance on a given quality metric, MCPs and DHCS shall take this into account as factor (outside the FQHC's control) if a CAP is triggered due to low performance on that quality measure. This will only be taken into account for the calendar year first affected the change in attribution methodology (but not subsequent CYs).

The source of the FQHC baseline engagement rate will be the MCP encounter data for the following three measures:

1. *AAP, NCQA*
2. *WCV, NCQA*
3. *W30, NCQA*

If the FQHC does not maintain one or more of the below thresholds, then the MCP will initiate a CAP on behalf of the State, as needed.

- Access Threshold (Gate): FQHC must maintain a floor of 70% PPS visits in the rate baseline year (sum of PPS visits and Alternative Encounters) to maintain participation in the APM. If a participating FQHC starts the APM on July 1st, then the measurement period for this access measure shall be July 1st to June 30th of the following year.
- Quality Threshold (Gate):
    - Report on all measures (not just the ones used for ladder), measured on a calendar year regardless of start date in the APM (e.g. if start date is July 1st, measurement is still for that entire calendar year for the first year)
    - Maintain baseline (PY 0) for the following measures:
        - Well Child Visits in the first 30 months (W30+ and W30-2+)
        - WCV
        - AAP
        - AQFS [31] (calculated from all reported measures)
- Note that if an FQHC starts the APM on July 1st, PY0 refers to the calendar year prior to starting the APM.

If a participating FQHC does not maintain either the minimum Access Performance Metric threshold or has a degradation of five percent or more of the Quality threshold set forth above, DHCS, through its designees the MCPs, shall place the participating FQHC on a CAP in conjunction with the MCPs contracting with that FQHC.

The CAP process shall include the following phases and the FQHC must be notified when the first phase is triggered (and the FQHC should be actively working on addressing performance metrics as soon a the first step is triggered):

- For the first 6 months, identification and auditing of performance metrics for which the participating FQHC is not maintaining performance levels.
- For the next 6 months of the CAP, formal initiation and implementation of a CAP in conjunction with the participating FQHC's contracting Medi-Cal MCP(s) for metrics the participating FQHC is not maintaining adequate performance levels or achieving pre-defined improvement/innovation efforts.
- If the participating FQHC's performance scores on the Access and/or Quality Performance Metrics do not return to required baseline standards (i.e., Program

[31] The quality workgroup will discuss how the AQFS will be calculated. The structure for the AQFS points are predetermined. DHCS would aggregate all rates for each measure and health plan to calculate an overall rate for each measure. Then DHCS would calculate the overall AQFS.

Year 0) after a period of twelve (12) months, at its sole discretion, DHCS may remove the participating FQHC from the APM or impose a five percent penalty consisting of the amount the participating FQHC's APM PMPM reimbursement exceeds its calculated PPS rate in any Program Year at issue in this section. Compliance with minimum Performance Standards. The 5 percent penalty is conducted in place of the maximum 10% of excess revenue at risk in the Quality Metric ladder calculations.

- If the participating FQHC does not maintain performance levels or achieve specifically defined standards within two (2) years, DHCS shall remove the participating FQHC from the APM or impose additional financial sanctions necessary to address the deficient performance.
- In no instance may a participating FQHC placed on a CAP be reimbursed less than its calculated PPS rate for covered services provided to Medi-Cal managed care beneficiaries.

Baseline Periods for Rates Versus Quality

PMPM Calculation Timeline

Baseline Financial Data for Calculating PMPM	
Action	**Year**
PMPM calculated based on SFY 2021-22 data	2023
PMPM implemented starting 7/1/2024 for Cohort 1A	2024
PMPM calculated based on SFY 2022-23 data starting 1/1/2025 for Cohort 1B	2025
PMPM calculated based on 2024 data. New FQHCs starting 1/1/2026 (SFY 2023-24 base) for Cohort 2	2026

Quality Data Timeline

Action	Year
Not used in quality data analysis or pay for performance	2022
Baseline quality data used to calculate baseline for 2024 (Project Year 1) for Cohort 1A	2023

Action	Year
Baseline quality data used to calculated baseline for 2025 (Project Year 1) for Cohort 1B	2024
Pay for reporting only in the first year of APM, compared to baseline Cohort 1A (2023) and 1B (2024) Baseline quality data used to calculate baseline for 2026 (Project Year 1) New FQHCs Cohort 2	2025
Beginning of pay for performance – Cohort 1A and 1B Pay for reporting only in the first year of APM, compared to 2025 baseline New FQHCs Cohort 2	2026

Alternative Encounters

- Encounters such as emailing and other engagement methods, in addition to face-to-face and telehealth encounters, will be factored into the access threshold (Gate) and will not be a variable in rate setting.
- Nothing in the APM relieves FQHCs of the responsibility to operate in accordance with all applicable state and federal laws, regulations, and guidance, including those including those regarding, licensure, and scope of practice. This includes, but is not limited to requirements imposed by CDPH, DCA, and boards of healing arts. [32]

[32] Each clinic must ensure that supervision and standing orders are in place and consistent with clinical contacts by non-physician practitioners.
42 USC 1396(d) describes medical assistance as "payment of part of all of the cost of the following services", including clinic services "furnished by or under the direction of a physician without regard to whether the clinic itself is administered by a physician" and FQHC and RHC services.
42 USC § 1395x further defines RHC and FQHC services as physician services and services incident to a physician's professional services; and services furnished by a physician assistant or a nurse practitioner; a clinical psychologist; a clinical social worker; a marriage and family therapist; or by a mental health counselor and such services and supplies furnished as an incident to these services.
Cal. Welf. & Inst. Code § 14132.100(g)(1) defines an FQHC visit as an encounter between a patient and physician (and then proceeds to list the type of authorized providers).

- FQHCs must meet the access threshold (Gate), which will include alternative care service contacts and encounter utilization to retain the full APM PMPM. Alternative Encounters will be valued equal to a PPS visit in determining if a clinic met the access threshold (Gate).
- The goal is for encounter data to capture all elements necessary for the calculation of quality metrics depending upon administrative data (i.e., encounter data) and that do not require hybrid data collection. All encounter data will go through the MCP to DHCS.
- Alternative Encounters will be coded only through CPT or HCPCS with ICD-10 diagnostic coding.
- For hybrid quality metrics, the goal is to ensure the relevant data feeds are sent to the plans and for the plans to share necessary data and performance outcomes back with the FQHCs to ensure complete calculation of metrics with electronic data submission.

Payment Linked to Quality

In all cases, each FQHC participating in the APM will receive at least the PPS rate in effect for that CY on a per encounter basis, for that FQHC. In order to retain the full APM PMPM reimbursement exceeding the amount that the FQHC would have received had the FQHC not participated in the APM, subject to the limits outlined below, the FQHCs must meet quality targets established by DHCS. Compliance with the quality targets will be determined by DHCS. These are in addition to the thresholds above.

- FQHCs must meet targets on a total of 12 measures, at least two measures from six domains. [33] The "Patient Experience of Access and Care" domain will be reporting only and outside of risk.

  Value-based Purchasing (Ladder): To retain 100% of the APM revenues in excess of the amount the FQHC would have received had the FQHC not participated in the APM, the FQHCs must satisfy minimum target performance outlined in (b)

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42 CFR 440.20 defines outpatient hospital services and RHC services as services "furnished by or under the direction of a physician" and 42 CFR 440.90 defines clinic services in the same manner. State Medicaid Manual 4320.

[33] The quality workgroup will discuss the quality targets. Minimum denominators for each of the 12 measures will be discussed in the quality workgroup. Thirty is the usual required denominator in other DHCS programs and likely will be followed in the APM. For measurement year 2024, the benchmarks released in the fall of 2024 would be used. This is standard practice in MCAS, Quality Incentive Program (QIP), and other programs.

and (c) below on a total of 12 quality measures, at least two measures from six domains: Access to Care; BH Integration; Chronic Care; Maternity Care; Prevention – Adult; Prevention – Peds; Patient Experience of Access and Care (reporting only). The "Patient Experience of Access and Care" domain will be reporting only and outside of risk. The selected quality metrics are linked to CalAIM and the DHCS Comprehensive Quality Strategy and Health Equity Roadmap. Metrics may change after the initial implementation based on overall DHCS goals and alignment with quality programs across the department based on DHCS decisions with input from affected stakeholders. These metrics are in addition to the Access and Quality Metrics thresholds above in Paragraph 7. Benchmarks for metric shall be national Medicaid benchmarks, when available, and state-calculated benchmarks when national Medicaid benchmarks are not available. For state-calculated benchmarks, DHCS shall notify stakeholders of the methodology used when state-calculated benchmarks are released. These metrics are in addition to the thresholds above.

- PY Benchmarks — Participating FQHCs also must satisfy applicable Benchmarks during the following PYs:
    - Year 1 (which corresponds to the first full Calendar Year (CY) in the APM; FQHCs starting on July 1st of a given year will report for an 18 month period and be measured on the first full CY). Participating FQHCs must satisfy reporting requirements only. Year 1 includes all data for the FQHC's participation through their first full calendar year of participation in the APM. If a participating FQHC begins on July 1st of a given year, then "Year 1" will cover 1.5 years (July 1st of the year of entering the APM through December 31st of the following year).
    - Year 2. Greater than or equal to the 33rd percentile of either the national or California-specific state benchmark (up to 1 percent of excess revenues at risk, evenly distributed across all selected metrics)
    - Year 3. Greater than or equal to the 50th percentile of either the national or California-specific state benchmark (up to three percent of excess revenues at risk, evenly distributed across all selected metrics)
    - Year 4. Greater than or equal to the 50th percentile of either the national or California-specific state benchmark (up to five percent of excess revenues at risk, evenly distributed across all selected metrics).
    - Year 5 and Beyond. Maintain minimum performance levels established by Year 4. (The FQHC is at risk for an increasing one-half of 1% per year of excess revenues not to exceed 10% of excess revenues). The potential risk

will be evenly distributed across all selected metrics for that CY. Example: In year 10 of participation in the pilot, an FQHC will have 8% of excess revenues above the PPS rate at risk spread across all metrics.

