

Health Plan Roster and Assessment

Managed Care Plan Roster

We are requesting a member level enrollment file for the Federally Qualified Health Centers (FQHC) members assigned to an FQHC requesting to participate in the Alternative Payment Model (APM) program effective January 1, 2026 (Cohort 2). The FQHC must give the health plan a list of all National Provider Identifiers (NPIs) for which they are requesting assigned member rosters. If the health plan does not assign members to the NPIs of attached clinics, please document that in the email submission. Please see the following Data Submission Guidelines and provide this information (securely) by **Monday, December 16, 2024**.

Data Submission Guidelines

1. Data Submission Schedule:

- a. Frequency: Every 6 Months
- b. Current Study Period: July 1, 2023 through September 30, 2024
- c. Current Submission Deadline: **Monday, December 16, 2024**

2. Data Format:

- a. File Format: One Comma Delimited Text File (.txt) with Headers
- b. File Naming Conventions: Name the file to reflect your health plan's name and data submitted
 - i. E.g. Health Plan Name Member Enrollment File – MMYYYY – MMYYYY.txt
- c. Required Fields:
 - i. AKA_CIN – Unique Member ID
 - ii. Month of Eligibility (MOE) as YYYYMM (e.g., 202401)
 - iii. Billing_NPI – This NPI should represent the parent site/unique PPS and should be an NPI as contained in the attached excel file. If the site that the member is assigned to is an intermittent site, the parent NPI should be used for this field.
 - iv. Site_NPI – This NPI should represent the site that the member is assigned to. If you assign at a site level, fill in this field; if not, leave this blank.
 - v. FQHC_NAME

3. Data Quality Checks:

- a. All required fields are populated
 - i. No null values present.
- b. There are not duplicate records
 - i. By AKA_CIN and MOE.
 - ii. If a member changes assignment mid-month, record the member as being assigned to their newly assigned location.
- c. Data is free from formatting errors
 - i. Ensure MOE is formatted as indicated above (YYYYMM).
- d. Verify that the data is current and accurate
 - i. Ensure member is actively enrolled in your health plan at month of eligibility, failure to do so will require resubmission of data.

4. Data Submission Method:

- a. Data submissions should be uploaded to the secure File Transfer protocol (FTP) (the State of California Department of Health Care Services [DHCS]-Capitated Rates Development Division [CRDD]-KICK).

5. Notification of Submission:

- a. Once you upload to the secure FTP (DHCS-CRDD-KICK) is complete, please notify the following individuals from DHCS and Mercer via email:
 - i. Nicholas Leach, Nicholas.Leach@dhcs.ca.gov
 - ii. David Bishop, David.Bishop@dhcs.ca.gov
 - iii. Rodney Armstrong, Rodney.Armstrong@mercer.com
 - iv. Dave Dombrowski, Dave.Dombrowski@mercer.com
 - v. Evelyn Mendoza, Evelyn.Mendoza@mercer.com
- b. Submission notification emails should indicate the total number of records being submitted (i.e., control totals).
- c. The submission email should indicate any NPIs requested by the FQHC with no assigned members

MCP Attestation

This Health Plan should prepare and submit the Health Plan Attestation Form by Monday, December 16, 2024 to document the FQHC applicant's standing with each respective primary State of California DHCS contracted health plan. An FQHC should obtain a Health Plan Assessment Form for each primary health plan contracting with DHCS for which it has a contract.

The Health Plan Assessment Form for an FQHC not directly contracted with the primary DHCS health plan (e.g., they are participating with the health plan through a subcontractor plan or an independent practice association [IPA] affiliation) should be obtained from the plan/IPA that has the closest relationship/contract with the FQHC.

The Health Plan Assessment Form should be submitted with the FQHC's submittal for the application.

1. Does the FQHC transmit encounter data as specified contractually and/or required by the Department?

☐ Yes ☐ No

If additional detail/context is needed, please note in the narrative box below question 10.

2. Are there any significant issues with the FQHC encounter data (problems with transmission, data quality, or quality performance)?

☐ Yes ☐ No

If additional detail/context is needed, please note in the narrative box below question 10.

3. Are there any significant issues with the FQHC quality measurement data (data not collected at all or no employed staff for that purpose, problems with data integrity or availability)?

☐ Yes ☐ No

If additional detail/context is needed, please note in the narrative box below question 10.

4. Are there any significant issues with the FQHC quality achievement scores?

☐ Yes ☐ No

If additional detail/context is needed, please note in the narrative box below question 10.

5. Does the FQHC have any major corrective actions (including but not limited to any of the following; State Medicaid Program (includes DHCS, Audit and Investigation Forms); Bureau of Primary Health Care, 330 Grant Program; and Medi-Cal Managed Care Plan(s)?

☐ Yes ☐ No

If additional detail/context is needed, please note in the narrative box below question 10.

6. Does the Health Plan have any open investigations on the FQHC?

☐ Yes ☐ No

If additional detail/context is needed, please note in the narrative box below question 10.

7. Does the FQHC have any open lawsuits between the FQHC and the health plan?

☐ Yes ☐ No

If additional detail/context is needed, for example the plan is aware of open lawsuits outside of litigation with the plan, please note in the narrative box below question 10.

8. Does the FQHC have sufficient appointment availability for primary and urgent care (as measured by health plan accessibility surveys)?

☐ Yes ☐ No

If additional detail/context is needed, please note in the narrative box below question 10.

9. Does the FQHC have grievances that document systemic problems?

☐ Yes ☐ No

If additional detail/context is needed, please note in the narrative box below question 10.

10. Are there other significant issues with the FQHC not noted above or further detail to provide on any issues noted above? If yes, please provide a narrative description below.

☐ Yes ☐ No

Narrative Box

Based on the assessment results noted above, the FQHC applicant is:

- ☐ In good standing and is recommended for the APM
- ☐ Not in good standing and is not recommended for APM

Signature of the Prime Health Plan contracted with DHCS

Date

If the signature above is not the prime health plan directly contracted with DHCS, then prior to the submittal of the form, the prime health plan must receive and review this form. The prime health plan will sign below that the plan can affirm it has received and reviewed this Health Assessment Form and is not aware of material information that directly contradicts the information provided herein.

Signature of Prime Health Plan

Date

Please sign below if the Prime health plan is aware of material information that directly contradicts the information provided herein:

Signature of Prime Health Plan

Date

FQHC APM
Capitated Rates Development Division
1501 Capitol Avenue, MS 4413
Sacramento, CA 95814

Email: FQHCAPM@dhcs.ca.gov

Internet Address:

<https://www.dhcs.ca.gov/services/Pages/Federally-Qualified-Health-Centers-Alternative-Payment-Methodology.aspx>