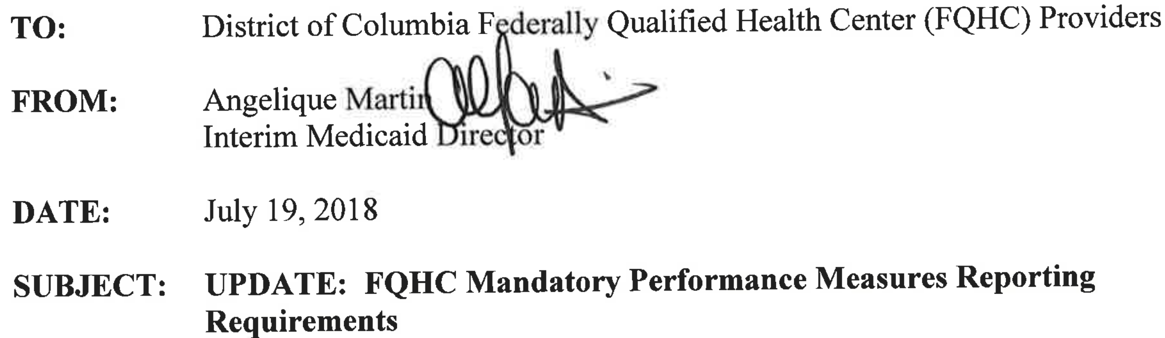
GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director/Medicaid Director

Transmittal # 18-21



TO: District of Columbia Federally Qualified Health Center (FQHC) Providers

FROM: Angelique Martin
Interim Medicaid Director

DATE: July 19, 2018

SUBJECT: **UPDATE: FQHC Mandatory Performance Measures Reporting Requirements**

The purpose of this Transmittal is to provide an update on the District of Columbia (DC) FQHC Pay-for-Performance (P4P) Program as outlined in the "Medicaid Reimbursement of Federally Qualified Health Centers (FQHC) Notice of Final Rulemaking," published on February 2, 2018, in the DC Register. The new program includes an additional payment based on performance of each FQHC.

The final rule requires that participating FQHCs will be eligible for bonus payments based on performance on nine (9) specified performance measures spanning Patient-Centered Access, Transitions of Care, and Utilization measurement domains. In accordance with Subsection 4514.2 of the FQHC final rule, DHCF has identified the need for four (4) corrections and is updating performance measures and measure specifications as indicated below:

1. Timely Transmission of Transition Record: One (1) of the 9 FQHC performance measures, "Timely Transmission of Transition Record," which was originally also a Health Homes measure, has been retired by CMS. DHCF is removing this measure and reapportioning its points to the remaining measure in the same domain, "Follow-up After Hospitalization for Mental Illness."

2. Follow-up After Hospital Discharge: Another of the 9 FQHC performance measures, "Follow-up After Hospital Discharge," which was originally borrowed from Minnesota's Health Care Homes (HCH) Program, was never implemented in Minnesota. DHCF is removing this measure and reapportioning its points to the remaining measure in the same domain, "Follow-up After Hospitalization for Mental Illness."

3. Follow-up After Hospitalization for Mental Illness: The remaining measure in the "Transitions of Care" Domain, "Follow-up After Hospitalization for Mental Illness,"

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includes two (2) elements: rate of follow-up within seven (7) days and within thirty (30) days of discharge. DHCF is splitting the measure into its 2 elements -- 7-day follow-up and 30-day follow-up -- and reapportioning its points between the two elements.

4. Transitions of Care: The "Transitions of Care" Domain is labeled as such in section 4514.1(b) of the final rule, but labeled correctly as the "Clinical Process" Domain in section 4515.17(c) of the final rule. The measurement domain name should be referred to as "Clinical Process" in all sections of the final rule.