- For Year 5 and Beyond. Participating FQHCs must also achieve ongoing and continuous performance with "Gap" methodology. At a minimum, participating FQHCs are required to perform at or above the 50th percentile of either the national or California-specific state benchmark for each APM Quality measure. Participating FQHCs with performance on a given measure at or above the 90th percentile benchmark for that measure will be considered to be at 100 percent of their quality goal and will be required to achieve performance that maintains or exceeds the measured 90th percentile benchmark for the subsequent PY. FQHCs with prior year performance at or above the 50th percentile (but below the 90th) will be required to close the Gap by 10 percent, as described in the following example:

Example: Quality Measure X

Year 5: 90th percentile benchmark 70.0%

Year 5: 50th percentile benchmark 50.0%

Year 4 performance (also known as Year 5 Baseline): 55.0%

Year 4 Performance > 50th percentile and < 90th percentile

Target is 10% gap closure between Year 4 performance and Year 5 90th percentile benchmark:

70% of 55% = 15%

10% of 15% = 1.5%

55% + 1.5% = 56.5%

Year 5 Target: 56.5%

Table: Target Setting by Prior Year Performance

Measure Performance in Prior Year	Current Year Target
≥90th Percentile Benchmark	Performance ≥ 90th Percentile Benchmark
≥ 50th Percentile Benchmark and <90th Percentile Benchmark	Gap to 90th Percentile closed by 10%

Measure Performance in Prior Year	Current Year Target
< 50th Percentile Benchmark	Performance >= 50th Percentile

- The FQHC has the potential to retain up to 100% of the excess revenues above the current PPS payments. The FQHC is at risk for an increasing one-half of 1% per year of excess revenues (not to exceed 10% of excess revenues). The potential risk will be evenly distributed across all selected metrics for that CY.
    - Example: In year 10 of participation in the pilot, an FQHC will have 8% of excess revenues (wedge) above the PPS rate at risk spread across all metrics.

Additional Clarification regarding Quality Metrics (Ladder)

- DHCS will select the subset of required quality measures prior to the start of the contract year and communicate those measures to the MCPs and FQHCs.
- Quality metrics will be collected and reported by MCPs by participating FQHC parent NPI
- Each domain will have at least one required measure health centers must report on if the denominator is sufficiently high (above 30 eligible patients).
- After selecting for the six required measures, FQHCs may choose any other measures of choice within the categories as noted to reach to a total of 12. However, FQHCs may not change the measures/metrics in the following year. FQHC select a set metrics they will have linked to payment year-over-year and those metrics will not change each year.
- DHCS will use national Medicaid benchmarks for MCAS measures where available. In the case there is no national measure comparison, DHCS will calculate California-specific state benchmark percentiles.
- Minimum denominators for each of the 12 measures will be discussed in the quality workgroup. Thirty is the usual required denominator in other DHCS programs and likely will be followed in the APM. If the FQHC does not meet the minimum and the metric is not a required measure, DHCS will let the FQHC switch to another metric in the category. If there is not another metric, then DHCS will work with the FQHC to not penalize them.
- The threshold metrics (Gate) are separate from the quality metrics (ladder).
- If measures are changed for existing APM participants, DHCS will determine reasonable thresholds for quality performance for participants.

- The Quality and Data Subcommittee will vet how the CG-CAHPS measures will be collected.

XI. FQHC APM – Covered Populations and Services

Covered Populations

Only populations in the Medi-Cal managed care population are included under the APM. Note, individuals with Unsatisfactory Immigration Status are in Medi-Cal managed care and will be treated like any other member, but the State of California will not be eligible for federal Medicaid matching funds for most services.

Excluded Populations

FQHC services to the following populations are excluded from APM PMPM and will continue to be paid as they are currently paid today:

- Medi-Cal FFS
- Dual Eligibles (full and partial duals)
    - Duals (MCP Medi-Cal/Medicare Advantage)
    - Duals (MCP Medi-Cal/Medicare FFS)
    - Duals (FFS Medi-Cal/Medicare Advantage)
    - Duals (FFS Medi-Cal/Medicare FFS)
- Presumptive Eligibility
- Emergency Medi-Cal
- Individuals with Medi-Cal managed care eligibility not yet enrolled in managed care

Both the MCPs and the FQHCs are responsible to make sure no excluded populations including dual eligible members are included in the APM. The MCP must ensure no APM PMPM payments are made for excluded members such as dual eligible members, and FQHCs must ensure they are not receiving APM PMPM payments for excluded members such as dual eligible members.

Covered Services

The APM model includes all Medi-Cal services under the MCP contracts and included in PPS (except dental services). *Some managed care benefits will be outside of the APM such as ECM.*

The APM includes all services included in the FQHC's PPS rate and are covered services under the MCP contract. *Note, specialty mental health services including peer support are not under the MCP contract.* Examples of included services are:

- Primary Care

- Mild to moderate behavioral health care
- Specialty care in the PPS (cardio, ophthalmology, optometry, dermatology). For FQHCs with included specialty services in their PPS rate, those services would also be part of the APM.
- Podiatry
- Chiropractic to the extent it is in the MCP contract
- Acupuncture
- Vaccine/select supplies to the extent included in the MCP contract and PPS. If outside of the PPS and/or MCP contract, then the FQHC will bill the MCP or DHCS as is done today. If the vaccine/supplies are in the PPS and MCP contract, then the FQHC will not bill the MCP/DHCS separately.
- Optometry, if included if in the MCP contract
- Comprehensive Perinatal Services Program (CPSP) practitioner services are a covered FQHC service and are treated the same under the APM as under FFS. FQHCs that are not currently enrolled as CPSP providers may find enrollment and program requirements with the California Department of Public Health, Maternal, Child and Adolescent Health Division. The clinic visits and those verified visits are included in the historic utilization. Note, a face-to-face encounter or an interaction using a telehealth modality with a CPSP practitioner also qualifies as a visit.
- EPSDT/Child Health and Disability Prevention Program services are covered FQHC services and treated the same under the APM as under FFS.

Which Services Are Excluded from the APM PMPM?

If a service is outside of the PPS or not under the MCP contract, the FQHC will continue to bill the MCP or DHCS as is done today. Specialty Mental health as defined under the MCP contract is not included in the APM. For example, peer support is only DMC specialty mental health, not approved for the FQHC mental health benefit [34].

The following services in the managed care contract are excluded from the APM and applicable managed care payments to FQHCs for services will continue as they are paid for today: [35]

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[34] https://www.dhcs.ca.gov/services/Pages/Peer-Support-Services.aspx

[35] State law specifically excludes dental services and services that are provided outside of the MCP contract.

- Dental
- ECM and associated CHW tied to ECM delivery
- Community supports (formerly "In Lieu of Services")
- Vaccine/select supplies to the extent not included in the MCP contract and PPS
- P4P payments that have been historically documented are outside of the APM PMPM

What is Allowed/Not Allowed in the Numerator (Total Cost) of the PPS? [36]

Allowed Costs in the Numerator of the PPS Rate:

- Behavioral health services
- Medication monitoring by a prescriber
- Remote patient monitoring beginning July 1, 2021
- Expenses associated with texting/messaging health information to the patient
- Tele-psychiatry and other telehealth costs compliant with federal HIPAA requirements
- Disease management, screening of assigned members, arranging transportation/visits is included
- Licensed clinical social worker, associate clinical social worker costs, Licensed Marriage and Family Therapists, Licensed Psychologists, Associate Clinical Social Workers and Associate Marriage and Family Therapists costs
- Nutritionist/dietitian costs
- Health coach costs registered nurse (RN)/licensed vocational nurse (LVN) costs
- Case manager costs outside of the ECM benefit
- Doula services starting January 1, 2023
- CHW benefit costs outside of the ECM benefit starting July 1, 2022, are under the PPS but are not eligible as an encounter under the FQHC benefit. There is a scope overlap with ECM, but CHW is in managed care.
- Medication assisted treatment billed to MCP.
- Non-APM services.

The following are examples of unallowable costs (not a comprehensive list):

[36] Costs not allowed in the PPS numerator are not the same as non-APM services. A service may be excluded from the APM but allowed in the PPS numerator (e.g., Dental).

- Participation in a community meeting or group session not designed to provide health services (i.e., informational sessions for prospective users, health presentations to community groups, high school classes, PTAs, etc.), or informational presentations about available FQHC health services
- Health services provided as part of a large-scale effort including mass-immunization program, a screening program, or community-wide service program (e.g., health fair)
- Food
- Wellness services such as, but not limited to, yoga, dance, and cooking
- ECM benefits beginning January 1, 2022 are outside of the PPS/APM

Dental costs are included in the numerator and dental visits are included in the denominator of the PPS rate if those services are provided by the FQHC even if those services are excluded from the managed care contract.

Costs Not Allowed in the Numerator:

- Participation in a community meeting or group session not designed to provide health services such as informational sessions for prospective users (health presentations to community groups, high school classes, PTAs, etc.), or informational presentations about available FQHC health services
- Health services provided as part of a large-scale effort including mass-immunization program, a screening program, or community-wide service program (e.g., health fair)
- Food
- Wellness services such as; but not limited to, yoga, dance, and cooking
- ECM benefits beginning January 1, 2022 are outside of the PPS/APM
- Peer Support Specialists serve in the Specialty Mental Health (SMHS) and the Drug Medi-Cal Organized Delivery System (DMC-ODS), and the services are covered/paid by the county. SMHS and DMC-ODS are not FQHC services and are not included in the PPS rate.

Dental costs may be included in the numerator of the PPS rate even if those services are excluded from the managed care contract.

What is Allowed in the Denominator (Billable Encounters)?

Encounters are defined as a visit in the WIC, Division 9, Part 3, Chapter 7, Article 4, Section 14132.100(g) and include a face-to-face or telehealth encounter (as updated to align with the final telehealth policy) between an FQHC patient and any of the following:

- A physician, physician assistant, nurse practitioner, certified nurse-midwife (CNM), clinical psychologist, licensed clinical social worker, visiting nurse, or marriage and family therapist. Physician includes a physician and surgeon, osteopath, podiatrist, dentist, optometrist, chiropractor.
- A dental hygienist oral dental hygienist in alternative practice.
- A comprehensive perinatal practitioner, and any other provider identified in the State Plan's definition of an FQHC or RHC visit.

Dental visits may be included in the denominator of the PPS rate even if those services are excluded from the managed care contract.

XII. FQHC APM – MCP APM Monitoring, Oversight, and Reporting

DHCS will amend the MCP contract language to include FQHC APM requirements and will issue an APL. Medi-Cal MCPs will be required to amend contracts with participating network FQHCs to incorporate the specific provisions and requirements of the proposed APM. Medi-Cal MCPs and FQHCs under the APM should negotiate updates to contracts to incorporate the specific provisions and requirements of the proposed APM during the readiness process prior to go-live. Contract negotiations should incorporate provisions (i.e., MOUs) so funds flow is not affected by delay of fully executed contracts. Medi-Cal MCPs and FQHCs under the APM should negotiate updates to contracts to incorporate the specific provisions and requirements of the proposed APM during the readiness process prior to go-live.

MCP Requirements

MCPs are required to oversee FQHC APM providers, holding FQHCs accountable to all APM requirements, the MCP contractual requirements, and any associated guidance issued by DHCS. MCPs are expected to incorporate all requirements reviewed and approved by DHCS, including all monitoring and reporting criteria into provider requirements with FQHC APM providers. DHCS will utilize the MCP compliance process to oversee MCPs and ensure compliance. To streamline the APM implementation, the following requirements apply for FQHCs, regardless of the contracting structures:

- The MCPs will not impose mandatory reporting requirements as a precondition of an FQHC participating in the APM that differ from or are additional to those required for encounter and supplemental reporting under the APM by DHCS.
- MCPs will collaborate with other MCPs within the same county on oversight of APM Providers
- Medi-Cal MCPs and FQHCs under the APM should negotiate updates to contracts to incorporate the specific provisions and requirements of the proposed APM during the readiness process prior to go-live. Contract negotiations should incorporate provisions (i.e., MOUs) so that funds flow is not affected by delay of fully executed contracts. See Section XII for clarification.

