org	This Care Transformation Arrangement ("Arrangement") is between, a care transformation anization (the "CTO"), and, (the "Practice") (each a "Party," and collectively the "Parties").
("N	The CTO has been selected by the Centers for Medicare and Medicaid Services ("CMS"), Center for Medicare and dicaid Innovation ("CMMI"), to serve as a care transformation organization in the Maryland Primary Care Program IDPCP"). The Practice is a primary care practice that provides health care services to Medicare beneficiaries, among others, he State of Maryland.
trai	This Arrangement sets forth the terms and conditions under which the CTO will provide to the Practice certain care as formation services and resources consistent with MDPCP requirements.
1.	<u>Participation Agreements</u> . 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.	<i>Effective Date</i> . 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.	<u>Term of Arrangement</u> . 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.	<u>Lead Care Manager</u> . 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.	<u>Data Sharing and Privacy</u> . 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. <u>Notification of Changes in Medicare Enrollment</u>. 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. <u>No Remuneration Provided</u>. 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. <u>Practice of Medicine or Professional Services Not Limited by this Arrangement</u>. 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. <u>Compliance with All Applicable Laws</u>. 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. <u>Termination</u>. 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. <u>Copies and Retention of Arrangement</u>. 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. <u>Amendments</u>. 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	
Printed Name	Printed Name	
MDPCP CTO ID	MDPCP Practice ID	
Title	Title	
Date Signed	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
	1.1 Empanel attributed beneficiaries to practitioner or care team.	Track 1 + 2
Access and Continuity	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
	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
Care Management	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
	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
Comprehensiveness and Coordination across the Continuum of Care	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
Experience	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%) – Option 1, Track 1

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FIE) to practice
Behavioral Health Integration (BHI)		- Assist practices with identification of behavioral health integration options that support local practice needs - As identified as a need, assist practices in establishing and maintaining a Care Management for Behavioral Health Model of BHI including integrating a behavioral health care manager to establish care plans and coordinate care for patients with specific behavioral health needs - Assist practices with identification and implementation of screening tools to identify patients in need - Coordinate comprehensive SBIRT (Screening, Brief Intervention and Referral to Treatment) training for providers and care team Provide screening, direct brief interventions (including cognitive behavioral therapy and motivational interviewing),	Medical Director & Behavioral Health Team Behavioral Health Care Manager Licensed Clinical Social Worker (LCSW)	
	V Y	and referral to specialty services and community resources as needed.		

Medication	Care Management 2.6	- Conduct medication	Pharmacist	1 per 20 practices
Management	Care Management 2.0	management services with	(PharmD)	1 per 20 practices
Wanagement		attributed members who	(FilatiliD)	
		have multiple chronic		
		diseases, are on complex		
		medication regimens and/or		
		are undergoing a transition		
		of care as needed.		
		- Assess patient's		
		medication regimens for		
		compliance, drug-		
		drug/drug-disease		
		interactions, adverse effects		
		and appropriateness based		
		on evidence-based		
		guidelines as needed.		
		- Develop patient centered		
		medication-related goals		
		with beneficiaries and		
		provide medications		
		recommendations to		
		providers as needed.		
Social Determinants	Comprehensiveness &	- Assess current state of	Licensed Clinical	1 per 20 practices
Screening & Referral	Coordination 3.3	practice in identifying	Social Worker	
		patients with social	(LCSW)	
		determinants of health		
		-Provide practices with	Lead Case Manager	1 per 5 practices
		resources in their		
	,	communities for addressing		
		patient social needs.	·	
		- Accept referrals to social		
		work to fully assess patient		
		social needs and eligibility		
		for community resources;		
		facilitate and advocate		
		access for patients.		
Alternative Care (e.g.,	Access & Continuity 1.3	- Support practices with	Licensed Clinical	1 per 20 practices
Telehealth, home visits)		alternative care modalities	Social Worker	
		such as Tele-Care	(LCSW)	
		Management support		
		services with nursing,	Lead Case Manager	1 per 5 practices
		pharmacy and social work.		
		Practices may need to make	Pharmacist	1 per 20 practices
		additional investments	(PharmD)	
		around legal, compliance		
		and technology to utilize	Practice	1 per 7 practices
		these services.	Transformation	
			Specialist	
		- For practices seeking		
_		Track advancement, provide		
		advisory guidance for		
		selection and		
`		implementation approach of		
		alternative care modalities		
		(eg., Telehealth).		
	1		1	

