SURVEY INSTRUCTIONS

1. Be sure to read the instructions for each question carefully. This survey will take approximately 15 minutes to complete.

2. Please complete this survey for your hospital. If you feel that this survey should also be completed for your integrated delivery network or your system, please indicate that at the end of the first section of the survey.

3. The survey may be completed by multiple individuals. For example, the chief medical officer may answer questions related to health services, and the chief quality officer may answer questions related to performance data. Please assign one person to oversee the completion and return of the survey.

4. For questions that ask you to provide specific numbers or percentages, please supply your best estimates in the space provided.

5. For questions that provide scales, please offer your best assessment based upon your hospital's experiences. If the statement strongly applies to only a small percentage of the departments in your hospital, you should tend to disagree with the statement as it applies to your entire hospital. However, if the statement strongly applies to most departments in your hospital, you should tend to agree with the statement.

YOUR PARTICIPATION IS GREATLY APPRECIATED

Definitions

The medical home concept refers to the provision of comprehensive primary care services that facilitates communication and shared decision-making between the patient, his/her primary care providers, other providers, and the patient's family. (Section 1a 4)

Narrow Networks are health insurance plans that place limits on the number of doctors and hospitals available to their subscribers. While there are many types of narrow networks, for purposes of this survey, we define a narrow network as one that includes fewer than 50% of the hospitals or doctors in the service area. (Section 1b.11)

Broad Networks are health insurance plans that place very few limits on the number of hospitals or doctors available to their subscribers. For the purposes of this survey, that would include 50% or greater of the hospitals or providers in the service area. (Section 1b. 11)

Tiered Networks group providers and hospitals into distinct tiers based on cost and quality. Higher tiers typically are made up of preferred hospitals and providers and generally require the least amount of subscriber cost sharing, such as co-pays or coinsurance. Lower tiers, typically are made up of non-preferred hospitals and providers and require higher cost sharing. Health plans use these networks to offer broad choice while using financial incentives to increase utilization of preferred tiers. (Section 1b.11)

Bundling is a payment mechanism whereby a provider entity sets a target price for services provided across one or more parts of the care continuum. For example, an entity might set a target price for the hospital and physician services provided as part of an inpatient stay or for the post-acute care services involved in a single episode of care or for all of the services (inpatient, physician, post-acute care) provided during a specified time period after a triggering event (e.g. hospital admission). The target price may become the payment the entity receives for the bundle of services and splits among those providing the care, or individual providers may be paid their usual rates with reconciliation against the target at the end of the year.

Capitation is an at-risk payment arrangement in which an organization receives a fixed prearranged payment and in turn guarantees to deliver or arrange all medically necessary care required by enrollees in the capitated plan. The fixed amount is specified within contractual agreements between the payer and the involved organization. The fixed payment amount is based on an actuarial assessment of the services required by enrollees and the costs of providing these services, recognizing enrollees' adjustment factors such as age, sex, and family size.
Definitions (continued)

Clinically Integrated Network is a “Clinically Integrated Network (CIN): A network of providers that establishes and operates on an ongoing and active basis: mechanisms to monitor and control utilization of healthcare services that are designed to control costs and ensure quality; selectively chooses network providers who are likely to further these efficiency objectives; and, utilizes investment of significant monetary and human capital in the necessary infrastructure and capability to realize the cost and quality objectives.”

Shared risk payments are payment arrangements in which a hospital and a managed care organization share the risk of adverse claims experience. Methods for sharing risk could include: capitation with partial refunds or supplements if billed hospital charges or costs differ from capitated payments, and service or discharge-based payments with withholds and bonus payouts that depend on expenditure targets.

Fee for service plus shared savings includes all risk-based surplus or deficit arrangement contracts, not just those from Medicare Shared Savings program. (Section 1b8c and 9c)

An ACO contract has two essential elements: (1) accountability for the total costs of care for the population of patients attributed to the primary care physicians in the organization; (2) financial incentives that link the magnitude of bonus payments to performance on quality measures (which could include technical quality, patient experience and/or health outcome measures). This will generally involve a contract where the payer establishes a target budget for one or more years for the total costs of care for the agreed-upon patient population, the payer tracks actual spending and performance on quality; and the provider receives bonus payments that could include a share of savings that are (or are not) contingent on meeting quality targets, with (or without) additional bonuses related to performance on those quality measures. Includes any type of qualifying contract, not just those relating to CMS.
Section 1: TO BE COMPLETED BY ALL HOSPITALS

