Alternative Payment Methodology for Federally Qualified Health Centers

Page updated February 2025

This section contains information on the Alternative Payment Methodology (APM) for participating Federally Qualified Health Center (FQHC) developed by the California Department of Health Care Services (DHCS).

Federal law allows states to establish an APM reimbursement structure with FQHCs based on the following:

- The state and FQHCs agree to the arrangement
- Reimbursement is at least equal to what the FQHC would have received under the prospective payment system (PPS) structure and
- Reimbursement does not exceed federal upper payment limits

The California State legislature passed bills authorizing an FQHC APM. DHCS implemented the FQHC APM program on July 1, 2024, for qualified participating FQHCs. In the managed care delivery system, qualified FQHCs are no longer reimbursed under a utilization-based reimbursement process using PPS encounter rate. Instead, they are paid a per member per month (PMPM) reimbursement methodology.

The following subsections describe functions of the APM, including:

1. Provider requirements (i.e., general APM standards and application instructions)
2. Member eligibility (i.e., which Medi-Cal members are included and excluded from the APM)
3. Covered and non-covered services (i.e., which services are reimbursed under the APM and which are reimbursed under traditional PPS)
4. Reimbursement, claims, and encounters (i.e., reimbursement structure for APM participating FQHCs, including how and to what entities FQHCs should submit claims for services depending on varying scenarios)

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Provider Requirements

FQHCs and FQHC look-alikes may voluntarily apply to participate in the FQHC APM and must meet the state criteria to be participate. The full FQHC APM application instructions, forms, and timelines can be found in the in the *FQHC APM Program Guide* on the FQHC APM webpage on the DHCS website.

The FQHC APM application consists of the following:

- Encounter data quality requirements and standards
- Data sharing capabilities with a managed care plan (MCP)
- Attestation that the participating FQHCs are in good standing with relevant state and federal authorities
- A description of the applicant's APM strategy
- A description of the applicant's experience with strategic practice transformation
- Additional items such certification from nationally recognized accrediting organizations or a list of local and/or federal initiatives that reflect care transformation experience
- Staffing capacity
- Quality improvement infrastructure
- Collaboration with MCPs
- Member rosters
- A description of the applicants financial standing
- Audited financial statements
- A letter of support from the Chief Executive Officer (CEO) or CEO designee attesting to practice transformation

The general program application requirements and timelines are outlined below. FQHCs interested in participating in the APM must self-identify, begin working with contracted 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; 12 months preceding the implementation date (for example, for FQHC APM participation effective January 1, 2026, the application due date is December 16, 2024).

DHCS validates FQHC APM applications based on pre-determined criteria and minimum readiness standards to help ensure the FQHC, as an organization, is prepared for payment and quality transformation. While the APM is voluntary and FQHCs may select the PPS parent sites which apply, 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.

Eligibility Requirements

Eligible Managed Care Members

The FQHC APM is for members in Medi-Cal managed care only. Certain Medi-Cal managed care members are excluded from the program and are described below under the "Non-Eligible Members" subsection. Individuals with Unsatisfactory Immigration Status are in Medi-Cal managed care and will be treated as other members.

Examples

A managed care member who lives in a participating county (for example, Santa Clara [SC] or Yolo County) receives a service covered under the APM, covered under managed care, and is assigned to an APM participating FQHC (for example, SC Family Health Plan [with accompanying delegates] and Anthem in SC County or Partnership in Yolo County).

The APM-participating FQHC will receive an APM from any MCP assigning members to the FQHC (for example, SC Family Health Plan [with accompanying delegates] and Anthem in SC County or Partnership in Yolo County).

Managed Care Members outside of participating counties or members of MCPs that do not assign to APM FQHC (for example, Yolo or SC) receives a service covered under the APM and under managed care or a member from Kaiser who does not assign members to any APM participating FQHCs. The APM participating FQHC bills the MCP the PPS rate for PPS eligible services (i.e., would be eligible for T1015 prior to the APM and qualifies for an encounter under W&I Code 14132.100 (g) for PPS eligible visits/providers).