Transitional Care	Care Management 2.2, 2.3,	- Assist Practices with	Practice	1 per 7 practices
			Transformation	1 per / practices
Management (TCM)	2.4, 2.5, 2.6	utilizing reports to efficiently identify IP and	Specialist	
		ED discharges and develop	Specialist	
		workflows to outreach to	Lead Case Managers	1 per 5 practices
			Lead Case Wallagers	1 per 3 practices
		those patients.	Pharmacist	
		-Work with practice to	Pharmacist	1 20
		identify patients who need	I in an and Climical	1 per 20 practices
		short term (episodic) care	Licensed Clinical	1 20
		management during these	Social Worker	1 per 20 practices
		transitions.	(LCSW)	
		- Provide episodic care		
		management to identified		
		patients discharged from		
		inpatient, ED, or post-acute		
		care including care		
		coordination and medication		
		reconciliation.		
Care Planning & Self-	Care Management 2.5,	-Provide longitudinal case	Lead Case Managers	1 per 5 practices
Management Support	Beneficiary & Caregiver	management and care		
	Experience 4.2	coordination services to	Pharmacist (PharmD)	1 per 20 practices
		high risk and rising risk		
		patients and caregivers in	Licensed Clinical	1 per 20 practices
		collaboration with their	Social Worker	
		Primary Care Provider	(LCSW)	
		(PCP)		
		- Promotes optimum level of		
		independence and autonomy		
	· ·	through self-management of		
		disease processes including	>	
		targeted education/support		
		for patients with Diabetes,		
		COPD, CHF and HTN,		
		treatment options, and		
		informed decision making.		
		-Support from		
		interdisciplinary care team		
		(IDCT) members		
		(pharmacist, social work,		
		behavioral health care		
		manager) and connection to		
		community partners		
		integrated into care		
	T T	planning.		
Population Health	Planned Care for Health	Assist with utilizing	Quality Analysts	1 per 10 practices
Management &	Outcomes 5.1, eCQMs,	available claims and EMR		r o prasticos
Analytics	Utilization	data to identify effective	Data Analysts	1 per 20 practices
,		strategies to impact cost,		r
		quality, and utilization	Practice	1 per 7 practices
		measures.	Transformation	- Por , Practices
			Specialist	
Clinical & Claims Data	Care Management 2.1-2.4,	Assist with utilizing	Data Analysts	1 per 20 practices
Analysis	Utilization	available claims and EMR	= =====================================	- Per 20 praerices
, 0.20		data to identify and target	Lead Case Managers	1 per 4 practices
		at-risk patients likely to	III IIII IIII	r · Practices
		benefit from care		
		management services.		
	l .	management set vices.		

Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	-Provide a project plan and identify tasks for PFAC implementation Provide PFAC toolkit for PFAC planning and setupsample PFAC Charter, Agenda, Discussion topics/initiatives etc., -Identify potential priorities for ongoing improvements.	Practice Transformation Specialist	1 per 7 practices
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	-Assist with utilizing available EMR and claims data to identify effective strategies to impact quality and utilization measuresAssist practices to identify opportunities, interpret patterns/trends and potential interventionsAssist practices to review	Quality Analysts Data Analysts Practice Transformation Specialist	1 per 10 practices 1 per 20 practices 1 per 7 practices
		data to drive performance and improvement strategies.		
24/7 Access	Access & Continuity 1.2	-Designate a lead Practice Transformation Specialist (PTS) Assist practice to track progress periodically with tracking toolsAssist practices with toolkit-assisted best practices to improve workflows for access to care (Eg., Tools for Practice selfassessment, Role of Teambased care, Improvement Strategies etc.,).	Practice Transformation Specialist	1 per 7 practices
Referral Management	Comprehensiveness & Coordination 3.1	-Help practices utilize data and identify opportunities for high-cost/high volume specialists. -Assist practice with tools such as Clinical Care Compacts for a specialist referral program.	Practice Transformation Specialist	1 per 7 practices

