Question	Summary of Changes
Structure **1. Does your organization have a formal, legally defined, organizational and leadership structure? (e.g., articles of incorporation, board governance, ownership or shareholder conditions, etc.)** Please select one: ○ No ○ Yes	
Financial Standards **2. For CA physician organizations only: Does your group meet the following SB 260 financial standards?** **For groups with statutory exemption, please mark "N/A."** Please select all that apply: ☐ N/A ☐ Yes - Tangible Net Equity ☐ Yes - Working Capital ☐ Yes - 95% of claims paid timely ☐ Yes - Calculate IBNR ☐ Yes - Cash ratio ☐ Yes - File quarterly comprehensive regulatory compliance report with DMHC	
Revenue Streams **3. Does your group (as distinct from individual practitioners) receive revenue from multiple payers?** Please select all that apply: ☐Delegated, capitated HMO contract with ○ 1 commercial health plan ○ 3 or more commercial health plans ○ 5 or more commercial health plans ☐Medicaid managed care health plan contract(s) ☐Medicaid Fee-For-Service (FFS) ☐Medicare Advantage HMO ☐"Traditional" FFS Medicare	

☐Dual Eligible ☐Workers Compensation ☐Children's Health Insurance Program ☐County Indigent Program ☐Military Health System (e.g., TriCare) ☐Foundation and/or Governmental Grants ☐Other, please specify (free text field) 4. **If you selected more than one revenue stream in Question #3, please specify what percentage of each revenue type is in your model. (For instance, 80% delegated, capitated HMO, 10% FFS Medicare, 5% Medicare Advantage HMO, and 5% Medicaid.)** (free text field) 5. **How are you paid by payers?** Please select all that apply: ☐Physician Organization is part of a health system that has a health plan component ☐Global/Full Capitation ☐Percentage (%) of Premium ☐FFS – (e.g., Case Rate, Percent (%) of Medicare) ☐Traditional Capitation (i.e., professional or institutional) ☐P4P (Performance Based Incentives) ☐Shared Savings ☐Other (please describe): ________________________ 6. **How do you pay your providers down-stream?** Please select all that apply: ☐Salary ☐FFS (e.g., Case rate, Percent (%) of Medicare) ☐Capitation, adjusted by age and gender ☐Capitation, additionally adjusted by clinical complexity score ☐Sub-capitation ☐Bundled payments for multi-provider care, i.e. joint replacement, MI, cataract surgery, prenatal care & delivery ☐Episode-based payment for single provider ☐RVU-based productivity	

- ☐Case management incremental fee for patients with known complexity
- ☐Payment for web-based encounters and services (as distinct from office visits)
- ☐Telemedicine services
- ☐Performance-based bonuses (P4P and other reward systems)
- ☐Earned surplus distributions
- ☐Other methods to incentivize desired services, i.e.
  - ☐Cap rate enhancement for extended hours
  - ☐FFS bonus for new patient first visit
  - ☐Enriched house call payment
  - ☐Enhanced payment for completion of preventive services

☐Acceptance of care management responsibility for complex patients

7. **If you selected more than one payment type in Question #6, please specify what percentage of each payment type is in your model. (For instance, 80% salary, 10% capitation, 5% FFS (percent of Medicare), and 5% bundled payments.)**
   (free text field)

8. **How do you bonus your providers down-stream for quality performance and resource utilization?**

Please select all that apply:

- ☐< 5% of compensation tied to quality or resource use metrics
- ☐5-10% of compensation tied to quality or resource use metrics
- ☐10-15% of compensation tied to quality or resource use metrics
- ☐>15% of compensation tied to quality or resource use metrics

Prior Authorizations for Services

9. **Does your group or affiliated MSO process prior authorizations?**

Please select one:

- ○ No. Please jump to question #12
- ○ Yes

10. **Please select all the ways you receive prior authorizations:**
    - ☐Electronically
    - ☐Fax
    - ☐Mail
11. **Are these logged by time of receipt and processed within legally mandated time frames?**

