FQHC APM APPLICATION/PARTICIPATION CRITERIA — INSTRUCTIONS

September 23, 2024

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, began 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, 2026, implementation date by December 16, 2024. MCPs must submit rosters for the FQHC National Provider Identifiers (NPIs) no later than December 16, 2024. DHCS (finance and quality) will vet applications based on criteria (below) 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

Deadlines

TASK	DEADLINE
WEBINAR TO ANNOUNCE TIMELINE, APPLICATION PROCESS, AND SUMMARY OF CHANGES FOR COHORT 2	SEPTEMBER 23, 2024
APPLICATION RELEASED FOR COHORT 2	SEPTEMBER 23, 2024
FQHCS CAN REQUEST THEIR NPIS ENCOUNTER/WRAP MATCH PERCENTAGE FROM DHCS	SEPTEMBER 23 – NOVEMBER 20, 2024
FQHCS REACH OUT TO MCPS REGARDING THEIR NPI PARTICIPATION IN THE APM	RECOMMENDED TO START OCTOBER 1, 2024
FQHCS AND MCPS WORK TO AGREE ON MEMBER ROSTERS FOR HISTORIC AS WELL AS CURRENT PERIOD	OCTOBER 2024– NOVEMBER 2024
MCPS SHARE ROSTERS WITH FQHCS FOR SUBMITTAL TO DHCS	RECOMMENDED BY NOVEMBER 15, 2024
LAST DAY FOR FQHCS TO REQUEST ASSIGNMENT ROSTERS FROM MCP	NOVEMBER 20, 2024
FQHC APPLICATION DUE	DECEMBER 16, 2024
ROSTERS FROM MCPS DUE FOR PARENT AND INTERMITTENT NPIS	DECEMBER 16, 2024
PARENT/IC NPI CROSSWALKS DUE FROM FQHCS	DECEMBER 16, 2024
INTERVIEW PROCESS FOR FQHCS, INCLUDING MEETINGS WITH MCPS	JANUARY 13–17, 2025
COHORT 2 SELECTED	MARCH 2025
KICK-OFF CALL WITH SELECTED FQHCS AND MCPS AND MEETING SERIES ESTABLISHED	MARCH 2025
ALL IC CHANGE OF OWNERSHIP MUST BE FINALIZED	MAY 30, 2025
DRAFT APM PER MEMBER PER MONTH (PMPM RATES RELEASED	JUNE 1, 2025
DEADLINE FOR SELECTED FQHCS IN COHORT 2 TO DECLINE TO PARTICIPATE	JULY 1, 2025
FQHCS AND MCPS COMPLETE READINESS ACTIVITIES (INCLUDING CODING IMPROVEMENT, STAFFING, DATA EXCHANGES) AND SELF-ASSESSMENTS	AUGUST 2025
LAST DAY FOR COHORT 2 SITES TO WITHDRAWAL FROM APM	SEPTEMBER 3, 2025

TASK	DEADLINE
MCPS AND FQHCS BEGIN SYSTEM TESTING ANY CODING AND DATA DASHBOARD CHANGES AND DATA EXCHANGES NECESSARY	SEPTEMBER 2025
READINESS REVIEW ATTESTATIONS DUE	NOVEMBER 3, 2025
GO LIVE DATE FOR COHORT 2	JANUARY 1, 2026

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

Health-Plan-Roster%20and%20Assessmen

Application-spreadsheet-format.xlsx

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".

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[1] 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

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

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:
  - 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[2]

- 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 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

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

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.[3]

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 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 APM, DHCS/Mercer will create a database of several data fields from FFS T1015

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

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[4] (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) 2023–2024 snapshot.

DHCS/Mercer Measure A Level Of "match" Between Mc-Paid Encounters And T1015 Wrap Visits Using The Following Methodology:

[4] 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.

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 Cohort 1A or 1B, the FQHC will need to complete all sections of the application.

For FQHCs already participating in Cohort 1A or 1B, the FQHC will only need to complete the portions of the application where there is a note for Cohort 1A or 1B FQHCs to include additional NPIs participate or change NPI structure effective January 1, 2026.

Section 1 — Spreadsheet Attachment (Cohort 1a And 1b Submit Additional Npis Or Npi Changes And Cohort 2 Submits In Entirety)

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, 2023 PPS Rate
FQHC A	1234567890	Sample Site 1	101 E First St, LA	1234567891	$200
FQHC A	1234567890	Sample Site 2	202 W, 10th St, LA	1234567891	$200
FQHC A	1234567890	Sample Site 3	303 N, 100th St, LA	1234567891	$200

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 SFY23–24	IS THIS AN INTERMITTENT OR PARENT SITE?
PARENT	**N/A**	**N/A**	**LA**	**10,000**	**PARENT**
INTERMITTENT	**1234567892**	**1234567891**	**LA**	**2,000**	**INTERMITTENT**
INTERMITTENT	**1234567893**	**1234567891**	**LA**	**ALL LIVES FOR THIS SITE ARE ASSIGNED TO THE PARENT**	**INTERMITTENT**

Section 2 — Data Capabilities (Cohort 2 only)

Encounter Data Quality Requirements and Standards (Cohort 2 only)

The FQHC should attach a narrative to the application that addresses each of the following issues:[5]

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:

[5] 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.

A. Encounter data submission functionality in 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

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 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[6]

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 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 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 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

[6] 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).

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.

Section 7 — Staffing Capacity (Cohort 2 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 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 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 Submit For Additional NPIs Or Changes In NPIs And Cohort 2 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 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.[7]

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 Only)

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

☐ Most recent audited financial statements

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 Only)

[7] 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.

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.