NOTICE OF GENERAL PUBLIC INTEREST

RELEASE DATE: JUNE 3, 2024

PROPOSED STATE PLAN AMENDMENT TO ADD ALTERNATIVE PAYMENT METHODOLOGY FOR CAPITATED REIMBURSEMENT OF PARTICIPATING FEDERALLY QUALIFIED HEALTH CENTERS

This notice is to provide information of public interest about a proposed State Plan Amendment (SPA) by the Department of Health Care Services (DHCS). SPA 24-0033 proposes to add an alternative payment methodology (APM) for federally qualified health centers (FQHCs) to voluntarily transition from a per-service reimbursement basis to a capitated reimbursement basis, as authorized by Senate Bill 184 (Ch. 47, Stats. 2022), for specified services included under the scope of the FQHC's Prospective Payment System (PPS) rate and Medi-Cal managed care plan contracts. This would enable FQHCs to transition their care model away from volume to high-quality, innovative care models. FQHCs participating in the APM will receive at least the same amount of funding that would be paid under the current prospective payment system (PPS). DHCS requests input from beneficiaries, providers, and other interested stakeholders concerning proposed SPA #24-0033, which is attached.

DHCS estimates that the impact to Medi-Cal expenditures for participating FQHCs will be budget neutral on an accrual basis. Medi-Cal expenditures include the full cost of PPS reimbursement, and this program will provide reimbursement on a capitated basis that is projected to be equivalent to the PPS rate.

The effective date of the proposed SPA is July 1, 2024. All proposed SPAs are subject to approval by the Centers for Medicare and Medicaid Services (CMS).

Public Review and Comments

The proposed changes included in draft SPA #24-0033 are enclosed in this notice for public comment. DHCS is requesting stakeholder input on the impact, if any, on access to services as a result of the proposed action.

Upon submission to CMS, a copy of proposed SPA #24-0033 will be published at the following internet address: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/Pending-2024.aspx.

If you would like to view the SPA in person once it becomes available, please visit your local county welfare department. You may also request a copy of proposed SPA #24-0033 or a copy of submitted public comments related to SPA #24-0033 by requesting it in writing to the mailing or email address listed below. Please indicate SPA #24-0033 in the subject line or message.

Written comments may be sent to the following address:

Department of Health Care Services
Capitated Rates Development Division
Attn: Nick Leach
P.O. Box 997413, MS 4413
Sacramento, California 95899-7413

Comments may also be emailed to PublicInput@dhcs.ca.gov. Please indicate SPA #24-0033 in the subject line or message.

To be assured consideration prior to submission of the SPA to CMS, comments must be received no later than July 3, 2024. Please note that comments will continue to be accepted after July 3, 2024, but DHCS may not be able to consider those comments prior to the initial submission of SPA #24-0033 to CMS.

B1. ALTERNATIVE PAYMENT METHODOLOGY (APM) for capitated payments to participating Federally Qualified Health Centers (FQHCs).

1. Definitions for this section

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

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

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

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

(e) Medi-Cal managed care plan (MCP) – the health plan defined under subdivision (j) of WIC Section 14184.101.

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

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

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

2. Alternative Payment Methodology Providing Reimbursement At Least Equivalent to PPS.

(a) Participating FQHCs in this APM will receive reimbursement for APM Enrollees from Medi-Cal managed care plans on the basis of a unique, per member per month (PMPM) payment that, in the aggregate, is verified annually to be at least equivalent to the amount the participating FQHC would receive in accordance with Section D through an annual reconciliation in accordance with Paragraph **5. Annual Reconciliation**.

(b) APM Project Implementation. Implementation of this APM shall begin on July 1, 2024.

(c) Eligible Providers. This APM is only available to FQHCs operating in the State of California that are assigned Medi-Cal Members for primary care services through a contract with a Medi-Cal managed care plan or subcontracting payer, which are selected by DHCS in accordance with the criteria set forth in Paragraph **6. Selection Criteria for Participation in the APM**.