Subcontractors

MCPs may subcontract with other entities to assist with administering the APM, provided they adhere to the following requirements:

- MCPs will maintain and be responsible for oversight of compliance with all contract provisions and covered services, regardless of the number of layers of subcontracting
- MCPs will be responsible for developing and maintaining DHCS approved policies and procedures to ensure subcontractors meet required responsibilities and functions
- MCPs will be responsible for evaluating the prospective Subcontractor's ability to perform services
- MCPs will remain responsible for ensuring the subcontractor's APM capacity is sufficient to serve eligible members
- MCPs will report to DHCS the names of all subcontractors by subcontractor type and service(s) provided, and identify the county or counties in which members are served
- MCPs will make all subcontractor agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation
- MCPs will ensure participating FQHCs receive the entire APM PMPM on a capitated basis each month even if multiple payments are made.
- MCPs are no longer permitted to pay FFS payment to participating APM FQHCs for covered APM services and populations.
- If an MCP does not contract with an APM FQHC, then the non-contracted MCP must reimburse the FQHC its PPS rate for covered APM populations and services.
- MCPs will ensure their agreements with any subcontractor mirrors the requirements set forth in this manual and any subsequent guidance, as applicable to subcontractor.
- MCPs are encouraged to collaborate with their subcontractors on the approach to the APM to minimize variance in how the APM will be implemented and to ensure a streamlined, seamless experience for FQHCs and Members.

Encounter Data Submission Process

DHCS requires MCPs to submit encounter data in accordance with requirements in the MCP contract and APL 14-019, or any subsequent updates. MCPs are required to submit encounter data for the APM through the existing encounter data reporting mechanisms for all covered services for which they have incurred any financial liability, whether directly or through subcontracts or other arrangements, using ASC X 12 837 version 5010x223 Institutional and Professional transactions or NCPDP 2.2 or 4.2 transactions

and the new Alternative Touch coding requirements, to the Post Adjudicated Claims and Encounters System beginning on July 1, 2024.

Alternative Encounters must be programmed consistent with Section XV with a Q2 modifier.

The Claims System under the APM should be capable of making two types of payments; an APM PMPM for each assigned member for FQHCs with a contract with the MCP and a PPS for each encounter for FQHCs without a contract with the MCP. The encounter data system should accept encounters for any FQHC under the APM for any service under the contract (including chiropractic care) as well as any Alternative Care Service code listed in Section XV with the modifier Q2 (for non-PPS eligible visits). No encounters from APM participating FQHCs should be rejected.[37] MCPs should be able to collect encounters and track payments on behalf of every MCP member at the provider level and send to DHCS via encounter data. Questions should be directed to DHCS in writing.

Scope of Monitoring Activities

DHCS will monitor MCPs implementation of and compliance with APM requirements across multiple domains, including membership, service provision, grievances and appeals, provider capacity, and quality. DHCS will monitor MCP compliance using existing monitoring processes.

Risk Corridor

The MCPs which will have a risk corridor on total FQHC payments included in the APM for both upside and downside risk. All FQHC APM revenues are under the risk corridor. There will be transparency in the capitated rates on revenue subject to the risk corridor. A Risk Sharing Mechanism will be in effect for each of the Rating Periods that the FQHC APM is in effect in accordance with W&I Code Section 14138.16.

- The Risk Sharing Mechanism may result in payment by the State to the MCP or by the MCP to the State in a form and manner specified by DHCS through APLs or other technical guidance.

[37] If the Medi-Cal beneficiary is not a member of the health plan, it is expected that the health plan reject the claim and will not reimburse the FQHC for a PPS eligible encounter. MCPs are not required to reimburse APM FQHCs PPS rates for non-PPS eligible visits coded with a Q2 modifier. Note: claims for members who are excluded populations such as dual eligible or services that are excluded under the APM such as dental should follow the regular FQHC claiming procedures under the MCP contract with the State for non-APM FQHCs.

- The Risk Sharing Mechanism will be symmetrical and based on the results of an FQHC APM risk corridor calculation performed in a form and manner specified by DHCS through APLs or other technical guidance, aggregated across applicable Medi-Cal Managed Care contracts between the MCP and the State for those capitation increments, services, and populations associated with the FQHC APM, as determined by DHCS.
- The MCP must provide and certify allowable medical expense data as necessary for the FQHC APM risk corridor calculation in a form and manner specified by DHCS. The data and any related substantiating documentation may be subject to review and adjustment at DHCS' discretion in a form and manner specified by DHCS through APLs or other technical guidance and may be subject to audit by the State or its designee.
- DHCS or its designee will initiate the FQHC APM Risk Corridor calculation for a given Rating Period no sooner than 12 months after the end of the applicable Rating Period.

Data Needed

- Data for Capitation Rate Calculation:
    - Historic MCP Payments to FQHCs
    - FFS PPS Wrap Cap Payments to FQHCs
    - The State's actuary will issue supplemental data requests as needed to determine what was paid to the FQHC versus IPA

Contracting

Standardized contract language will be established for all plans to implement the APM. The standardized contract language between the State and plan to implement the APM will be shared with participating FQHCs. The contract language will have requirements for aligning APM payment methodologies with existing MCP incentive programs for providers.

While DHCS will standardize contract language for the State/Medi-Cal MCP level, DHCS will also issue guidance to plans via APL which will include suggested practice for plan efforts to modify their contracts with participating FQHCs. DHCS will require plans to ensure FQHCs receive the APM PMPM amount in a manner that can be documented to the State.

Medi-Cal MCPs and FQHCs under the APM should negotiate updates to contracts to incorporate the specific provisions and requirements of the proposed APM during the

readiness process prior to go-live. Contract negotiations should incorporate provisions (i.e., MOUs) so that funds flow is not affected by delay of fully executed contracts.

The State will offer more clarification to plans on aligning the APM with existing MCP incentive programs for providers but does not anticipate approving those programs. For example, while the State is aligning the QIP, MCPs run their own incentive programs and DHCS does not review or approve any of those reimbursement programs. Plans have to report the incentive programs to DHCS but there is no official approval of those incentive programs. The approval works through the managed care operations division through the plan representative. Incentive programs are not funded under the capitated rates.

All plans should ensure that contract language with FQHCs (either directly or through contracted subdelegates) to implement this program will include:

- Contract revision implementation timeline
- APM PMPM must be paid to FQHCs for each assigned member
- Medi-Cal populations covered and not covered by the APM payment methodology
- Scope of services included in the APM
- Timing of DHCS notification to the plans of the capitation rate and the clinic specific APM PMPMs
- FQHC payment requirements
- Detailed reporting requirements (e.g., format, frequency, and timing of assigned pilot member reporting)
- Reconciliation process
- Procedures for collecting and reporting accurate encounter data
- Aligning the new payment methodology with existing MCP incentive programs for providers
- Risk corridor structure
- Process for resolving disputes between MCPs and clinics, including situations when the MCP does not have a relationship with the clinic

The selected quality metrics are linked to CalAIM. MCPs are requested to align the APM payment methodologies with existing MCP incentive programs for providers.

XIII. FQHC APM – Member Scenarios

Member Assignment Scenarios

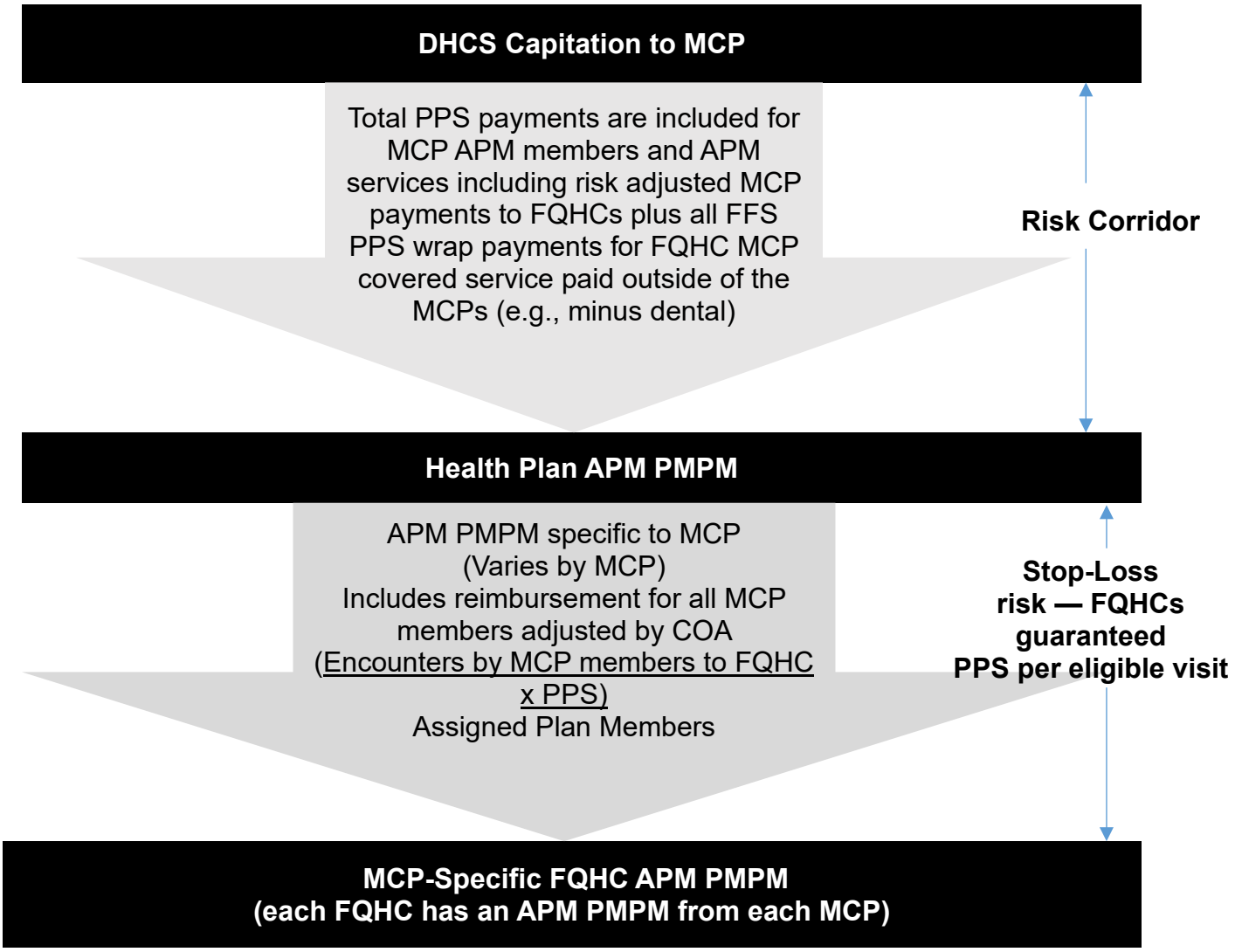
If an MCP member visits a participating contracted FQHC site, to which the member is not assigned, that FQHC does not receive a separate payment. Those funds have been incorporated into the FQHC's APM PMPM.

