MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

This Care Transformation Arrangement ("Arrangement") is between Netrin Accountable Care, 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	Access to psychiatrist for CoCM assistance and maintenance with establishment of the primary care behaviorist model . Netrin uses predictive analytics using two models to identify patients that need BHI. This is in addition to any referrals from the PCPs. Conduct regular multidisciplinary team huddles to review cases on a periodic basis to optimize CoCM.; All protocols and methodologies for all categories are reviewed and categorized with Physician input.	Psychiatrist BHI Care Manager Patient Care Navigator	1 per 20 practices 1 per 5 practices 1 per 8 practices
Medication Management	Care Management 2.6	Netrin's Pharmacists assigned to high risk patients reviews the medication lists and identify intervention. Pharmacist may also be requested to perform some level of virtual medication reconciliation post discharge. Based on PCP's request, We will have periodic virtual huddles with the practices on demand.; Pharmacist reviews the medications for certain frequent fliers and reviews the medications. All protocols and methodologies for all categories are reviewed and categorized with Physician input. Netrin also reviews areas of optimization of using Generics where applicable with Physician oversight and without impacting efficacy.	Pharmacist Patient Care Navigator	1 per 20 practices 1 per 8 practices
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	Netrin has integrated with the Social Determinants of health using Netrin's Care Management framework. Netrin currently captures this data real-time from the Care Management system. Identification and establishment of social service resources and ongoing updating of these resources. Maintaining a social service resource contact for point of care referrals. Adding all the Social Determinants of Health screening questions at the point of care system. These are also asked by the Care Team during the Care Team visits (virtual) with the patients. We integrate with Aunt Bertha and Netrin's Social Connect to get the patients the right community level resource. Netrin uses this information to connect with the right resources in the community to address the relevant SDOH.	Lead Care Manager Patient Care Navigator Community Health Worker	1 per 10 practices 1 per 8 practices 1 per 10 practices
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	Netrin has integrated Virtual visits into its existing Care Management Process and tools. Netrin has been using some of the Telehealth / Virtual Visits under its existing Chronic Care Management services. Netrin also has extended providers that provide Home Visits to the patients as required using evidence based guidelines.; Netrin has created the Telehealth module technology. This works on Mobile devices and Care Management Consoles. Netrin has the ability to integrate other remote patient monitoring devices. In addition to the virtual Care Team, Netrin provides the Community Health Worker for potential home visits by the patient. Netrin is piloting remote patient monitoring for Diabetes & Hypertension patients in partnership with remote patient monitoring devices.	CHW Lead Care Manager Patient Care Navigator Remote Patient Monitoring	1 per 10 practices 1 per 10 practices 1 per 8 practices
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	Netrin team can monitor the ENS notifications from CRISP to enable Transition Care Management. Netrin Identifies patients being discharged from hospital and ED, Conduct transitional care visit. We will also conduct some level of medical reconciliation for the TCM visits. We will review any gaps in care and update this information in the practice EMR where applicable. This will minimize any gaps in Care. We will ensure timely appointments with the PCP practice under the practice guidelines. We will activate the TCM based on CRISP Encounter Notification Services. ENS notifications create alerts to the Care Team.	Lead Care Manager Pharmacist Patient Care Navigator	1 per 5 practices 1 per 15 practices 1 per 8 practices
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	Netrin provides Care Management to patients based on three mechanisms. First level is based on any referrals from the practices. Second level is based on predictive analytics and tools created by Netrin. Netrin uses the HCC Risk scoring, ACG Risk, and Netrin's proprietary color coded models to refer patients to our Care Management teams. Third is based on the patients that we touch as part of the ENS/TCM visits.; Netrin utilizes multiple ways of engaging patients into Care Planning. Netrin uses the various predictive analytics to identify patients that need care management services. Netrin also has mechanisms for practices to direct patients into Care Management services. Netrin constantly monitors the patient experience and Care give experience at all stages of the process on a periodic basis. Care Team huddle prioritizes the patients on a periodic basis.	Lead Care Manager Patient Care Navigator Community Health Worker Pharmacist	1 per 5 practices 1 per 8 practices 1 per 10 practices 1 per 20 practices

Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	Netrin leverages 2 different Population Health Analytics tools. Netrin is able to consume the claims data, clinical data and the social determinants of health data within its data infrastructure.; Netrin leverage robotic process automation tools where applicable to get data entered into the alerts systems. Netrin loads the Cost and Utilization data within our data system.	Population Health Data Analyst Data Scientist Data Integration Analyst Clinical Data Analyst	All practices
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	Netrin has the ability for direct extract or robotic process automation techniques to gather data from various clinical systems. Practice would need to give access to their practice EMR systems for Netrin to access. Netrin is able to load the CCLF files if made available. If the Practice is also on the Netrin ACO, Netrin is able to have access to all the CCLF data for all the Medicare lives attributed to the practices.; Netrin team has access to the CRISP CRS as well as the Netrin Care Management Module. Netrin gathers the data from the CRISP CRS and creates data uploads the Netrin home grown Care Management. Netrin creates 3 flavors of Care Management. Netrin also integrates the social determinants of health data.	Population Health Data Analyst Data Scientist Data Integration Analyst Clinical Data Analyst	All Practices
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	Netrin is working on a PFAC that will enable practices to fulfill a critical care delivery program requirement of many current alternative payment models. Netrin is helping rolling out Creating a PFAC for all the participating practices. . Netrin will assess the Practice's readiness for partnering with patients and their families. Netrin selects the PFAC Coordinator and prepares clinician and staff for PFAC collaboration. Netrin will define the PFAC's Purpose, Structure and Membership selecting the PFAC.	Patient Care Navigator Medical Director Lead Care Manager	1 per 15 practices 1 for all practices 1 per 5 practices
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	CTO will consistently track and measure the cost, utilization and Quality performance 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. CTO is rolling out new custom dashboards for each practice in the MDPCP program to track.	Data Analyst Clinical Quality Data Analyst Medical Director	1 Per 15 practices 1 for 15 practices 1 for all practices
24/7 Access	Access & Continuity 1.2	Patients will have 24x7 Access the Care team. Netrin staff will have 24x7 Access to the patient medical record. Netrin Care Team also have 24x7 Telemedicine / Secure Video conferencing module.	Lead Care Manager Patient Care Navigator	All practices
Referral Management	Comprehensiveness & Coordination 3.1	Netrin's team acts as a gate keeps for the patients attributed to their ACO.	Lead Care Manager Patient Care Navigator Community Health Worker Pharmacist	All practices
Other	Social Determinants of Health Data Capture	Netrin Team is getting the social risk score of the patients.	Netrin eCare System Lead Care Manager Patient Care Navigator	All practices
Other	Telehealth	Netrin has access to Telehealth. This module is leveraged communicating to the patients and their families.	Netrin Telehealth Lead Care Manager Patient Care Navigator	All practices
Other	E M R – Template Optimization	Netrin would create / optimize the templates for the EMR at the practices. This would help capture the relevant data during the Annual Wellness Vists, Transition Care Management visits, General Care Management vists. This would help in capturing the relevant data for the quality measure reporting for the ACO and the CTO.	E H R Optimization Analyst	1 for every 10 Practices
Other	H C C Training	Netrin would train the practice staff on HCCs.	Value Based Care Training	All practices
Other	Workflow Analysis / Process Optimization	Netrin would assess the existing process and perform a process optimization for the practice.	Process Optimization Consultant	All practices.

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	Access to psychiatrist for CoCM assistance and maintenance with establishment of the primary care behaviorist model . Netrin uses predictive analytics using two models to identify patients that need BHI. This is in addition to any referrals from the PCPs. Conduct regular multidisciplinary team huddles to review cases on a periodic basis to optimize CoCM. All protocols and methodologies for all categories are reviewed and categorized with Physician input.	Psychiatrist BHI Care Manager Patient Care Navigator	1 per 20 practices 1 per 5 practices 1 per 8 practices
Medication Management	Care Management 2.6	Netrin's Pharmacists assigned to high risk patients reviews the medication lists and identify intervention. Pharmacist may also be requested to perform some level of virtual medication reconciliation post discharge. Based on PCP's request, We will have periodic virtual huddles with the practices on demand.; Pharmacist reviews the medications for certain frequent fliers and reviews the medications. All protocols and methodologies for all categories are reviewed and categorized with Physician input. Netrin also reviews areas of optimization of using Generics where applicable with Physician oversight and without impacting efficacy.	Pharmacist Patient Care Navigator	1 per 20 practices 1 per 8 practices
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	Netrin has integrated with the Social Determinants of health using Netrin's Care Management framework. Netrin currently captures this data real-time from the Care Management system. Identification and establishment of social service resources and ongoing updating of these resources. Maintaining a social service resource contact for point of care referrals. Adding all the Social Determinants of Health screening questions at the point of care system. These are also asked by the Care Team during the Care Team visits (virtual) with the patients. We integrate with Aunt Bertha and Netrin's Social Connect to get the patients the right community level resource.; Netrin uses this information to connect with the right resources in the community to address the relevant SDOH.	Lead Care Manager Patient Care Navigator Community Health Worker	1 per 10 practices 1 per 8 practices 1 per 10 practices
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	Netrin has integrated Virtual visits into its existing Care Management Process and tools. Netrin has been using some of the Telehealth / Virtual Visits under its existing Chronic Care Management services. Netrin also has extended providers that provide Home Visits to the patients as required using evidence based guidelines.; Netrin has created the Telehealth module technology. This works on Mobile devices and Care Management Consoles. Netrin has the ability to integrate other remote patient monitoring devices. In addition to the virtual Care Team, Netrin provides the Community Health Worker for potential home visits by the patient. Netrin is piloting remote patient monitoring for Diabetes & Hypertension patients in partnership with remote patient monitoring devices.	CHW Lead Care Manager Patient Care Navigator Remote Patient Monitoring Device	1 per 10 practices 1 per 10 practices 1 per 8 practices
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	Netrin team can monitor the ENS notifications from CRISP to enable Transition Care Management.; Netrin Identifies patients being discharged from hospital and ED, Conduct transitional care visit. We will also conduct some level of medical reconciliation for the TCM visits. We will review any gaps in care and update this information in the practice EMR where applicable. This will minimize any gaps in Care. We will ensure timely appointments with the PCP practice under the practice guidelines. We will activate the TCM based on CRISP Encounter Notification Services. ENS notifications create alerts to the Care Team.	Lead Care Manager Pharmacist Patient Care Navigator	1 per 5 practices 1 per 15 practices 1 per 8 practices
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	Netrin provides Care Management to patients based on three mechanisms. First level is based on any referrals from the practices. Second level is based on predictive analytics and tools created by Netrin. Netrin uses the HCC Risk scoring, ACG Risk, and Netrin's proprietary color coded models to refer patients to our Care Management teams. Third is based on the patients that we touch as part of the ENS/TCM visits.; Netrin utilizes multiple ways of engaging patients into Care Planning. Netrin uses the various predictive analytics to identify patients that need care management services. Netrin also has mechanisms for practices to direct patients into Care Management services. Netrin constantly monitors the patient experience and Care give experience at all stages of the process on a periodic basis. Care Team huddle prioritizes the patients on a periodic basis.	Lead Care Manager Patient Care Navigator Community Health Worker Pharmacist	1 per 8 practices 1 per 8 practices 1 per 10 practices 1 per 20 practices
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	Netrin leverages 2 different Population Health Analytics tools. Netrin is able to consume the claims data, clinical data and the social determinants of health data within its data infrastructure.; Netrin leverage robotic process automation tools where applicable to get data entered into the alerts systems. Netrin loads the Cost and Utilization data within our data system.	Population Health Data Analyst Data Scientist Data Integration Analyst Clinical Data Analyst	All practices

Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	Netrin has the ability for direct extract or robotic process automation techniques to gather data from various clinical systems. Practice would need to give access to their practice EMR systems for Netrin to access. Netrin is able to load the CCLF files if made available. If the Practice is also on the Netrin ACO, Netrin is able to have access to all the CCLF data for all the Medicare lives attributed to the practices. Netrin team has access to the CRISP CRS as well as the Netrin Care Management Module. Netrin gathers the data from the CRISP CRS and creates data uploads the Netrin home grown Care Management. Netrin creates 3 flavors of Care Management. Netrin also integrates the social determinants of health data.	Population Health Data Analyst Data Scientist Data Integration Analyst Clinical Data Analyst	All Practices
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	Netrin is working on a PFAC that will enable practices to fulfill a critical care delivery program requirement of many current alternative payment models. Netrin is helping rolling out Creating a PFAC for all the participating practices. . Netrin will assess the Practice's readiness for partnering with patients and their families. Netrin selects the PFAC Coordinator and prepares clinician and staff for PFAC collaboration. Netrin will define the PFAC's Purpose, Structure and Membership selecting the PFAC.	Patient Care Navigator Medical Director Lead Care Manager	1 per 15 practices 1 for all practices 1 per 5 practices
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	CTO will consistently track and measure the cost, utilization and Quality performance 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. CTO is rolling out new custom dashboards for each practice in the MDPCP program to track.	Data Analyst Clinical Quality Data Analyst Medical Director	1 Per 15 practices 1 for 15 practices 1 for all practices
24/7 Access	Access & Continuity 1.2	Patients will have 24x7 Access the Care team. Netrin staff will have 24x7 Access to the patient medical record. Netrin Care Team also have 24x7 Telemedicine / Secure Video conferencing module.	Lead Care Manager Patient Care Navigator	All practices
Referral Management	Comprehensiveness & Coordination 3.1	Netrin's team acts as a gate keeps for the patients attributed to their ACO.	Lead Care Manager Patient Care Navigator Community Health Worker Pharmacist	All practices
Other	Social Determinants of Health Data Capture	Netrin Team is getting the social risk score of the patients.	Netrin eCare System Lead Care Manager Patient Care Navigator	All practices
Other	E M R – Template Optimization	Netrin would create / optimize the templates for the EMR at the practices. This would help capture the relevant data during the Annual Wellness Vists, Transition Care Management visits, General Care Management vists. This would help in capturing the relevant data for the quality measure reporting for the ACO and the CTO.	E H R Optimization Analyst	1 for every 10 Practices
Other	H C C Training	Netrin would train the practice staff on HCCs.	Value Based Care Training	All practices
Other	Workflow Analysis / Process Optimization	Netrin would assess the existing process and perform a process optimization for the practice.	Process Optimization Consultant	All practices.

*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 (50%)

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]