If you have any questions regarding this transmittal, please contact Abby Kahn, Compliance Officer, Division of Quality and Health Outcomes, via telephone at (202) 442-4650, or email at abigail.kahn@dc.gov.

cc: Medical Society of the District of Columbia
DC Hospital Association
DC Primary Care Association
DC Health Care Association
DC Home Care Association
DC Behavioral Health Association
DC Coalition of Disability Service Providers

[Date]

Abby Kahn
Compliance Officer
Division of Quality and Health Outcomes
DC Department of Health Care Finance
441 4th St NW
Washington, DC 20001

RE: Letter of Intent to Participate in the FQHC Performance Payment Program

Dear Ms. Kahn:

[Facility Name] intends to participate in the Federally Qualified Health Center Performance Payment Program outlined in the final rule, "Medicaid Reimbursement of Federally Qualified Health Centers (FQHC) Notice of Final Rulemaking," published in the District of Columbia Register on February 2, 2018. Enclosed you will find our participant requirements:

1. Current HRSA-approved quality improvement plan; and
2. Annual HRSA UDS "Quality of Care" and "Health Outcomes and Disparities" measures, which may be located at the HRSA Bureau of Primary Care website at https://www.bphc.hrsa.gov/datareporting/reporting/index.html.

Please consider this letter and enclosures as our official notification to DHCF of our participation in the FQHC program *and* to be eligible for performance bonus payments. Please contact me at [address, phone number, e-mail] with any questions.

Sincerely,

[Sender's Name]
[Sender's Title]
[Facility Name]
[Address]

Enclosures:
Enclosure 1 – Current HRSA-approved quality improvement plan
Enclosure 2 – 2017 HRSA UDS "Quality of Care" and "Health Outcomes and Disparities" measures

FQHC Performance Measurement Guide

Department of Health Care Finance

Division of Quality and Health Outcomes

July 19, 2018

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Performance Measurement Guide Overview

Introduction

The final rule, "Medicaid Reimbursement of Federally Qualified Health Centers (FQHC) Notice of Final Rulemaking,"[1] published in the District of Columbia Register on February 2, 2018, outlined the parameters for a new Medicaid reimbursement methodology for FQHCs. The new program replaces a Prospective Payment System (PPS) reimbursement model that has been in place since January 2001. The new program features four (4) new components, including an additional payment based on performance of each FQHC, beginning in January 2018. This Performance Measurement Guide describes ONLY the FQHC performance measures in the pay-for-performance (P4P) program.

Goals and Guiding Principles

In implementing this new P4P program for FQHCs, the goals of the Department of Health Care Finance (DHCF) are to:

- Improve the health of Medicaid beneficiaries accessing services at FQHCs in the District;
- Incentivize primary and preventive care versus ED visits and inpatient admissions; and
- Align with other DHCF incentive programs across provider types and settings, (e.g. MCO P4P program, My Health GPS, Nursing Facility Quality program).

FQHC P4P Program

Participant Requirements

Beginning October 1, 2017, to be eligible to participate in the FQHC P4P program and receive bonus payments, each FQHC must elect the alternative payment methodology (APM) rate and submit to DHCF by September 1, 2018, and annually thereafter, the following:

- A letter of intent;
- Most current Health Resources and Services Administration (HRSA)-approved quality improvement plan; and
- HRSA Uniform Data System (UDS) "Quality of Care" and "Health Outcomes and Disparities" measures, which may be located at the HRSA Bureau of Primary Care website at https://www.bphc.hrsa.gov/datareporting/reporting/index.html.

While an FQHC may elect to establish eligibility to earn bonus payments, reporting performance measurement data is **mandatory** for all District FQHCs.

Timeframes

The FQHC P4P program's baseline year (BY) will be the first year in which FQHC performance is measured to benchmark improvement for future years. The first BY for FQHCs that elect to participate and for which performance measures 1-7 will be calculated is October 1, 2017 through September 30,

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[1] Medicaid Reimbursement of Federally Qualified Health Centers (FQHC) Notice of Final Rulemaking. (Accessed from https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Medicaid%20Reimbursement%20for%20Federally%20Qualified%20Health%20Centers%20Notice%20of%20Final%20Rulemaking.pdf on May 4, 2018).

