MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

This Care Transformation Arrangement ("Arrangement") is between **St. Agnes HealthCare Inc. DBA Ascension Saint Agnes Community Health Partners,** 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, 2023. 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. *CTO Payment Split*. CMS will calculate the Practice's Care Management Fees ("CMF"), Health Equity Advancement and Resource Transformation ("HEART") payment, and Population-Based Payment ("PBP"), as applicable, according to the CTO Participation Agreement, the Practice Participation Agreement, and the Payment Methodologies described therein. In accordance with the Practice's selection that was submitted to CMS, the payment split will be as follows:
   - □ **Option 1: CTO provides Lead Care Manager**
     - o For Track 1 and Track 2 practices, the CTO will receive **50%** of the practice's CMF payment amount calculated by CMS (including HEART payment), and the remaining **50%** of such CMF payment amount will be paid to the partner Practice.
     - o For Track 3 practices, the CTO will receive **40%** of the PBP payment and the HEART payment, and the remaining **60%** of the PBP and the HEART payment will be paid to the partner Practice.
   - X **Option 2: Practice provides Lead Care Manager**
     - o For Track 1 and Track 2 practices, the CTO will receive **30%** of the practice's CMF payment amount calculated by CMS (including HEART payment) and the remaining **70%** of such CMF payment amount will be paid to the partner Practice.
     - o For Track 3 practices, the CTO will receive **24%** of the PBP and HEART payment, and the remaining **76%** of the PBP and HEART payment will be paid to the partner Practice.

6. *Lead Care Manager*. For practices choosing Option 1, 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 Option 2, 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 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:	**FOR THE PRACTICE:**
______________________	______________________
Signature	Signature
Mitchell Lomax	J. William Cook IV, MD
Printed Name	Printed Name

MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

Chief Financial Officer	President and Dyad Leader, Ascension Medical Group
Title	Title
CTO0166	______________________________
MDPCP CTO ID	MDPCP Practice ID
Ascension Saint Agnes Community Health Partners	
MDPCP CTO Name	MDPCP Practice Name
______________________________	______________________________
Date Signed	Date Signed

MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

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.	Tracks 1, 2, 3
	1.2 Ensure attributed beneficiaries have 24/7 access to a care team or practitioner with real-time access to the EHR.	Tracks 1, 2, 3
	1.3 Ensure attributed beneficiaries have regular access to the care team or practitioner through at least one alternative care strategy.	Tracks 2 & 3only
Care Management	2.1 Ensure all empaneled, attributed beneficiaries are risk stratified.	Tracks 1, 2, 3
	2.2 Ensure all attributed beneficiaries identified as increased risk and likely to benefit receive targeted, proactive, relationship-based (longitudinal) care management.	Tracks 1, 2, 3
	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.	Tracks 1, 2, 3
	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.	Tracks 1, 2, 3
	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.	Tracks 2 & 3only
	2.6 Ensure attributed beneficiaries in longitudinal care management have access to comprehensive medication management.	Tracks 2 & 3only
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.	Tracks 1, 2, 3
	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	Tracks 1, 2, 3
	3.3 Facilitate access to resources that are available in your community for beneficiaries with identified health-related social needs	Tracks 2 & 3 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.	Tracks 1, 2, 3
	4.2 Engage attributed beneficiaries and caregivers in a collaborative process for advance care planning	Tracks 2 & 3 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.	Tracks 1, 2, 3

MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

Appendix B:

CTO Services/Personnel Offered and Practice Selection

Package A (Option 1: CTO provides Lead Care Manager (50/50% for T1 & T2, 40/60% for T3))

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2	● CTO Care Management staff will offer navigation of behavioral health linkages and resources when appropriate. ● CTO will provide support for practices to develop their capabilities to deliver behavioral health services ● CTO Care Management Team will utilize SBIRT Screening tools, PHQ-2 and if needed PH-9 and refer/link patients to the appropriate services.	● RN Care Manager	1:2,000 patients
Medication Management	Care Management 2.6	● Upon the request of the participating practice, Pharmacist will work directly with RN Care managers to identify quality improvement opportunities as it relates to medication. ● Participating practice will refer patients with medical management needs to RN Care Management for further assessment. If appropriate, the Care Management team will facilitate all referrals to CTO's pharmacy services.	● Program Coordinator ● Pharmacist ● RN Care Manager	● All practices ● All practices ● 1:2,000 patients
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	● CTO will provide Community Resource Guide to practice upon completion of CTO agreement; additional copies can be provided upon request from practice. These will be reviewed, updated, and maintained quarterly. ● CTO will assist practice with the development of internal Social Determinants of Health Screening workflows and processes. ● CTO has integrated Social Determinants of Health Screening into our Care Management Standards of Work and Processes.	● Program Coordinator ● RN Care Manager	● 1:2,000 patients ● 1:2,000 patients
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	● CTO has integrated virtual and telephonic visits into our existing Care Management Standards of Work and Procedures. ● CTO will provide telehealth educational materials upon request of the practice.	●Program Coordinator	● All practices

Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	● CTO Care Manager will utilize Pre-AH reports to track and engage high-risk patients for Care Management Services. ● CTO Care Management Team will monitor CRISP ENS notifications to identify patients in need of Transition of Care follow up visits. ● Practice will provide CTO access to their EMR. ● CTO Care Management Team will complete medication reconciliation for Transition of Care visit as needed. ● CTO Care Management Team will enroll appropriate beneficiaries in care management services as needed after the completion of transition of care communications.	● RN Care Manager	● 1:2,000 patients
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	● CTO Care management team will utilize the list of risk stratified patients in CRISP to provide targeted outreach to high risk patients. ● CTO will accept direct referral from providers for care management services. ● As part of the enrollment workflow, the CTO Care Management team will educate patients and caregivers on Advanced Care Planning and assist as needed with the completion of paperwork. Copies of completed Advanced Directive will be provided to providers.	● RN Care Manager	● 1:2,000 patients
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	● Based upon the data provided by the practice the CTO will provide assessment on utilization and offer recommendations in line with current best practice.	● Quality and Transformation Analytics Team	● All Practices
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	● Practice will provide CTO access to their practice EMR. ● Practice will facilitate access for CTO to CRISP CRS. ● Practice is responsible for ensuring their patient panel is updated every 90 days via CRISP Direct Mail. ● CTO will assist practice in tracking and evaluating beneficiary utilization, cost, and quality performance. ● CTO will provide guidance as needed to improve the practice's clinical quality metrics and operational performance.		

Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	● CTO will provide templates for PFAC Membership Agreement, PFAC Marketing Flyer, PFAC agenda. ● CTO will complete a PFAC readiness assessment to practice and develop PFAC development and implementation plan based on results. ● CTO will assist with facilitation (upon the request of the Practice) of PFAC. ● CTO will provide PFAC "How-To" planning document and tracking tool upon completion of CTO agreement.	● Program Coordinator	● 1:2,000 patients
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	● Practice will submit raw quality data/numbers to CTO by the close of each quarter. CTO will create and distribute a Quality Dashboard to show performance on the following measures:: Blood Pressure, HbA1c, Depression Screening, and BMI. ● Practice is responsible for collection and submission to the CTO of quality data from their EMR quarterly. ● Practice is responsible for managing internal data collection.	● Program Coordinator ● Quality Data Analyst	● 1:2,000 patients ● All practices
24/7 Access	Access & Continuity 1.2	● Practice will develop and maintain a call schedule that facilitates 24/7 access for patients to a care team or provider.	● Program Coordinator	● 1:2,000 patients
Referral Management	Comprehensiveness & Coordination 3.1	● CTO will coordinate timely and appropriate referrals to high quality specialists for patients enrolled in Care Management Services. ● CTO Care Management Team will educate practices as needed on utilization of high-cost specialists.	RN Care Manager	1:2,000 patients
Other		● CTO will provide a template for Book of Evidence documentation for each practice year. Recommendations for types of documentation necessary will be provided upon request of practice	Program Coordinator	All practices

MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

Package B (Option 1: CTO provides Lead Care Manager (50/50% for T1 & T2, 40/60% for T3))