(d) Voluntary program. This Alternative Payment Methodology is voluntary. FQHCs who apply and are selected by DHCS because they meet the criteria in Paragraph **6. Selection Criteria for Participation in the APM** below may participate, but are not required to. FQHCs that do opt to participate for a calendar year must do so for the entirety of that year.

(e) Nothing in the APM relieves FQHCs of the responsibility to operate in accordance with all applicable state and federal laws, regulations, and guidance, including those including those regarding, licensure, and scope of practice. This includes, but is not limited to requirements imposed by CDPH, DCA, and boards of healing arts.

3. APM PMPM Reimbursement for Participating FQHCs.

(a) DHCS shall establish a unique APM PMPM for a participating FQHC parent site billing NPI, based on historical utilization and other trend and utilization adjustments as appropriate in order to reflect the level of reimbursement that is projected to have been received by the participating FQHCs in the absence of the APM project. (b) The resulting PMPMs calculated on a Category of Aid basis are combined into a single PMPM for the Parent Site NPI. The data source used for calculating the APM PMPM shall be either:

(i) the volume of PPS encounters based on a utilization base year, to be determined on the basis of the most recent, complete and appropriate utilization data covering the past three years of the FQHC's operation in the county, which may be stratified by managed care plan, or

(ii) an average of the two most recent years of available data for a participating FQHC. DHCS and its actuary shall have sole discretion to determine the best available data source and may concurrently rely upon data associated with other existing FQHCs with characteristics similar to the participating FQHC.

(c) Two APM PMPMs will be calculated annually for each parent site billing NPI to correspond with the time-periods of each PPS rate as annually adjusted by the MEI index (January – September) and (October – December). A third APM PMPM may be calculated based on an updated PPS if the FQHC has a change in scope effective with the beginning of its fiscal year. In the case of a change in scope, the PPS would be updated effective with the beginning of its fiscal year, andthe prospective APM would be calculated based upon the interim CSOSR

attestation if a change in scope has not yet been determined in accordance with Section K. The prospective APM based on the final CSOSR or interim CSOSR would be reconciled after the fact, based on the APM PMPM calculated using the final PPS determined in accordance with the State Plan scope change process set forth in Section K compared to the APM PMPM calculated using the interim CSOSR, if any.

(d) For the July 1 through December 31, 2024 period, the APM PMPM formula for each parent site billing NPI=

(Count of SFY 2021–2022 Medi-Cal PPS encounters for Medi-Cal managed care members (including unassigned walk-in utilization with adjustments) for APM services)
x (Participating FQHC's PPS for the current year)
SFY 2021–2022 APM Enrollee Medi-Cal Managed Care Member Months

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

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

(f) DHCS shall calculate an applicable APM PMPM rate for the participating FQHC's parent site. Medi-Cal MCPs without members assigned to a participating FQHC, must reimburse such participating FQHC its PPS rate for any PPS-eligible APM service encounters by the Medi-Cal MCP's enrollees.

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

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

(i) DHCS annually shall verify that Medi-Cal MCPs made required APM PMPM payments to participating FQHCs in accordance with this APM.

(j) 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:

(i) Identification and documentation of the participating FQHC's contracts for Medi-Cal program services with MCP(s);

(ii) 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;

(iii) The Prospective Payment System (PPS) rate for the participating FQHC (by NPI number); and

(iv) Historic FFS wrap payment utilization for the participating FQHC (by NPI number) with MCPs submitting historic MCP encounter data for the participating FQHCs to DHCS.

(k) If necessary, 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 the following information in the time and manner determined by DHCS:

(i) 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. *Note: DHCS may increase the minimum benchmarks in 2025 and thereafter*;

(ii) 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);

(iii) 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 specified in the application or at least 180 days in advance and must include the specific changes to be made. The data associated with these changes must be identifiable to be able to be moved to match the new structure effective with the beginning of the next CY.