2018. If an FQHC elects to participate in a future year, the baseline will begin October 1 and end the following September 30. The measurement year (MY) is any year following an FQHC meeting the participation requirements and the completion of the BY.

For the required HRSA UDS "Quality of Care" and "Health Outcomes and Disparities" measures, each FQHC shall submit measures to DHCF once HRSA has approved the FQHC's final report. These annual performance data must be sent to DHCF no later than September 1st of each year. For example, FQHCs must submit these two sections of their final UDS report for calendar year 2017 to DHCF by September 1, 2018.

For performance measures 1-2 (described below), FQHCs must submit the required documentation of evidence by no later than September 30th of each year, beginning September 30, 2018. All required performance measure documentation must be submitted to Abby Kahn, Compliance Officer, Division of Quality and Health Outcomes, at abigail.kahn@dc.gov.

FQHC Performance Measures

FQHCs will be measured on seven (7) performance measures, within three (3) domains: Patient-Centered Access; Clinical Process; and Utilization. FQHCs will be responsible for submitting documentation of evidence for performance measures 1 and 2, while DHCF will calculate measures 3-7.

Figure 1. FQHC Measure Domains and Performance Measures

Domain	Measure Name	Steward	Description
Patient-Centered Access	1. Extended After Hours	NCQA	FQHC offers extended hours beyond the traditional 8am-5pm business hours.
	2. 24/7 Access Policy	NCQA	Make access to care available 24/7. At a minimum, 24/7 access includes the availability of clinical services and advice at times that assure accessibility and meet the needs of the population to be served, and access to clinical telephonic advice when the FQHC is closed. When the FQHC is closed, 24/7 access includes the provision of telephone access to an individual with qualification and training (consistent with licensing requirement sin the District) to exercise professional judgment in assessing a FQHC patient's need for emergency medical care, and the ability to direct a patient on how to seek emergency care. A patient's need for emergency care might arise from an emergent physical, oral, behavioral and/or other health need. If the patient's needs are not immediate, the individual responding to the patient via the FQHC's telephone access line shall also have the capacity to refer patients to a physician or to a licensed or certified independent

Domain	Measure Name	Steward	Description
			practitioner that delivers health care services within the FQHC or outside the FQHC, if needed, for further assessment and future care.
	3. Adults' Access to Preventive/ Ambulatory Health Services	NCQA	The percentage of patients 20 years and older who had an ambulatory or preventive care visit. Numerator: Number patients who had one or more ambulatory or preventive care visits during the MY. Denominator: Patients age 20 years and older as of December 31 of the MY.
Clinical Process	4.a. Follow Up after Hospitalization for Mental Illness – 7-day	NCQA	For discharges of patients age 6 and older who were hospitalized for treatment of selected mental health disorders, the percentage that had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. One rate is reported: • The percentage of discharges for which the patient received follow-up within seven calendar days of discharge.
	4.b. Follow Up after Hospitalization For Mental Illness – 30-day		For discharges of patients age 6 and older who were hospitalized for treatment of selected mental health disorders, the percentage that had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. One rate is reported: • The percentage of discharges for which the patient received follow-up within 30 calendar days of discharge.
Utilization	5. All-Cause Readmissions	NCQA	For FQHC patients 18-64, the number of acute inpatient stays during the MY that were followed by an acute readmission for any diagnosis within 30 calendar days and the predicted probability of an acute readmission. Data is reported in the following categories: 1. Numerator: Count of 30-Day Readmissions 2. Denominator: Count of Index Hospitals Stays 3. Average adjusted Probability of Readmission

Domain	Measure Name	Steward	Description
	6. Potentially Preventable Hospitalization	AHRQ	Percentage of inpatient admissions among FQHC patients for specific ambulatory care conditions that may have been prevented through appropriate outpatient care.
	7. Low Acuity Non-Emergent (LANE) Emergency Department (ED) Visits	DHCF	Percentage of avoidable low-acuity non-emergent ED visits.

Patient-Centered Access Domain

The measures in this domain gauge the FQHCs' ability to enhance patient access, improve outcomes and experience of care, and reduce costs of care.

