

# MARYLAND PRIMARY CARE PROGRAM

## CARE TRANSFORMATION ARRANGEMENT

This Care Transformation Arrangement (“Arrangement”) is between Greater Baltimore Health Alliance, 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 the later of January 1, 2020, or January 1 of the year following the date this Arrangement is signed by the last Party to sign it (as indicated by the date associated with that Party’s signature). A Party’s performance obligations under this Arrangement shall not begin prior to the Effective Date.
3. ***Term of Arrangement.*** This Arrangement is effective for a minimum of one full Performance Year, which consists of a 12-month period beginning on January 1 of each year, and will renew automatically on January 1 of each year, until terminated by either party in accordance with Section 12 of this Arrangement, 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.
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.

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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

**Appendix A:**  
**Care Transformation Requirements**

| Comprehensive Primary Care Functions of Advanced Primary Care   | Care Transformation Requirement   | Practice Track Requirement |
|---|---|----------------------------|
| Access and Continuity   | 1.1 Empanel attributed beneficiaries to practitioner or care team.  | Track 1 + 2                |
|   | 1.2 Ensure attributed beneficiaries have 24/7 access to a care team or practitioner with real-time access to the EHR.   | Track 1 + 2                |
|   | 1.3 Ensure attributed beneficiaries have regular access to the care team or practitioner through at least one alternative care strategy.  | Track 2 only               |
| Care Management   | 2.1 Ensure all empaneled, attributed beneficiaries are risk stratified.   | Track 1 + 2                |
|   | 2.2 Ensure all attributed beneficiaries identified as increased risk and likely to benefit receive targeted, proactive, relationship-based (longitudinal) care management.  | Track 1 + 2                |
|   | 2.3 Ensure attributed beneficiaries receive a follow-up interaction from your practice within one week for ED discharges and two business days for hospital discharges.   | Track 1 + 2                |
|   | 2.4 Ensure targeted, attributed beneficiaries who have received follow-up after ED, hospital discharge, or other triggering events receive short-term (episodic) care management.   | Track 1 + 2                |
|   | 2.5 Ensure attributed beneficiaries in longitudinal care management are engaged in a personalized care planning process, which includes at least their goals, needs, and self-management activities.                                  | Track 2 only               |
|   | 2.6 Ensure attributed beneficiaries in longitudinal care management have access to comprehensive medication management.   | Track 2 only               |
| Comprehensiveness and Coordination across the Continuum of Care | 3.1 Ensure coordinated referral management for attributed beneficiaries seeking care from high-volume and/or high-cost specialists as well as EDs and hospitals.  | Track 1 + 2                |
|   | 3.2 Ensure attributed beneficiaries with behavioral health needs have access to care consistent with at least one option from a menu of options for integrated behavioral health supplied to attributed beneficiaries by the Practice | Track 1 + 2                |
|   | 3.3 Facilitate access to resources that are available in your community for beneficiaries with identified health-related social needs   | Track 2 only               |
| Beneficiary & Caregiver Experience                              | 4.1 Convene a Patient-Family/ Caregiver Advisory Council (PFAC) at least annually and integrate PFAC recommendations into care and quality improvement activities.  | Track 1 + 2                |
|   | 4.2 Engage attributed beneficiaries and caregivers in a collaborative process for advance care planning   | Track 2 only               |
| Planned Care for Health Outcomes                                | 5.1 Continuously improve your performance on key outcomes, including cost of care, electronic clinical quality measures, beneficiary experience, and utilization measures.  | Track 1 + 2                |