Please select one: ○ No ○ Yes **If yes, does your group report authorization processing timeliness and volume every 6 months to a regulatory body, such as Industry Collaborative Effort (ICE)?** Please select one: ○ No ○ Yes **12. Does your group have peer reviewed authorization criteria for all authorization types?** Please select one: ○ No ○ Yes Please select all that apply: ☐ These criteria are available to network providers ☐ Website ☐ Hardcopy document ☐ By request ☐ These criteria annually reevaluated by a formal professional body within the organization and approved by the governing board ☐ Authorization criteria for some conditions (typically newer procedures, controversial technologies, conflicting academic opinions, etc.) vary by different health plans. Does your group have a policy to address such inconsistencies? Please select one: ○ No. We handle these based upon individual merits. ○ Yes **13. Does your group have guideline-based or criteria-based automatic approval opportunities for authorizations for selected conditions?** Please select one: ○ No	

○ Yes **14. In event of deferred or denied authorizations, is there clear documentation of evaluation and determination by a physician with an unrestricted medical license in your state?** Please select one: ○ No ○ Yes **15. Are authorization approvals electronically linked to claims payment methodologies to facilitate timely disbursement?** Please select one: ○ No ○ Yes **16. What is the turnaround time for providers in obtaining an authorization approval?** Please select one: ○ Real-time ○ Same day ○ 1-5 days ○ 5-10 days ○ >10 days **How do providers obtain the authorization approval?** ○ Via secure electronic means ○ Via phone call ○ Via Fax	
Claims Processing and Payment **17. Does your group process claims and disburse payments to the following providers?** Please select all that apply: ☐ Physician payments ☐ Licensed provider services (including behavioral health) ☐ Optometry ☐ Podiatry	

☐Physical therapy ☐Chiropractic ☐Acupuncture ☐Occupational therapy ☐Ancillary service payments ☐Radiology (including mammography & bone density) ☐Pathology ☐Lab ☐DME ☐Prosthetics ☐Free standing surgery center ☐Hospital inpatient ☐SNF inpatient ☐Pharmacy dispensed drugs ☐Pharmacy ancillary services	
Member Eligibility **18. Does your group have a methodology to determine member eligibility with nearly instant turnaround time?** Please select one: ○ No ○ Yes	
Variable Benefits **19. Does your group determine and administer variable benefit packages for multiple insurance products?** Please select all that apply: ☐ Covered versus non-covered services ☐ Co-pays ☐ Deductibles ☐ Accumulators	
Customer Service **20. Our group has a formal customer service department with the following:** Please select all that apply: ☐ Patient or member access including:	

☐ Live telephone in business hours ☐ Regular mail ☐ Fax ☐ Web portal, and ☐ Secure e-mail? ☐ If telephonic, does your organization have on site staff with capability to engage members speaking languages other than English? ☐ Spanish ☐ Chinese ☐ Tagalog ☐ Vietnamese ☐ Other please specify ☐ Our group's customer service department has formal and regular member outreach functions including both clinical and procedural education and assistance, including: ☐ Web portal ☐ Mail ☐ Direct telephone ☐ Social media ☐ We have a formal complaints and grievance protocol and designated responsible individual(s). ○	
Annual Fiscal Report **21. Does your group produce an audited annual fiscal report?** Please select one: ○ For our board of directors and shareholders ○ For our network providers ○ For a regulatory agency or agencies ○ For contracted health plans ○ A redacted and/or simplified report for the general public	
Financial Risk **22. Does your group assume financial risk for the following kinds of service in one or more of our contracted relationships? (DOFR elements)**	