1. Extended After Hours

This measure follows specifications for the National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) Standards and Guidelines, Patient-Centered Access and Continuity (AC), Competency A, "AC 03 (Core) Appointments Outside Business Hours."[2] Providing extended access includes offering routine and urgent care appointments outside typical business hours, (e.g. starting at 7am or open until 8pm on certain days and/or offering hours on weekends). FQHCs must show both evidence of a documented process and evidence of implementation. DHCF will determine attainment of this measure based on documentation of NCQA PCMH certification that covers the period of performance, starting with the BY. If an FQHC offers extended hours appointments on site, DHCF will review patient materials stating that the FQHC provides appointments during extended hours. If an FQHC arranges extended hours appointments with an offsite facility, DHCF reviews a documented process for staff to follow when arranging routine and urgent appointment access with other facilities or clinicians outside regular business hours. **FQHCs must submit this documentation no later than September 30 of each year.**

2. 24/7 Access Policy

This measure follows specifications for NCQA Patient Centered Medical Home (PCMH) Standards and Guidelines, Patient-Centered Access and Continuity (AC), Competency A, "AC 04 (Core) Timely Clinical Advice by Telephone."[3] Timely means patients can telephone the practice any time of the day or night and receive interactive clinical advice. Clinical advice refers to a response to an inquiry regarding symptoms, health status, or an acute/chronic condition. Practices must demonstrate they have expected response times and a plan to monitor performance against those standards. FQHCs must show both

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[2] NCQA PCMH Standards and Guidelines (2017 Edition, Version 2) September 30, 2017 (available to download at http://store.ncqa.org/index.php/catalog/product/view/id/2776/s/2017-pcmh-standards-and-guidelines-epub/, June 1, 2018).

[3] NCQA PCMH Standards and Guidelines (2017 Edition, Version 2) September 30, 2017 (available to download at http://store.ncqa.org/index.php/catalog/product/view/id/2776/s/2017-pcmh-standards-and-guidelines-epub/, June 1, 2018).

evidence of a documented process and a report of at least 7 days of calls. DHCF will determine attainment of this measure based on documentation of NCQA PCMH certification that covers the period of performance, starting with the BY. DHCF reviews a documented process for providing timely clinical advice to patients by telephone, whether the FQHC is open or closed. The FQHC must show evidence that it: 1) defines the time frame for a response; and 2) monitors the timeliness of the response against the FQHC's time frame. DHCF reviews a report summarizing the FQHC's response times for at least 7 consecutive days, during office hours and when the office is closed. The report may be system generated. **FQHCs must submit this documentation no later than September 30 of each year.**

3. Adults' Access to Preventive/Ambulatory Health Services[4]

This measure assesses whether adult patients twenty (20) years of age and older receive preventive and ambulatory services from the organization. It assesses the percentage of patients who have had a preventive or ambulatory visit to their physician. Without a patient visit, patients do not receive counseling on diet, exercise, smoking cessation, seat belt use and behaviors that put them at risk. If the organization's services are not being used, are there barriers to access? Maintaining access to care requires more than making providers and services available—it involves analysis and systematic removal of barriers to care. **DHCF will calculate this measure, therefore no submission is required by FQHCs.**

Clinical Process Domain

The measure in this domain gauges the FQHCs' effectiveness in using the types of care and interventions directly furnished by the FQHC to impact health care events outside the FQHC.

4. Follow-Up After Hospitalization for Mental Illness[5]

This measure assesses continuity of care for mental illness. It measures the percentage of patients six (6) years of age and older who were hospitalized for treatment of selected mental disorders (generally including schizophrenia; delusional and psychotic disorders; manic and depressive episodes and bipolar disorder; mood disorders; OCD; PTSD; psychosis; personality disorders; certain manias; impulse disorders; autistic disorders, Asperger's syndrome, ADHD, and other pervasive developmental disorders; conduct disorders and other childhood emotional disorders) and who had a follow-up visit by a mental health provider within seven (7) and thirty (30) days after discharge from the hospital. This includes discharges from an acute inpatient setting (including acute care psychiatric facilities). This measure includes two elements: a) the rate of 7-day follow-up, and b) the rate of 30-day follow-up.