Section 1a: Ability to Provide Integrated Primary, Acute, and Post-Acute Services

1. Does your hospital arrange for the provision of the following health care services? Please indicate the health care services provided and the type of arrangement. (check all that apply)

<table>
<thead>
<tr>
<th>Health Service</th>
<th>Owned or provided by my hospital or my system</th>
<th>Provided by my network or through a formal contractual arrangement/joint venture in my community</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Primary Care</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b. Routine Specialty Care (e.g., cardiology, orthopedics)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>c. Specialized Care (e.g., transplant, hand surgery)</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>d. Urgent Care/Emergency Care</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>e. Hospital Inpatient Care</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>f. Rehabilitation Care</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>g. Home Health</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>h. Skilled Nursing</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>i. Behavioral Health</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>j. Pediatric Care</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>k. Palliative/Hospice Care</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>l. Other, please describe:</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
2. Please indicate the activities your hospital engages in to coordinate care across settings and the extent to which they are used.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Not used at all</th>
<th>Used minimally</th>
<th>Used moderately</th>
<th>Used widely</th>
<th>Used hospital-wide</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Chronic care management processes or programs to manage patients with high-volume, high-cost chronic conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Use of predictive analytic tools to identify individual patients at high risk for poor outcomes or extraordinary resource use</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>c. Prospective management of patients at high risk for poor outcomes or extraordinary resource use by experienced case managers</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>d. Assignment of case managers for outpatient follow-up to patients at risk for hospital admission or readmission</td>
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<tr>
<td>e. Medication reconciliation as part of an established plan of care</td>
<td></td>
<td></td>
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<tr>
<td>f. Provision of visit summaries to patients as part of all outpatient encounters and scheduling of follow up visit and/or specialty referrals at the time of the initial encounter</td>
<td></td>
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<tr>
<td>g. Post-hospital discharge continuity of care program with scaled intensiveness based upon a severity or risk profile for adult medical-surgical patients in defined diagnostic categories or severity profiles</td>
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<tr>
<td>h. Arrangement of home visits by physicians, advanced practice nurses, or other professionals for homebound and complex patients for whom office visits constitute a physical hardship</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>i. Nurse case managers whose primary job is to improve the quality of outpatient care for patients with chronic conditions (e.g., asthma, CHF, depression, diabetes)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>j. Disease management programs for one or more chronic care conditions (e.g., asthma, diabetes, COPD)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Hospitalists for medical/surgical inpatients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. Telephonic outreach to discharged patients within 72 hours of discharge</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>m. Integration of physical and behavioral health services in primary care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n. Integration of physical and behavioral health services on inpatient units (e.g. cardiology, obstetrics, oncology, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. Do you have patient-centered medical homes associated with your hospital? □ Yes □ No

4. If yes, how many patient-centered medical homes are associated with your hospital?

<table>
<thead>
<tr>
<th>Number of homes</th>
<th>Number of patients receiving care</th>
<th>Do not know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Number owned by my hospital</td>
<td>□□□□</td>
<td>□</td>
</tr>
<tr>
<td>b. Number affiliated with my hospital</td>
<td>□□□□</td>
<td>□</td>
</tr>
<tr>
<td>c. Number NCQA certified</td>
<td>□□□□</td>
<td>□</td>
</tr>
</tbody>
</table>

5a. Does your hospital have a process for facilitating safe transitions? □ Yes □ No

5b. If yes, describe your hospital's process for facilitating safe transitions. (Check all that apply)

<table>
<thead>
<tr>
<th>How is the process administered?</th>
<th>Is the process:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Standard?</td>
</tr>
<tr>
<td>1. Identifying patients who transition between settings of care</td>
<td>□</td>
</tr>
<tr>
<td>2. Sharing clinical information between settings of care</td>
<td>□</td>
</tr>
<tr>
<td>3. Providing patient discharge summaries to primary care providers</td>
<td>□</td>
</tr>
<tr>
<td>4. Providing patient discharge summaries to other providers (e.g., rehabilitation hospitals)</td>
<td>□</td>
</tr>
<tr>
<td>5. Tracking the status of transitions, including the timing of information exchange</td>
<td>□</td>
</tr>
<tr>
<td>6. Confirmed patients and their advocates understand next steps in care process</td>
<td>□</td>
</tr>
</tbody>
</table>
Section 1b. Ability to Manage Financial Risk, Receive Bundled Payment, and Calculate and Distribute Shared Savings

