MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

The Care Transformation Arrangement ("Arrangement") is between Maryland Collaborative Care Transformation Organization, Inc., a care transformation organization (the "CTO"), and TIN Legal Business Name, (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, 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 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 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 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.
   - □ **Option 2: Practice provides Lead Care Manager**
     - o For 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:

_____
Signature

_____
Printed Name

FOR THE PRACTICE:

_____
Signature

_____
Printed Name

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Title	Title
CTO00094	
MDPCP CTO ID	MDPCP Practice ID
Maryland Collaborative Care Transformation Organization, Inc.	
MDPCP CTO Name	MDPCP Practice Name
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, attributed 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 (Option 1: CTO provides Lead Care Manager (50/50% for 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 3.3	Access to our Behavioral Health Integration preferred partners that will assist in establishing a primary behaviorist model for your practice or furnish services on your behalf. In addition, we provide 24/7 access to a nurse line and a population health tool with accessible screenings and stratified cohort managed by our specialized care team in behavioral health.	Program Clinical Manager, RN Lead Care Manager Social worker Community Health worker Program Market Manager or specialist	1:50 practices 1: 6 practices 1:20 practices 1:10 practice 1 per program
Medication Management	Care Management 2.6	Access to our robust Medication Management vendor partners. Our vendor partner furnishes a pharmacist that completes Comprehensive Medication Management with remote monitoring fully integrated in the practice. In addition, our case management team will perform a medication review and reconciliation for all patients in care management to identify interventions. We refer to our remote team of pharmacist for intervention plans.	Program Clinical Manager RN, Lead Care Manager Clinical integrated pharmacist vendor Pharmacist/ Pharm Tech (Vendor partnership) Program Market Manager or specialist	1 per 50 practices 1 per 6 practices All practices 1 per 50 practices 1 per program
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.4	Services Beyond Healthcare: through Centene Community Connections, you can connect to a wide range of services that help you live a better, healthier life. Access line given to all practices. Access CHS healthy Impact 360 with fully integrated screening assessments that integrates with your EMR	Telephonic Care Coordinators Social worker Community Health Worker Program Market Manager or specialist	1 per 15 practices 1 per 20 practices 1:10 practice 1 per program
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.4	Access to CHS HI360 population tool to use for all practice population with privileges to CHS ignite tool (HIPAA compliant) Tele- Med vendor at no cost. In addition to the care manager who will perform home visits.	Practice Transformation coaches CHS HI360	1 per 6 practices All practice

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Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	Access to a diverse interdisciplinary care coordination team aligned to provider Transition of Care (TOC) outreaches. We utilize our population health tool to identify patients being discharged from hospital and ED. The Care team initiate the non-face to face portion of transitional Care visit for all align patient in need of a TOC. Practice Transformation coach educate and train office staff on workflow and billing of TCM.	Program Clinical Manager, RN Lead Care Manager Social worker Community Health worker Practice Transformation Coach Program Market Manager or specialist	1:50 practices 1: 6 practices 1:20 practices 1:10 practice 1:6 practice 1per program
Care Planning & Self-Management Support	Care Management 2.4, Beneficiary & Caregiver Experience 4.1	Our interdisciplinary care team utilized the population health tool to Identify, initiate and completed a care plan in collaboration with patient and /or caregiver for all complex to high-risk patients using the risk stratification tool.	Program Clinical Manager, RN Lead Care Manager CHS HI360	1:50 practice 1:6 practices All practices
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	Our quality improvement team and practice transformation coaches provide education and training on the quality measures. Access to CHS HI360 population health tool and complete EMR integration to supplement tracking of performance.	Practice Transformation Coach Program Market Manager or specialist Access to HI360 Pop health Data Analytical team	1:5 practice 1: Program All practices All practices
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	Provide data analysis to help meet the care transformation requirements. We offer a health IT system to help promote effective strategy for treatment planning and monitoring health outcomes	Population health Analytical team CHS HI360	All practices All practices
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	Provider guideline tools for engaging beneficiaries and caregivers to ensure optimal care delivery. Identify areas to engage beneficiaries in goal setting and shared decision-making. Help facilitate meetings or platform to host meeting,	Practice Transformation Coach Program Market Manager or specialist	1:6 practice 1: program
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	Help identify and close gaps in the at-risk population. Will apply evidence-based protocols for screening and treatment. Complete access to EMR integration to CHS HI360 pop health tool.	Practice Transformation Coach Program Market Manager or specialist Pop health Data Analytical team	1:6 practice 1: Program All practices