A follow-up visit generally includes mental/behavioral health screening or assessment by a non-physician or visit with a clinical social worker or psychologist, including individual and group counseling and therapy, crisis intervention, partial hospitalization, day treatment, assertive community treatment, rehabilitation, community support services, and medication training and support. These services are provided generally at an FQHC, provider's office, patient's home, mobile unit, urgent care facility, ambulatory surgical center, prison/correctional facility, school, and via telehealth.

The organization should make a practice of assisting with scheduling follow-up appointments when a patient is discharged, as part of the treatment or case management plan, and should educate patients and

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[4] National Committee for Quality Assurance (NCQA). *HEDIS 2016: Healthcare Effectiveness Data and Information Set. Vol. 1, narrative.* Washington (DC): National Committee for Quality Assurance (NCQA); 2015. various p.
[5] Ibid.

practitioners about the importance of follow-up visits. Systems should be established to generate reminder or "reschedule" notices that are mailed to patients if a follow-up visit is missed or canceled. In many cases, it may also be necessary to develop outreach systems or assign Case Managers to encourage recently released patients to keep follow-up appointments or reschedule missed appointments. **DHCF will calculate this measure, therefore no submission is required by FQHCs.**

Utilization Domain

The measures in this domain gauge the FQHCs' effectiveness in improving care coordination and ensuring beneficiaries receive care in the appropriate setting.

5. All-Cause Readmission

This measures the number of acute inpatient stays during the year, for patients ages 18-64 years, that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. There is extensive evidence about adverse events in patients, and this measure aims to distinguish readmissions from complications of care and pre-existing comorbidities. FQHCs should aim to reduce any potentially avoidable hospitalization and readmission to the hospital within 30 days of discharge, as this is a particularly critical point where interventions may reduce unnecessary hospitalization. For this measure, the average adjusted probability of readmission is calculated using a count of 30-day readmissions (numerator) over a count of acute inpatient hospital stays (denominator). Non-acute hospital stays are excluded from the denominator, including but not limited to hospital stays for pregnancy, maintenance chemotherapy, rehabilitation, organ transplant, or other planned procedures.

Hospital readmissions may indicate poor care or missed opportunities to better coordinate care. Research shows that specific hospital-based initiatives to improve communication with beneficiaries and their caregivers, coordinate care after discharge and improve the quality of care during the initial admission can avert many readmissions. Potentially preventable readmissions are defined as readmissions that are directly tied to conditions that could have been avoided in the inpatient setting. While not all preventable readmissions can be avoided, most potentially preventable readmissions can be prevented if the best quality of care is rendered and clinicians are using current standards of care. **DHCF will calculate this measure, therefore no submission is required by FQHCs.**

6. Potentially Preventable Hospitalization

For patients ages 18 years and older, this measure assesses the rate of discharges for ambulatory care sensitive conditions (ACSC) and the risk-adjusted ratio of observed to expected discharges for ACSC by chronic and acute conditions. ACSCs included in this measure are diabetes with short-term and long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease (COPD), asthma, hypertension, or heart failure without a cardiac procedure. Ambulatory care sensitive conditions are acute and chronic health conditions that can be managed or treated in the outpatient setting. Hospitalizations due to ACSCs, such as hypertension and pneumonia, should be largely prevented if ambulatory care is provided in a timely and effective manner. Evidence suggests that effective primary care is associated with lower ACSC hospitalization (also referred to as avoidable hospitalization). Appropriate access to care, high-quality care coordination, a focus on chronic disease self-management and connection to community resources can reduce the probability that individuals with these chronic and acute conditions will develop complications or

exacerbations that result in hospitalization. **DHCF will calculate this measure, therefore no submission is required by FQHCs.**

