MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT [SAMPLE]

This Care Transformation Arrangement ("Arrangement") is between _____Healthlincs___, a care transformation organization (the "CTO"), and _____, (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 January 1, 2021.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 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 the Practice's selection that was submitted to CMS, the CMF payment split will be as follows:
   - ☐ CTO will receive **30%** of the practice's CMF payment amount calculated by CMS, and the remaining **70%** of such CMF payment amount will be paid to the Practice.
   - ☐ CTO will receive **50%** of the practice's CMF payment amount calculated by CMS and the remaining **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. Practice will identify care manager responsible for working with the CTO.

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 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 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:

_____
Signature

_____
Printed Name

_____
MDPCP CTO ID

_____
Title

_____
Date Signed

FOR THE PRACTICE:

_____
Signature

_____
Printed Name

_____
MDPCP Practice ID

_____
Title

_____
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%)

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2	Provide BH screening & care management based on the BH Care Manager Model; & partner with vendors for additional BH resources based on patients' needs	Mental Health Care Manager (MHCM) Licensed Clinical Social Worker (Partner) Psychiatrist (Partner)	1 per 5 practices 1 per 10 practices 1 per 10 practices
Medication Management	Care Management 2.6	Conduct Medication Reconciliation for complex and high-risk patients' in LCM & ECM; and provide education on medication adherence. Also collaborate with Primary Care Physician (PCP) as needed	Lead Care Manager, RN	1 per 5 practices
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	Screen LCM & ECM patients for social needs (barriers to care), then establish & implement intervention plans to address their social needs. Also maintain an inventory of social needs resource & share with other practice staff.	Community Health Worker (CHW)	1 per 5 practices
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	Provide home visits to address social needs	Community Health Worker (CHW)	1 per 5 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 using CRISP ENS. Conduct transitional care management. Also provide automated calling to triage for post-discharge follow up	Lead Care Manager, RN Outreach vendor	1 per 5 practices 1 for 10 practices
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	Identify & assess patients for longitudinal care management (@least 5% of high-risk patients); and develop care plans for them. Provide targeted, proactive care management inclusive of addressing patient's goals, medical and psychosocial needs & self-management support.	Lead Care Manager, RN Community Health Worker (CHW)	1 per 5 practices 1 per 5 practices
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	Target and track performance on required key outcomes monthly, quarterly, annually	Quality Improvement (QI) Specialist Data Analyst (DA)	1 per 15 practices 1 per 15 practices

Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	Target and track performance compliance for episodic care, longitudinal care, behavioral health, eCQMs, utilization monthly, quarterly, annually	Quality Improvement (QI) Specialist Data Analyst (DA) Lead Care Manager, RN	1 per 15 practices 1 per 15 practices 1 per 5 practices
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	Identify beneficiaries and care givers and establish PFAC. Support with coordinate PFAC meetings	Transformation Consultant Lead Care Manager, RN Community Health Worker (CHW)	1 per 15 practices 1 per 5 practices 1 per 5 practices
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	Support with process improvement using PDSA. Target and track performance on required key outcomes. Initiate QI corrective action based on verified reliable monthly, quarterly data	Quality Improvement (QI) Specialist Data Analyst (DA) Lead Care Manager, RN	1 per 15 practices 1 per 15 practices 1 per 5 practices
24/7 Access	Access & Continuity 1.2	Train practice staff/PCP with ensuring Care Team 24/7 access to Practice's EHR.	Transformation Consultant IT Specialist	1 per 15 practices 1 per 15 practices
Referral Management	Comprehensiveness & Coordination 3.1	Identify high volume, high cost specialist and ED usage, and support practice to establish care collaboratives as needed. Coordinate referrals especially for patient receiving longitudinal care management geared to reduce utilization	Data Analyst (DA) Lead Care Manager, RN	1 per 15 practices 1 per 5 practices

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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 3.2	Support Practice BH care Manager with behavioral health screening & refer for care management and other patient's needs.	Support Care Coordinator (CC)	1 per 5 practices
Medication Management	Care Management 2.6	Support Practice Lead Care Manager with review of complex and high-risk patients' medication lists and refer for medication reconciliation.	Support Care Coordinator (CC)	1 per 5 practices
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	Screen LCM patients for social needs (barriers to care), then establish & implement intervention plans to address their social needs. Also maintain an inventory of social needs resource & share with other practice staff.	Community Health Worker (CHW)	1 per 5 practices
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	Provide home visits to address social needs for assigned patients	Community Health Worker (CHW)	1 per 5 practices
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	Support with outreach of patients with episodic / transitional care	Support Care Coordinator (CC)	1 per 5 practices
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	Provide training to Practice Lead care manager on Longitudinal care management and care planning	Care Manager	1 per 5 practices
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	Support Practice Quality Lead to review performance with care team on required key outcomes and advise on quality improvement initiatives	Quality Improvement (QI) Specialist	1 per 15 practices
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	Support Practice Quality Lead to review performance with care team on required key outcomes and advise on quality improvement initiatives	Quality Improvement (QI) Specialist	1 per 15 practices
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	Support Practice Manager/Lead with identifying beneficiaries and caregivers and establish PFAC. Support with coordinate PFAC meetings	Community Health Worker (CHW)	1 per 5 practices

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Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	Train practice on quality improvement process and provide guidance as needed	Quality Improvement (QI) Specialist	1 per 15 practices
24/7 Access	Access & Continuity 1.2	Train practice staff on importance of Care Team 24/7 access to Practice's EHR.	Transformation Consultant	1 per 15 practices
Referral Management	Comprehensiveness & Coordination 3.1	Train practice staff/PCP on identifying high volume, high cost specialist and ED usage, and establishing care collaboratives as needed.	Transformation Consultant	1 per 15 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 _____ CTO Signature _____

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Appendix C:

Business Associate Agreement between the CTO and the Practice

[Attached hereto]