

# Survey of Texas Physicians 2014

## Research Findings



Physicians Caring for Texans

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## **TMA 2014 Physician Survey Executive Summary**

Every two years, the Texas Medical Association conducts a survey of Texas physicians to identify emerging issues, track the impact of practice and economic changes, assess physician priorities, and develop data to support TMA advocacy efforts. The following results are based on an email survey conducted January – September 2014.

### **Biggest Challenge**

- Texas physicians' report inadequate reimbursement and economic survival are the biggest challenges currently facing them. Physicians are concerned about the Affordable Care Act (ACA) and its administrative burden, which is further threatening the economic viability of their practice. Administrative burden, rules, and regulations are a top concern for physicians who are frustrated with the amount of and increasingly complex paperwork, which is increasing overhead cost and interfering in the patient-physician relationship. Concerns about increasing mandates are often paired with comments about increasing interference in the practice of medicine by third-parties, particularly government and insurers. Another group of physicians are concerned about interference from hospitals and the corporate practice of medicine. Physicians express concern about the consolidation of private practices and worry that as their colleagues struggle with increasing overhead costs, they will be driven into large and hospital-owned groups. Further, physicians worry about remaining competitive with hospital-owned groups particularly while their own expenses continue to rise. Health information technology (HIT), particularly ICD-10 and Electronic Health Records (EHRs), are a bigger concern for physicians this year than in years past. Physicians are concerned about the expense of implementing ICD-10 and EHRs and its impact on the financial viability of their practice. Physicians currently using EHRs are frustrated with the decrease in productivity and the interference in the patient-physician relationship. Physicians feel this is one more area in which third-parties are interfering in the practice of medicine and increasing overhead cost, but not increasing the quality of care. Quality of and access to care remain a concern for physicians. Quality concerns are often secondary to new rules and regulations and their associated administrative burden, which is taking time away from patients.

### **Practice Viability**

- For the fifth biennial period a majority physicians report their income from medical practice has decreased in the past two years (61 percent).
- Sixty-one percent of physicians have experienced cash flow problems due to slow payment, nonpayment, or underpayment of claims by insurers or government payers in the past year.

### **Practice Description**

- Solo practitioners, consistently below the 1990 high, have decreased since 2012. Meanwhile, group practice employees have nearly doubled. The percentage of hospital employees has also grown, but remains small at 7 percent.

- Half of physicians are in groups or partnerships with eight or fewer physicians. When analyzed with solo practitioners, a majority are in practices with one to three physicians (63 percent).
- A large minority of physicians started medical practice after residency as a group practice employee (34 percent), which is consistent with previous research showing physicians start in employed settings and then move into a practice ownership role.
- A majority of physicians describe their current practice as wholly owned by one or more physicians in the practice and report the physician or physicians in the practice have authority for making practice management decisions.
- Seventy-four percent of physicians receive a salary paid by the physicians' practice (reported on a W-2 form) and 75 percent of physicians' report some or all of their compensation is based on productivity.
- The majority of physicians' report a hospital or non-physician organization does **not** own, employ, or provide professional liability insurance (70 percent), office and other practice equipment (65 percent), support staff (63 percent), or office space (59 percent).
- Few physicians are in an Accountable Care Organization (ACO) or other clinical co-management arrangement (18 percent). Among them, a little more than half are participating in the Medicare shared savings program (55 percent).
- Few physicians (9 percent) are participating in alternative payment models (e.g., bundled payments).
- Physicians do **not** feel the structure, policies, and relationships of their medical practice impairs their independence in making clinical decisions (64 percent). However, 52 percent feel they are at risk of losing their independence in clinical decision-making. Physicians agree if they lose their ability to make independent clinical decisions, it is bad for physicians and patients (98 percent).
- Fifty-five percent of physicians report their practice has not hired a new physician in the past year. Among them, 84 percent report their practice is not or they don't know if their practice is planning to in the next year. Thirty-five percent these physicians would if the economic environment were different. These physicians rank the cost of maintaining an employed physician (76 percent), uncertainty regarding health system reform (74 percent), and Medicare/Medicaid fees (67 percent) as very important in their decision not to hire a new physician.
- Seventy percent of physicians' rate employment in an established physician practice with a subsequent option to buy in to ownership is the first or second most desirable practice type for most new physicians.
- A small percentage of Texas physicians practice concierge medicine (2 percent) and/or their practice is all or mostly cash (9 percent).

## EHRs

- A majority of physicians use an EHR in their practice (69 percent).
- Among physicians using an EHR, 59 percent report their practice applied for Stage 1 Meaningful Use incentives and 80 percent of these respondents plan to advance to Stage 2 Meaningful Use.

- Twenty-one percent of physicians report their practice uses scribes for EHR data entry. Among them, 47 percent retrained existing staff and 34 percent retrained existing and hired new staff.

### **Patient Billing and Practice Revenues**

- Sixty-three percent of physicians report their practice gives out-of-network or uninsured patients a “prompt payment” discount.
- Physicians give patients individual charges or possible payment ranges when they ask for them or have the patient discuss what they need to do with their administrative/billing staff (64 percent).
- Thirty-three percent of average practice revenues are derived from programs funded and regulated by state or federal government and 20 percent are from PPO-covered patients, including services for patients provided out of network.
- The mean amount of charity care reported for each physician in practice in 2013 is \$40,034 and uncollectible debts per physician was \$75,095.

### **Health Plan Contracts**

- Physicians have a median of six Preferred Provider Organization (PPO) contracts and one Health Maintenance Organization (HMO) contract.
- The majority of physicians are contracted with at least one of the five major payers: Aetna (78 percent), Blue Cross and Blue Shield of Texas (82 percent), Cigna (78 percent), Humana (75 percent), and UnitedHealthcare (81 percent).
- In the past two years, 24 percent of physicians approached a plan with which they were not contracted in an attempt to join its network. Of those respondents, 30 percent received no response from the plan and 32 percent of respondents received an offer, but it was unacceptable.
- In the past two years, 49 percent of respondents attempted to negotiate the terms of a health plan contract. Of those who tried, more than half were sometimes, often, or always successful in getting changes in a plan’s contract language, payment terms, or both (55 percent).
- Twenty-seven percent of respondents terminated a managed care contract in the past two years, most frequently due to payment rate cuts imposed by the plan (57 percent).
- When patients have some financial responsibility to pay for services, physicians and patients need specific information about the patient’s share. Only one third of physicians report this information is available to them often or always. If physicians and patients don’t have the information they need to determine the patient’s share of payment, the patient is more likely to be surprised by medical bills after services are rendered.
- Sixty-one percent of physicians have detected cases where they were listed as a participating provider in a health plan’s directory when they were not participating and 56 percent of physicians have detected cases when they were not listed as a participating provider when they were one.

### **Availability of Care**

- A low percentage of physicians will accept all new Medicaid patients (37 percent).

- The percentage of physicians who accept all new Medicare patients (63 percent) is significantly less than the percentage of physicians who accepted all new Medicare patients in 2000 (78 percent).
- In response to the ongoing problems with the Medicare fee schedule, 24 percent of physicians have imposed new limits on their acceptance of Medicare patients and 39 percent have added limits on Medicaid. Forty-six percent of physicians are considering renegotiating or terminating some health plan contracts.

### **Health Care Reform**

- Thirty-six percent of physicians will accept all new health insurance exchange plan patients and 41 percent will limit their acceptance. When asked what types of limits their practice will impose, the majority will accept patients enrolled in a plan with which they are already contracted (53 percent).
- Physicians who will treat ACA exchange patients out of network will always bill patients directly (46 percent) or sometimes bill directly and sometimes take assignment (39 percent).
- The majority of physicians (68 percent) are aware of the 90-day grace period rule for health plans in the exchange, which does not require health plans to pay claims for some enrolled patients who fail to pay their premiums.
- Twenty-three percent of physicians have changed (or are changing) their eligibility verification procedures for exchange plan enrollees, which adds to administrative burden and overhead costs for physicians practices.

### **Medicaid Managed Care**

- Forty-two percent of physicians treat Medicaid managed care patients.
- The most frequently reported reason for not treating Medicaid HMO patients is inadequate payment (51 percent).
- On average, 14 percent of a practice's patients are derived from Medicaid HMOs and 13 percent from Medicaid fee-for-service (FFS).
- Physicians would not (47 percent) or might (33 percent) accept more Medicaid patients if rates increased by five to 10 percent. Among these physicians, 8 percent would accept more Medicaid HMO patients if rates increased by 10 percent or more.
- Sixty-seven percent of physicians report there is nothing they like about Medicaid HMOs.
- Fifty-three percent of physicians report it is extremely difficult to find in-network specialty care.
- Physicians who find obtaining prescription drugs an issue, most frequently report it is time-consuming to get prior approval when required for prescription drugs (77 percent), it is difficult to get prior-approval for non-preferred prescription drugs (69 percent), and it is unclear which prescription drugs or drug classes require prior approval (64 percent).
- While there are differences among Medicaid HMOs, physicians are universally dissatisfied with reimbursement (93 percent).
- Twenty-three percent of physicians' participate in a STAR HMO, primarily Amerigroup (60 percent), Superior (55 percent), and Blue Cross Blue Shield (50 percent).



- Among physicians who treat Medicaid STAR HMO patients, a quarter plan to terminate one or more of their existing contracts due to inadequate payments (75 percent), payment problems (72 percent), administrative burdens (67 percent), or quality-of-care concerns (50 percent).
- Twenty percent of physicians participate in a Medicaid STAR+PLUS HMO, primarily Amerigroup (71 percent) and Superior (62 percent).
- Among physicians who participate in a STAR+PLUS HMO, 28 percent plan to terminate one or more of their existing contracts in the next year because of inadequate payments (83 percent), administrative burdens (79 percent), payment problems (71 percent), or quality-of-care concerns (61 percent).
- Sixteen percent of physicians report their practice used the STAR+PLUS service coordinators. Among them, half report the service coordinator contacted the practice on behalf of the patient. Eighty-three percent report the service coordinator did not result in improved patient care.
- Among physicians with practice privileges in an emergency department (ED), 35 percent report the ED has staff, policies, and/or programs in place to direct patients to community providers when emergency care is not appropriate.

### **Damage to Care Quality**

- Seventy percent of physicians report in the past year there has been at least one instance in their practice in which the operating policies or utilization controls of a private-sector health plan impacted patient care quality adversely. The most frequently reported causes of poor care quality from private-sector health plans include limited networks (76 percent) and formulary limitations (75 percent).
- In 2011, Novitas Solutions Inc. took over from Trailblazer Enterprises as Texas' Medicare Administrative Contractor (MAC). Nearly one in three physicians' report their practice has experienced problems with Novitas (29 percent), including payment problems (69 percent) and administrative burden or hassles (68 percent).
- Fifty-eight percent of physicians think CMS should re-evaluate Novitas as the MAC for Texas.
- Thirty-seven percent of physicians with practice privileges in a hospital report in the in the past year there has been at least one case in their practice in which the operating policies or utilization controls of a hospital or surgical facility affected patient care adversely. The most frequently reported causes of poor care quality include inadequate and inconsistent facility staffing (64 and 58 percent respectively).
- A majority of physicians report their medical staff privileges require them to accept patients who report to the emergency room without a physician (57 percent). Few physicians are reimbursed for being on call or responding to emergency call (26 percent).
- Eighty percent of physicians report there are hospitals, Ambulatory Surgical Centers (ASCs), or other facilities in their area that are physician-owned. Among these physicians, 31 percent practice in a hospital, ASC, or facility that is physician-owned and a little more than half are owners or investors in the facility (53 percent).
- Physicians agree the physician-owned facility is a more convenient place for patients than others in the community (59 percent).

- Thirty percent of respondents have seen cases where physicians lost employment, contracts, or hospital privileges because they raised issues about hospital regulatory compliance or patient care quality (up from 21 percent in 2012) and 38 percent of physicians are concerned it could happen to them.

### **Legislative Issues**

- Physicians' top legislative priorities are defending Texas' liability reforms (84 percent), opposing commercial payer intrusion in medical decisions, opposing government intrusion in medical decisions, and reducing administrative and regulatory burdens in practice (79 percent).
- Physicians' top federal legislative priorities are revising all physician quality-of-care measures to eliminate penalties dependent on patient compliance (66 percent) and ensuring failure to report Medicare and/or Medicaid overpayments is not treated as fraud (60 percent).
- Physicians support requiring EHR companies to maintain patient data for seven years (79 percent), enacting a statewide ban on texting while driving (79 percent), and background checks on all firearm purchases in all settings (72 percent).
- Physicians support vouchers to beneficiaries to purchase plans and incentives to reduce total Medicare spending in order to address Medicare solvency (54 percent).
- Physicians prefer high-deductible insurance with spending accounts like health saving accounts (85 percent) and financial incentives for medical homes (57 percent) to address health care costs and utilization.
- If the ACA had never passed and physicians could start over to design solutions for individuals who are uninsured, physicians support a federal income tax deduction for all medical expenses and funding or subsidies for physicians who provide charity care (87 percent).
- Opinion is divided whether physicians support or oppose a requirement to post or otherwise disclose standard charges for services they frequently perform.
- Twelve percent of physicians report their practice has had a Medicare Recovery Audit Contractor (RAC) review. These physicians report having a median of two RAC reviews and 55 percent report increased administrative costs to manage responses to RAC requests and/or appeals.
- Twelve percent of physicians have had problems with the Texas Medical Board (TMB).
- Seventy-six percent of physicians have end-of-life-care discussions with patients.
- If a patient has advance directives, 77 percent keep a copy or note its existence in the medical record.
- Physicians agree legislation that requires physicians and facilities to continue treatment indefinitely if requested by the family or until transfer can be arranged will increase costs (84 percent) and patient suffering (72 percent). Few physicians (12 percent) support this legislation.
- Physicians do not believe Texas should revise the definition of brain death (81 percent).
- Physicians do **not** believe mid-level practitioners (APNs and PAs) should be permitted to independently diagnose patients and prescribe medicine (83 percent).

- Forty-two percent of physicians report their practice uses mid-level practitioners. The mid-level practitioners in physician practices are responsible for less than or no practice management and administrative duties (83 percent). Efforts to permit mid-level practitioners to practice independently could have the unintended consequence of increasing practice management and administrative duties for mid-level practitioners, thereby decreasing the amount of time spent with patients.

## Summary of Findings

### ***Biggest Challenge (March Q1)***

In an open-ended question, respondents were asked to identify the biggest challenge currently facing Texas physicians. The first mentioned response was analyzed to determine the top of the mind concern. The top concerns for physicians are low and declining payment (21 percent) and the squeeze between decreasing payments and increasing practice expenses, severe enough to threaten the economic survival of their practice (7 percent).

An increasing percentage of physicians are concerned with the ACA (16 percent) and its administrative burden (12 percent). Physicians are frustrated with increasing and increasingly complex paperwork, which is increasing overhead costs and decreasing time with patients. Increasing rules and regulations are adding to the feeling of a loss of control over their profession. Physicians remain uncertain how to deliver care in a time of ambiguity, such as dealing with health insurance exchange patients, changes in reimbursement, and in practice patterns.

<b><i>Biggest Challenge</i></b>								
	<b><u>2000</u></b>	<b><u>2002</u></b>	<b><u>2004</u></b>	<b><u>2006</u></b>	<b><u>2008</u></b>	<b><u>2010</u></b>	<b><u>2012</u></b>	<b><u>2014</u></b>
	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>
<b>Low/Declining payments</b>	<b>15</b>	<b>32</b>	<b>28</b>	<b>31</b>	<b>43</b>	<b>33</b>	<b>38</b>	<b>21</b>
<b>Health system reform</b>	<b>&lt;1</b>	<b>3</b>	<b>&lt;1</b>	<b>3</b>	<b>2</b>	<b>18</b>	<b>11</b>	<b>16</b>
<b>Administrative burden</b>								<b>12</b>
<b>Third-party interference</b>	<b>2</b>	<b>9</b>	<b>6</b>	<b>7</b>	<b>5</b>	<b>11</b>	<b>15</b>	<b>10</b>
<b>Health information tech</b>							<b>2</b>	<b>7</b>
<b>Economic survival</b>	<b>&lt;1</b>	<b>3</b>	<b>9</b>	<b>13</b>	<b>15</b>	<b>16</b>	<b>12</b>	<b>7</b>
<b>Corporate practice</b>								<b>6</b>
<b>Quality/Access to care</b>	<b>4</b>	<b>4</b>	<b>4</b>	<b>7</b>	<b>2</b>	<b>4</b>	<b>4</b>	<b>6</b>
<b>Uninsured/Underinsured</b>	<b>3</b>	<b>2</b>	<b>6</b>	<b>11</b>	<b>10</b>	<b>5</b>	<b>5</b>	<b>3</b>
<b>Managed care/insurers</b>	<b>44</b>	<b>16</b>	<b>9</b>	<b>9</b>	<b>7</b>	<b>2</b>	<b>2</b>	<b>3</b>
<b>Scope of practice</b>							<b>2</b>	<b>1</b>
<b>Physician supply</b>	<b>2</b>	<b>2</b>	<b>3</b>	<b>3</b>	<b>2</b>	<b>3</b>	<b>1</b>	<b>1</b>
<b>Liability reform</b>	<b>6</b>	<b>25</b>	<b>33</b>	<b>5</b>	<b>4</b>	<b>2</b>	<b>1</b>	<b>1</b>
<b>TMB</b>					<b>2</b>	<b>0</b>	<b>1</b>	<b>1</b>
<b>Other</b>	<b>5</b>	<b>3</b>	<b>2</b>	<b>6</b>	<b>8</b>	<b>5</b>	<b>6</b>	<b>6</b>

Often paired with comments about administrative burden, third-party interference is a top concern for ten percent of physicians. Physicians are concerned about the erosion of physician independence and the patient-physician relationship. Physicians feel government and insurers are making medical decisions and mandating care that is driving up costs, but not increasing the quality of care. An additional six percent of physicians are concerned about the corporate practice of medicine. These physicians are worried about hospitals buying physician practices, the loss of small, independent physicians, and remaining competitive with hospital-owned practices.

This year technology, specifically ICD-10 and EHRs, is more frequently mentioned as a challenge for physicians (7 percent). Physicians express concerns over the cost to implement ICD-10 and EHRs. Physicians using EHRs are frustrated with decreased productivity and feel more like scribes than physicians. Technology mandates are increasing overhead expenses yet physicians are not seeing a commensurate increase in reimbursement, further threatening the economic viability of their practice. Furthermore, physicians feel this is one more way in which they are losing autonomy within their profession and EHRs are intruding into the patient-physician relationship and decreasing care quality.

Six percent of physicians are concerned about the quality of and access to care for patients. Physicians are uncertain how to provide quality care post-ACA, with increased paperwork taking time away from patients. Three percent of physicians are concerned about the uninsured and underinsured (i.e., Medicare and Medicaid). Physicians are concerned about the increasing number of uninsured patients and are uncertain how to provide quality care for these patients.

Concern about managed care/insurers has increased from two to three percent. Physicians feel third-party payers are directing health care and driving physicians into larger groups.

One percent of physicians are concerned about scope of practice expansions. Physicians are concerned over the erosion of the physician-directed health care team and an increasing reliance on mid-level providers due to a shortage of physicians. One percent of physicians express concern over the physician supply.

One percent of physicians express concerns over attempts to overturn liability legislation and concern over the “inquisition-style” behavior of the TMB.

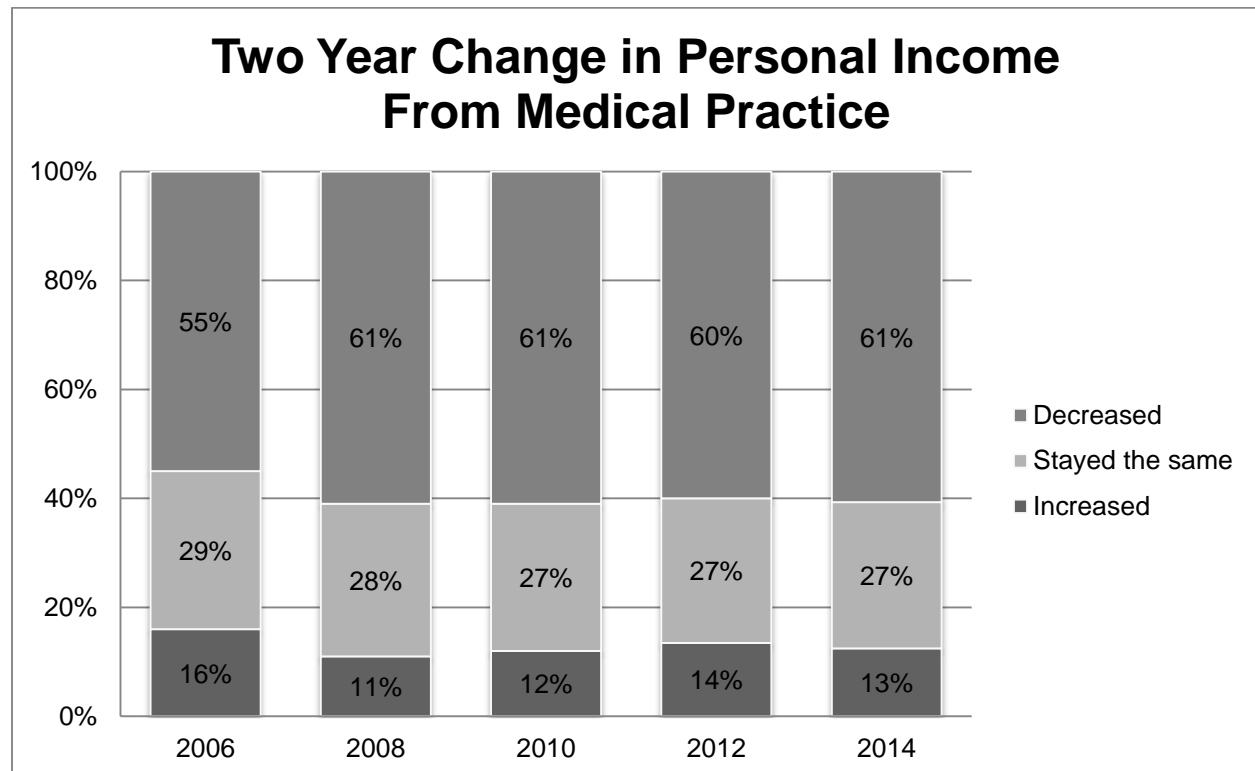
Other concerns expressed by physicians include public health issues, uncertainty over the future of medicine, and the need for a unified voice for physicians (6 percent).

## Practice Viability

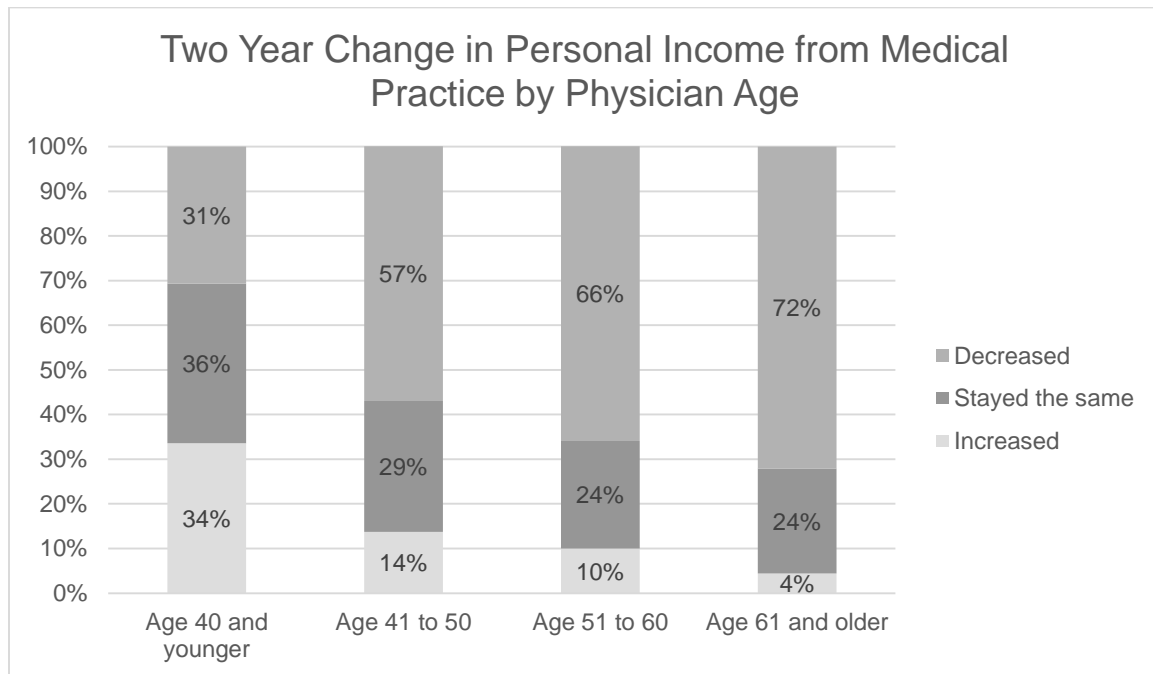
A large section of survey findings are specific to the economic and business issues faced by physician practices.

### ***Physician Income (March Q3)***

For the fifth biennial period, a majority of physicians saw their income from medical practice decrease (61 percent).

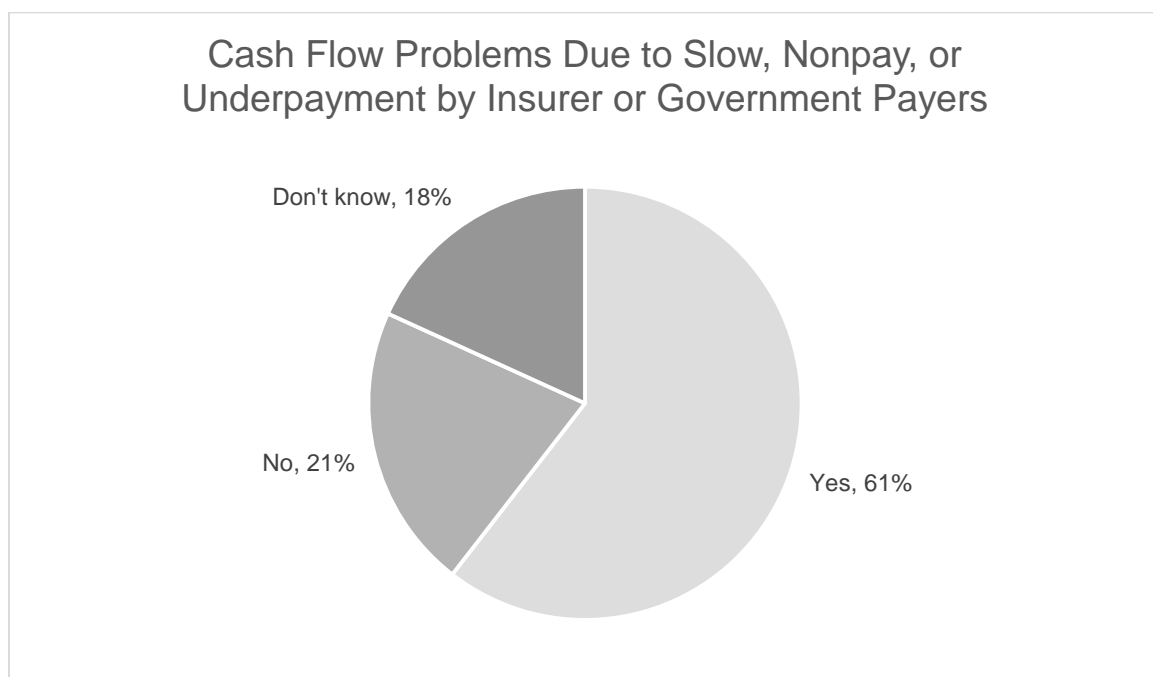


Of particular concern are the majorities of physicians' age 41 to 60 who report their income decreased as these are their prime income earning years.



### ***Cash Flow Problems (March Q4)***

Sixty-one percent of physicians report their practice experienced cash flow problems due to slow payment, nonpayment, or underpayment of claims by insurer or government payers.



### ***Response to Cash Flow Problems (March Q5)***

In response to cash flow problems, physicians reduced employees, employee hours, and/or benefits (44 percent) or drew from personal funds to cover current practice operations (40 percent).

<b><i>Response to Cash Flow Problems</i></b>							
	<u>2002</u>	<u>2004</u>	<u>2006</u>	<u>2008</u>	<u>2010</u>	<u>2012</u>	<u>2014</u>
	%	%	%	%	%	%	%
Reduce employees/hours/benefits					33	27	44
Draw from personal funds	46	68	39	33	51	52	40
Reduce services to gov't payers					20	28	27
Terminate/Renegotiate contracts					23	21	27
Secure commercial loans	33	46	32	22	33	26	23
Close or sell a practice					5	4	8
Other					19	17	14

### **Practice Description**

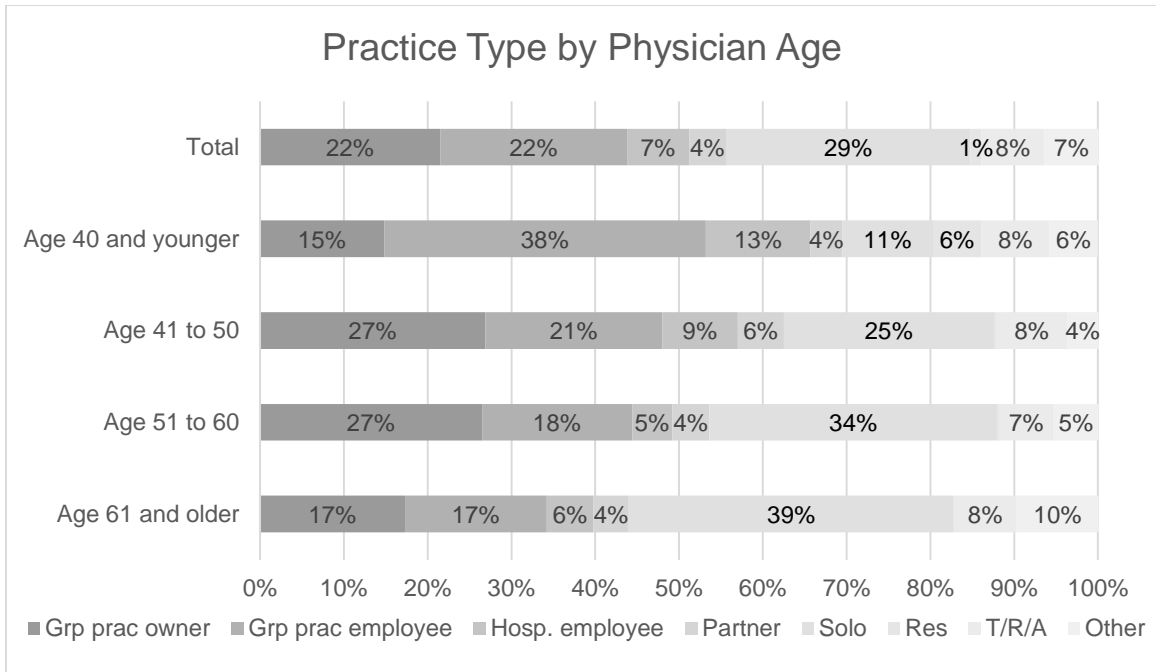
#### ***Type of Practice (January Q2)***

Solo practitioners have decreased since 2012 while group practice employees have nearly doubled. The percentage of hospital employees has also grown, but remains small at 7 percent. A majority of physicians have an ownership role in practice (55 percent). Previous surveys show most physicians start in practice as a group practice employee and subsequently buy-in or leave for an ownership position. However, uncertainty due to the ACA and the economic environment has reduced the number of physician group practices hiring new physicians and fewer physicians may be willing to leave the security of group employment. It remains to be seen whether this trend will continue into the future.

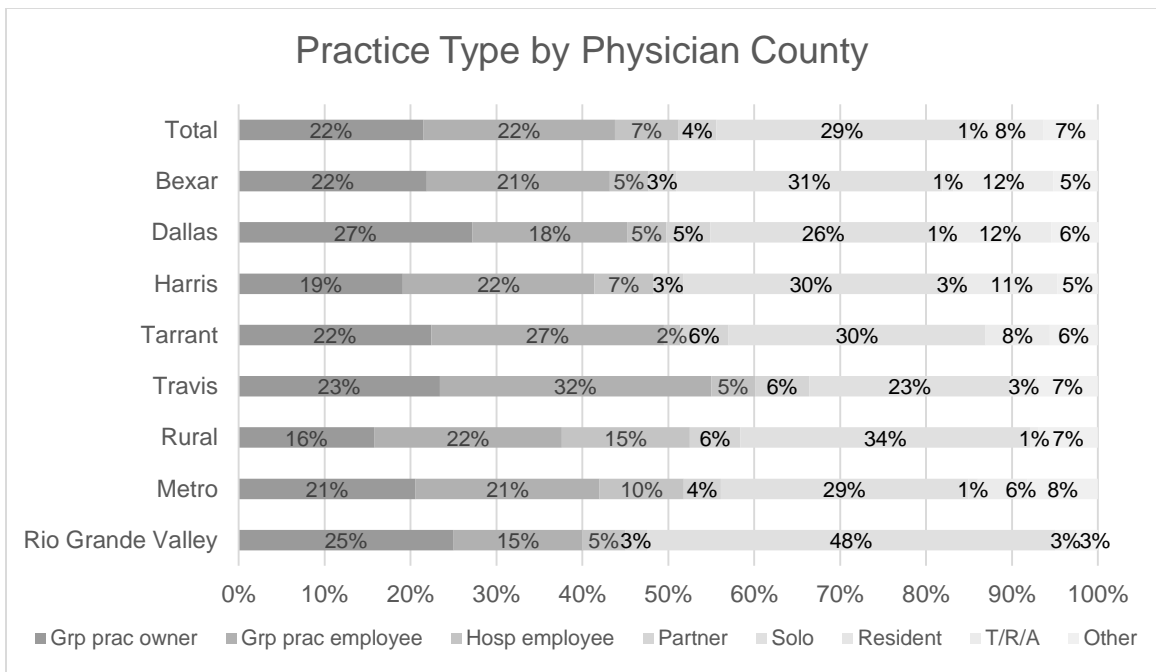
<b><i>Type of Practice</i></b>									
	<u>1990</u>	<u>2000</u>	<u>2002</u>	<u>2004</u>	<u>2006</u>	<u>2008</u>	<u>2010</u>	<u>2012</u>	<u>2014</u>
	%	%	%	%	%	%	%	%	%
Solo	50	32	42	40	44	40	34	44	29
Group practice owner, co-owner or shareholder	24	20	28	24	25	27	28	24	22
Group practice employee		20	13	15	13	14	18	13	22
Partnership	10	9	9	11	7	9	8	5	4
Teach/Admin/Research		7	5	5	7	6	7	5	8
Hospital employee								4	7
Resident		7		0.1			1	0.3	1
Other	16	5	4	6	4	5	5	5	7

An analysis of practice type by physician age confirms physicians in the youngest age group are more likely than other physicians to describe themselves a group practice employee (38 percent) or hospital employee (13 percent).



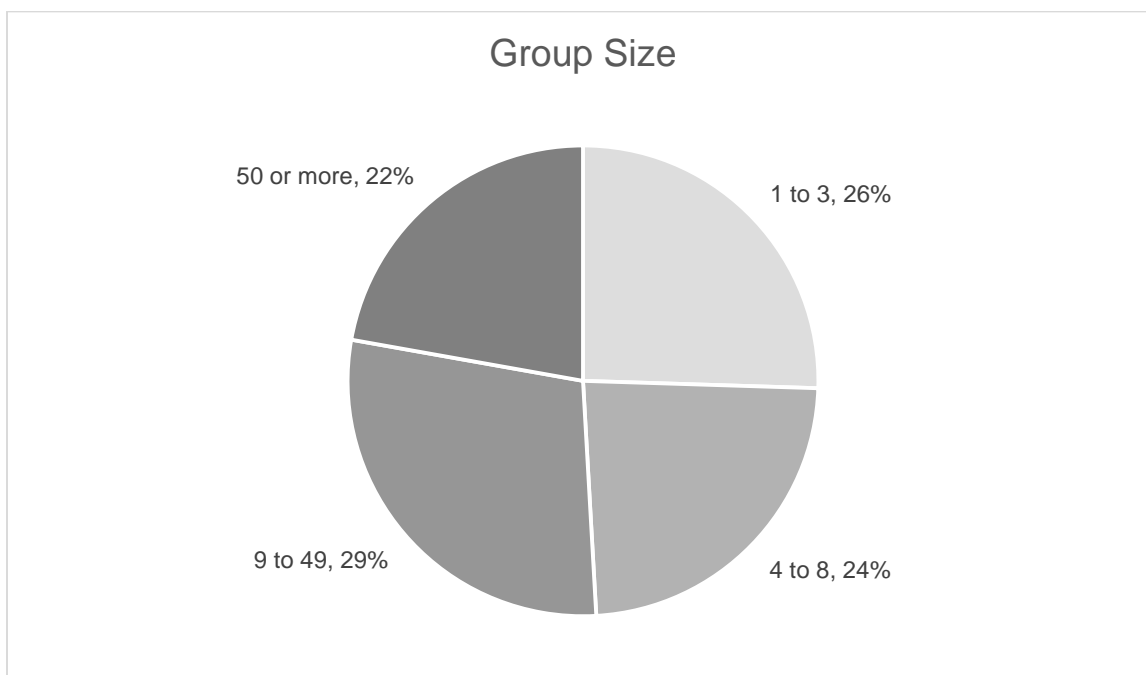


Physicians in rural counties are more likely than other physicians to be hospital employees (15 percent), however, they are most likely to be solo (34 percent). Physicians in Travis County are most likely to be group practice employees (32 percent).

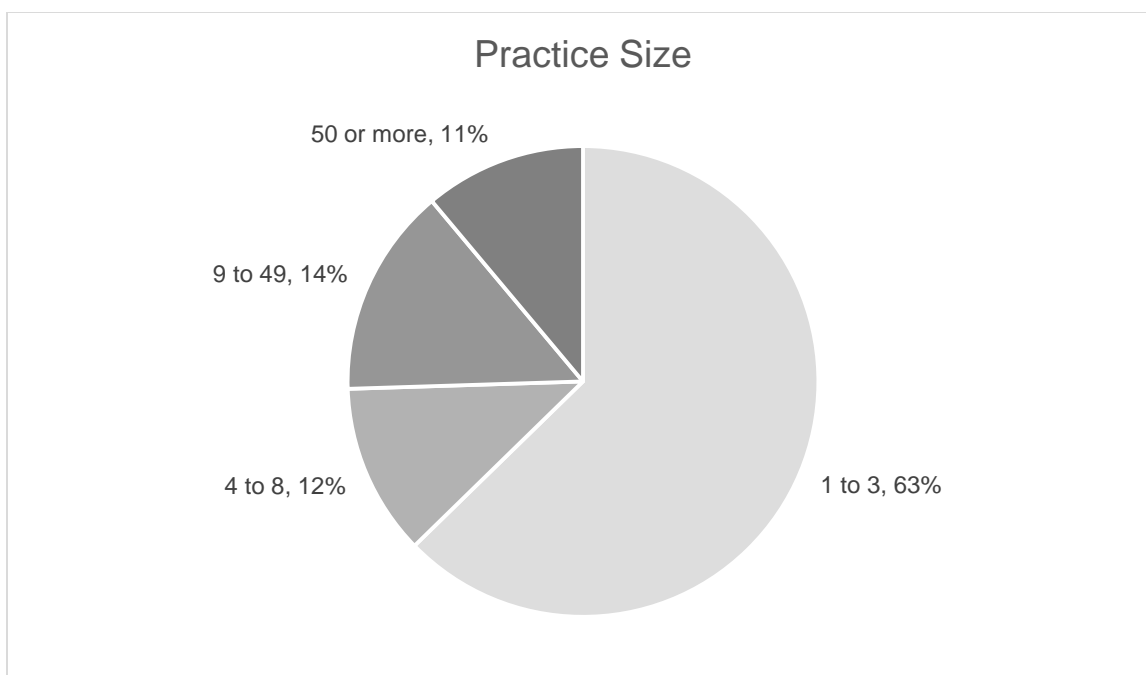


### **Group Size (January Q3)**

Physicians in groups or partnerships were asked about the number of physicians in their practice. Half are in groups with 8 or fewer physicians.

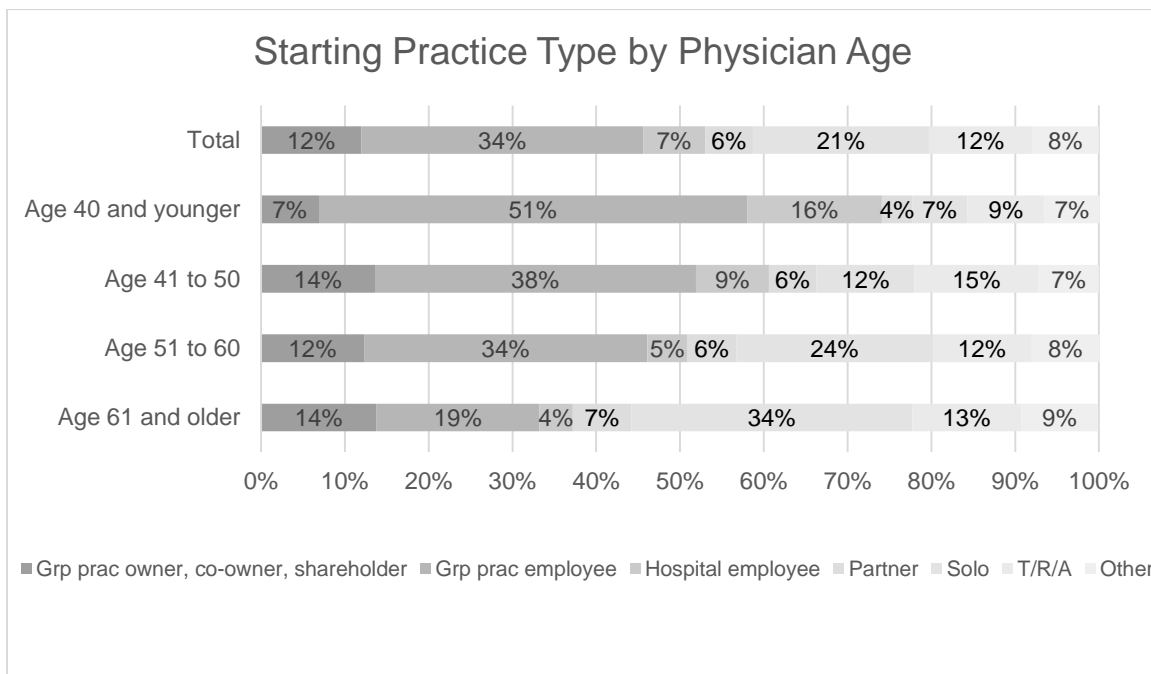


When analyzed with the percentage of physicians who describe themselves as solo, the majority are practicing with three or fewer physicians (63 percent).



