FEDERALLY QUALIFIED HEALTH CENTER APPLICATION

Section 1 — Spreadsheet Attachment

Cohort 1A or 1B — Attach the spreadsheet noting any changes to the number of sites intending to participate. List additional or deleted addresses, National Provider Identifier (NPIs), residing counties, and addresses of all satellite sites under the selected prospective payments systems (PPS) rates effective January 1, 2026.

Cohort 2 — Attach the spreadsheet noting the number of sites intending to participate. List addresses, NPIs, residing counties, and addresses of all satellite sites under the selected PPS rates effective January 1, 2026

Section 2 — Data Capabilities (Cohort 2 Only)

Encounter Data Quality Requirements and Standards (Cohort 2 Only)

The Federally Qualified Health Center (FQHC) should attach a narrative to the application that addresses each of the following issues:[1]

1. Please describe how encounter data is submitted to the State of California (State), independent (individual) practice association (IPA), and/or managed care plan (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 medical record (EMR) or via clearing houses 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

[1] The FQHC should specifically address all three areas in the Application Instructions in sufficient detail to determine if the FQHC was prepared for alternative payment model (APM) participation.

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 the State of California Department of Health Care Services (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) and a Q2 modifier. 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 EMR or via clearing houses 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 EMR Health Practice Management tools such as I2I and Arcadia) and the FQHCs ability to interface with various portals thereby enabling the sharing of quality data to MCPs (e.g., Manifest Medex [Health Information Exchange], 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 EMR Health Practice Management tools such as I2I and Arcadia) and the FQHCs 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 EMR 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 Current Procedural Terminology and Healthcare Common Procedure Coding System 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, registered nurse, licensed professional counselors 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.[2]

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 Audits and Investigations, Health Resources and Services Administration, 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 program, advancing value-based payment models etc.). How

[2] 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).

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 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.

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.)?

Section 10 — Attachments (Cohort 1A and 1B submit for additional NPIs or changes in NPIs and Cohort 2 submits for all NPIs)

List all Primary Managed Care Plans and IPAs that have assigned member lives to your FQHC below.

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☐ Attach Health Plan Roster and Assessment Forms from all primary DHCS MCPs that have assigned member lives to your FQHC.

Please include one form letter for each MCP that has assigned member lives to your FQHC.

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.[3]

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

A. Describe FQHC/System financial health including sufficient cash or other funding mechanism to fund changes outlined in the APM Strategy

B. 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

C. List any recent history (within the past 12 months) of financial sanctions or penalties imposed by relevant State and federal authorities

[3] 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.

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)

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 of Support from CEO or designees must attest to commitment to the:

- 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.