MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

This Care Transformation Arrangement ("Arrangement") is between _____, a care transformation organization (the "CTO"), and _____, (the "Practice") (each a "Party," and collectively the "Parties").

The CTO has been selected by the Centers for Medicare and Medicaid Services ("CMS"), Center for Medicare and Medicaid Innovation ("CMMI"), to serve as a care transformation organization in the Maryland Primary Care Program ("MDPCP"). The Practice is a primary care practice that provides health care services to Medicare beneficiaries, among others, in the State of Maryland.

This Arrangement sets forth the terms and conditions under which the CTO will provide to the Practice certain care transformation services and resources consistent with MDPCP requirements.

1. *Participation Agreements*. Prior to the Effective Date of this Arrangement, the CTO must sign an MDPCP Participation Agreement with CMMI (the "CTO Participation Agreement"). Prior to the Effective Date of this Arrangement, the Practice must sign an MDPCP Participation Agreement with CMMI (the "Practice Participation Agreement"). If either Party does not sign a Participation Agreement with CMMI prior to the Effective Date of this Arrangement, then this Arrangement shall be deemed null ab initio.

2. *Effective Date*. The Effective Date of this Arrangement is January 1, 2021.A Party's performance obligations under this Arrangement shall not begin prior to the Effective Date.

3. *Term of Arrangement*. This Arrangement is effective for a minimum of one full Performance Year, which consists of a 12-month period beginning on January 1 of each year, and will renew automatically on January 1 of each year, until terminated by either party in accordance with Section 12 of this Arrangement, or upon the execution of a new CTO Arrangement. This Arrangement is subject to early termination by either Party only if: (1) CMS terminates either the CTO Participation Agreement or the Practice Participation Agreement, or (2) if CMS authorizes, in writing, such early termination of this Arrangement.

4. *Offer and Selection of CTO Services*. The Practice is responsible for meeting the Care Transformation Requirements as listed in Appendix A. The CTO will support the Practice in meeting those requirements including any support specified in the either the CTO or Practice Participation Agreements. The CTO has offered to provide any and all of the CTO Services to the Practice, as listed in the package selected in Appendix B. The CTO offers these same CTO Services to all participating practices within the same service option level and Track.

5. *Care Management Fees*. CMS will calculate the Practice's Care Management Fees ("CMF") according to the CTO Participation Agreement, the Practice Participation Agreement, and the methodologies described therein. In accordance with the Practice's selection that was submitted to CMS, the CMF payment split will be as follows:
   - ☐ CTO will receive **30%** of the practice's CMF payment amount calculated by CMS, and the remaining **70%** of such CMF payment amount will be paid to the Practice.
   - ☐ CTO will receive **50%** of the practice's CMF payment amount calculated by CMS and the remaining **50%** of such CMF payment amount will be paid to the Practice.

6. *Lead Care Manager*. For practices choosing the 50% option, the CTO will provide the Practice with one or more individuals who are fully dedicated to care management functions of the Practice (the "Lead Care Manager"), and additional services selected in accordance with Section 4. For practices choosing the 30% option, the practice will have its own care manager(s) to work in conjunction with the CTO and the CTO's offerings in accordance with Section 4. Practice will identify care manager responsible for working with the CTO.

7. *Data Sharing and Privacy*. The Practice authorizes the CTO to have access to all clinical data available in the electronic medical records or shared through the State-Designated Health Information Exchange ("HIE"), including personal health information, of MDPCP Beneficiaries attributed to the Practice. The Practice authorizes the CTO to have access via CRISP to quality and utilization reports available to the Practice. The CTO will include a Business Associate Agreement ("BAA") for the Practice to approve. The BAA will govern their data sharing, use, and confidentiality, a copy of which is in Appendix C. Each Party will comply with HIE policies and regulations, including patient education requirements, and will execute any separate agreement that may be required by CRISP.

8. *Notification of Changes in Medicare Enrollment*. The Practice will notify the CTO of any changes to the Practice's Medicare beneficiary enrollment information within thirty (30) days after such changes occur.