6. Does your hospital have a legal structure in place to receive and distribute payments to participating providers of care?
   a. □ Yes, a limited liability corporation
   b. □ Yes, an independent practice association
   c. □ Yes, a corporation
   d. □ Yes, a foundation
   e. □ Yes, a provider-based rural health clinic
   f. □ No, but we plan to establish one in the next year
   g. □ No
   h. □ Other, please describe:__________________________

7. What types of arrangements or models does your hospital or your owned medical groups currently have in place? (check all that apply)
   a. □ Medicare Shared Savings ACO
   b. □ Medicare Pioneer ACO
   c. □ Medicare bundled payments
   d. □ Medicaid contract with state or through a Medicaid health plan
   e. □ Bundled payments with insurance companies or through direct contracts with employers
   f. □ Direct contractual relationships with employers
   g. □ Insurance products offered through the hospital’s own insurance license
   h. □ Insurance products offered through a contract with an insurance company administrator
   i. □ Insurance products offered through a shared risk partnership with an insurance company
   j. □ Commercial bundled payments
   k. □ Fee-for-service contracts with insurance payers
   l. □ Other, please describe:__________________________

8. What types of arrangements or models does your hospital or your owned medical groups anticipate launching in the next two years? (check all that apply)
   a. □ Medicare Shared Savings ACO
   b. □ Medicare Pioneer ACO
   c. □ Medicare bundled payments
   d. □ Medicaid contract with state or through a Medicaid health plan
   e. □ Bundled payments with insurance companies or through direct contracts with employers
   f. □ Direct contractual relationships with employers
g. □ Insurance products offered through the hospital’s own insurance license
h. □ Insurance products offered through a contract with an insurance company administrator
i. □ Insurance products offered through a shared risk partnership with an insurance company
j. □ Commercial bundled payments
k. □ Fee-for-service contracts with insurance payers
l. □ Other, please describe: __________________________

9. Does your hospital/health system have, or plan to have in the next two years, a state-approved health insurance license to provide health insurance services?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Yes, in the next two years</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Commercial/employer</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>b. Medicare</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>c. Medicaid</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

10. Does your organization have, or plan to have in the next two years, a contractual relationship with a licensed insurance company to offer an insurance product that features your organization as the primary network?

□ Yes          □ Yes, in the next two years □ No

11. If yes to question 9 or 10, how is your organization positioned within the network of insurance products that you offer through either your own insurance license or a contractual relationship with an insurance partner? (check all that apply)

a. □ Narrow network where my organization provides all, or nearly all, of the care
b. □ Narrow network where my organization is a top tier provider
c. □ Narrow network where my organization is not a top tier provider
d. □ Broad network where my organization is a top tier provider
e. □ Broad network where my organization is not a top tier provider
f. □ Broad network where there are no distinct provider tiers

12. Does your hospital contract directly with self-funded employee plans? □ Yes □ No

13. What percentage of your hospital’s revenue is from capitated arrangements? Please indicate the percentages for arrangements with a health plan (hospital-owned, partnership agreement, or contractual arrangement), directly from Medicare Advantage, or with your state’s Medicaid program.

g. Health plan  _______ %
h. Medicare Advantage  _______ %
i. Medicaid  _______ %
14. Does your hospital have contracts with payers where payment is tied to performance on a defined set of quality/safety measures?

☐ Yes  ☐ No

a. If yes, what percentage of your hospital’s net patient revenue is paid on this basis? _____% 
b. Please estimate what percentage of your hospital’s net patient revenue will be paid on this basis 2 years from now. _____% 

15. Please indicate below the percentage of your hospital’s net patient revenue that is paid based on the following payment mechanisms.