Non-Eligible Members

FQHC services provided to excluded APM excluded populations will continue to be paid outside of the APM. FQHCs will bill visits for these individuals using the Medi-Cal Fiscal Intermediary (FI) billing instructions. Medi-Cal members excluded from the FQHC APM include:

- Partial or full Medicare dually eligible members in fee-for-service (FFS) or managed care (Medicare Advantage and traditional Medicare)
  - Aid Code: 80 or with a Medicare indicator
- Medi-Cal members enrolled in FFS who are not eligible for managed care including Presumptive Eligibility, Pregnancy only Medi-Cal, Emergency only Medi-Cal:
  - Presumptive Eligibility Aid Codes: 5C, 5D, 5E, 7F, 8X, H6
  - Pregnancy only Medi-Cal Aid Codes: 1U, 44, 48, 5F, 5W, 7F, 7G, 7K, 7N, 76, 8T, 8Y, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1-D9, E1, E2, E3, E5, G4, M2, M4, M6, M8, M9, M0, F2, F4, G2, P6, T6, T7, 0U, 0V, 0X, 0Y
  - Emergency Medi-Cal Aid Codes: 0U, 0V, 0X, 0Y, 1U, 5F, 5K, 5L, 5T, 5W, 69, 7C, 7K, 74, 8N, 8T, 8V, C1-C9, D1-D9, E1, E2, E4, E5, F2, F4, G2, G4, M2, M4, M6, M8, M9, M0, P6, P8, P0, T6, T7, T8, T9, T0
- Individuals not yet enrolled in Managed Care who are in their first month with Medi-Cal

Covered and Non-Covered Services

Encounter data should be submitted for all services provided. If the service was not from a physician, nurse practitioner, physician assistant, licensed clinical social worker, or other PPS eligible provider, then the Q2 modifier must be added (i.e., the service would not be eligible for T1015 prior to the APM and does not qualify for an encounter under W&I Code 14132.100 (g) for PPS eligible visits/providers).

Covered Services

Covered services in the FQHC APM include Medi-Cal services covered under managed care contracts and included in the participating FQHC's PPS rate. Exceptions are listed in the "Non-Covered Services" subsection.

Examples of eligible services that may be covered under the managed care contract and included in the participating FQHC's PPS rate include:

- Primary Care
- Mild to moderate behavioral health care
- Specialty care such as cardiology, ophthalmology, optometry, dermatology
- Podiatry
- Chiropractic
- Acupuncture
- Vaccine/select supplies
  - If vaccine/select supplies are outside of the managed care contract and/or outside of the FQHC's PPS rate, the FQHC will bill the MCP or DHCS outside of the APM. If the vaccine/supplies are in the PPS rate and managed care contract, then the vaccine/supplies are under the APM and the FQHC will not bill the MCP/DHCS separately
- Optometry
- Comprehensive Perinatal Services Program practitioner services
- Early and Periodic Screening, Diagnostic, and Treatment/Child Health and Disability Prevention Program services

Note: If an APM participating FQHC provides a covered service to an eligible member, the FQHC receives an APM and should follow the billing instructions.

Non-Covered Services

Services not covered under the FQHC APM include services outside of the participating FQHC's PPS rate and/or not covered in the managed care contract. For example, specialty mental health services including peer support are not under covered in managed care and are therefore not covered in the FQHC APM. Not all Medi-Cal members are eligible for the APM, nor all Medi-Cal covered services. For those services and excluded members, FQHCs should continue to bill MCPs and DHCS for claims outside of the APM.

The following services are excluded from the APM, applicable wrap and FFS payments to FQHCs.

