KentuckyOne Health Partners, LLC -- Accountable Care Organization

APPLICATION QUESTIONNAIRE

INSTRUCTIONS: Please complete this form to apply to participate in KentuckyOne Health Partners, LLC ("KYOne HP"). Return your completed Application Questionnaire to:

KentuckyOne Health Partners, LLC
201 Abraham Flexner Way, 14th Floor
Louisville, KY 40202

If you wish, you may fax this to: 502.587.4891 or scan and e-mail to: info@kentuckyonehealthpartners.org.

I: Demographics

Name of Participant:_____

Principal Address:_____

National Provider Identifier (NPI):_____

Tax Identification #
(TIN):_____
Do you have any TINs other than the one listed above? □ **YES** □ **NO**
If yes, please list all other TINs:_____
_____

Primary Service Area:
To permit KYOne HP to complete its antitrust analysis, for each specialty offered, please list the lowest number of zip codes from which each specialty as a group that bills under the Participant's TIN obtains 75% of its patients[1]:

_____
_____
_____
_____

Complete Attachment A for each individual physician and midlevel for whom the Participant listed above submits bills to payors under its TIN.

II: Other

Please complete (A) for Participant and each individual identified on Attachment A.

A: Have you agreed to participate in any other Medicare or commercial ACOs?
□ **YES** □ **NO** If yes, list sponsor_____

[1] KYOne HP requires this information to complete its Antitrust analysis and may need to request follow up information, if necessary, to complete its analysis. Please contact us if you have questions regarding how to obtain this data, or regarding the purpose or use of this information.

B: Participation in CMS Pilots and Incentive Programs

1.) Do you currently participate in *any* of the following Medicare programs?
□ YES □ NO

- Pioneer Accountable Care Organization Model Demonstration
- Independence at Home Medical Practice Demonstration
- Medicare Health Care Quality Demonstration Programs
- Multipayer Advanced Primary Care Practice Demonstration with shared savings arrangement
- Care Management for High-Cost Beneficiaries Demonstration

2.) Do you currently participate in the Physician Quality Reporting System (PQRS)?
□ YES □ NO
If yes, through which of the following do you report (circle one):
a.) to CMS on Medicare Part B claims
b.) to a qualified Physician Quality Reporting registry, or
c.) to CMS via a qualified electronic health record (EHR) product

C: Health Information Technology

3.) Do you currently use an Electronic Health Record (EHR)?
□ YES □ NO
If yes, which vendor do you use (including version)? _____
If yes, have you applied for certification of "meaningful use" with CMS?
□ YES □ NO
If no, do you plan on implementing an EHR in the next three years?
□ YES □ NO

4.) Do you currently e-prescribe?
□ YES □ NO
If yes, have you applied for the Electronic Prescribing (eRx) Incentive Program with CMS? **□ YES □ NO**

5.) Do you perform any electronic clinical data exchanges with other providers?
□ YES □ NO

6.) Do you participate in a Health Information Exchange?
□ YES □ NO
If yes, which one? _____

D: Patient Management

7.) Are you a NCQA recognized Patient Centered Medical Home (PCMH)?
□ YES □ NO
If yes, what level? _____

8.) Do you maintain a Disease Registry?
□ YES □ NO

9.) Do you have a nurse dedicated to patient/care management?
□ YES □ NO

10.) Do you use a Hospitalist group?
□ YES □ NO
If yes, please provide us with the group name.
_____

11.) Do you have processes for identifying potential care gaps?
□ YES □ NO

12.) Are you engaging in other forms of patient/care management?
□ YES □ NO
If yes, please explain:

_____
_____
_____
_____
_____
_____
_____

III: <u>KYOne HP Involvement</u>

13.) List the physicians identified on Attachment A who may be interested in participating in a KYOne HP committee or sub-committee. Be specific if there is a specific committee that is desired.
□ YES □ NO

<u>Verification</u>. I represent and warrant that I have authority to submit this Questionnaire on behalf of the individuals listed on Attachment A. To the best of my knowledge, the information provided in this Application Questionnaire is complete and accurate. I authorize KYOne HP to access information regarding my practice and the practice entity (listed by TIN) listed as a Participant on this Application Questionnaire to evaluate this application to participate in KYOne HP. Further, I agree to provide additional information that KYOne HP might reasonably request in connection with that evaluation. I understand that completing this application neither obligates nor entitles the Participant to participate in KYOne HP. I further understand and agree that if my application is accepted, the Participant and the individuals listed on Attachment A may need to execute an "Participant Participation Agreement," other agreements and take certain other actions to participate in KYOne HP.

Signature:_____

Print Name and Title:_____

Name of Participant: _____

Date:_____

ATTACHMENT A

Name	Addresses where services are provided	Specialty	Primary Service Area[2]	NPI

[2] List the lowest number of zip codes from which the individual physician obtains 75% of his/her patients.