<table>
<thead>
<tr>
<th>Type of Payment Arrangement</th>
<th>Percent of Net Patient Revenue (must sum to 100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Fee for Service – DRG</td>
<td>_________</td>
</tr>
<tr>
<td>b. Fee for Service – Per Diem</td>
<td>_________</td>
</tr>
<tr>
<td>c. Fee for Service plus shared savings</td>
<td>_________</td>
</tr>
<tr>
<td>d. Bundled payments (inpatient plus physician)</td>
<td>_________</td>
</tr>
<tr>
<td>e. Bundled payments (inpatient, physician and post-acute)</td>
<td>_________</td>
</tr>
<tr>
<td>f. Partial and global capitation payments</td>
<td>_________</td>
</tr>
<tr>
<td>g. Other, please describe:</td>
<td>____________________________________________</td>
</tr>
</tbody>
</table>

16. Please estimate below the percentage of your hospital’s net patient revenue that will be paid based on the following payment mechanisms 2 years from now.

<table>
<thead>
<tr>
<th>Type of Payment Arrangement</th>
<th>Percent of Net Patient Revenue (must sum to 100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Fee for Service – DRG</td>
<td>_________</td>
</tr>
<tr>
<td>b. Fee for Service – Per Diem</td>
<td>_________</td>
</tr>
<tr>
<td>c. Fee for Service plus shared savings</td>
<td>_________</td>
</tr>
<tr>
<td>d. Bundled payments (inpatient plus physician)</td>
<td>_________</td>
</tr>
<tr>
<td>e. Bundled payments (inpatient, physician and post-acute)</td>
<td>_________</td>
</tr>
<tr>
<td>f. Partial and global capitation payments</td>
<td>_________</td>
</tr>
<tr>
<td>g. Other, please describe:</td>
<td>____________________________________________</td>
</tr>
</tbody>
</table>

17. Regarding bundled payment involving inpatient and ambulatory services (such as for orthopedics or cardiac services), is your hospital:

a. ☐ Currently in a bundled payment arrangement (check all the apply)

b. ☐ In negotiations with a private insurer or employer about a bundled payment program to start in the next 12 months

c. ☐ Considering applying for a bundled payment program in the next 12 months (check all the apply)
   1. ☐ Retrospective acute hospital stay plus post-acute care (CMS)
   2. ☐ Retrospective post-acute care only (CMS)
   3. ☐ Acute care hospital stay only (CMS)
   4. ☐ Medicaid
   5. ☐ Private Payer
   6. ☐ Employer

d. ☐ Not considering a bundled payment program in the next 12 months
Section 1c. Monitor and Share Performance Data

18. Does the hospital have the ability to detect readmissions, even when the patient is readmitted to a different hospital?
   a. ☐ Yes, we can detect virtually all readmissions
   b. ☐ Yes, we can detect most readmissions
   c. ☐ Yes, we can detect readmissions, but only to our hospital
   d. ☐ No

19. Does your hospital systematically track the source of the readmission (e.g., readmitted from home, rehabilitation facility, etc.)?
   ☐ Yes ☐ No

20. Does your hospital have leadership and team programs to improve communication within the clinical team and with patients?
   ☐ Yes ☐ No

21a. Does your hospital have an organized program to train clinical leadership in continuous quality improvement methods (e.g., statistical analysis tools, Lean production, Six Sigma) and team training?
   ☐ Yes ☐ No

21b. If yes, what methods/programs does your hospital use? (Check all that apply)
   1. ☐ Lean
   2. ☐ Six Sigma
   3. ☐ Baldridge
   4. ☐ PDSA (Plan-Do-Study-Act)
   5. ☐ Other, please describe: __________________________________________

22. Has your hospital established a Clinically Integrated Network? ☐ Yes ☐ No

23. What is the total number of your employed physicians? ___________

24. What is the percent of your employed physicians that are primary care? ________%

25. Are your employed or self-employed physicians part of your ACO or clinically integrated network (CIN)
   ☐ Yes ☐ No
26. Are you currently partnering with another entity that has established or is establishing an ACO? (Check all that apply)

a. ☐ Yes, formal partnership or joint venture arrangement with physicians and other professionals in group practices
b. ☐ Yes, formal partnership or joint venture arrangement with physicians and other professionals in network of practices
c. ☐ Yes, informal arrangement with other provider(s)
d. ☐ Yes, formal partnership with insurer
e. ☐ No, but have plans to do so in the next year
f. ☐ No, but considering to do so in the future
g. ☐ No

27. Do you feel that this survey should also be completed by an integrated delivery network or system with which you are affiliated?