- Dental services (either FFS or managed care)
- Enhanced care management (ECM) and associated community health worker services tied to ECM delivery

- Community supports (formerly known as “In Lieu of Services” or ILOS)
- Specific vaccines outside of the APM (Covid-19 vaccines to the extent not included in the MCP contract and PPS)
- Community-Based Adult Services (CBAS) is not an FQHC or rural health clinic (RHC) service however, CBAS is a Medi-Cal waiver benefit that an FQHC or RHC may provide and is reimbursable at the CBAS rate

If a service is outside of the participating FQHC’s PPS rate and or not covered under the managed care contract, the FQHC will continue to bill the MCP or DHCS, as currently done, following the independent physician association (IPA)/Client Index Number (CIN)/MCP guidance or Medi-Cal FI billing instructions.

Certain claims will continue to be paid under the Medi-Cal FI for FQHCs regardless of population. The following services are excluded from the APM, applicable wrap and FFS payments to FQHCs. For those services and excluded members, FQHCs should continue to bill MCPs and DHCS for claims outside of the APM.

Services are excluded from the APM

Revenue Code	Procedure Code	Description	Explanation
3101	99205	CBAS Initial assessment day (with subsequent attendance)	Limit of up to three assessment days. Same center may not bill for assessment days again within 12 months of the last day of service. If the participant transfers to another center, up to three assessment days may be billed by the second center without the 12-month restriction of the previous center’s assessment.
3101	T1015	CBAS Initial assessment day (without subsequent attendance)	A statement explaining why the participant did not attend the center subsequent to assessment must be entered in the *Remarks* area of the claim (same limitations as for other billing code sets associated with revenue code 3101).
3103	None	CBAS Regular day of service	Minimum four-hour day at the center excluding transportation time. Refer to the *Community-Based Adult Services (CBAS)* section of the appropriate Part 2 manual.

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Services are excluded from the APM (continued)

Revenue Code	Procedure Code	Description	Explanation
None	03	Dental Services	This code is for FFS beneficiaries. APM FQHCs will bill dental FFS using the 03 local code Medi-Cal FI billing instructions. APM FQHC providers billing for FFS dental wrap payments will continue to bill 03 local code.
0512	T1015 SE	Managed Dental Services	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

Services are excluded from the APM (continued)

Vaccine Name and Dosage	CPT® Code	Vaccine Administration Code
Pfizer-BioNTech (30 mcg/0.3 mL)	91300	0001A (1st dose) 0002A (2nd dose) 0003A (3rd dose) 0004A (booster)
Pfizer-BioNTech (10 mcg/0.2 mL)	91307	0071A (1st dose) 0072A (2nd dose)
Moderna (100 mcg/0.5 mL)	91301	0011A (1st dose) 0012A (2nd dose) 0013A (3rd dose)
Moderna booster (50 mcg/0.3 mL)	91306	0064A (booster)
Janssen (5X 10^{10} viral particles/0.5 mL)	91303	0031A (single dose) 0034A (booster)
Novavax	91304	0041A (1st dose) 0042A (2nd dose)

Vaccine-only encounters are visits where the administration of the vaccine does not otherwise meet the criteria for a qualifying office visit. These vaccines only encounters are not reimbursable at the PPS rate for FQHC/RHC providers, nor the APM for Tribal FQHC providers.

FQHC, RHC, and Tribal FQHC providers may receive reimbursement up to a maximum allowable rate of $67.00 for COVID-19 vaccines administered during a vaccine-only encounter. FQHC, RHC, and Tribal FQHC providers should refer the Medi-Cal Providers website for billing guidance and effective dates for each vaccine and dose for Pfizer-BioNTech COVID-19, Moderna COVID-19 and Janssen COVID-19 Vaccines.