9. *No Remuneration Provided*. Neither the CTO nor the Practice has offered, given, or received remuneration in return for, or to induce business other than the business covered under this CTO Arrangement.

10. *Practice of Medicine or Professional Services Not Limited by this Arrangement*. The Arrangement does not limit or restrict in any way the ability of the Practice and its clinician(s) to make medical decisions that they consider in their professional judgment to be in the best interest of a MDPCP Beneficiary.

11. *Compliance with All Applicable Laws*. This Arrangement does not alter or amend the Parties' being bound to comply with all relevant federal and State laws, including, but not limited to, health care fraud and abuse laws, HIPAA, and the Maryland Medical Practice Act. The CTO will continue to be bound by the terms of the CTO Participation Agreement, and the Practice will continue to be bound by the terms of the Practice Participation Agreement.

12. *Termination*. Either Party may terminate this Arrangement annually or earlier by providing written notice of termination to the other Party, CMS and the Program Management Office. If the Practice or CTO decides to terminate this Arrangement for any reason, it must provide written notice in accordance with the notification and termination requirements stated in the applicable MDPCP Participation Agreements. This Arrangement automatically terminates on the Effective Date of the termination of either the CTO Participation Agreement or the Practice Participation Agreement.

13. *Copies and Retention of Arrangement*. The Practice will provide a copy of this Arrangement to the CTO and the Maryland Department of Health, Program Management Office, within thirty (30) days of execution. The CTO will retain copies of this Arrangement for a period of ten (10) years following expiration or termination of the CTO Participation Agreement. The CTO will, upon request, provide copies of this Arrangement to the federal government, including, but not limited to, CMS, the HHS Office of the Inspector General, or the Comptroller General.

14. *Amendments*. The Parties may amend this Arrangement including, but not limited to, the CTO Services offered and provided, at any time upon mutual written consent. The CTO must continue to offer the same CTO Services to all participating practices within the same service option level and Track, as specified in Section 4 of this Arrangement.

IN WITNESS THEREOF, and in acknowledgement of the aforementioned, the authorized representatives of the CTO and the Practice do hereby indicate their approval and consent:

FOR THE CARE TRANSFORMATION ORGANIZATION:	**FOR THE PRACTICE:**
_____	_____
Signature	Signature
_____	_____
Printed Name	Printed Name
_____	_____
MDPCP CTO ID	MDPCP Practice ID
_____	_____
Title	Title
_____	_____
Date Signed	Date Signed

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Appendix A:

Care Transformation Requirements

Comprehensive Primary Care Functions of Advanced Primary Care	Care Transformation Requirement	Practice Track Requirement
Access and Continuity	1.1 Empanel attributed beneficiaries to practitioner or care team.	Track 1 + 2
	1.2 Ensure attributed beneficiaries have 24/7 access to a care team or practitioner with real-time access to the EHR.	Track 1 + 2
	1.3 Ensure attributed beneficiaries have regular access to the care team or practitioner through at least one alternative care strategy.	Track 2 only
Care Management	2.1 Ensure all empaneled, attributed beneficiaries are risk stratified.	Track 1 + 2
	2.2 Ensure all attributed beneficiaries identified as increased risk and likely to benefit receive targeted, proactive, relationship-based (longitudinal) care management.	Track 1 + 2
	2.3 Ensure attributed beneficiaries receive a follow-up interaction from your practice within one week for ED discharges and two business days for hospital discharges.	Track 1 + 2
	2.4 Ensure targeted, attributed beneficiaries who have received follow-up after ED, hospital discharge, or other triggering events receive short-term (episodic) care management.	Track 1 + 2
	2.5 Ensure attributed beneficiaries in longitudinal care management are engaged in a personalized care planning process, which includes at least their goals, needs, and self-management activities.	Track 2 only
	2.6 Ensure attributed beneficiaries in longitudinal care management have access to comprehensive medication management.	Track 2 only
Comprehensiveness and Coordination across the Continuum of Care	3.1 Ensure coordinated referral management for attributed beneficiaries seeking care from high-volume and/or high-cost specialists as well as EDs and hospitals.	Track 1 + 2
	3.2 Ensure attributed beneficiaries with behavioral health needs have access to care consistent with at least one option from a menu of options for integrated behavioral health supplied to attributed beneficiaries by the Practice	Track 1 + 2
	3.3 Facilitate access to resources that are available in your community for beneficiaries with identified health-related social needs	Track 2 only
Beneficiary & Caregiver Experience	4.1 Convene a Patient-Family/ Caregiver Advisory Council (PFAC) at least annually and integrate PFAC recommendations into care and quality improvement activities.	Track 1 + 2
	4.2 Engage attributed beneficiaries and caregivers in a collaborative process for advance care planning	Track 2 only
Planned Care for Health Outcomes	5.1 Continuously improve your performance on key outcomes, including cost of care, electronic clinical quality measures, beneficiary experience, and utilization measures.	Track 1 + 2

