MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

This Care Transformation Arrangement (“Arrangement”) is between ___________________, a care transformation organization (the “CTO”), and _______________________, (the “Practice”) (each a “Party,” and collectively the “Parties”).

The CTO has been selected by the Centers for Medicare and Medicaid Services (“CMS”), Center for Medicare and Medicaid Innovation (“CMMI”), to serve as a care transformation organization in the Maryland Primary Care Program (“MDPCP”). The Practice is a primary care practice that provides health care services to Medicare beneficiaries, among others, in the State of Maryland.

This Arrangement sets forth the terms and conditions under which the CTO will provide to the Practice certain care transformation services and resources consistent with MDPCP requirements.

1. *Participation Agreements*. Prior to the Effective Date of this Arrangement, the CTO must sign an MDPCP Participation Agreement with CMMI (the “CTO Participation Agreement”). Prior to the Effective Date of this Arrangement, the Practice must sign an MDPCP Participation Agreement with CMMI (the “Practice Participation Agreement”). If either Party does not sign a Participation Agreement with CMMI prior to the Effective Date of this Arrangement, then this Arrangement shall be deemed null ab initio.

2. *Effective Date*. The Effective Date of this Arrangement is January 1, 2021.A Party’s performance obligations under this Arrangement shall not begin prior to the Effective Date.

3. *Term of Arrangement*. This Arrangement is effective for a minimum of one full Performance Year, which consists of a 12-month period beginning on January 1 of each year, and will renew automatically on January 1 of each year, until terminated by either party in accordance with Section 12 of this Arrangement, or upon the execution of a new CTO Arrangement. This Arrangement is subject to early termination by either Party only if: (1) CMS terminates either the CTO Participation Agreement or the Practice Participation Agreement, or (2) if CMS authorizes, in writing, such early termination of this Arrangement.

4. *Offer and Selection of CTO Services*. The Practice is responsible for meeting the Care Transformation Requirements as listed in Appendix A. The CTO will support the Practice in meeting those requirements including any support specified in the either the CTO or Practice Participation Agreements. The CTO has offered to provide any and all of the CTO Services to the Practice, as listed in the package selected in Appendix B. The CTO offers these same CTO Services to all participating practices within the same service option level and Track.

5. *Care Management Fees*. CMS will calculate the Practice’s Care Management Fees (“CMF”) according to the CTO Participation Agreement, the Practice Participation Agreement, and the methodologies described therein. In accordance with the Practice’s selection that was submitted to CMS, the CMF payment split will be as follows:
   - ☐ CTO will receive **30%** of the practice’s CMF payment amount calculated by CMS, and the remaining **70%** of such CMF payment amount will be paid to the Practice.
   - ☐ CTO will receive **50%** of the practice’s CMF payment amount calculated by CMS and the remaining **50%** of such CMF payment amount will be paid to the Practice.

6. *Lead Care Manager*. For practices choosing the 50% option, the CTO will provide the Practice with one or more individuals who are fully dedicated to care management functions of the Practice (the “Lead Care Manager”), and additional services selected in accordance with Section 4. For practices choosing the 30% option, the practice will have its own care manager(s) to work in conjunction with the CTO and the CTO’s offerings in accordance with Section 4. Practice will identify care manager responsible for working with the CTO.

7. *Data Sharing and Privacy*. The Practice authorizes the CTO to have access to all clinical data available in the electronic medical records or shared through the State-Designated Health Information Exchange (“HIE”), including personal health information, of MDPCP Beneficiaries attributed to the Practice. The Practice authorizes the CTO to have access via CRISP to quality and utilization reports available to the Practice. The CTO will include a Business Associate Agreement (“BAA”) for the Practice to approve. The BAA will govern their data sharing, use, and confidentiality, a copy of which is in Appendix C. Each Party will comply with HIE policies and regulations, including patient education requirements, and will execute any separate agreement that may be required by CRISP.

