**Phone Number** 

## Appendix A1 Letter of Intent Template

Letters of Intent must be submitted on letterhead by 11:59 p.m. Central Time on Friday, August 2, 2024. Letters must be submitted on letterhead via email to Mathew Spaan, Manager of Care Delivery and Payment Reform, at Mathew.Spaan@state.mn.us, cc IHP.Admin.DHS@state.mn.us.

Math	new.Sp	oaan@s	state.mn.us, cc IHP.Admin.DHS@state.mn.us.						
<ins< td=""><td>ERT IH</td><td>IP LOGO</td><td>)&gt;</td><td></td></ins<>	ERT IH	IP LOGO	)>						
<mo< td=""><td>nth D</td><td>D, YYY</td><td>Y&gt;</td><td></td></mo<>	nth D	D, YYY	Y>						
<ihp< td=""><td>NAM</td><td>1E&gt;</td><td></td><td></td></ihp<>	NAM	1E>							
<res< td=""><td>spond</td><td>er Nan</td><td>ne&gt;</td><td></td></res<>	spond	er Nan	ne>						
<res< td=""><td>spond</td><td>er Add</td><td>ress&gt;</td><td></td></res<>	spond	er Add	ress>						
l.									
	A. Organization Name and Contact Information								
			<organizat< td=""><td>ion Name&gt;</td></organizat<>	ion Name>					
			"Doing Business As" (If Applicable)						
			Organization Type						
			Organization Taxpayer Identification Number (TIN)/Employer Identification Number (EIN)						
			Street Address						
			City, State, Zip Code						
			Website (If Applicable)						
B. Primary Contact									
			Primary	Contact					
			First and Last Name						
			Title/Position						
			Email Address						
			Phone Number						
	C.	Secon	ndary Contact						
			Secondary Contact						
			First and Last Name						
			Title/Position						
			Email Address						

## II. Letter of Intent

A.	Confirm that the Responder's intent is to submit an application for participation in Integrated Health Partnership (IHP) for 2025.  1. Is the applicant currently an IHP?  □ Yes □ No									
	2.	Does the applicant have experience with other Value-Based or accountable care programs? $\square$ Yes $\square$ No								
		If <b>yes</b> , which programs and approximately how many providers/lives were covered under each program?								
	Program Type		Number Of Providers	Number Of Lives Covered						
В.	<ul> <li>i. Health Care Home (HCH) Certification  Yes  No</li> <li>1. If yes, what level?</li> <li>ii. National Committee for Quality Assurance (NCQA) Accredited Accountable Care Organization (ACO) Yes  No</li> <li>iii. Patient Centered Medical Home (PCMH) Recognized Yes  No</li> <li>Please list the main medical groups, clinics, and hospitals that will be included in the applicant IHP.</li> </ul>									
	Medical Group/Clinic/Hospitals Included									

pp	endix	A-1: Letter of Intent Template
	C.	Please confirm which track, Track 1 or Track 2, the applicant intends to participate in as an IHP starting in 2025.
		☐ Track 1 ☐ Track 2
	D.	Please provide a brief narrative explanation of why the Applicant IHP would like to participate in the IHP program.
	Ε.	If selected to be an IHP, what will your system do differently than what you are currently doing now?
	F.	If the applicant organization is currently an IHP, wishing to continue in the program, what are some lessons learned as an IHP that you plan to work to improve or do differently?