Other – Clinical	-For practices that are	Quality Analysts	1 per 7 practices
Informatics, Process Improvement, and Policy Support	encountering challenges with their EMR specific to program requirements,	Practice Transformation Specialist	1 per 10 practices
	assist with clinical integration and/or informatics support to	Policy Support	1 per 50 practices
	improve compliance.		
	Practices may need to make additional investments to		
	meet these requirements For identified practice		
	transformation and/or		
	clinical process improvement initiatives,		
	provide project management		
	support to assist practices with local implementation.		
	- As identified, provide updates regarding emerging		
	federal quality/payment, innovation and health IT		
	programs, policies and regulations.		

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Package B (50%) – Option 1, Track 2

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FIE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2	- Assist practices with identification of behavioral health integration options that support local practice	Medical Director & Behavioral Health Team	1 per 50 practices
		needs As identified as a need, assist practices in	Behavioral Health Care Manager	1 per 10 practices
		assist practices in establishing and maintaining a Care Management for Behavioral Health Model of BHI including integrating a behavioral health care manager to establish care plans and coordinate care for patients with specific behavioral health needs. - Assist practices with identification and implementation of screening tools to identify patients in need. - Coordinate comprehensive SBIRT (Screening, Brief Intervention and Referral to Treatment) training for providers and care team. - Provide screening, direct brief interventions (including cognitive behavioral therapy and motivational interviewing), and referral to specialty services and community resources as needed.	Licensed Clinical Social Worker (LCSW)	1 per 20 practices

Medication	Care Management 2.6	- Conduct medication	Pharmacist	1 per 20 practices
Management	Care Management 2.0	management services with	(PharmD)	1 per 20 practices
Management		attributed members who	(Filarillo)	
		have multiple chronic		
		diseases, are on complex		
		medication regimens and/or		
		are undergoing a transition		
		of care as needed.		
		- Assess patient's	<u> </u>	
		medication regimens for		
		compliance, drug-		
		drug/drug-disease		
		interactions, adverse effects		
		and appropriateness based		
		on evidence-based		
		guidelines as needed.		
		- Develop patient centered		
		medication-related goals		
		with beneficiaries and		
		provide medications		
		recommendations to		
		providers as needed.		
		-Provide curb side consults		
		to providers that have		
		specific drug-related		
		questions as needed.		
Social Determinants	Comprehensiveness &	-Assess current state of	Licensed Clinical	1 per 20 practices
Screening & Referral	Coordination 3.3	practice in identifying	Social Worker	1 per 20 practices
Screening & Referral	Coordination 3.3	patients with social	(LCSW)	
		determinants of health.	(LCSW)	
		-Assist with identification		
		and implementation of		
		validated screening tools for		
		social determinants		
		according to practice		
		readiness.		
		-Provide practices with		
		resources in their		
		communities for addressing		
		patient social needs.		
		-Accept referrals to social		
		work to fully assess patient		
		social needs and eligibility		
		for community resources;		
		facilitate and advocate		
		access for patients.		