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Appendix B:

CTO Services/Personnel Offered and Practice Selection

Package A (50%)

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2	Access to behavioral health team consisting of a licensed mental health professional, LCSW-C or LCPC, (Health Behavioral Specialist) and psychiatrist who work together to support primary care staff caring for patients with behavioral health needs. HBS staff will be embedded (on the premises) at some sites and will support other regional sites primarily telephonically. HBS will provide on-site services to assigned regional sites. The JMAP psychiatrist is available for consultation to discuss psychotropic management, recommend treatment approaches and referrals.	Behavioral Health Medical Director Psychiatrist HBS Supervisor Health Behavior Specialist (LCSW-C or LCPC)	All practices On average 0.3 per 8 practices All practices On average 1 per 4 practices
Medication Management	Care Management 2.6	Access to pharmacy services as part of a multi-disciplinary care team either embedded in partner practice sites or who service the geographic region. Services include: • Chronic disease state management • Medication therapy adjustments • Polypharmacy assessment • Medication adherence support and interventions • In-depth medication reconciliation • Patient education • Drug information and medication consults	Pharmacists	On average 1 per 10 practices
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	Provides assistance with workflows and capabilities to implement screening tools for health-related social needs and connections to community resources.	Lead Care Manager (RN or LCSW-C) Quality Improvement & Practice Transformation Coach	On average 1 per 2 practices (1 per 2,000 patients) On average, 1 per 10 practices

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Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	All care coordination team members are equipped to provide telehealth services through appropriate access to resources and training.	Lead Care Manager (RN or LCSW-C) Psychiatrist Health Behavior Specialist (LCSW-C or LCPC) Pharmacist	On average 1 per 2 practices (1 per 2,000 patients) On average 0.3 per 8 practices On average 1 per 4 practices On average 1 per 10 practices
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	Provides support with identifying patients being discharged from hospital and with establishing a process for transitional care follow-up, including: • Notification of patient admission to outpatient care team member • Medication reconciliation • Communication between care settings and providers • Timely contact with patients after hospitalization to schedule follow-up visits with primary care • Connect patients to community-based resources as needed • Guidance and assistance with workflows, best practices, and performance improvement	Lead Care Manager (RN or LCSW-C) Quality Improvement & Practice Transformation Coach	On average 1 per 2 practices (1 per 2,000 patients) On average 1 per 10 practices

