

Federally Qualified Health Center – Letter of Intent

Requested Information	Responses
Number of PPS rates / sites ¹ intending to participate (addresses, NPIs, residing counties and addresses of all satellite sites):	PPS 1: _____ Associated Sites: _____ PPS 2: _____ Associated Sites: _____ PPS 3: _____ Associated Sites: _____
Number of total Medi-Cal lives assigned/contracted by PPS rate:	
Average percent of FQHC client base that is Medi-Cal:	
<input type="checkbox"/> Current capacity for submitting encounter data that meets health plan/DHCS requirements (i.e., NPI, Provider Type, Diagnosis code, etc.)	Describe the FQHCs capacity for submitting encounter data:
Attachments: <input type="checkbox"/> Executive support of participation in APM	<input type="checkbox"/> Letter from FQHC Chief Executive Officer
<input type="checkbox"/> Primary health plan(s) contracting with DHCS for which the FQHC has a contract, even if that contract is delegated to another plan or IPA.	List the primary health plan(s) contracting with DHCS for which the FQHC has a contract, even if that contract is delegated to another plan or IPA: _____ _____ _____
<p>Note: An FQHC will 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(s) should be submitted prior to the FQHC’s submittal of the application with the LOI or, at the latest, attached to the APM application. The Health Plan Assessment Form for an FQHC not directly contracted with the Primary DHCS health plan (i.e., they are participating with the health plan through an IPA affiliation) should be obtained from the plan/IPA that has the closest relationship/contract with the FQHC. The Health Plan Assessment Form will acknowledge that the FQHC is in good standing regarding: Encounter data, quality, no outstanding major corrective actions, no open investigations, no open lawsuit, appointment availability (primary care an urgent care – Health plan accessibility surveys), grievances, assigned members.</p>	

¹All sites within a single PPS including intermittent sites associated with the PPS must participate. An FQHC may not select only a subset of sites associated with a PPS.

Narrative (125 words or less)

Describe your interest and desire to participate in the APM and how you will leverage this opportunity to transform care and improve quality and health equity outcomes. Specifically, what operational and clinical changes do you envision as a result of APM participation over the next five years? Please note that responses will not disqualify interested applicants and will be used for informational purposes only.

FQHC APM

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