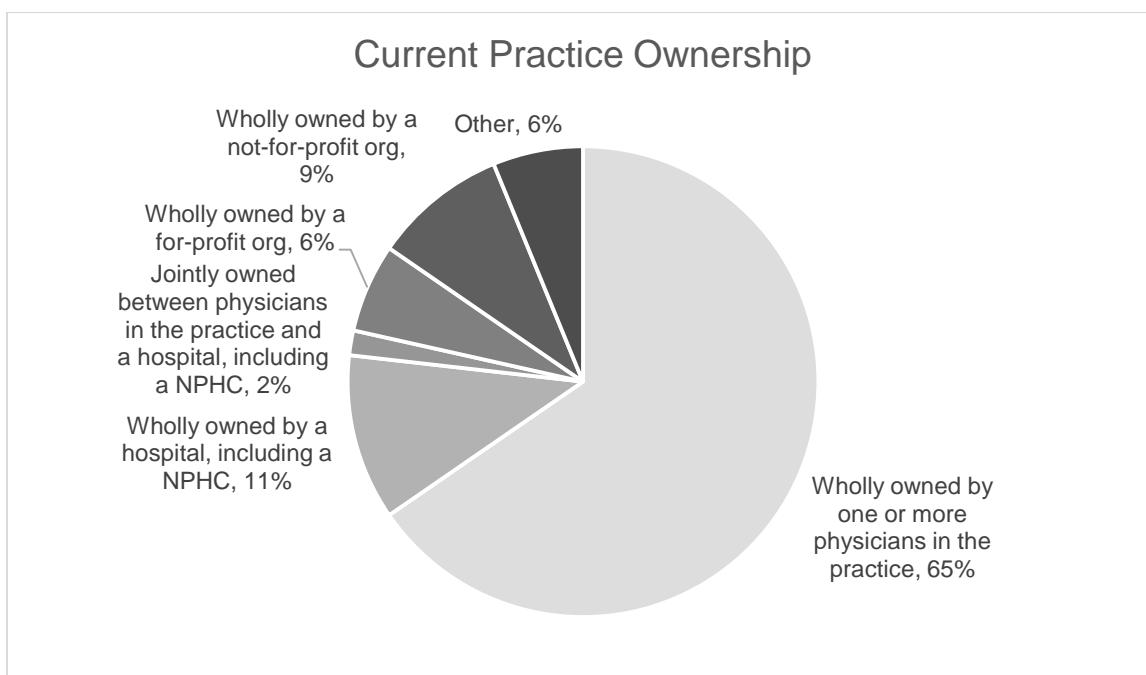
### Starting Practice Type (January Q4)

Physicians were asked to describe their primary form of medical practice when they first started after residency. A large minority started as a group practice employee (34 percent), which is consistent with previous research showing physicians start as a group practice employee and then move into an ownership role. Younger physicians are more likely to report starting as a group practice employee and may continue in this role as administrative costs continue to rise and make it harder for physicians to start their own practice.



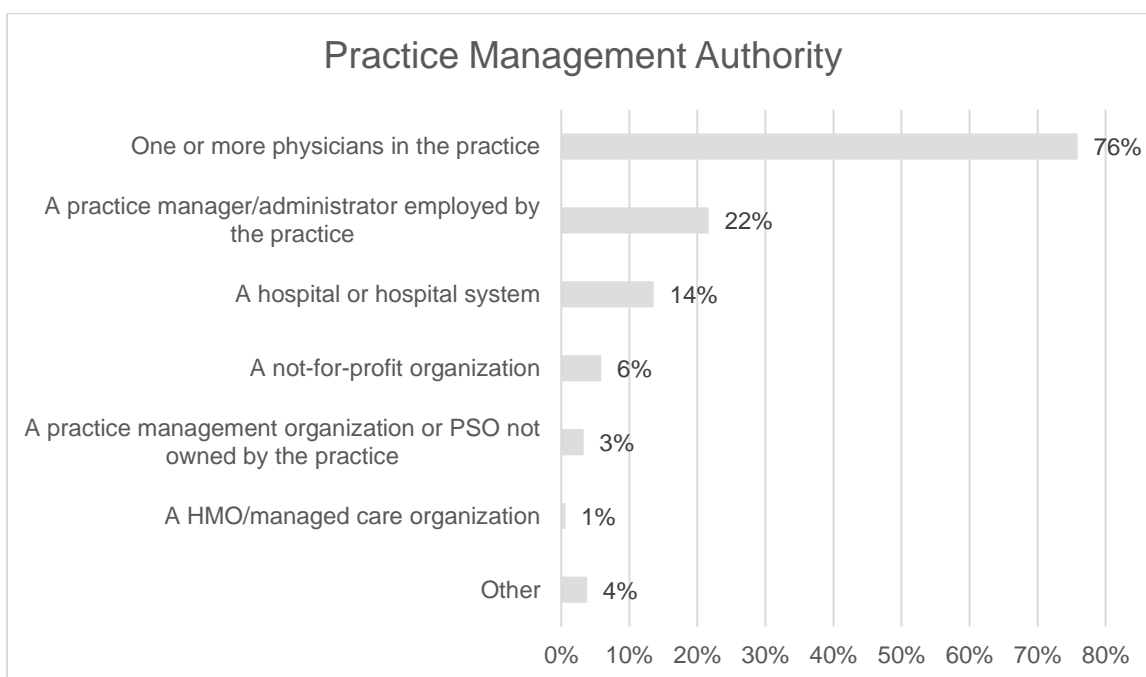
### ***Practice Ownership (January Q5)***

Sixty-five percent of physicians describe their current practice as wholly owned by one or more physicians in the practice.



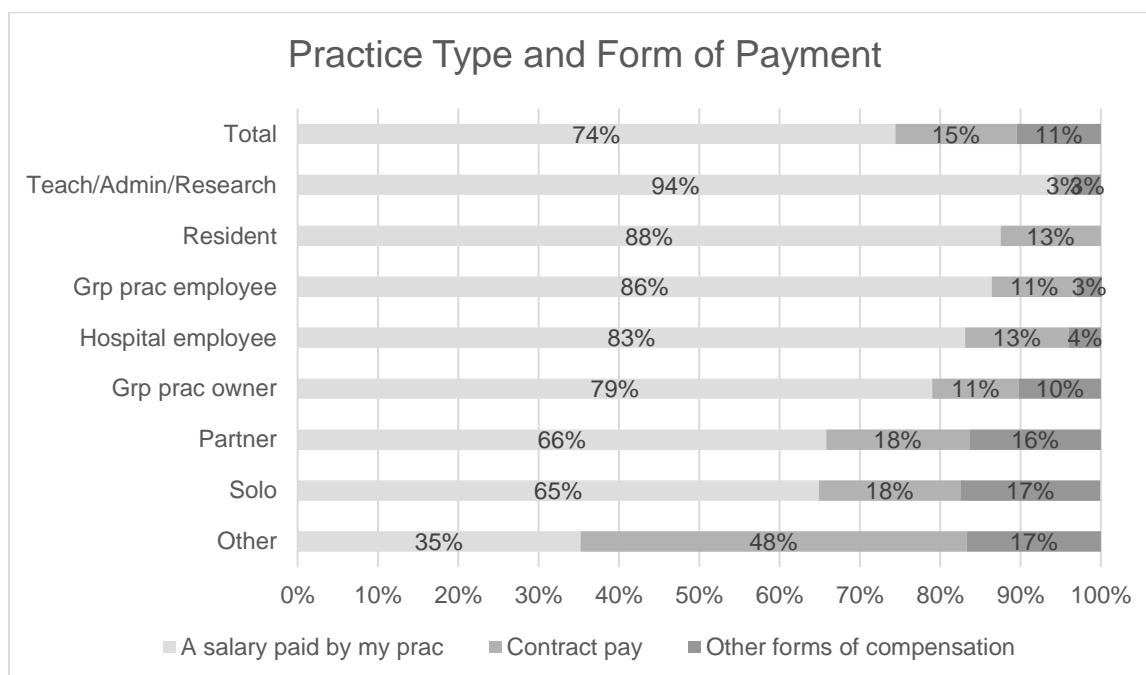
### ***Practice Management Authority (January Q6)***

The majority of physicians report the physician or physicians in the practice have authority for making practice management decisions (76 percent).



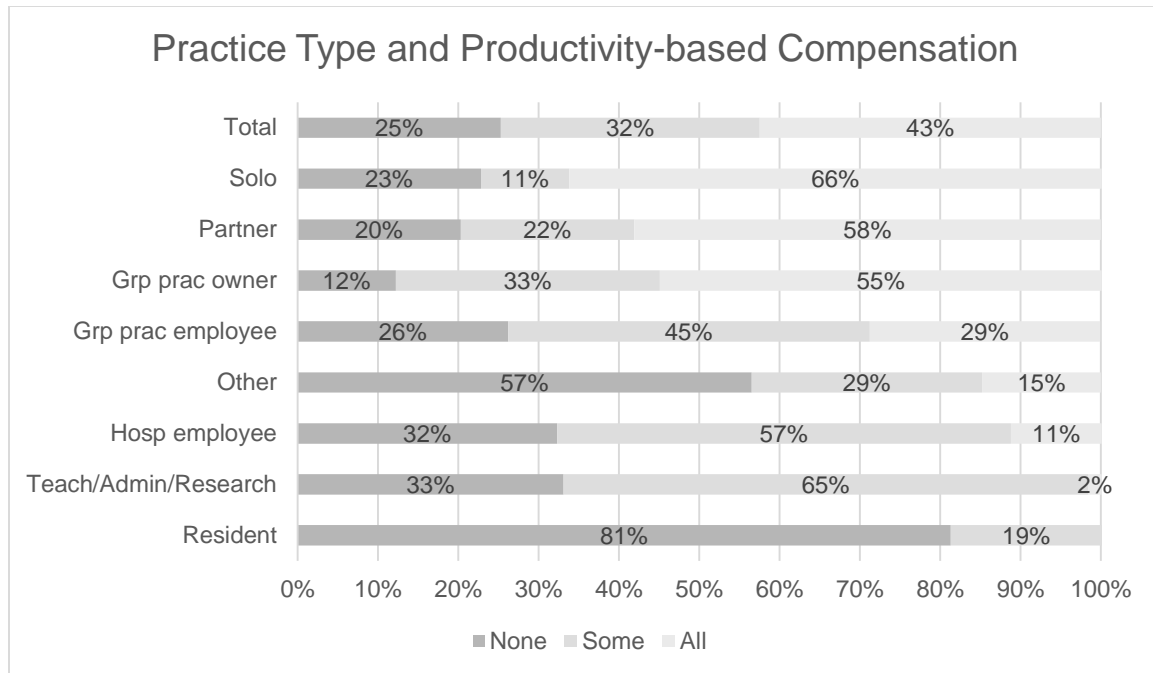
### ***Form of Payment (January Q7)***

A salary paid by the physicians' practice (reported on a W-2 form) comprises the largest part of physicians' personal income (74 percent).



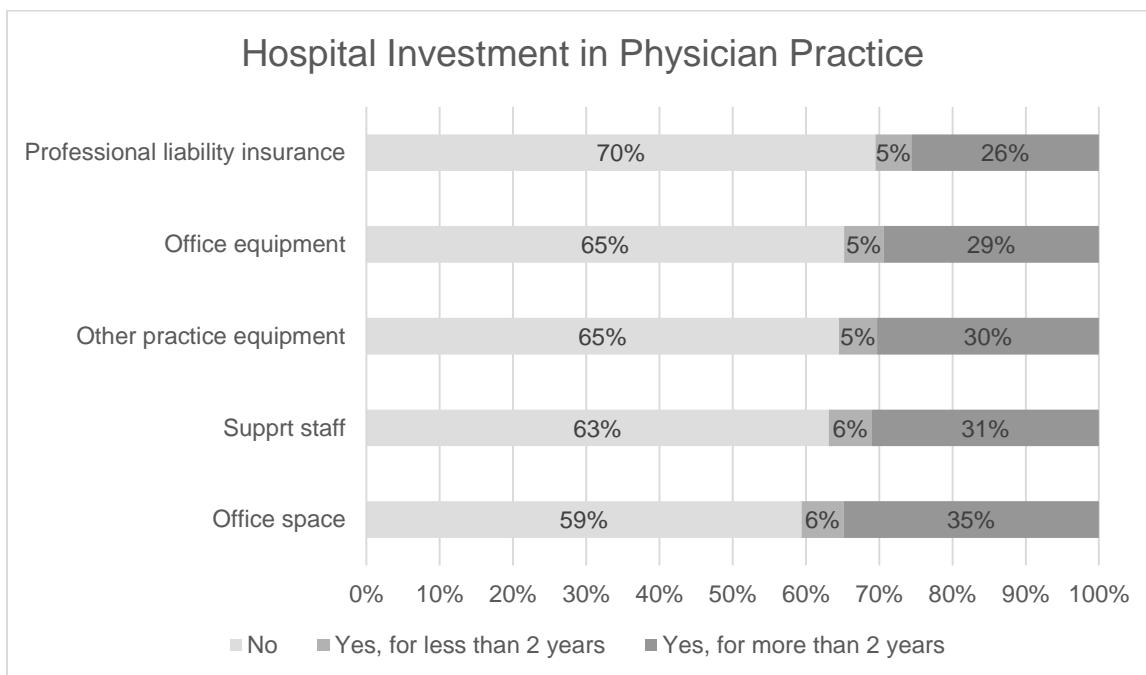
### ***Physician Compensation and Productivity (January Q8)***

The majority of physicians' report their compensation is based some or all on productivity (75 percent). Practice owners are more likely to report all their compensation is based on productivity.



### ***Hospital Investment in Physician Practice (January Q9)***

The majority of physicians' report a hospital or non-physician organization does **not** own, employ, or provide professional liability insurance (70 percent), office and other practice equipment (65 percent), support staff (63 percent), or office space (59 percent). Those physicians who are receiving overhead support from a hospital have been in this practice arrangement for more than two years.

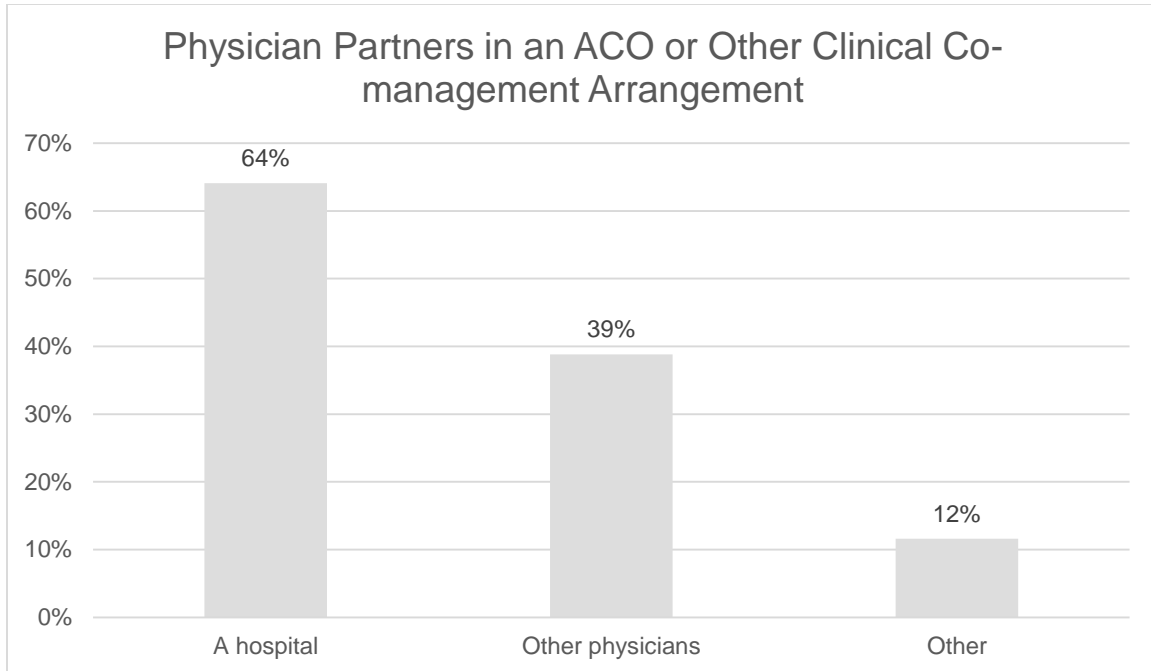


### ***Integrated Delivery System (January Q10)***

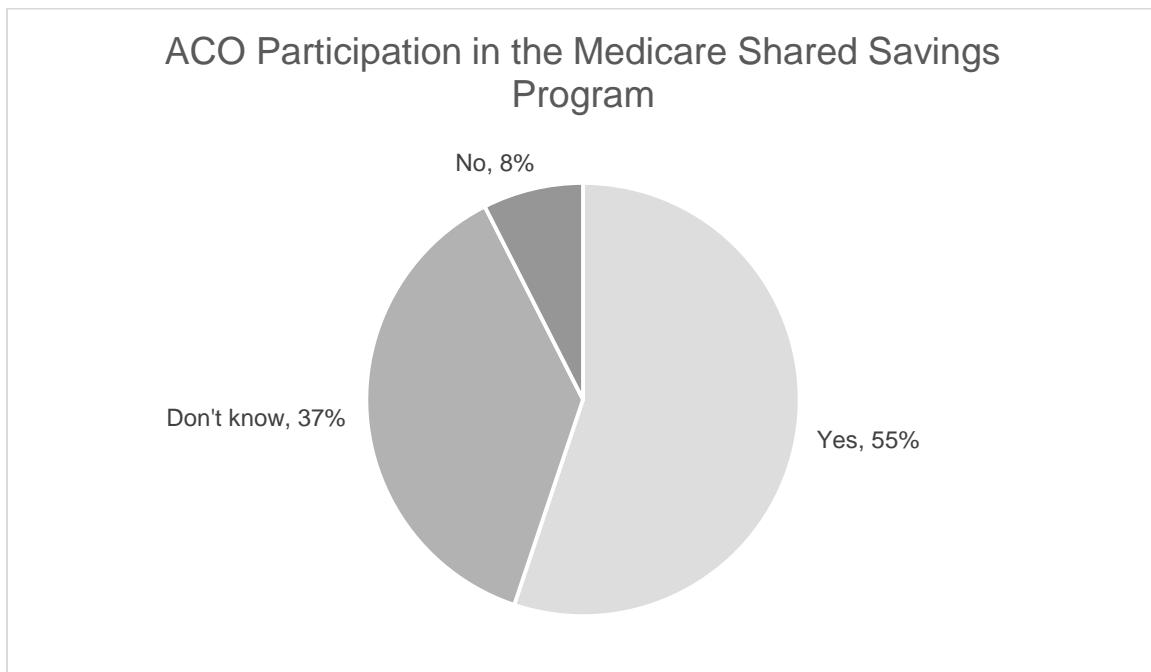
An Integrated Delivery System (IDS) is a network of organizations that provide, coordinate, and/or arrange for the provision of a continuum of health care services to consumers that may be built through virtual integrations processes encompassing direct ownership, contractual arrangements, and strategic alliances. Eighteen percent of physicians describe their practice as an IDS.

### ***Accountable Care Organizations (January Q11-13)***

Few physicians are in an ACO or other clinical co-management arrangement (18 percent). Physicians in an ACO or other clinical co-management arrangement are primarily partnered with a hospital (64 percent).



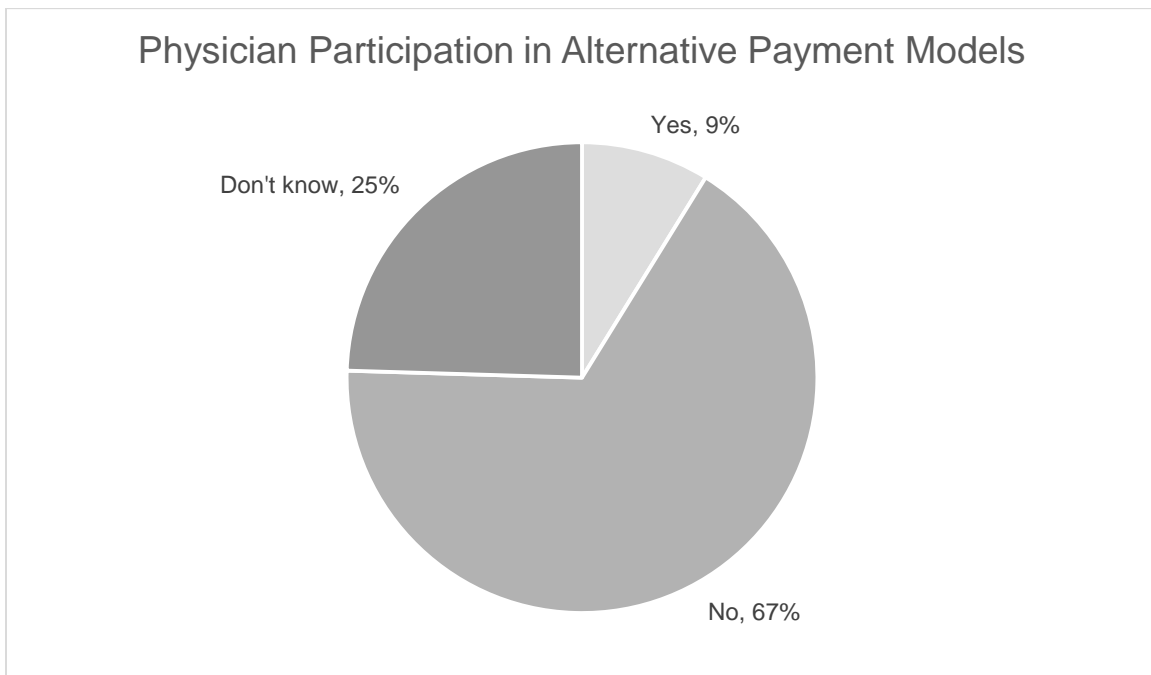
Fifty-five percent of physicians' report their ACO is participating in the Medicare shared savings program.





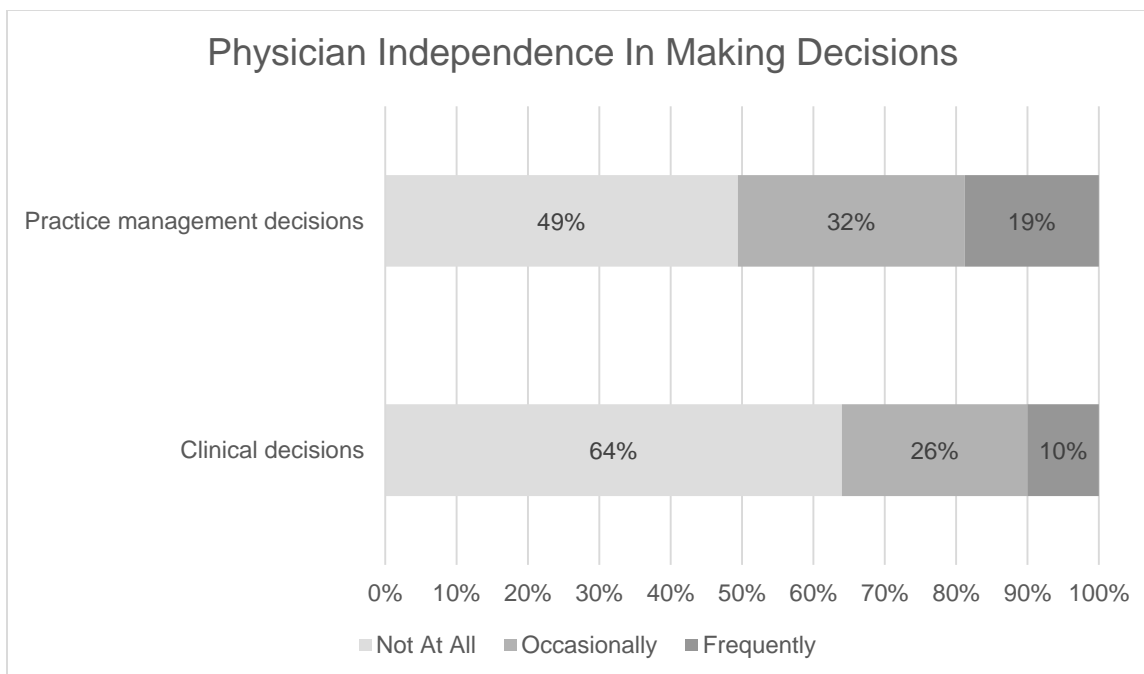
### ***Alternative Payment Models (January Q14)***

Few physicians (9 percent) are participating in alternative payment models (e.g., bundled payments).



### ***Independent Decision-Making (January Q15-17)***

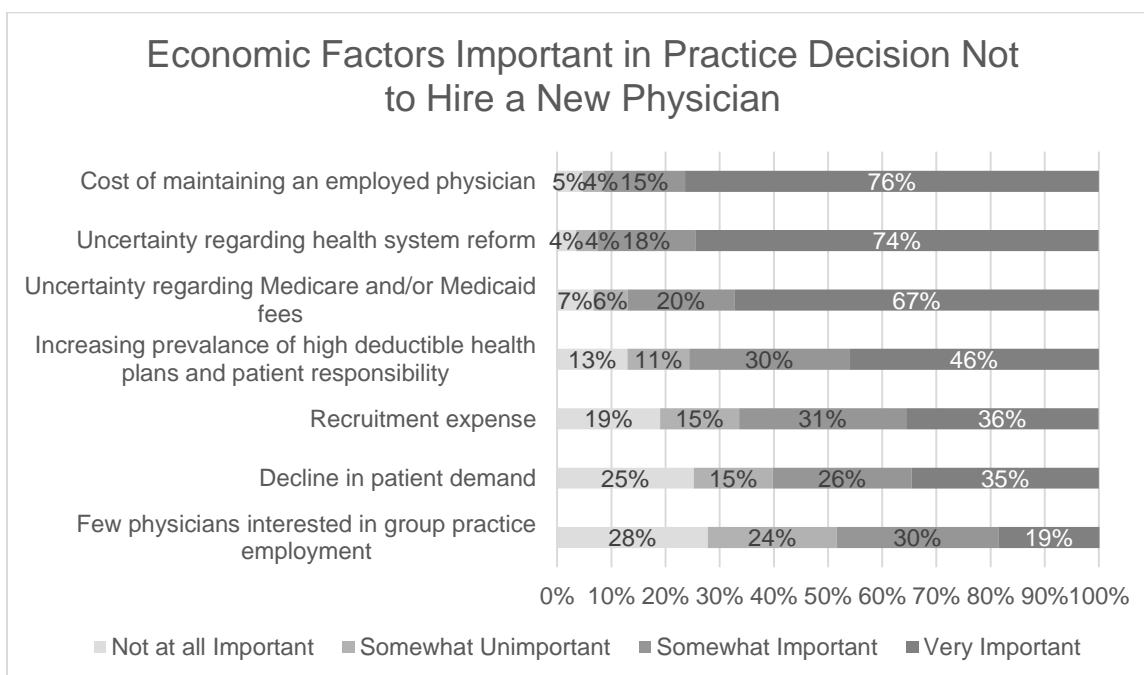
Currently, physicians feel the structure, policies, and relationships of their medical practice does not at all impair their independence in making clinical decisions (64 percent).



However, 52 percent of physicians feel they are at risk of losing their independence in clinical decision-making and physicians agree if they lose their ability to make independent clinical decisions, it is bad for physicians and patients (98 percent).

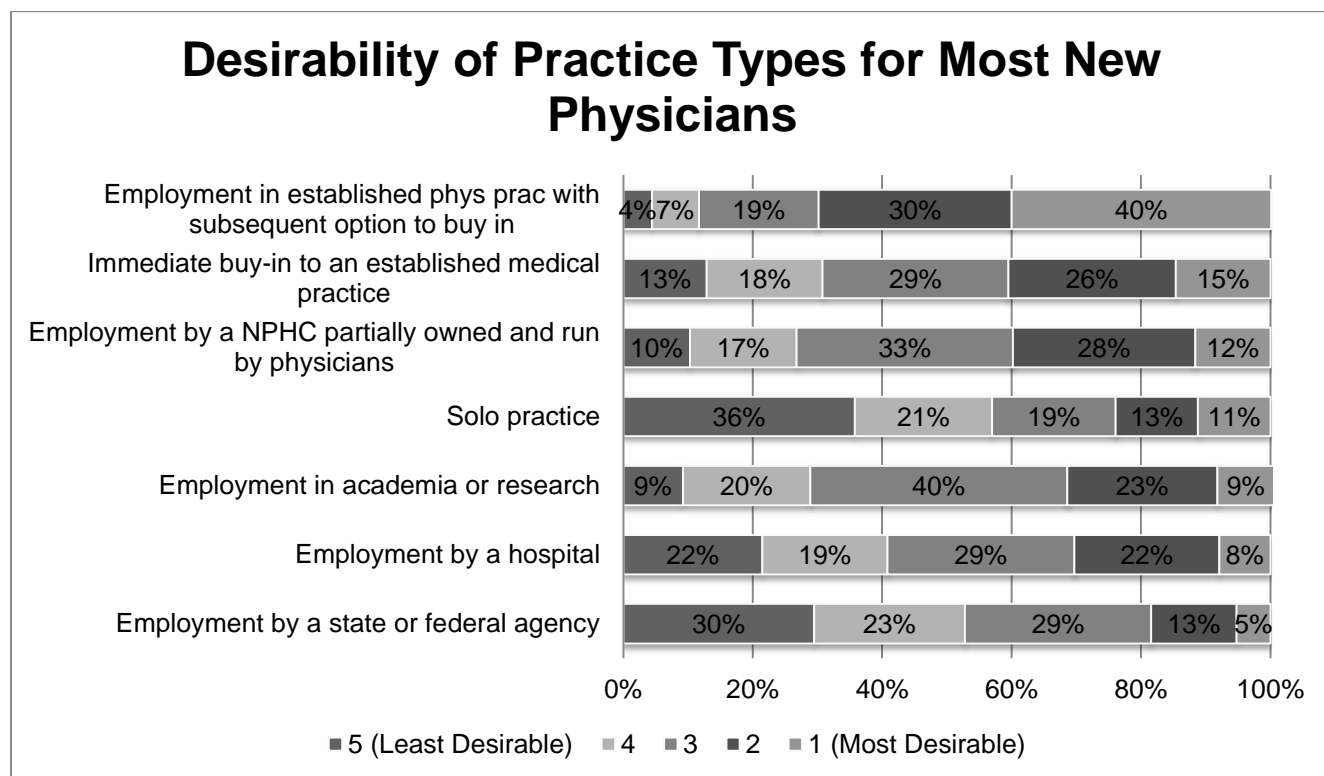
### Physician Recruitment (January Q18-21)

The majority of physicians report their practice has not hired a new physician in the past year (55 percent) and few are planning to hire a new physician in the next year (16 percent). Among those who have not and have no plans to do so, 35 percent would if the economic environment was different. These physicians rank the cost of maintaining an employed physician (76 percent), uncertainty regarding health system reform (74 percent), and Medicare and/or Medicaid fees (67 percent) as very important in their decision not to hire a new physician.

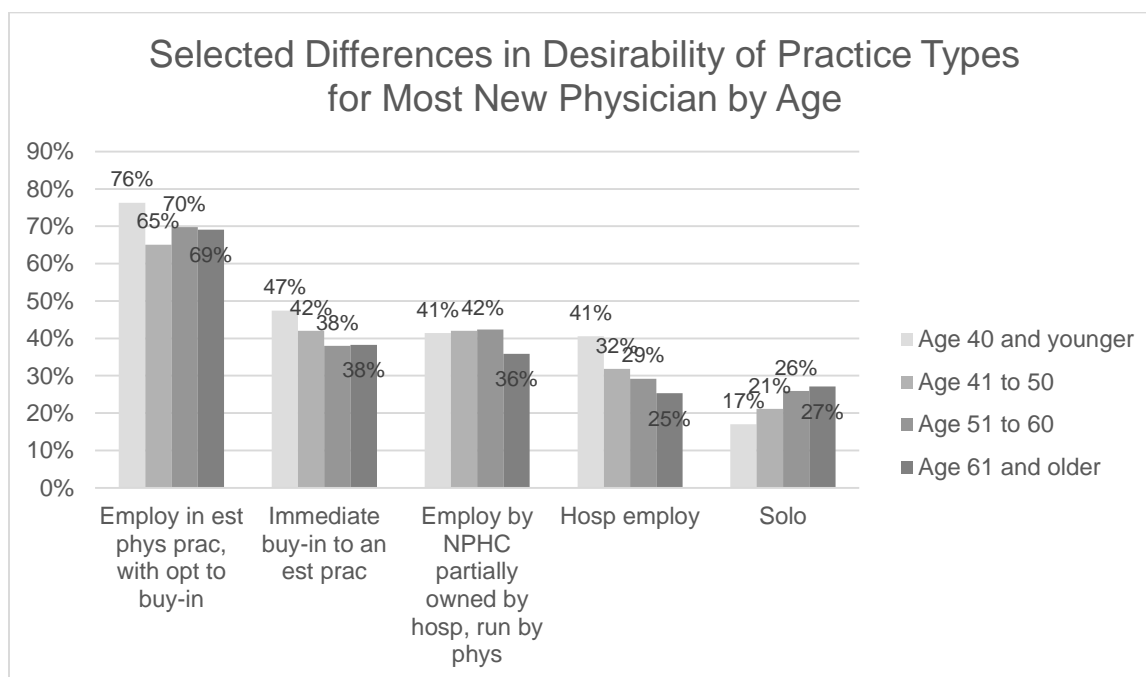


### Practice Type Desirability (January Q24)

Seventy percent rate employment in an established physician practice with a subsequent option to buy in to ownership is the first or second most desirable practice type for most new physicians.

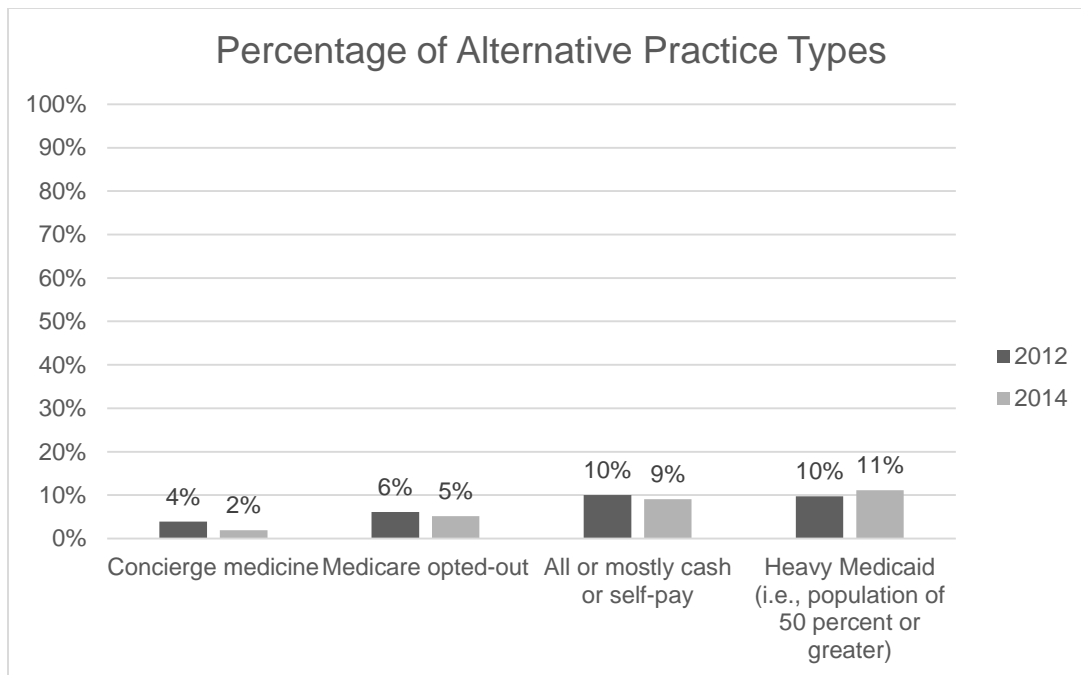


Physicians in the youngest age group are most likely to rank employment in an established physician practice with the option to buy-in is the first or second most desirable practice type (76 percent).



### ***Alternative Practice Types (March Q16)***

Although a great deal of attention has been paid to concierge practices in the news, a small percentage of Texas physicians practice this type of medicine (2 percent). Nine percent of physicians report their practice is all or mostly cash. Nine percent of physicians report their practice is all or mostly cash.



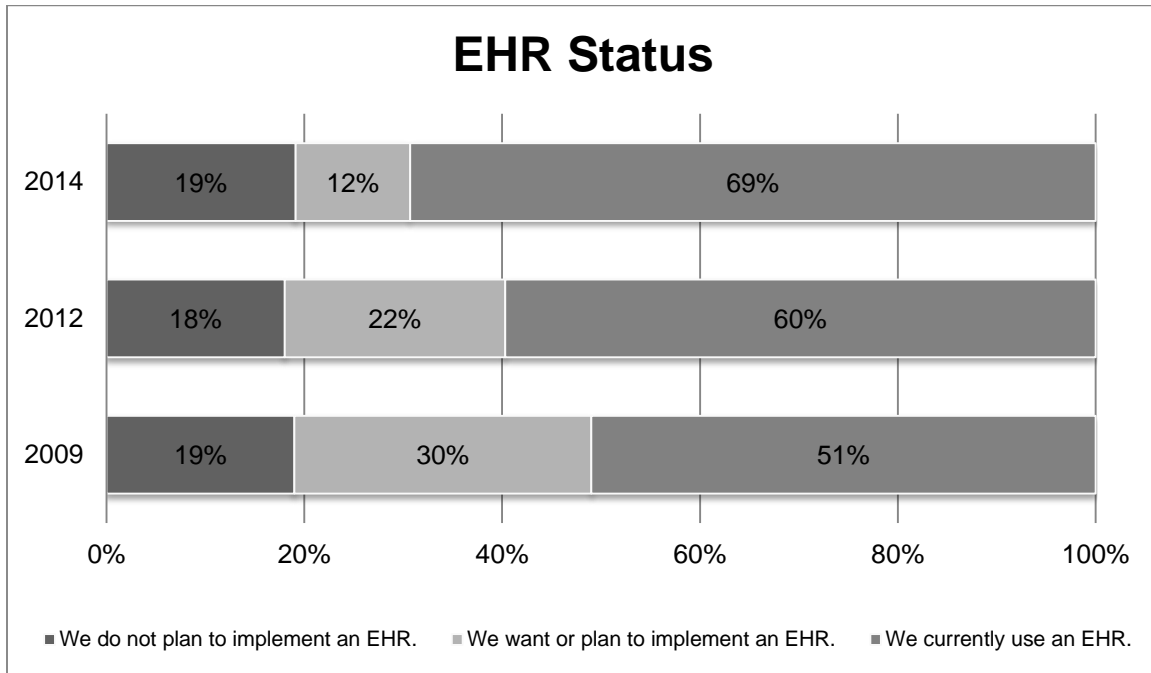
### ***Franchise Tax Fees and Preparation (June Q1-2)***

Thirty-six percent of physician practices paid the Texas franchise tax in 2013. Those who paid the franchise tax paid a mean tax liability of \$6,257.

## Electronic Health Records

### *EHR Status (February Q1)*

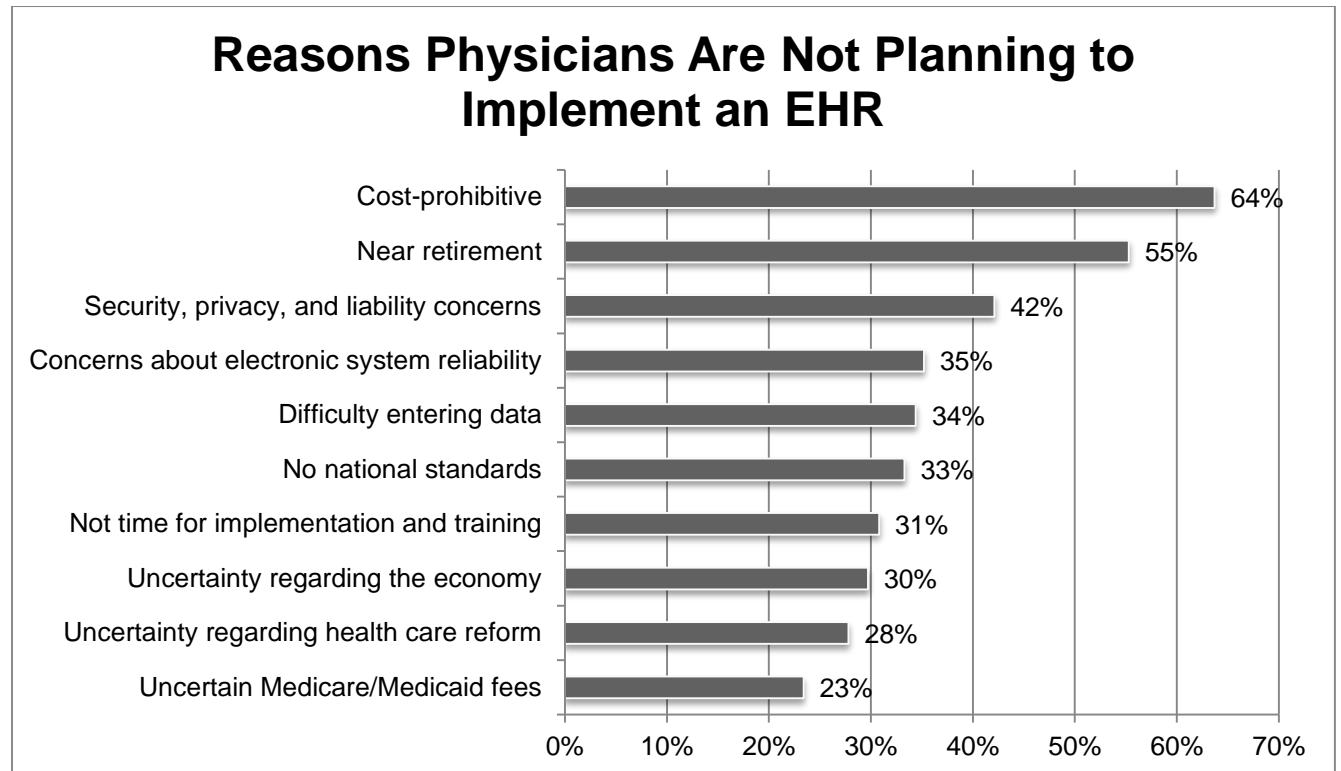
The majority of respondents plan to implement or currently use an EHR (81 percent).



## Practices with No Plans to Implement an EHR

### *Reasons for Not Implementing an EHR (January Q2)*

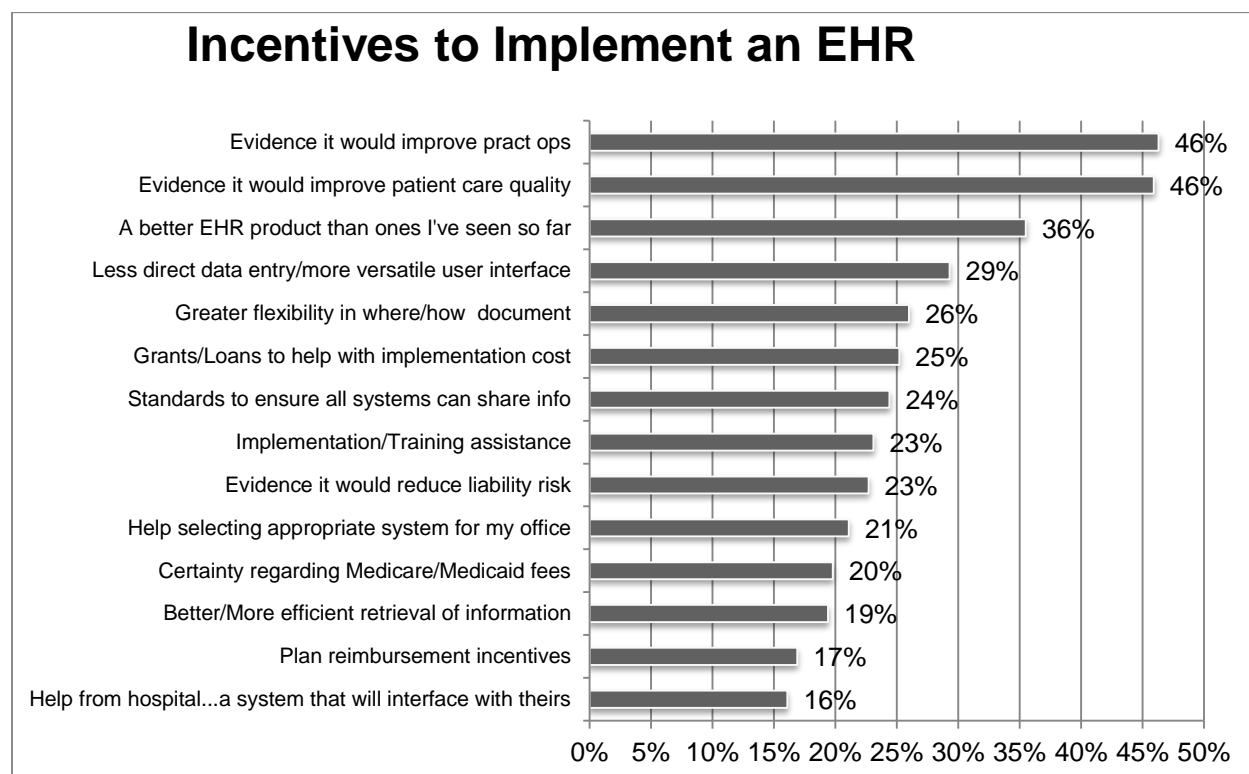
Physicians who do not plan to implement an EHR report it is cost-prohibitive (64 percent) and/or they are near retirement (55 percent).