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Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	Lead care managers are based at the primary care site(s) to promote in-person communication and collaboration with primary care team. Additional offerings include: - Providing comprehensive medical, cognitive, and social needs assessment and creates an individualized care plan for the most vulnerable patients. - Provide episodic care for patients with transient needs. - Act as a "communications hub" for providers and other team members about patient care. - Providing transitional care at times of high need (e.g. during hospitalization) by proactively connecting and coordinating with inpatient care teams. - In addition to face-to-face interactions, provide direct telephonic access to patients. - Leverage EMR clinical data, claims, CRISP, and primary care referrals to identify high-risk patients.	Care Coordination Medical Director Director of Care Coordination Care Coordination Managers Lead Care Manager (RN or LCSW-C) Psychiatrist Health Behavior Specialist (LCSW-C or LCPC) Pharmacist Quality Improvement & Practice Transformation Coach	All practices All practices All practices On average 1 per 2 practices (1 per 2,000 patients) On average 0.3 per 8 practices On average 1 per 4 practices On average 1 per 10 practices On average, 1 per 10 practices
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	Provides access to reports and information to assist practices with identifying areas of opportunities to make improvements.	Data Analyst Quality Improvement & Practice Transformation Coach	On average, 1 per 10 practices On average, 1 per 10 practices
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	- Support for implementation of predictive analytics (Johns Hopkins ACG System, Hilltop reports, Milliman Predictive Model Tool), as feasible, dependent upon access to claims data, to assist in the optimal deployment of care coordination resources and to guide practices to focus on high-cost, high need patients - Guidance, assistance, and support for utilizing CRISP reporting to obtain real-time alerts from ENS on admissions, emergency department visits, and transfers to skilled nursing facilities - Technical assistance / consulting services to assess gaps and develop an implementation plan to meet program requirements	Quality Improvement & Practice Transformation Coach Data Analyst	On average, 1 per 10 practices On average, 1 per 10 practices

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Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	Provides guidance, assistance, and best practices with PFAC implementation and ongoing improvement.	Quality Improvement & Practice Transformation Coach	On average, 1 per 10 practices
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	Provides guidance on program requirements, facilitates practice transformation through the development of processes to establish and maintain quality improvement projects geared towards optimizing performance. Practice transformation is accomplished using data analytics, reviewing primary care office workflows, and incorporating best practices to improve care. Provides practices with the data and tools to deliver high-quality, patient-centered care, and advocates for innovation and continuous performance improvement using Lean Six Sigma tools and methodologies. Provides guidance for use of quality and utilization measures, and other metrics to demonstrate primary care function requirements (e.g. advance care planning, self-management) through Best practice guides and specific tool development.	Quality Improvement & Practice Transformation Coach Data Analyst	On average, 1 per 10 practices On average, 1 per 10 practices
24/7 Access	Access & Continuity 1.2	Provides technical assistance with EMR assessment (e.g. access to a patient portal) and consulting services to assess gaps and develop an implementation plan to meet program requirements.	Quality Improvement & Practice Transformation Coach Data Analyst	On average, 1 per 10 practices On average, 1 per 10 practices
Referral Management	Comprehensiveness & Coordination 3.1	Provides technical assistance with workflows, reporting capabilities, and potential EMR solutions to track referrals and identify high value specialists, using Milliman Medical Episode Grouping (MEG) Functionality to identify high cost specialists.	Quality Improvement & Practice Transformation Coach Data Analyst	On average, 1 per 10 practices On average, 1 per 10 practices

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Package B (30%)*

*Practice will provide its own Lead care manager to work in conjunction with the CTO and the CTO's offerings. Partner practices have the option of requesting or purchasing access to additional care coordination resources.

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2	Access to behavioral health team consisting of a licensed mental health professional, LCSW-C or LCPC, (Health Behavioral Specialist) and psychiatrist who work together to support primary care staff caring for patients with behavioral health needs. HBS staff will be embedded (on the premises) at some sites and will support other regional sites primarily telephonically. HBS will provide on-site services to assigned regional sites. The JMAP psychiatrist is available for consultation to discuss psychotropic management, recommend treatment approaches and referrals.	Behavioral Health Medical Director Psychiatrist HBS Supervisor Health Behavior Specialist (LCSW-C or LCPC)	All practices On average 0.2 per 8 practices All practices On average 0.8 per 4 practices
Medication Management	Care Management 2.6	Access to pharmacy services as part of a multi-disciplinary care team either embedded in partner practice sites or who service the geographic region. Services include: • Chronic disease state management • Medication therapy adjustments • Polypharmacy assessment • Medication adherence support and interventions • In-depth medication reconciliation • Patient education • Drug information and medication consults	Pharmacists	On average 0.8 per 10 practices
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	Provides assistance with workflows and capabilities to implement screening tools for health-related social needs and connections to community resources.	Quality Improvement & Practice Transformation Coach	On average, 1 per 10 practices
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	All care coordination team members are equipped to provide telehealth services through appropriate access to resources and training.	Psychiatrist Health Behavior Specialist (LCSW-C or LCPC) Pharmacist	On average 0.2 per 8 practices On average 0.8 per 4 practices On average 0.8 per 10 practices
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	Provides support with identifying patients being discharged from hospital and support with establishing a process for transitional care follow-up. including: • Guidance and assistance with workflows, best practices, and performance improvement	Quality Improvement & Practice Transformation Coach	On average, 1 per 10 practices