☐ Yes    ☐ No    If yes, name of entity ______________________________

28. Has your hospital established a separate legal entity for an ACO with the goal of being able to accept contracts to provide health care for a defined population?

a. ☐ Yes, my hospital has established an ACO (Continue to Section 2)
b. ☐ Yes, my hospital is part of an ACO (Continue to Section 2)
c. ☐ No, but my hospital is actively working to establish or join an ACO in the future (Continue to Section 2)
d. ☐ No, my hospital is no longer engaged in an ACO. (End of Survey)
e. ☐ No (End of Survey)
f. ☐ Do not know (End of Survey)

Please note that if you have indicated that your hospital has or is working to establish or join an ACO please continue to section 2.

If you have indicated that your hospital is not engaged in or working to establish or join an ACO, this is the end of the survey. We thank you for your time and participation.
Section 2: COMPLETE THIS SECTION ONLY IF YOUR HOSPITAL HAS OR INTENDS TO ESTABLISH OR JOIN AN ACO. THESE QUESTIONS ASK YOU ABOUT YOU AS THE ACO, NOT YOU AS THE HOSPITAL.

IF YOU ARE WORKING TO ESTABLISH OR JOIN AN ACO, YOUR RESPONSE SHOULD REFLECT HOW THE ACO PLANS TO OPERATE.

Section 2a: ACO Organization

1. What is the name of your ACO or the name of the ACO you have joined?

Name ________________________________________________________________

Address ______________________________________________________________

City ______________________________________ State ______

Primary Contact ______________________________________ Telephone Number ______________

2. What legal structure does the ACO use?
   a. ☐ Existing parent legal structure
   b. ☐ New legal entity, such as an LLC
   c. ☐ PHO (Physician Hospital Organization)
   d. ☐ Other, please describe: ______________________

3. How would you characterize the governance of the ACO?
   a. ☐ Physician-led ACO
   b. ☐ Hospital-led ACO
   c. ☐ Consumer-led ACO
   d. ☐ Employer-led ACO
   e. ☐ Payer-led ACO
   f. ☐ Joint venture: physician- and hospital-led ACO
   g. ☐ System-led ACO
   h. ☐ Community stakeholder organization
   i. ☐ Other, please describe:____________________

4. How many members of the governing board of the legal entity that oversees the ACO are considered “patient” or “consumer” representatives?

_________ Consumer members of _________ total number on board
5. What shared savings program(s) has your ACO pursued? (Check all that apply)
   a. ☐ Medicare Shared Savings Program that began in January 2012
   b. ☐ Center for Medicare and Medicaid Innovation ACO programs (Pioneer Model)
   c. ☐ Commercial payer partnership (including self-insured employers)
   d. ☐ Medicaid Program
   e. ☐ Do not know

6. What kind of risk arrangements does the ACO contract specify at any point during the first three years? (Check all that apply)
   a. ☐ Upside risk or simple shared savings model, in which the ACO receives a share of savings when actual spending is below the total cost of care target, but is not at risk for losses if spending exceeds the total cost of care target.
   b. ☐ Two-sided or symmetric shared savings model, in which the ACO receives a share of savings when actual spending is below the total cost of care target and is at risk for losses if spending exceeds the total cost of care target.
   c. ☐ Global payment under fee-for-service, in which the ACO has an established spending target and gets to retain all of the savings below the established target and is at risk for most or all of the costs above the target.
   d. ☐ Partial capitation, in which the ACO receives a per member, per month payment for specific services such as primary care, but others are still paid on a fee-for-service basis. The ACO will be expected to return some or all of these per member payments to the extent that the total cost of care target is exceeded.
   e. ☐ Other, please describe: ____________________________

7. Under Medicare regulations, ACOs may select to operate using one of two risk models during the first three years. Which did your ACO choose?
   a. ☐ One-sided risk model, where the ACO is eligible to share in savings for the first two years and savings and losses for the third year, with a maximum savings eligibility of up to 50%
   b. ☐ Two-sided risk model, where the ACO shares both savings and losses, with a maximum savings eligibility of up to 60%
   c. ☐ Do not know

8. Is your organization currently negotiating with at least one private payer to establish an ACO contract? (i.e., a contract that establishes accountability for the total costs of care and links performance on quality measures to the size of the bonus payments.)
   a. ☐ Yes, we have an ACO contract.
   b. ☐ Yes, we have a signed letter of agreement
   c. ☐ No (Skip to Question 12)
9. If yes, when do you plan on having a signed shared savings ACO contract with either a private or public payer?
   a. □ Already have signed contract
   b. □ Within one year
   c. □ In two to three years
   d. □ In four to five years