### ***Incentives to Implement an EHR (February Q3)***

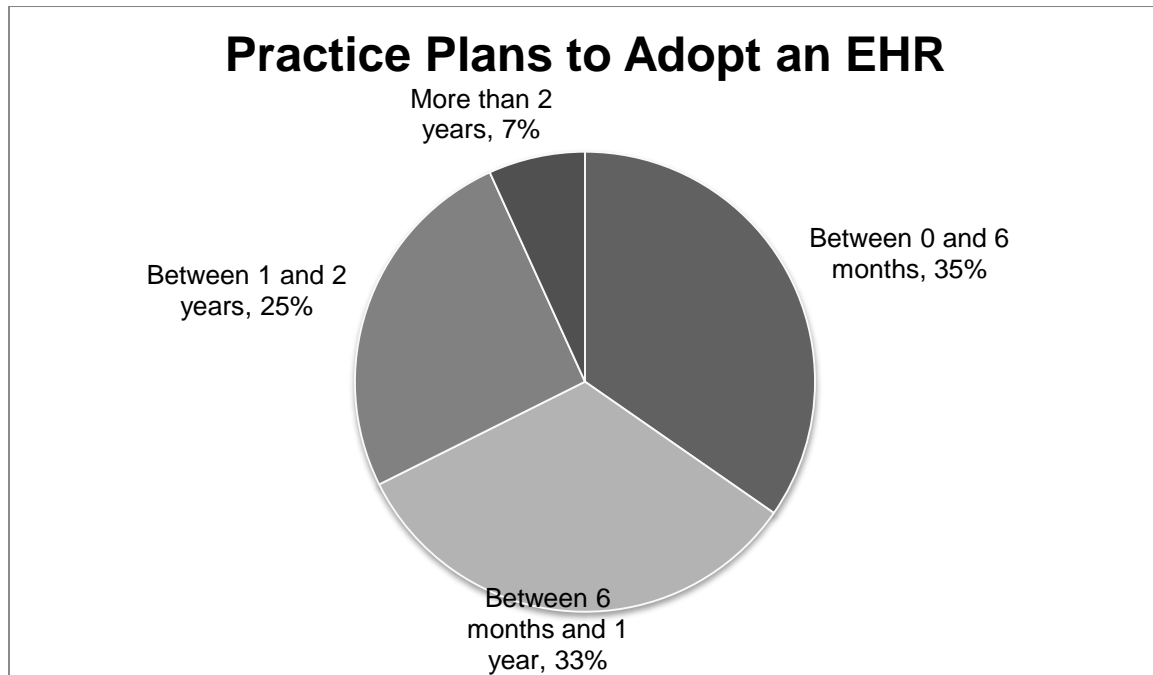
A large minority of physicians report evidence it would improve practice operations or the quality of patient care (46 percent) would convince them to implement an EHR.



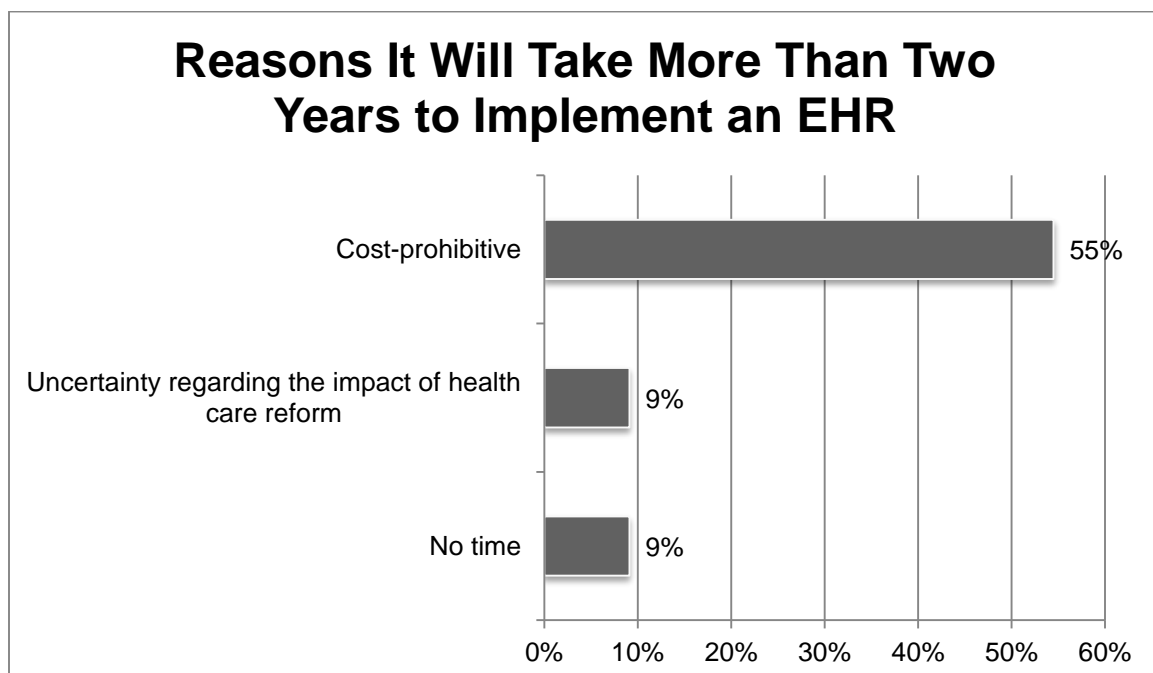
## Practices with Plans to Implement an EHR

### *Time until EHR Implementation (January Q4-5)*

Practices that want to or plan to implement an EHR anticipate doing so within one year (68 percent).

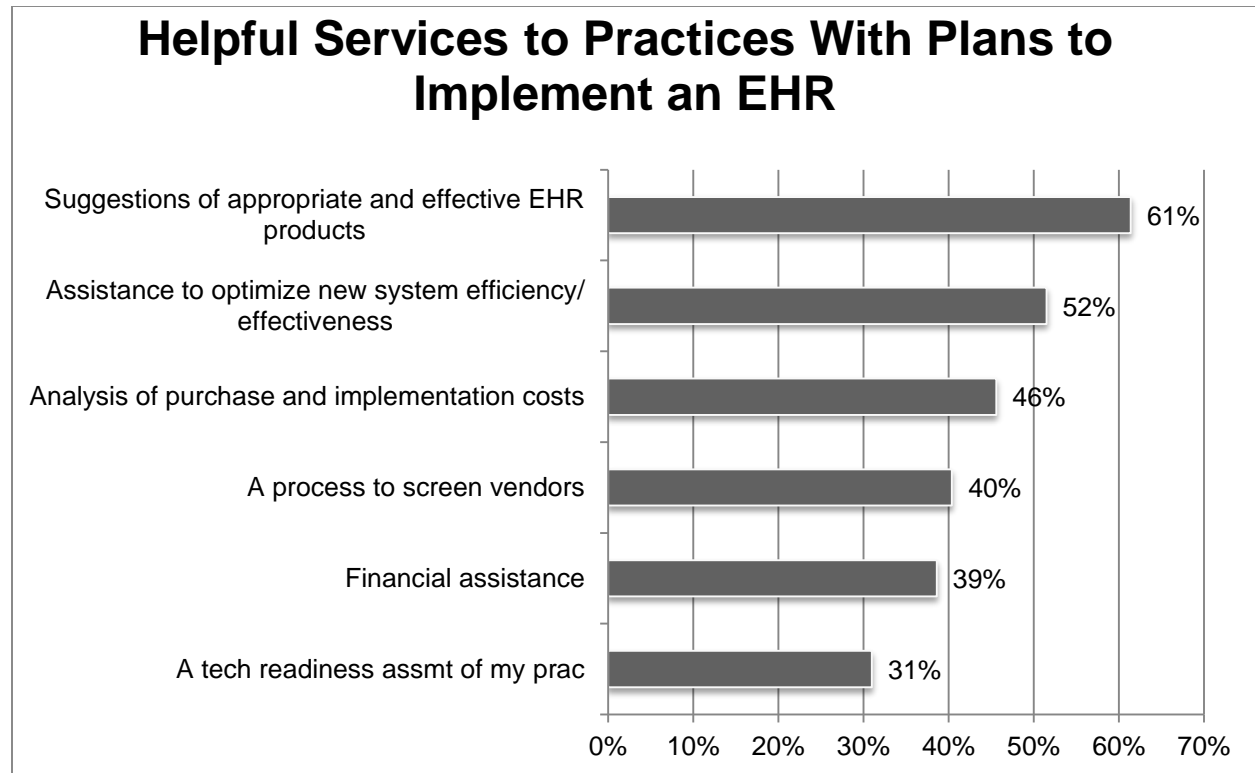


Physicians who report it will take their practice more than two years to implement an EHR specify the cost as prohibitive (55 percent).



### ***Helpful Services for Implementation (January Q6)***

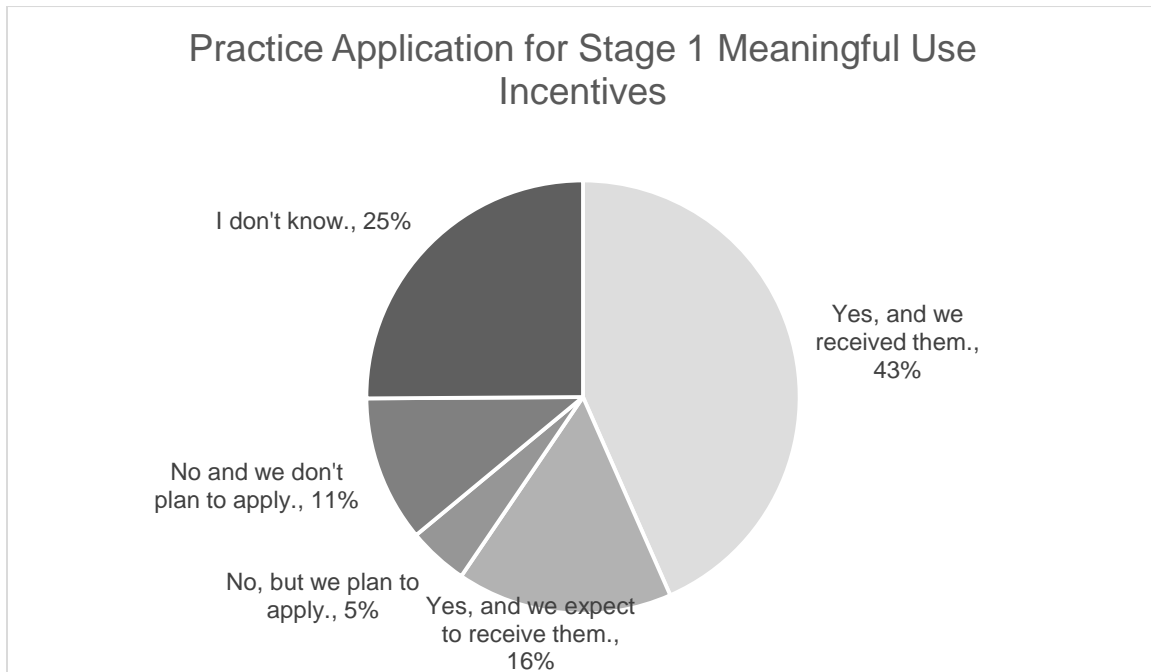
Physicians with plans to implement an EHR report suggestions of appropriate and effective EHR products (61 percent) and assistance optimizing new system efficiency and effectiveness (52 percent) would be the most helpful.



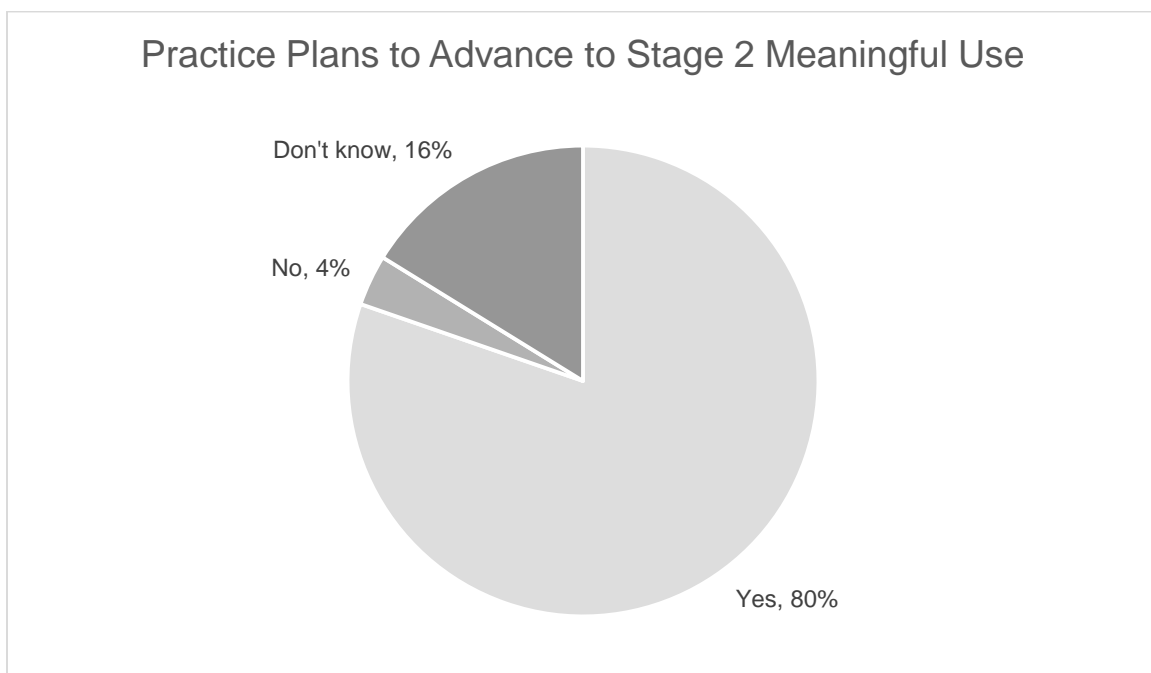
## Practices That Have Implemented an EHR

### *Meaningful Use Incentives (January Q7-8)*

A little more than half of physicians applied for Stage 1 Meaningful Use incentives (59 percent).

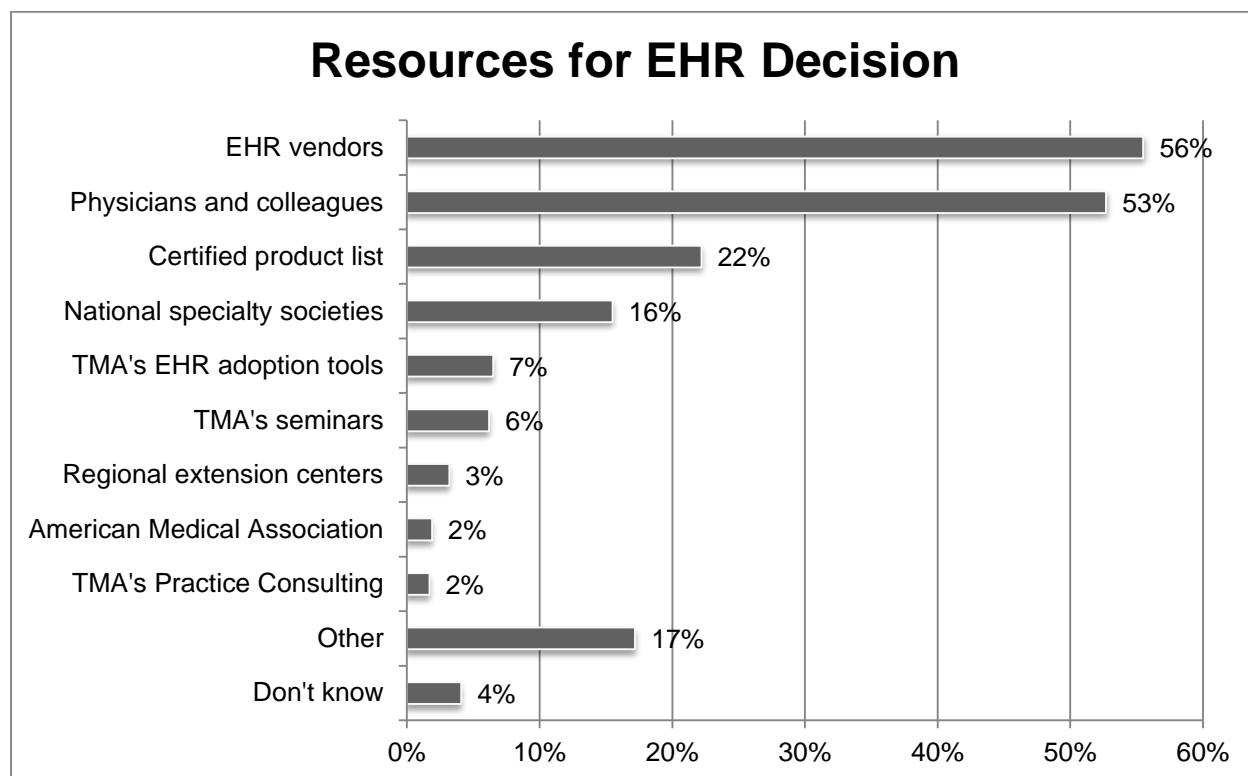


Among physicians who applied or plan to apply for Stage 1 Meaningful Use incentives, 80 percent plan to advance to Stage 2 Meaningful Use.

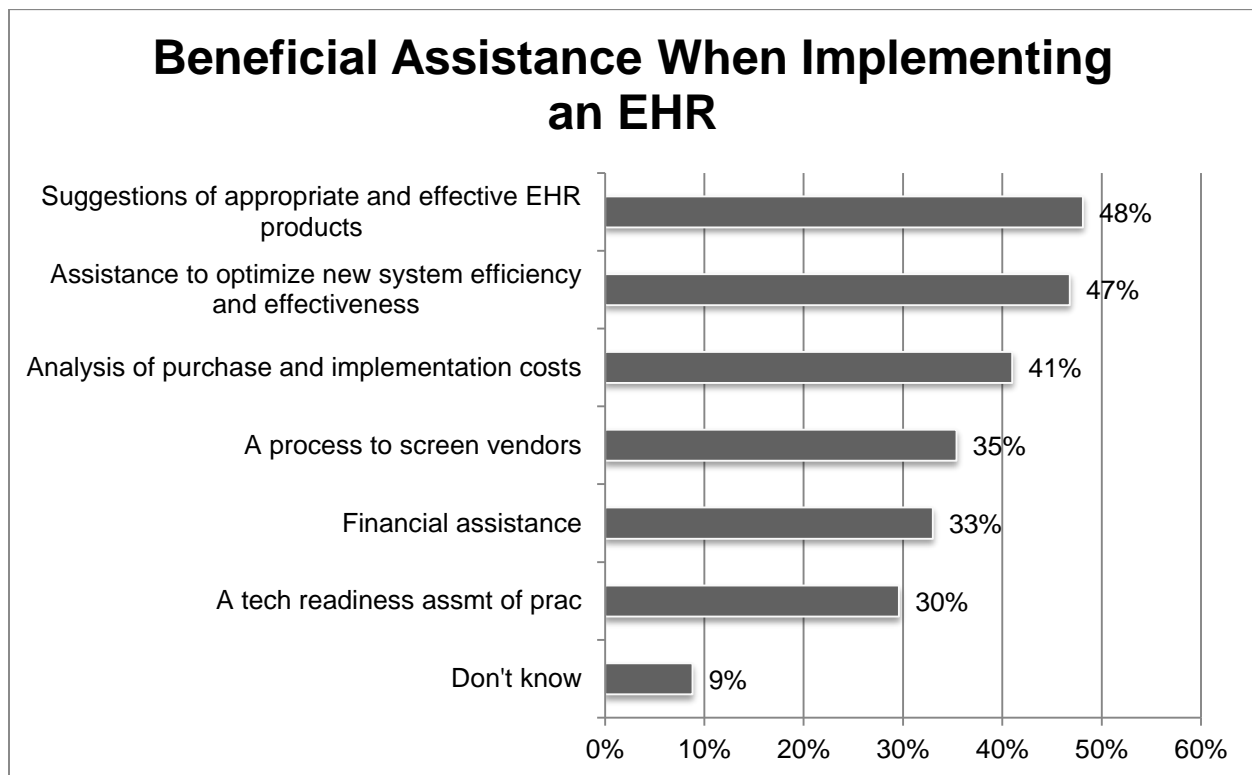


### ***Physician Involvement in EHR Selection (February Q9-11)***

Forty-six percent of physicians were involved in the initial selection of their EHR. These physicians used other physicians and colleagues (56 percent) and EHR vendors to make their purchase decision (53 percent). Twenty-four percent used TMA resources.

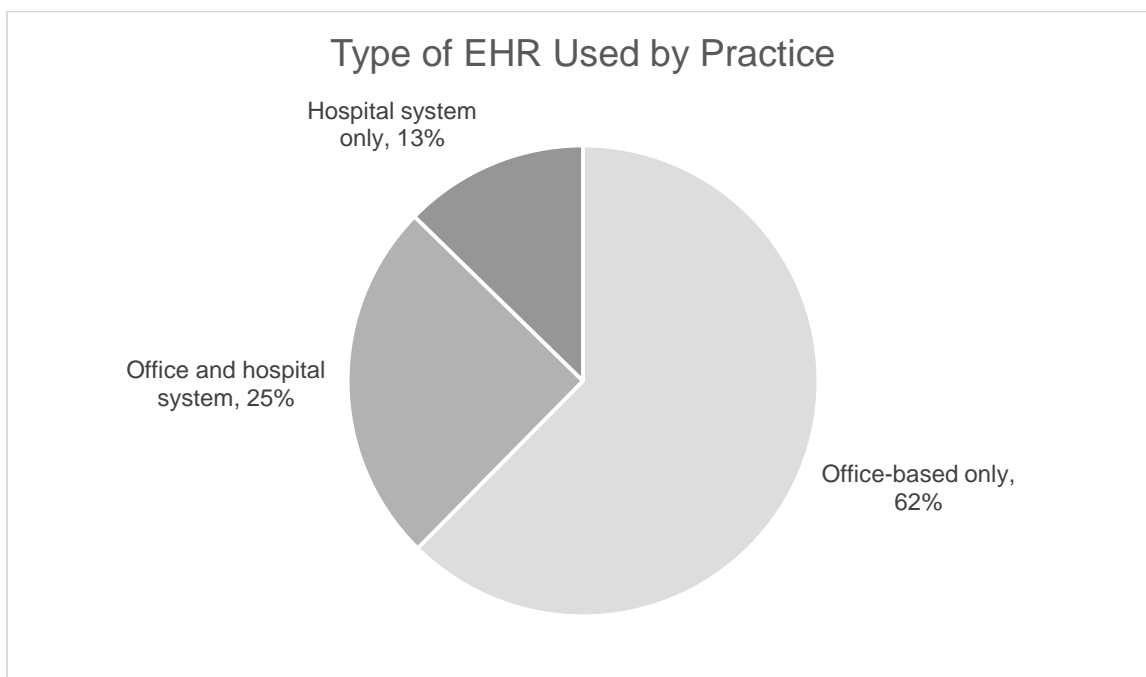


When implementing their EHR, physicians would have benefited from suggestions of appropriate and effective products (48 percent) and assistance with optimizing new system efficiency and effectiveness (47 percent).



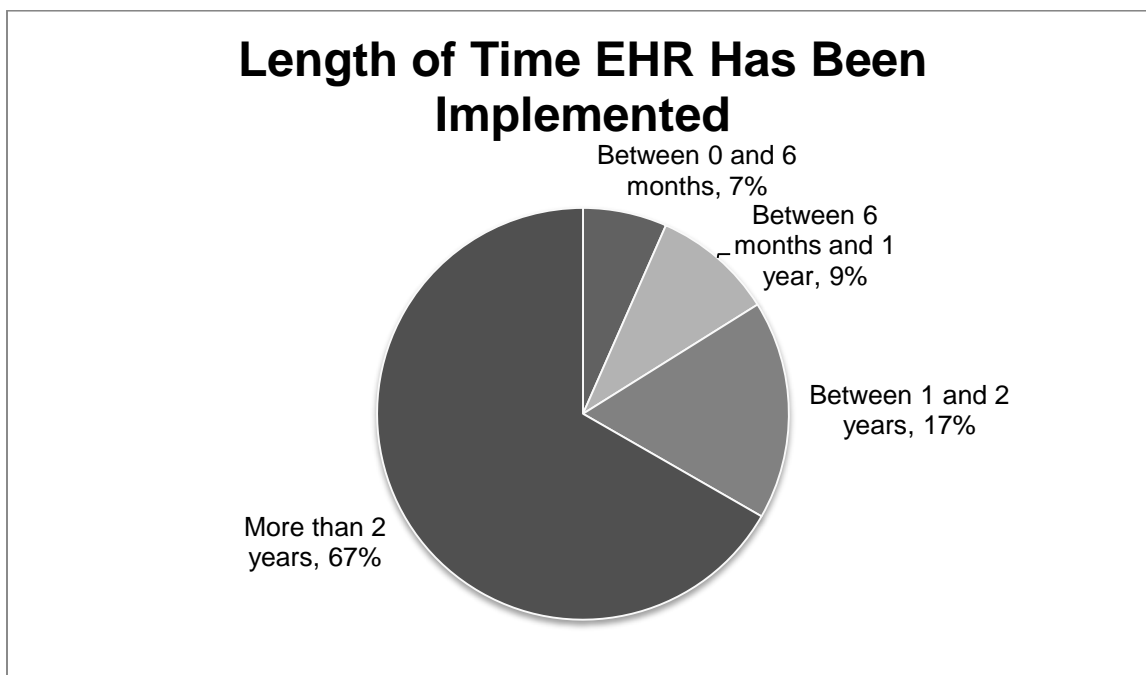
### ***Type of EHR (February Q12)***

The majority of physicians use an office-based only EHR (62 percent).



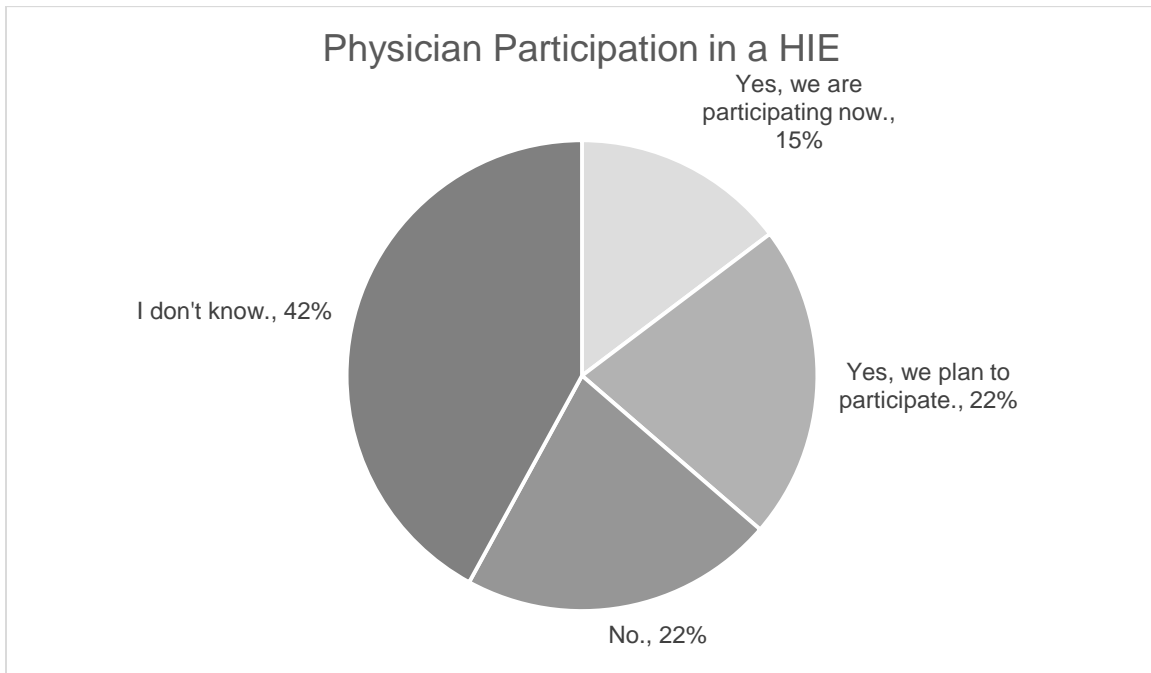
### ***Length of Time EHR Has Been in Use (February Q13)***

Physicians who currently use an EHR report it has been implemented more than two years (67 percent).



### ***Health Information Exchange Participation (February Q14)***

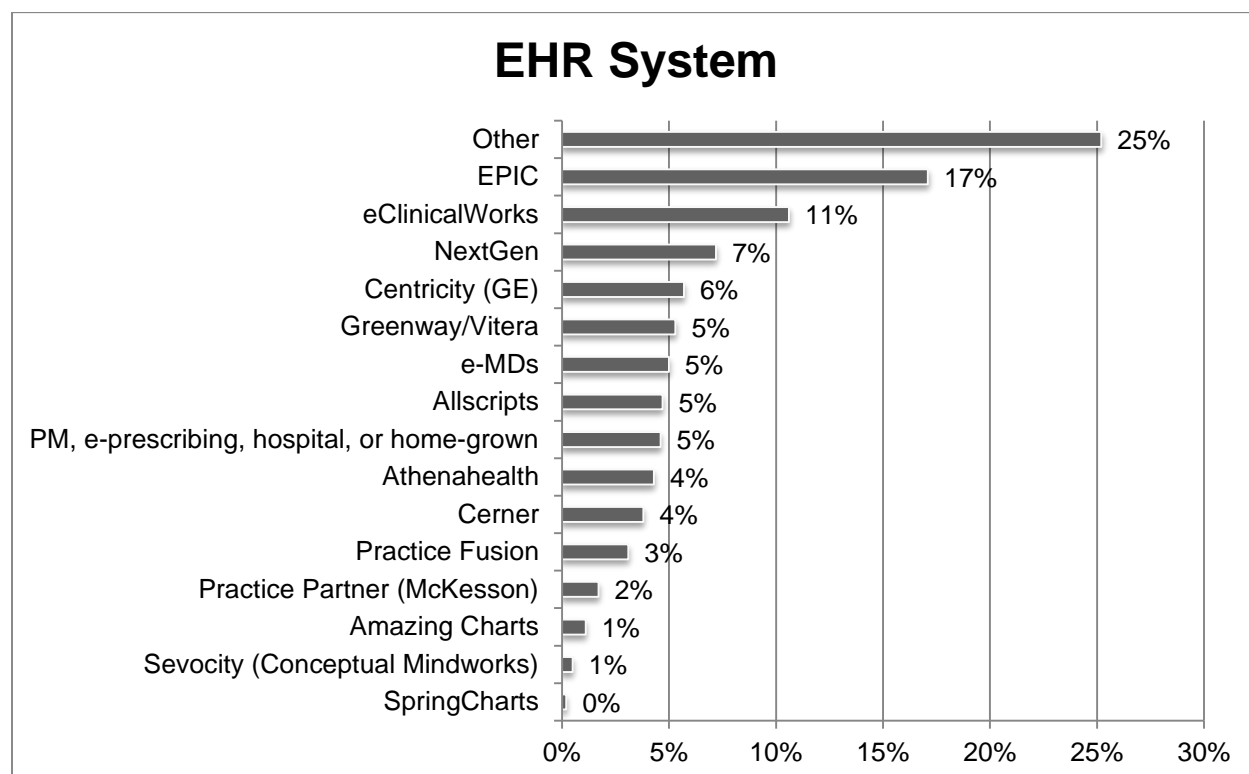
Thirty-seven percent of physicians are participating or plan to participate in a local HIE to share EHR data among health care providers.





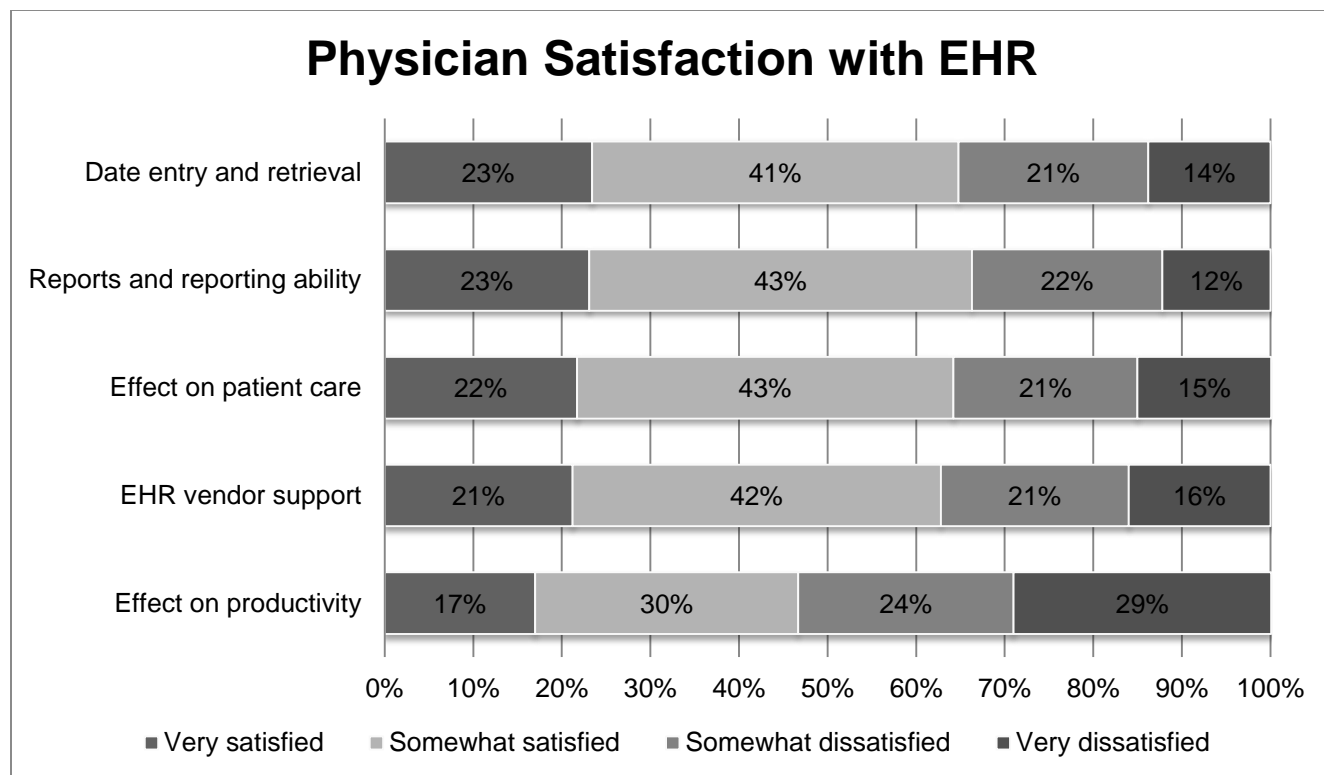
### ***EHR System (February Q15)***

The EHR system with the largest percentage of users is EPIC (17 percent). A quarter of physicians use “other” EHR systems, too numerous to mention.



### ***EHR Satisfaction (February Q16)***

Users were asked to rate their satisfaction with their system on various dimensions. Overall, physicians are most satisfied with their EHR's reports and reporting ability (66 percent).

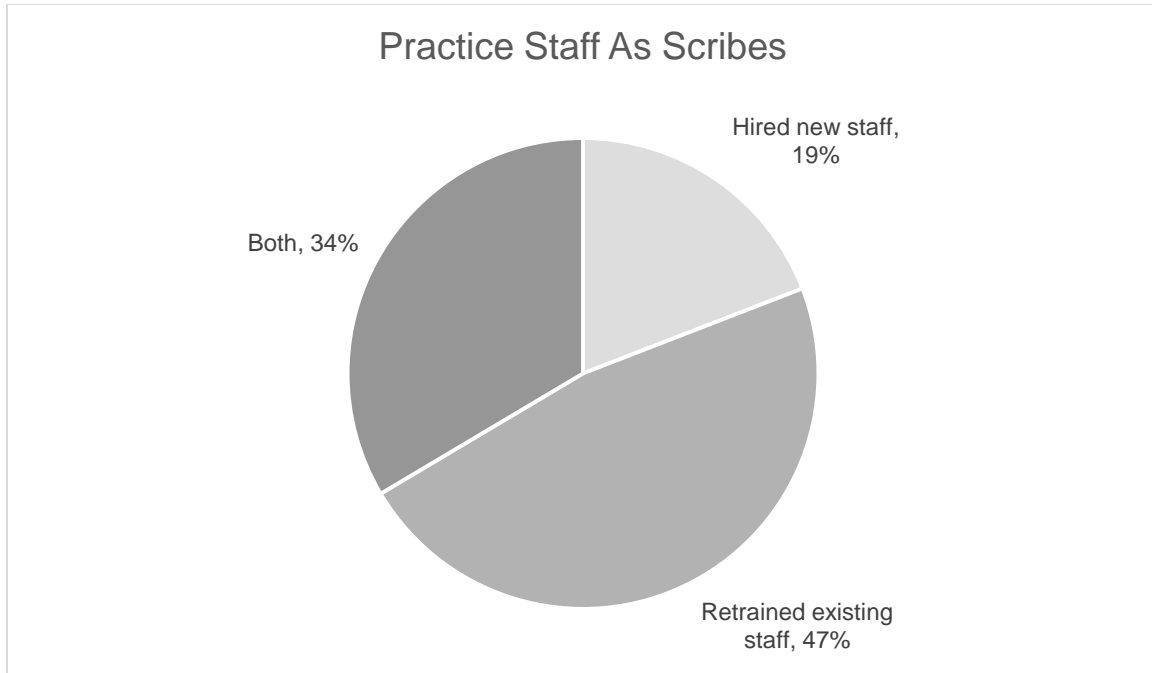


### ***EHR Recommendation (February Q17)***

Fifty-seven percent of physicians would recommend their system to another practice.

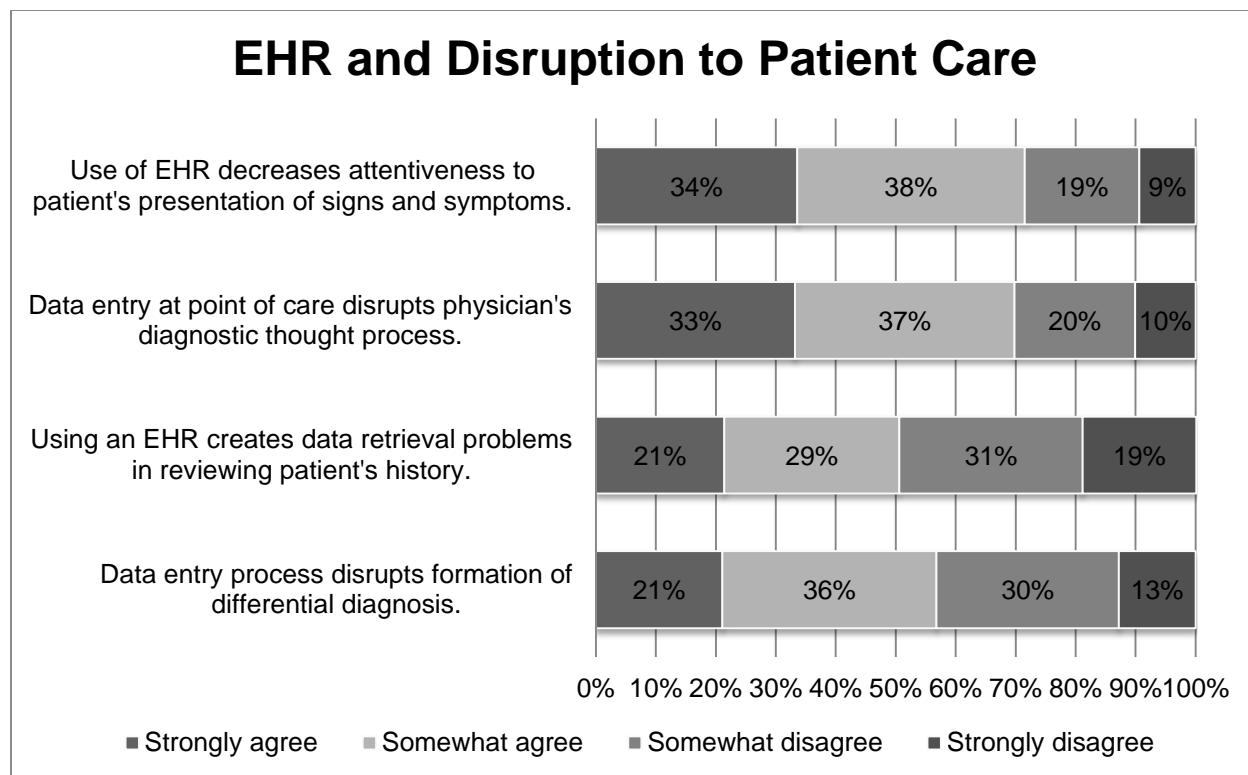
### ***Scribes (February Q18-19)***

Twenty-one percent of physicians report their practice uses scribes for EHR data entry. Among them, 47 percent retrained existing staff and 34 percent retrained existing and hired new staff.



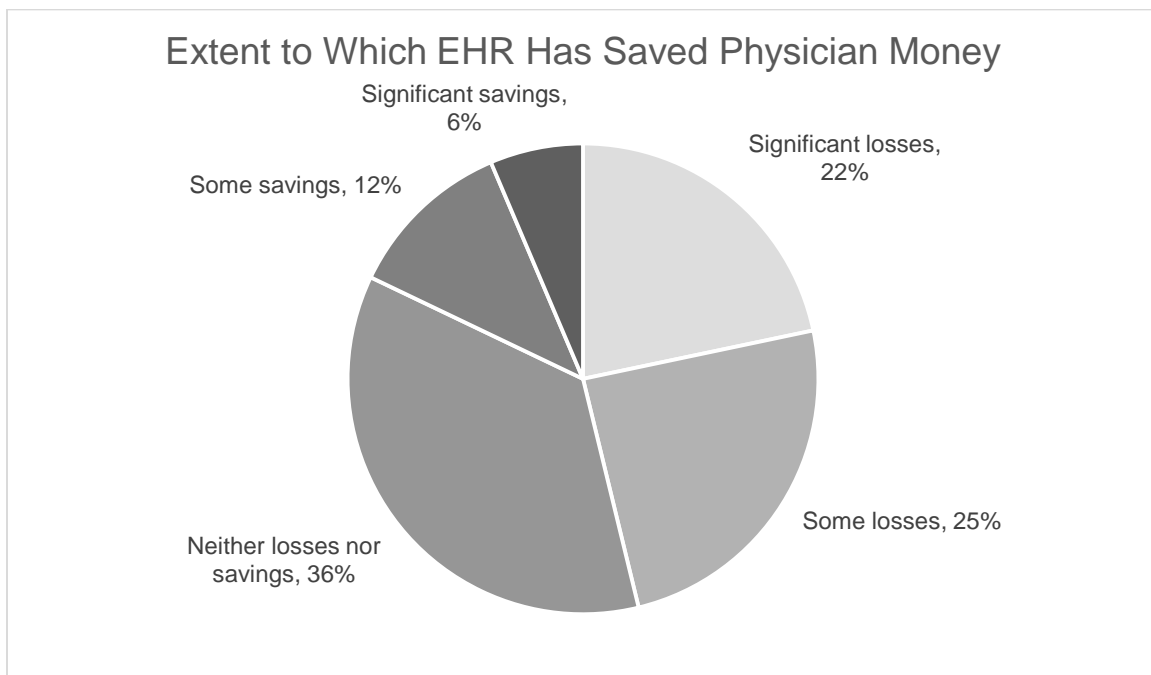
### ***EHR Disruption to Patient Care (February Q20)***

Physicians agree use of the EHR decreases attentiveness to the patient's presentation of signs and symptoms (72 percent) and data entry at the point of care disrupts a physician's diagnostic thought process (70 percent).