Please select all that apply:
☐Physician professional services for "physical medical" conditions
☐Behavioral health services (physician, PhD, LCSW, counselors, etc.)
☐ Licensed non-physician professional services (podiatry, audiology, pharmacist consultation, PT, OT, acupuncture)
☐ Refractions, retinal exams, and other vision services by licensed optometrists
☐ Out of network patient-solicited services
☐ Out of area approved referral services
☐Experimental and investigational therapies
☐Organ Transplants
    ☐ Professional fees
    ☐ Tertiary facility fees
    ☐ Candidacy evaluation
    ☐ Donor evaluation and surgery
☐ Inpatient institutional services - acute hospital
☐ Inpatient institutional services - SNF
☐Short term acute rehab (OT/PT/ST/Cardiac)
☐Ambulatory Surgery center institutional services—free standing
☐ Ambulatory Surgery institutional services – hospital based
☐In-Area ER institutional services (defined as within 30 miles)
☐Out of Area ER institutional services
☐ Urgent Care in area
☐ Durable medical equipment
☐Prosthetics including artificial limbs
☐Hearing Aids
☐Standard Laboratory services
☐Esoteric genetic testing
☐Outpatient pharmacy
☐Diabetic Supplies (insulin, lancets, syringes, test strips)
☐Self-injectable drugs
☐ In-office injectables
☐In-office infusions
☐Immunizations – Pediatric and Adult
☐Ambulance in area
☐Planned, non-emergency transportation	

☐Home health care services ☐Radiation Therapy ☐Dialysis ☐Other please specify	
Risk Stratification **23. Our group stratifies risk using the following criteria.** Please select all that apply: ☐Age and gender ☐Claims-derived information ☐Diagnosis of chronic illness (i.e. hypertension, diabetes, osteoporosis, back pain) ☐ Acute medical conditions (i.e. angina, pregnancy, hip fracture, new cancer diagnosis) ☐Care patterns (i.e. frequent ER visits, prolonged opiate use, multiple pharmacy fill sites and/or ordering physicians for controlled substances) ☐HCC coding ☐ Internal case management information regarding vulnerable conditions (i.e. recent admission for CVA, neurosurgery referral for back pain, nerve conduction study for CTS, frail elderly, spouse's death) ☐Physician referral	
Individual Physician Resource Use **24. Does your group provide individual physician reports regarding resource use, referral patterns, and cost of care for internal review, discussion, and collegial provider engagement?** Please select one: ○ No ○ Yes	
Cost, Data and Demographic Integration **25. Can your group integrate cost, clinical data, and demographics into an actionable report to inform local group decisions, care management priorities, and assessment of network adequacy?** Please select one: ○ No	

○ Yes	
HIPAA Compliance **26. Does your group have a formally designated HIPAA Compliance officer and a formally defined officer or department charged with compliance with state and federal laws and regulations?** Please select one: ○ No ○ Yes	
Relationships with Local Employers **27. Does your organization have a formal relationship with a local employer for worksite-based health services coordinated with mainstream medical group care?** Please select one: ○ No ○ Yes	
Patient Rights **28. Does organization have a formal policy defining patient rights and responsibilities, commitment to equity, and privacy assurances?** Please select one: ○ No ○ Yes	
PPO Care Management **29. Does your organization have a program to provide coordinated care services, i.e. the same systematic supports offered for HMO patients, for referred PPO patients with clinical complexity?** Please select one: ○ No ○ Yes	

Medicare Contracts **30. Please select all the CMS programs in which you participate?** Please select all that apply: ☐CMS demonstration projects ▫ Please list which one(s): ________________ ☐ Capitated contract with a Medicare Advantage (MA) plan ☐ MSSP ACO Track 1 ☐ MSSP ACO Track 2 ☐ MSSP ACO Track 3 ☐ Next Gen ACO ☐ ACO Track 1+ ☐ Comprehensive ESRD Care ☐ CPC+ (Comprehensive Primary Care Plus) ☐ Oncology Care (two-sided risk arrangement) ☐ Physician Group Practice Transition ☐ Bundled Payments for Care Improvement ☐ New Voluntary Bundled Payment ☐ Comprehensive Care for Joint Replacement Payment (Certified Electronic Health Record Technology [CEHRT]) ☐ Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT track) ☐ Transforming Clinical Practices Initiative ☐ Million Hearts ☐ Health Care Innovation ☐ Other (free text field)	