(iv) 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 sufficient information for the State's actuary to set actuarially sound rates.

4. Annual Adjustments to the Clinic-Specific APM PMPM.

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

(b) For FQHCs in years subsequent to their initial year of participation in the APM, the APM PMPM formula for each parent site billing NPI =

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

(c) DHCS may prospectively adjust a participating FQHC's APM PMPM on an annual basis to account for changes in the scope of services that are anticipated to trigger an update to a participating FQHC's PPS rate in accordance with the State Plan scope change process set forth in Section K. The prospective adjustment to the APM PMPM may only reflect an increase to the FQHC's existing PPS rate of between 2.5 and 10 percent. Such adjustments to the APM PMPM shall be on an interim basis and will be reconciled to the participating FQHC's actual PPS rate calculated in accordance with the State Plan, including the scope change process set forth in Paragraph K. Final payments under this provision will be based on the APM PMPM calculated using the actual PPS rate under State Law in accordance with subsection 7. Calculation of the APM PMPM Rate remains subject to an Annual Reconciliation in accordance with Paragraph **5. Annual Reconciliation**.

5. Annual Reconciliation.

(a) DHCS shall annually review and reconcile the total payments made to each participating FQHC to ensure the aggregate APM PMPM amount paid by the Medi-Cal MCP(s) in the applicable year is at least equal to the amount the FQHC would have received in the year if the FQHC had been paid its applicable PPS rate in effect for that calendar year including the appropriate MEI index, per PPS eligible managed care encounter for APM services.

(b) If aggregate APM PMPM payments are less than the total amount that would have been paid under the current PPS rate methodology for each PPS eligible Medi-Cal managed care encounter for a particular participating FQHC under the APM, DHCS shall pay the participating FQHC the difference between the amount paid by the MCP(s) and the amount the participating FQHC would have been entitled to under the PPS rate methodology for the total number of PPS eligible Medi-Cal managed care encounters for APM services.

(c) The State will reconcile actual utilization to the APM PMPM using Medi-Cal managed care encounter data.

(d) Participating FQHCs must submit to Medi-Cal MCPs the necessary records of all encounter claims involving that Medi-Cal MCP by no later than 90 days after the conclusion of a calendar year to afford adequate time for completion of the annual reconciliation required in this subsection.

(e) DHCS shall base reconciliation calculations on information submitted by Medi-Cal MCPs from APM participating FQHCs within this deadline and reserves the right to audit data upon which reimbursement is based.

6. Selection Criteria for Participation in the APM.

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

(i) Complete application and Commitment to APM: The FQHC has submitted a complete, written application, including a letter of support from the applying FQHC's CEO or designees attesting to the following:

A. Commitment to the APM care transformation strategy,
B. Willingness to commit staff participation in quality collaborative/learning communities,
C. Organizational commitment to creating and maintaining an effective quality improvement infrastructure, and
D. Organizational commitment to redesigning the FQHC's Care team to improve quality of care outcomes.

(ii) Encounter Data/FFS Wrap Claim Match and Percentage of Assigned Encounter Data: FQHC's data must meet a minimum benchmark of at least 66% of T1015 wrap payments 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. In addition, FQHCs must meet DHCS determined utilization thresholds of reported MCP encounters incurred by assigned APM enrollees. This demonstrates a commitment to medical home models of care and ensuring that 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.

(iii) Data Capabilities: The FQHC has appropriate data capabilities including the ability to submit complete, timely and compliant encounter data including alternative encounters. 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.

(iv) Capacity for Care Transformation: APM Strategy: The FQHC has outlined at least a five-year strategy for participation in the APM to transform its care delivery model and improve quality and health equity.

(v) 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.

(vi) 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.

(vii) Quality Improvement Infrastructure. The FQHC or system has a formal quality improvement infrastructure to improve HEDIS/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.

