MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

This Care Transformation Arrangement ("Arrangement") is between Doctors Health Systems, 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

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

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, NQF 0004	Established communication line for direct access with behavioral health specialist. Customizable per practice. provide counseling and direction to people dealing with challenges like addiction, physical limitations and mental illness	Behavioral Health Specialist	1 per 25 practices
Medication Management	Care Management 2.6	Review of high risk patients' medication list and share with provider. Care Team, which would involve the Lead Care Manager(s), will perform medication reconciliation / management post-discharge with the patient, under the guidance / supervision of the primary care provider. Where applicable, the Lead Care Manager will bring in the pharmacist based on polypharmacy, multiple chronic conditions and risk factors. Work with practices to create an appointment slot for the patient(s) for such appointments in a timely manner.	Care Manager, Pharmacist	1 per 4 practices 1 per 25 practices
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	Identification and establishment of social service resources with ongoing updates of these resources. Maintaining a social service resource contact for point of care referrals. Based on identified social needs of certain beneficiaries, facilitate introduction to services such as: Food assistance programs, Housing assistance programs, Goods and medical supply programs, Transportation assistance programs, Legal assistance programs	Care Manager	1 per 4 practices
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	The Care Manager will work with the practice to ensure that the entire Care Management Team has real-time read/write access to the practice's EHR and that an on-call person has been assigned. This access would be limited to the duration of the participation agreement. Provide Community Health Worker for home visits. Customizable per practice.	Care Manager Community Health Worker, CHW	1 per 4 practices 1 per 10 practices
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	Identify patients being discharged from hospital and ED, conduct transitional care visit. The Lead Care Manager will facilitate referrals for patients seeking care from high-volume and/or high-cost specialist as well as EDs and hospitals based on each patient's needs and under the guidance of the patient's primary care provider. The Care Team also will monitor specialist utilization within the CRISP portal to help manage and coordinate referrals and will discuss with practices as necessary.	Care Manager	1 per 4 practices

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	Create a standard template recommendation regarding advance care planning that can be made available to all practices. This would help the individual providers at the practices communicate with the patients about advance care planning.	Care Manager	1 per 4 practices
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	Aggregation of patient data across multiple health information technology resources, the analysis of that data into a single, actionable patient record, and the actions through which care providers can improve both clinical and financial outcomes	Data Analyst	1 per 25 practices
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	The CTO will facilitate a Patient-Family / Caregiver Advisory Council at least annually and work to integrate PFAC recommendations into improving the care and wellbeing of patients. These services would include the following: Facilitate setting up the council, Facilitating the discussion, Facilitating some action items, Creating a recommendation back to clinical / general leadership. Communicating outcome to the individual practices to get the next steps available to the beneficiary representative(s) and the practices	Quality Program Navigator	1 per CTO
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	The Lead Care Manager and the CTO will consistently track and measure the cost and utilization for all patients that are attributed to the CTO. Based on this tracking / measuring, the CTO will make suggestions to improve each practice's performance on key outcomes, including cost of care, electronic clinical quality measures, beneficiary experience, and utilization measures. Suggestions could involve changes to the workflow of the practice, data entry by the practice into its relevant EHR and based on data that is made available to the CTO, via the CRISP Portal. This process may help in the success of annual clinical quality data submission, which is a requirement for both the CTO and the participating practice.	Lead Care Manager, Quality Program Navigator	1 per 4 practices 1 per CTO

Example Package B (30%)*

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	Established communication line for direct access with behavioral health specialist. Customizable per practice. Provide counseling and direction to people dealing with challenges like addiction, physical limitations and mental illness	Behavioral Health Specialist	1 per 25 practices
Medication Management	Care Management 2.6	Where applicable, your Lead Care Manager will bring in the pharmacist based on polypharmacy, multiple chronic conditions and risk factors. Work with practices to create an appointment slot for the patient(s) for such appointments in a timely manner.	Pharmacist	1 per 25 practices
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	Provide your Lead Care Manager with tools and resources for the identification and establishment of social service resources with ongoing updates of these resources such as: Food assistance programs, Housing assistance programs, Goods and medical supply programs, Transportation assistance programs, Legal assistance programs	Quality Program Navigator	1 per CTO
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	Provide Community Health Worker for home visits. Customizable per practice.	Community Health Worker, CHW	1 per 10 practices
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	Aggregation of patient data across multiple health information technology resources, the analysis of that data into a single, actionable patient record, and the actions through which care providers can improve both clinical and financial outcomes	Data Analyst	1 per 20 practices
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	The CTO may assist your Lead Care Manager in facilitating a Patient-Family / Caregiver Advisory Council at least annually and work to integrate PFAC recommendations into improving the care and wellbeing of patients. Communicating outcome to the individual practices to get the next steps available to the beneficiary representative(s) and the practices	Quality Program Navigator	1 per CTO
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	Your Lead Care Manager in conjunction with the CTO will consistently track and measure the cost and utilization for all patients that are attributed to your practice. Based on this tracking / measuring, the CTO will make suggestions to improve each practice's performance on key outcomes, including cost of care, electronic clinical quality measures, beneficiary experience, and utilization measures. Suggestions could involve changes to the workflow of the practice, data entry by the practice into its relevant EHR and based on data that is made available to the CTO, via the CRISP Portal. This process may help in the success of annual clinical quality data submission, which is a requirement for both the CTO and the participating practice.	Quality Program Navigator	1 per CTO

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

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

Appendix C:

Business Associate Agreement between the CTO and the Practice

[Attached hereto]