Date

Hospital

Address

Dear HSCRC,

Please accept this completed Letter of Intent, which must be electronically submitted by the State’s deadline of **November 18, 2016** to the following email address: [**hscrc.care-redesign@maryland.gov**](mailto:hscrc.care-redesign@maryland.gov).

In accordance with the provisions of the All-Payer Model Amendment Participation Agreement, this Letter of Intent serves as a non-binding indication of \_\_[insert name of hospital ]\_\_\_’s interest in participating in [one or both] Care Redesign Programs as indicated below:

|  |  |
| --- | --- |
| **Care Redesign Program** | **Participation-- *mark X to select program(s)*** |
| Complex and Chronic Care Improvement Program (CCIP) |  |
| Hospital Care Improvement Program (HCIP) |  |

In preparation for receiving comprehensive Medicare data from CMS as part of the Care Redesign Programs, please provide the individual(s) responsible for Medicare data at your hospital. You may provide up to three contacts. If providing more than one person, please indicate who will be the primary point of contact.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Title** | **Contact Information** | **Please indicate the primary POC with an X** |
|  |  | Email Address:  Ph: |  |
|  |  | Email Address:  Ph: |  |
|  |  | Email Address:  Ph: |  |

We look forward to receiving further information and documents from the State and CMS regarding necessary requirements for participation in these programs, and to continuing our partnership to improve patient and population health outcomes while controlling total cost of care in the State.

Sincerely,

Admin/Hospital Representative

\_\_\_\_\_ Hospital

Address

Tel:

E: