MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

This Care Transformation Arrangement ("Arrangement") is between Holy Cross Health CTO, 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.

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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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<u>Appendix A</u>:

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, NQF 0004	Integrated behavioral health provided via collaborative care model (i.e., remote behavioral health-specific care managers with psychiatric oversight)	Behavioral Health Care Manager Psychiatrist	All Practices
Medication Management	Care Management 2.6	For patients engaged in care management, provide access to a pharmacist for comprehensive medication management services, including assessing the patient's medication therapy regimen, and developing and initiating a plan to address risks and offer potential alternatives.	Lead RN Care Manager Pharmacist (PharmD)	1 per 5 1 per 25
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	For patients engaged in care management, screen for social needs and provide navigation to community-based organizations and social services. Maintain a compendium of community-based and social service organizations, including current point of contact for referrals.	Lead RN Care Manager Community Health Worker Licensed Clinical Social Worker	1 per 5 1 per 10 1 per 25
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	Provide technical assistance with establishing processes for alternative care and telemedicine capabilities. Provide community health worker for home visits to assist with patient activation and self-management.	Practice Transformation Specialist Community Health Worker	1 per 10 1 per 10
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	Daily monitoring of real-time CRISP alerts for hospital, ED and SNF discharges; outreach to patients to schedule appointment, reconcile medication and provide education. Identification of patients who would benefit from episodic and longitudinal care management.	Lead RN Care Manager Care Coordination Assistant	1 per 5 1 per 5

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Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	Provide comprehensive care management for high- and rising-risk patients including: assess healthcare, educational, and psychosocial needs of the patient/family; collaborate with PCP and other care team member to develop individualized plan of care; provide patient/family education and support; and upload care alerts and care plans into CRISP. Offer training for practice staff in patient self-management support techniques; provide inventory of condition-specific self-management resources.	Lead RN Care Manager Care Coordination Assistant Practice Transformation Specialist Certified Diabetes Educator Licensed Clinical Social Worker	1 per 5 1 per 5 1 per 10 1 per 25 1 per 25
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	Provide technical assistance with optimizing EHR for panel management, including developing disease registry to monitor rising-risk patients, implementing care guideline templates when appropriate, and identifying and closing care gaps.	Care Coordination Assistant Practice Transformation Specialist	1 per 5 1 per 10
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	As data flows permit, leverage tools to provide quarterly risk stratification based on claims and EHR data. Provide technical assistance and support for utilizing CRISP to obtain real-time alerts on ED visits, hospital admissions and transfers to SNFs.	Care Coordination Assistant Practice Transformation Specialist	1 per 5 1 per 10
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	Provide technical assistance with implementation of semi-annual PFAC meeting, including identifying participants, developing committee charter, planning logistics and facilitating meeting.	Lead RN Care Manager Care Coordination Assistant Practice Transformation Specialist	1 per 5 1 per 5 1 per 10
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	Ongoing monitoring and analysis of quality and utilization metrics; facilitate monthly quality improvement meetings with practice staff; assist in identifying opportunities for improvement.	Care Coordination Assistant Practice Transformation Specialist	1 per 5 1 per 10
24/7 Access	Access & Continuity 1.2	Provide technical assistance with evaluating operational considerations for 24/7 access, assessing gaps and developing implementation plan.	Practice Transformation Specialist	1 per 10

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Referral Management	Comprehensiveness & Coordination 3.1	Creation of quarterly report from CRISP data detailing practice's referral patterns and associated costs. Technical assistance with executing care coordination agreements with high-value providers.	Care Coordination Assistant Practice Transformation Specialist	1 per 5 1 per 10

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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	Integrated behavioral health provided via collaborative care model (i.e., remote behavioral health-specific care managers with psychiatric oversight)	Behavioral Health Care Manager Psychiatrist	All Practices
Medication Management	Care Management 2.6	Identify potential patients for comprehensive medication management. Provide technical assistance for practice-led endeavors around medication management.	Care Coordination Assistant Practice Transformation Specialist	1 per 5 1 per 10
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	Provide technical assistance with workflows to implement screening for health-related social needs. Maintain a compendium of community-based and social service organizations, including current point of contact for referrals.	Practice Transformation Specialist	1 per 10
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	Provide technical assistance with establishing processes for alternative care and telemedicine capabilities.	Practice Transformation Specialist	1 per 10
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	Daily monitoring of real-time CRISP alerts for hospital, ED and SNF discharges. Provide technical assistance with development of workflows to support transitional care management visits.	Care Coordination Assistant Practice Transformation Specialist	1 per 5 1 per 10
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	Provide assistance with identifying potential patients for annual wellness visits, advanced illness management, and episodic and longitudinal care management. Offer training for practice staff in patient self-management support techniques; provide inventory of condition-specific self-management resources.	Care Coordination Assistant Practice Transformation Specialist	1 per 5 1 per 10
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	Provide technical assistance with optimizing EHR for panel management, including developing disease registry to monitor rising-risk patients, implementing care guideline templates when appropriate, and identifying and closing care gaps.	Care Coordination Assistant Practice Transformation Specialist	1 per 5 1 per 10

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Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	As data flows permit, leverage tools to provide quarterly risk stratification based on claims and EHR data. Provide technical assistance and support for utilizing CRISP to obtain real-time alerts on ED visits, hospital admissions and transfers to SNFs.	Care Coordination Assistant Practice Transformation Specialist	1 per 5 1 per 10
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	Provide technical assistance with implementation of PFAC meeting, including developing committee charter, and materials and guidance to help practice facilitate PFAC.	Practice Transformation Specialist	1 per 10
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	Ongoing monitoring and analysis of quality and utilization metrics; facilitate monthly quality improvement meetings with practice staff; assist in identifying opportunities for improvement.	Care Coordination Assistant Practice Transformation Specialist	1 per 5 1 per 10
24/7 Access	Access & Continuity 1.2	Provide technical assistance with evaluating operational considerations for 24/7 access, assessing gaps and developing implementation plan.	Practice Transformation Specialist	1 per 10
Referral Management	Comprehensiveness & Coordination 3.1	Provide technical assistance with workflows and reporting capabilities to identify high-value specialists and track referrals.	Practice Transformation Specialist	1 per 10

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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]

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