MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

This Care Transformation Arrangement ("Arrangement") is between PHS Doctors CTO, LLC, 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.

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:

MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

FOR THE CARE TRANSFORMATION ORGANIZATION:	FOR THE PRACTICE:
Signature	Signature
Feroz A. Padder, MD, FACC, FSCAI	
Printed Name	Printed Name
MDCTO-0169	
MDPCP CTO ID	MDPCP Practice ID
Founder and Managing Partner	
Title	Title
Date Signed	Date Signed

MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

Appendix A:

Care Transformation Requirements

Comprehensive Primary Care Functions of Advanced Primary Care	Care Transformation Requirement	Practice Track Requirement
Access and Continuity	1.1 Empanel attributed beneficiaries to practitioner or care team.	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

MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

Appendix B:

CTO Services/Personnel Offered and Practice Selection

Package A (50%)

Service Category	Care Requirement & Quality	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2	We provide access to a psychiatrist in a collaborative care arrangement, as well as access to an embedded BH counselor.	Psychiatrist BH Counselor Lead Care Manager	All practices All practices 1:2K patients
Medication Management	Care Management 2.6	We provide access to a Clinical Pharmacist for comprehensive Medication Therapy Management (MTM.)	Pharmacist Lead Care Manager	All practices 1:2K Patients
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	We provide access to a LCSW for coordination of patient needs with available community resources.	Licensed Clinical Social Worker Lead Care Manager	All practices 1:2K Patients
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	We provide support services for Telemedicine, as well as access to Home Health resources and Remote Patient Monitoring (RPM.)	Lead Care Manager Technical Support	1:2K Patients 1 per 10 practices
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	We train all practice Care Teams in the use of CRISP Encounter Notification Service (ENS.) CRISP ENS will be monitored daily to track patients discharged from hospitals or emergency departments and to schedule them for follow-up visits.	Lead Care Manager Care Coordinator	1:2K Patients 1 per 10 practices
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	We train all practice Care Teams in the setup, identification of the main elements of a Care Plan, such as Goals, Interventions, and Actions, and the implementation of Care Plans. The goals where patients can be involved in self-management of their conditions are discussed and local resources for patient education are provided to each Care Team. Providers and Care Teams are trained in engaging patients and their caregivers in the process of advance care planning. The Lead Care Manager, the Care Coordinator, and the Pharmacist work closely with each practice Care Team to monitor and address Care Plans.	Lead Care Manager Care Coordinator Pharmacist	1 per 5 practices, 1:2K patients 1 per 10 practices All practices
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	We train all practice Care Teams in monitoring NCQA/HEDIS quality measure to make sure that all Gaps in Care are addressed according to a carefully designed workflow. The Lead Care Manager works closely with each practice Care Team implement the workflow.	Population Health Data Analyst Practice Transformation Coach Lead Care Manager	All practices All Practices 1:2K Patients

MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	We use clinical data from CRISP Reporting System (CRS), claims data from the CMS Portal, and CRISP Encounter Notification Service (ENS) alerts to intensively train practice Care Teams in the following areas: patient risk stratification; care plans for longitudinal care management; transitional care management and IP/ED discharge follow-up scheduling; and care plans for episodic care management. IP/ED utilization data is analyzed to assist in improving longitudinal and episodic care plans.	Lead Care Manager Care Coordinator Practice Transformation Coach	1:2K patients 1 per 10 practices All Practices
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	We provide training for designated care team members in charge of organizing PFACs and discuss methods of engaging patients, their family, and caregivers to provide feedback to assist in improving the quality of care at our partner practices.	Medical Director Lead Care Manager Care Coordinator	All practices 1 per 5 practices 1 per 10 practices
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	We provide a very innovative and state-of the-art online practice portal for each practice. The practice portal dashboard provides regularly updated data on key performance measures such as the number of Annual Wellness Visits (AWV); follow-up visits within 7-day and 14-day of IP/ED discharge; compliant Gaps in Care; IP/ED utilization; and patient satisfaction survey results. The Medical Director and the Governing Board members representing the participating practices use this data to allocate the necessary resources to improve patient care.	Medical Director Population Health Data Analyst Technical Support	All practices
24/7 Access	Access & Continuity 1.2	Patients with Care Plans will have 24/7 Access to the Care Coordinators.	Lead Care Manager Care Coordinator	1:5 practices 1:10 practices
Referral Management	Comprehensive ness & Coordination 3.1	We aggregate information from our participating practices and to identify the specialists and hospitals providing the best combination of comprehensive care and cost.	Lead Care Manager Care Coordinator	1:5 practices 1:10 practices
Other	HCC Training	We provide intensive training on HCC coding in order to reflect an accurate risk tier for each patient.	Population Health Data Analyst	All Practices

MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

Package B (30%)*

*Practice will have its own Lead Care Manager to work in conjunction with the CTO and the CTO's offerings.

Service Category	Care Requirement & Quality	Description	Staff Type	Ratio of staff (FTE) to practice
Behavioral Health Integration (BHI)	Comprehensiveness & Coordination 3.2	We provide access to a psychiatrist in a collaborative care arrangement, as well as access to an embedded BH counselor.	Psychiatrist BH Counselor	All practices All practices
Medication Management	Care Management 2.6	We provide access to a Clinical Pharmacist for comprehensive Medication Therapy Management (MTM.)	Pharmacist	All practices
Social Determinants Screening & Referral	Comprehensiveness & Coordination 3.3	We provide access to a LCSW for coordination of patient needs with available community resources.	Licensed Clinical Social Worker	All practices
Alternative Care (e.g., Telehealth, home visits)	Access & Continuity 1.3	We provide support services for Telemedicine, as well as access to Home Health resources and Remote Patient Monitoring (RPM.)	Technical Support	1 per 10 practices
Transitional Care Management (TCM)	Care Management 2.2, 2.3, 2.4, 2.5, 2.6	We train all practice Care Teams in the use of CRISP Encounter Notification Service (ENS.) CRISP ENS will be monitored daily to track patients discharged from hospitals or emergency departments and to schedule them for follow-up visits.	Care Coordinator	1 per 10 practices
Care Planning & Self-Management Support	Care Management 2.5, Beneficiary & Caregiver Experience 4.2	We train all practice Care Teams in the setup, identification of the main elements of a Care Plan, such as Goals, Interventions, and Actions, and the implementation of Care Plans. The goals where patients can be involved in self-management of their conditions are discussed and local resources for patient education are provided to each Care Team. Providers and Care Teams are trained in engaging patients and their caregivers in the process of advance care planning. The Lead Care Manager, the Care Coordinator, and the Pharmacist work closely with each practice Care Team to monitor and address Care Plans.	Care Coordinator Pharmacist	1 per 10 practices All practices
Population Health Management & Analytics	Planned Care for Health Outcomes 5.1, eCQMs, Utilization	We train all practice Care Teams in monitoring NCQA/HEDIS quality measure to make sure that all Gaps in Care are addressed according to a carefully designed workflow. The Lead Care Manager works closely with each practice Care Team implement the workflow.	Population Health Data Analyst Practice Transformation Coach	All practices All Practices

MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

Clinical & Claims Data Analysis	Care Management 2.1-2.4, Utilization	We use clinical data from CRISP Reporting System (CRS), claims data from the CMS Portal, and CRISP Encounter Notification Service (ENS) alerts to intensively train practice Care Teams in the following areas: patient risk stratification; care plans for longitudinal care management; transitional care management and IP/ED discharge follow-up scheduling; and care plans for episodic care management. IP/ED utilization data is analyzed to assist in improving longitudinal and episodic care plans.	Care Coordinator Practice Transformation Coach	1 per 10 practices All Practices
Patient Family Advisory Councils (PFACs)	Beneficiary & Caregiver Experience 4.1	We provide training for designated care team members in charge of organizing PFACs and discuss methods of engaging patients, their family, and caregivers to provide feedback to assist in improving the quality of care at our partner practices.	Medical Director Care Coordinator	All practices 1 per 10 practices
Quality & Utilization Performance	Planned Care for Health Outcomes 5.1, eCQMs	We provide a very innovative and state-of the-art online practice portal for each practice. The practice portal dashboard provides regularly updated data on key performance measures such as the number of Annual Wellness Visits (AWV); follow-up visits within 7-day and 14-day of IP/ED discharge; compliant Gaps in Care; IP/ED utilization; and patient satisfaction survey results. The Medical Director and the Governing Board members representing the participating practices use this data to allocate the necessary resources to improve patient care.	Medical Director Population Health Data Analyst Technical Support	All practices
24/7 Access	Access & Continuity 1.2	Patients with Care Plans will have 24/7 Access to the Care Coordinators.	Care Coordinator	1:10 practices
Referral Management	Comprehensive ness & Coordination 3.1	We aggregate information from our participating practices and to identify the specialists and hospitals providing the best combination of comprehensive care and cost.	Care Coordinator	1:10 practices
Other	HCC Training	We provide intensive training on HCC coding in order to reflect an accurate risk tier for each patient.	Population Health Data Analyst	All Practices

MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

Final Practice Selection

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

Practice Signature_____ CTO Signature _____

MARYLAND PRIMARY CARE PROGRAM

CARE TRANSFORMATION ARRANGEMENT

Appendix C:

Business Associate Agreement
between the CTO and the Practice

[Attached hereto]