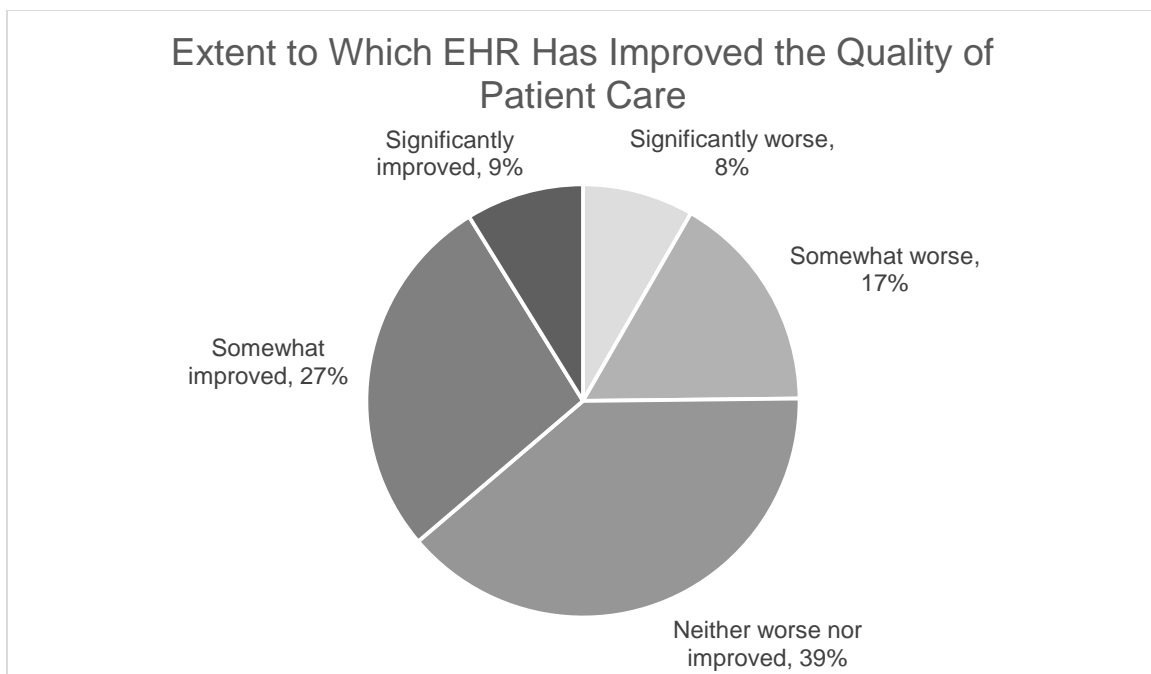


### ***EHR Cost and Care (February Q21-24)***

Few physicians report their EHR has saved them money (18 percent).

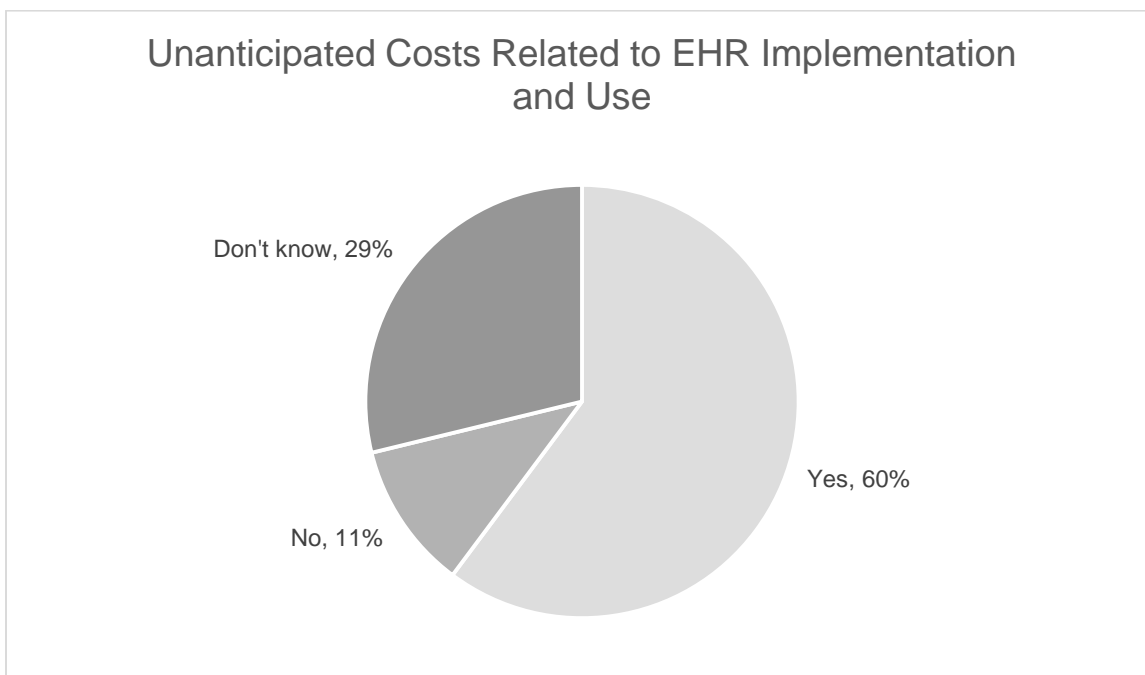


Few physicians report their EHR has improved the quality of patient care (36 percent).



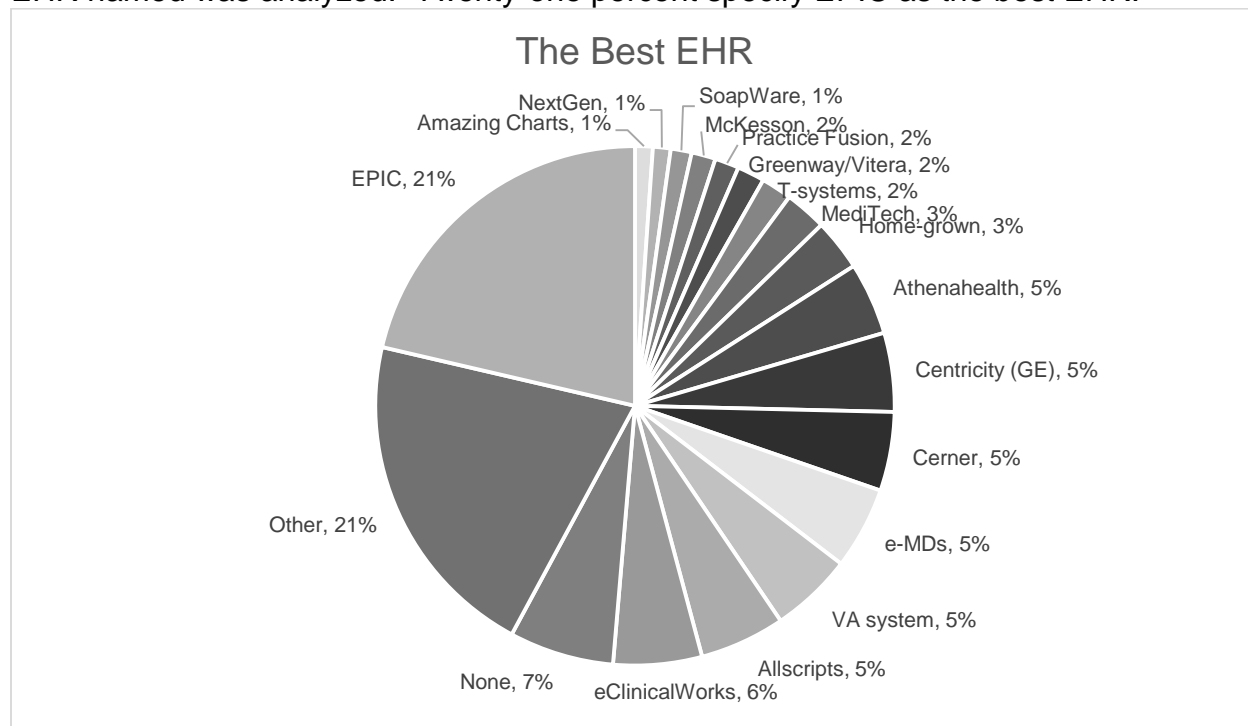
A minority of physicians report their EHR has been worth the effort, resources, and cost (47 percent).

Sixty percent report there were unanticipated costs related to EHR implementation and use.



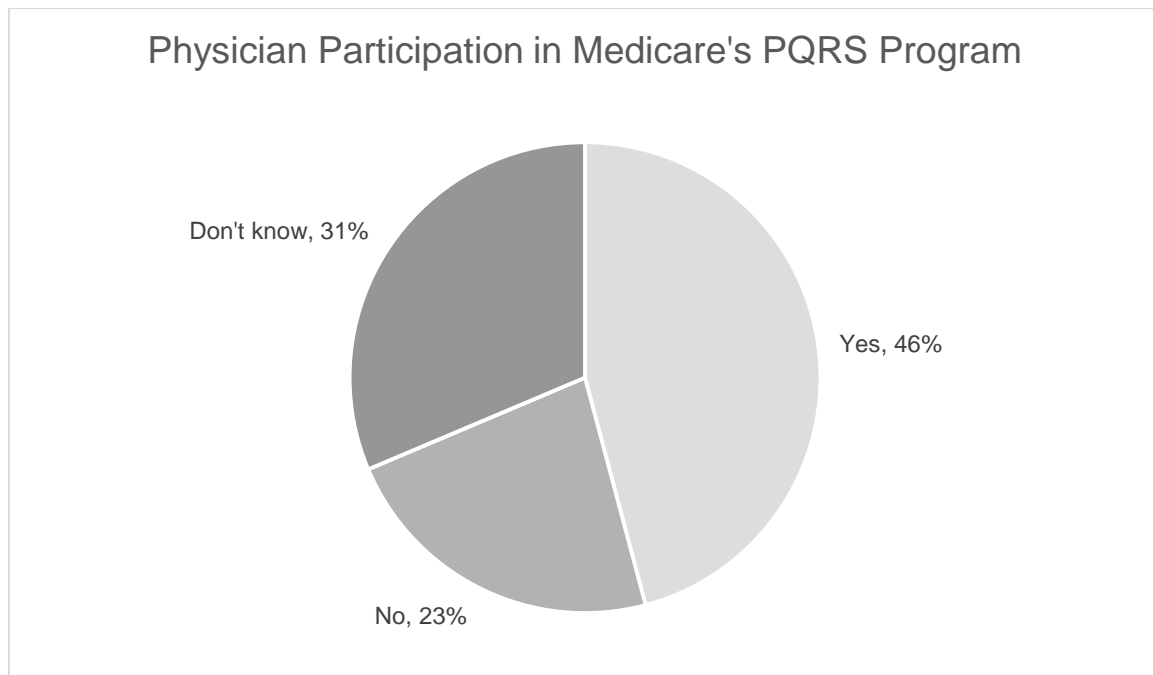
### ***Use of More Than One EHR (February Q25-Q26)***

Sixty-eight percent of physicians have used more than one EHR in their entire medical career. Physicians who have used more than one EHR were asked to specify the best one. Some physicians specified more than one, in which case, the first EHR named was analyzed. Twenty-one percent specify EPIC as the best EHR.



### ***Physician Quality Reporting System Participation (February Q27)***

Forty-six percent of physicians are currently reporting quality data for Medicare's PQR program from their EHR.



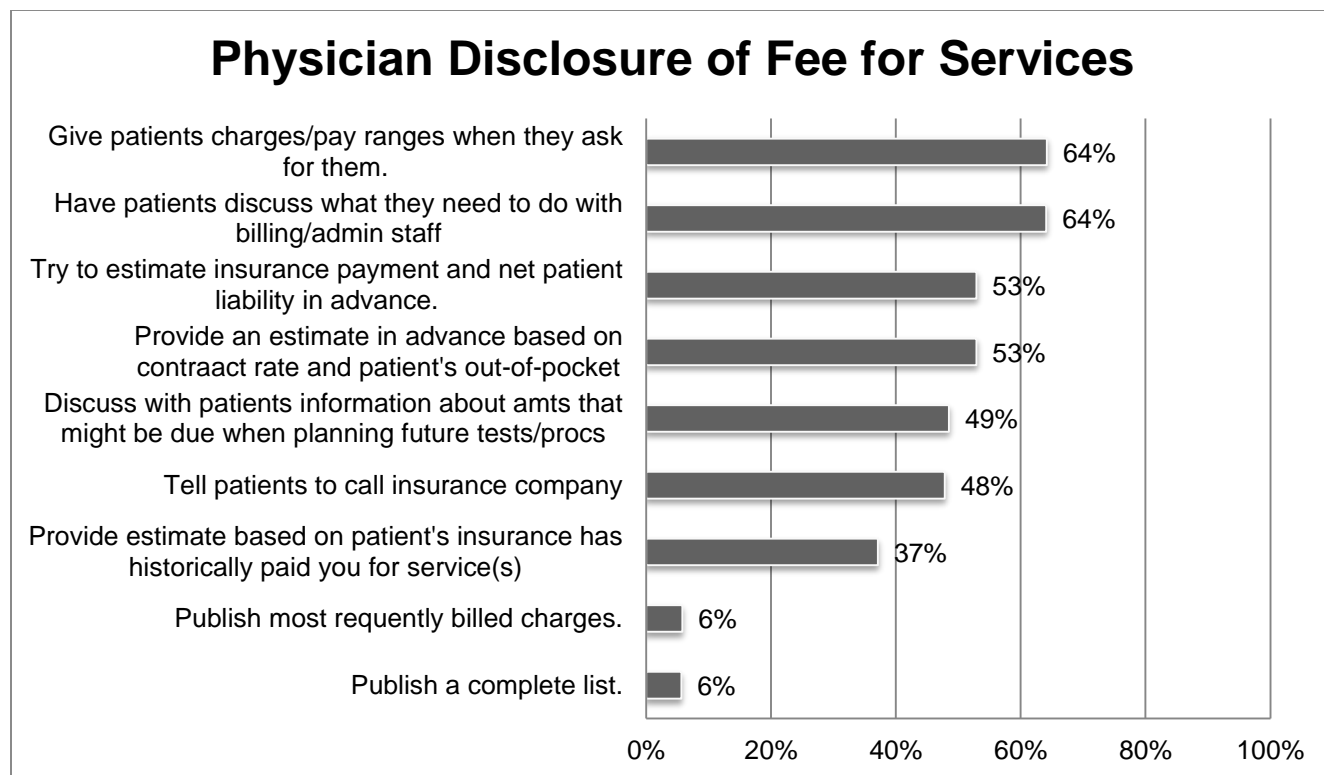
## **Patient Billing**

### ***Prompt Payment Discounts (April Q18)***

When patients are uninsured or seek care from physicians who do not have managed care contracts with their insurers, they are not eligible for contracted fee discounts. The majority of physicians offer discounts to those patients when they pay promptly for the services they receive (63 percent).

### ***Fee Disclosure (May Q11)***

Physicians give patients individual charges or possible payment ranges or have the patient discuss what they need to do with their administrative/billing staff (64 percent) to assist patients with their out-of-pocket costs.

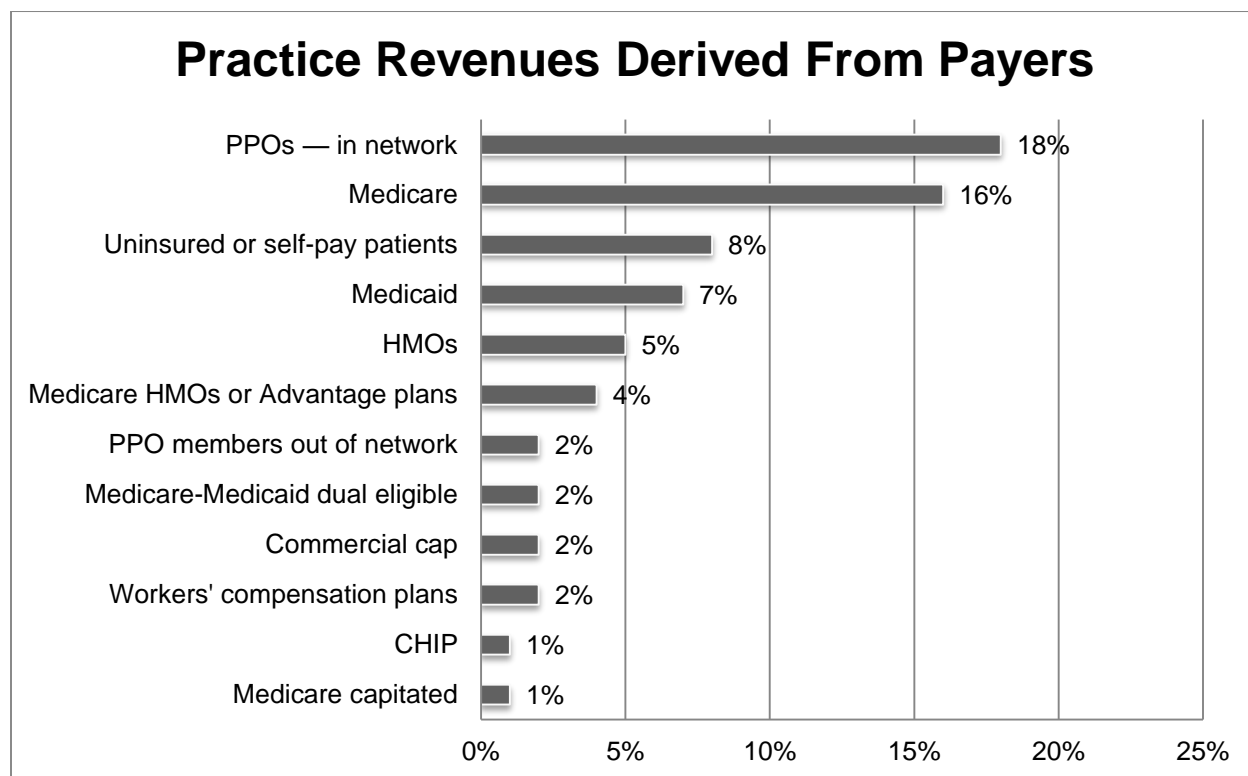




## Practice Revenues

### ***Sources of Practice Revenues (March Q15)***

Physicians were asked to estimate their revenue percentages by payer type. Thirty-three percent of average practice revenues are derived from programs funded and regulated by state or federal government: 16 percent from Medicare, 7 percent from Medicaid, 4 percent from Medicare HMO or Advantage plans, 2 percent from payments for dual-eligible patients, 2 percent from workers' compensation plans, 1 percent from the Children's Health Insurance Program (CHIP), and 1 percent from Medicare capitated programs. Revenues for PPO-covered patients constitute 20 percent of physician practice receipts, including services for patients provided out of network.



### ***Charity Care and Bad Debt (June Q3-4)***

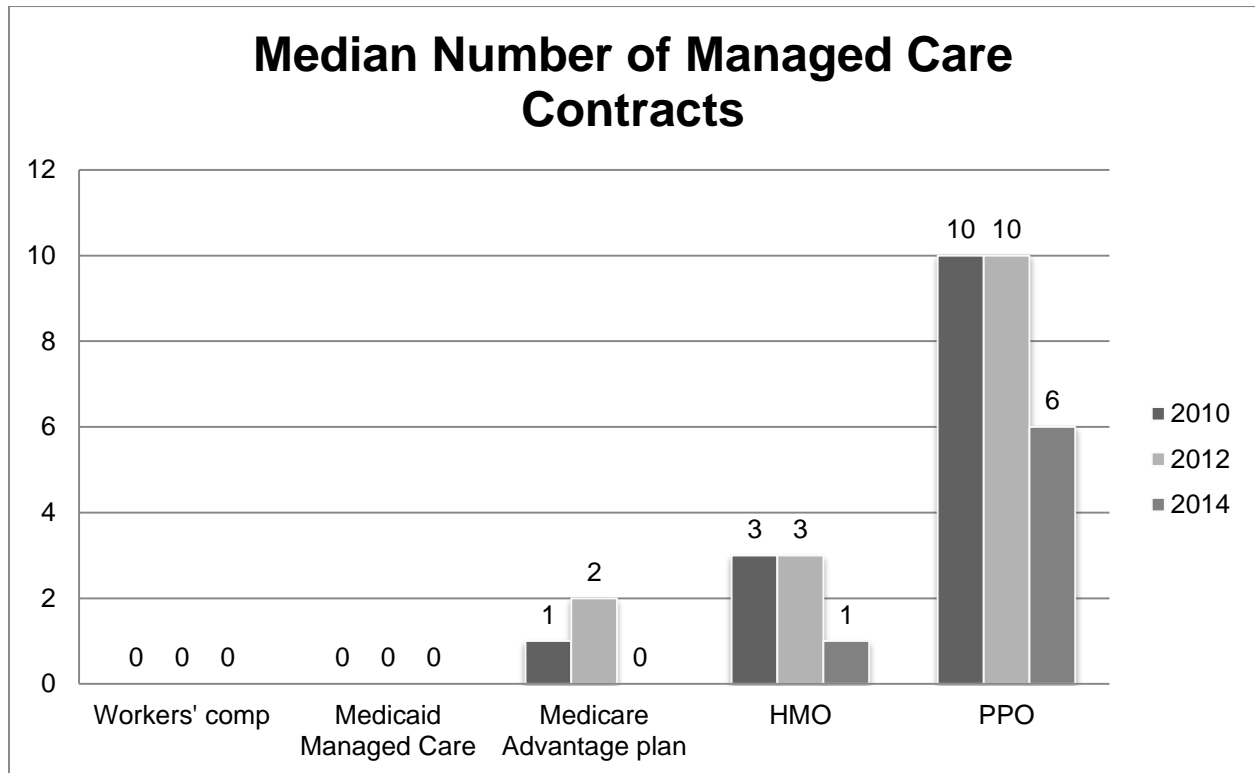
Charity care is defined as medical care provided with prior knowledge that the patient will be unable to pay for services. Physicians were asked to report the estimated value for each physician in their practice last year. The mean amount of charity care reported in 2013 is \$40,034.

Bad debt is the uncollectible debts over and above charity care. The average amount of uncollectible debts per physician in 2013 was \$75,095.

## Health Plans

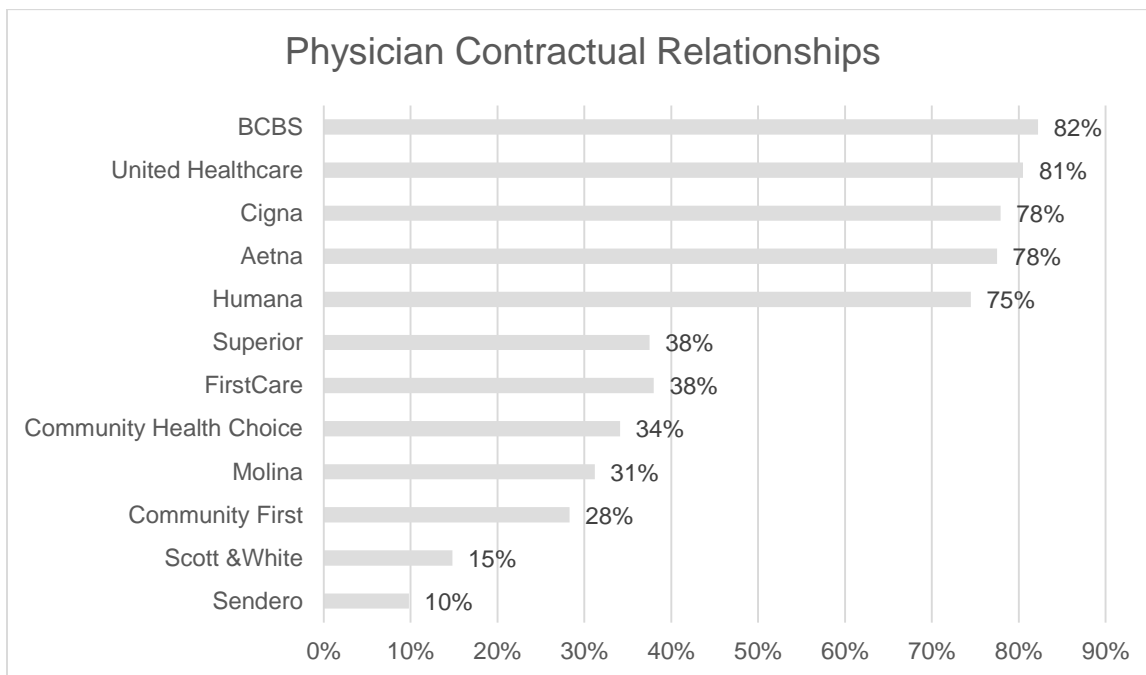
### *Managed Care Contracts (April Q2)*

Respondents have a median of six PPO contracts and one HMO contract, both of which have decreased since 2012.

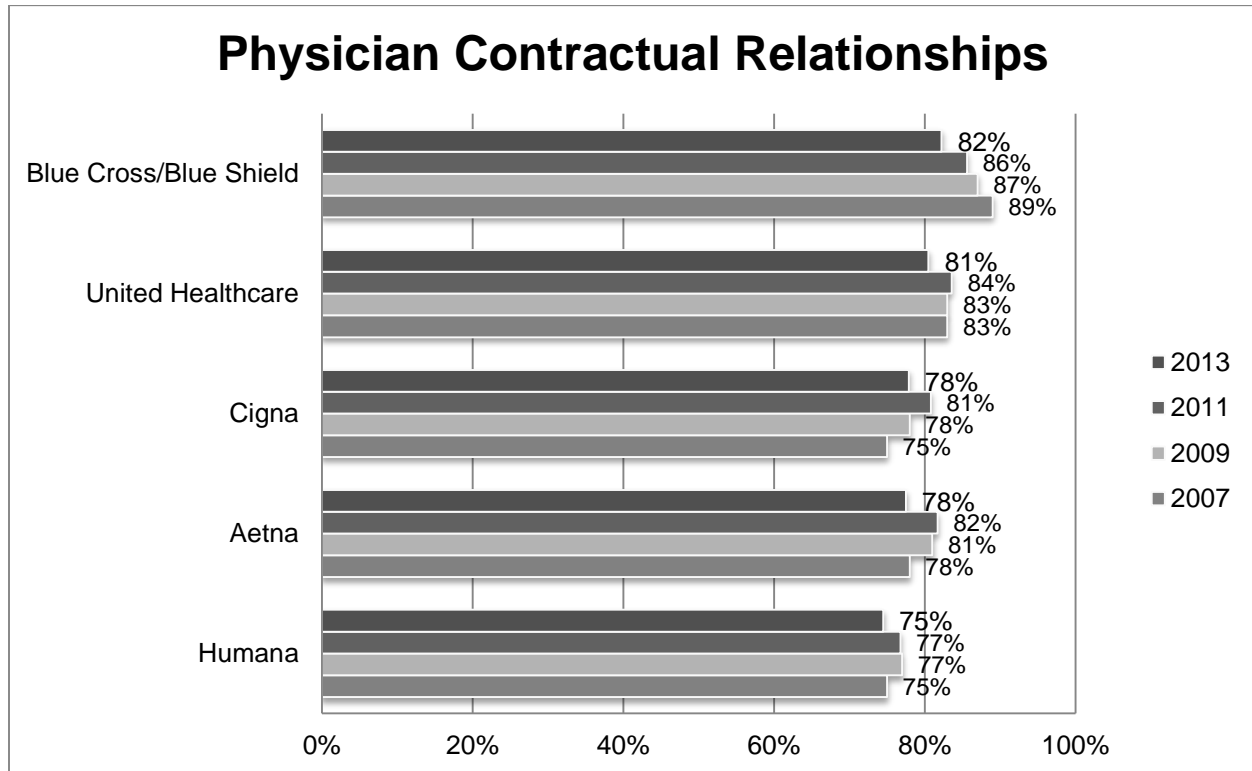


### **Contract Status (February Q5)**

A large majority of physicians were contracted with Blue Cross and Blue Shield of Texas (82 percent), United Healthcare (81 percent), Cigna (78 percent), Aetna (78 percent), and Humana (75 percent) in 2013.

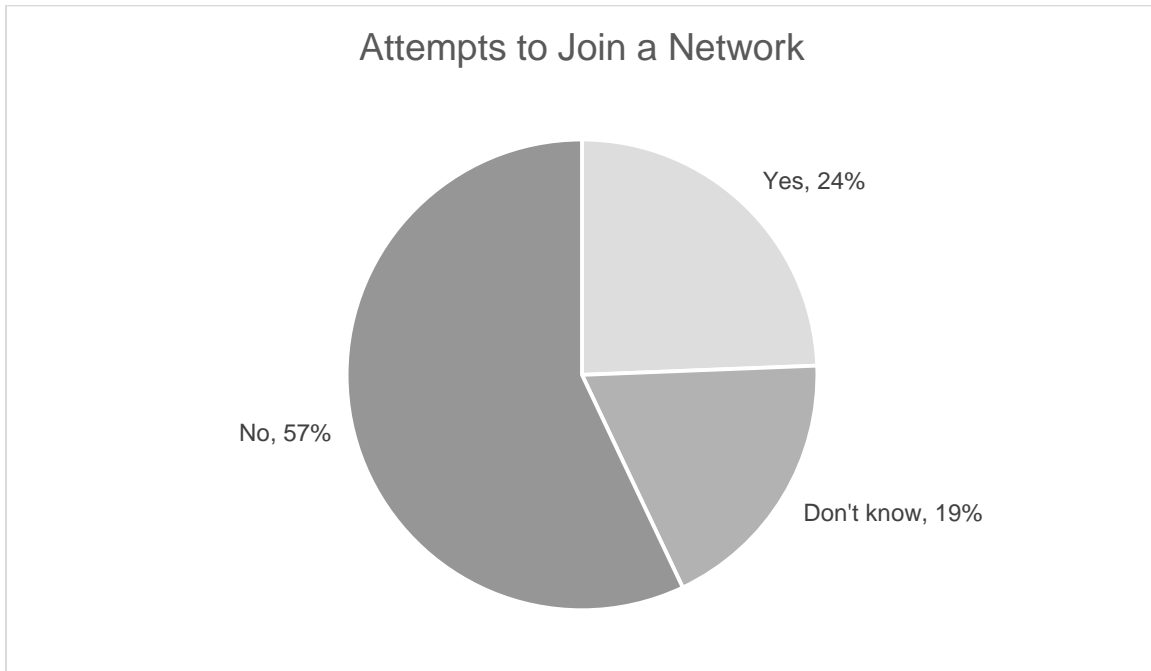


Although a majority of physicians are contracted with at least one of the five major payers, the percentage has decreased. This could be a result of the frustration physicians are feeling when dealing with insurers and uncertainty regarding the health insurance exchanges.



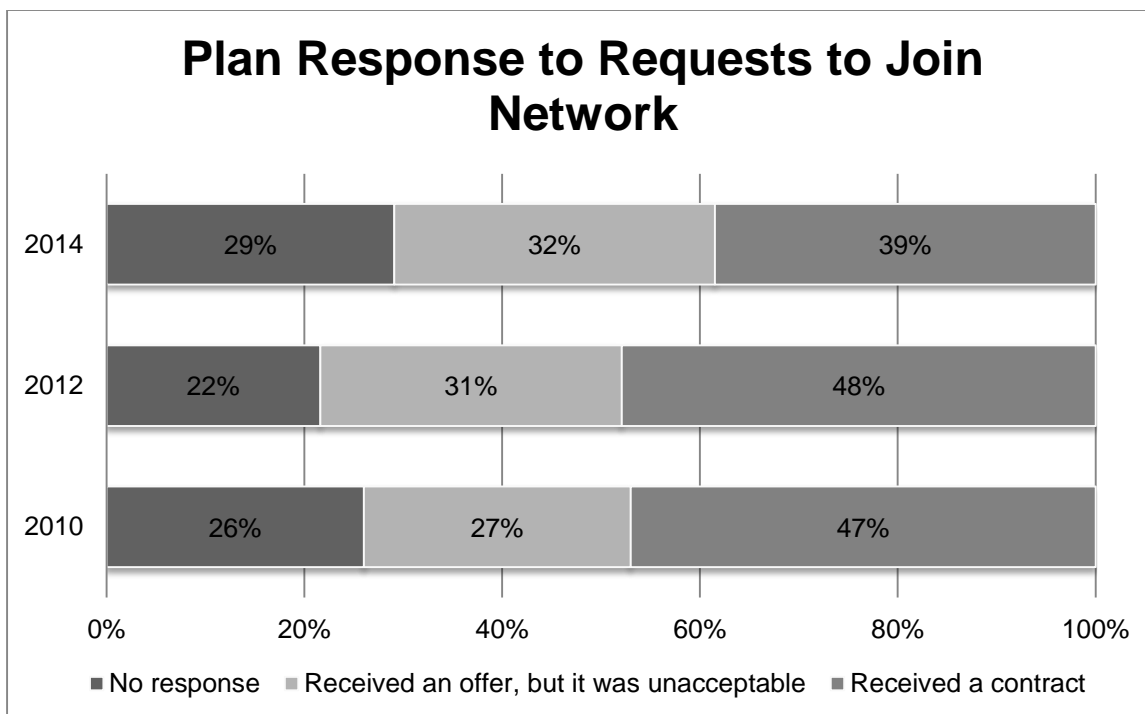
***Physician Attempts to Join a Network (April Q4)***

Nearly a quarter of respondents approached a plan with which they are not contracted in attempt to join its network in the past two years (24 percent).



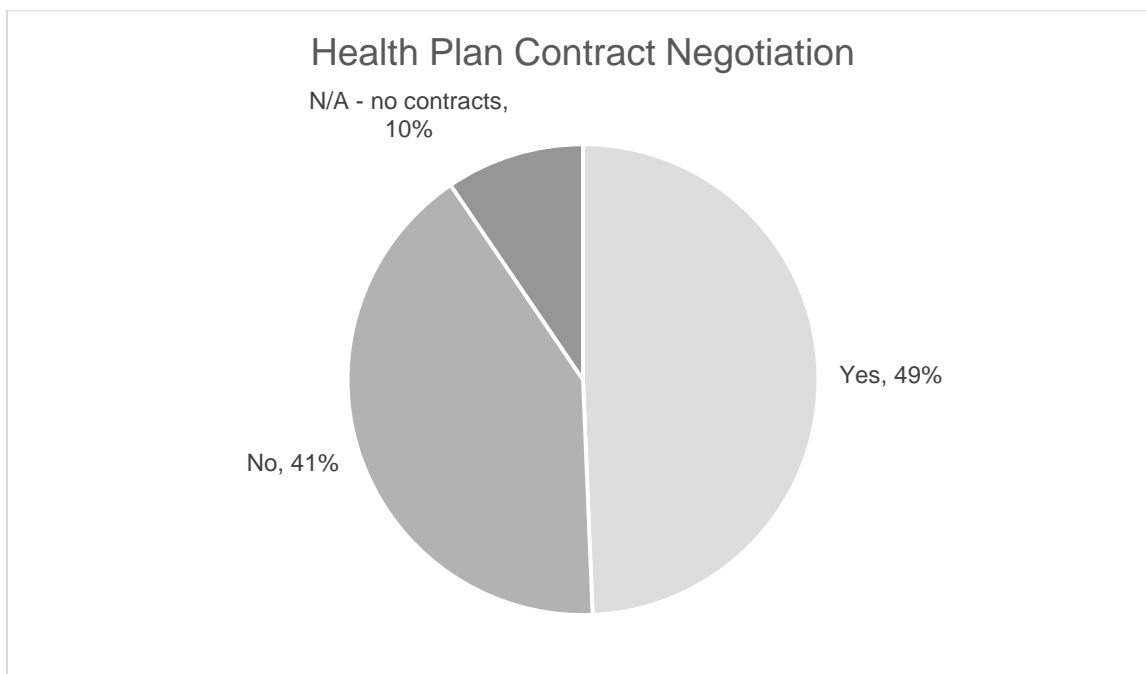
### ***Outcome of Attempt to Join a Network (April Q5)***

Among physicians who approached a plan in an attempt to join its network, 29 percent received no response from the plan (up from 22 percent in 2012) and 32 percent received an unacceptable offer.

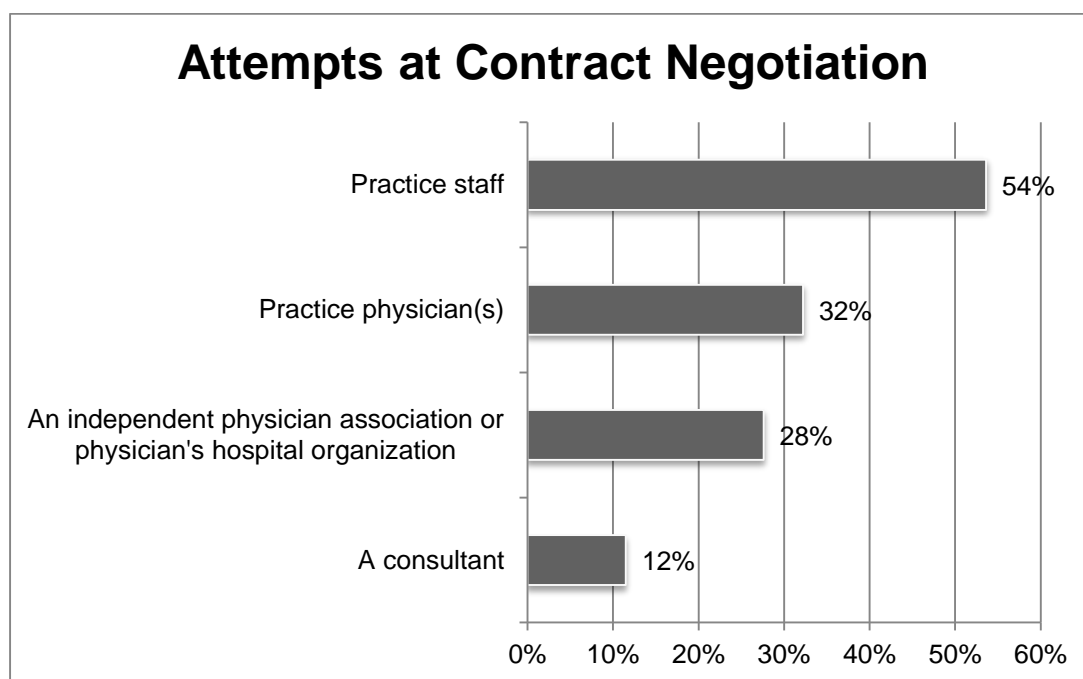


### ***Health Plan Contract Negotiation (April Q6-7)***

Respondents were asked about their experience in managed care contract negotiation. A large minority have attempted to negotiate the terms of a health plan contract in the past two years (49 percent).

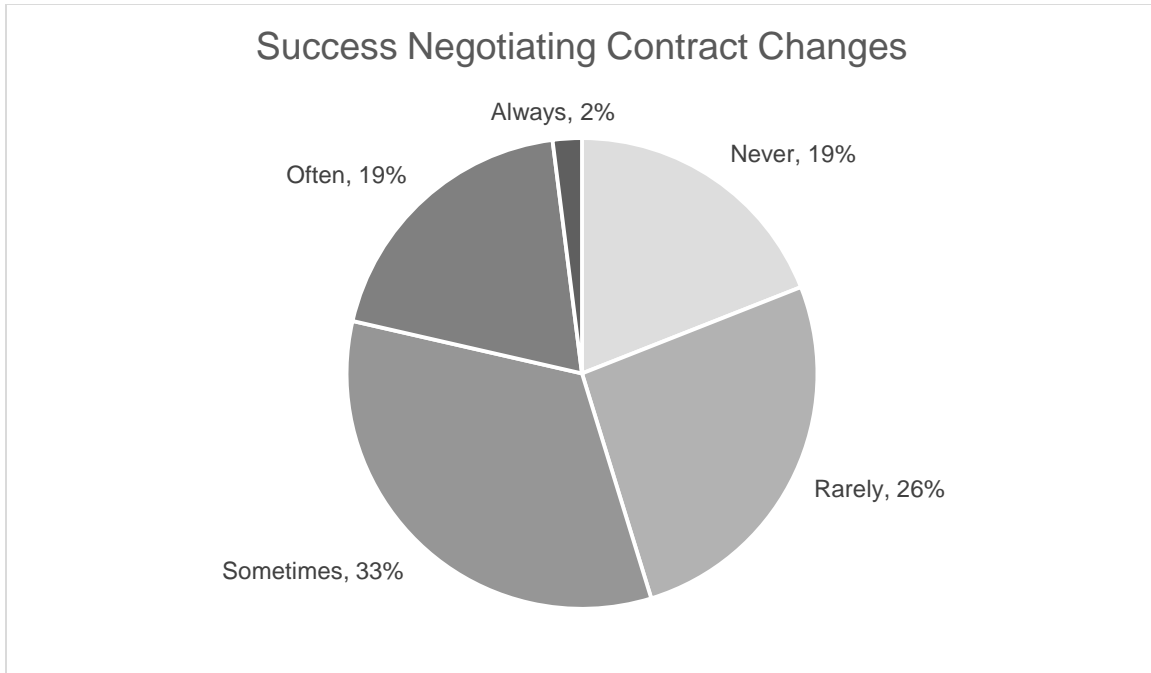


Attempts at contract negotiation were primarily made by practice staff (54 percent).



### ***Success Negotiating Contract Changes (April Q8)***

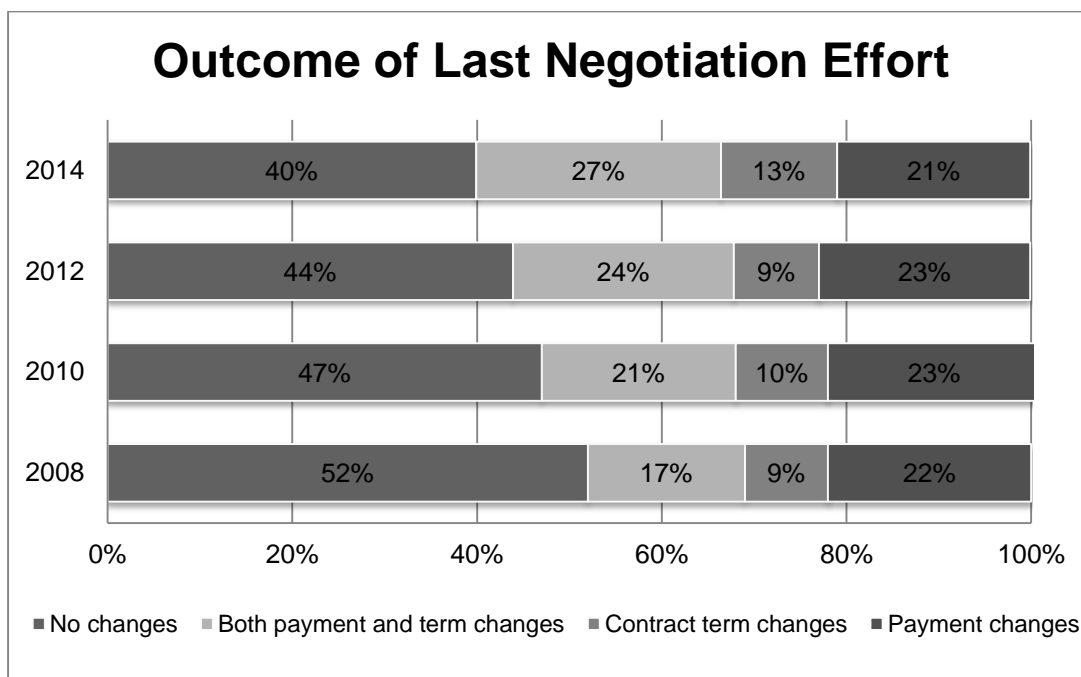
Respondents who attempted contract negotiations were asked to report on the success of those efforts. More than half were sometimes, often, or always successful (54 percent).