Alternative Care (e.g.,	Access & Continuity 1.3	- Support practices with	Licensed Clinical	1 per 20 practices
Telehealth, home visits)		alternative care modalities	Social Worker	i per 20 praetices
Telementen, nome visits)		such as Tele-Care	(LCSW)	
		Management support		
		services with nursing,	Lead Case Manager	1 per 5 practices
		pharmacy and social work.		
		1 2	Pharmacist	1 per 20 practices
		Practices may need to make additional investments	(PharmD)	
		around legal, compliance	Practice	1 per 7 practices
		and technology to utilize	Transformation	
		these services.	Specialist	
		- For practices seeking		
		Track advancement, provide		
		advisory guidance for		
		selection and		
		implementation approach of		
		alternative care modalities		
		(eg., Telehealth).		
Transitional Care	Care Management 2.2, 2.3,	-Assist practices with	Practice	1 per 7 practices
Management (TCM)	2.4, 2.5, 2.6	utilizing reports to	Transformation	
		efficiently identify IP and	Specialist	
		ED discharges and develop		
		workflows to outreach to	Lead Case Managers	1 per 5 practices
		those patients.		
		-Work with practice to	Pharmacist	1 per 20 practices
		identify patients who need		
		short term (episodic) care		
		management during these		
		transitions.		
		-Provide episodic care		
		management to identified patients discharged from		
		inpatient, ED, or post-acute		
		care including care		
		coordination and medication		
		reconciliation.		
		reconcination.		

Care Planning & Self-	Care Management 2.5,	-Provide longitudinal case	Lead Case Managers	1 per 5 practices
Management Support	Beneficiary & Caregiver	management and care	Lead Case Wanagers	1 per 5 praetices
	Experience 4.2	coordination services to	Practice	1 per 7 practices
	-	high risk and rising risk	Transformation	
		patients and caregivers in	Specialist	
		collaboration with their		
		Primary Care Provider (PCP).	Pharmacist	1 per 20 practices
		- Promote optimum level of	Licensed Clinical	1 per 20 practices
		independence and autonomy	Social Worker	
		through self-management of	(LCSW)	
		disease processes including		
		targeted education/support		
		for patients with Diabetes,		
		_		
		COPD, CHF and HTN, treatment options, and		
		informed decision making.		
		- Support and provide		
		practices with best practices		
		and toolkit for		
		implementation of		
		Advanced Care Planning.		
		(Eg., documentation &		
		billing requirements).		
		-Support from		
	4	interdisciplinary care team		
		(IDCT) members		
		(pharmacist, social work,		
		behavioral health care		
	_	manager) and connection to		
		community partners integrated into care		
		planning.		
		-Collaborate with patients		
		and caregivers to support		
		Advance Care Planning, as		
		requested.		
Population Health	Planned Care for Health	Assist with utilizing	Quality Analysts	1 per 10 practices
Management &	Outcomes 5.1, eCQMs,	available claims and EMR		
Analytics	Utilization	data to identify effective	Data Analysts	1 per 20 practices
		strategies to impact cost,		
		quality, and utilization	Practice	
		measures.	Transformation	1 per 7 practices
Clinical & Claims Data	Cara Managarant 2.1.2.4	Assist with utilizing	Specialist Data Applyata	1 per 20 practices
Analysis	Care Management 2.1-2.4, Utilization	Assist with utilizing available claims and EMR	Data Analysts	1 per 20 practices
1 May 515	Cimzation	data to identify and target	Lead Case Managers	1 per 5 practices
		at-risk patients likely to	Lead Case Managers	1 per 5 praetices
		benefit from care		
		management services.		
	<u>r</u>			

Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	-Provide a project plan and identify tasks for PFAC implementation - Provide PFAC toolkit for PFAC planning and setupsample PFAC Charter, Agenda, Discussion topics/initiatives etc., -Identify potential priorities for ongoing improvements.	Practice Transformation Specialist	1 per 7 practices
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	-Assistance with utilizing available EMR and claims data to identify effective strategies to impact quality and utilization measures Quality Analysts assist practices to identify clinical opportunities, interpret patterns/trends, and design performance improvement plansPTS assist practices to review data to drive performance and improvement strategies.	Quality Analysts Data Analysts Practice Transformation Specialist	1 per 10 practices 1 per 20 practices 1 per 7 practices
24/7 Access	Access & Continuity 1.2	-Designate a lead Practice Transformation Specialist (PTS) Assist practice to track progress periodically with tracking tools -Assist practices with toolkit-assisted best practices to improve workflows for access to care (Eg., Tools for Practice self- assessment, Role of Team- based care, Improvement Strategies etc.,).	Practice Transformation Specialist	1 per 7 practices
Referral Management	Comprehensiveness & Coordination 3.1	-Help practices utilize data and identify opportunities for high-cost/high volume specialistsAssist practice with tools such as Clinical Care Compacts for a specialist referral program.	Practice Transformation Specialist	1 per 7 practices

