

Attachment D2: MAPCP Practice Manager Survey

The Multi-payer Advanced Primary Care Practice Demonstration Provider Survey

Sponsored by:

U.S. Department of Health and Human Services,
Centers for Medicare & Medicaid Services

Begin New Survey

Resume Previous Survey

Public Burden Statement: According to the Paperwork Reduction Act of 1995, a federal agency may not conduct, and a person is not required to respond to, an information collection request unless it displays a currently valid OMB control number. The valid OMB control number for this information collection is [XXXX-XXXX]. The time required to complete this information collection is estimated to average 6 minutes per respondent, including the time to review instructions and complete and review the information collection. If you have comments concerning the accuracy of this burden estimate or any suggestions for reducing this burden, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, MD 21244-1850.

OMB No.: [xxxx-xxxx]
Expires: [3 yrs from OMB approval date]

You can close this web survey and return to it at any time using your Respondent ID#, which acts as your password for this survey.

Your Respondent ID is: [#####]

Please write this number down in case you need to return to your survey.

Clicking "Next" on each page of this survey automatically saves your responses.

NEXT

HELP

Your Participation in this Survey

This survey is being fielded among all practices participating in the Centers for Medicare and Medicaid Services' Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration, which includes providers participating in [state]'s [state-specific name of MAPCP demonstration].

There is no “passing grade” for this voluntary survey, nor will your responses have any consequences for payment.

Your responses will be linked to claims data using an encrypted identifier, and analyzed by researchers (at RTI International, The Urban Institute, and the National Academy for State Health Policy) contracted to evaluate this demonstration. Researchers will report the results of this survey and their analyses in reports to CMS that will be made available to other federal agencies, state governments, and the general public in a non-identifiable, aggregated form.

We estimate that this survey will take **6 minutes** to complete.

If you are willing to participate in this research, please complete this survey by **[insert date that is 4.5 months after OMB approves this survey]**.

If you have difficulty or questions when completing this survey, please contact Stephen Zuckerman at szuckerman@urban.org or 202-261-5679.

PREVIOUS

NEXT

HELP

The Questions in this Survey

This survey asks about practice finances and organizational characteristics, participation in other initiatives, and current practice staff and roles.

Please complete all questions in the survey to the best of your knowledge. If your practice has multiple physical locations, please respond based on the practice site that is participating in [state]'s [state-specific name of MAPCP Demonstration initiative]. For practices with more than one physical location participating in [state]'s [state-specific name of MAPCP Demonstration], we will contact each location to complete the survey.

Input can be requested from other staff in the practice as needed.

[PREVIOUS](#)[NEXT](#)[HELP](#)

Please indicate which category (or categories) describes your practice.

CHECK ALL THAT APPLY

- Solo practice
- Single-specialty primary care practice
- Multiple specialty group practice
- Group or staff model HMO
- Community health center established to serve low-income or rural patients
- Hospital or hospital system
- Faculty practice / residency / medical school / teaching clinic
- Other (*specify*): _____

PREVIOUS

NEXT

DON'T KNOW / PREFER NOT TO SAY

HELP

Please indicate the types of organizations that your practice is part of or affiliated with.

CHECK ALL THAT APPLY

- Hospital
- Integrated health care system
- Multi-specialty group practice
- Independent Practice Association (IPA)
- Physician-Hospital Organization (PHO)
- Accountable Care Organization (ACO)
- Other

Specify: _____

PREVIOUS

NEXT

DON'T KNOW / PREFER NOT TO SAY

HELP

What percentage of the patients at this practice have the following insurance as their primary insurance type? Please provide your best estimate. TOTAL SHOULD EQUAL 100%

Medicare (includes dual Medicaid and Medicare patients)	_ _ _ %
Medicare Advantage/managed care plans (includes dual Medicaid and Medicare patients)	_ _ _ %
Medicaid (non-dual) / CHIP	_ _ _ %
Privately insured	_ _ _ %
TRICARE or other veteran's insurance	_ _ _ %
Uninsured	_ _ _ %
Other insurance type (<i>Please describe below</i>)	_ _ _ %

Please describe other insurance type: _____

PREVIOUS

NEXT

DON'T KNOW / PREFER NOT TO SAY

HELP

Is your practice accepting all, most, some, or no new patients who are insured through the traditional Medicare fee-for-service (FFS) program (not Medicare Advantage)?