7. Low-Acuity Non-Emergent (LANE) Emergency Department Visits

This measure gauges the FQHC's effectiveness at providing an adequate level of primary and preventive care to help patients avoid going to the emergency department when not experiencing a true emergency. It measures the total number of non-emergent emergency room visits out of the total number of emergency room visits. It does not include emergency room visits that result in an inpatient stay, which would indicate an appropriately high acuity level as in a true emergency. **DHCF will calculate this measure, therefore no submission is required by FQHCs.**

Patient Attribution Methodology

The patient attribution methodology used for the FQHC performance measures mirrors that used for the District's My Health GPS Health Homes program. Of non-Alliance Medicaid beneficiaries who saw a FQHC medical service provider in the prior fiscal year, patients will be attributed to the FQHC at which they most frequently received services in the fiscal year prior to the BY. If two (2) or more providers have the same number of claims for a patient, the patient will be assigned to the provider last seen. Further, in a case where 2 or more providers last saw a patient on the same date, then the attributed provider will be randomly selected. To be attributed to an FQHC, patients must be continuously enrolled in Medicaid during the year and not receiving hospice services.

The goal of the attribution methodology is to gauge the effectiveness of the patient's regular primary care provider in preventive care by measuring the patient's access to services in terms of primary care visits and follow-up visits as well as health outcomes in terms of ED visits, inpatient admissions, and readmissions.

Scoring Methodology

Allocation of Points

DHCF will calculate annual performance scores for each participating FQHC based on a point scale of 0-100 points. The total points are distributed across each domain and measure, based on DHCF's priorities. Figure 2 displays DHCF's point distribution for MYs 1-3 (FY2019-2021). Future point distribution for measurement attainment or improvement will be provided by DHCF to FQHCs via a Transmittal on an annual basis, ninety (90) calendar days before October 1, (i.e. June 30).

Figure 2. FQHC Performance Measure Point Distribution Methodology

Domain	Measures	Points per Measure per Year		
		MY1 (FY2019)	MY2 (FY2020)	MY3 (FY2021)
Patient-Centered Access	1. Extended Hours	6.67	5	3.34
	2. 24/7 Access	6.67	5	3.34
	3. Adults' Access to Preventive Services	6.67	5	3.34
	Domain Total	20	15	10
Clinical Process	4.a. Follow Up after Hospitalization for Mental Illness– 7-day	15	12.5	10
	4.b. Follow Up after Hospitalization for Mental Illness – 30-day	15	12.5	10
	Domain Total	30	25	20
Utilization	5. All-Cause Readmissions	16.67	20	23.3
	6. Potentially Preventable Hospitalizations	16.67	20	23.3
	7. LANE ED Visits	16.67	20	23.3
	Domain Total	50	60	70
	Total Points	**100**	**100**	**100**

Points for each performance measure shall be awarded in cases where an FQHC meets either the attainment or improvement benchmark based on the prior year's performance as described below:

- For measures 1 and 2, an FQHC shall receive the total points per measure if the required documentation is submitted by the established deadline. These measures are "PASS/FAIL."
- For measures 3 through 7, an FQHC shall receive the total points per measure if the FQHC:
    - MET or EXCEEDED the 75th percentile attainment benchmark first established in the BY and each subsequent MY, **OR**
    - MET its improvement threshold, described below.
- If an FQHC neither attains the 75th percentile benchmark nor meets its improvement threshold on a given measure, zero points will be awarded for that measure. The 75th percentile marks the point at which 75% of the FQHCs fall below this mark. An FQHC that meets or exceeds the 75th percentile is performing in the top quartile of FQHCs.

DHCF may adjust the point distribution or weights to domains and measures at its discretion. DHCF will provide notice to FQHCs of any changes via Transmittal, no later than 90 calendar days before the start of the measurement year, (i.e. June 30).

Setting Improvement Thresholds

FQHCs shall be assessed based on either the attainment of the goal or improvement to a defined threshold. If an FQHC did not attain its goal, then DHCF shall assess whether the FQHC improved from the previous year. The following guidelines are set forth below:

- For measures 3 through 7, the improvement threshold will be a statistically significant improvement in the performance of a measure as compared to the prior year's performance, starting with MY1 compared to the BY. A statistically significant improvement has a probability of 0.05 that the improvement was not due to random error. DHCF shall perform the appropriate statistical analysis to determine that the performance between years is a result that cannot be attributed to chance.

