MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

This Care Transformation Arrangement ("Arrangement") is between Aledade Accountable Care 30, a care transformation organization (the "CTO"), and [name of Practice], (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 the later of January 1, 2019, or January 1 of the year following the date this Arrangement is signed by the last Party to sign it (as indicated by the date associated with that Party's signature). 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. 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 CTO Option Selection Form A, the CTO will receive **30/50%** of the practice's CMF payment amount calculated by CMS, and the remaining **70/50%** 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.

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 B. 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:

__SAMPLE Only – Do NOT Complete Now__
Signature

__SAMPLE Only – Do NOT Complete Now__
Printed Name

__SAMPLE Only – Do NOT Complete Now__
MDPCP CTO ID

__SAMPLE Only – Do NOT Complete Now__
Title

__SAMPLE Only – Do NOT Complete Now__
Date Signed

FOR THE PRACTICE:

__SAMPLE Only – Do NOT Complete Now__
Signature

__SAMPLE Only – Do NOT Complete Now__
Printed Name

__SAMPLE Only – Do NOT Complete Now__
MDPCP Practice ID

__SAMPLE Only – Do NOT Complete Now__
Title

__SAMPLE Only – Do NOT Complete Now__
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%)

Personnel and Services, Defined:

Medical Director (HQ): Centralized MD to oversee clinical strategy.
Medical Directors (Maryland): Practicing Maryland MD partnering with Aledade CTO to work closely with HQ Medical Director to facilitate program execution.
Executive Director: Oversees performance and operational strategy across the state.
Practice Transformation Specialist: Devoted to visiting practices to help with implementation of initiatives and adoption of the Aledade App.
Program Coordinator: Dedicated staff to understand policy structure of MDPCP, to ensure compliance of all practices with the program, and to assist with attestation and reporting in the partner practices
Care Management (CM) Coordinator: Aledades CM Coordinator provides Site & Virtual visits with practices for training and CM onboarding, Practice Training sessions, Instant Messaging service for quick facilitation of assistance, patient management, resources and teamwork assistance, and tools to ensure success and progression in the MDPCP program
Lead Care Manager: Practice-imbedded care manager hire and managed by the Aledade CTO.
The Aledade App: Point-of-care population health tool designed to enhance practice workflows, risk stratify population, and care for patients most in need.
Data Analytics: Fully staffed Aledade Analytics team dedicated to generating Key Performance Indicators (KPIs) for specific initiatives (AWVs, TCMs, Care Management, Risk) that will deliver success in the MDPCP.
EHR Coordinator: Expert dedicated to Maryland to ensure integration of practice EMR with CRISP and Aledade App, and to build templates.

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2, NQF 0004	Integrated behavioral health provided via remote behavioral health-specific care management with weekly psychiatric oversight.	MD	1 per 15 practices
Medication Management	Care Management 2.6	Centralized pharmacist dedicated to Maryland and overseen by Aledades pharmacy team; will implement Aledade's Medication Therapy Management (MTM) approach.	PharmD	All Practices
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	Aledade's CM Coordinator provides training and a Health Risk Assessment to determine Social Determinants of Health of the population, including resources for referral and management based on results, need, and location. Lead Care Manager will conduct.	RN CM Coordinator Lead Care Manager	1 per 15 practices 1 per 2K patients
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	Team will train practice and staff on cohort-based care management with emphasis on transitions of care for high utilizers. Services to facilitate include The Aledade App, training materials, on-site training retreats, 1:1 CM Coordinator training and Medicare Director leadership. Lead care manager will be imbedded in the practice and perform TCM.	N/A RN CM Coordinator Medical Director Lead Care Manager	1 per 15 practices 1 per 15 practices 1 per 15 practices 1 per 2K patients

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Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	The Aledade App's care manager module to manage CM patients; care plan template creation and training by the CM Coordinator; toolkits to train on care management; training in advance care planning state-specific documentation and the Serious Illness Conversation Guide; Lead Care Manager will receive training and provide longitudinal care management.	RN CM Coordinator Aledade App MD Lead Care Manager EHR Coordinator	1 per 15 practices All practices 1 per 15 practices 1 per 2K patients All Practices
Population Health Management & Analytics & Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	Aledade has a dedicated Analytics team that tracks outcomes and develops process metrics for improvement (e.g AWV and TCM performance in the App; patient-specific "rifle shots" to improve performance on BP and A1C). Executive director and PTS develop reports and provide strategic guidance. The Daily huddle in the Aledade App facilitates interdisciplinary care team meetings to enhance beneficiary care, and the Aledade risk stratification tool allows for identification of high-risk patients; Lead Care Manager will oversee process in the practice.	App + Analytics PTS Executive Director Aledade App Lead Care Manager	All Practices 1 per 15 Practices All Practices All Practice 1 per 2K patients
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	Aledade offers a four-tiered risk stratification tool that incorporates into the Aledade App; Lead Care Manager will do risk stratification. The stratification uses the Aledade risk score, which combines HCC with clinical and utilization data to derive an overall score. This allows for actionable step-one stratification; the Aledade App's care management module allows for second-step stratification and for tracking and management of longitudinal care management. The CM coordinator and the PTS train on all of these workflows, and provide additional materials and trainings on effective, utilization-based care management.	Aledade App CM Coordinator PTS Lead Care Manager	All Practices 1 per 15 Practices 1 per 15 Practices 1 per 2K patients
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	Provide materials and guidance to help facilitate PFAC; access to national network of CPC+ partner practices with established resources doing PFAC; Lead Care Manager will work in conjunction with Aledade CTO team and providers in the practice to conduct PFAC.	Executive Director CM Coordinator PTS Lead Care Manager	All Practices 1 per 15 Practices 1 per 15 Practices 1 per 2K patients
Referral Management	Comprehensiveness & Coordination 3.1	Identification of high-value, low-cost specialists; workflow coaching to refine referral process; identification of specialist "super utilizers" on whom to intervene.	PTS Aledade App Aledade Referral Management Team	1 per 15 practices All Practices All Practices
Other	Program Tracking	The CTO will provide a practice-specific milestones document that will track the practice's performance on program requirements through three states of maturity. CTO will also provide practice-specific tracking on Key Performance Metrics (KPIs) relating to the incentivized metrics (quality and utilizations). The CM coordinator and Medicare Directors will work closely with Lead Care Manager and providers to discuss performance and path towards improvement.	CM Coordinator Medical Director Lead Care Manager	1 per 15 practices All Practices 1 per 2K patients

