

Application is hereby made to become an Organizational
Member of America's Physician Groups,
a 501(c)(6) not-for-profit corporation

COMPANY INFORMATION

Organization's full legal name Established/Founded (Year)

Senior physician executive name and title (America's Physician Groups delegate)

Telephone Mobile Email

Senior administrative executive name and title (America's Physician Groups delegate)

Telephone Mobile Email

Chief Medical Officer/Medical Director name and title

Telephone Mobile Email

Government Affairs Contact (for advocacy purposes) name and title

Telephone Mobile Email

Organization's street address

City State Zip

Organization's web address

Main Telephone Number Main Fax Number

Name and title of individual to whom dues billing should be sent

Telephone Mobile Email

Address (if different from above)

DUES

MONTHLY DUES CALCULATION

America's Physician Groups monthly dues are based on your geographical location and business structure. Please complete ALL the sections below. Enter "0" if you do not have any lives in that category.

Section 1: Equivalent Lives

1. Total number of Commercial managed care lives _____ x 1.0 = _____
 2. Total number of Medicaid managed care lives _____ x 0.5 = _____
 3. Total number of Medicare Advantage lives _____ x 3.0 = _____
 4. Total number of Duals (Medicaid/Medicare) lives _____ x 3.0 = _____
 5. Total number of Commercial ACO lives _____ x 0.25 = _____
 6. Total number of Medicare ACO (All ACO Programs) lives _____ x 0.5 = _____
- Total Equivalent lives (add 1 through 6) _____

Section 2: Physician FTEs

Total Number of FTEs (employed and contracted physicians) _____

Section 3: Monthly Dues

To complete this section, use tables below to determine your monthly dues \$ _____ .00

Dues Calculation Guide

Geographical/Business Structure	Reference	Use Column
Non-California IPA, MSO, CIN, ACO	Use Table 1	Equivalent Lives
Non-California Staff Model Medical Group	Use Table 1	Medical Groups FTEs
California IPA, Staff Model Medical Group, MSO, ACO, CIN	Use Table 2	Equivalent Lives
Multi-state Integrated Healthcare System	Use Multi-State	\$ 7,031

Table 1: Operating in non-California State(s)

Total Equivalent Lives	Medical Groups FTEs	Dues per Month
up to 10,000	up to 25	\$ 618
10,001 – 43,000	26 – 125	\$ 1,048
43,001 – 100,000	126 – 300	\$ 1,524
100,001 – 235,000	301 – 700	\$ 2,227
Over 235,000	Over 700	\$ 2,889

Table 2: Operating in California and other States*

Total Equivalent Lives	Dues per Month
up to 10,000	\$ 1,055
10,001 – 43,000	\$ 1,368
43,001 – 100,000	\$ 0.03284 per equivalent lives
100,001 – 235,000	\$ 0.02966 per equivalent lives
Over 235,000	\$ 7,031

Multi-State Integrated Healthcare Systems	Dues Per Month
Multi-State Integrated healthcare system is defined as an organization owning one or more hospitals, one or more medical groups, and operating in multiple states.	\$ 7,031

*dues include separate advocacy efforts in Sacramento, CA

PROFILE INFORMATION

1. Provide the number of employed and contracted physicians in each category

a. Number of primary care physicians: Employed _____ Contracted _____
(includes pediatrics, family practice, internal medicine, OB/GYN, urgent care and general practice)

b. Number of specialist physicians: Employed _____ Contracted _____

2. Your organization For profit Not-for-profit

3. Affiliation or ownership Hospital-affiliated Health plan-affiliated Equity Partnership(s)

Other *(please specify)* _____

4. Indicate the business structure(s) that describes your organization (check all that apply) *(for MSO, please attach a list of organizations)*

Medical Group IPA MSO Medical Foundation Integrated Health System

ACO FQHC Other *(please specify)* _____

5. Does your organization use a management services organization (MSO) with defined services?

Yes No If yes, please identify the organization that provides these services:

6. Medical Groups only: Number of satellite offices *(please attach list of locations)* _____

7. Integrated Health Systems Only: # of hospitals _____ # of medical groups _____

8. Does your organization hold a partial or full insurance license (LKK, RKK)? _____

9. Please list the state(s) in which your organization is based

10. For our advocacy purposes, please check **ALL** lines in which you participate and list total number of patients

Commercial Health Plan Medicare Advantage Medicaid Direct to Employers

Bundles *(please specify)* _____ APM *(please specify)* _____

Medicare ACO: MSSP Basic MSSP Enhanced DCE/ACO REACH

Other Medicare ACO: _____

Total number of patients in all business lines, including self-pay _____

11. **Please check the attributes of coordinated care that your organization has or provides**

The attributes below are based on APG Standards of Excellence™ survey. For more information visit apg.org/SOE.

Domain I: Population Health Management

High risk case management/Disease management

Hospitalists/Post-discharge continuity

Readmission reduction/Avoidable emergency room use

Social determinants of health

Domain II: Information Technology

- Preventive care and chronic care registries
- Electronic capture and reporting/EHR
- Secure electronic communication and prescription

Domain III: Accountability and Transparency

- Compliance with strict regulations regarding financial solvency and management capability
- Formal measurement and public reporting of patient satisfaction
- Formal measurement and public reporting of clinical quality performance
- Awareness, peer dialogue, and feedback with practitioners regarding tests and images

Domain IV: Patient-Centered Care

- Patients’ electronic access to their doctors and clinics
- Same day access/after-hours and weekend services
- Shared decision making

Domain IV: Group Support of Advanced Primary Care

- Team-based care
- Practice transformation initiatives throughout primary care practice
- Physician leadership program

HEALTHCARE INDUSTRY BUSINESS REFERENCES

Name (1) Title

Company name

Phone Email

Name (2) Title

Company name

Phone Email

APPLICATION SUBMISSION

Please sign and date application, then mail to America’s Physician Groups, 611 N Brand Blvd, Ste 1300, Glendale, CA 91203 or email to Lhawkins@apg.org. For more information, please contact us at (213) 624-2274. Completed applications will be submitted to the Board of Directors for approval. Dues will be invoiced the month following application approval.

Signature **Date**