**Appendix B:**

**CTO Services/Personnel Offered and Practice Selection**

**Package A (50%)**

| Service Category                                 | Care Requirement & Quality Measure                          | Description  | Staff Type   | Ratio of staff (FTE) to practice   |
|--|---|--|--|--|
| Behavioral Health Integration (BHI)              | Comprehensiveness & Coordination 3.2, NQF 0004              | Services: Standardized behavioral health integration workflow and CTO Care Team staff support [Tracks 1 and 2]   | LCSW Behavioral Health Consultant  | 1 FTE available for defined patient population (i.e., patients that meet certain parameters)   |
| Medication Management                            | Care Management 2.6   | [Track 2 only]<br>Through a collaboration with the CTO's pharmacist and RN Care Manager, attributed beneficiaries in longitudinal care management will have access to comprehensive medication management.   | Pharmacist   | 1 FTE available for defined patient population (i.e., patients that meet certain parameters)   |
| Social Determinants Screening & Referral         | Comprehensiveness & Coordination 3.3                        | Standardized screening for social determinants of health, referral to community resources.   | Care Coordinator   | 1 FTE available for defined patient population (i.e., patients that meet certain parameters)   |
| Alternative Care (e.g., Telehealth, home visits) | Access & Continuity 1.3                                     | [Track 2 only]<br>Attributed beneficiaries have regular access to the care team or practitioner through one or more alternative care strategies.   | CTO Care Team staff (RN Care Manager, Care Coordinator, Behavioral Health Consultant, and administrative program team) | 1 FTE available for defined patient population (i.e., patients that meet certain parameters)   |
| Transitional Care Management (TCM)               | Care Management 2.2, 2.3, 2.4, 2.5, 2.6                     | Standardized long-term care planning workflow; standardized transition of care workflow; standardized short-term care planning workflow.   | CTO Care Team staff (RN Care Manager, Care Coordinator, Behavioral Health Consultant, and administrative program team) | 1 FTE available for defined patient population (i.e., patients that meet certain parameters)   |
| Care Planning & Self-Management Support          | Care Management 2.5, Beneficiary & Caregiver Experience 4.2 | [Track 2 only]<br>Attributed beneficiaries and other primary care patients and caregivers will have access to a collaborative process for advance care planning.   | CTO Care Team staff (RN Care Manager, Care Coordinator, Behavioral Health Consultant, and administrative program team) | 1 FTE available for defined patient population (i.e., patients that meet certain parameters)   |
| Population Health Management & Analytics         | Planned Care for Health Outcomes 5.1, eQMs, Utilization     | CTO Admin assesses, at least quarterly, provider- and practice-level performance on key programmatic measures including utilization, cost, and quality metrics; provision of technical assistance; and refinement of existing standardized workflows and/or creation of new standardized workflows for CTO Care Team use | CTO Care Team staff (RN Care Manager, Care Coordinator, Behavioral Health Consultant, and administrative program team) | CTO Administrative team centralized supports, with front line implementation by Care Manager, Care Coordinator, and Behavioral Health Consultant |
| Clinical & Claims Data Analysis                  | Care Management 2.1-2.4, Utilization                        | Standardized long-term care planning workflow; standardized transition of care workflow; standardized short-term care planning workflow.<br>Application of risk stratification approach, as well as the provision of technical assistance  | CTO Care Team staff (RN Care Manager, Care Coordinator, Behavioral Health Consultant, and administrative program team) | CTO Administrative team centralized supports, with front line implementation by Care Manager, Care Coordinator, and Behavioral Health Consultant |
| Patient Family Advisory Councils (PFACs)         | Beneficiary & Caregiver Experience 4.1                      | Provision of logistical support for convening a PFAC at least annually and summary of recommendations for care and quality improvement.  | CTO administrative program team  | CTO Administrative team centralized supports   |

|                                   |  |  |  |  |
|-----------------------------------|--|--|--|--|
| Quality & Utilization Performance | Planned Care for Health Outcomes 5.1, eQMs | CTO Admin assesses, at least quarterly, provider- and practice-level performance on key programmatic measures including utilization, cost, and quality metrics; provision of technical assistance; and refinement of existing standardized workflows and/or creation of new standardized workflows for CTO Care Team use | CTO administrative program team  | CTO Administrative team centralized supports   |
| 24/7 Access                       | Access & Continuity 1.2                    | Standardized 24-hour on call workflow and CTO care team staff support  | CTO Care Team staff (RN Care Manager, Care Coordinator, Behavioral Health Consultant, and administrative program team) | 1 FTE available for defined patient population (i.e., patients that meet certain parameters)   |
| Referral Management               | Comprehensiveness & Coordination 3.1       | CTO Admin identification of high-volume/high-cost providers and standardized referral management workflow for CTO Care Team staff use with providers   | CTO administrative program team  | CTO Administrative team centralized supports, with front line implementation by Care Manager, Care Coordinator, and Behavioral Health Consultant |