10. What is the relationship between the shared savings bonus and achievement of quality measurement targets?
    a. □ We are only eligible for shared savings bonuses if we meet ALL quality targets
    b. □ We are eligible for shared savings bonuses if we meet some quality targets
    c. □ All bonus payments are based on cost savings alone
    d. □ We are eligible for some bonus payments based on cost savings alone
    e. □ Not applicable (partial capitation or global payment model)

11. What percentage of additional income could the ACO receive if it achieves a high level of performance? (*If the ACO has multiple contracts with differing performance standards, please provide your best estimate of additional income if performance standards were met across all contracts.)
    ______ % of total ACO patient care revenue

12. How are primary care and physician specialists involved in the governance/oversight of your ACO? Please check appropriate boxes below, if known.

    | Board Member | Board Officer | Board Committee Chair |
    |--------------|--------------|-----------------------|
    a. Primary care physicians | □ | □ | □ |
    b. Physician specialists | □ | □ | □ |

13. Do primary care and physician specialists have an equity position in the ACO? Please check appropriate boxes below, if known.

    | Equity holder | Non-Equity holder |
    |---------------|-------------------|
    a. Primary care physicians | □ | □ |
    b. Physician specialists | □ | □ |
14. In which of the following physician arrangements does your ACO participate? For physician arrangements that are reported, please enter the number of physicians involved, if known. (check all that apply)

My ACO Participates in the arrangement

<table>
<thead>
<tr>
<th>My ACO Participates in the arrangement</th>
<th>Number of Physicians participating in the arrangement</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Independent Practice Association</td>
<td></td>
</tr>
<tr>
<td>b. Group practice without walls</td>
<td></td>
</tr>
<tr>
<td>c. Open Physician-Hospital Organization (PHO)</td>
<td></td>
</tr>
<tr>
<td>d. Closed Physician-Hospital Organization (PHO)</td>
<td></td>
</tr>
<tr>
<td>e. Management Service Organization (MSO)</td>
<td></td>
</tr>
<tr>
<td>f. Integrated Salary Model</td>
<td></td>
</tr>
<tr>
<td>g. Equity Model</td>
<td></td>
</tr>
<tr>
<td>h. Foundation</td>
<td></td>
</tr>
<tr>
<td>i. Other, please describe:</td>
<td></td>
</tr>
</tbody>
</table>

15. Please report the total number of physicians with privileges at your hospital that participate in your ACO.

<table>
<thead>
<tr>
<th>(1) Total Employed</th>
<th>(2) Total Individual Contract</th>
<th>(3) Total Group Contract</th>
<th>(4) Not Employed or Under Contract</th>
<th>(5) Total Privileged</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Primary care (general practitioner, general internal medicine, family practice, general pediatrics, obstetrics/gynecology, geriatrics)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Emergency medicine physician</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Hospitalist</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>d. Intensivist</td>
<td></td>
<td></td>
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<tr>
<td>e. Radiologist/pathologist/anesthesiologist</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Other specialist, please describe:</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

16. What percentage of the primary care practices (PCP) that serve your ACO population(s) have an advanced patient-centered medical home (e.g., team-based care, care managers, patient registries, automated patient and provider reminders, disease management programs, open access scheduling, etc.)?

<table>
<thead>
<tr>
<th>% with advanced patient-centered medical homes</th>
<th>Do not know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Owned PCPs serving the ACO population(s)</td>
<td></td>
</tr>
<tr>
<td>b. Aligned PCPs serving the ACO population(s)</td>
<td></td>
</tr>
<tr>
<td>c. Other PCPs serving the ACO population(s)</td>
<td></td>
</tr>
</tbody>
</table>
17. For each item, please rate on a scale from 1 (no challenge) to 5 (extreme challenge) the perceived challenge your organization or partner organization faced in becoming an ACO.