Claims submitted for COVID-19 vaccine-only encounters do not currently require revenue codes for reimbursement and utilize the appropriate Current Procedural Terminology (CPT) code for the vaccine manufacturer and dose provided

Special Instructions for Managed Care Dental Wrap Claims

All dental claims are outside of the APM pursuant to state statute. APM participating FQHCs will use a new code set to bill Dental Managed Care wrap claims following the FI billing instructions. APM participating FQHCs billing for a Dental Managed Care differential will utilize 0512 T1015 SE for all claims. This code set is currently only eligible for APM participating FQHCs. APM participating FQHCs billing for FFS dental wrap payments will continue to bill using a 03 local code.

Alternative Encounters

DHCS has established minimum performance thresholds for APM participating FQHCs. One performance threshold is for FQHCs to maintain access to services which is known as the "access gate threshold." Under the "access gate threshold," APM participating FQHCs must maintain at least 70 percent of the utilization (based on historical PPS eligible visits) used in the calculation of the APM PMPM rate. While alternative encounters, such as care team support, member education and communication, case management, or covered services that are provided by non-PPS eligible providers, are not a factor in rate setting and do not trigger an APM PMPM, these encounters are used to calculate compliance with the "access gate threshold."

Alternative encounters should be coded only through CPT or Healthcare Common Procedure Coding System with ICD-10 diagnostic coding found in the FQHC APM Program Guide on the FQHC APM webpage on the DHCS website. Alternative encounters should always be submitted with a Q2 modifier.

Reimbursement, Claims, and Encounters

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 PMPM 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.

Reimbursement, claims, and encounter submissions for member visits will vary depending on several factors for FQHCs participating in the APM. The FQHC participating in APM will either receive an APM PMPM or will continue to be paid as current, outside of the APM. Information on each reimbursement pathway (i.e., encounters that would result in a PMPM or traditional PPS reimbursement).

Per-Member-Per-Month Reimbursement

A prospective PMPM reimbursement amount will be determined for each FQHC participating in the APM program. If the APM participating FQHC provides a covered service from a PPS-eligible provider to an assigned, eligible member, the FQHC will receive the PMPM amount from the contracted MCP. FQHCs should follow claims submissions process established by the contracted MCPs in these cases.

The PMPM is intended to cover visit costs from both assigned and unassigned members for covered services. If a member visits a participating contracted FQHC site (i.e., the MCP assigns membership to the FQHC), 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 (i.e., the MCP does not assign members to the FQHC). As such, the plan pays the non-contracted FQHC participating in the APM the PPS rate.

Wrap payments are also covered through the PMPM amount received. APM participating FQHCs should not bill 0521 T1015 SE wrap claims in cases where the FQHC receives the PMPM.

Encounter data should be submitted for all services provided. If the service was not from a physician, nurse practitioner, physician assistant, licensed clinical social worker, or other PPS eligible provider, then the Q2 modifier must be added (i.e., the service would not be eligible for T1015 prior to the APM and does not qualify for an encounter under W&I Code 14132.100 (g) for PPS eligible visits/providers). This is an important factor in calculating the “access gate threshold”.

Traditional PPS Reimbursement

There are several cases where an APM participating FQHC will not receive the PMPM, and instead use existing billing practices and PPS rates, including when services are:

- Provided to a member who is ineligible for the APM (members enrolled in FFS, partial or full Medicare dual eligibles, or those not enrolled in managed care [Presumptive Eligibility, Pregnancy only Medi-Cal, Emergency only Medi-Cal])
- Provided to a member whose MCP does not contract with the FQHC; and
- Not covered by the APM

In these cases, the APM participating FQHC should bill using the IPA/CIN/MCP guidance or Medi-Cal FI billing instructions. FQHCs will also continue to bill wrap claims in these scenarios.

See the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* manual section for RHCs and FQHC billing services.

See the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Biling Codes* manual section for RHCs and FQHC billing services.

Billing Scenarios

If an MCP member visits a participating contracted FQHC site (i.e., contracted means that the MCP assigns membership to the FQHC who is considered in network), 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 (i.e., not contracted means that the MCP does not assign members to the FQHC). 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 the plans can pay the correct PPS rate if/when those FQHCs see an MCP member. MCPs are provided the PPS and APM rates of participating FQHCs at least 90 days prior to the rating period by DHCS.