The exception is visits to FQHCs not contracted with the MCP. In that case, the plan pays the non-contracted FQHC participating in the APM the PPS rate.

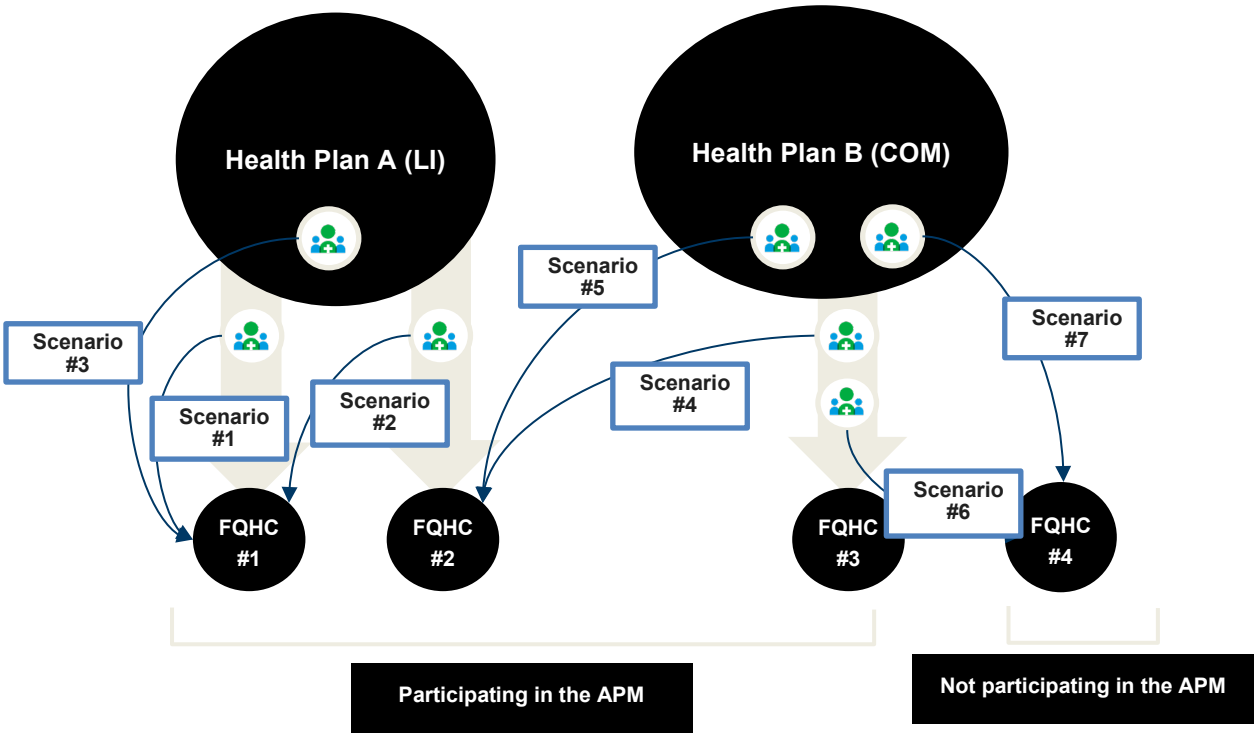
If an FQHC performs a traditional PPS-eligible encounter with Medi-Cal enrollees from non-contracted plans, they will bill the non-contracted plan their FFS PPS rate.

MCPs will need access to the PPS rates for non-contracted FQHC sites participating in the APM so that the plans can pay the correct PPS rate if/when those FQHCs see an MCP member.

Member Scenarios



Member Assignment MCP/FQHC Member Scenarios



#	Scenarios	Payment
1	Assigned member visits assigned/participating/contracted FQHC	Costs included within FQHC #1 APM PMPM
2	Assigned member visits unassigned/participating/contracted FQHC	Costs included within FQHC #1 APM PMPM
3	Unassigned member visits participating/contracted FQHC	Costs included within FQHC #1 APM PMPM
4	Assigned member visits unassigned/participating/non-contracted FQHC	PPS from HP B
5	Unassigned member visits participating/non-contracted FQHC	PPS from HP B
6	Assigned member visits non-participating FQHC	PPS from FFS

#	Scenarios	Payment
7	Unassigned member visits non-participating FQHC	MCP B + FFS Wrap

XIV. FQHC APM – Quality Metrics for SFY2024 (Ladder)

	APM Quality Category	Measure Name	Measure Abbreviation	Measure Steward	Equity Metrics	Proposed Required Measure (if sufficient N)
1	Prevention – Adult	Cervical Cancer Screening	CCS	NCQA		
2	Prevention – Adult	Colorectal Cancer Screening	COL	NCQA	X	X
3	Prevention – Adult	Breast Cancer Screening	BCS	NCQA		
4	Prevention – Adult	Chlamydia Screening in Women	CHL	NCQA		
5	Access to Care	Child and Adolescent Well-Care Visits	WCV	NCQA	X	X
6	Access to Care	Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.	W30-6+	NCQA		

	APM Quality Category	Measure Name	Measure Abbreviation	Measure Steward	Equity Metrics	Proposed Required Measure (if sufficient N)
7	Access to Care	Well-Child Visits for Age 15 Months — 30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.	W30-2+	NCQA		
	Access to Care	Adults Access to Preventive/Ambulatory Health Services	AAP	NCQA		
8	Prevention – Peds	Childhood Immunization Status (CSOSR 10)	CSOSR	NCQA	X	
9	Prevention – Peds	Immunization for Adolescents	IMA	NCQA	X	
10	Prevention – Peds	Fluoride Varnish		DQA		
11	Behavioral Health Integration	Pharmacotherapy for Opioid Use Disorder	POD	NCQA		
12	Behavioral Health Integration	Depression Screening and Follow-Up for Adolescents and Adults	DSF-E	NCQA		X

	APM Quality Category	Measure Name	Measure Abbreviation	Measure Steward	Equity Metrics	Proposed Required Measure (if sufficient N)
13	Behavioral Health Integration	Depression Remission or Response for Adolescents and Adults	DRR-E	NCQA		
14	Chronic Care	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	CDC-H9	NCQA	X	X
15	Chronic Care	Controlling High Blood Pressure	CBP	NCQA	X	X
16	Chronic Care	Asthma Medication Ratio	AMR	NCQA		
17	Maternity Care	Prenatal and Postpartum Care (Postpartum Care)	PPC-Pst	NCQA	X	X
18	Maternity Care	Prenatal and Postpartum Care (Timeliness of Prenatal Care)	PPC-Pre	NCQA	X	
19	Maternity Care	Prenatal depression screening and follow-up	PND-E	NCQA	X	
20	Maternity Care	Postpartum depression screening and follow-up	PDS-E	NCQA	X	

	APM Quality Category	Measure Name	Measure Abbreviation	Measure Steward	Equity Metrics	Proposed Required Measure (if sufficient N)
21	Patient Experience of Access and Care (reporting only)	CG-CAHPS: Getting Needed Care	CG-CAHPS	NCQA		
22	Patient Experience of Access and Care (reporting only)	CG-CAHPS: Getting Care Quickly	CG-CAHPS	NCQA		
	Note: Patient Experience of Access and Care measures will be outside of risk					

Baseline Periods for Rates Versus Quality

PMPM Calculation Timeline

Baseline Financial Data for Calculating PMPM	
Action	**Year**
PMPM calculated based on SFY 2021-22 data	2023
PMPM implemented starting 7/1/2024 for Cohort 1A	2024
PMPM calculated based on SFY 2022-23 data starting 1/1/2025 for Cohort 1B	2025
PMPM calculated based on 2024 data. New FQHCs starting 1/1/2026 (SFY 2023-24 base) for Cohort 2	2026

Quality Data Timeline

Action	Year
Not used in quality data analysis or pay for performance	2022
Baseline quality data used to calculate baseline for 2024 (Project Year 1) for Cohort 1A	2023
Baseline quality data used to calculated baseline for 2025 (Project Year 1) for Cohort 1B	2024
Pay for reporting only in the first year of APM, compared to baseline Cohort 1A (2023) and 1B (2024) Baseline quality data used to calculate baseline for 2026 (Project Year 1) New FQHCs Cohort 2	2025
Beginning of pay for performance – Cohort 1A and 1B Pay for reporting only in the first year of APM, compared to 2025 baseline New FQHCs Cohort 2	2026

XV. FQHC APM – Alternative Encounters

The intent for the Alternative Encounters is to include practitioner types and telehealth for non-PPS billable providers (e.g., pharmacy, RN, CHWs who cannot generate PPS encounters). While the list of Alternative Encounters may include office visit codes billed with a telehealth modifier, which are then mapped to different domains (communication and telehealth or for integrated behavioral health providers who use some of the psychotherapy codes), the intent is to include codes where other non-PPS eligible practitioner types may provide services.

Codes

The Alternative Care Service Coding guidance lists the HCPCS and CPT codes that must be used by MCPs and FQHCs for Alternative Encounters for non-traditional providers and/or non-traditional FQHC services. In some cases, the FQHCs may be utilizing a historic Medicaid billing code to report a non-traditional Medicaid provider.

DHCS expects MCPs to support their APM participating FQHCs in reporting and translating their delivered Alternative Encounters to these required codes. MCPs must use the below codes and modifiers for reporting applicable alternative care service encounters to DHCS. The FQHC and MCP must still report encounters to DHCS for every service rendered by that provider, using the HCPCS codes and modifiers below. If an alternative care service is provided through telehealth, the additional modifier GQ must be used. All telehealth services must be provided in accordance with DHCS policy. [38]

Alternative practitioners must meet minimum qualifications established by DHCS (e.g., CHW requirements) and conform to all clinic policies in order to serve Medi-Cal members. FQHCs have the ability to enroll as an entity and report encounter data using the FQHC billing ID. It is expected that additional clinic personnel will submit claims using the Medi Cal enrolled supervising provider as the rendering provider (similar to the CHW guidance) and a diagnosis code assigned by a qualified practitioner including relevant Z codes. Please note that the CHW guidance does not allow an FQHC to be the supervising provider for CHW services. The Data Subcommittee will discuss options for how FQHCs may implement this policy at the clinic level. However, a Q2 modifier will need to be utilized to note that personnel are not qualified to bill an encounter under

[38] For more information refer to the DHCS Medi-Cal Provider Manuals.

statute to ensure the proper reconciliation of the FQHCs claims or that the service is not a PPS eligible service. The selected modifier (Q2) is a national standard HCPCS modifier.