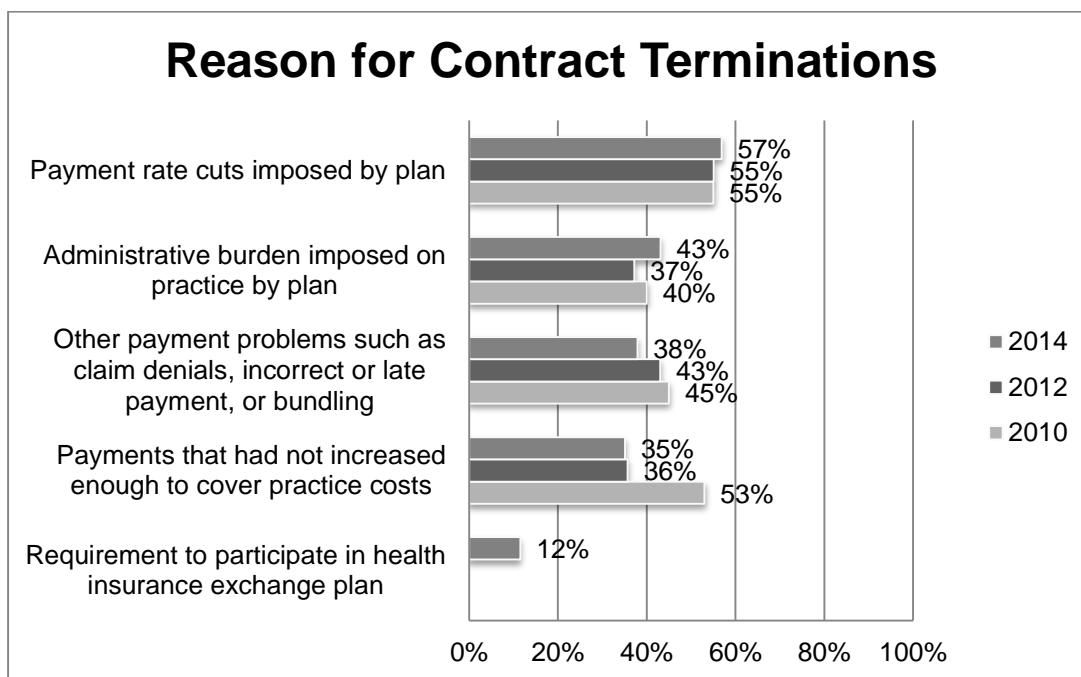
### Outcome of Last Negotiation Effort (April Q9)

The percentage of respondents who secured contract changes in contract payment, terms, or both continues to increase.

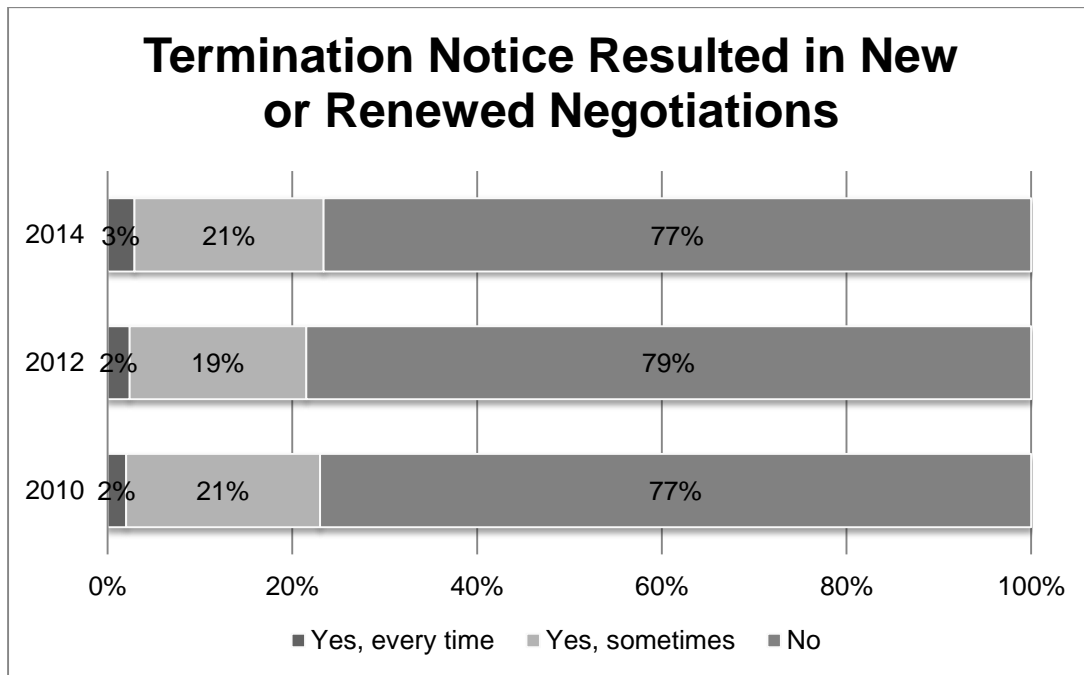


### Contract Terminations (February Q10-11)

Twenty-seven percent of respondents terminated a health plan contract in the past two years, primarily because of payment rate cuts imposed by the plan (57 percent).

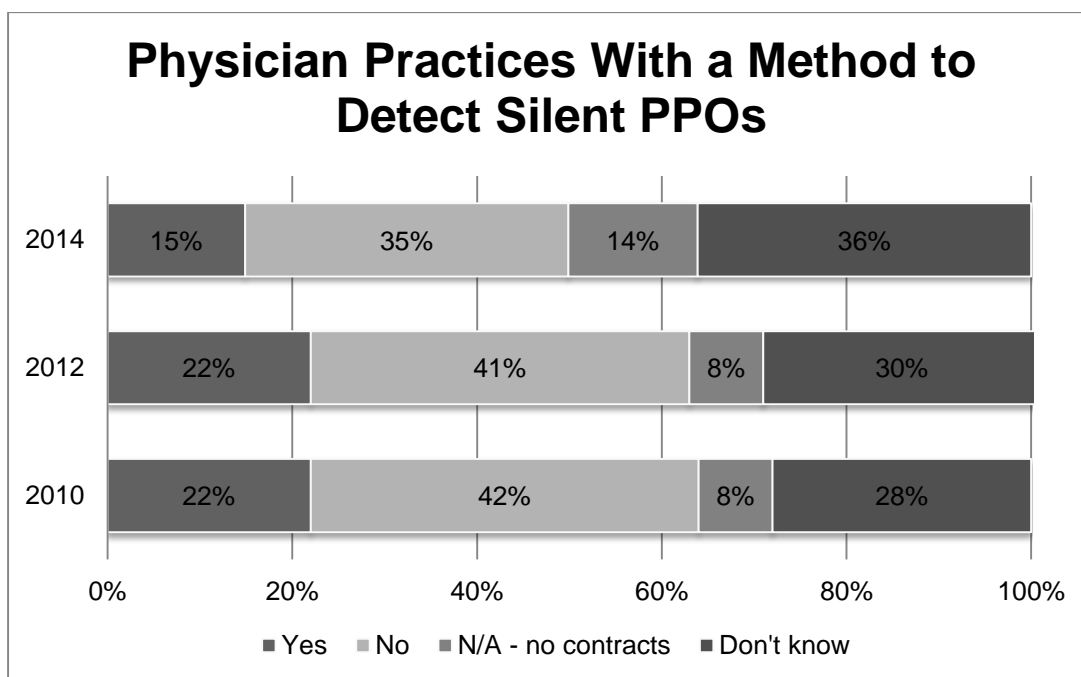


Among respondents who have terminated health plan contracts, 24 percent report their termination notice resulted in new or renewed negotiations that ultimately produced a new contract with no lapse in coverage sometimes or every time.

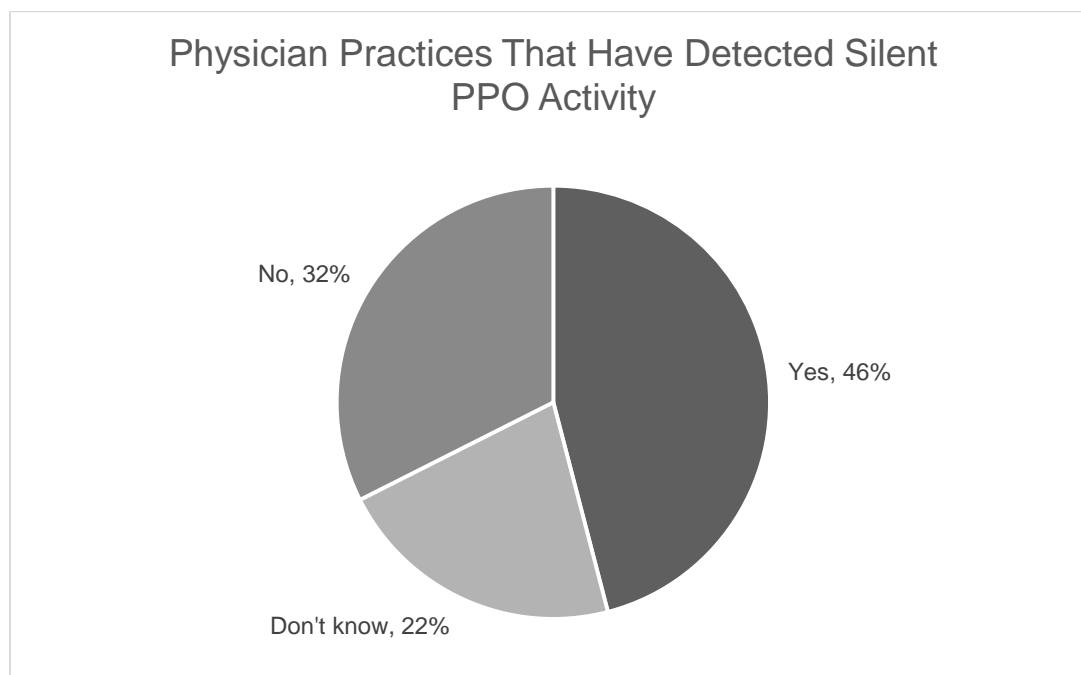


### ***Silent PPOs (April Q16-17)***

Fifteen percent of physician practices have a method to detect unauthorized access to contracted discounts, as in a silent PPO.

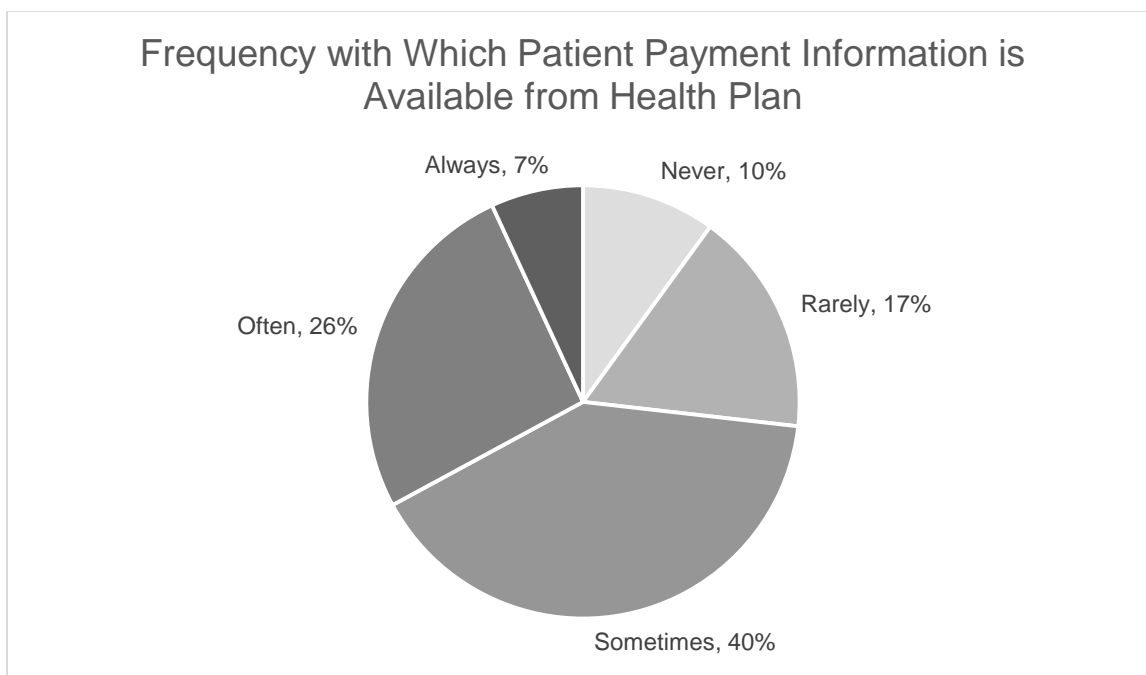


Among practices with a method to detect a silent PPO, 46 percent have detected such activity.



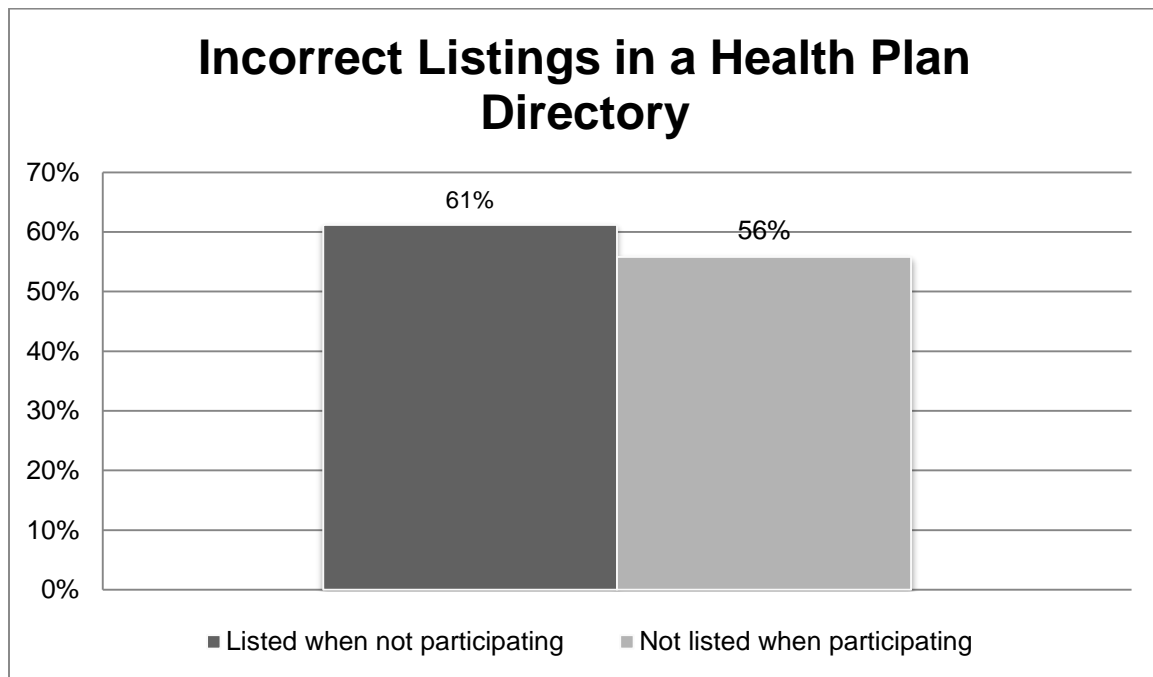
### ***Patient Payments and Out-of-Network Billing (April Q19)***

When patients have high deductibles or are using out-of-network services, physicians and patients need specific information to determine the patient's share of payment. Physicians were asked whether the necessary information is available from the health plan at the time of service or in advance. Sixty-seven percent of respondents report the necessary patient payment information is available sometimes, rarely, or never. The small percentage of respondents who have the specific information needed always or often is a problem. If practices can't determine the patient's share of payment, the patient is more likely to receive a "surprise" bill after services are rendered.



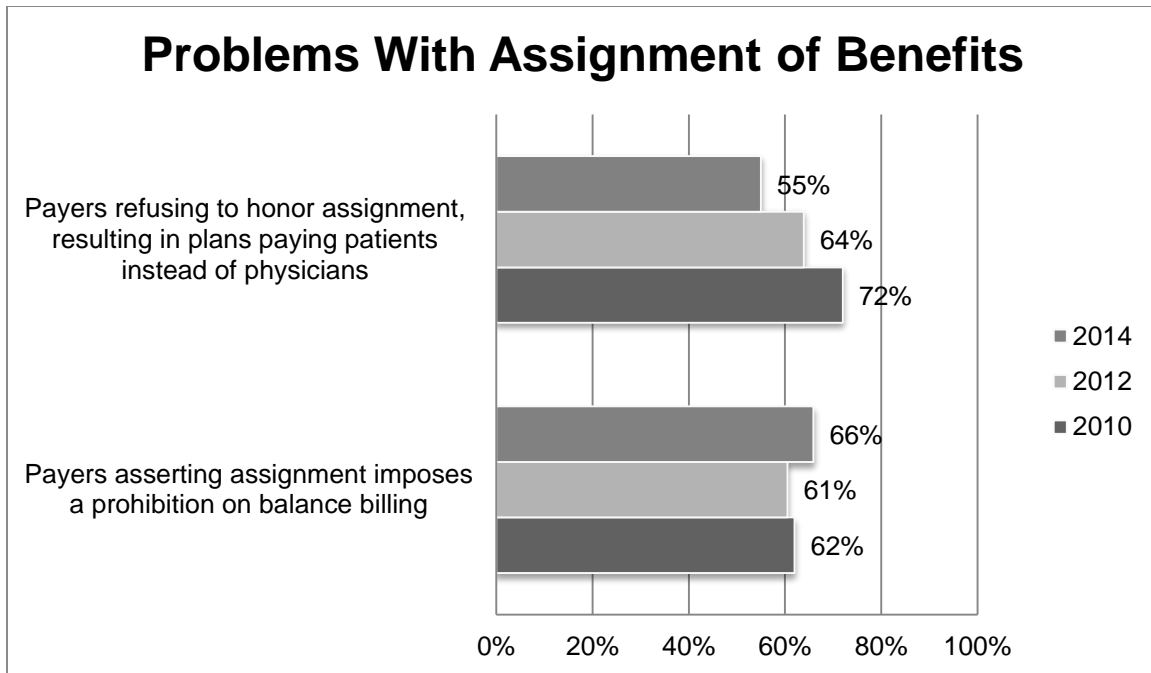
### ***Incorrect Listings in Health Plan Directories (March Q20-21)***

A majority of physicians have detected cases where they were listed incorrectly in a health plan's directory. Sixty-one percent of physicians were listed as a participating provider when they were not and 56 percent of physicians were not listed when they were participating in a plan. The high percentage of inaccurate health plan directories is a problem. If patients don't know which physicians are in-network, they are more likely to be surprised with out-of-network charges.



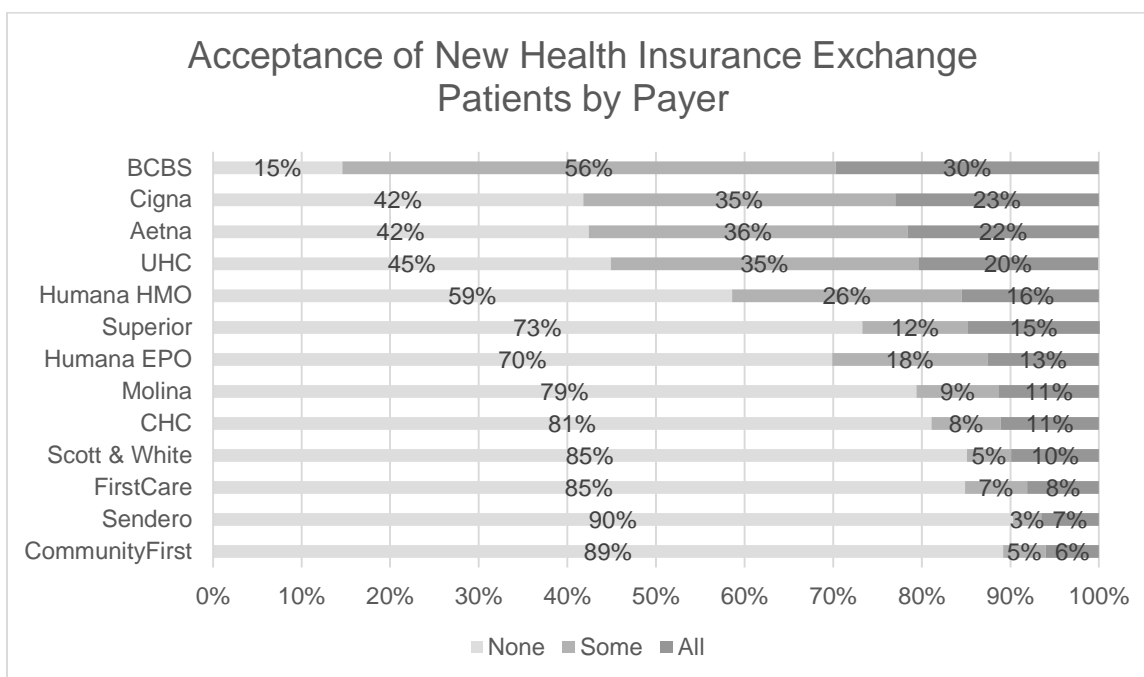
### ***Assignment of Benefits (April Q21)***

Respondents experienced problems with payers refusing to honor assignment, resulting in plans paying patients instead of physicians (55 percent) and payers asserting assignment of benefits imposes a prohibition on balance billing (66 percent).



### **Acceptance of Health Insurance Exchange Patients (April Q13-15)**

Twenty-five percent of physicians indicate their practice is accepting new patients on a health insurance exchange product. Physicians who are accepting new patients were asked about their specific policies towards new patients covered by various plans. The majority of physicians will participate in some or all health insurance exchange plans with Blue Cross and Blue Shield of Texas (86 percent), Cigna (58 percent), Aetna (58 percent), United Healthcare (55 percent).



Sixty-three percent of physicians report the hospital they normally refer to is in-network for the health insurance exchange plans they participate in.

## Healthy Environment

Many questions in the survey investigate the current health care environment for patients and physicians.

### Availability of Care

#### *Acceptance of New Patients (March Q6-7)*

Ninety-four percent of physicians indicate their practice is accepting new patients. Physicians who are accepting new patients were asked about their specific policies towards new patients covered by various payers. The results are reported as percentages of the physicians whose practices are not closed to new patients.

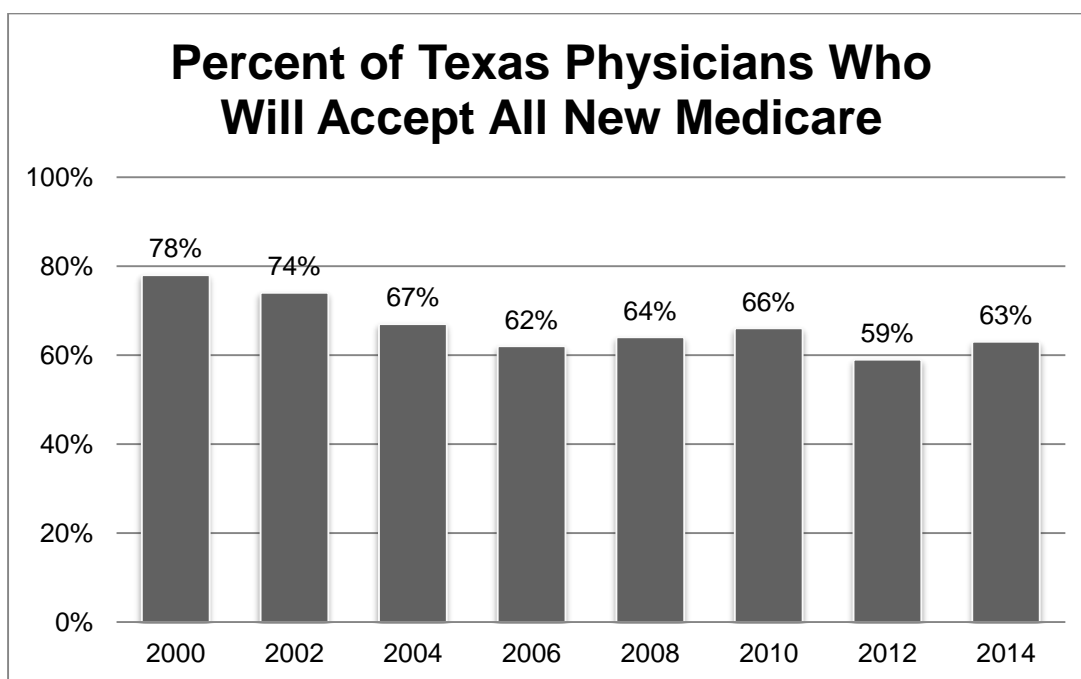
<i>Acceptance of New Patients by Payer Type</i>						
	2012			2014		
	<u>Accept</u>	<u>Decline</u>	<u>Limit</u>	<u>Accept</u>	<u>Decline</u>	<u>Limit</u>
	%	%	%	%	%	%
<b>PPOs</b>	<b>80</b>	<b>5</b>	<b>15</b>	<b>78</b>	<b>5</b>	<b>16</b>
<b>Uninsured</b>	<b>67</b>	<b>5</b>	<b>29</b>	<b>68</b>	<b>4</b>	<b>28</b>
<b>The military health care plan, TRICARE</b>	<b>60</b>	<b>22</b>	<b>18</b>	<b>64</b>	<b>19</b>	<b>17</b>
<b>Medicare</b>	<b>59</b>	<b>19</b>	<b>22</b>	<b>63</b>	<b>18</b>	<b>19</b>
<b>HMOs</b>	<b>54</b>	<b>19</b>	<b>27</b>	<b>50</b>	<b>21</b>	<b>29</b>
<b>Medicare-Medicaid dual-eligible</b>	<b>41</b>	<b>33</b>	<b>26</b>	<b>47</b>	<b>33</b>	<b>20</b>
<b>Medicare Advantage plans</b>	<b>42</b>	<b>30</b>	<b>29</b>	<b>43</b>	<b>27</b>	<b>31</b>
<b>Medicaid</b>	<b>32</b>	<b>42</b>	<b>26</b>	<b>37</b>	<b>39</b>	<b>24</b>
<b>CHIP</b>	<b>32</b>	<b>53</b>	<b>15</b>	<b>36</b>	<b>49</b>	<b>15</b>
<b>Workers' compensation</b>	<b>24</b>	<b>64</b>	<b>12</b>	<b>28</b>	<b>59</b>	<b>13</b>

*PPOs:* Seventy-eight percent of physician practices accept all new patients covered by PPOs.

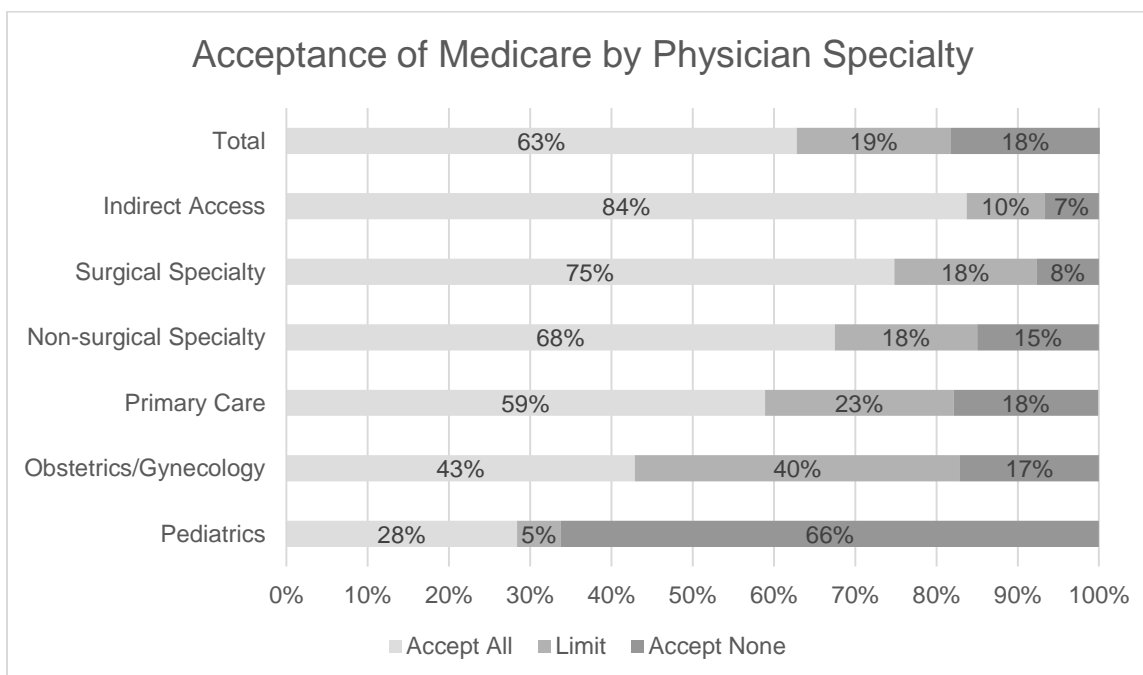
*Uninsured:* Few physician practices exclude uninsured patients completely (4 percent).



*Medicare:* Access to care for Medicare patients remains significantly reduced from the levels recorded in 2000. Since that year, the percentage of physicians who accept all new Medicare patients has decreased from 78 percent to 63 percent.

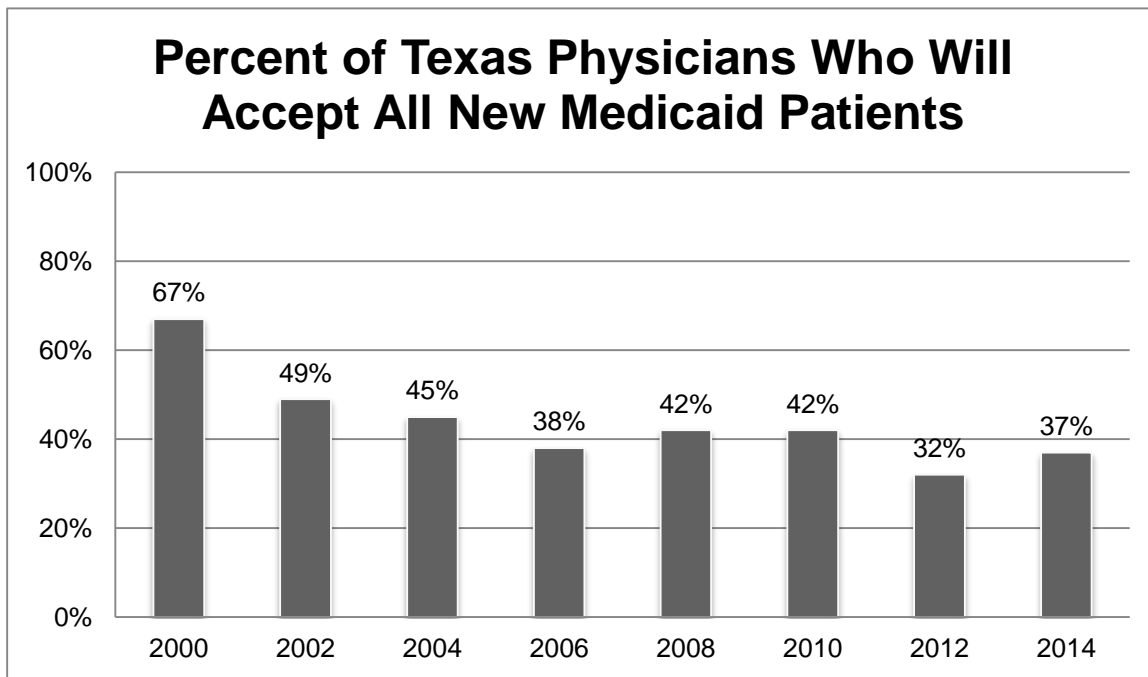


Physicians in the Indirect Access specialties (e.g., Radiologists, Anesthesiologists, Hospitalists, Pathologists, and Emergency Medicine specialties) are most likely to accept all new Medicare patients (84 percent).

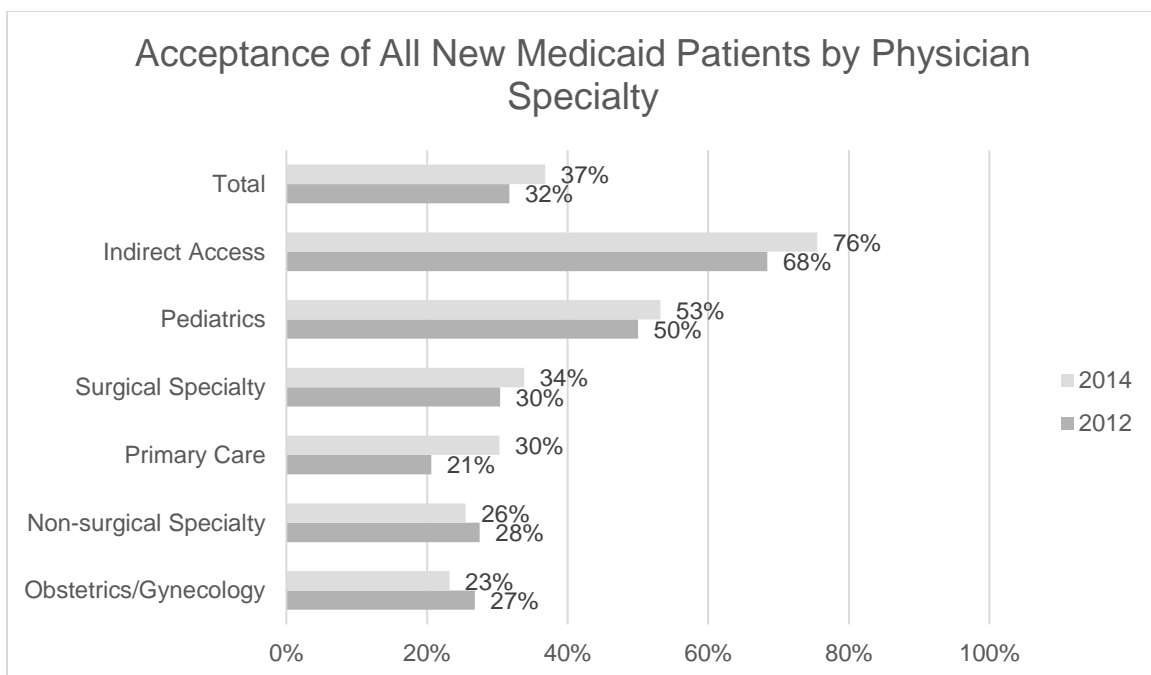


There are no differences in Medicare acceptance by county.

*Medicaid:* Inadequate Medicaid payments have damaged access to care for Medicaid patients which remains significantly reduced from the 67 percent who accepted all new Medicaid patients in 2000. However, a five percent increase in the percentage of physicians who will accept all new Medicaid patients could be the result of federally-required temporary payment increases to Primary Care physicians.



Pediatricians and Primary Care physicians are more likely to accept all new Medicaid patients in 2014.

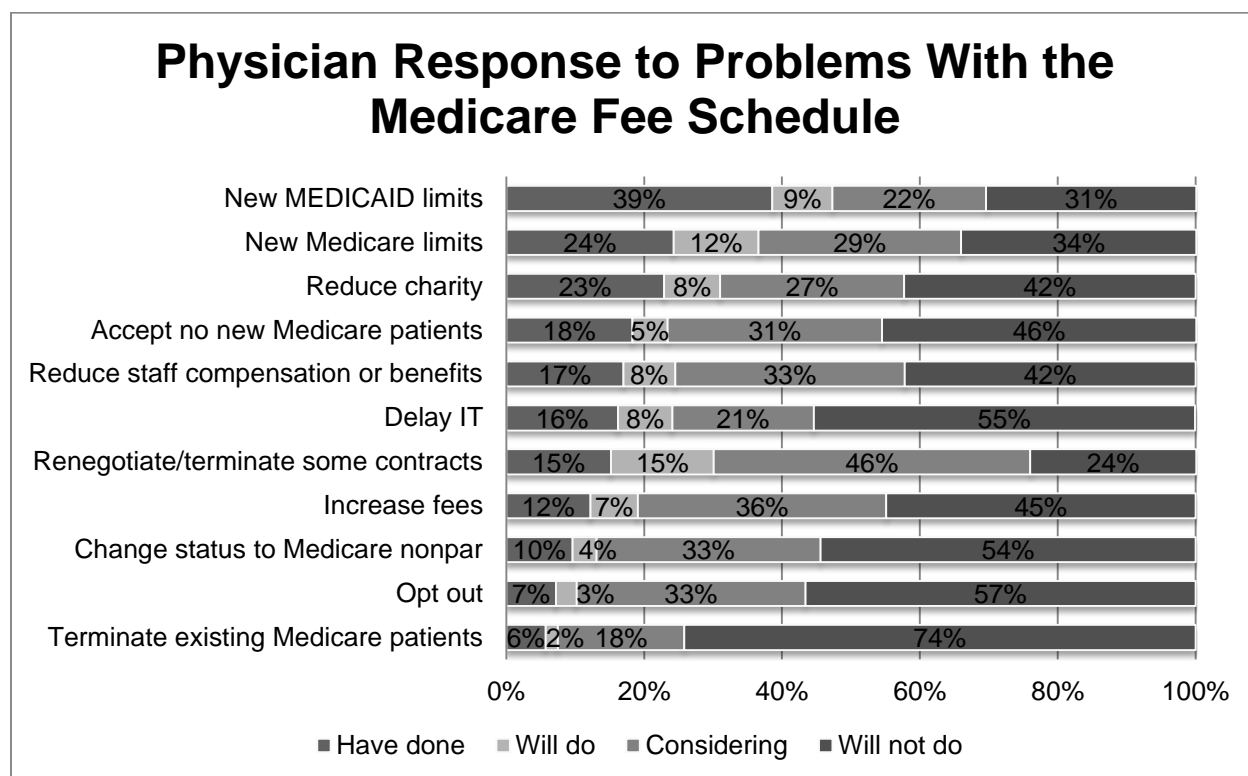


There are no differences in Medicaid acceptance by county

## Medicare Fees

### *Response to Medicare Fee Schedule (March Q8)*

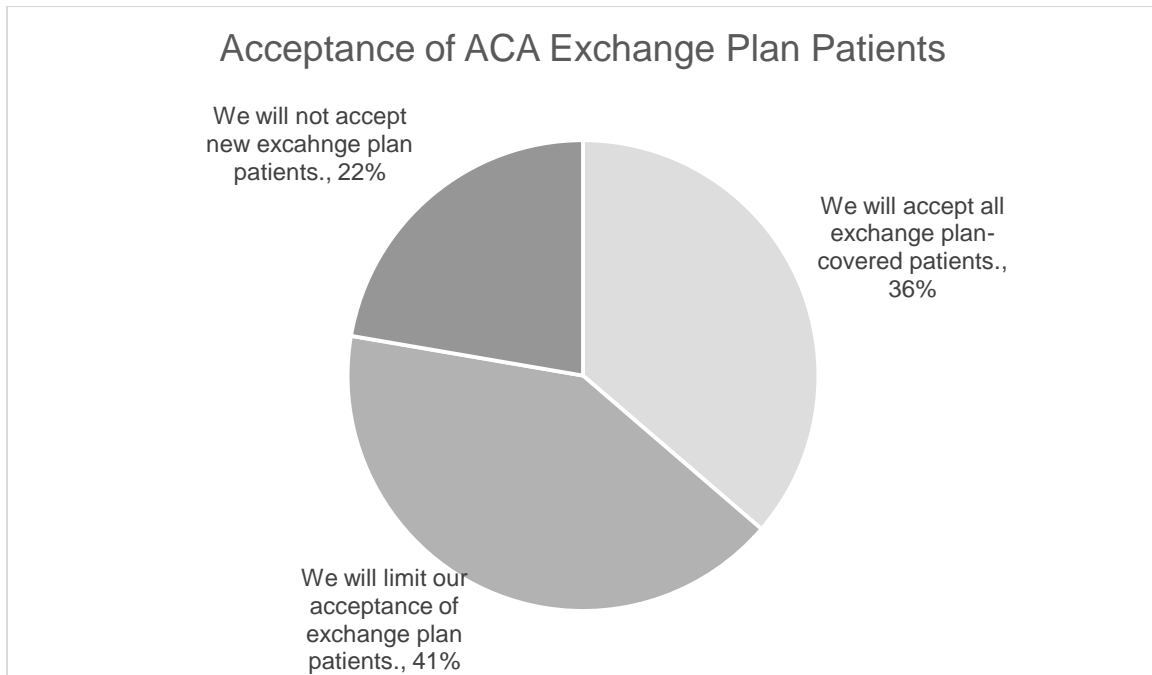
The failure to find a permanent resolution to the Medicare fee schedule continues to take a toll on access to care for patients. Thirty-nine percent of physicians have placed new or additional limits on Medicaid acceptance and 31 percent will or are considering doing so. Nearly a quarter of physicians have added limits to Medicare and an additional 41 percent will or are considering doing so. If the problem remains unresolved physicians are considering terminating or renegotiating health plan contracts (46 percent) and increasing standard fees charged to other patients (36 percent).



## Health Care Reform

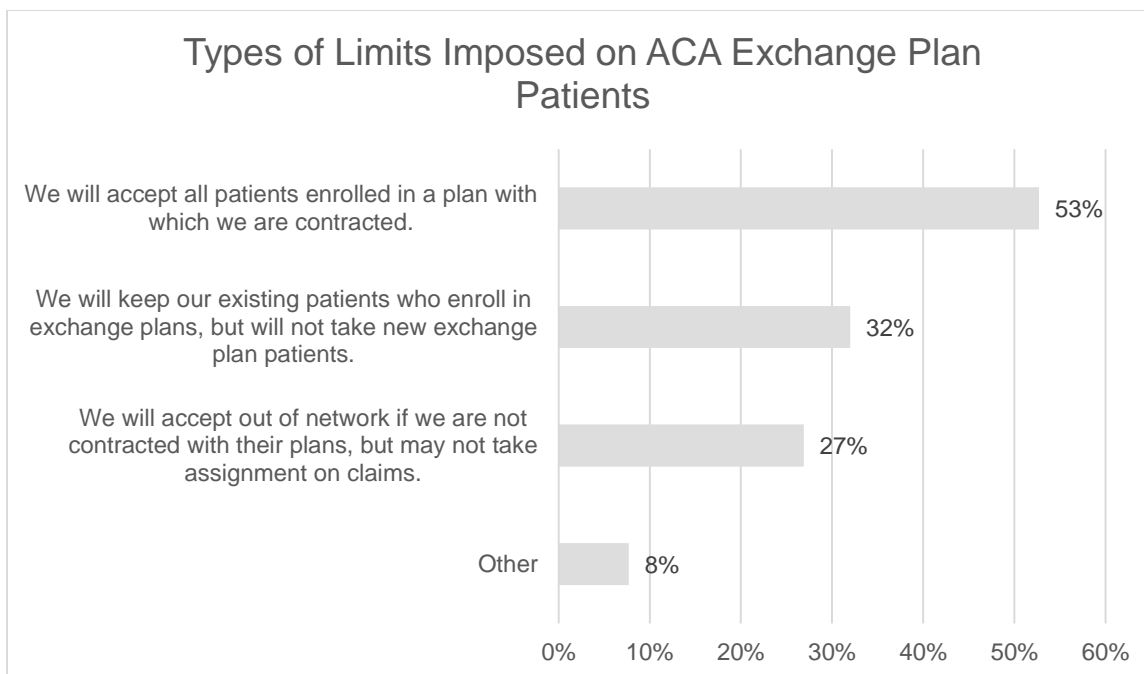
### ***Acceptance of ACA Exchange Patients (March Q10)***

In March, 36 percent of physicians reported their practice will accept all exchange plan-covered patients and 41 percent will limit their acceptance.