<table>
<thead>
<tr>
<th></th>
<th>1 No challenge</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 Extreme challenge</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Motivating physicians to participate in the ACO</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Developing physician leadership</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>c.</td>
<td>Resolving issues between primary care and specialty physicians</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>d.</td>
<td>Raising start-up capital</td>
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<tr>
<td>e.</td>
<td>Developing a workable governance structure (e.g., agreeing on the number of physicians and hospital reps to sit on the board)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>f.</td>
<td>Reducing clinical variation</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>g.</td>
<td>Developing clinical and management information systems</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>h.</td>
<td>Developing and maintaining common culture</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>i.</td>
<td>Aligning incentives to encourage provider productivity, while minimizing unnecessary utilization of services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j.</td>
<td>Reducing costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k.</td>
<td>Accessing capital and investing on a system wide basis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>l.</td>
<td>Increasing the size of the covered patient population</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>m.</td>
<td>Intra-system operability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n.</td>
<td>Data analytics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o.</td>
<td>Developing mechanisms for shared savings distributions</td>
<td></td>
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</tr>
</tbody>
</table>
18. Which of these provisions in the Medicare ACO regulations posed a challenge to your organization’s ability to participate in the Medicare Shared Savings Program? (Check all that apply)

a. ☐ Application process and requirements
b. ☐ Legal and governance structure
c. ☐ ACO marketing guidelines
d. ☐ Attribution methodology
e. ☐ Quality measurement and reporting requirements
f. ☐ Shared savings payments
g. ☐ Expenditure benchmark and technical adjustments to the benchmark
h. ☐ ACO Antitrust policy
i. ☐ Other, please describe: ________________________________

19. Does your ACO arrange for the provision of the following health care services? Please indicate the health care services provided and the type of arrangement. (Check all that apply)

<table>
<thead>
<tr>
<th>Health Service</th>
<th>Owned or provided by my ACO</th>
<th>Provided by my network or through a formal contractual arrangement/joint venture in my community</th>
<th>Name of Network/Contractual Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Primary Care</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>b. Routine Specialty Care (e.g., cardiology, orthopedics)</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>c. Specialized care (e.g., transplant, hand surgery)</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>d. Urgent Care/Emergency Care</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>e. Hospital Inpatient Care</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>f. Rehabilitation Care</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>g. Home Health</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>h. Skilled Nursing</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>i. Behavioral Health</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>j. Pediatric</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>k. Palliative/Hospice Care</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>l. Other, please describe:</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>
20. How does your ACO determine its patient population? (Check all that apply)
   a. Demographic information of the community
   b. Based on estimated volume of services
   c. Based on estimated volume of patient panels of affiliated providers
   d. Based on population using ACO primary care physicians
   e. Enrollment in a program
   f. Other, please describe: ________________________________
   g. We do not estimate the number of patients (Skip to Question 22)

21. What is the total number of patients that are attributed to your ACO? _____________

22. Does your ACO categorize its patient population based on patients’ health needs (e.g., chronic conditions)?
   a. Yes
   b. No
   c. Do not know

23. Are patients notified when they are attributed to the ACO and given the option to opt out?
   a. No
   b. Yes, they will be notified and can opt out
   c. Yes, they will be notified but cannot opt out
   d. Do not know

24. Does your ACO have a systematic process for identifying eligible patients and providing the following population health management services? (Check all that apply)
   a. Wellness or preventive care services
   b. Chronic disease management services
   c. End of life/palliative care services
   d. Complex case management services
   e. None of the above (Skip to Question 26)

25. Does your ACO’s process to identify patients qualifying for the above services include the following data types? (Check all that apply)
   a. Health risk assessments
   b. Outpatient claims or encounter data from participating practitioners and providers
   c. Outpatient claims or encounter data from non-participating practitioners and providers
   d. Inpatient claims or encounter data from participating practitioners and providers
26. To what degree are ACO patients’ transitions between settings across the continuum of care (including specialists, acute care, and post-acute sites of care) coordinated with the patients' primary care providers?

   a. □ Not at all
   b. □ Some of the time
   c. □ Most of the time
   d. □ All of the time

Section 2b: Communication of Clinical Information to All Providers/Health Information Technology

27. Please indicate the level of participation of your ACO in a regional health information exchange or regional health information organization.

   a. □ Participating and actively exchanging data in at least one HIE/RHIO
   b. □ Have the electronic framework to participate but not participating in any HIE/RHIO at this time
   c. □ Do not have the electronic framework to participate and not participating in any HIE/RHIO at this time
   d. □ Do not have the electronic framework to participate and not participating in any HIE/RHIO at this time, but plan to so in the next year

28. Please indicate below the organizations with which your ACO exchanges clinical information. (Check all that apply)

   a. □ With ambulatory providers inside our ACO
   b. □ With ambulatory providers outside of our ACO
   c. □ With other providers outside of our ACO