The MCPs should ensure that all codes in Section XV are programmed into the data warehouse and that there is a P&P to accept that data from the FQHCs. 30 days prior to go live, all MCPs must have a P&P outlining the ability and procedures to receive all required encounters including alternative care service data. The State does not have a relationship with the delegated entities. It is up to the MCP and FQHCs to decide on a data flow that best meets its needs in an efficient manner. This may include delegated entities at MCP/FQHC option. Note, Alternative care service data will be coded with a Q2 modifier.

DHCS will review and update the codes as needed. Any participating FQHC or MCP may suggest coding changes for DHCS's consideration.

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	90791		Q2	Psychiatric diagnostic evaluation by non-physician
Care Team Support	90832		Q2	Psychotherapy, 30 minutes with patient
Care Team Support	90833		Q2	Psychotherapy, 30 minutes with patient when performed with an evaluation and management (E/M) service (List separately in addition to the code for primary procedure)
Care Team Support	90834		Q2	Psychotherapy, 45 minutes with patient
Care Team Support	90836		Q2	Psychotherapy, 45 minutes with patient when performed with an E/M service (List separately in addition to the code for primary procedure)
Care Team Support	90837		Q2	Psychotherapy, 60 minutes with patient
Care Team Support	90838		Q2	Psychotherapy, 60 minutes with patient when performed with an E/M service (List separately in addition to the code for primary procedure)
Care Team Support	90839		Q2	Psychotherapy for crisis; first 60 minutes

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	90840		Q2	Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)
Care Team Support	90845		Q2	Psychoanalysis
Education	90846		Q2	Family psychotherapy (without the patient present), 50 minutes
Care Team Support	90846		Q2	Family psychotherapy (without the patient present), 50 minutes
Care Team Support	90846		Q2	Family psychotherapy (without the patient present), 50 minutes
Education	90847		Q2	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
Care Team Support	90847		Q2	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
Education	90849		Q2	Multiple-family group psychotherapy
Care Team Support	90849		Q2	Multiple-family group psychotherapy
Education	90853		Q2	Group psychotherapy (other than of a multiple-family group)

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	96127		Q2	Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder scale), with scoring and documentation, per standardized instrument
Care Team Support	96156		Q2	Health behavior assessment, or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making)
Education	96167		Q2	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes
Care Team Support	96167		Q2	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes
Education	96168		Q2	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
Care Team Support	96168		Q2	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
Education	96170		Q2	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	96170		Q2	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes
Education	96171		Q2	Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
Care Team Support	96171		Q2	Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
Care Team Support	97010		Q2	Application of a modality to one or more areas; hot or cold packs
Care Team Support	97012		Q2	Application of a modality to one or more areas; traction, mechanical
Care Team Support	97014		Q2	Application of a modality to one or more areas; electrical stimulation (unattended)
Care Team Support	97032		Q2	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
Care Team Support	97035		Q2	Application of a modality to one or more areas; ultrasound, each 15 minutes

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	97110		Q2	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
Care Team Support	97112		Q2	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
Care Team Support	97116		Q2	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)
Care Team Support	97140		Q2	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	97161		Q2	Physical therapy (PT) evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; an examination of body system(s) using standardized tests and measures addressing 1–2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; a clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	97162		Q2	PT evaluation: moderate complexity, requiring these components: A history of present problem with 1–2 personal factors and/or comorbidities that impact the plan of care; an examination of body systems using standardized tests and measures in addressing a total of three or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; an evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family
Care Team Support	97530		Q2	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
Care Team Support	97535		Q2	Self-care/home management training (e.g., activities of daily living and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	97750		Q2	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
Education	97802		Q2	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
Education	97803		Q2	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
Education	97804		Q2	Medical nutrition therapy; group (two or more individual[s]), each 30 minutes
Care Team Support	97810		Q2	Acupuncture, one or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
Care Team Support	97811		Q2	Acupuncture, one or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)
Care Team Support	98940		Q2	CMT; spinal, 1–2 regions

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	98941		Q2	CMT; spinal, 3–4 regions
Care Team Support	98942		Q2	CMT; spinal, five regions
Care Team Support	98943		Q2	CMT; extraspinal, one or more regions
Education	98961		Q2	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2–4 patients
Education	98962		Q2	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5–8 patients

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	98966		Q2	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion
Communication	98966	GT, GQ, 95 modifier for telemedicine	Q2	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	98967		Q2	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11–20 minutes of medical discussion
Communication	98967	GT, GQ, 95 modifier for telemedicine	Q2	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11–20 minutes of medical discussion

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	98968		Q2	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21–30 minutes of medical discussion
Communication	98970		Q2	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 5–10 minutes
Communication	98970	GT, GQ, 95 modifier for telemedicine	Q2	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 5–10 minutes
Communication	98971		Q2	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 11–20 minutes

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	98971	GT, GQ, 95 modifier for telemedicine	Q2	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 11–20 minutes
Communication	98972		Q2	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes
Communication	98972	GT, GQ, 95 modifier for telemedicine	Q2	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes
Care Team Support	99050		Q2	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday, or Sunday), in addition to basic service
Care Team Support	99051		Q2	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	99056		Q2	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service
Education	99078		Q2	Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions)
Communication	99091		Q2	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days
Communication	99202	GT	Q2	Office or other outpatient visit for the E/M of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15–29 minutes of total time is spent on the date of the encounter

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	99203	GT	Q2	Office or other outpatient visit for the E/M of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30–44 minutes of total time is spent on the date of the encounter
Communication	99204	GT	Q2	Office or other outpatient visit for the E/M of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45–59 minutes of total time is spent on the date of the encounter
Communication	99205	GT	Q2	Office or other outpatient visit for the E/M of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60–74 minutes of total time is spent on the date of the encounter
Communication	99211	GQ	Q2	Office or other outpatient visit for the E/M of an established patient that may not require the presence of a physician or other qualified health care professional

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	99211	GT	Q2	Office or other outpatient visit for the E/M of an established patient that may not require the presence of a physician or other qualified health care professional
Care Team Support	99211		Q2	Office or other outpatient visit for the E/M of an established patient that may not require the presence of a physician or other qualified health care professional
Communication	99212	GQ	Q2	Office or other outpatient visit for the E/M of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10–19 minutes of total time is spent on the date of the encounter
Communication	99212	GT	Q2	Office or other outpatient visit for the E/M of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10–19 minutes of total time is spent on the date of the encounter

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	99213	GQ	Q2	Office or other outpatient visit for the E/M of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20–29 minutes of total time is spent on the date of the encounter
Communication	99213	GT	Q2	Office or other outpatient visit for the E/M of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20–29 minutes of total time is spent on the date of the encounter
Communication	99214	GQ	Q2	Office or other outpatient visit for the E/M of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30–39 minutes of total time is spent on the date of the encounter
Communication	99214	GT	Q2	Office or other outpatient visit for the E/M of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30–39 minutes of total time is spent on the date of the encounter

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	99215	GT	Q2	Office or other outpatient visit for the E/M of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40–54 minutes of total time is spent on the date of the encounter

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	99231	GQ	Q2	Subsequent hospital care, per day, for the E/M of a patient, which requires at least two of these three key components: • A problem focused interval history • A problem focused examination • Medical decision making that is straightforward or of low complexity Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	99232	GQ	Q2	Subsequent hospital care, per day, for the E/M of a patient, which requires at least two of these three key components: • An expanded problem focused interval history • An expanded problem focused examination • Medical decision making of moderate complexity Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	99233	GQ	Q2	Subsequent hospital care, per day, for the E/M of a patient, which requires at least two of these three key components: • A detailed interval history • A detailed examination • Medical decision making of high complexity Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	99241	GQ	Q2	Office consultation for a new or established patient, which requires these three key components: • A problem focused history • A problem focused examination • Straightforward medical decision making Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	99241	GT (distant site)	Q2	Office consultation for a new or established patient, which requires these three key components • A problem focused history • A problem focused examination • Straightforward medical decision making Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	99242	GQ	Q2	Office consultation for a new or established patient, which requires these three key components: • An expanded problem focused history • An expanded problem focused examination • Straightforward medical decision making Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	99242	GT (distant site)	Q2	Office consultation for a new or established patient, which requires these three key components: • An expanded problem focused history • An expanded problem focused examination • Straightforward medical decision making Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	99243	GQ	Q2	Office consultation for a new or established patient, which requires these three key components: • A detailed history • A detailed examination • Medical decision making of low complexity Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	99243	GT (distant site)	Q2	Office consultation for a new or established patient, which requires these three key components: • A detailed history • A detailed examination • Medical decision making of low complexity Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	99244	GT (distant site)	Q2	Office consultation for a new or established patient, which requires these three key components: • A comprehensive history • A comprehensive examination • Medical decision making of moderate complexity Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	99245	GT (distant site)	Q2	Office consultation for a new or established patient, which requires these three key components: • A comprehensive history • A comprehensive examination • Medical decision making of high complexity Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	99251	GQ	Q2	Inpatient consultation for a new or established patient, which requires these three key components: • A problem focused history • A problem focused examination • Straightforward medical decision making Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the presenting problem(s) are self-limited or minor. Typically, 20 minutes are spent at the bedside and on the patient's hospital floor or unit

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	99252	GQ	Q2	Inpatient consultation for a new or established patient, which requires these three key components: • An expanded problem focused history • An expanded problem focused examination • Straightforward medical decision making Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the presenting problem(s) are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	99253	GQ	Q2	Inpatient consultation for a new or established patient, which requires these three key components: • A detailed history • A detailed examination • Medical decision making of low complexity Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the presenting problem(s) are of moderate severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	99341		Q2	Home visit for the E/M of a new patient, which requires these three key components: • A problem focused history • A problem focused examination • Straightforward medical decision making Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent face-to-face with the patient and/or family

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	99342		Q2	Home visit for the E/M of a new patient, which requires these three key components: • An expanded problem focused history • An expanded problem focused examination • Medical decision making of low complexity Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	99343		Q2	Home visit for the E/M of a new patient, which requires these three key components: • A detailed history • A detailed examination • Medical decision making of moderate complexity Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	99344		Q2	Home visit for the E/M of a new patient, which requires these three key components: • A comprehensive history • A comprehensive examination • Medical decision making of moderate complexity Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	99345		Q2	Home visit for the E/M of a new patient, which requires these three key components: • A comprehensive history • A comprehensive examination • Medical decision making of high complexity Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent face-to-face with the patient and/or family