APM participating FQHC billing scenarios are based on:

- Varying member assignment
- FQHC administrative partnerships; and
- Delegate billing scenarios

Member Assignment Scenarios

If the FQHC participates in the APM

- The APM FQHC contracted with a specific MCP or that has assigned members from a specific MCP will either receive PMPM reimbursement from the MCP for:
  - Member visits from that MCP where the members were assigned to the APM participating FQHC; or
  - Member visits from that MCP where the member was not assigned to the APM participating FQHC. There will be no separate, additional PMPM or PPS paid for unassigned member visits
- The APM FQHC that does not have a contract with a specific MCP (for example, Kaiser) or who does not have assigned members from an MCP (for example, a member from an out of county health plan) will be paid PPS encounter rates for each visit for:
  - Unassigned member visits from the MCP without a relationship to the APM participating FQHC

If the FQHC Does Not Participate in the APM the non-participating FQHC will bill MCPs and the FFS delivery system following the MCP contract and the FI billing instructions.

Delegate Billing Scenarios

The following scenarios do not apply to FQHCs contracting directly with MCPs.

- The APM FQHC with a contract with a specific MCP or that has assigned members from a specific MCP either directly or through a contracted IPA/CIN will receive APM reimbursement from the MCP for:
  - Member visits from that MCP where the members were assigned to the APM participating FQHC; or
  - Member visits from that MCP where the member was not assigned to the APM participating FQHC. There will be no separate, additional APM or PPS paid for unassigned member visits
- The APM FQHC that does not have a contract with a specific MCP (for example, Kaiser) or who does not have assigned members from an MCP (for example, a member from an out of county health plan) will be paid PPS encounter rates for each visit for:
  - Unassigned member visits from the MCP without a relationship to the APM participating FQHC or its contracted IPA/CIN

In the delegate billing scenarios, it is assumed that there could potentially be two delegates, a contracted IPA/CIN (for example, Valley Health in SC) or a behavioral health delegate (for example, Carelon). Contracted MCPs will also provide guidance on encounter data submissions.

Billing for Alternative Encounters

When the APM participating FQHC is providing alternative encounters to either assigned or unassigned member and has a contract with an IPA/CIN or behavioral health delegate or is providing alternative encounters to an unassigned member and is a member of the non-affiliated IPA/CIN, the FQHC sends claims using the Q2 modifier to the member's IPA/CIN, behavioral health delegate, or MCP. If claims are sent to the member's IPA/CIN or behavioral health delegate, these entities will forward the claims to the MCP. MCPs must inform provider groups and delegated entities about this arrangement. FQHCs need to track these closely for rejection and to ensure encounter data makes its way up to the MCPs.

Billing for Members from a Non-APM County

If the APM participating FQHC is providing APM covered services to a member who lives in a non-APM county and is not assigned to the APM-participating FQHC, the FQHC sends claims to the contracted MCP for PPS eligible services and receives the PPS rate. If the claim is for an alternative encounter using a Q2 modifier, no payment is made. The FQHC will need to bill non-contracted MCPs the FQHC PPS rate for non-assigned member visits and may need to appeal payments less than PPS rate and inform DHCS if PPS rate not paid.

Billing for Kaiser Members

If the APM participating FQHC is providing APM covered services to a Kaiser member who is not assigned to the APM-participating FQHC, the FQHC sends claims to the contracted MCP for PPS eligible services and receives the PPS rate. If the claim is for an alternative encounter using a Q2 modifier, no payment is made. The FQHC will need to bill non-contracted MCPs the FQHC PPS rate for non-assigned member visits and may need to appeal payments less than PPS rate and inform DHCS if PPS rate not paid.

Legend

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Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.