- All new Medicare FFS patients
- Most new Medicare FFS patients
- Some new Medicare FFS patients
- No new Medicare FFS patients

PREVIOUS

NEXT

DON'T KNOW / PREFER NOT TO SAY

HELP

What percentage of your practice's total revenue for clinical services comes from the following sources? Please provide your best estimate. TOTAL SHOULD EQUAL 100%

Fee-for-service payments	_ _ _ %
Capitation (e.g., a fixed monthly payment for physician services for a patient)	_ _ _ %
Episode-based payments (e.g., a fixed payment for all physician services related to a specific condition, such as diabetes)	_ _ _ %
Care management fees for patients with complex conditions	_ _ _ %
Incentive bonuses for keeping patients' costs and/or utilization below a target	_ _ _ %
Incentive bonuses for quality performance	_ _ _ %
Other payments (<i>Please describe below</i>)	_ _ _ %

Please describe other payments: _____

PREVIOUS

NEXT

DON'T KNOW / PREFER NOT TO SAY

HELP

Within your practice, which of the following disciplines are present?

If your practice has multiple physical locations, please respond based on the practice site that is participating in [state]'s [state-specific name of MAPCP Demonstration initiative].

If a staff member at your practice fits into more than one job category, divide his or her full-time equivalent (FTE) time across the appropriate categories (for example, an RN that spends 20 hours a week serving as a clinical nurse and 20 hours a week serving as a care manager would be reflected as an 0.5 FTE registered nurse and an 0.5 FTE care manager).

In the third column, please check the box if any staff have joined your practice during the past 12 months for each job category.

	ANY IN PRACTICE?	NUMBER OF FTE STAFF	JOINED PRACTICE WITHIN PAST 12 MONTHS?
Physicians	<input type="checkbox"/>	_____	<input type="checkbox"/>
Nurse practitioners and physician assistants (NPs/PAs)	<input type="checkbox"/>	_____	<input type="checkbox"/>
Registered nurses (RNs, excluding RN care managers)	<input type="checkbox"/>	_____	<input type="checkbox"/>
Care managers/care coordinators who coordinate care for patients in the practice with other providers, or community services and resources	<input type="checkbox"/>	_____	<input type="checkbox"/>
Social workers	<input type="checkbox"/>	_____	<input type="checkbox"/>
Health educators	<input type="checkbox"/>	_____	<input type="checkbox"/>
Nutritionists	<input type="checkbox"/>	_____	<input type="checkbox"/>
Pharmacists	<input type="checkbox"/>	_____	<input type="checkbox"/>
Behavioral health counselors	<input type="checkbox"/>	_____	<input type="checkbox"/>
Licensed practical or vocational nurses (LPNs/LVNs)	<input type="checkbox"/>	_____	<input type="checkbox"/>
Medical assistants	<input type="checkbox"/>	_____	<input type="checkbox"/>

Administrative (reception, medical records, appointment, health IT, finance, management, etc.)

<input type="checkbox"/>	_____	<input type="checkbox"/>
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PREVIOUS

NEXT

DON'T KNOW / PREFER NOT TO SAY

HELP

Does your practice charge a “retainer” or “concierge” fee for some or all of your patients? (This is an additional fee patients pay either monthly or annually beyond what insurance pays or the patient co-pay, for enhanced care – such as phone or email contact with clinicians after hours, or full access to an online patient portal.)

- Yes
- No

PREVIOUS

NEXT

DON'T KNOW / PREFER NOT TO SAY

HELP

How long has your practice had an electronic health record (EHR) system?

- No EHR
- Less than 1 year
- Between 1 and 3 years
- More than 3 years

PREVIOUS

NEXT

DON'T KNOW / PREFER NOT TO SAY

HELP

Thank you for completing this survey.