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	99347		Q2	Home visit for the E/M of an established patient, which requires at least two of these three key components: • A problem focused interval history • A problem focused examination • Straightforward medical decision making Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	99348		Q2	Home visit for the E/M of an established patient, which requires at least two of these three key components: • An expanded problem focused interval history • An expanded problem focused examination • Medical decision making of low complexity Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	99349		Q2	Home visit for the E/M of an established patient, which requires at least two of these three key components: • A detailed interval history • A detailed examination • Medical decision making of moderate complexity Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	99350		Q2	Home visit for the E/M of an established patient, which requires at least two of these three key components: • A comprehensive interval history • A comprehensive examination • Medical decision making of moderate to high complexity Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	99367		Q2	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician
Care Team Support	99368		Q2	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional
Care Team Support	99406		Q2	Smoking and tobacco use cessation counseling visit; intermediate, greater than three minutes up to 10 minutes
Care Team Support	99407		Q2	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
Education	99411		Q2	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
Education	99412		Q2	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	99421		Q2	Online digital E/M service, for an established patient, for up to seven days, cumulative time during the seven days; 5–10 minutes
Communication	99421	GT, GQ, 95 modifier for telemedicine	Q2	Online digital E/M service, for an established patient, for up to seven days, cumulative time during the seven days; 5–10 minutes
Communication	99422		Q2	Online digital E/M service, for an established patient, for up to seven days, cumulative time during the seven days; 11–20 minutes
Communication	99422	GT, GQ, 95 modifier for telemedicine	Q2	Online digital E/M service, for an established patient, for up to seven days, cumulative time during the seven days; 11–20 minutes
Communication	99423		Q2	Online digital E/M service, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes
Communication	99423	GT, GQ, 95 modifier for telemedicine	Q2	Online digital E/M service, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	99441		Q2	Telephone E/M service by a physician or other qualified health care professional who may report E/M services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion
Communication	99441	GQ	Q2	Telephone E/M service by a physician or other qualified health care professional who may report E/M services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion
Communication	99441	GT, GQ, 95 modifier for telemedicine	Q2	Telephone E/M service by a physician or other qualified health care professional who may report E/M services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	99442		Q2	Telephone E/M service by a physician or other qualified health care professional who may report E/M services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11–20 minutes of medical discussion
Communication	99442	GT, GQ, 95 modifier for telemedicine	Q2	Telephone E/M service by a physician or other qualified health care professional who may report E/M services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11–20 minutes of medical discussion
Communication	99443		Q2	Telephone E/M service by a physician or other qualified health care professional who may report E/M services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21–30 minutes of medical discussion

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	99443	GT, GQ, 95 modifier for telemedicine	Q2	Telephone E/M service by a physician or other qualified health care professional who may report E/M services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21–30 minutes of medical discussion
Communication	99451		Q2	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, five minutes or more of medical consultative time
Communication	99453		Q2	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment
Communication	99454		Q2	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	99457		Q2	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes
Care Team Support	99457		Q2	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes
Communication	99458		Q2	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	99458		Q2	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)
Communication	99473		Q2	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration
Care Team Support	99473		Q2	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration
Communication	99474		Q2	Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	99474		Q2	Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient
Care Team Support	99484		Q2	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Case Management	99487		Q2	Complex chronic care management services with the following required elements; multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
Case Management	99489		Q2	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Case Management	99490		Q2	Chronic care management services with the following required elements. Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Case Management	99492		Q2	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements. Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional, initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan, review by the psychiatric consultant with modifications of the plan if recommended, entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant, and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	99492		Q2	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements. Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional, initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan, review by the psychiatric consultant with modifications of the plan if recommended, entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant, and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies

Case Management	99493		Q2	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements. Tracking patient follow-up and progress using the registry, with appropriate documentation, participation in weekly caseload consultation with the psychiatric consultant, ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers, additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant, provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies, monitoring of patient outcomes using validated rating scales, and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment

Care Team Support	99493		Q2	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements. Tracking patient follow-up and progress using the registry, with appropriate documentation, participation in weekly caseload consultation with the psychiatric consultant, ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers, additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant, provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies, monitoring of patient outcomes using validated rating scales, and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment
Case Management	99494		Q2	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
				physician or other qualified health care professional (List separately in addition to code for primary procedure)
Care Team Support	99494		Q2	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)
Case Management	99495		Q2	Transitional Care Management Services with the following required elements. Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	99497		Q2	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
Care Team Support	99498		Q2	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)
Care Team Support	99499		Q2	Unlisted E/M service
Care Team Support	99501		Q2	Home visit for postnatal assessment and follow-up care
Care Team Support	99502		Q2	Home visit for newborn care and assessment

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	99605		Q2	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient
Care Team Support	99606		Q2	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, established patient
Care Team Support	99607		Q2	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; each additional 15 minutes (List separately in addition to code for primary service)
Care Team Support	G0042		Q2	Referral to physical, occupational, speech, or recreational therapy
Care Team Support	G0043		Q2	Patients with mechanical prosthetic heart valve

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	G0162		Q2	Skilled services by a RN for management and evaluation of the plan of care; each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting)
Communication	G0181		Q2	Physician or allowed practitioner supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician or allowed practitioner development and/or revision of care plans
Communication	G0182		Q2	Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	G0406		Q2	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth
Communication	G0406	GT, GQ, 95 modifier for telemedicine	Q2	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth
Communication	G0407		Q2	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth
Communication	G0407	GT, GQ, 95 modifier for telemedicine	Q2	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth
Communication	G0408		Q2	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth
Communication	G0408	GT, GQ, 95 modifier for telemedicine	Q2	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	G0425		Q2	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth
Care Team Support	G0425		Q2	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth
Communication	G0426		Q2	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth
Care Team Support	G0426		Q2	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth
Communication	G0427		Q2	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth
Care Team Support	G0427		Q2	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Education	G0438		Q2	Annual wellness visit; includes a Personalized Prevention Plan Services, initial visit
Education	G0439		Q2	Annual wellness visit, includes a Personalized Prevention Plan Services, subsequent visit
Communication	G0459		Q2	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
Case Management	G0506		Q2	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)
Communication	G0508		Q2	Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth
Communication	G0509		Q2	Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Case Management	G0511		Q2	RHC or FQHC only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month
Care Team Support	G0511		Q2	RHC or FQHC only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month
Care Team Support	G0512		Q2	RHC or FQHC only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	G2010		Q2	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment
Communication	G2010	GT, GQ, 95 modifier for telemedicine	Q2	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment
Communication	G2012		Q2	Brief communication technology-based service, (e.g., virtual check-in, by a physician or other qualified health care professional who can report E/M services), provided to an established patient, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Communication	G2012	GT, GQ, 95 modifier for telemedicine	Q2	Brief communication technology-based service, (e.g., virtual check-in, by a physician or other qualified health care professional who can report E/M services), provided to an established patient, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion
Education	G2087		Q2	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month
Education	G2088		Q2	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure)

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Case Management	G2214		Q2	Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional
Care Team Support	G2214		Q2	Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional
Care Team Support	G8431		Q2	Screening for depression is documented as being positive and a follow-up plan is documented
Care Team Support	G9919		Q2	Screening performed and positive and provision of recommendations
Care Team Support	G9920		Q2	Screening performed and negative
Care Team Support	H0001	SUD counselor modifier	Q2	Alcohol and/or drug assessment

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	H0004	SUD counselor modifier	Q2	Behavioral health counseling and therapy, per 15 minutes
Education	H0005		Q2	Alcohol and/or drug services; group counseling by a clinician
Care Team Support	H0006	CM modifier	Q2	Alcohol and/or drug services; case management
Care Team Support	H0007	Crisis intervention modifier	Q2	Alcohol and/or drug services; crisis intervention (outpatient)
Care Team Support	H0015	IOP modifier	Q2	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least three hours/day and at least three days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education
Care Team Support	H0025		Q2	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
Education	H0035		Q2	Mental health partial hospitalization, treatment, less than 24 hour

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	H0038		Q2	Self-help/peer services, per 15 minutes
Care Team Support	H0038	HQ	Q2	Self-help/peer services, per 15 minutes Group
Care Team Support	H0049	SBIRT modifier	Q2	Alcohol and/or drug screening
Care Team Support	H0050	SBIRT modifier	Q2	Alcohol and/or drug services, brief intervention, per 15 minutes
Case Management	H1001		Q2	Prenatal care, at-risk enhanced service; antepartum management
Education	H2012		Q2	Behavioral health day treatment, per hour
Care Team Support	S0220		Q2	Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient is present); approximately 30 minutes
Care Team Support	S0221		Q2	Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient is present); approximately 60 minutes

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Case Management	S0315		Q2	Disease management program; initial assessment and initiation of the program
Education	S5190		Q2	Wellness assessment, performed by non-physician
Case Management	S9140		Q2	Diabetic management program, follow-up visit to non-MD provider
Education	S9436		Q2	Childbirth preparation/Lamaze classes, non-physician provider, per session
Education	S9437		Q2	Childbirth refresher classes, non-physician provider, per session
Education	S9438		Q2	Cesarean birth classes, non-physician provider, per session
Education	S9439		Q2	Vaginal birth after cesarean classes, non-physician provider, per session
Education	S9441		Q2	Asthma education, non-physician provider, per session
Education	S9442		Q2	Birthing classes, non-physician provider, per session
Education	S9443		Q2	Lactation classes, non-physician provider, per session
Education	S9444		Q2	Parenting classes, non-physician provider, per session
Education	S9445		Q2	Patient education, not otherwise classified, non-physician provider, individual, per session

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Education	S9446		Q2	Patient education, not otherwise classified, non-physician provider, group, per session
Education	S9447		Q2	Infant safety (including CPR) classes, non-physician provider, per session
Education	S9449		Q2	Weight management classes, non-physician provider, per session
Education	S9451		Q2	Exercise classes, non-physician provider, per session. *Must be provided by the FQHC and documented in the medical record as part of a larger medical regimen*
Education	S9452		Q2	Nutrition classes, non-physician provider, per session. *Must be provided by the FQHC and documented in the medical record as part of a larger medical regimen*
Education	S9454		Q2	Stress management classes, non-physician provider, per session
Education	S9455		Q2	Diabetic management program, group session
Education	S9460		Q2	Diabetic management program, nurse visit
Education	S9465		Q2	Diabetic management program, dietitian visit
Education	S9480		Q2	Intensive outpatient psychiatric services, per diem

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Care Team Support	T1002		Q2	RN services, up to 15 minutes
Care Team Support	T1003		Q2	Licensed practical nurse/LVN services, up to 15 minutes
Case Management	T1016		Q2	Case management, each 15 minutes
Care Team Support	T1016		Q2	Case management, each 15 minutes
Case Management	T1017		Q2	Targeted case management, each 15 minutes
Case Management	T2022		Q2	Case management, per month
Case Management	T2023		Q2	Targeted case management; per month
Education	98960		Q2	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient [could include caregiver/family] each 30 minutes; individual patient) Note: CHW Code