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24/7 Access	Access & Continuity 1.2	Access to the CTO established 24 hours Nurse line to supplement after hour coverage at the practice. Assist your practice with establishing workflow and coverage protocols. Provider tools and support to educate beneficiaries of access protocols and proper use of emergency rooms.	Nurse Line Practice Transformation Coach Program Market Manager or specialist CHS HI360	All practices 1:6 practice 1: Program All practices
Referral Management	Comprehensiveness & Coordination 3.1	Collaborate with practice to identify, coordinate and provider alternate interventions for referral management. Especially for from high-volume and/or high-cost specialists as well as EDs and hospitals.	Program Clinical Manager, RN Lead Care Manager Social worker Community Health worker Practice Transformation Coach Program Market Manager or specialist	1:50 practices 1: 6 practices 1:20 practices 1:10 practice 1:6 practice 1per program
Other		Access to the CTO established 24 hours Nurse line to supplement after hour coverage at the practice. Assist your practice with establishing workflow and coverage protocols. Provider tools and support to educate beneficiaries of access protocols and proper use of emergency rooms.	Nurse Line Practice Transformation Coach Program Market Manager or specialist CHS HI360	All practices 1:6 practice 1: Program All practices

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Package B (Option 2: Practice provides Lead Care Manager (30/70% for 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 3.3	Access to our Behavioral Health Integration preferred partners that will assist in establishing a primary behaviorist model for your practice or furnish services on your behalf. In addition, we provide 24/7 access to a nurse line and a population health tool with accessible screenings and stratified cohort that will help your Care Manager target the right patients.	Practice Transformation Coach Program Market Manager or specialist	1:6 practice 1 per program
Medication Management	Care Management 2.6	Access to Population Health tool HI360 with screening assessments and identified cohorts of patients that your lead Care manager can focus on.	Practice Transformation Coach Program Market Manager or specialist	1:6 practice 1 per program
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.4	Services Beyond Healthcare: through Centene Community Connections, you can connect to a wide range of services that help you live a better, healthier life. Access line given to all practices. Access CHS healthy Impact 360 with fully integrated screening assessments that integrates with your EMR	Telephonic Care Coordinators Practice Transformation Coach Program Market Manager or specialist	1 per 15 practices 1:6 practice 1 per program
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.4	Access to the CTO established 24 hours Nurse line to supplement after hour coverage at the practice. Assist your practice with establishing workflow and coverage protocols. Provider tools and support to educate beneficiaries of access protocols and proper use of emergency rooms.	Nurse Line Practice Transformation Coach Program Market Manager or specialist CHS HI360	All practices 1:6 practice 1: Program All practices
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	Access to CHS HI360 population tool to use for attributed practice population with privileges to CHS ignite tool at no cost. The tool has assessments that your team can use to furnish the non- face to face contact and assessments. Practice transformation coach educate and train office staff on workflow and billing of TCM.	CHS HI360 Practice Transformation Coach Program Market Manager or specialist	All practice 1:6 practice 1: program

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Care Planning & Self-Management Support	Care Management 2.4, Beneficiary & Caregiver Experience 4.1	Access to CHS HI360 population tool to use for attributed practice population with privileges to CHS ignite tool at no cost. The tool has built in disease care plans, triage assessments, longitudinal, and episodic template care plans that your team can use to document outreach. All clinically integrated to your EMR.	CHS HI360 Practice Transformation Coach Program Market Manager or specialist	All practice 1:6 practice 1: practice
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	Our quality improvement team and practice transformation coaches provide education and training on the quality measures. Access to CHS HI360 population health tool and complete EMR integration to supplement tracking of performance.	Practice Transformation Coach Program Market Manager or specialist Access to HI360 Pop health Data Analytical team	1:5 practice 1: Program All practices All practices
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	Provide data analysis to help meet the care transformation requirements. We offer a health IT system to help promote effective strategy for treatment planning and monitoring health outcomes. Coach your staff to interpret	Population health Analytical team CHS HI360	All practices All practices
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	Provider guideline tools for engaging beneficiaries and caregivers to ensure optimal care delivery. Identify areas to engage beneficiaries in goal setting and shared decision-making. Help facilitate meetings or platform to host meeting,	Practice Transformation Coach Program Market Manager or specialist	1:6 practice 1: program
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	Help identify and close gaps in the at-risk population. Will apply evidence-based protocols for screening and treatment. Complete access to EMR integration to CHS HI360 pop health tool.	Practice Transformation Coach Program Market Manager or specialist Pop health Data Analytical team	1:6 practice 1: Program All practices
24/7 Access	Access & Continuity 1.2	Access to the CTO established 24 hours Nurse line to supplement after hour coverage at the practice. Assist your practice with establishing workflow and coverage protocols. Provider tools and support to educate beneficiaries of access protocols and proper use of emergency rooms.	Nurse Line Practice Transformation Coach Program Market Manager or specialist CHS HI360	All practices 1:6 practice 1: Program All practices

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Referral Management	Comprehensiveness & Coordination 3.1	Collaborate with practice to identify, coordinate and provider alternate interventions for referral management. Especially for from high-volume and/or high-cost specialists as well as EDs and hospitals.	Practice Transformation Coach Program Market Manager or specialist	1:6 practice 1per program
Other		Access to our vendor partners and negotiated contracts. Practices can leverage the use of our vendors for care management opportunities and optimization at cost to the practice.		

*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 (Option 1: CTO provides Lead Care Manager (50/50% for T2, 40/60% for T3)
- ☐ Package B (Option 2: Practice provides Lead Care Manager (30/70% for T2, 24/76% for T3)

Practice Signature _____ CTO Signature _____

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Appendix C:

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

[Attached hereto]