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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

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Date Signed

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Appendix A:

Care Transformation Requirements

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

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Appendix B:

CTO Services/Personnel Offered and Practice Selection

Package A (50%) – Option 1, Track 1

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2	- 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), and referral to specialty services and community resources as needed.	Medical Director & Behavioral Health Team Behavioral Health Care Manager Licensed Clinical Social Worker (LCSW)	1 per 50 practices 1 per 10 practices 1 per 20 practices

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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.	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 health -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.	Licensed Clinical Social Worker (LCSW) Lead Case Manager	1 per 20 practices 1 per 5 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 services. - For practices seeking Track advancement, provide advisory guidance for selection and implementation approach of alternative care modalities (eg., Telehealth).	Licensed Clinical Social Worker (LCSW) Lead Case Manager Pharmacist (PharmD) Practice Transformation Specialist	1 per 20 practices 1 per 5 practices 1 per 20 practices 1 per 7 practices

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Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	- Assist Practices with utilizing reports to efficiently identify IP and ED discharges and develop workflows to outreach to those patients. -Work with practice to 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.	Practice Transformation Specialist Lead Case Managers Pharmacist Licensed Clinical Social Worker (LCSW)	1 per 7 practices 1 per 5 practices 1 per 20 practices 1 per 20 practices
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	-Provide longitudinal case management and care coordination services to high risk and rising risk patients and caregivers in collaboration with their Primary Care Provider (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 planning.	Lead Case Managers Pharmacist (PharmD) Licensed Clinical Social Worker (LCSW)	1 per 5 practices 1 per 20 practices 1 per 20 practices
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	Assist with utilizing available claims and EMR data to identify effective strategies to impact cost, quality, and utilization measures.	Quality Analysts Data Analysts Practice Transformation Specialist	1 per 10 practices 1 per 20 practices 1 per 7 practices
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	Assist with utilizing available claims and EMR data to identify and target at-risk patients likely to benefit from care management services.	Data Analysts Lead Case Managers	1 per 20 practices 1 per 4 practices

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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 setup-sample 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 measures. -Assist practices to identify opportunities, interpret patterns/trends and potential interventions. -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 specialists. -Assist practice with tools such as Clinical Care Compacts for a specialist referral program.	Practice Transformation Specialist	1 per 7 practices

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Other – Clinical Informatics, Process Improvement, and Policy Support		-For practices that are encountering challenges with their EMR specific to program requirements, assist with clinical integration and/or 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.	Quality Analysts Practice Transformation Specialist Policy Support	1 per 7 practices 1 per 10 practices 1 per 50 practices

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Package B (50%) – Option 1, Track 2

Service Category	Care Requirement & Quality Measure	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2	- 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), and referral to specialty services and community resources as needed.	Medical Director & Behavioral Health Team Behavioral Health Care Manager Licensed Clinical Social Worker (LCSW)	1 per 50 practices 1 per 10 practices 1 per 20 practices

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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 curb side consults to providers that have specific drug-related questions as needed.	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 health. -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.	Licensed Clinical Social Worker (LCSW)	1 per 20 practices

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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 services. - For practices seeking Track advancement, provide advisory guidance for selection and implementation approach of alternative care modalities (eg., Telehealth).	Licensed Clinical Social Worker (LCSW) Lead Case Manager Pharmacist (PharmD) Practice Transformation Specialist	1 per 20 practices 1 per 5 practices 1 per 20 practices 1 per 7 practices
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	-Assist practices with utilizing reports to efficiently identify IP and ED discharges and develop workflows to outreach to those patients. -Work with practice to 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.	Practice Transformation Specialist Lead Case Managers Pharmacist	1 per 7 practices 1 per 5 practices 1 per 20 practices

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Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	-Provide longitudinal case management and care coordination services to high risk and rising risk patients and caregivers in collaboration with their Primary Care Provider (PCP). - Promote 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 and provide practices with best practices and toolkit for implementation of Advanced Care Planning. (Eg., documentation & billing requirements). -Support from 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.	Lead Case Managers Practice Transformation Specialist Pharmacist Licensed Clinical Social Worker (LCSW)	1 per 5 practices 1 per 7 practices 1 per 20 practices 1 per 20 practices
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	Assist with utilizing available claims and EMR data to identify effective strategies to impact cost, quality, and utilization measures.	Quality Analysts Data Analysts Practice Transformation Specialist	1 per 10 practices 1 per 20 practices 1 per 7 practices
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	Assist with utilizing available claims and EMR data to identify and target at-risk patients likely to benefit from care management services.	Data Analysts Lead Case Managers	1 per 20 practices 1 per 5 practices