Other – Clinical Informatics, Process Improvement, and Policy Support	-For practices that are encountering challenges with their EMR specific to program requirements, assist with clinical	Quality Analysts Practice Transformation Specialist	1 per 7 practices 1 per 10 practices
	integration and/or informatics support to improve compliance. Practices may need to mal additional investments to meet these requirements. - For identified practice transformation and/or clinical process improvement initiatives, provide project manageme support to assist practices with local implementation. - As identified, provide updates regarding emerging federal quality/payment, innovation and health IT programs, policies and regulations.	ent 1.	1 per 50 practices

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Example Package C (30%) – Option 2, Track 1*

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FIE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2	- Assist practices with identification of behavioral health integration options that support local practice	Medical Director & Behavioral Health Team	1 per 50 practices
		needs As identified as a need, assist practices in	Behavioral Health Care Manager	1 per 10 practices
		assist practices in establishing and maintaining a Care Management for Behavioral Health Model of BHI including integrating a behavioral health care manager to establish care plans and coordinate care for patients with specific behavioral health needs. - Assist practices with identification and implementation of screening tools to identify patients in need. - Coordinate comprehensive SBIRT (Screening, Brief	Licensed Clinical Social Worker (LCSW)	1 per 20 practices
		Intervention and Referral to Treatment) training for providers and care team.	•	
		- Provide screening, direct brief interventions (including cognitive behavioral therapy and		
		motivational interviewing), and referral to specialty services and community resources as needed.		

Madigation	Cara Managament 2.6	Conduct medication	Dhormooist	1 par 20 practices
Medication Management	Care Management 2.6	- Conduct medication management services with attributed members who have multiple chronic diseases, are on complex medication regimens and/or are undergoing a transition of care as needed. - Assess patient's medication regimens for compliance, drug-drug/drug-disease interactions, adverse effects and appropriateness based on evidence-based guidelines as needed. - Develop patient centered medication-related goals with beneficiaries and provide medications recommendations to providers as needed. -Provide education to practice care management team regarding pharmacy services, as indicated.	Pharmacist (PharmD)	1 per 20 practices
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	-Assess current state of practice in identifying patients with social determinants of healthProvide practices with resources in their communities for addressing patient social needs Accept referrals to social work to fully assess patient social needs and eligibility for community resources; facilitate and advocate access for patients.	Licensed Clinical Social Worker (LCSW)	1 per 20 practices
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	-Support practices with alternative care modalities such as Tele-Care Management support services with nursing, pharmacy and social work. Practices may need to make additional investments around legal, compliance and technology to utilize these servicesFor practices seeking Track advancement, provide advisory guidance for selection and implementation approach of alternative care modalities (eg., Telehealth).	Medical Director Pharmacist (PharmD) Practice Transformation Specialist	1 per 50 practices 1 per 20 practices 1 per 7 practices