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Education	98961		Q2	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient [could include caregiver/family] each 30 minutes; 2-4 patients) Note: CHW Code
Education	98962		Q2	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient [could include caregiver/family] each 30 minutes; 5-8 patients) Note: CHW Code
Telehealth	92550	GT or GQ; POS 2	Q2	Tympanometry and reflex threshold measurements
Telehealth	92568	GT or GQ; POS 2	Q2	Acoustic reflex testing, threshold/unlisted audiologic services
Telehealth	92586	GT or GQ; POS 2	Q2	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system/limited/unlisted auditory services
Telehealth	92587	GT or GQ; POS 2	Q2	Evoked optoacoustic emissions, limited/unlisted audiologic services

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Telehealth	92588	GT or GQ; POS 2	Q2	Evoked optoacoustic emissions, comprehensive or diagnostic evaluation/unlisted audiologic services
Telehealth	99201	GT or GQ; POS 2	Q2	New Patient: Office or outpatient visit for E/M,10 minutes(m/min)
Telehealth	99202	GT or GQ; POS 2	Q2	Office or other outpatient visit, new patient, 20 minutes
Telehealth	99203	GT or GQ; POS 2	Q2	Office or other patient visit for E/M of new patient, 30 minutes
Telehealth	99204	GT or GQ; POS 2	Q2	Office or other outpatient visit, new patient, 45 minutes, mod-high
Telehealth	99205	GT or GQ; POS 2	Q2	Office or other outpatient visit, new patient, 45 minutes high complex
Telehealth	99211	GT or GQ; POS 2	Q2	Office or other outpatient, E/M, established patient, 5 minutes
Telehealth	99212	GT or GQ; POS 2	Q2	Office or other outpatient, E/M, minor, 10 minutes
Telehealth	99213	GT or GQ; POS 2	Q2	Office or other outpatient, 15 min, low to moderate complexity

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Telehealth	99214	GT or GQ; POS 2	Q2	Office or other outpatient, 25 min, moderate to high complexity
Telehealth	99215	GT or GQ; POS 2	Q2	Office or other outpatient, 40 min, moderate to high complexity
Telehealth	S0265	GT or GQ; POS 2	Q2	Genetics counseling
Telehealth	97750	GP and GT or GQ; POS 2	Q2	Physical performance test or measurement (e.g., musculoskeletal, functional capacity) with written report, each 15 minutes
Telehealth	97755	GP and GT or GQ; POS 2	Q2	Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes
Telehealth	97165	GT or GQ; POS 2	Q2	Occupational therapy evaluation: low complexity: 30 min
Telehealth	97166	GT or GQ; POS 2	Q2	Occupational Therapy Evaluations: moderate complexity: 45 min
Telehealth	97167	GT or GQ; POS 2	Q2	Occupational Therapy Evaluations: High complexity: 60 min

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Telehealth	97168	GT or GQ; POS 2	Q2	Reevaluation of occupational therapy established plan of care, requiring these components: • An assessment of changes in patient functional or medical status with revised plan of care; • An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and • A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. 30 min
Telehealth	92521	GN and GT or GQ; POS 2	Q2	Evaluation of speech fluency (e.g., stuttering, cluttering)
Telehealth	92522	GN and GT or GQ; POS 2	Q2	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Telehealth	92523	GN and GT or GQ; POS 2	Q2	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive, and expressive language)
Telehealth	92524	GN and GT or GQ; POS 2	Q2	Behavioral and qualitative analysis of voice and resonance
Telehealth	92507	GN and GT or GQ; POS 2	Q2	Treatment of speech, language, voice, communication, and/or auditory processing disorder. Not a time-based code and should be reported per session.
Telehealth	G9002	EP and GT or GQ; POS 2	Q2	Coordinated care fee, maintenance rate or just "MCCD maintenance rate" for short, used in medical care.
Telehealth	T1001	EP, TD and GT or GQ; POS 2	Q2	Nursing assessment/evaluation
Telehealth	99366	EP and GT or GQ; POS 2	Q2	Medical Team Conference, Direct (Face-to-Face) Contact with Patient and/or Family

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Telehealth	99367	EP and GT or GQ; POS 2	Q2	Medical Team Conference, Without Direct (Face-to-Face) Contact with Patient and/or Family. 30 min or more
Telehealth	99368	EP and GT or GQ; POS 2	Q2	Medical Team Conference, Without Direct (Face-to-Face) Contact With Patient and/or Family
Telehealth	99080	EP and GT or GQ; POS 2	Q2	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form.
Telehealth	G9008	GT or GQ; POS 2	Q2	Coordinated care fee, physician coordinated care oversight services
Telehealth	S0220	EP and GT or GQ; POS 2	Q2	Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient is present); approximately 30 minutes

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Telehealth	S0221	EP and GT or GQ; POS 2	Q2	Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient is present); approximately 60 minutes or just "Medical conference, 60 min
Telehealth	T1024	GT or GQ; POS 2	Q2	T1024 valuation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter
Telehealth	99078	EP and GT or GQ; POS 2	Q2	Physician educational services rendered to patients in a group setting.
Telehealth	S9446	EP and GT or GQ; POS 2	Q2	Patient education, not otherwise classified, non-physician provider, group, per session
Telehealth	99487	EP and GT or GQ; POS 2	Q2	Complex CCM is a 60-minute timed service provided by clinical staff to substantially revise or establish comprehensive care plan that involves moderate- to high-complexity medical decision making. *(Note: cross walked to local code Z5408: Allied professional. NEC PROG/CL Consult – HR)*

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Telehealth	99487	ED, AM and GT or GQ; POS 2	Q2	Complex CCM is a 60-minute timed service provided by clinical staff to substantially revise or establish comprehensive care plan that involves moderate- to high-complexity medical decision making. *(Note: cross walked to local code Z5422 Program consultation/clinic (MED), Hour)*
Telehealth	99244	EP and GT or GQ; POS 2	Q2	Office consultation for a new or established patient, which requires these three key components: A comprehensive history; A comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family. May need modifier 95 if done as telemedicine.

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Telehealth	99245	EP and GT or GQ; POS 2	Q2	Office consultation for a new or established patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.
Telehealth	92579	EP and GT or GQ; POS 2	Q2	Visual Reinforcement Audiometry is used to estimate hearing sensitivity by determining the type and sensitivity of hearing loss using a reinforces response procedure.
Telehealth	92582	EP and GT or GQ; POS 2	Q2	Audiologic function tests, conditioned play audiometry test procedure to assess hearing in young children
Telehealth	92533	EP and GT or GQ; POS 2	Q2	Vestibular function tests without electrical recording

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Telehealth	92555	EP and GT or GQ; POS 2	Q2	Audiologic Function Tests, Speech Audiometry Threshold
Telehealth	92556	EP and GT or GQ; POS 2	Q2	Audiologic Function Tests, Speech Audiometry Threshold; with Speed Recognition
Telehealth	92583	EP and GT or GQ; POS 2	Q2	Audiologic Function Tests, Hearing tests in a booth
Telehealth	92650	TC or 26 and GT or GQ; POS 2	Q2	Audiologic Function Tests, screening of auditory provoked potentials with broadband stimuli automated analysis excludes professional-driven analysis or interpretation of a waveform
Telehealth	92651	TC or 26 and GT or GQ; POS 2	Q2	Audiologic Function Tests, follow up test to 92650 for newborns who failed one or more portions of the newborn screening.
Telehealth	92652	TC or 26 and GT or GQ; POS 2	Q2	Audiologic Function Tests. Threshold estimation at multiple frequencies with interpretation and report.

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Telehealth	92653	TC or 26 and GT or GQ; POS 2	Q2	Auditory evoked potentials; neurodiagnostic with interpretation and report. To identify site of legion on the auditory nerve and/or brain nuclei
Telehealth	92550	EP and GT or GQ; POS 2	Q2	Audiologic Function Tests, special otorhinolaryngological services to assess eardrum and muscles functions. Tympanometry and reflex threshold measurements
Telehealth	92570	EP and GT or GQ; POS 2	Q2	Audiologic Function Tests. Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing.
Telehealth	92587	EP and TC or 26 and GT or GQ; POS 2	Q2	Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3–6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report
Telehealth	92588	EP and TC or 26 and GT or GQ; POS 2	Q2	Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report

Alternative Engagement Coding				
Domain	**Code**	**Modifier**	**Alt. Service Modifier**	**Description**
Telehealth	92626	EP, GT or GQ; POS 2	Q2	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour
Telehealth	92627	EP, GT or GQ; POS 2	Q2	92627 Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes (list separately in addition to code for primary procedure) (Use 92627 in conjunction with 92626)

XVI. APM Resource Directory

APM Resource Directory	
Resource	**Description**
FQHC APM September 2022 Overview	Overview of FQHC APM
FQHC Application FQHC APM Application/Participation Criteria - Instructions FQHC Letter of Intent Health Plan Assessment Application Spreadsheet Format	Documents needed for the APM application process
FQHC APM Frequently Asked Questions September Webinar	Answers to key APM policy questions. Document from the State's September 2022 Webinar

Check the APM website https://www.dhcs.ca.gov/services/Pages/FQHC_APM.aspx for the latest updates and versions of APM documents.

XVII. Glossary of Terms

Alternative Payment Methodology (APM): Under the BIPA of 2000, section 702, California was required to adopt a PPS for FQHC for federally defined encounters by qualified practitioners. Under that legislation, the State also has the option of developing APM.

APM Enrollee: A Medi-Cal member who is assigned by a Medi-Cal managed care plan (MCP) or subcontracting payer to a participating FQHC site for primary care services and who is under the APM. All FFS beneficiaries and any MCP members who are in a dual eligible Category of Aid are excluded from the APM.

APM Service: A service that is in the scope of services for a participating FQHC for which it is entitled to receive a per-encounter rate under PPS, but only to the extent that it is covered under the Medi-Cal MCP contract and not excluded from the APM. Dental services, Community-Based Adult Services and benefits available in Medi-Cal managed care but not under the State Plan, such as enhanced care management (ECM), are excluded from the definition of APM Service.

Behavioral Health: Mental health and SUD services.

Behavioral Health Managed Care Plan: The county prepaid inpatient health plan that would provide specialty mental health services and SUD treatment services under a single contract with DHCS, after full implementation of the behavioral health integration proposal.

California Advancing and Innovating Medi-Cal (CalAIM): DHCS' multi-year initiative to implement overarching policy changes across all Medi-Cal delivery systems with the following objectives:

- Identify and manage member risk and need through Whole Person Care Approaches and addressing SDOH
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

County Inmate Pre-Release Application Process: A CalAIM proposal that all counties must implement an inmate pre-release Medi-Cal application process to ensure county inmates/juveniles who are eligible for Medi-Cal and need ongoing physical or behavioral health treatment receive timely access to services upon release from

incarceration. The proposed process would require all county jails and juvenile facilities to implement a process for facilitated referral and linkage from county jail release to specialty mental health, Drug Medi-Cal, Drug Medi-Cal Organized Delivery System (DMC ODS) and Medi-Cal managed care providers in cases where the inmate was receiving behavioral health services while incarcerated to allow for continuation of behavioral health treatment in the community.