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2	● CTO Care Management staff will offer navigation of behavioral health linkages and resources when appropriate. ● CTO will provide support for practices to develop their capabilities to deliver behavioral health services ● CTO Care Management Team will utilize SBIRT Screening tools, PH-Q2 and if needed PH-9 and refer/link patients to the appropriate services.	● RN Care Manager	1:2,000 patients
Medication Management	Care Management 2.6	● Upon the request of the participating practice, Pharmacist will work directly with RN Care managers to identify quality improvement opportunities as it relates to medication. ● Participating practice will refer patients with medical management needs to RN Care Management for further assessment. If appropriate, the Care Management team will facilitate all referrals to CTO's pharmacy services.	● Program Coordinator ● Pharmacist ● RN Care Manager	● All practices ● All practices ● 1:2,000 patients
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	● CTO will provide Community Resource Guide to practice upon completion of CTO agreement; additional copies can be provided upon request from practice. These will be reviewed, updated, and maintained by quarterly. ● CTO will assist practice with the development of internal Social Determinants of Health Screening workflows and processes. ● CTO has integrated Social Determinants of Health Screening into our Care Management Standards of Work and Processes.	● Program Coordinator ● RN Care Manager	● 1:2,000 patients ● 1:2,000 patients
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	● CTO has integrated virtual and telephonic visits into our existing Care Management Standards of Work and Procedures. ● CTO will provide telehealth educational materials upon request of the practice.	●Program Coordinator	● All practices

Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	● CTO Care Manager will utilize Pre-AH reports to track and engage high-risk patients for Care Management Services. ● CTO Care Management Team will monitor CRISP ENS notifications to identify patients in need of Transition of Care follow up visits. ● Practice will provide CTO access to their EMR. ● CTO Care Management Team will complete medication reconciliation for Transition of Care visit as needed. ● CTO Care Management Team will enroll appropriate beneficiaries in care management services as needed after the completion of transition of care communications.	● RN Care Manager	● 1:2,000 patients
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	● CTO Care management team will utilize the list of risk stratified patients in CRISP to provide targeted outreach to high risk patients. ● CTO will accept direct referral from providers for care management services. ● As part of the enrollment workflow, the CTO Care Management team will educate patients and caregivers on Advanced Care Planning and assist as needed with the completion of paperwork. Copies of completed Advanced Directive will be provided to providers.	● RN Care Manager	● 1:2,000 patients
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	● Based upon the data provided by the practice the CTO will provide assessment on utilization and offer recommendations in line with current best practice.	● Quality and Transformation Analytics Team	● All Practices
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	● Practice will provide CTO access to their practice EMR. ● Practice will facilitate access for CTO to CRISP CRS. ● Practice is responsible for ensuring their patient panel is updated every 90 days via CRISP Direct Mail. ● CTO will assist practice in tracking and evaluating beneficiary utilization, cost, and quality performance. ● CTO will provide guidance as needed to improve the practice's clinical quality metrics and operational performance.		

Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	● CTO will provide templates for PFAC Membership Agreement, PFAC Marketing Flyer, PFAC agenda. ● CTO will complete a PFAC readiness assessment to practice and develop PFAC development and implementation plan based on results. ● CTO will assist with facilitation (upon the request of the Practice) of PFAC. ● CTO will provide PFAC "How-To" planning document and tracking tool upon completion of CTO agreement.	● Program Coordinator	● 1:2,000 patients
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	● Practice will submit raw quality data/numbers to CTO by the close of each quarter. CTO will create and distribute a Quality Dashboard to show performance on the following measures:: Blood Pressure, HbA1c, Depression Screening, and BMI. ● Practice is responsible for collection and submission to the CTO of quality data from their EMR quarterly. ● Practice is responsible for managing internal data collection.	● Program Coordinator ● Quality Data Analyst	● 1:2,000 patients ● All practices
24/7 Access	Access & Continuity 1.2	● Practice will develop and maintain a call schedule that facilitates 24/7 access for patients to a care team or provider.	● Program Coordinator	● 1:2,000 patients
Referral Management	Comprehensiveness & Coordination 3.1	● CTO will coordinate timely and appropriate referrals to high quality specialists for patients enrolled in Care Management Services. ● CTO Care Management Team will educate practices as needed on utilization of high-cost specialists.	RN Care Manager	1:2,000 patients
Other		● CTO will provide a template for Book of Evidence documentation for each practice year. Recommendations for types of documentation necessary will be provided upon request of practice	Program Coordinator	All practices

MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

Package C (Option 1: CTO provides Lead Care Manager (50/50% for T1 & T2, 40/60% for T3))