Transitional Care	Care Management 2.2, 2.3,	-Assist Practices with	Practice	1 per 7 practices
Management (TCM)	2.4, 2.5, 2.6	utilizing reports to	Transformation	
		efficiently identify IP and ED discharges and develop	Specialist	
		workflows to outreach to	Licensed Clinical	1 per 20 practices
		those patients.	Social Worker	
		-Provide pharmacy and social work support as	(LCSW)	
		requested for patients during	Pharmacy	1 per 20 practices
		transitions of care.		
Care Planning & Self- Management Support	Care Management 2.5, Beneficiary & Caregiver	-Provide pharmacy and social work support to high	Licensed Clinical Social Worker	1 per 20 practices
Wanagement Support	Experience 4.2	risk and rising risk patients	(LCSW)	
		and caregivers in		
		collaboration with their	Pharmacist	1 per 20 practices
		Primary Care Provider (PCP) as requested.	(PharmD)	
Population Health	Planned Care for Health	- Assist with utilizing	Quality Analysts	1 per 10 practices
Management &	Outcomes 5.1, eCQMs,	available claims and EMR	D. A. I.	1 20
Analytics	Utilization	data to identify effective strategies to impact cost,	Data Analysts	1 per 20 practices
		quality, and utilization	Practice	1 per 7 practices
		measures.	Transformation	
Clinical & Claims Data	Care Management 2.1-2.4,	Assist with utilizing	Specialist Data Analysts	1 per 20 practices
Analysis	Utilization	available claims and EMR	Data Alialysts	1 per 20 practices
. ,		data to identify and target		
		at-risk patients likely to		
		benefit from care management services.		
Patient Family Advisory	Beneficiary & Caregiver	-Provide a project plan and	Practice	1 per 7 practices
Councils (PFACs)	Experience 4.1	identify tasks for PFAC	Transformation	
		implementation Provide PFAC toolkit for	Specialist	
		PFAC planning and setup-		
		sample PFAC Charter,		
		Agenda, Discussion topics/initiatives etc.		
		-Identify potential priorities		
		for ongoing improvements.		
Quality & Utilization	Planned Care for Health	Assist with utilizing	Quality Analysts	1 per 10 practices
Performance	Outcomes 5.1, eCQMs	available EMR and claims data to identify effective	Data Analysts	1 per 20 practices
		strategies to impact quality	Zatu i murj oto	1 per 20 praetices
		and utilization measures.	Practice	1 per 7 practices
		-Assist practices to identify clinical opportunities,	Transformation Specialist	
		interpret patterns/trends, and	specialist	
		design performance		
		improvement plans.		
		-Assist practices to review data to		
		drive performance and		
		improvement strategies.		

24/7.4	A 0.0 .: 1.1.2	D : (1 1D ::	D .:	1 7
24/7 Access	Access & Continuity 1.2	-Designate a lead Practice	Practice	1 per 7 practices
		Transformation Specialist	Transformation Specialist	
		(PTS) Assist practice to track	Specialist	
		progress periodically with		
		tracking tools.		
		-Assist practices with		
		toolkit-assisted best		
		practices to improve		
		workflows for access to care		
		(Eg., Tools for Practice self-		
		assessment, Role of Team-		
		based care, Improvement		
		Strategies etc.,).		
Referral Management	Comprehensiveness &	-Help practices utilize data	Practice	1 per 7 practices
	Coordination 3.1	and identify opportunities	Transformation	- F F
		for high-cost/high volume	Specialist	
		specialists.		
		-Assist practice with tools		
		such as Clinical Care		
		Compacts for a specialist		
		referral program.		
Other – Clinical		-For practices that are	Quality Analysts	1 per 7 practices
Informatics, Process		encountering challenges		
Improvement, and		with their EMR specific to	Practice	1 per 10 practices
Policy Support		program requirements,	Transformation	
		assist with clinical	Specialist	
			D 11 G	1 50
		integration and/or	Policy Support	1 per 50 practices
		informatics support to		
		improve compliance.		
		Practices may need to make		
		additional investments to		
		meet these requirements.		
		- For identified practice		
		transformation and/or		
		clinical process		
		improvement initiatives,		
		provide project management		
		support to assist practices		
		with local implementation.		
		- As identified, provide		
		updates regarding emerging		
		federal quality/payment,		
		innovation and health IT		
	,	programs, policies and		
		regulations.		

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

CARE TRANSFORMATION ARRANGEMENT

Example Package D (30%) – Option 2, Track 2*

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Coordination 3.2	- Assist practices with identification of behavioral	Medical Director	1 per 50 practices
integration (BIII)	Coordination 5.2	health integration options that support local practice needs.	Behavioral Health Care Manager	1 per 10 practices
		- As identified as a need, assist practices in establishing and maintaining	Licensed Clinical Social Worker (LCSW)	1 per 20 practices
		a Care Management for Behavioral Health Model of BHI including integrating a	(265.1)	
		behavioral health care manager to establish care plans and coordinate care		
		for patients with specific behavioral health needs Assist practices with		
		identification and implementation of screening tools to identify patients in		
		need Coordinate comprehensive SBIRT		
		(Screening, Brief Intervention and Referral to Treatment) training for	Þ	
		providers and care team Provide screening, direct brief interventions		
		(including cognitive behavioral therapy and motivational interviewing),		
		and referral to specialty services and community resources as needed.		