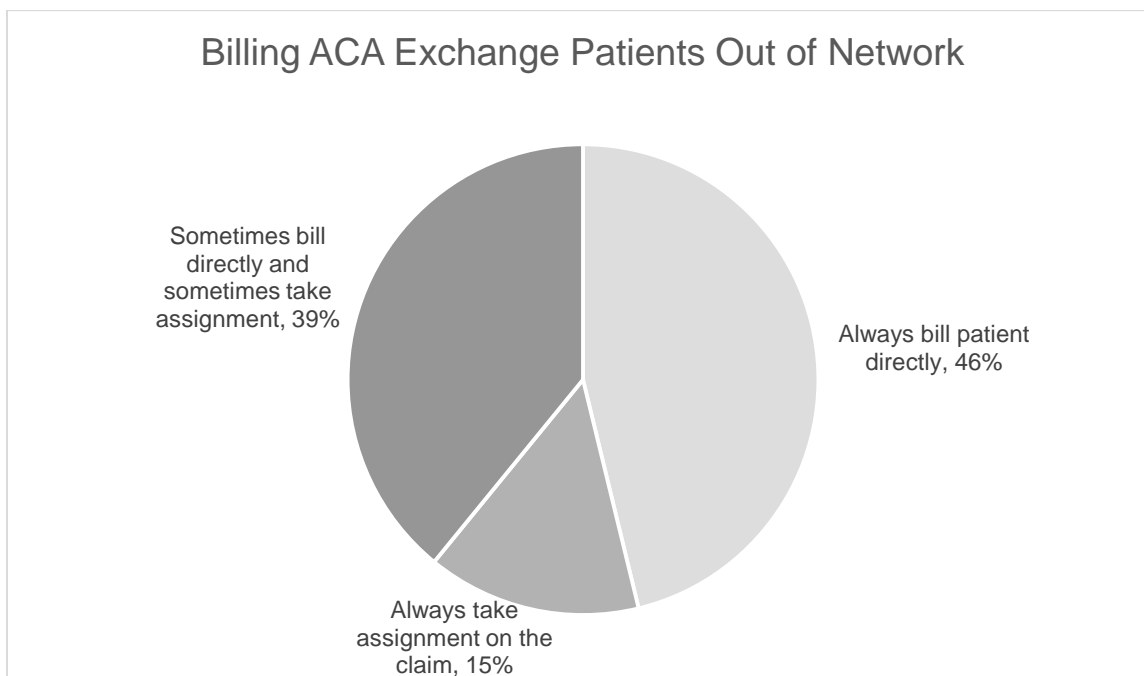
### ***Types of Limits Imposed on ACA Exchange Patients (March Q11)***

Physicians who will limit their acceptance of exchange plan patients, were asked what types of limits their practice will impose on them. The majority report their practice will accept all patients enrolled in a plan with which they are contracted (53 percent).



### ***Billing Out of Network ACA Exchange Patients (March Q12)***

Physicians who will treat ACA exchange patients out of network will bill patients directly (46 percent) or sometimes bill directly and sometimes take assignment (39 percent).



### ***Grace Period (March Q13)***

The majority of physicians are aware of the 90-day grace period rule for health plans in the exchanges, which does not require health plans to pay claims for some enrolled patients who fail to pay their premiums (68 percent).

### ***Change in Eligibility Verification Procedures (March Q14)***

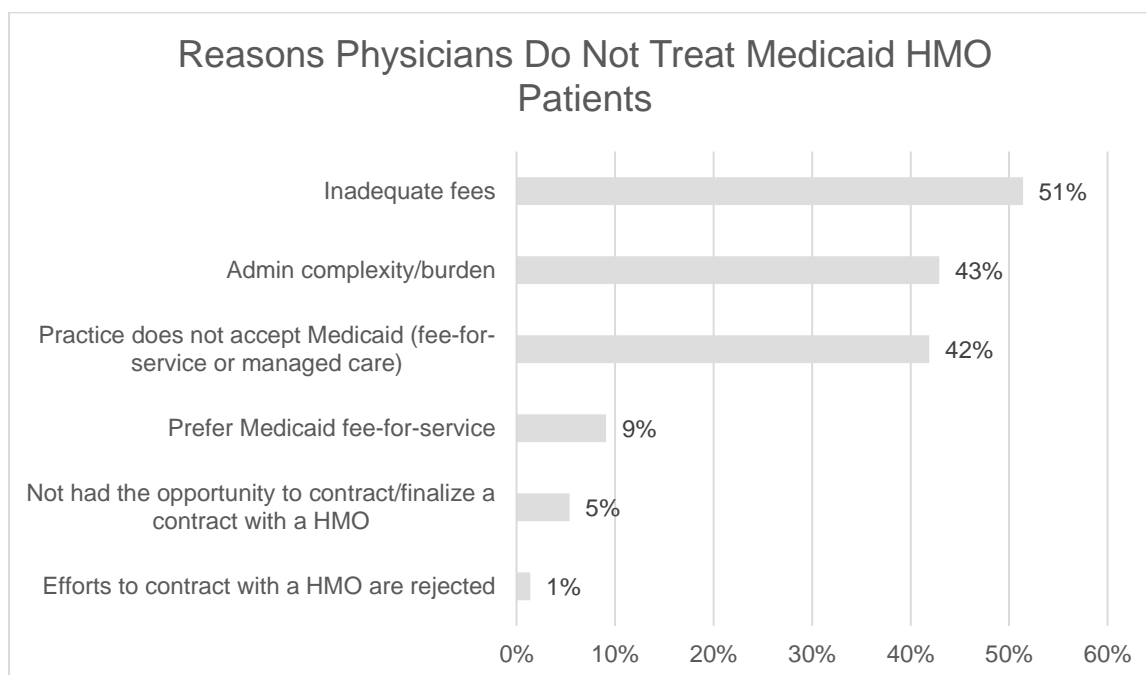
Twenty-three percent of physicians have changed (or are changing) their eligibility verification procedures for exchange plan enrollees. This is an additional administrative burden for these practices and will increase operating costs.

## **Medicaid Managed Care**

### ***Acceptance of Medicaid HMO Patients (September Q1-2)***

Forty-two percent of physicians treat Medicaid HMO patients. Physicians who do not treat Medicaid HMO patients were asked the reason or reasons why.

Primarily physicians do not treat Medicaid HMO patients because reimbursement is too low to cover the cost of the services (51 percent).

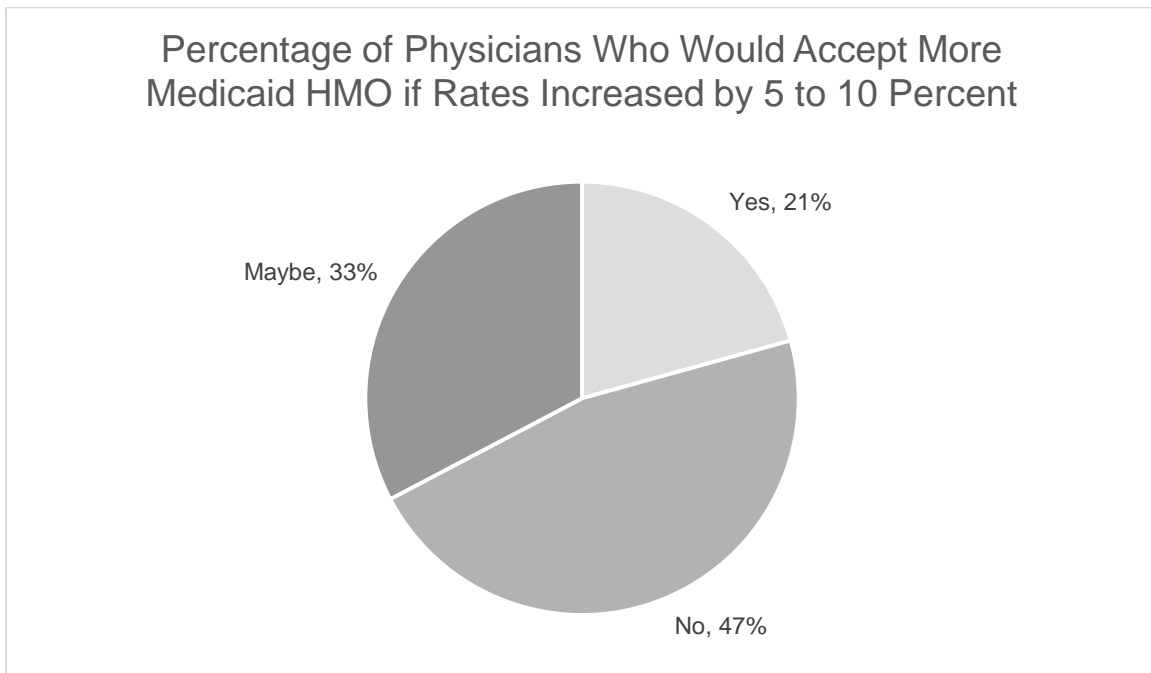


### ***Sources of Medicaid Patients (September Q3)***

Physicians were asked to estimate their percentage of Medicaid patients. Physicians report their practice has a mean percentage of 14 Medicaid HMO patients and 13 Medicaid FFS patients.

### ***Acceptance of Medicaid HMOs (September Q4-6)***

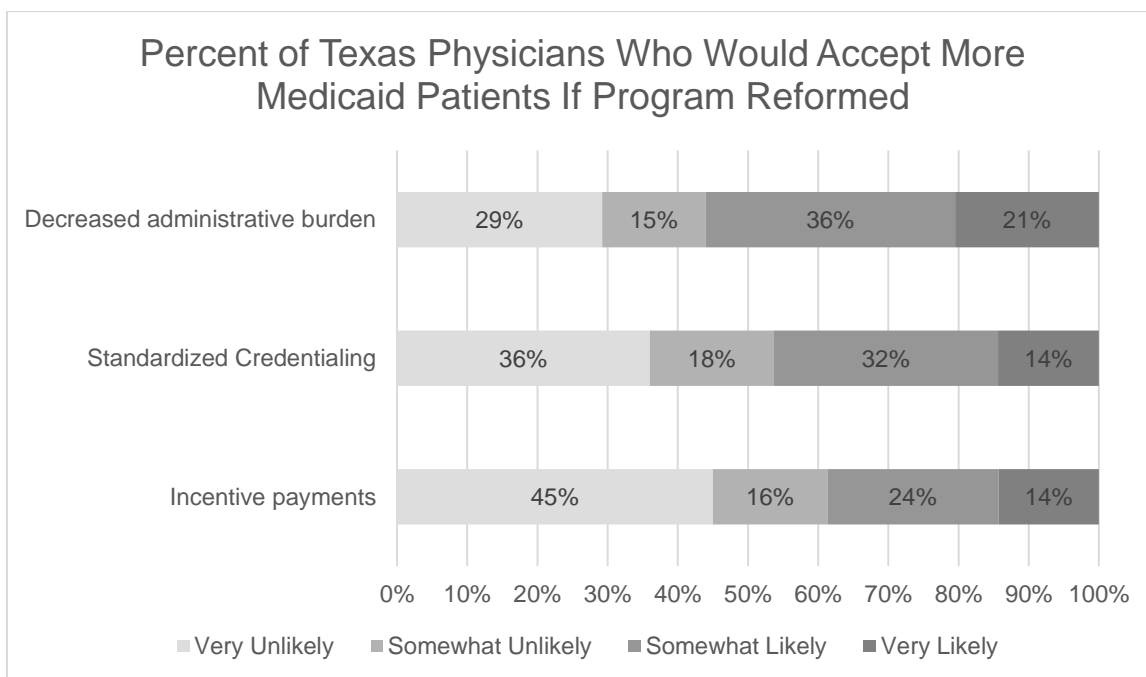
Twenty-one percent of physicians would accept more Medicaid HMO patients if rates increased by five to ten percent.



Among physicians who might or would not accept more Medicaid HMO patients, eight percent would accept more Medicaid HMO patients if rates increased by ten percent or more.

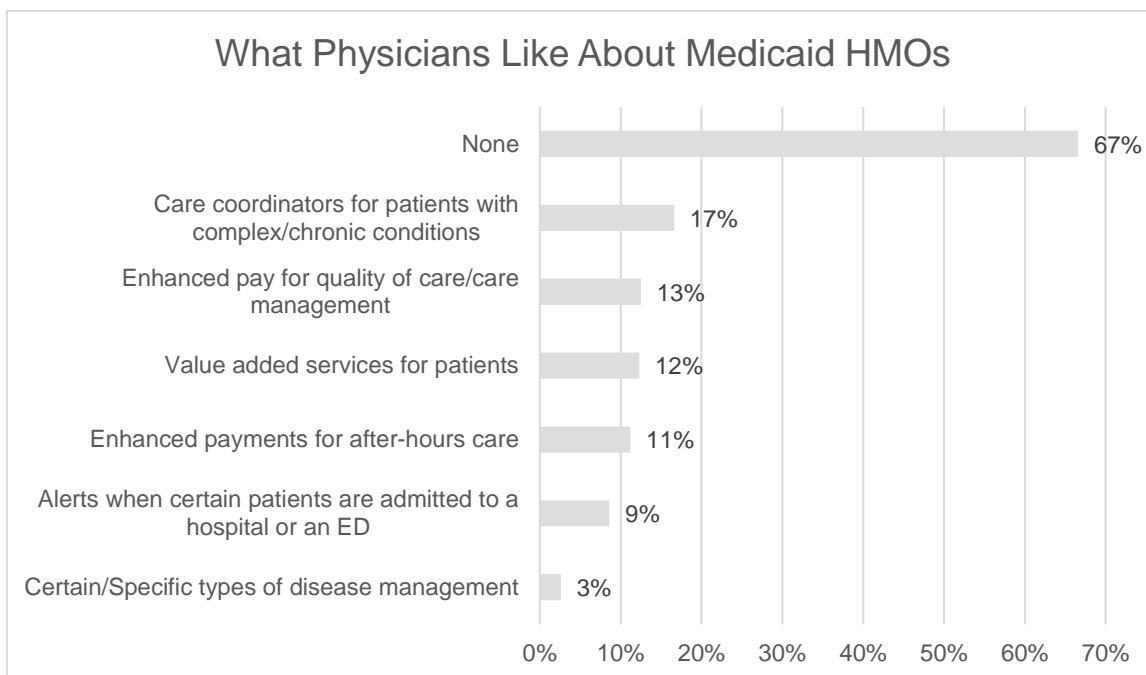


Fifty-seven percent of physicians are likely to accept more Medicaid HMO and/or FFS patients if the program is reformed to decrease administrative burden (e.g., simplified Preferred Drug List, prior approval processes).



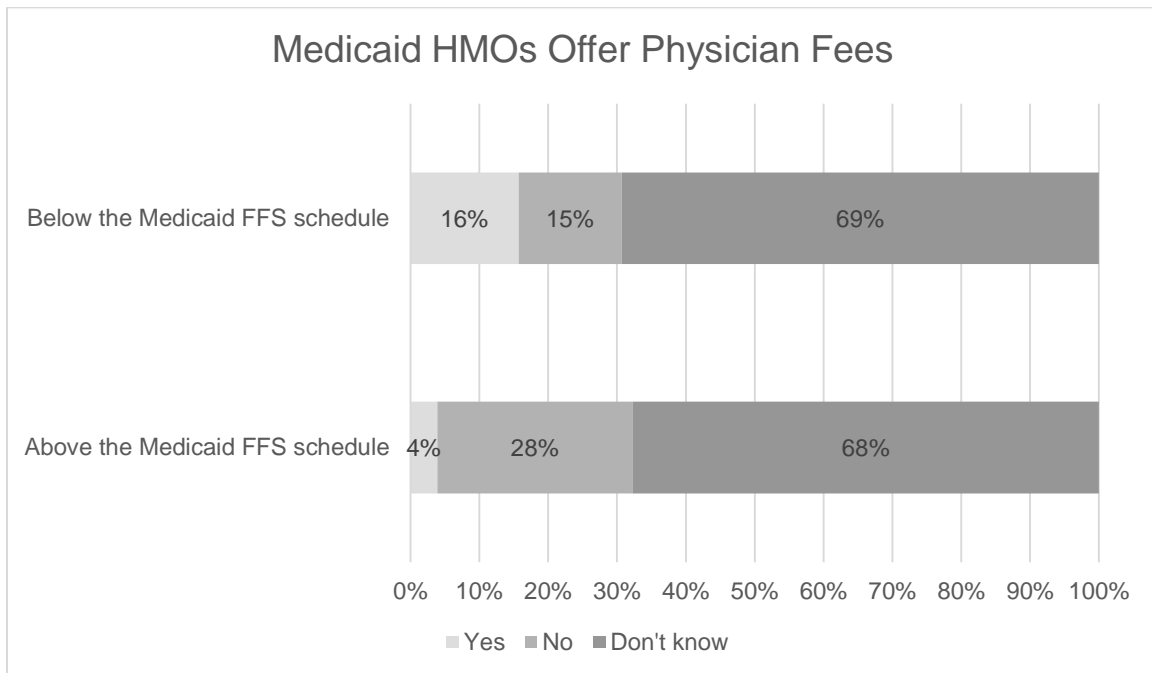
### ***What Physicians Like about Medicaid HMOs (September Q7)***

The majority of physicians like nothing about Medicaid HMOs (67 percent).



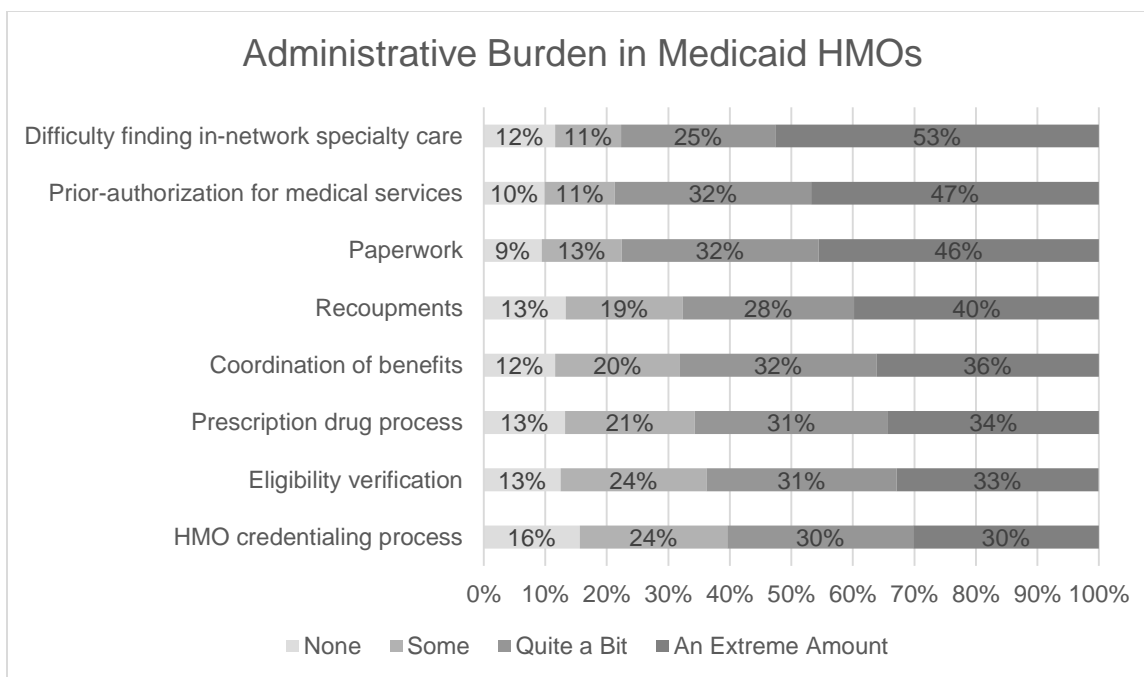
### **Medicaid HMO Fees (September Q8)**

The majority of physicians don't know if a Medicaid HMO offers them fees above or below the Medicaid FFS schedule (68 and 69 percent respectively).

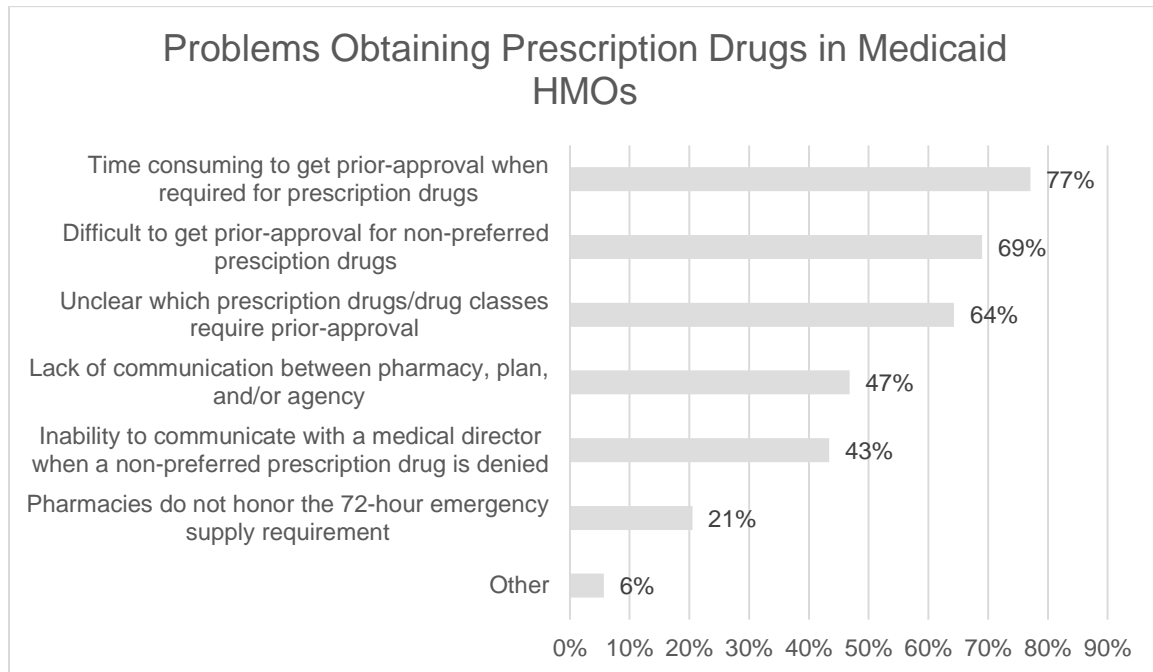


### **Medicaid HMO Administrative Burden (September Q9-10)**

Administrative burden has been identified as an issue when participating in Medicaid HMOs (STAR and STAR+PLUS). Physicians identify finding in-network specialty care as extremely difficult (53 percent), specifically Dermatology, Psychiatry, Ophthalmology, eye subspecialties, and Plastic Surgery.

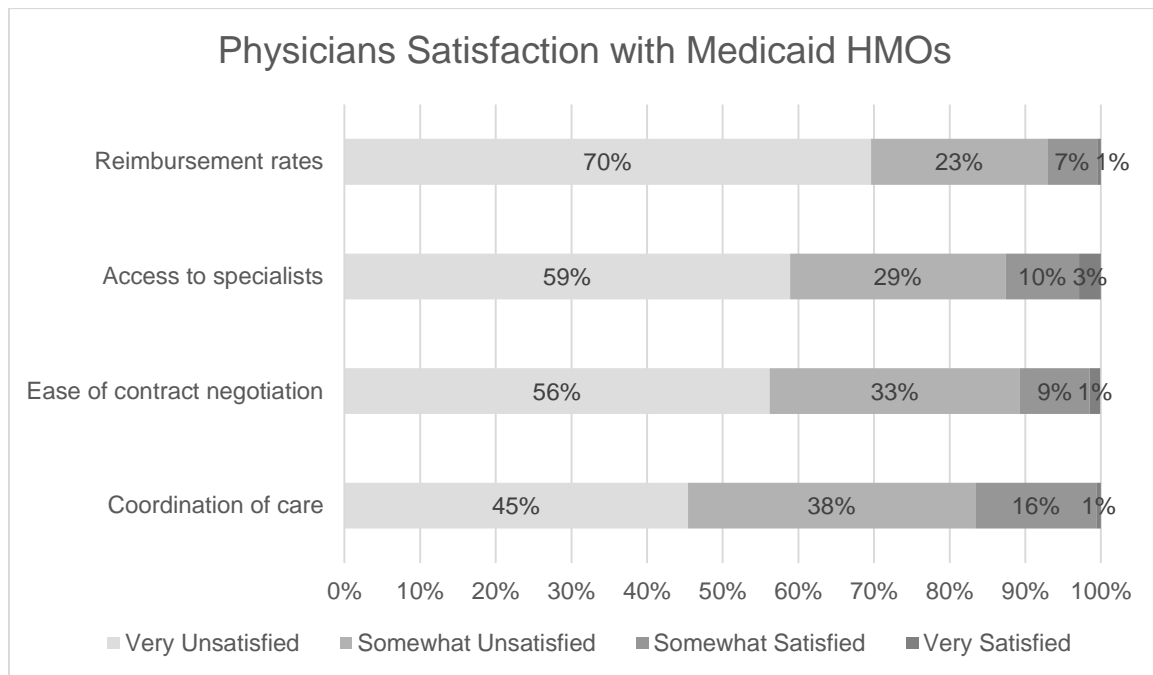


Physicians who find obtaining prescription drugs an issue report it is time-consuming to get prior approval when required for prescription drugs (77 percent), it is difficult to get prior-approval for non-preferred prescription drugs (69 percent), and it is unclear which prescription drugs or drug classes require prior approval (64 percent).



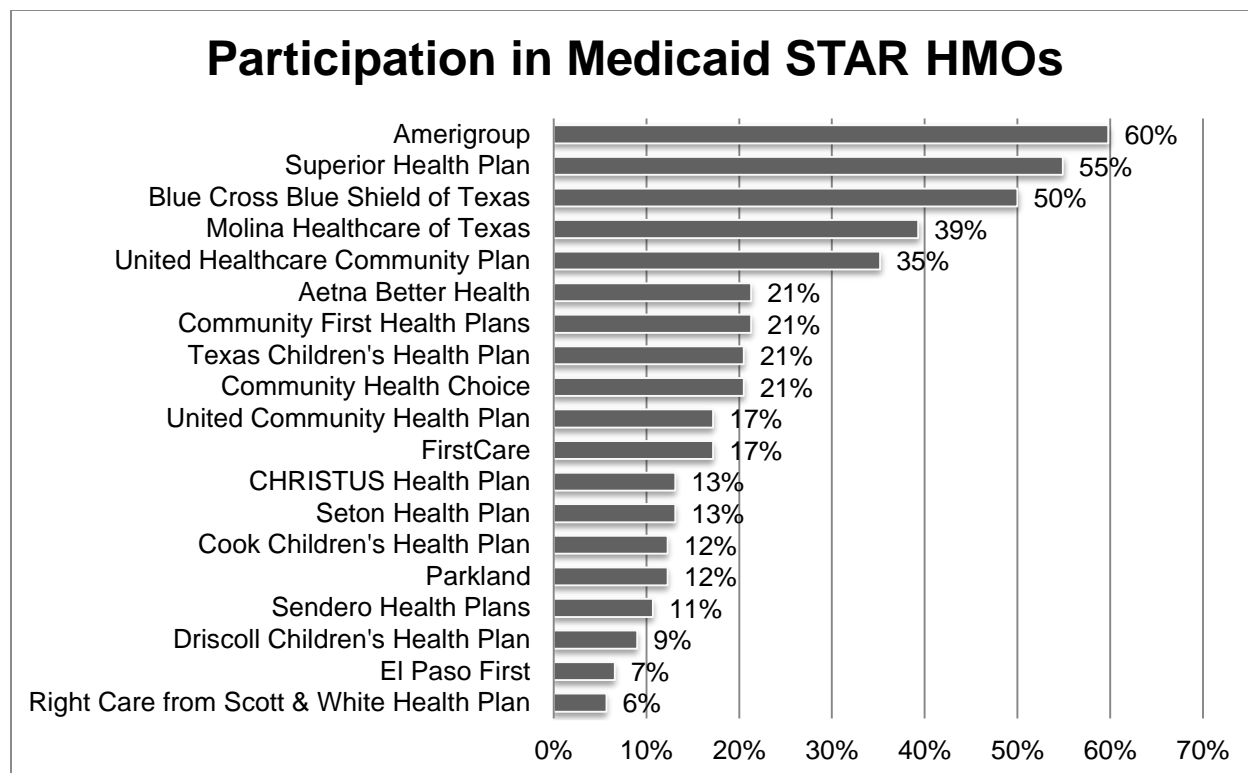
### ***Physician Satisfaction with Medicaid HMOs (September Q11)***

While there are differences among Medicaid HMOs, an overwhelmingly large percentage of physicians are dissatisfied with reimbursement (93 percent).



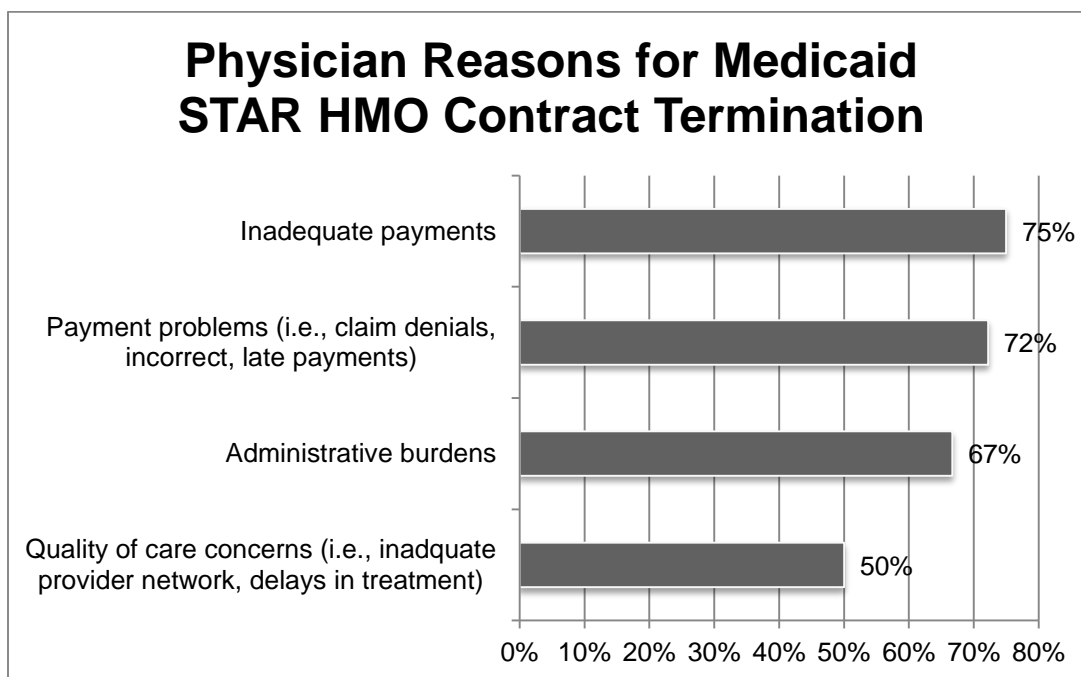
### ***Participation in Medicaid STAR HMOs (September Q12-13)***

Medicaid STAR HMOs primarily cover pregnant women and children. Twenty-three percent of physicians participate in a STAR HMO, primarily Amerigroup (60 percent), Superior (55 percent), and Blue Cross Blue Shield (50 percent).



### ***Intention to Terminate Medicaid STAR HMO Contracts (September Q14-16)***

Among physicians who treat Medicaid STAR HMO patients, 25 percent plan to terminate one or more of their existing contracts due to inadequate payments (75 percent), payment problems (72 percent) administrative burdens (67 percent), and quality-of-care concerns (50 percent).



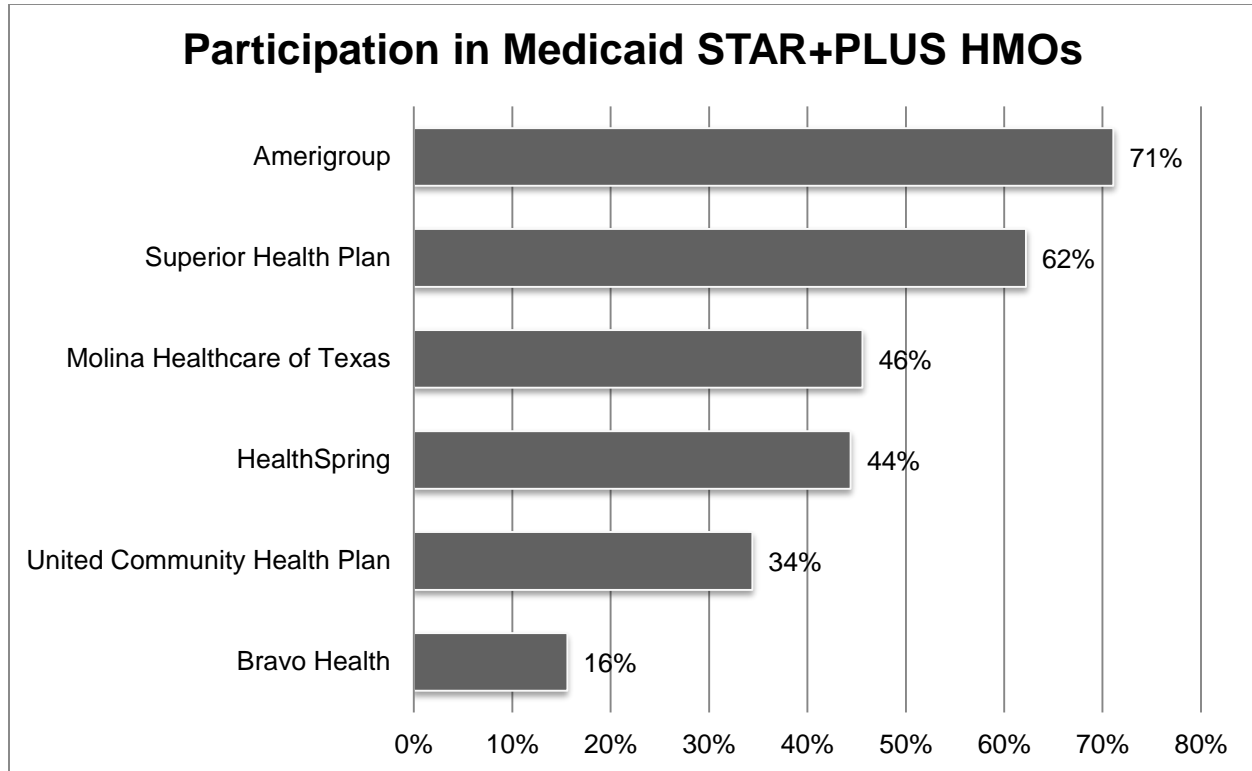
These physicians intend to terminate contracts with Amerigroup, Community First, Molina, and Superior.

### ***Intent to Contract with Any Medicaid STAR HMO (September Q17-18)***

Six percent of physicians intend to contract with an additional Medicaid STAR HMO in the next year and 22 percent might. When asked to specify which ones, physicians don't know or unsure.

***Participation in Medicaid STAR+PLUS HMOs (September Q19-20)***

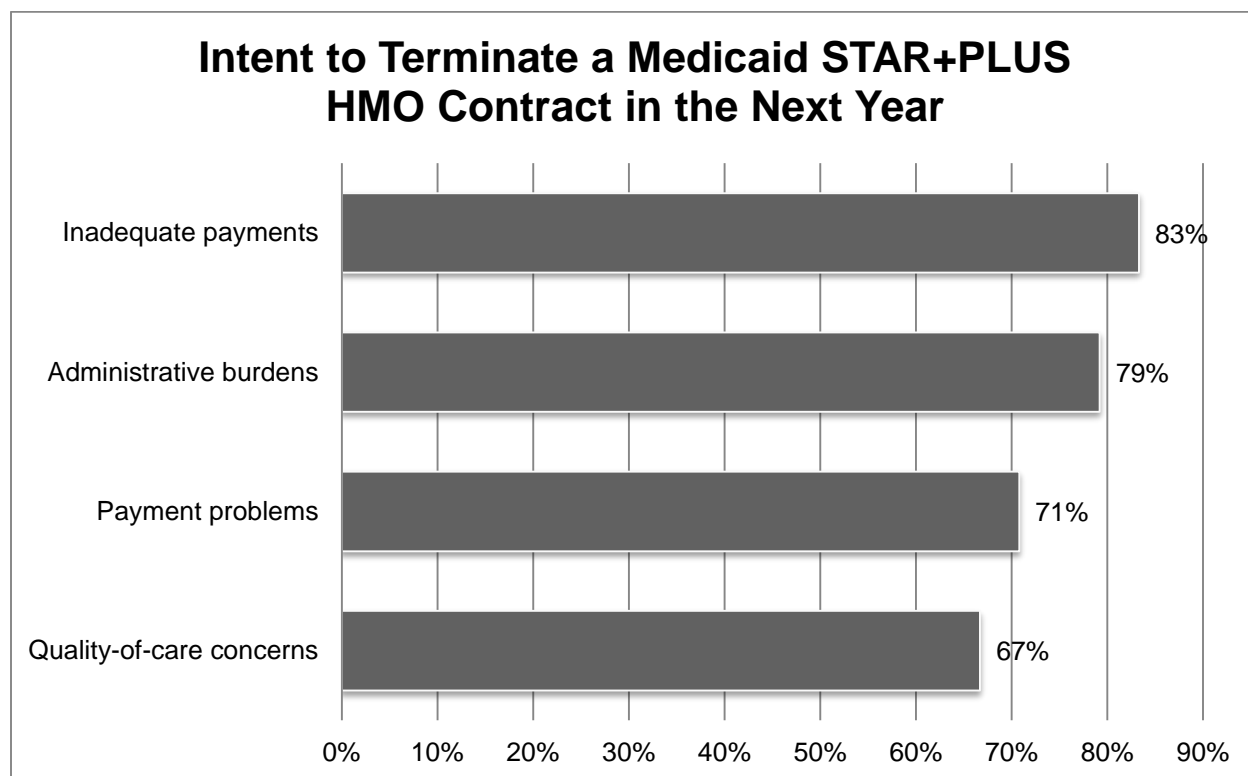
The Medicaid STAR+PLUS HMOs primarily cover adults with disabilities. Twenty percent of physicians participate in a Medicaid STAR+PLUS HMO, primarily Amerigroup (71 percent) and Superior (62 percent).





### ***Intent to Terminate Medicaid STAR+PLUS HMO Contracts (September Q21-23)***

Among physicians participating in the STAR+PLUS HMOs, 28 percent plan to terminate one or more of their existing contracts in the next year because of inadequate payments (83 percent), administrative burdens (79 percent), payment problems (71 percent), and quality-of-care concerns (61 percent).



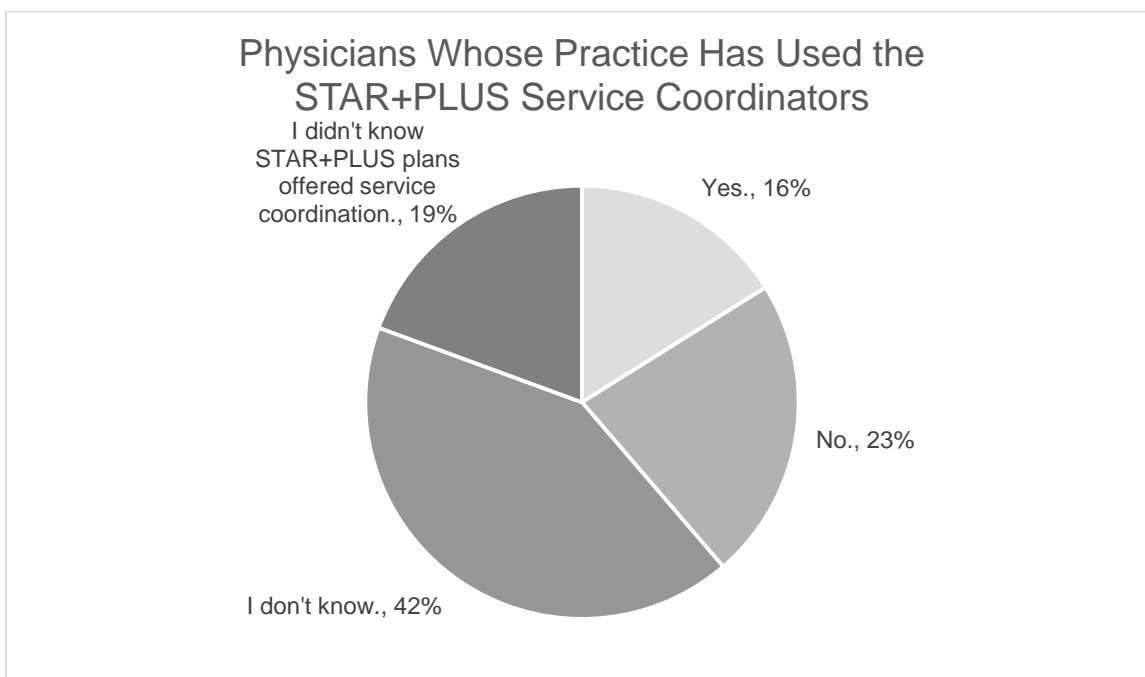
Physicians who intend to terminate a Medicaid STAR+PLUS contract specify Amerigroup, Molina, and Superior.

### ***Intent to Contract with a Medicaid STAR+PLUS HMO (September Q24-25)***

Four percent will and 21 percent of physicians might contract with a Medicaid STAR+PLUS HMO in the next year, specifically Amerigroup, Superior, or United.

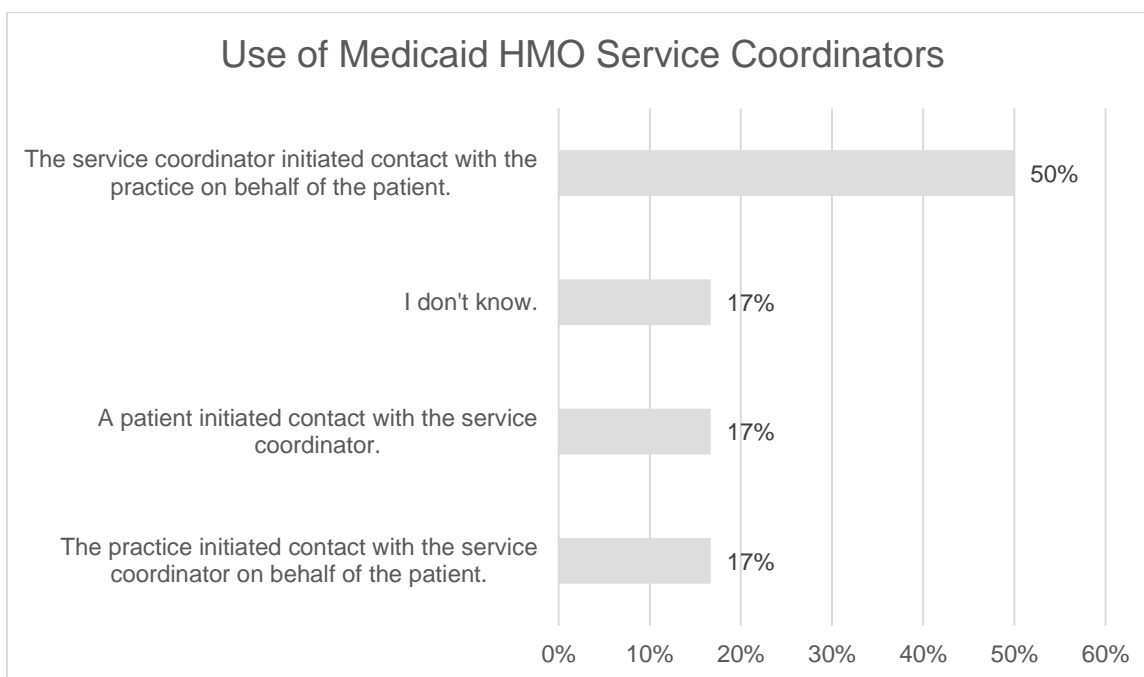
### **Medicaid HMO Service Coordinators (September Q26)**

Texas Medicaid managed care provides this definition for a service coordinator: A health plan service coordinator (such as a nurse, social worker, or other health plan staff member) will work directly with plan members, family members, doctors, and community supports to make sure all health care and long-term services and support needs are met. Sixteen percent of physicians report their practice used the STAR+PLUS service coordinators.



