MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

This Care Transformation Arrangement ("Arrangement") is between _____, a care transformation organization (the "CTO"), and _____, a Federally Qualified Health Center (FQHC) (the "FQHC") (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 FQHC is a Federally Qualified Health Center 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 FQHC 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 FQHC must sign an MDPCP Participation Agreement with CMMI (the "FQHC Participation Agreement"). If either Party does not sign a Participation Agreement with CMMI prior to the Effective Date of this Arrangement, then this Arrangement shall be deemed null ab initio.

2. *Effective Date*. The Effective Date of this Arrangement is January 1, 2025. A Party's performance obligations under this Arrangement shall not begin prior to the Effective Date.

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

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

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

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

7. *Data Sharing and Privacy*. The FQHC 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 FQHC. The FQHC authorizes the CTO to have access via CRISP to quality and utilization reports available to the FQHC. The CTO will include a Business Associate Agreement ("BAA") for the FQHC to approve. The BAA will govern their data sharing, use, and confidentiality, a copy of which is in Appendix C. Each Party will comply with HIE policies and regulations, including patient education requirements, and will execute any separate agreement that may be required by CRISP.

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

9. *No Remuneration Provided*. Neither the CTO nor the FQHC 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 FQHC 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 FQHC will continue to be bound by the terms of the FQHC 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 FQHC 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 FQHC Participation Agreement.

13. *Copies and Retention of Arrangement*. The FQHC 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 FQHCs within the same service option level and Track, as specified in Section 4 of this Arrangement.

15. *Provision of CTO Services.* The CTO will offer to provide CTO Services to all participating FQHC sites listed in Appendix D, as needed and requested by the FQHC.

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

FOR THE CARE TRANSFORMATION ORGANIZATION:	**FOR THE FQHC:**
_____	_____
Signature	Signature
_____	_____
Printed Name	Printed Name
_____	_____
MDPCP CTO ID	MDPCP FQHC ID

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_____	_____
Title	Title
_____	_____
Date Signed	Date Signed

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Appendix A:

Care Transformation Requirements

Comprehensive Primary Care Functions of Advanced Primary Care	MDPCP Track 2 and Track 3 Practices Must Meet the Following Care Transformation Requirements
Access and Continuity	1.1 Empanel MDPCP Beneficiaries to MDPCP Practitioner or care team.
	1.2 Ensure MDPCP Beneficiaries have 24/7 access to a care team or MDPCP Practitioner with real-time access to the beneficiary's EHR.
	1.4 Ensure MDPCP Beneficiaries have regular access to the care team or MDPCP Practitioner through at least two alternative care strategies, in addition to telehealth.
Care Management	2.1 Ensure all empaneled, MDPCP Beneficiaries are risk stratified .
	2.2a.Ensure all empaneled MDPCP Beneficiaries identified as increased risk and likely to benefit receive targeted, proactive, relationship-based (longitudinal) care management.
	2.5 Ensure empaneled MDPCP Beneficiaries receive a follow-up interaction from the MDPCP Practice within one week for ED discharges and two business days for hospital discharges.
	2.2b. Ensure targeted, attributed beneficiaries who have received follow-up after ED, hospital discharge, or other triggering events receive short-term (episodic) care management.
	2.3 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.
	2.6 Ensure attributed beneficiaries in longitudinal care management have access to comprehensive medication management.
Comprehensiveness and Coordination Across the Continuum of Care	3.1 Ensure coordinated referral management for MDPCP Beneficiaries seeking care from high-volume and/or high-cost specialists as well as EDs and hospitals.
	3.3 Ensure MDPCP 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 MDPCP Beneficiaries by the MDPCP Practice.
	3.4 Facilitate access to resources that are available in the MDPCP Practice's community for MCPCP Beneficiaries with identified health-related social needs
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.
	4.2 Engage attributed beneficiaries and caregivers in a collaborative process for advance care planning
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.

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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 3.3			
Medication Management	Care Management 2.6			
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.4			
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.4			
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6			
Care Planning & Self-Management Support	Care Management 2.4, Beneficiary & Caregiver Experience 4.1			
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization			
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization			
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1			
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs			
24/7 Access	Access & Continuity 1.2			
Referral Management	Comprehensiveness & Coordination 3.1			
Other				

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Package B (50%)

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.3			
Medication Management	Care Management 2.6			
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.4			
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.4			
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6			
Care Planning & Self-Management Support	Care Management 2.4, Beneficiary & Caregiver Experience 4.1			
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization			
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization			
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1			
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs			
24/7 Access	Access & Continuity 1.2			
Referral Management	Comprehensiveness & Coordination 3.1			
Other				

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Package C (50%)

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.3			
Medication Management	Care Management 2.6			
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.4			
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.4			
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6			
Care Planning & Self-Management Support	Care Management 2.4, Beneficiary & Caregiver Experience 4.1			
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization			
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization			
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1			
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs			
24/7 Access	Access & Continuity 1.2			
Referral Management	Comprehensiveness & Coordination 3.1			
Other				

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Example Package D (30%)*

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.3			
Medication Management	Care Management 2.6			
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.4			
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.4			
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6			
Care Planning & Self-Management Support	Care Management 2.4, Beneficiary & Caregiver Experience 4.1			
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization			
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization			
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1			
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs			
24/7 Access	Access & Continuity 1.2			
Referral Management	Comprehensiveness & Coordination 3.1			
Other				

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

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Example Package E (30%)*

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.3			
Medication Management	Care Management 2.6			
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.4			
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.4			
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6			
Care Planning & Self-Management Support	Care Management 2.4, Beneficiary & Caregiver Experience 4.1			
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization			
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization			
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1			
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs			
24/7 Access	Access & Continuity 1.2			
Referral Management	Comprehensiveness & Coordination 3.1			
Other				

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

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Example Package F (30%)*

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.3			
Medication Management	Care Management 2.6			
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.4			
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.4			
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6			
Care Planning & Self-Management Support	Care Management 2.4, Beneficiary & Caregiver Experience 4.1			
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization			
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization			
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1			
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs			
24/7 Access	Access & Continuity 1.2			
Referral Management	Comprehensiveness & Coordination 3.1			
Other				

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

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Final FQHC Selection

- □ Package A (50%)
- □ Package B (50%)
- □ Package C (50%)
- □ Package D (30%)
- □ Package E (30%)
- □ Package F (30%)

FQHC Signature _____ CTO Signature _____

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Appendix C:

Business Associate Agreement between the CTO and the FQHC.
Required regardless of ownership status.

[Attached hereto]

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Appendix D:

List of FQHC sites