29. Please indicate which of the following elements your exchange process includes. (Check all that apply)

   a. □ An agreement with primary care physicians about how to exchange information (e.g., content of information, timelines for response)
   b. □ An agreement with physician specialists about how to exchange information (e.g., content of information, timelines for response)
   c. □ An agreement with other providers about how to exchange information (e.g., content of information, timelines for response)
   d. □ A description of how the ACO/hospital/health system facilitates referrals (e.g., content of information, timelines for response)
30. Does your ACO provide resources or support for the use of chronic care registries for one or more diagnosis-based conditions (e.g., diabetes, CHR, asthma, CAD, COPD)?

   a. ☐ Yes, we have a chronic care registry for one condition (e.g., diabetes)
   b. ☐ Yes, we have a chronic care registry for two conditions (e.g., diabetes and asthma)
   c. ☐ Yes, we have a chronic care registry for 3 or more conditions (e.g., diabetes, asthma, CAD)
   d. ☐ No (Skip to question 32)

31. If yes, please indicate if the registry includes any of the following features. (Check all that apply)

   a. ☐ Real time information (data update cycle ≤ 30 days) available to office practitioners
   b. ☐ Generation of action lists for patients who are due or overdue for tests or services according to standard guidelines
   c. ☐ Generation of action lists for practitioners with patients whose measures fall outside target ranges
   d. ☐ Links to the ACO/hospital/health system’s electronic health record

Section 2c: Ability to Manage Financial Risk, Receive Bundled Payment, and Calculate and Distribute Shared Savings

32. Does your ACO have a legal structure in place to receive and distribute payments to participating providers of care?

   a. ☐ Yes, a limited liability corporation
   b. ☐ Yes, an independent practice association
   c. ☐ Yes, a corporation
   d. ☐ Yes, foundation
   e. ☐ No, but we plan to establish one in the next year
   f. ☐ No

33. Does your ACO have the capability to manage its resources effectively, as evidenced by having a financial risk management plan in place with the following features? (Check all that apply)

   a. ☐ A process for verifying patient eligibility and benefits
   b. ☐ Information systems to track utilization
   c. ☐ Risk adjustment methodology to determine required reimbursement levels
   d. ☐ Process to conduct ongoing monitoring of services rendered and the cost for those services compared to the revenue received
   e. ☐ Stop-loss or reinsurance provisions
   f. ☐ Financial strength requirements to accept risk
   g. ☐ None of the above
34. Please indicate which performance indicators you currently provide, are planning to provide, or not planning provide to practitioners, based on the performance of the ACO as a whole.

<table>
<thead>
<tr>
<th>Incentives and Indicators</th>
<th>Currently Provide</th>
<th>Planning to Provide</th>
<th>Not planning to provide</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Clinical Quality Indicators</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>b. Patient Experience/Satisfaction Indicators</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>c. Cost/Efficiency Indicators</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

**Section 2d: Monitor and Share Performance Data**

35. Does your ACO track and routinely share performance against measures with all members of the ACO?

☐ a. Yes, we can do so now (check all that apply)

1. □ Financial measures by each setting of care (e.g., hospital, physician practice, home health, long term care)
2. □ Utilization measures by each setting of care (e.g., hospital, physician practice, home health, long term care)
3. □ Patient satisfaction measures by each setting of care (e.g., hospital, physician practice, home health, long term care)
4. □ Clinical quality measures by each setting of care (e.g., hospital, physician practice, home health, long term care)

☐ b. No, but we will be able to do so in the next 12 months

☐ c. No, but we will be able to do so in the next 12 to 36 months

36. Is the purchasing function for things that the ACO needs primarily centralized at the ACO administrative level or primarily decentralized across participating organizations?

☐ a. Purchasing is primarily centralized

☐ b. Purchasing is primarily decentralized

Thank you for your cooperation in completing this survey. If there are any questions about your responses, who should be contacted?

___________________________________________________________________________(        )________________________

Name (please print)      Title          (Area Code) Telephone Number

_____/_____/_____      (      )

Date of Completion  Chief Executive Officer   (      ) Hospital’s Main Fax Number

Contact Email address: ________________________________________________

*Thank you for your participation. Your time and efforts are appreciated. You will receive a summary of the survey’s findings once the data has been compiled.*