(viii) Collaboration and care coordination with Medi-Cal MCPs. The FQHC has identified specific methods of collaborating with its current Medi-Cal MCP contractors to achieve the APM strategic goal and care transformation and to improve patient health.

(ix) 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 Capacity to Enact Transformation.

(x) Operational Considerations. Medi-Cal 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.

(xi) The FQHC is in good standing with State and Federal regulators.

(xii) 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.

(b) 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.

(c) 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 Medi-Cal managed care rating period.

(d) In its sole discretion, DHCS may exclude FQHCs for which actuarially appropriate rates cannot be calculated in accordance with subsection **6. Selection Criteria for Participation in the APM.**

(e) 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 Medi-Cal MCP any reasons, including but not limited to:

(i) The utilization data in the base year from Intermittent Sites/Mobile Units cannot be accurately identified and isolated;

(ii) 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

(iii) 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.

(f) 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.

7. Ongoing participation in the APM.

   (a) Participating FQHCs must submit data and information to Medi-Cal MCPs who will submit the calculated numerator and denominator of selected APM metrics to DHCS on all measures in subdivisions (i) and (ii) in a manner and timing determined by DHCS. Participating FQHCs must meet the quality standards in accordance with subdivisions (i) and (ii) in order to continue participation in this APM as outlined in 9. Compliance with Minimum Performance Standards. A participating FQHC's continued participation in the APM is contingent upon satisfaction of the following minimum standards for access and quality measures.

      (i) Access Performance Metrics: Annually, participating FQHCs must provide access to at least 70 percent of the utilization rate (based on historical PPS eligible visits) used in the calculation of the APM PMPM Rate in accordance with Paragraph 3 for APM enrollees. Access may also include services not recognized as a "visit" under subdivision (g) of Section 14132.100 of the California Welfare and Institutions Code if the service may be provided under State law and is reported by the FQHC consistent with a list of approved codes set by DHCS with input from stakeholders and updated periodically to include services recognized as improving Health-Related Social Needs but not qualifying as a PPS visit. APM PMPM reimbursement will be set consistent with Paragraph **3.Calculation of the APM PMPM Rate** for APM enrollees not based upon those additional codes. The additional codes will not qualify as a visit under PPS reconciliation under the APM in subsection **5. Annual Reconciliation**.

      (ii) Quality Performance Metrics: Annually, participating FQHCs must maintain baseline performance for the following measures at a level at least equal to the performance achieved in the FQHC's last Calendar Year prior to beginning participation in the APM:

         A. Well Child Visits in the first 30 months (W30+ & W30-2+)

         B. Child and Adolescent Well-Care Visits (WCV)

         C. Adults' Access to Preventive/Ambulatory Health Services (AAP)

         D. Aggregated Quality Factor Score (AQFS; calculated from all reported measures in subsection **8. Value-based Purchasing** below)

8. Value-based Purchasing

   (a) To retain 100% of the APM revenues in excess of the amount the FQHC would have received had the FQHC not participated in the APM, the FQHCs must satisfy minimum target performance outlined in (b) and (c) below on a total of 12 quality measures, at least two measures from six domains: Access to Care; BH Integration; Chronic Care; Maternity Care; Prevention – Adult; Prevention – Peds; Patient Experience of Access and Care (reporting only). The "Patient Experience of Access and Care" domain will be reporting only and outside of risk. The selected quality metrics are linked to CalAIM and the DHCS Comprehensive Quality Strategy and Health Equity Roadmap. Metrics may change after the initial implementation based on overall DHCS goals and alignment with quality programs across the department based on DHCS decisions with input from affected stakeholders. These metrics are in addition to the Access and Quality Metrics

thresholds above in Paragraph 7. Benchmarks for metric shall be national Medicaid benchmarks, when available, and state-calculated benchmarks when national Medicaid benchmarks are not available. For state-calculated benchmarks, DHCS shall notify stakeholders of the methodology used when state-calculated benchmarks are released.