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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 setup-sample 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 plans. -PTS 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 specialists. -Assist practice with tools such as Clinical Care Compacts for a specialist referral program.	Practice Transformation Specialist	1 per 7 practices

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Other – Clinical Informatics, Process Improvement, and Policy Support		-For practices that are encountering challenges with their EMR specific to program requirements, assist with clinical integration and/or 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.	Quality Analysts Practice Transformation Specialist Policy Support	1 per 7 practices 1 per 10 practices 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 (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2	- 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), and referral to specialty services and community resources as needed.	Medical Director & Behavioral Health Team Behavioral Health Care Manager Licensed Clinical Social Worker (LCSW)	1 per 50 practices 1 per 10 practices 1 per 20 practices

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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 health. -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.	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 services. -For 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

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Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	-Assist Practices with utilizing reports to efficiently identify IP and ED discharges and develop workflows to outreach to those patients. -Provide pharmacy and social work support as requested for patients during transitions of care.	Practice Transformation Specialist Licensed Clinical Social Worker (LCSW) Pharmacy	1 per 7 practices 1 per 20 practices 1 per 20 practices
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	-Provide pharmacy and social work support to high risk and rising risk patients and caregivers in collaboration with their Primary Care Provider (PCP) as requested.	Licensed Clinical Social Worker (LCSW) Pharmacist (PharmD)	1 per 20 practices 1 per 20 practices
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	- Assist with utilizing available claims and EMR data to identify effective strategies to impact cost, quality, and utilization measures.	Quality Analysts Data Analysts Practice Transformation Specialist	1 per 10 practices 1 per 20 practices 1 per 7 practices
Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	Assist with utilizing available claims and EMR data to identify and target at-risk patients likely to benefit from care management services.	Data Analysts	1 per 20 practices
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 setup-sample 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 measures. -Assist practices to identify clinical opportunities, interpret patterns/trends, and design performance improvement plans. -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

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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 specialists. -Assist 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 integration and/or 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.	Quality Analysts Practice Transformation Specialist Policy Support	1 per 7 practices 1 per 10 practices 1 per 50 practices

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

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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)	Comprehensiveness & Coordination 3.2	- 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), and referral to specialty services and community resources as needed.	Medical Director Behavioral Health Care Manager Licensed Clinical Social Worker (LCSW)	1 per 50 practices 1 per 10 practices 1 per 20 practices

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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 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 needed.	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 health. -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.	Licensed Clinical Social Worker (LCSW)	1 per 20 practices

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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 services. -For 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 Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	-Assist Practices with utilizing reports to efficiently identify IP and ED discharges and develop workflows to outreach to those patients. -Provide pharmacy and social work support as requested for patients during transitions of care.	Practice Transformation Specialist Licensed Clinical Social Worker (LCSW) Pharmacist (PharmD)	1 per 7 practices 1 per 20 practices 1 per 20 practices
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	-Provide pharmacy and social work support to high risk and rising risk patients and caregivers in collaboration with their Primary Care Provider (PCP) as requested. -Collaborate with patients and caregivers to support Advance Care Planning, as requested. - Support and provide practices with Advanced Care Planning (Eg., documentation & billing requirements.	Pharmacist Licensed Clinical Social Worker (LCSW) Practice Transformation Specialist	1 per 20 practices 1 per 20 practices 1 per 7 practices
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	-Assist with utilizing available claims and EMR data to identify effective strategies to impact cost, quality, and utilization measures. -PTS 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

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CARE TRANSFORMATION ARRANGEMENT

Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	Assist with utilizing available claims and EMR data to identify and target at-risk patients likely to benefit from care management services.	Data Analysts	1 per 20 practices
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 setup- sample 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 measures. -Assist practices to identify clinical opportunities, interpret patterns/trends, and design performance improvement plans. -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 specialists. -Assist practice with tools such as Clinical Care Compacts for a specialist referral program.	Practice Transformation Specialist	1 per 7 practices

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Other – Clinical Informatics, Process Improvement, and Policy Support		-For practices that are encountering challenges with their EMR specific to program requirements, assist with clinical integration and/or 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.	Quality Analysts Practice Transformation Specialist Policy Support	1 per 7 practices 1 per 10 practices 1 per 50 practices

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

SAMPLE

MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

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 ___________________________________

SAMPLE

MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

Appendix C:

Business Associate Agreement between the CTO and the Practice

[Attached hereto]

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