Medication	Care Management 2.6	- Conduct medication	Pharmacist	1 per 20 practices
Management		management services with	(PharmD)	F
2		attributed members who		
		have multiple chronic		
		diseases, are on complex		
		medication regimens and/or		
		are undergoing a transition		
		of care as needed.		
		- Assess patient's		
		medication regimens for		
		compliance, drug-		
		drug/drug-disease		
		interactions, adverse effects		
		and appropriateness based		
		on evidence-based		
		guidelines as needed.		
		- Develop patient centered		
		medication-related goals		
		with beneficiaries and		
		provide medications		
		recommendations to		
		providers as needed.		
		-Provide curb side consults		
		to providers that have		
		specific drug-related		
		questions as needed		
		-Provider education to		
		provider office care		
		management team regarding		
		pharmacy services as		
Social Determinants	Community on airron and for	neededAssess current state of	Licensed Clinical	1 man 20 mmaatiaaa
	Comprehensiveness & Coordination 3.3		Social Worker	1 per 20 practices
Screening & Referral	Coordination 3.3	practice in identifying patients with social	(LCSW)	
		determinants of health.	(LCSW)	
		-Assist with identification		
		and implementation of		
		validated screening tools for		
		social determinants		
		according to practice		
		readiness.		
		-Provide practices with		
		resources in their		
		communities for addressing		
		patient social needs.		
		-Accept referrals to social		
		work to fully assess patient		
		social needs and eligibility		
		for community resources;		
		facilitate and advocate		
		access for patients.		

Alternative Care (a. a.	Aggas & Continuity 1.2	Cumport prostings with	Medical Director	1 nor 50 nmostices
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	-Support practices with alternative care modalities	Medical Director	1 per 50 practices
1 eleneann, nome visits)		such as Tele-Care	Pharmacist	1 per 20 practices
		Management support	(PharmD)	i per 20 praetices
		services with nursing,	,	
		pharmacy and social work.	Practice	1 per 7 practices
		Practices may need to make	Transformation	
		additional investments	Specialist	
		around legal, compliance		
		and technology to utilize		
		these services.		
		-For practices seeking Track		
		advancement, provide		
		advisory guidance for		
		selection and		
		implementation approach of		
		alternative care modalities		
		(eg., Telehealth).		
Transitional Care	Care Management 2.2, 2.3,	-Assist Practices with	Practice	1 per 7 practices
Management (TCM)	2.4, 2.5, 2.6	utilizing reports to	Transformation	
		efficiently identify IP and	Specialist	
		ED discharges and develop	Licensed Clinical	1 20
		workflows to outreach to those patients.	Social Worker	1 per 20 practices
		-Provide pharmacy and	(LCSW)	
		social work support as	(ECSW)	
		requested for patients during	Pharmacist	1 per 20 practices
	· ·	transitions of care.	(PharmD)	
Care Planning & Self-	Care Management 2.5,	-Provide pharmacy and	Pharmacist	1 per 20 practices
Management Support	Beneficiary & Caregiver	social work support to high		
	Experience 4.2	risk and rising risk patients	Licensed Clinical	1 per 20 practices
		and caregivers in	Social Worker	
		collaboration with their	(LCSW)	
		Primary Care Provider	Practice	1 per 7 practices
		(PCP) as requested.	Transformation	per / praetices
		-Collaborate with patients	Specialist	
		and caregivers to support	•	
		Advance Care Planning, as		
A		requested.		
		- Support and provide		
		practices with Advanced		
		Care Planning (Eg., documentation & billing		
		requirements.		
Population Health	Planned Care for Health	-Assist with utilizing	Quality Analysts	1 per 10 practices
Management &	Outcomes 5.1, eCQMs,	available claims and EMR		- por 10 practices
Analytics	Utilization	data to identify effective	Data Analysts	1 per 20 practices
		strategies to impact cost,	-	
		quality, and utilization	Practice	1 per 7 practices
		measures.	Transformation	
		-PTS assist practices to review data to	Specialist	
		drive performance and		
		improvement strategies.		
	<u> </u>	improvement strategies.	<u> </u>	