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2	● CTO Care Management staff will offer navigation of behavioral health linkages and resources when appropriate. ● CTO will provide support for practices to develop their capabilities to deliver behavioral health services ● CTO Care Management Team will utilize SBIRT Screening tools, PH-Q2 and if needed PH-9 and refer/link patients to the appropriate services.	● RN Care Manager	1:2,000 patients
Medication Management	Care Management 2.6	● Upon the request of the participating practice, Pharmacist will work directly with RN Care managers to identify quality improvement opportunities as it relates to medication. ● Participating practice will refer patients with medical management needs to RN Care Management for further assessment. If appropriate, the Care Management team will facilitate all referrals to CTO's pharmacy services.	● Program Coordinator ● Pharmacist ● RN Care Manager	● All practices ● All practices ● 1:2,000 patients
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	● CTO will provide Community Resource Guide to practice upon completion of CTO agreement; additional copies can be provided upon request from practice. These will be reviewed, updated, and maintained by quarterly. ● CTO will assist practice with the development of internal Social Determinants of Health Screening workflows and processes. ● CTO has integrated Social Determinants of Health Screening into our Care Management Standards of Work and Processes.	● Program Coordinator ● RN Care Manager	● 1:2,000 patients ● 1:2,000 patients

Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	● CTO has integrated virtual and telephonic visits into our existing Care Management Standards of Work and Procedures. ● CTO will provide telehealth educational materials upon request of the practice.	●Program Coordinator	● All practices
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	● CTO Care Manager will utilize Pre-AH reports to track and engage high-risk patients for Care Management Services. ● CTO Care Management Team will monitor CRISP ENS notifications to identify patients in need of Transition of Care follow up visits. ● Practice will provide CTO access to their EMR. ● CTO Care Management Team will complete medication reconciliation for Transition of Care visit as needed. ● CTO Care Management Team will enroll appropriate beneficiaries in care management services as needed after the completion of transition of care communications.	● RN Care Manager	● 1:2,000 patients
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	● CTO Care management team will utilize the list of risk stratified patients in CRISP to provide targeted outreach to high risk patients. ● CTO will accept direct referral from providers for care management services. ● As part of the enrollment workflow, the CTO Care Management team will educate patients and caregivers on Advanced Care Planning and assist as needed with the completion of paperwork. Copies of completed Advanced Directive will be provided to providers.	● RN Care Manager	● 1:2,000 patients

Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	● Based upon the data provided by the practice the CTO will provide assessment on utilization and offer recommendations in line with current best practice.	● Quality and Transformation Analytics Team	● All Practices
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	● Practice will provide CTO access to their practice EMR. ● Practice will facilitate access for CTO to CRISP CRS. ● Practice is responsible for ensuring their patient panel is updated every 90 days via CRISP Direct Mail. ● CTO will assist practice in tracking and evaluating beneficiary utilization, cost, and quality performance. ● CTO will provide guidance as needed to improve the practice's clinical quality metrics and operational performance.		
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	● CTO will provide templates for PFAC Membership Agreement, PFAC Marketing Flyer, PFAC agenda. ● CTO will complete a PFAC readiness assessment to practice and develop PFAC development and implementation plan based on results. ● CTO will assist with facilitation (upon the request of the Practice) of PFAC. ● CTO will provide PFAC "How-To" planning document and tracking tool upon completion of CTO agreement.	● Program Coordinator	● 1:2,000 patients

Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	● Practice will submit raw quality data/numbers to CTO by the close of each quarter. CTO will create and distribute a Quality Dashboard to show performance on the following measures:: Blood Pressure, HbA1c, Depression Screening, and BMI. ● Practice is responsible for collection and submission to the CTO of quality data from their EMR quarterly. ● Practice is responsible for managing internal data collection.	● Program Coordinator ● Quality Data Analyst	● 1:2,000 patients ● All practices
24/7 Access	Access & Continuity 1.2	● Practice will develop and maintain a call schedule that facilitates 24/7 access for patients to a care team or provider.	● Program Coordinator	● 1:2,000 patients
Referral Management	Comprehensiveness & Coordination 3.1	● CTO will coordinate timely and appropriate referrals to high quality specialists for patients enrolled in Care Management Services. ● CTO Care Management Team will educate practices as needed on utilization of high-cost specialists.	RN Care Manager	1:2,000 patients
Other		● CTO will provide a template for Book of Evidence documentation for each practice year. Recommendations for types of documentation necessary will be provided upon request of practice	Program Coordinator	All practices

MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

Package D (Option 2: Practice provides Lead Care Manager (30/70% for T1 & T2, 24/76% for T3))*

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2	● CTO will provide support for practices to develop their capabilities to deliver behavioral health services. ● Upon request from the practice, CTO assist in the development of screening assessment tools and referrals workflows.	● Program Coordinator	All practices
Medication Management	Care Management 2.6	● Upon the request of the practice, the CTOŧs Pharmacist will be available to review the medications of 5Đ high risk patients and make appropriate recommendations focused on improving patient outcomes.	● Pharmacist	● All practices
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	● CTO will provide Community Resource Guide to practice upon completion of CTO agreement; additional copies can be provided upon request from practice. These will be reviewed/updated/maintained by CTO quarterly. ● Upon request, CTO will assist practice with the development and implementation of Social Determinants of Health Screening and associated workflows.	● Program Coordinator	1:2,000 patients
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	● CTO will provide telehealth educational materials upon request of practice.	● Program Coordinator	All practices
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	● Upon request of the practice, CTO will train office staff to complete the recommended transition of care best practice. ● Upon the request of the practice, CTO will connect practice with CRISP content expert and facilitate training for utilization of CRISP ENS portal.	● Program Coordinator	● 1:2,000 patients
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	n/a	n/a	n/a

Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	● Upon request and based upon the data provided by the practice, the CTO will provide assessment on utilization and offer recommendations in line with current best practice.	● Quality and Transformation Analytics team	● All practices
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	● Practice is responsible for ensuring their patient panel is updated every 90 days via CRISP Direct Mail. ● Upon request, CTO will assist practice with training and workflow development to track and evaluate beneficiary utilization, cost, and quality performance. ● Upon request, CTO will provide guidance as needed to improve the practice's clinical quality metrics and operational performance	● Program Coordinator ● Director of Care Transformation & Quality	● All practices ● All practices ● All practices
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	● CTO will provide PFAC readiness assessment to practice and provide recommendations designed to facilitate successful PFAC development and implementation.	● Program Coordinator	● All practices
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	● Upon request and based upon the data provided by the practice, CTO will assist practice with quarterly assessment of eCQM measures and provide suggestions for improvement opportunities with the goal of improving patient outcomes and reducing utilization.	● Quality and Transformation Analytics Team	● All practices
24/7 Access	Access & Continuity 1.2	● Practice will develop and maintain a call schedule that facilitates 24/7 access for patients to a care team or provider.	● Program Coordinator	● All practices
Referral Management	Comprehensiveness & Coordination 3.1	n/a	n/a	n/a
Other				

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

MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

Package E (Option 2: Practice provides Lead Care Manager (30/70% for T1 & T2, 24/76% for T3))*

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2	● CTO will provide support for practices to develop their capabilities to deliver behavioral health services. ● Upon request from the practice, CTO assist in the development of screening assessment tools and referrals workflows.	● Program Coordinator	All practices
Medication Management	Care Management 2.6	● Upon the request of the practice, the CTOɫs Pharmacist will be available to review the medications of 5Đ high risk patients and make appropriate recommendations focused on improving patient outcomes.	● Pharmacist	● All practices
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	● CTO will provide Community Resource Guide to practice upon completion of CTO agreement; additional copies can be provided upon request from practice. These will be reviewed/updated/maintained by CTO quarterly. ● Upon request, CTO will assist practice with the development and implementation of Social Determinants of Health Screening and associated workflows.	● Program Coordinator	1:2,000 patients
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	● CTO will provide telehealth educational materials upon request of practice.	● Program Coordinator	All practices
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	● Upon request of the practice, CTO will train office staff to complete the recommended transition of care best practice. ● Upon the request of the practice, CTO will connect practice with CRISP content expert and facilitate training for utilization of CRISP ENS portal.	● Program Coordinator	● 1:2,000 patients
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	n/a	n/a	n/a

Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	● Upon request and based upon the data provided by the practice, the CTO will provide assessment on utilization and offer recommendations in line with current best practice.	● Quality and Transformation Analytics team	● All practices
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	● Practice is responsible for ensuring their patient panel is updated every 90 days via CRISP Direct Mail. ● Upon request, CTO will assist practice with training and workflow development to track and evaluate beneficiary utilization, cost, and quality performance. ● Upon request, CTO will provide guidance as needed to improve the practice's clinical quality metrics and operational performance	● Program Coordinator ● Director of Care Transformation & Quality	● All practices ● All practices ● All practices
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	● CTO will provide PFAC readiness assessment to practice and provide recommendations designed to facilitate successful PFAC development and implementation.	● Program Coordinator	● All practices
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	● Upon request and based upon the data provided by the practice, CTO will assist practice with quarterly assessment of eCQM measures and provide suggestions for improvement opportunities with the goal of improving patient outcomes and reducing utilization.	● Quality and Transformation Analytics Team	● All practices
24/7 Access	Access & Continuity 1.2	● Practice will develop and maintain a call schedule that facilitates 24/7 access for patients to a care team or provider.	● Program Coordinator	● All practices
Referral Management	Comprehensiveness & Coordination 3.1	n/a	n/a	n/a
Other				

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

MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

Package F (Option 2: Practice provides Lead Care Manager (30/70% for T1 & T2, 24/76% for T3)) *

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2	● CTO will provide support for practices to develop their capabilities to deliver behavioral health services. ● Upon request from the practice, CTO assist in the development of screening assessment tools and referrals workflows.	● Program Coordinator	All practices
Medication Management	Care Management 2.6	● Upon the request of the practice, the CTOȿs Pharmacist will be available to review the medications of 5Đ high risk patients and make appropriate recommendations focused on improving patient outcomes.	● Pharmacist	● All practices
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	● CTO will provide Community Resource Guide to practice upon completion of CTO agreement; additional copies can be provided upon request from practice. These will be reviewed/updated/maintained by CTO quarterly. ● Upon request, CTO will assist practice with the development and implementation of Social Determinants of Health Screening and associated workflows.	● Program Coordinator	1:2,000 patients
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	● CTO will provide telehealth educational materials upon request of practice.	● Program Coordinator	All practices
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	● Upon request of the practice, CTO will train office staff to complete the recommended transition of care best practice. ● Upon the request of the practice, CTO will connect practice with CRISP content expert and facilitate training for utilization of CRISP ENS portal.	● Program Coordinator	● 1:2,000 patients
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	n/a	n/a	n/a

Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	● Upon request and based upon the data provided by the practice, the CTO will provide assessment on utilization and offer recommendations in line with current best practice.	● Quality and Transformation Analytics team	● All practices
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	● Practice is responsible for ensuring their patient panel is updated every 90 days via CRISP Direct Mail. ● Upon request, CTO will assist practice with training and workflow development to track and evaluate beneficiary utilization, cost, and quality performance. ● Upon request, CTO will provide guidance as needed to improve the practice's clinical quality metrics and operational performance	● Program Coordinator ● Director of Care Transformation & Quality	● All practices ● All practices ● All practices
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	● CTO will provide PFAC readiness assessment to practice and provide recommendations designed to facilitate successful PFAC development and implementation.	● Program Coordinator	● All practices
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	● Upon request and based upon the data provided by the practice, CTO will assist practice with quarterly assessment of eCQM measures and provide suggestions for improvement opportunities with the goal of improving patient outcomes and reducing utilization.	● Quality and Transformation Analytics Team	● All practices
24/7 Access	Access & Continuity 1.2	● Practice will develop and maintain a call schedule that facilitates 24/7 access for patients to a care team or provider.	● Program Coordinator	● All practices
Referral Management	Comprehensiveness & Coordination 3.1	n/a	n/a	n/a
Other				

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

MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

Final Practice Selection

- □ Package A (Option 1: CTO provides Lead Care Manager (50/50% for T1 & T2, 40/60% for T3)
- □ Package B (Option 1: CTO provides Lead Care Manager (50/50% for T1 & T2, 40/60% for T3)
- □ Package C (Option 1: CTO provides Lead Care Manager (50/50% for T1 & T2, 40/60% for T3)
- **X Package D (Option 2: Practice provides Lead Care Manager (30/70% for T1 & T2, 24/76% for T3)**
- □ Package E (Option 2: Practice provides Lead Care Manager (30/70% for T1 & T2, 24/76% for T3)
- □ Package F (Option 2: Practice provides Lead Care Manager (30/70% for T1 & T2, 24/76% for T3)

Practice Signature ____________________________ CTO Signature _________________________________

MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

Appendix C:

Business Associate Agreement
between the CTO and the Practice

[Attached hereto]