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Example Package D (30%)*

Personnel and Services, Defined:

Medical Director (HQ): Centralized MD to oversee clinical strategy.
Medical Directors (Maryland): Practicing Maryland MD partnering with Aledade CTO to work closely with HQ Medical Director to facilitate program execution.
Executive Director: Oversees performance and operational strategy across the state.
Practice Transformation Specialist: Devoted to visiting practices to help with implementation of initiatives and adoption of the Aledade App.
Program Coordinator: Dedicated staff to understand policy structure of MDPCP, to ensure compliance of all practices with the program, and to assist with attestation and reporting in the partner practices
Care Management (CM) Coordinator: Aledades CM Coordinator provides Site & Virtual visits with practices for training and CM onboarding, Practice Training sessions, Instant Messaging service for quick facilitation of assistance, patient management, resources and teamwork assistance, and tools to ensure success and progression in the MDPCP program
The Aledade App: Point-of-care population health tool designed to enhance practice workflows, risk stratify population, and care for patients most in need.
Data Analytics: Fully staffed Aledade Analytics team dedicated to generating Key Performance Indicators (KPIs) for specific initiatives (AWVs, TCMs, Care Management, Risk) that will deliver success in the MDPCP.
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Medication Management	Care Management 2.6	Centralized pharmacist dedicated to Maryland and overseen by Aledades pharmacy team; will implement Aledade's Medication Therapy Management (MTM) approach.	PharmD	All Practices
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	Aledade's CM Coordinator provides training and a Health Risk Assessment to determine Social Determinants of Health of the population, including resources for referral and management based on results, need, and location.	RN CM Coordinator	1 per 15 practices
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	Team will train practice and staff on cohort-based care management with emphasis on transitions of care for high utilizers. Services to facilitate include The Aledade App, training materials, on-site training retreats, 1:1 CM Coordinator training. and Medicare Director leadership	N/A RN CM Coordinator Medical Director	1 per 15 practices 1 per 15 practices 1 per 15 practices
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	The Aledade App's care manager module to manage CM patients; care plan template creation and training by the CM Coordinator; toolkits to train on care management; Training in advance care planning state-specific documentation and the Serious Illness Conversation Guide.	RN CM Coordinator Aledade App MD EHR Coordinator	1 per 15 practices All practices 1 per 15 practices
Population Health Management & Analytics & Quality &	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	Aledade has a dedicated Analytics team that tracks outcomes and develops process metrics for improvement (e.g AWV and TCM performance in the App; patient-specific "rifle shots" to improve performance on BP and A1C). Executive director and PTS develop reports and provide strategic guidance. The Daily huddle in the Aledade App	App + Analytics PTS Executive Director Aledade App	All Practices 1 per 15 Practices All Practices All Practice

Utilization Performance		facilitates interdisciplinary care team meetings to enhance beneficiary care, and the Aledade risk stratification tool allows for identification of high-risk patients.		
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	Aledade offers a four-tiered risk stratification tool that incorporates into the Aledade App. The stratification uses the Aledade risk score, which combines HCC with clinical and utilization data to derive an overall score. This allows for actionable step-one stratification; the Aledade App's care management module allows for second-step stratification and for tracking and management of longitudinal care management. The CM coordinator and the PTS train on all of these workflows, and provide additional materials and trainings on effective, utilization-based care management.	Aledade App CM Coordinator PTS	All Practices 1 per 15 Practices 1 per 15 Practices
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	Provide materials and guidance to help facilitate PFAC; access to national network of CPC+ partner practices with established resources doing PFAC.	Executive Director CM Coordinator PTS	All Practices 1 per 15 Practices 1 per 15 Practices
Referral Management	Comprehensiveness & Coordination 3.1	Identification of high-value, low-cost specialists; workflow coaching to refine referral process; identification of specialist "super utilizers" on whom to intervene.	PTS Aledade App Aledade Referral Management Team	1 per 15 practices All Practices All Practices
Other	Program Tracking	The CTO will provide a practice-specific milestones document that will track the practice's performance on program requirements through three states of maturity. CTO will also provide practice-specific tracking on Key Performance Metrics (KPIs) relating to the incentivized metrics (quality and utilizations). The CM coordinator and Medicare Directors will check in with practices and providers to discuss performance and path towards improvement.	CM Coordinator Medical Director	1 per 15 practices All Practices

*Practice will have its own care manager to work in conjunction with the CTO and the CTO's offerings.

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Final Practice Selection

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

Practice Signature SAMPLE Only – Do NOT Complete Now CTO Signature SAMPLE Only – Do NOT Complete Now

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Appendix C:

Business Associate Agreement between the CTO and the Practice

[Attached hereto]