### ***Medicaid HMO Use of Service Coordinators (September Q27)***

Among physicians whose practice used the STAR+PLUS service coordinators, half report the service coordinator contacted the practice on behalf of the patient.

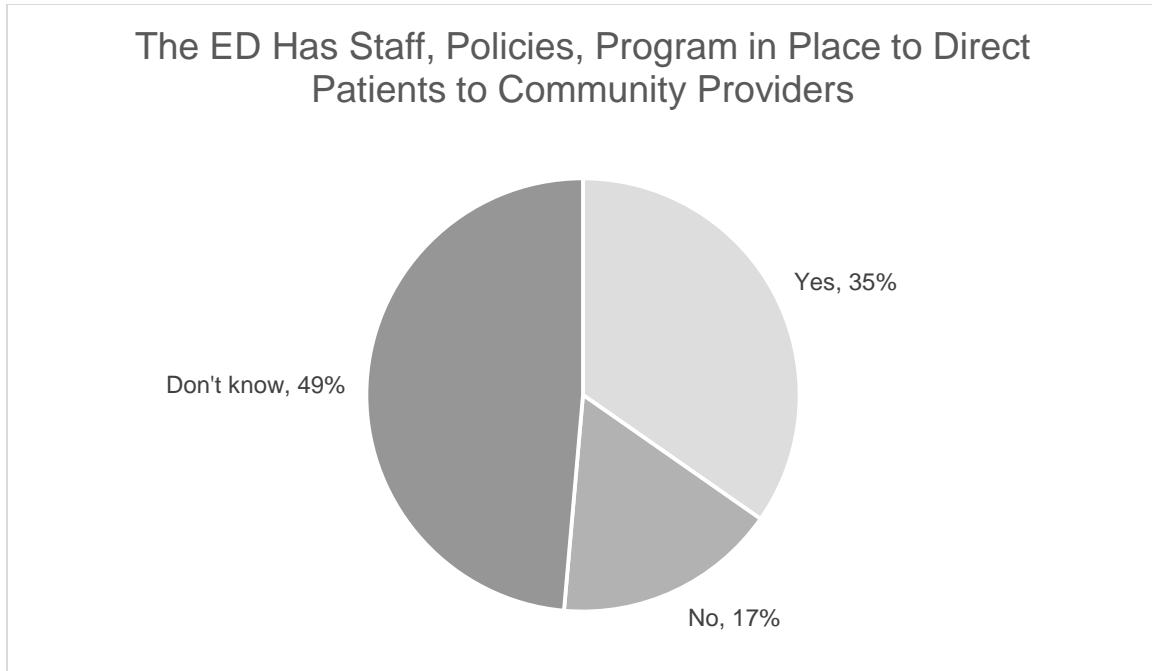


### ***Medicaid STAR+PLUS Service Coordinator Improve Patient Care (September Q28)***

Eighty-three percent of physicians report the service coordinator did not result in improved patient care and 17 percent don't know.

***ED Directing Patients to Community Care (September Q29-30)***

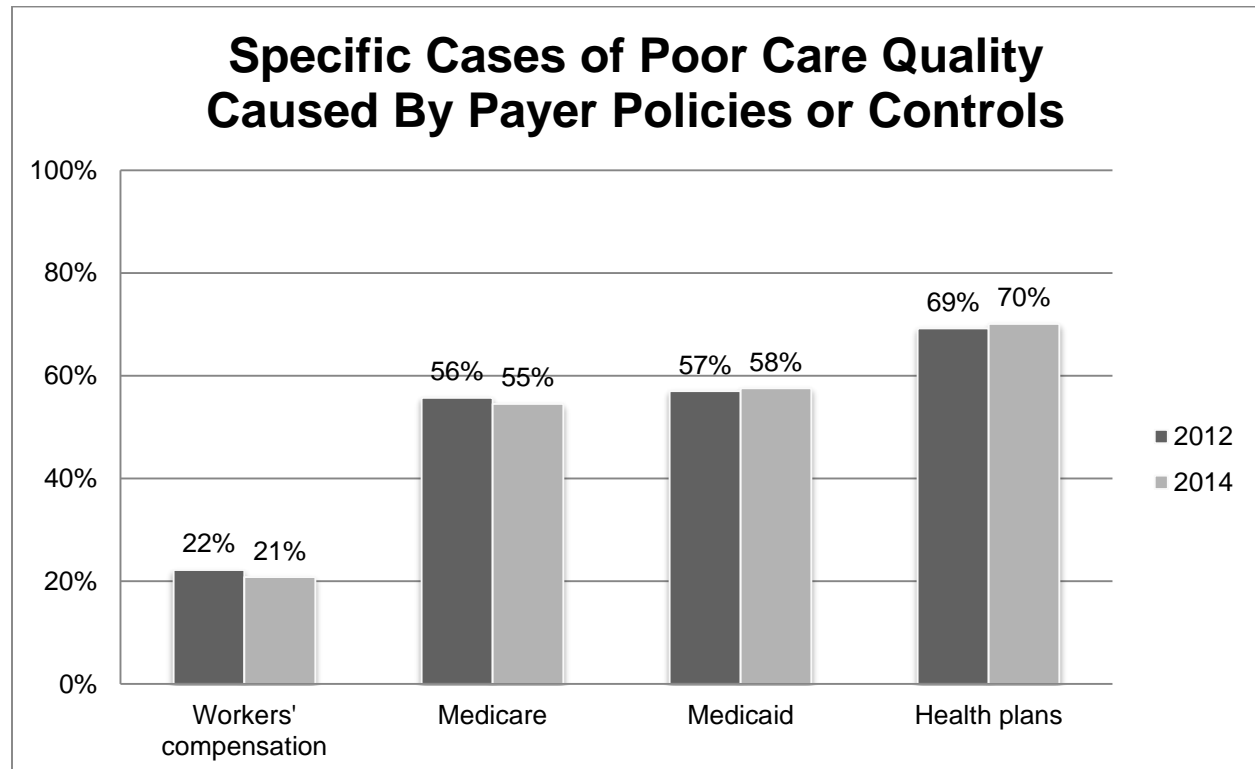
Among physicians with practice privileges in an emergency department (ED), 35 percent report the ED has staff, policies, and/or programs in place to direct patients to community providers when emergency care is not appropriate.



## Care Quality Impact — Payers

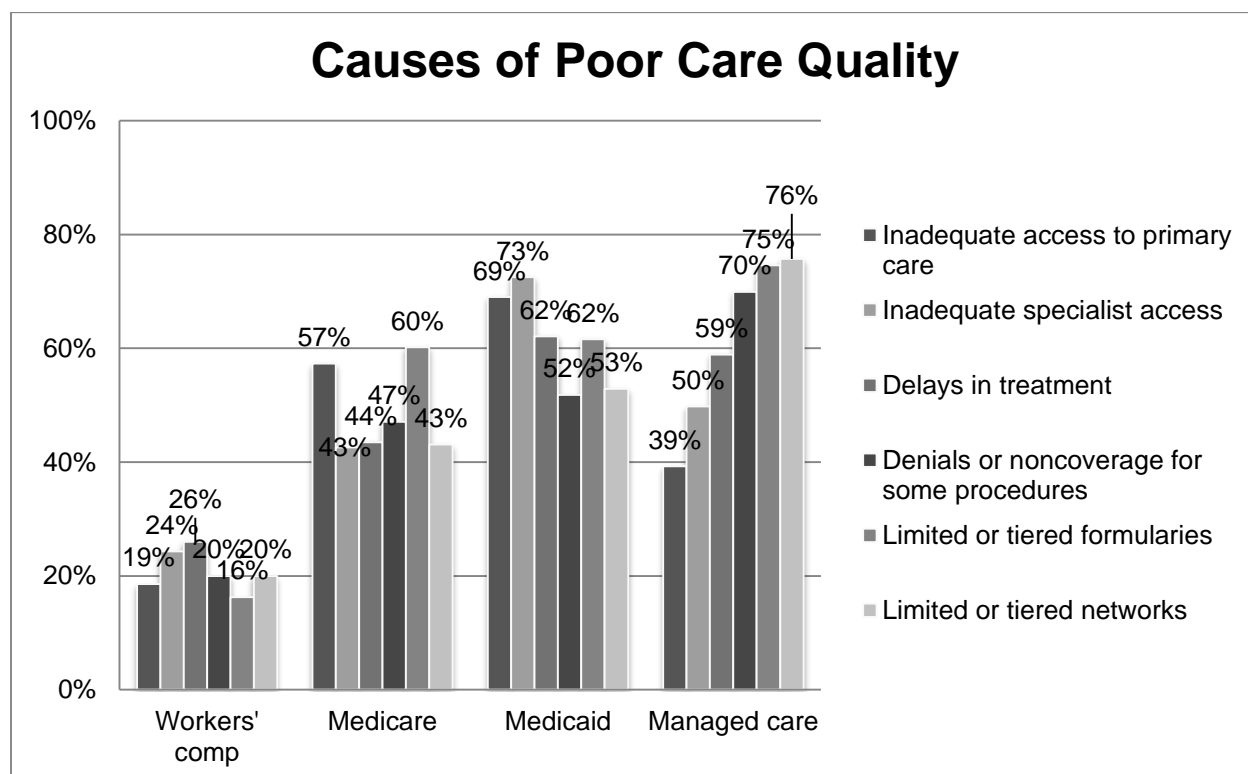
### *Poor Care Quality Due to Third-Party Payer Practices (July Q1)*

Respondents were asked to report whether they had seen specific cases in which the quality of patient care was adversely affected by the policies of a managed care plan or government program. A majority indicate in the past year there has been at least one instance in their practice in which patient care quality was adversely impacted by a health plan (70 percent), Medicaid (58 percent), Medicare (55 percent), or Medicare (55 percent).



### ***Cause of Adverse Impact by Third-Party Payers (July Q2)***

Physicians who saw care quality problems were asked to report the reason or reasons for the adverse impact. The most frequently identified cause varied by payer.



**Managed care:** Respondents who witnessed quality problems in health plans report that problems were caused by limited networks and formulary limitations (76 and 75 percent respectively).

**Medicaid:** Quality problems in Medicaid are most frequently attributed to inadequate access to specialists and primary care (73 and 69 percent respectively).

**Medicare:** Medicare quality problems are most frequently attributed to limited or tiered formularies (60 percent) and limited access to primary care (57 percent).

**Workers' compensation:** Among physicians who have seen specific cases of care quality problems in workers' compensation, treatment delays were the most frequently listed reason (26 percent).

### ***Participation in a Quality Improvement Program (July Q3-4)***

Twenty-six percent of physicians report their practice has participated in a quality improvement program for a carrier. The average per physician bonus payment was \$1,523 with Blue Cross Blue Shield.

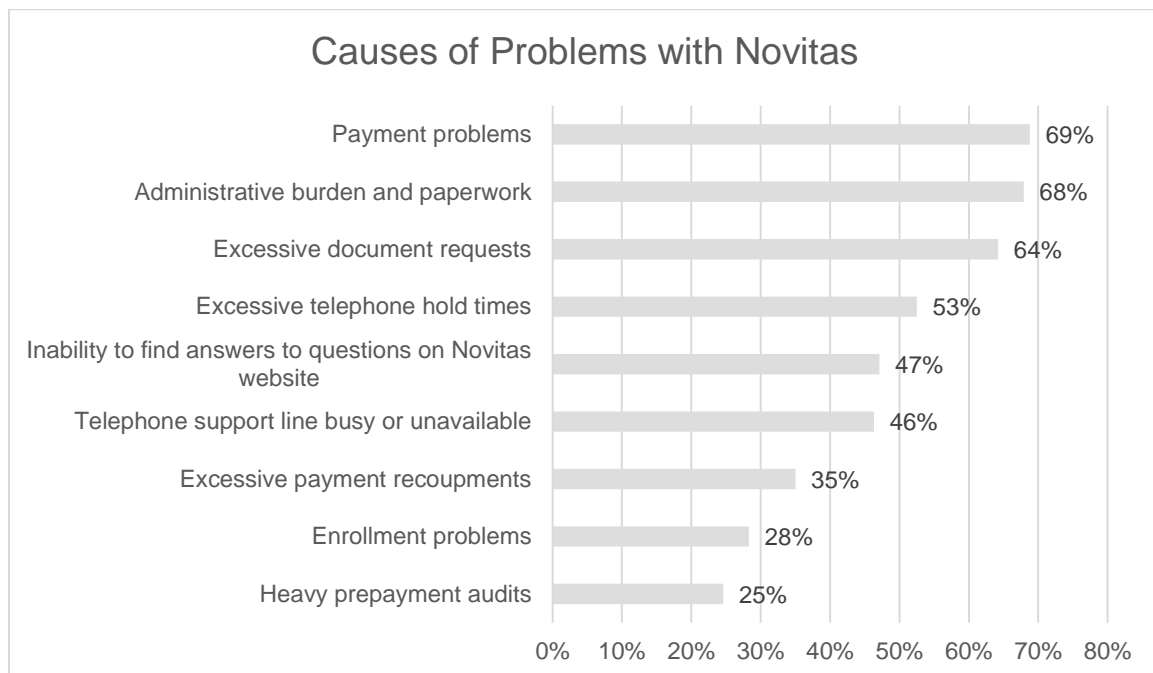
## Care Quality Impact — Novitas

### ***Poor Care Quality Due to Novitas Practices (July Q5)***

Novitas Solutions Inc. took over from Trailblazer Enterprises as Texas' Medicare carrier in 2011. Nearly one third of physicians have experienced problems with Novitas (29 percent).

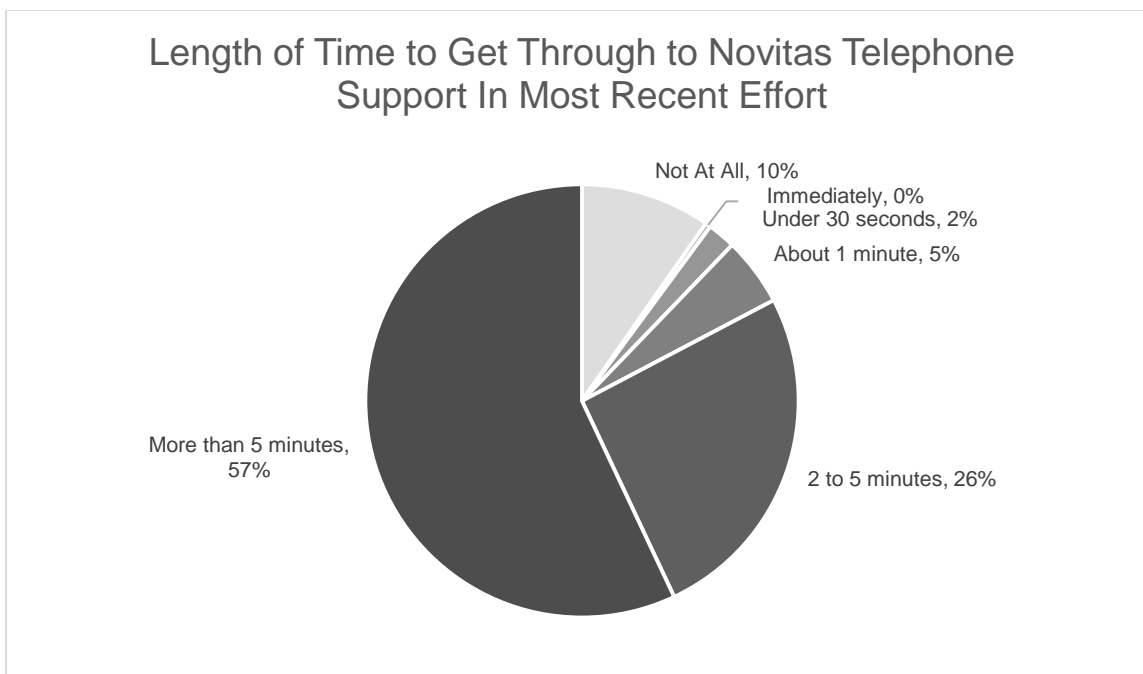
### ***Cause of Problems with Novitas (July Q6)***

Respondents who encountered problems with Novitas most frequently identified payment problems (69 percent) and administrative burden and paperwork (68 percent).

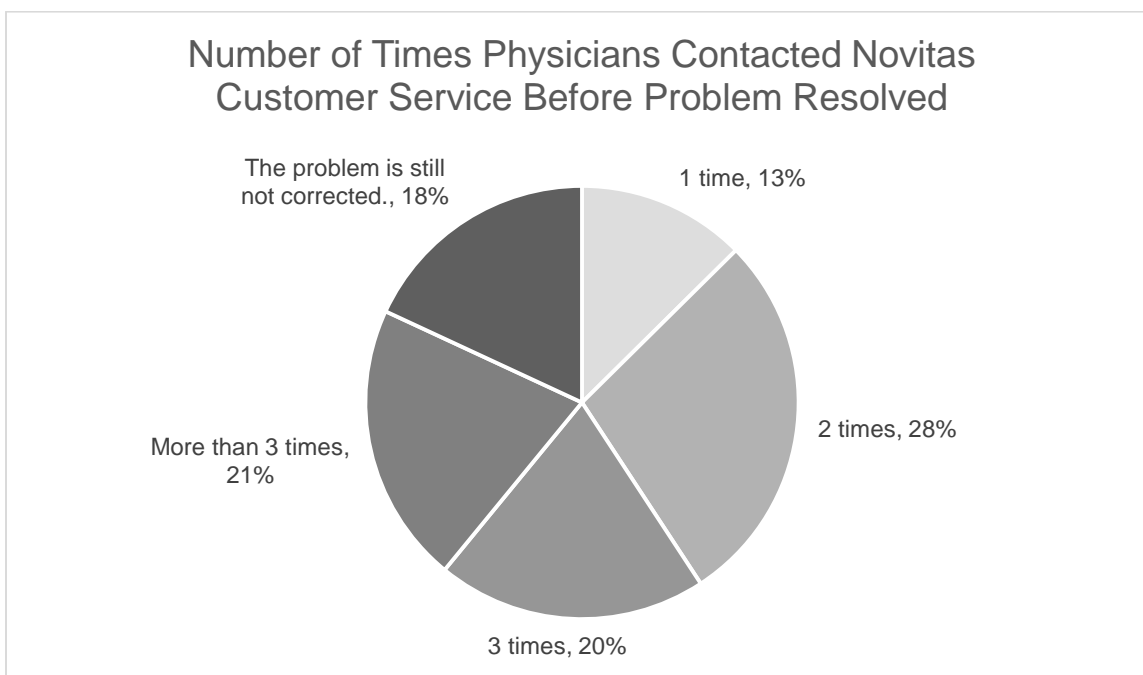


### **Novitas Telephone Support (July Q7-10)**

Twenty-seven percent of respondents tried to contact Novitas customer support by telephone. In their most recent effort, it took more than 5 minutes to get through or they did not get through at all (67 percent).

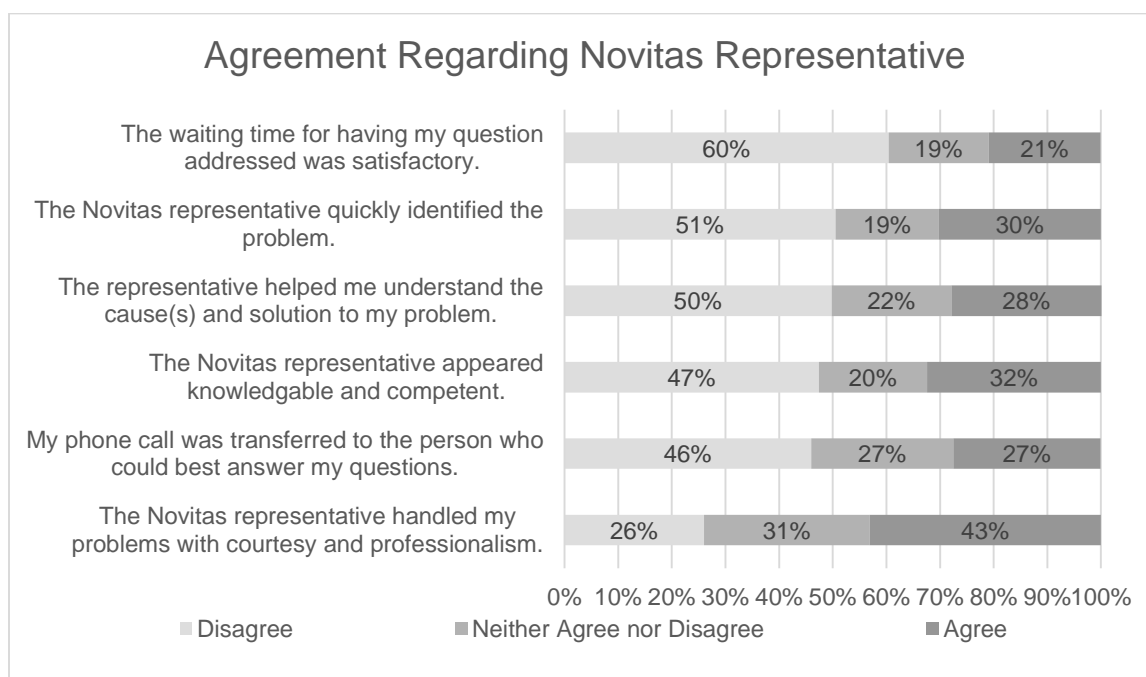


Physicians had to contact customer service three times or more before the problem was corrected (41 percent). Eighteen percent report the problem is still not corrected.

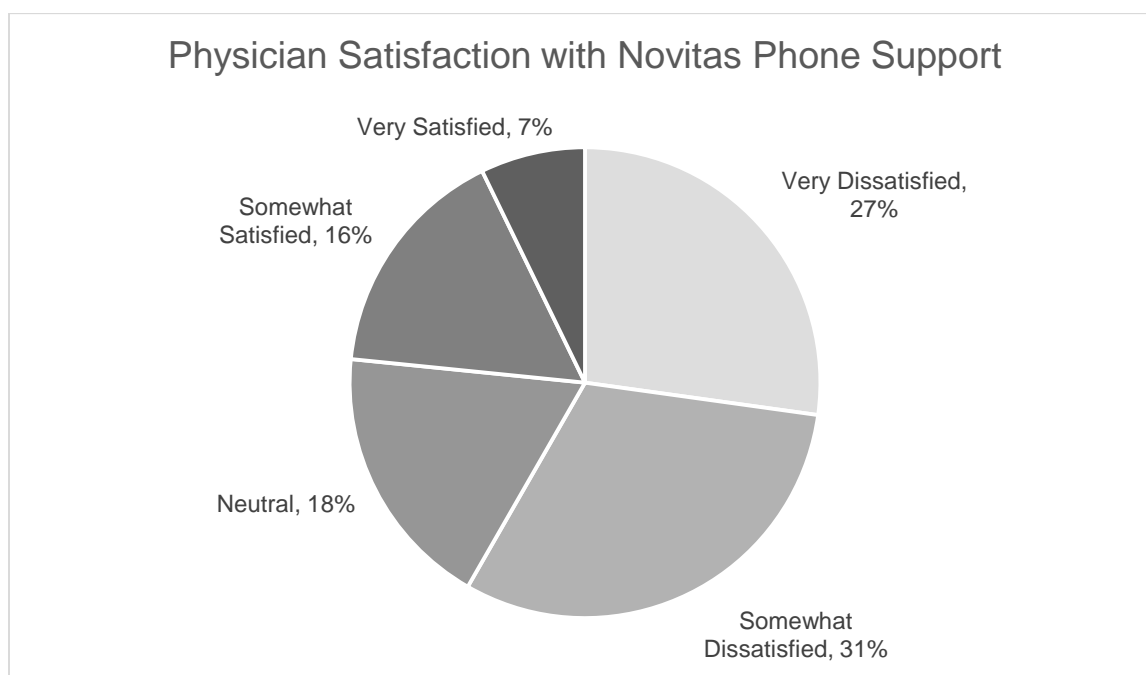




When thinking about the Novitas representative, physicians disagree the waiting time for having their question addressed was satisfactory (60 percent) and the Novitas representative quickly identify the problem (51 percent).



Overall, physicians are dissatisfied with Novitas phone support (58 percent).



### ***Attempt to Use the Novitas Website (July Q12-13)***

A quarter of respondents attempted to use the Novitas website. Few found sufficient information available to answer their question (32 percent).

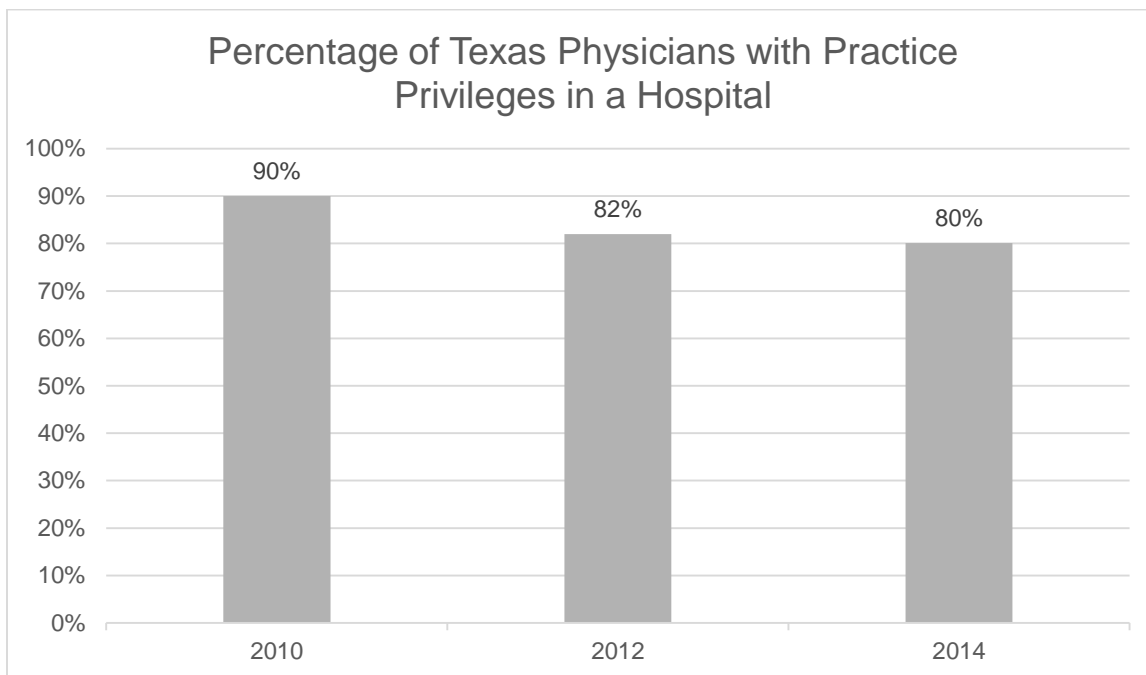
### ***CMS Evaluation of Novitas (July Q14)***

Fifty-eight percent of physicians think the CMS should re-evaluate Novitas as the MAC.

## **Physicians and Hospitals**

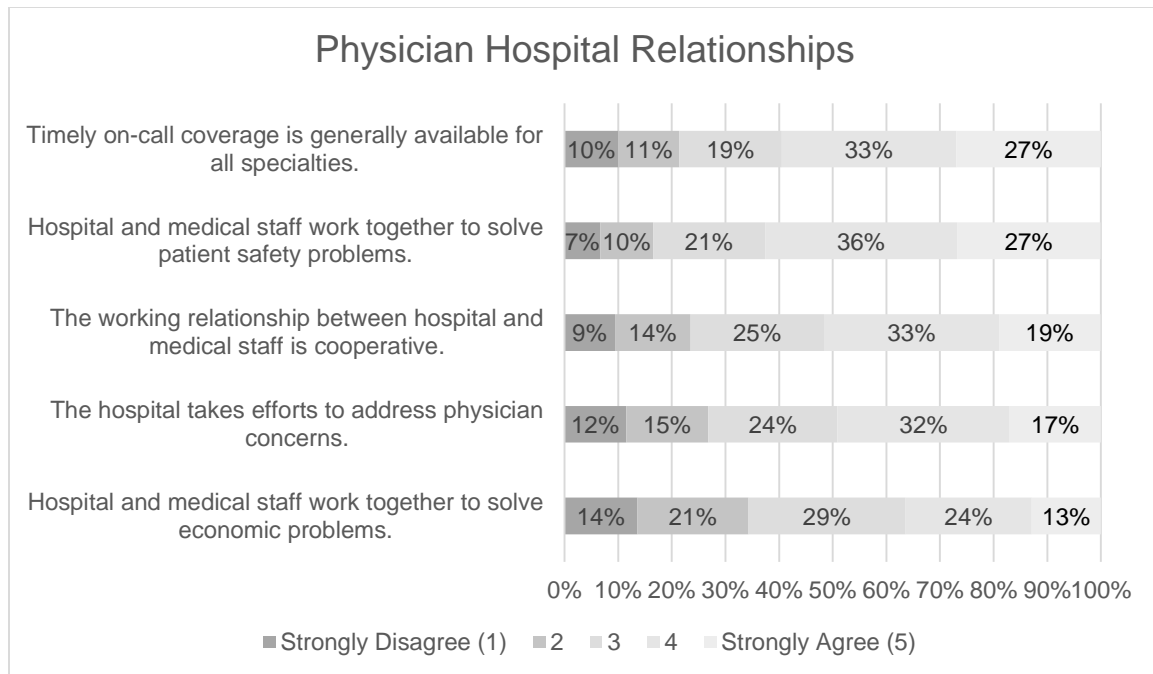
### ***Hospital Practice (July Q15-17)***

The percentage of physicians with practice privileges in a hospital has decreased to 80 percent.



Ten percent of physicians' report the hospital in which they primarily practice is owned partially or entirely by physicians.

Thinking about the hospital in which they primarily practice, physicians agree hospital and medical staff work together to solve patient safety problems (63 percent), timely on-call coverage is available for all specialties, and the working relationship between hospital and medical staff is cooperative (52 percent).



### ***Poor Care Quality Due to Hospital or Facility Practices (July Q18-19)***

Thirty-seven percent of physicians witnessed specific cases in their practice in which the quality of patient care was adversely affected by the policies or operations of a hospital or surgical facility (up from 32 percent in 2012). Physicians who have seen damage to care quality are most likely to report inadequate and inconsistent facility staffing (64 and 58 percent respectively).

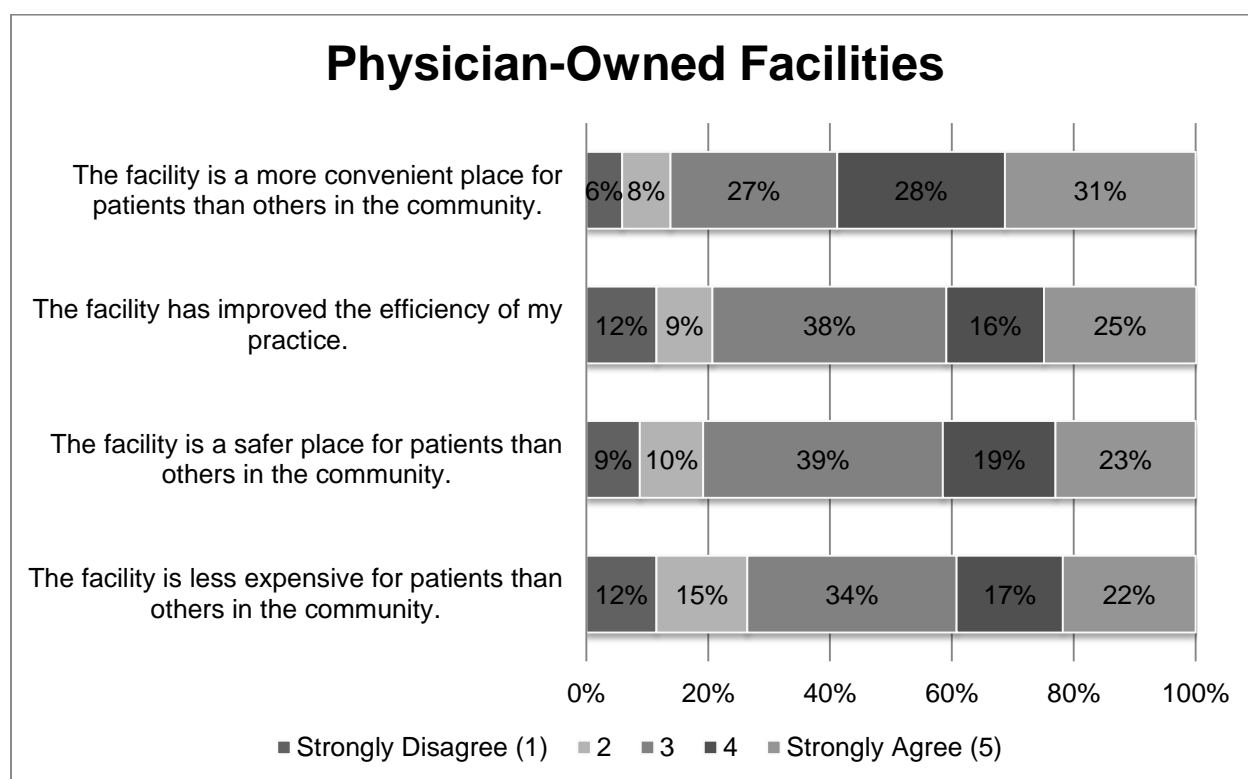


### ***Hospitals and Call Coverage (July Q20-21)***

Among physicians with practice privileges at a hospital, 57 percent are required to accept patients without a physician who report to the emergency department. Few physicians are compensated in some manner by the hospital for caring for medically indigent patients (26 percent).

### ***Physician-Owned Hospitals (July Q22-25)***

Eighty percent of physicians report there are physician-owned specialty hospitals, ASCs, or imaging centers in their area. Among these physicians, 31 percent practice in a physician-owned facility, but a little more than half are an owner or investor in the facility (53 percent). Physicians agree the facility is a more convenient place for patients than others in the community (59 percent).



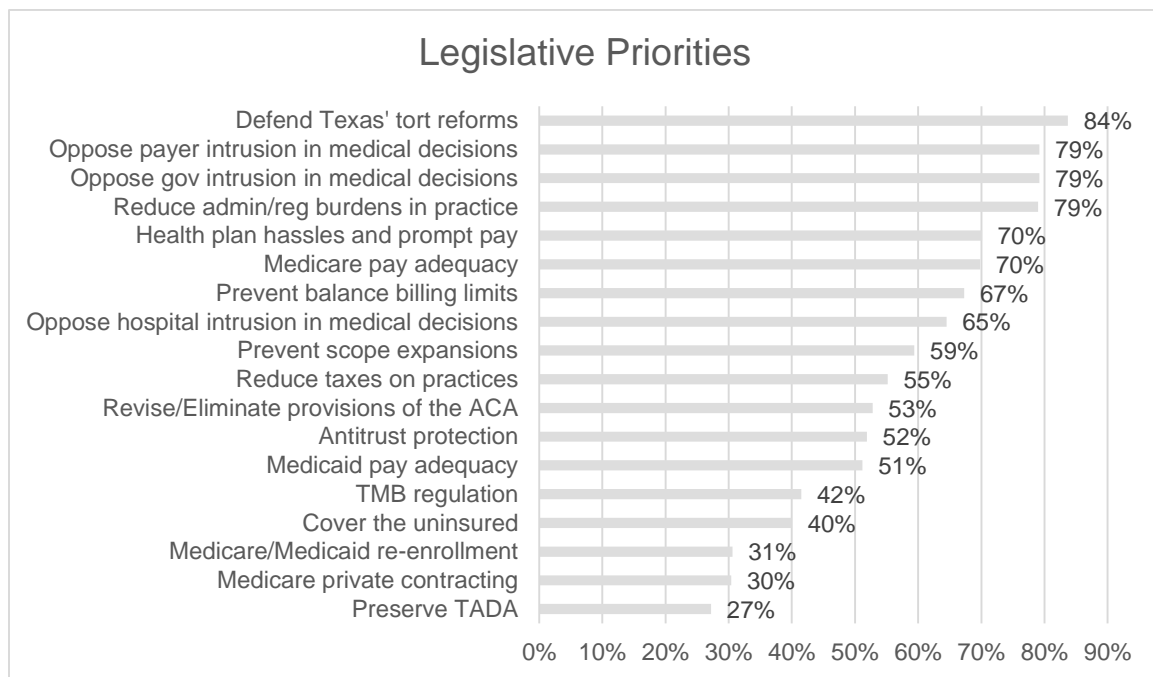
### ***Adverse Quality of Care and Physician Employment (January Q22-23)***

Thirty percent of respondents have seen cases where physicians lost employment, contracts, or hospital privileges because they raised issues about hospital regulatory compliance or patient care quality (up from 21 percent in 2012). Thirty-eight percent of physicians are concerned it could happen to them.

## One Voice — Legislative Issues

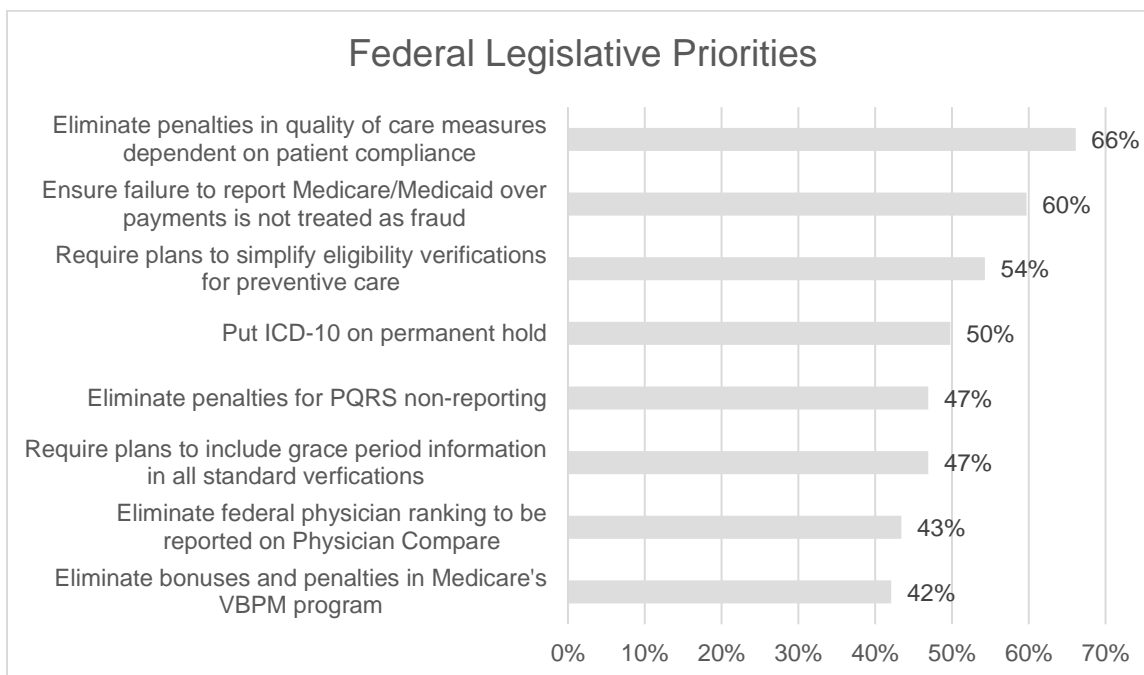
### *Legislative Priorities (May Q1)*

The top legislative priorities are defending Texas' liability reforms (84 percent), opposing commercial payer intrusion in medical decisions, opposing government intrusion in medical decisions, and reducing administrative and regulatory burdens in practice (79 percent).



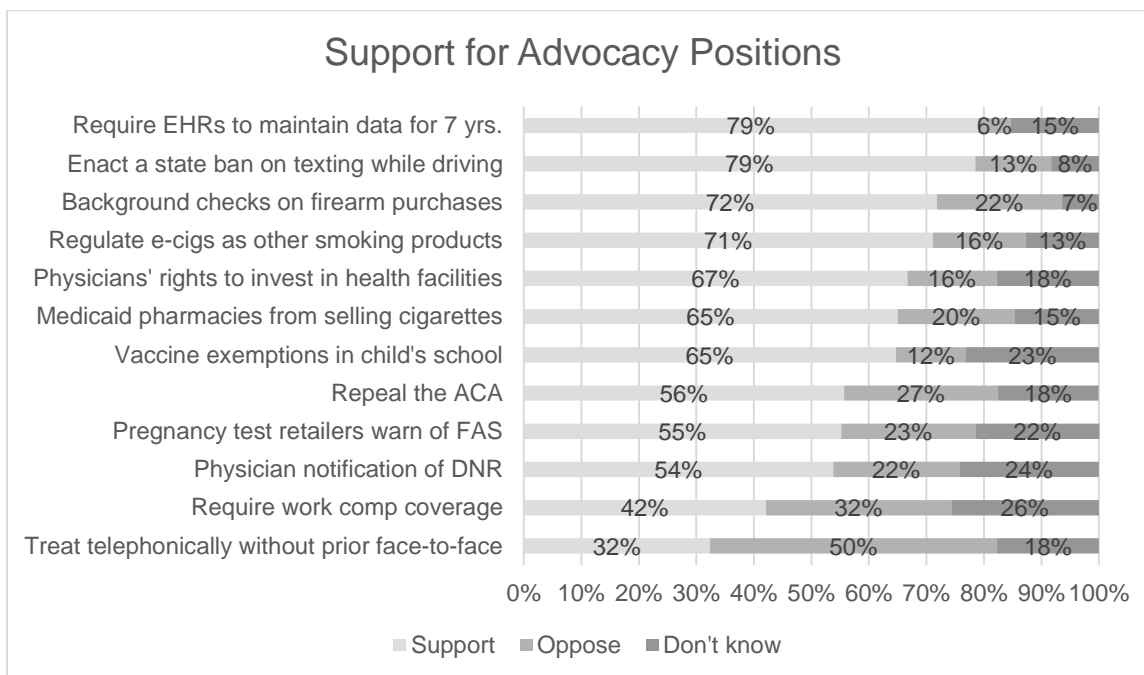
### ***Federal Legislative Priorities (May Q2)***

The top federal legislative priorities, rated very important by a majority of Texas physicians, are revising all physician quality of care measures to eliminate penalties dependent on patient compliance (66 percent), ensuring failure to report Medicare or Medicaid over payments is not treated as fraud (60 percent), and requiring health plans to simplify eligibility verifications for preventive care benefits (54 percent).