Clinical R Claims Date	C M	A:-4:414:1::	Data Amalasata	1 20
Clinical & Claims Data	Care Management 2.1-2.4,	Assist with utilizing	Data Analysts	1 per 20 practices
Analysis	Utilization	available claims and EMR		
		data to identify and target		
		at-risk patients likely to		
		benefit from care		
		management services.		
Patient Family Advisory	Beneficiary & Caregiver	-Provide a project plan and	Practice	1 per 7 practices
Councils (PFACs)	Experience 4.1	identify tasks for PFAC	Transformation	
		implementation.	Specialist	
		- Provide PFAC toolkit for		
		PFAC planning and setup-		
		sample PFAC Charter,		
		Agenda, Discussion		
		topics/initiatives etc.		
		-Identify potential priorities		
		for ongoing improvements.		
Quality & Utilization	Planned Care for Health	-Assist with utilizing	Quality Analysts	1 per 10 practices
Performance	Outcomes 5.1, eCQMs	available EMR and claims	()	r == - p. acciecs
		data to identify effective	Data Analysts	1 per 20 practices
		strategies to impact quality	Data I mary 505	1 per 20 praerices
		and utilization measures.	Practice	1 per 7 practices
		-Assist practices to identify	Transformation	r i per / praetices
		clinical opportunities,	Specialist	
		interpret patterns/trends, and	Specialist	
		design performance		
		improvement plans.		
	4	-Assist practices to		
		review data to		
		drive performance and		
		improvement strategies.		
24/7 Access	Access & Continuity 1.2	-Designate a lead Practice	Practice	1 per 7 practices
		Transformation Specialist	Transformation	
		(PTS).	Specialist	
		- Assist practice to track		
		progress periodically with		
		tracking tools.		
		-Assist practices with		
		toolkit-assisted best		
		practices to improve		
		workflows for access to care		
		(Eg., Tools for Practice self-		
		assessment, Role of Team-		
		based care, Improvement		
		Strategies etc.).		
Referral Management	Comprehensiveness &	-Help practices utilize data	Practice	1 per 7 practices
	Coordination 3.1	and identify opportunities	Transformation	r r
		for high-cost/high volume	Specialist	
		specialists.	-r ·········	
		-Assist practice with tools		
		such as Clinical Care		
		Compacts for a specialist		
		referral program.		
	<u> </u>	referrat program.	l	l

Other – Clinical	-For practices that are	Quality Analysts	1 per 7 practices
Informatics, Process Improvement, and Policy Support	encountering challenges with their EMR specific to program requirements,	Practice Transformation Specialist	1 per 10 practices
	assist with clinical integration and/or informatics support to	Policy Support	1 per 50 practices
	improve compliance.		
	Practices may need to make additional investments to		
	meet these requirements For identified practice		
	transformation and/or		
	clinical process improvement initiatives,		
	provide project management		
	support to assist practices with local implementation.		
	- As identified, provide updates regarding emerging		
	federal quality/payment, innovation and health IT programs, policies and		
	regulations.		

^{*}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%) - Option 1, Track 1 ☐ Package B (50%) - Option 1, Track 2 ☐ Package C (30%) - Option 2, Track 1 ☐ Package D (30%) - Option 2, Track 2	
Practice Signature	CTO Signature
Practice Signature	

CARE TRANSFORMATION ARRANGEMENT

Appendix C:

Business Associate Agreement between the CTO and the Practice

[Attached hereto]