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Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	Practice will provide Lead CM. Partner practices have the option of requesting or purchasing access to additional care coordination resources. Pharmacy and behavioral health services will continue to support high risk patients as requested.	Care Coordination Medical Director Behavioral Health Medical Director Psychiatrist HBS Supervisor Health Behavior Specialist (LCSW-C or LCPC) Pharmacist Quality Improvement & Practice Transformation Coach	All practices All practices On average 0.2 per 8 practices All practices On average 0.8 per 4 practices On average 0.8 per 10 practices On average, 1 per 10 practices
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	Provides access to reports and information to assist practices with identifying areas of opportunities to make improvements, using Milliman tools for benchmarking and claims data analytics and CRISP reporting suite.	Data Analyst Quality Improvement & Practice Transformation Coach	On average, 1 per 10 practices On average, 1 per 10 practices
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	- Support for implementation of predictive analytics (Johns Hopkins ACG System, Hilltop reports, Milliman Predictive Model Tool), as feasible, dependent upon access to claims data, to assist in the optimal deployment of care coordination resources and to guide practices to focus on high-cost, high need patients, - Guidance, assistance, and support for utilizing CRISP reporting to obtain real-time alerts from ENS on admissions, emergency department visits, and transfers to skilled nursing facilities - Technical assistance / consulting services to assess gaps and develop an implementation plan to meet program requirements	Quality Improvement & Practice Transformation Coach Data Analyst	On average, 1 per 10 practices On average, 1 per 10 practices
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	Provides guidance, assistance, and best practices with PFAC implementation and ongoing improvement.	Quality Improvement & Practice Transformation Coach	On average, 1 per 10 practices

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Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	Provides guidance on program requirements, facilitates practice transformation through the development of processes to establish and maintain quality improvement projects geared towards optimizing performance. Practice transformation is accomplished using data analytics, reviewing primary care office workflows, and incorporating best practices to improve care. Provides practices with the data and tools to deliver high-quality, patient-centered care, and advocates for innovation and continuous performance improvement using Lean Six Sigma tools and methodologies. Provides guidance for use of quality and utilization measures, and other metrics to demonstrate primary care function requirements (e.g. advance care planning, self-management) through Best practice guides and specific tool development.	Quality Improvement & Practice Transformation Coach Data Analyst	On average, 1 per 10 practices On average, 1 per 10 practices
24/7 Access	Access & Continuity 1.2	Provides technical assistance with EMR assessment (e.g. access to a patient portal) and consulting services to assess gaps and develop an implementation plan to meet program requirements.	Quality Improvement & Practice Transformation Coach Data Analyst	On average, 1 per 10 practices On average, 1 per 10 practices
Referral Management	Comprehensiveness & Coordination 3.1	Provides technical assistance with workflows, reporting capabilities, and potential EMR solutions to track referrals and identify high value specialists	Quality Improvement & Practice Transformation Coach Data Analyst	On average, 1 per 10 practices On average, 1 per 10 practices

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Final Practice Selection

- ☐ Package A (50%)
- ☐ Package B (30%)

Practice Signature _____ CTO Signature _____

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Appendix C:

Business Associate Agreement between the CTO and the Practice

[Attached hereto]