**Package B (30%)\***

| Service Category                                 | Care Requirement & Quality Measure                          | Description  | Staff Type                        | Ratio of staff (FTE) to practice   |
|--|---|--|-----------------------------------|--|
| Behavioral Health Integration (BHI)              | Comprehensiveness & Coordination 3.2, NQF 0004              | Services: Standardized behavioral health integration workflow and CTO Care Team staff support  | LCSW Behavioral Health Consultant | 1 FTE available for defined patient population (i.e., patients that meet certain parameters)                   |
| Medication Management                            | Care Management 2.6   | [Track 2 only]<br>Through a collaboration with the CTO's pharmacist and RN Care Manager, attributed beneficiaries in longitudinal care management will have access to comprehensive medication management.   | Pharmacist                        | 1 FTE available for defined patient population (i.e., patients that meet certain parameters)                   |
| Social Determinants Screening & Referral         | Comprehensiveness & Coordination 3.3                        | Standardized screening tool made available to practices for social determinants of health, as well as administrative support in identifying community resources.   | CTO administrative program team   |  |
| Alternative Care (e.g., Telehealth, home visits) | Access & Continuity 1.3                                     | [Track 2 only]<br>CTO will work with practices in Track 2 to identify strategies through which attributed beneficiaries have regular access to the care team or practitioner through one or more alternative care strategies.  | CTO administrative program team   |  |
| Transitional Care Management (TCM)               | Care Management 2.2, 2.3, 2.4, 2.5, 2.6                     | CTO will assist practices in establishing standardized long-term care planning workflow; standardized transition of care workflow; standardized short-term care planning workflow.   | CTO administrative program team   |  |
| Care Planning & Self-Management Support          | Care Management 2.5, Beneficiary & Caregiver Experience 4.2 | [Track 2 only]<br>CTO will work with practices in Track 2 to ensure that attributed beneficiaries and other primary care patients and caregivers will have access to a collaborative process for advance care planning.  | CTO administrative program team   |  |
| Population Health Management & Analytics         | Planned Care for Health Outcomes 5.1, eCQMs, Utilization    | CTO Admin assesses, at least quarterly, provider- and practice-level performance on key programmatic measures including utilization, cost, and quality metrics; provision of technical assistance; and refinement of existing standardized workflows and/or creation of new standardized workflows for Practice.         | CTO administrative program team   | CTO Administrative team centralized supports, with front line implementation by Practice-employed Care Manager |
| Clinical & Claims Data Analysis                  | Care Management 2.1-2.4, Utilization                        | CTO will provide tools and support for standardized long-term care planning workflow; standardized transition of care workflow; standardized short-term care planning workflow. Application of risk stratification approach, as well as the provision of technical assistance  | CTO administrative program team   | CTO Administrative team centralized supports, with front line implementation by Practice-employed Care Manager |
| Patient Family Advisory Councils (PFACs)         | Beneficiary & Caregiver Experience 4.1                      | Provision of logistical support for convening a PFAC at least annually and summary of recommendations for care and quality improvement.  | CTO administrative program team   | CTO Administrative team centralized supports   |
| Quality & Utilization Performance                | Planned Care for Health Outcomes 5.1, eCQMs                 | CTO Admin assesses, at least quarterly, provider- and practice-level performance on key programmatic measures including utilization, cost, and quality metrics; provision of technical assistance; and refinement of existing standardized workflows and/or creation of new standardized workflows for CTO Care Team use | CTO administrative program team   | CTO Administrative team centralized supports   |
| 24/7 Access                                      | Access & Continuity 1.2                                     | CTO will work with practices to identify strategies for a standardized 24-hour on call workflow  | CTO administrative program team   |  |
| Referral Management                              | Comprehensiveness & Coordination 3.1                        | CTO Admin identification of high-volume/high-cost providers and standardized referral management workflow for CTO Care Team staff use with providers   | CTO administrative program team   | CTO Administrative team centralized supports, with front line implementation by Practice-employed Care Manager |

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

Final Practice Selection

- Package A (50%)
- Package B (30%)

CTO Signature \_\_\_\_\_ Practice Signature \_\_\_\_\_

SAMPLE

**Appendix C:**  
**Business Associate Agreement**  
**between the CTO and the Practice**

[Attached hereto]

SAMPLE