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(b) Program Year Benchmarks. Participating FQHCs also must satisfy applicable Benchmarks during the following Program Years:

(i) Year 1. Participating FQHCs must satisfy reporting requirements only. Year 1 includes all data for the FQHC's participation through their first full calendar year of participation in the APM. If a participating FQHC begins on July 1st of a given year, then "Year 1" will cover 1.5 years (July 1st of the year of entering the APM through December 31st of the following year).

(ii) Year 2. Greater than or equal to the 33rd percentile of either national or California-specific state benchmark (up to 1 percent of excess revenues at risk, evenly distributed across all selected metrics)

(iii) Year 3. Greater than or equal to the 50th percentile of either national or California-specific state benchmark (up to 3 percent of excess revenues at risk, evenly distributed across all selected metrics)

(iv) Year 4. Greater than or equal to the 50th percentile of either national or California-specific state benchmark (up to 5 percent of excess revenues at risk, evenly distributed across all selected metrics).

(v) Year 5 and Beyond. Maintain minimum performance levels established by Year 4. (The FQHC is at risk for an increasing one-half of 1% per year of excess revenues (not to exceed 10% of excess revenues). The potential risk will be evenly distributed across all selected metrics for that calendar year. Example: In year 10 of participation in the pilot, an FQHC will have 8% of excess revenues above the PPS rate at risk spread across all metrics.)

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

Example: Quality Measure X

Year 5: 90th percentile benchmark: 70.0%
Year 5: 50th percentile benchmark: 50%
Year 4 performance (AKA Year 5 baseline): 55.0%
Year 4 Performance > 50th percentile and < 90th percentile

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

70% of 55% = 15%
10% of 15% = 1.5%
55% + 1.5% = 56.5%

Year 5 Target: 56.5%

d) Any recoveries will follow the processes consistent with the amounts outlined in this subsection and **9. Compliance with Minimum Performance Standards (b (iv and v)** below developed by the department with input from affected stakeholders, if the following conditions are met:

(ii) Actual utilization during the period is less than 70 percent of historic utilization on a PMPM (utilization per 1,000) basis as outlined in subsection **7. Ongoing participation in the APM**, or

(ii) The FQHC fails to meet Access Performance Metrics and Quality Performance Metrics as outlined in this section 7.

9. Compliance with Minimum Performance Standards.

(a) If a participating FQHC does not maintain either the minimum Access Performance Metric or has a degradation of 5 percent or more of the Quality Performance Metrics Measures set forth above in **7. Ongoing participation in the APM**, DHCS shall place the participating FQHC on a corrective action plan (CAP) in conjunction with the managed care plans contracting with that FQHC.

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

(i) For the first 6 months, identification and auditing of performance metrics for which the participating FQHC is not maintaining performance levels;

(i) For the next 6 months of the CAP, formal initiation and implementation of a CAP in conjunction with the participating FQHC's contracting Medi-Cal managed care plan(s) for metrics the participating FQHC is not maintaining adequate performance levels or achieving pre-defined improvement/innovation efforts;

(ii) If the participating FQHC's performance scores on the Access and/or Quality Performance Metrics do not return to required baseline standards (i.e., Program Year 0) after a period of twelve (12) months, at its sole discretion, DHCS may remove the participating FQHC from the APM or impose a 5 percent penalty consisting of the amount that the participating FQHC's APM PMPM reimbursement exceeds its calculated PPS rate in any Program Year as outlined in 9. Compliance with Minimum Performance Standards. The 5 percent penalty is conducted in place of the maximum 10% of excess revenue at risk in 8 Value Based Purchasing.

(iii) If the participating FQHC does not maintain performance levels or achieve minimum performance standards within two (2) years, DHCS shall remove the participating FQHC from the APM or impose additional financial sanctions necessary to address the deficient performance.

(iv) In no instance may a participating FQHC placed on a CAP be reimbursed less than its calculated PPS rate for covered services provided to Medi-Cal managed care beneficiaries.

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