DHCF shall provide written notification to each FQHC of its individualized improvement thresholds no later than 180 calendar days after the conclusion of each year, beginning with the BY. Starting March 30, 2019, each FQHC will have the opportunity to earn the total points per measure if it meets or exceeds its own improvement thresholds for MY 1.

Annual Performance Percentage

The Annual Performance Percentage for each qualifying FQHC shall be calculated using the following methodology:

- Sum points awarded for each measure in the domain to determine the domain totals;
- Sum domain totals to determine total performance points; and
- Divide total performance points by the maximum allowed points, (i.e., 100 points, to determine the annual performance percentage).

Provider Aggregation Option

Performance points will be awarded to each FQHC. However, FQHCs may opt to aggregate their beneficiary population with another FQHC's for the purposes of calculating attainment of a performance measure or improvement on any of the required measures. Aggregation across FQHCs allows both providers to increase their total pool of attributed patients. FQHCs may also aggregate to take advantage of each other's various quality improvement activities, which may impact performance on these measures. FQHCs opting to aggregate their populations must do so for calculation of *all* measures during a BY or MY. An FQHC may elect the option to aggregate annually and may change their selection, including opting against pooling or opting to pool with a different FQHC, on an annual basis. **Each FQHC must notify DHCF of their selection of the aggregation option by no later than September 1st, prior to the BY or new MY.**

Provider Communication and Quality Management

DHCF will maintain ongoing communication processes with FQHCs through its implementation of the FQHC P4P Program. This will include Transmittals, notices, and letters about the various activities occurring during the baseline and measurement periods. DHCF will calculate results for Performance Measures 3-7 on a quarterly basis, in addition to the final calculation due March 30 of each MY, and share these interim results with the FQHCs for quality improvement purposes. DHCF will also actively engage the DC Primary Care Association (DCPCA), which represents and provides technical assistance to

the District's FQHCs, to help the FQHCs understand the implications of the FQHC P4P Program for their individual practices. Figure 3 includes the proposed schedule of quarterly Quality Management Committee (QMC) meetings at which FQHCs will be able to discuss performance and provide any feedback to DHCF.

Figure 3. FQHC Quality Management Committee (QMC) Meetings Schedule and Program Milestones

Date	Milestone
October 1, 2017	Start of BY1
June 2018	FQHC Performance Measures Provider Orientation
September 30, 2018	Documentation for Performance Measures 1-2 DUE from FQHCs
October 1, 2018	Start of MY1
October 2018	FQHC Quarterly QMC meeting
January 2018	FQHC Quarterly QMC Meeting
March 30, 2019	Final BY1 Results Calculated; MY1 Improvement Thresholds Calculated
April 2019	FQHC Quarterly QMC Meeting
July 2019	FQHC Quarterly QMC Meeting
September 30, 2019	Documentation for Performance Measures 1-2 DUE from FQHCs
October 1, 2019	Start of MY2
October 2019	FQHC Quarterly QMC Meeting
January 2019	FQHC Quarterly QMC Meeting
April 2020	FQHC Quarterly QMC Meeting
March 30, 2020	Final MY1 Results Calculated *and* Bonus Payments Disbursed; MY2 Improvement Thresholds Calculated

Public Reporting

DHCF plans to publicly post the results on all FQHC performance measures. More information will be released via DHCF Transmittals.

Program Monitoring

Ongoing program monitoring by DHCF will be critical to the success and sustainability of the FQHC P4P program. These efforts will include sharing quarterly performance measure data and providing technical assistance to resolve any barriers to improvement. DHCF will monitor FQHCs' performance to determine whether they not only continue to meet program requirements, but also provide an adequate level of services needed to keep District Medicaid beneficiaries healthy.

Contact

For more information about the FQHC performance measures, contact Abby Kahn, Compliance Officer, Division of Quality and Health Outcomes, at abigail.kahn@dc.gov.