County Organized Health System (COHS): A local agency created by a county board of supervisors to contract with the Medi-Cal program. Nearly all Medi-Cal members in a COHS county receive their care from the COHS MCP.

Cal MediConnect: A program that coordinates medical, behavioral, and long-term services and supports (i.e., both Medicare and Medi-Cal benefits) for dual eligibles in seven California Coordinated Care Initiative counties.

Community Supports (in lieu of services): Services offered by a Medi-Cal MCP that are not included in the State Plan, but are medically appropriate, cost-effective substitutes for State Plan services included within the contract. Applicable in lieu of services must be specifically included in an MCP's contract. Services are offered at the plan's option and a member cannot be required to use them.

Dental Transformation Initiative (DTI): The DTI is a component of the Medi-Cal 2020 demonstration that aims to increase the use of preventive dental services for children, prevent and treat more early childhood caries, and increase continuity of care for children.

Designated Public Hospitals: A California hospital operated by a county, a city and a county, or the University of California.

Designated State Health Programs: Existing State-funded health programs that have not previously qualified for federal funding, including Medicaid. CMS released a State Medicaid Director Letter informing States that they would phase-out federal funding for Designated State Health Programs beginning in 2017.

Dispute Resolution: DCHS will outline a recommended MCP dispute resolution process for the MCP to have with its APM-participating FQHCs including:

- A defined period of time for the MCP and FQHC to try and resolve the dispute
- Parameters around what can be disputed (e.g., quality/encounter data reporting, APM payments, member assignment)

Drug Medi-Cal: Drug Medi-Cal pays for the SUD treatment services a Medi-Cal member receives through a Drug Medi-Cal certified program.

Drug Medi-Cal Organized Delivery System (DMC-ODS): DMC-ODS is a continuum of care modeled after the American Society of Addiction Medicine Criteria for SUD treatment services. The program enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. These systems are currently operating in 30 California counties. This program was initially authorized in during the 2010 Bridge to Reform demonstration and was reauthorized in the current Medi-Cal 2020 demonstration.

Enhanced Care Management (ECM): A collaborative and interdisciplinary benefit to provide intensive and comprehensive ('whole-person') care management services to high-need Medi-Cal members.

FQHC: Any community or public "federally qualified health center," as defined in Section 1396d(l)(2)(B) of Title 42 of the United States Code and providing services as defined in Section 1396d(a)(2)(C) of Title 42 of the United States Code.. Qualifying tribal entities such as Urban Indian Health Organizations must meet this definition and may participate in the FQHC APM only if they: (1) Affirmatively obtain FQHC status; and (2) Are reimbursed via a PPS rate at the time of their requested participation in the APM. Tribal entities reimbursed under the IHS rate are not included in this definition. Rural Health Clinics are excluded from this definition.

Full Integration Plan: A CalAIM proposal to consolidate multiple Medi-Cal delivery systems (Medi-Cal managed care, mental health managed care, DMC-ODS, and dental) under one contract with DHCS. This proposal would only be implemented in select areas with MCPs and corresponding counties who have mutually volunteered to participate.

Gap: The difference between the participating FQHC's end of prior-program year performance and the current program year's high performance benchmark. A participating FQHCs' performance rate and final target shall be rounded to the same number of decimal places as the measure's benchmark.

Global Payment Program: Established a statewide pool of funding for the remaining uninsured by combining federal disproportional share hospital and uncompensated care funding, where select Designated Public Hospital systems can achieve their "global budget" by meeting a service threshold that incentivizes movement from high cost, avoidable services to providing higher value, preventive services.

Health Homes Program: Enables participating MCPs to provide a range of supports to Med-Cal members with complex medical needs and chronic conditions. The Health

Homes Program includes coordination of the full range of physical health, behavioral health, and community-based long-term services and supports.

Indian Health Care Providers: A health care program operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization per 42 CFR §438.14(a).

Institution for Mental Diseases: A hospital, nursing facility, or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care to persons with mental diseases (42 U.S.C. §1396d(i)).

Intermittent Site/Mobile Unit: (1) an FQHC site that is open for 40 or fewer hours per week, is exempt from licensure, and that bills Medi-Cal under an associated Parent Site billing NPI number OR (2) a mobile unit shares a rate with the Parent Site. Intermittent Sites/Mobile Units must be included on the HRSA scope and Notice of Award, approved by the department to be included on the Parent Site's provider master file with DHCS, consistent with DHCS policy, and, except when the Parent Site is license exempt, included on the Parent Site's license. Intermittent Sites/Mobile Units must be included in the APM application.

Long-Term Care: Included skilled nursing facilities, subacute facilities, pediatric subacute facilities, and intermediate care facilities.

Long-Term Service and Supports: Services that include medical and non-medical care for people with a chronic illness or disability. Long-term care services are those provided to an individual who requires a level of care equivalent to that received in a nursing facility. Most long-term care services assist people with Activities of Daily Living, such as dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, or in a facility.

Managed Long-Term Services and Supports Program: The delivery of long-term services and supports through capitated Medi-Cal managed care programs.

Medicaid Section 1115 Demonstration Waivers: Section 1115 waivers permit States to use federal Medicaid funds in ways that are not otherwise allowed under federal rules, as long as the U.S. Secretary of Health and Human Services determines that the initiative is an "experimental, pilot, or demonstration project" that is "likely to assist in promoting the objectives of the program." Section 1115 waivers are generally approved for a five year period.

Medi-Cal 2020 (now California Advancing and Innovating Medi-Cal or CalAIM): California's current Section 1115 waiver authorizing the Whole Person Care program,

Global Payment Program, the Public Hospital Redesign, and Incentives in Medi-Cal (PRIME) Program, DTI, and extended several other California waiver programs including the Drug Medi-Cal Organized Delivery System.

Medi-Cal Managed Care Plan: The health plan defined under subdivision (j) of WIC Section 14184.101. An MCP that has a contract with DHCS to deliver most physical health care and mild-to-moderate mental health care services to Medicaid members through a network of providers at a capitated rate. MCPs emphasize primary and preventive care.

Mental Health MCP: An MCP that has a contract with DHCS to provide specialty mental health services to Medi-Cal members. Mental health MCPs in California are administered by the counties.

National Committee for Quality Assurance (NCQA): A health care accreditation organization with a focus on improving health care quality.

Parent Site: An FQHC site with or without associated Intermittent Site/Mobile Units (identified by NPI number). An FQHC may identify the Parent Site through any billing NPI when it applies for the APM, but must include all Intermittent Site/Mobile Units and mobile units/sites associated with that billing NPI under the APM.

Population Health Management Program: A cohesive plan of action for addressing member needs across the continuum of care, based on data-driven risk stratification, predictive analytics, and standardized assessment processes. Each Medi-Cal MCP will provide DHCS with a strategy for how it will:

- Keep all members healthy by focusing on preventive and wellness services
- Identify and assess member risks and needs on an ongoing basis
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination
- Identify and mitigate the SDOH and reduce health disparities or inequities

Public Hospital Redesign and Incentives in Medi-Cal (PRIME): An incentive program for Designated Public Hospitals and District and Municipal Public Hospitals designed to improve their delivery systems through a focus on providing high quality, value-based care. PRIME is the successor program to the first-in-the-nation Delivery System Reform Incentive Payment program that was authorized in the Bridge to Reform demonstration in 2010. PRIME funding was authorized under the Medi-Cal 2020 demonstration.

Quality Incentive Program (QIP): The QIP ties Medi-Cal managed care payments to public hospital performance on designated performance metrics in four strategic

categories: primary care, specialty care, inpatient care, and resource utilization. The payments are linked to delivery of services under Medi-Cal managed care contracts and increase the amount of funding tied to quality outcomes. California's Designated Public Hospitals receive incentive payments based on achievement of specified improvement targets. Under CalAIM, the District and Municipal Public Hospitals started to participate in the QIP once PRIME expired.

Reconciliation: DHCS will review and annually reconcile the total payments made to each FQHC that participates in the APM PMPM to ensure the APM PMPM payment made by the MCP is at least equal to the PPS rate in effect for that CY, on a per managed care encounter basis, for that FQHC. If the payments are less than the total amount that would have been paid under the PPS rate methodology for that FQHC, DHCS will pay the FQHC the difference between the amount paid and the amount the FQHC would have been due under the PPS rate methodology for the total number of encounters provided. Payments related to yearly reconciliations will be made in accordance with the two-year payment requirement at 42 CFR § 447.45 and 45 CFR § 95, Subpart A. DHCS will require FQHCs to submit records of all encounter claims to the appropriate managed care health plans no later than 45 days after the conclusion of the CY to ensure sufficient time to complete the reconciliation.

Regional Rates: A CalAIM proposal to develop regional managed care capitation rates, rather than plan- and county-based rates, in order to simplify the rate-setting process for the Medi-Cal program and allow for more capacity to implement outcomes and value based payment structures.

Safety Net Care Pools: Federal Medicaid funding for safety net providers' uncompensated care costs associated with Medicaid eligible and uninsured individuals. California had Safety Net Care Pools in the Section 1115 demonstrations that began in 2005 and in 2010. This funding transitioned to be a component of the Global Payment Program in the Medi-Cal 2020 demonstration.

Section 1915(b) "Freedom of Choice" Waivers: States generally use section 1915(b) waivers to require enrollment in managed care delivery systems for certain populations. Many States originally used Section 1115 waiver authority to move enrollees into managed care, but the new federal regulations acknowledge that managed care is now the predominant delivery system in Medicaid and CMS has indicated that Section 1115 waivers may not be the most appropriate authority vehicle for managed care.

Section 1915(c) "Home- and Community-Based Services" Waivers: States generally use 1915(c) waivers to develop programs that meet the needs of people who prefer to

get long-term care services and supports in their home or community, rather than in an institutional setting.

Serious Mental Illness/Seriously Emotional Disturbance Demonstration Opportunity: A federal opportunity for States to receive federal Medicaid funding for short-term residential treatment services in settings otherwise subject to the Institution for Mental Diseases exclusion. (See SMD #18-011).

Social Determinants of Health (SDOH): Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Healthy People 2020).

Targeted Case Management: A Medi-Cal program that provides specialized case management services to certain Medi-Cal eligible individuals to gain access to needed medical, social, educational, and other services. The TCM Program is an optional Medi Cal Program operated with federal and local funds. Eligible populations include:

- Children under age 21
- Medically fragile individuals
- Individuals at risk of institutionalization
- Individuals in jeopardy of negative health or psycho-social outcomes
- Individuals with a communicable disease

Traditional wrap-around payment (wrap): means the supplemental payments payable to an FQHC in absence of the APM project with respect to services provided to Medi-Cal managed care enrollees, which are made by the department pursuant to subdivision (e) of WIC Section 14087.325 and subdivision (h) of WIC Section 14132.100.

Whole Person Care: A pilot program that provides approved counties with funding to coordinate health, behavioral health, and social services for Medi-Cal members.