### Support for Advocacy Positions (May Q3)

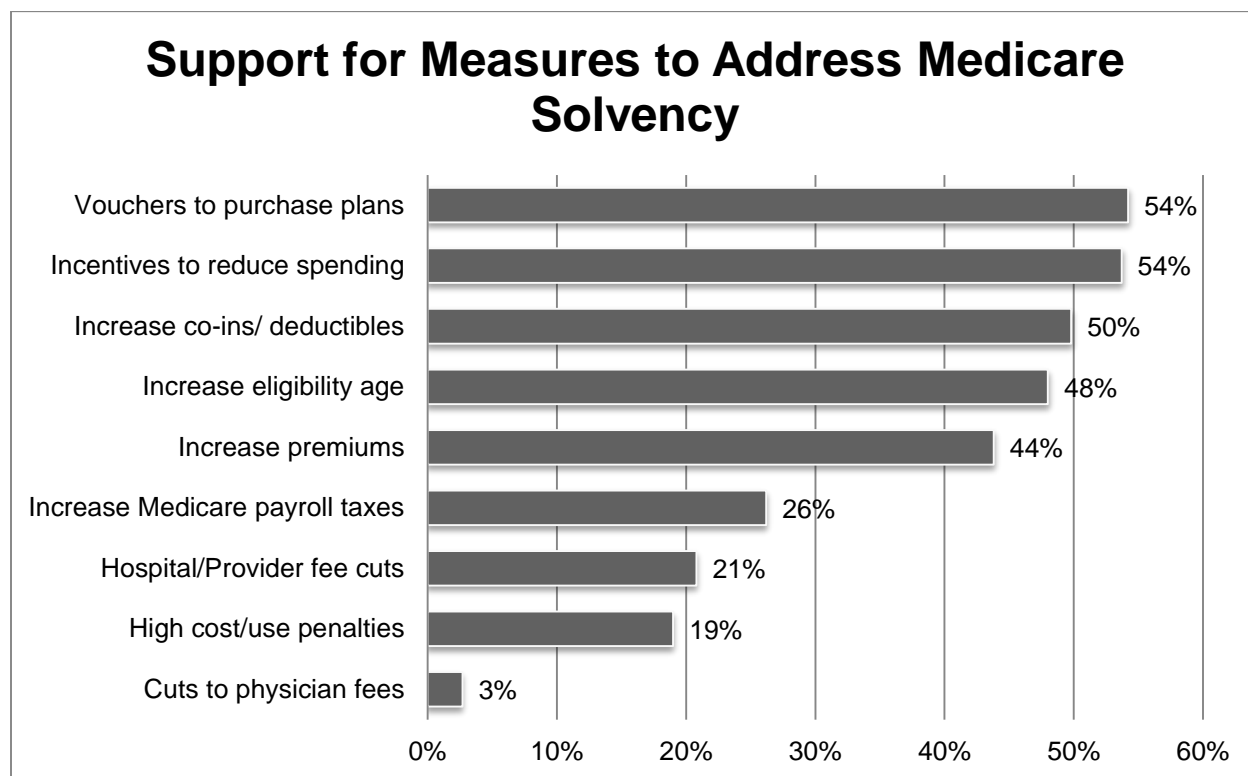
The top advocacy positions are requiring EHR companies to maintain patient data for seven years and enacting a statewide ban on texting while driving (79 percent). Also supported by a large majority of physicians are background checks on all firearm purchases in all settings (72 percent), regulating e-cigarettes the same as other smoking products and limiting minor access (71 percent), restoring physicians' rights to invest in health care facilities (67 percent), prohibiting Medicaid pharmacies from selling cigarettes, and permitting parents to know how many vaccine exemptions have been filed on their child's school campus (65 percent).





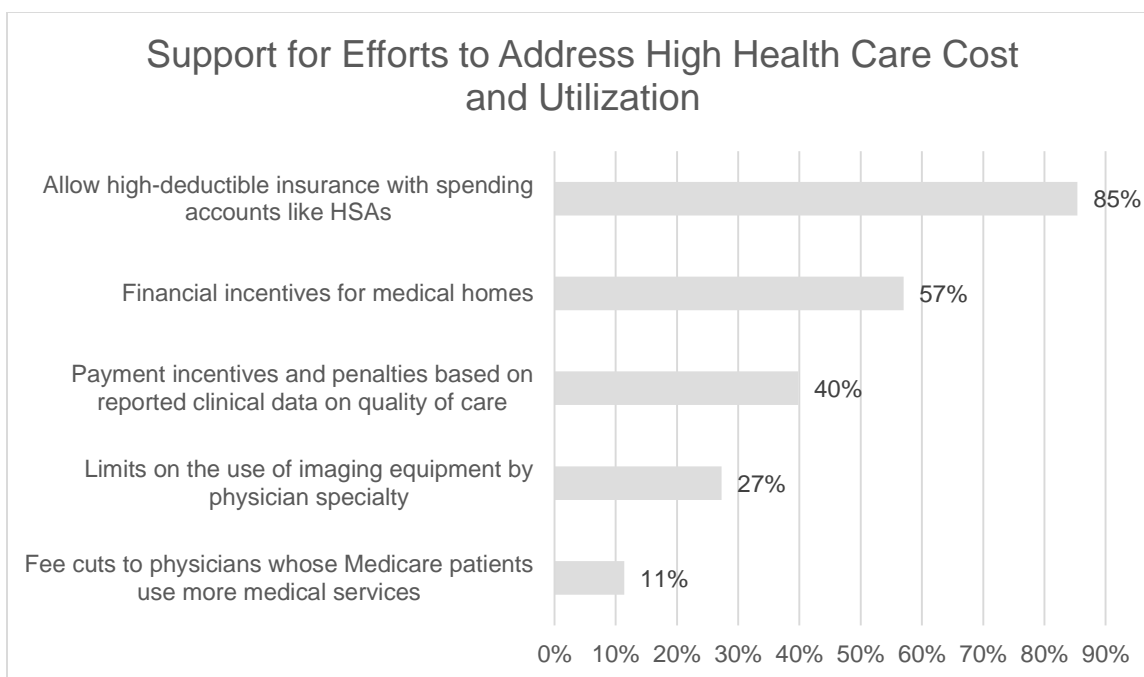
### ***Efforts to Address Medicare Solvency (May Q5)***

Physicians support providing beneficiaries with vouchers to purchase plans and incentives to physicians and hospitals to reduce total Medicare spending (54 percent) to address Medicare solvency.



### ***Efforts to Address Health Care Costs and Utilization (May Q6)***

Physicians support allowing high-deductible insurance with spending accounts like health savings accounts (85 percent) and financial incentives for medical homes (57 percent) to address high health care costs and/or overutilization of medical care services.



### ***Support for Uninsured Initiatives (May Q10)***

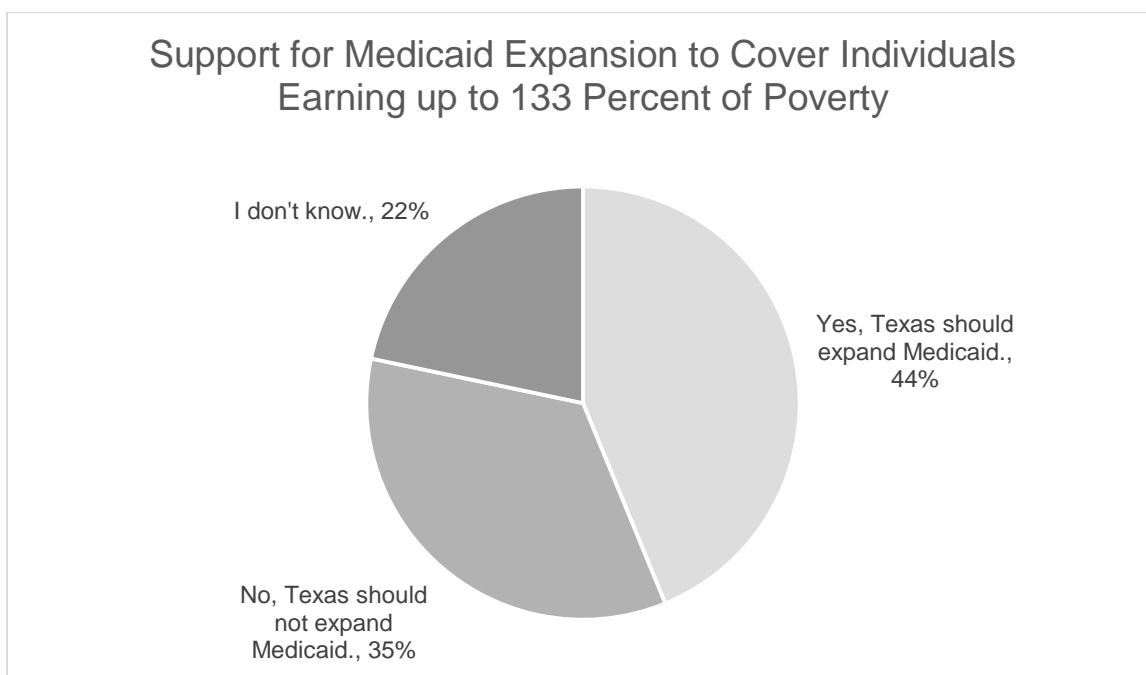
Physicians were asked about their support for various methods of providing medical care for the uninsured if the ACA had never passed and they could start over. The most favored methods include federal tax law changes, direct charity subsidies, subsidies for high-risk pool premiums, and encouraging Medicaid or CHIP enrollment for individuals who are eligible.

#### ***Support for Uninsured Initiatives***

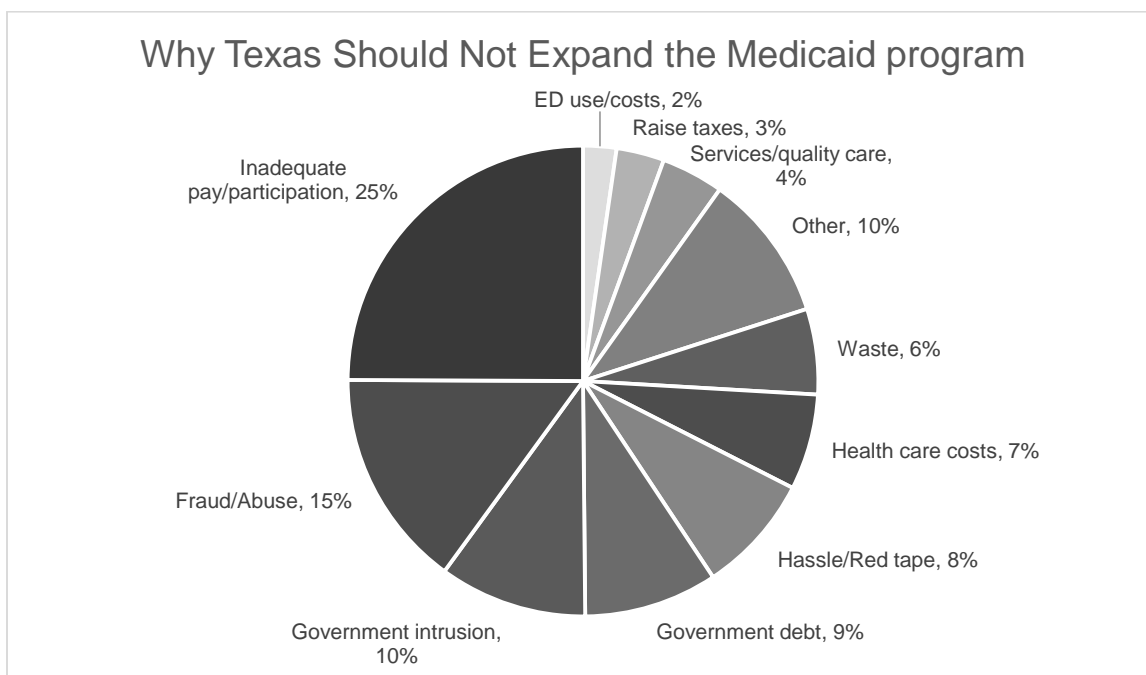
	<b><u>2004</u></b>	<b><u>2006</u></b>	<b><u>2008</u></b>	<b><u>2012</u></b>	<b><u>2014</u></b>
Federal tax deduction for all medical expenses	85%	87%	92%	85%	87%
Funding or tax credits for physician charity care	N/A	88%	94%	81%	87%
Subsidies for high-risk pool premiums				76%	82%
Encourage eligible people to enroll in Medicaid or CHIP	N/A	82%	85%	74%	81%
More funding for outpatient charity clinics	78%	80%	82%	76%	81%
More direct funding for hospital charity care	N/A	81%	81%	75%	77%
Expand CHIP	N/A	N/A	70%	64%	76%
Vouchers or tax credits for purchase of insurance	73%	77%	82%	73%	75%
Expand Medicaid	46%	57%	51%	44%	60%
Expand Medicare	44%	40%	36%	38%	53%
Individual mandate	N/A	55%	45%	36%	43%
Employer mandate	N/A	45%	35%	30%	38%
Federal single-payer health insurance plan	38%	44%	32%	31%	34%

### **Support for Medicaid Expansion (March Q19-21)**

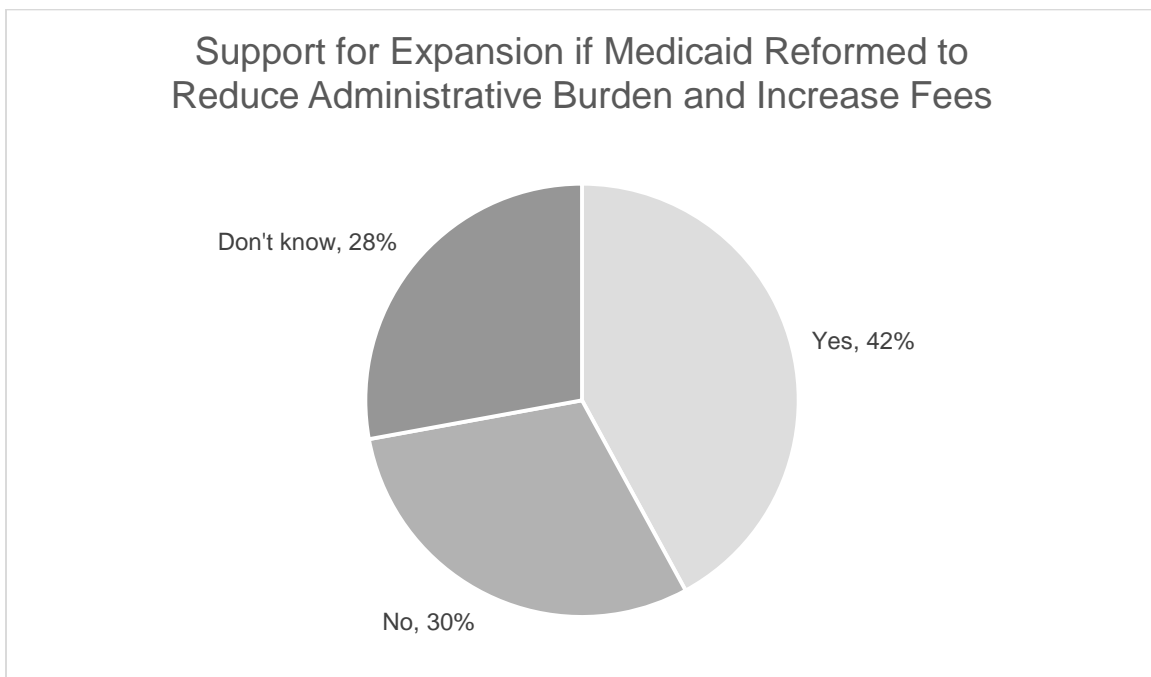
Forty-four percent of physicians believe Texas should expand the Medicaid program to cover individuals earning up to \$14,856 (133 percent of poverty).



Physicians who believe Texas should not expand Medicaid were asked the most important reason why not. These physicians report inadequate reimbursement and, as a result, too few participating physicians in the program (25 percent).

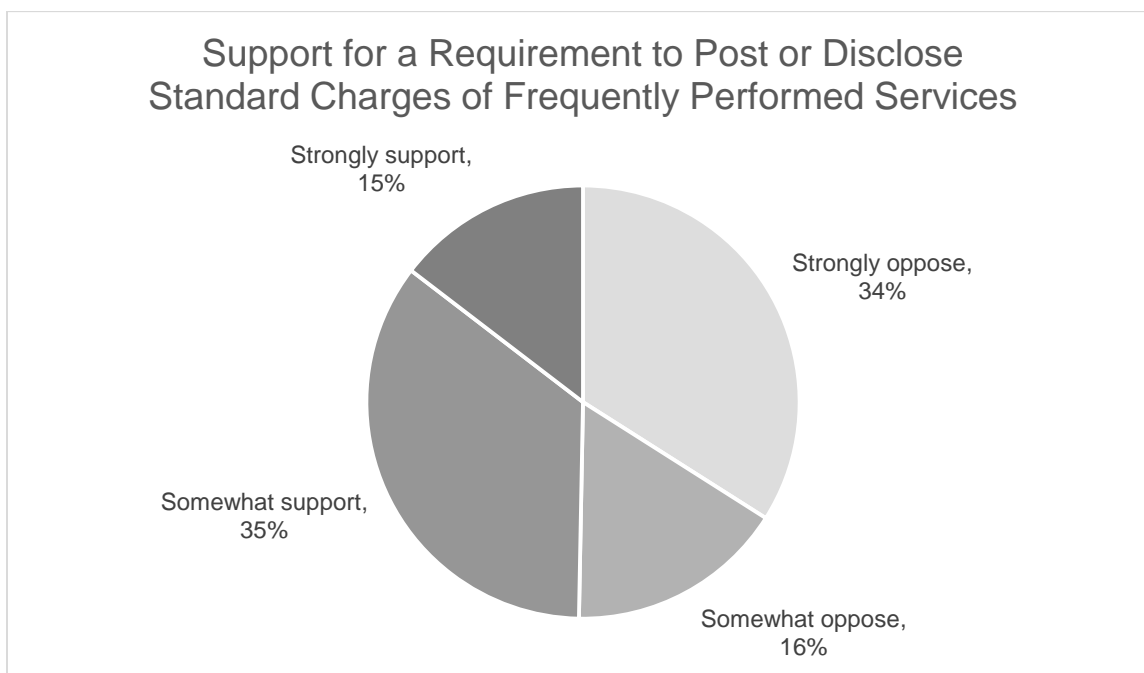


A large minority of physicians who don't know or do not believe Texas should expand Medicaid, would support expansion if the program was reformed to reduce administrative burden and increase physician fees to Medicare parity (42 percent).



### ***Support for Price Disclosure (May Q13)***

The Texas Legislature is likely to pass a bill requiring disclosure of prices of health care providers. Previous efforts to do so included onerous provisions like prohibitions on balance billing. In an attempt to avoid requirements that could be more intrusive and financially or administratively burdensome, physicians were asked if they would support or oppose a requirement that they post or otherwise disclose standard charges (not contract rates) for services frequently performed, retaining the right to offer discounts. Opinion is divided.



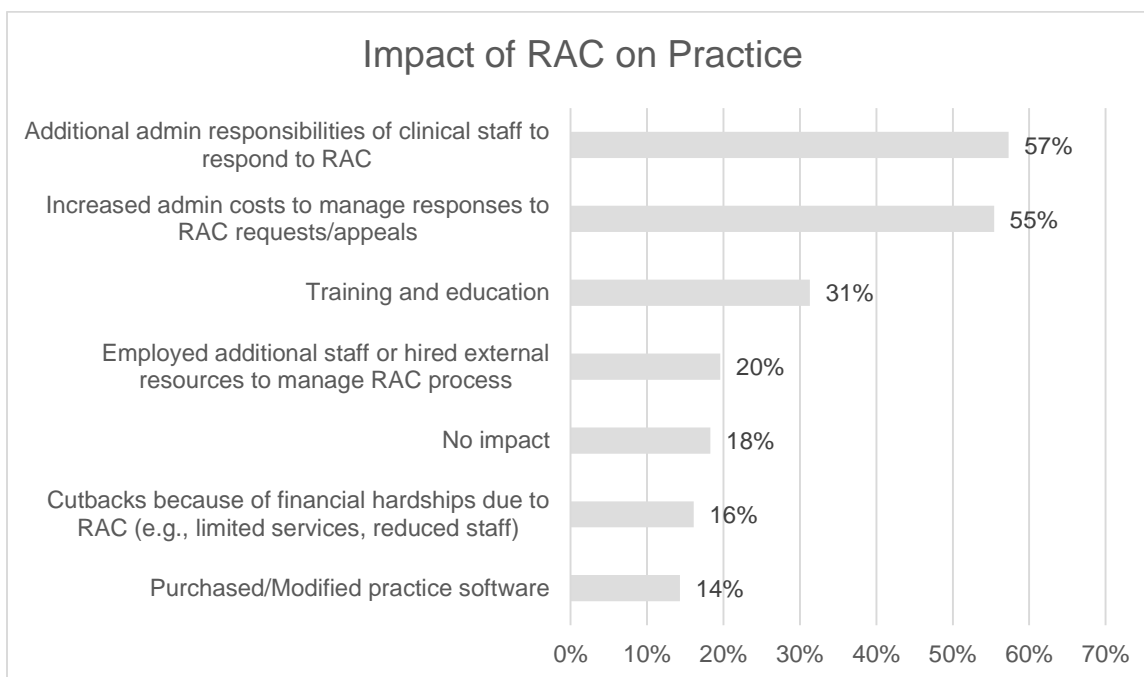
### **Medicare Recovery Audit Contractor Reviews**

#### ***Number of Medicare RAC Reviews (May Q14-15)***

Twelve percent of physicians report their practice has had a RAC review. Physicians whose practice had a RAC review had a median of two.

### ***Impact of RACs (May Q16)***

Physicians who experienced a RAC review were asked about the impact (financial recoupment of dollars, costly appeals process, and increased administrative burden) on their practice. Physicians' report their practice increased administrative responsibilities of clinical staff to respond to RAC (57 percent) and increased administrative costs to manage responses to RAC requests and/or appeals (55 percent).



## **Texas Medical Board**

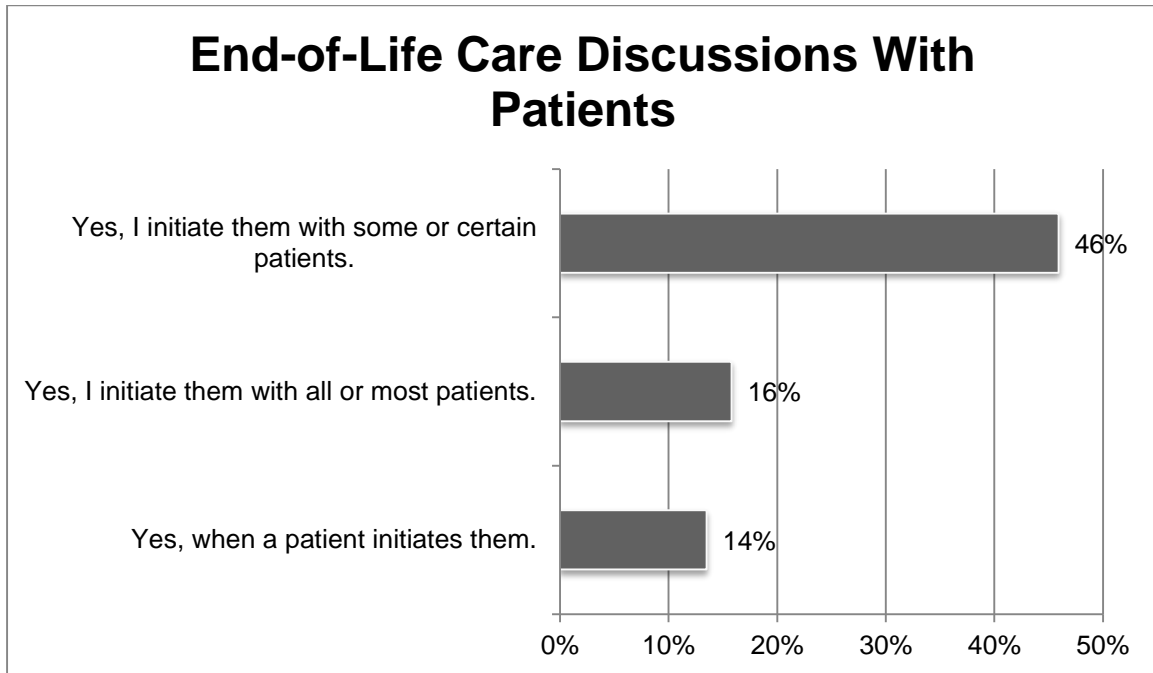
### ***Texas Medical Board (May Q17)***

Twelve percent of physicians have had problems with the TMB.

## Advance Directives

### *End-of-Life Care Discussions (May Q19)*

Seventy-six percent of physicians have end-of-life-care discussions with patients.



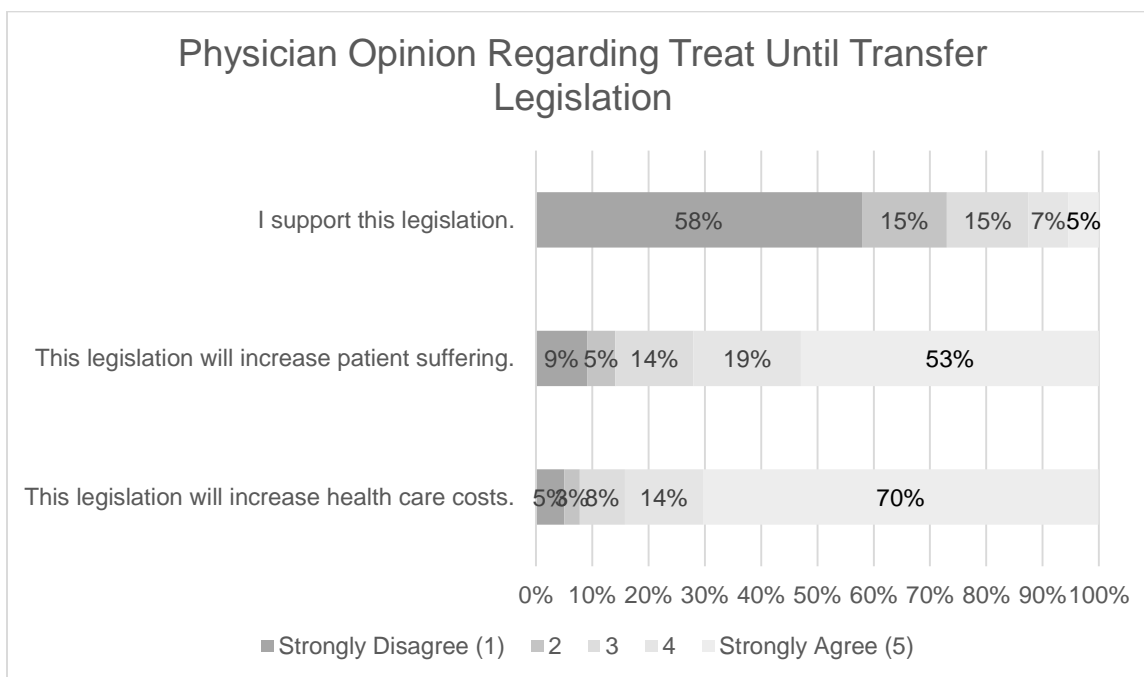
### *Documentation of Advance Directives (May Q20)*

If a patient has an advance directive, physicians keep a copy or note its existence in the medical record (77 percent).



### ***Legislative Proposals and Medically Inappropriate Treatment (May Q21)***

Currently, there is a process that allows health care physicians and facilities to withdraw medically inappropriate treatment for patients. There are legislative proposals to require physicians and hospitals to continue treatment indefinitely if requested by the family or until transfer can be arranged to another health care facility and physician. Physicians agree this legislation will increase health care costs (84 percent) and patient suffering (72 percent). Few physicians support this legislation (12 percent).



### ***Brain Death (May Q22)***

According to Texas law, if artificial means of support preclude a determination that a person's spontaneous respiratory and circulatory functions have ceased, the person is dead when, in the announced opinion of a physician, according to the ordinary standards of medical practice there is irreversible cessation of all spontaneous brain function. Physicians believe Texas should not revise the definition of brain death (81 percent).

## **Scope of Practice**

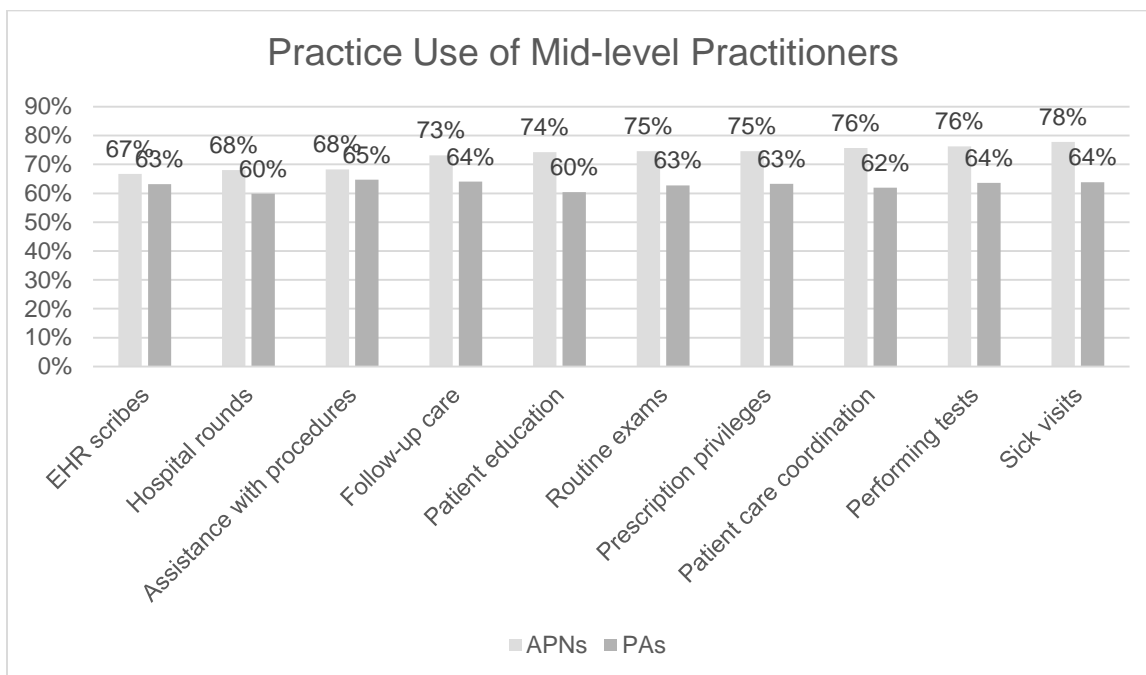
### ***Independent Mid-level Practitioners (June Q5)***

Eighty-three percent of physicians do **not** believe mid-level practitioners (APNs and PAs) should be permitted to independently diagnose patients and prescribe medicine.

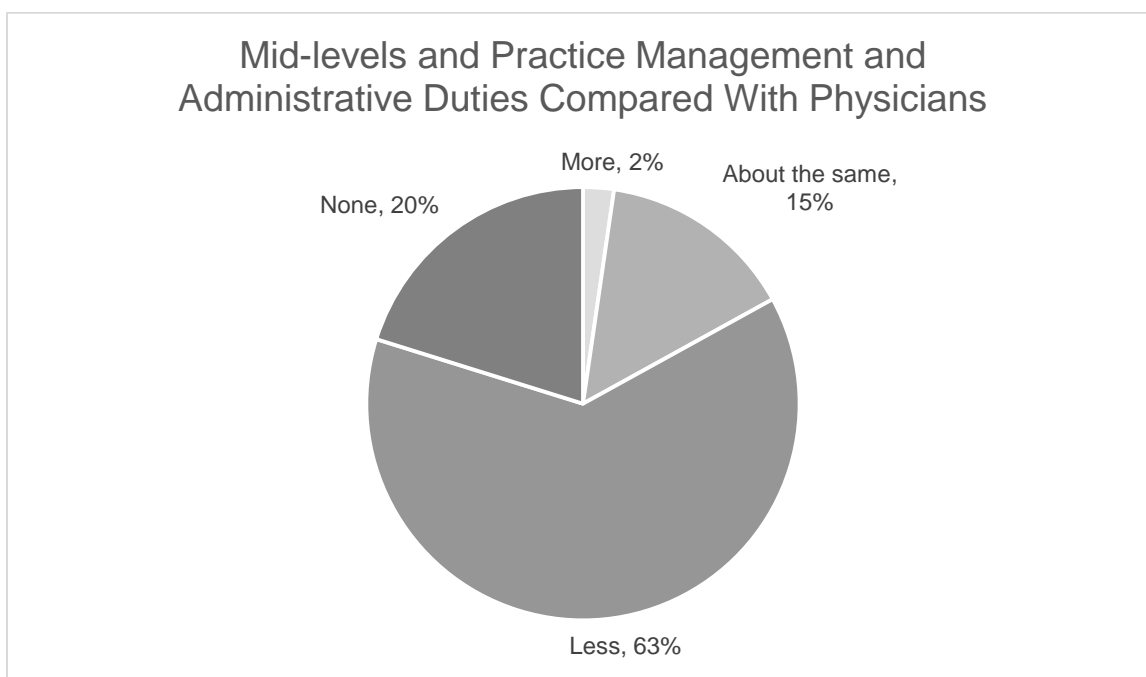
### ***Practice Use of Mid-level Practitioners (June Q6-9)***

Forty-two percent of physicians report their practice uses mid-level practitioners. The majority of these physicians use APNs and PAs for sick visits, performing tests, patient

care coordination, routine exams, patient education, follow-up care, assistance with procedures, hospital rounds, and as EHR scribes.



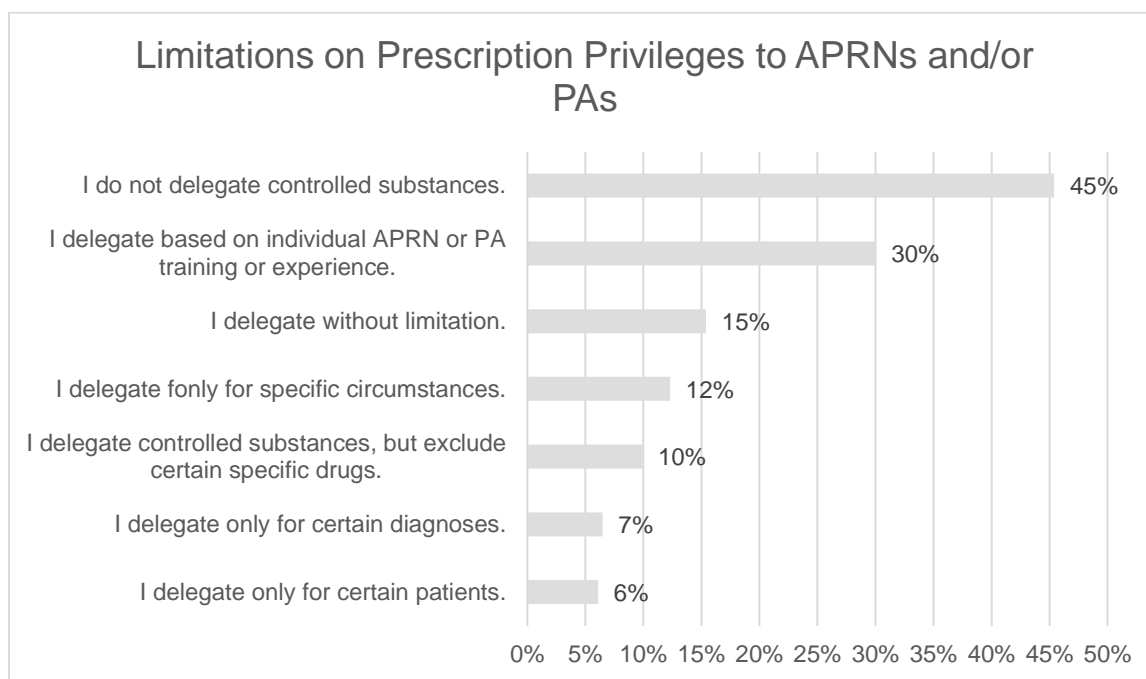
The mid-level practitioners are responsible for less than or no practice management and administrative duties (83 percent) allowing them to concentrate on clinical duties.



Efforts to permit mid-level practitioners to practice independently could have the unintended consequence of increasing practice management and administrative duties of mid-level practitioners thereby decreasing access to care for patients.

Twenty percent of physicians report their mid-level practitioners supervise other practice staff.

Physicians who delegate prescription privileges to APRNs and/or PAs were asked if they place any limitations. Forty-five percent do not delegate controlled substances. Thirty percent of physicians delegate based on individual APRN or PA training or experience.



## **Physician Demographics**

### ***Gender***

	<u>1990</u> %	<u>2000</u> %	<u>2002</u> %	<u>2004</u> %	<u>2006</u> %	<u>2008</u> %	<u>2010</u> %	<u>2012</u> %	<u>2014</u> %
Male	89	84	83	84	78	78	75	73	70
Female	11	16	17	16	22	22	25	27	30

### ***Age***

	<u>2010</u> %	<u>2012</u> %	<u>2014</u> %
40 and younger	21	19	18
41 to 50	27	23	22
51 to 60	33	32	27
61 and older	19	25	33

### ***Specialty***

	<u>2010</u> %	<u>2012</u> %	<u>2014</u> %
Indirect Access	14	15	16
Primary Care	25	26	30
Pediatrics	7	8	10
Obstetrics/Gynecology	7	7	7
Surgical Specialty	13	13	13
Non-surgical Specialty	33	32	24

### ***County***

	<u>2010</u> %	<u>2012</u> %	<u>2014</u> %
Bexar	9	8	9
Dallas	13	12	13
Harris	19	17	18
Tarrant	8	6	6
Travis	9	8	9
Rural	6	6	6
Metro	34	41	37
Rio Grande Valley	3	3	2

### ***TMA Membership Status***

	<u>2010</u> %	<u>2012</u> %	<u>2014</u> %
Member	87	86	83
Nonmember	13	14	17

## Survey Methodology

Since 1990, TMA has conducted a biennial survey of Texas physicians focusing primarily on health care practice, economic, and legislative issues. The survey findings provide a cross-sectional snapshot and a longitudinal tracking of physician opinions on key health care issues and their experiences to support the association's policy development, political focus, and strategic planning process.

The 2014 Survey of Texas Physicians was conducted by TMA as a monthly email survey. The survey contained a total of 208 questions, many with multiple response items. Not all questions were answered by all respondents due to skip patterns and the monthly design. The survey included a mix of closed-ended response items, Likert Scale, and open-ended response items. Many of the questions were structured for multiple choice or nominal scale responses.

Approximately 30,250 Texas physician and residents with email addresses in the TMA database were emailed a personalized link to the survey each month along with an announcement inviting them to participate and an incentive to answer the survey for the month with a larger incentive for completing every monthly survey of the year. Survey content was comprehensive, covering a broad range of physician opinion and experience and not limited to specific issues. There were no published links that allowed uninvited responses. Each link was unique and carried with it respondent demographic information. Each respondent was allowed to respond only once to the survey. Reminders requesting participation from physicians who did not answer the survey were emailed one week later. Responses were received by 4,280 Texas physicians, members and nonmembers of TMA.

Data was analyzed using SPSS statistical software. Open-ended responses were assigned to categories for analysis. In analysis, respondents are segregated by demographic variables and compared with the whole population. Results at the 95% confidence level are reported.

## APPENDIX — Survey Instrument

Practice Settings - January 2014

1. Do you currently treat patients in active medical practice?

- ☐ Yes
- ☐ No

If No Is Selected, Then Skip to Please rate the desirability, in your opinion...?

2. Which of the following best describes your primary form of medical practice?

- ☐ Group practice owner, co-owner, or shareholder
- ☐ Group practice employee
- ☐ Hospital employee
- ☐ Partnership
- ☐ Solo
- ☐ Resident
- ☐ Teaching, administration, or research
- ☐ Other (please specify): \_\_\_\_\_

Answer If Which of the following best describes your primary form of medical practice? Group practice owner, co-owner, or shareholder is Selected or Which of the following best describes your primary form of medical practice? Group practice employee is Selected or Which of the following best describes your primary form of medical practice? Partnership Is Selected

3. How many physicians are in your group or partnership? (Please enter an approximate number).

4. When you first started medical practice after residency, which of the following best described your primary form of medical practice?

- ☐ Group practice owner, co-owner, or shareholder
- ☐ Group practice employee
- ☐ Hospital employee
- ☐ Partnership
- ☐ Solo
- ☐ Teaching, administration, or research
- ☐ Other (please specify): \_\_\_\_\_
- ☐ Not applicable

5. Which of the following best describes the current ownership of your practice?
- ☐ Wholly owned by one or more physicians in the practice
  - ☐ Wholly owned by a hospital or hospital system including a non-profit health corporation (formerly known as a 5.01[a])
  - ☐ Jointly owned between physicians in the practice and a hospital or hospital system including a non-profit health corporation (formerly known as a 5.01[a])
  - ☐ Wholly owned by a for-profit organization
  - ☐ Wholly owned by a not-for-profit organization
  - ☐ Other (please specify): \_\_\_\_\_
  - ☐ I don't know
6. Who has authority for making practice management decisions in your practice? (Check all that apply).
- ☐ One or more physicians in the practice
  - ☐ A practice manager/administrator employed by the practice
  - ☐ A practice management organization or Physicians Services Organization (PSO) that is not owned by the practice
  - ☐ A HMO/Managed care organization
  - ☐ A hospital or hospital system
  - ☐ A not-for-profit organization
  - ☐ Other (please specify): \_\_\_\_\_
7. Which form of payment comprises the largest part of your personal income?
- ☐ A salary paid by my practice (reported on a W-2 form)
  - ☐ Contract payments (reported on an IRS 1099)
  - ☐ Other form of compensation
8. Is your compensation based on productivity?
- ☐ None
  - ☐ Some
  - ☐ All

9. Does a hospital or non-physician organization own, employ, or provide the following in your practice:

	No	Yes, for less than 2 years	Yes, for more than 2 years
Your office space	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your office equipment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other equipment in your practice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Professional liability insurance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Support staff	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. An Integrated Delivery System (IDS) is a network of organizations that provide, coordinate and/or arrange for the provision of a continuum of health care services to consumers that may be built through virtual integration processes encompassing direct ownership, contractual arrangements and strategic alliances. Does this describe your practice?

- ☐ Yes
- ☐ No

11. Are you in an Accountable Care Organization (ACO) or other clinical co-management arrangement?

- ☐ Yes
- ☐ No

Answer If Are you in an Accountable Care Organization (ACO) or other clinical co-management arrangement? Yes Is Selected

12. If yes, with who? (Check all that apply).

- ☐ A hospital
- ☐ Other physicians
- ☐ Other (please specify): \_\_\_\_\_

Answer If Are you in an Accountable Care Organization (ACO) or other clinical co-management arrangement? Yes Is Selected

13. Is your ACO participating in the Medicare shared savings program?

- ☐ Yes
- ☐ No
- ☐ I don't know



14. Are you participating in any alternative payment models (e.g., bundled payments)?

- ☐ Yes
- ☐ No
- ☐ I don't know

15. Do you feel that the structure, policies and relationships of your current medical practice impair your independence in making:

	Not At All	Occasionally	Frequently
Clinical decisions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Practice management decisions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

16. Do you feel you are at risk of losing your independence in clinical decision-making?

- ☐ Yes
- ☐ No

17. If physicians lose their ability to make independent clinical decisions, do you feel this is bad for:

	No	Yes
Physicians	<input type="radio"/>	<input type="radio"/>
Patients	<input type="radio"/>	<input type="radio"/>

18. Has your practice hired a new physician in the past year?

- ☐ Yes
- ☐ No

If Yes Is Selected, Then Skip to Have you seen cases where physicians...

19. Is your practice planning to hire a new physician in the next year?

- ☐ Yes
- ☐ No
- ☐ I don't know

If Yes Is Selected, Then Skip to Have you seen cases where physicians...

20. Would you hire a new physician if the economic environment was different?

- ☐ Yes
- ☐ No
- ☐ I don't know

Answer If Would you hire a new physician if the economic environment was different? Yes Is Selected

21. Please rate the following factors on how important they are in your decision not to hire a new physician.

	Not at all Important	Somewhat Unimportant	Somewhat Important	Very Important
Uncertainty regarding Medicare and/or Medicaid fees	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Uncertainty regarding health system reform	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Decline in patient demand	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Recruitment expense	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Few physicians interested in group practice employment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cost of maintaining an employed physician	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increasing prevalence of high deductible health plans and patient responsibility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (please specify):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

22. Have you seen cases where physicians lost employment, contracts, or hospital privileges because they raised issues about hospital regulatory compliance or patient care quality?

- ☐ Yes
- ☐ No

23. Are you concerned this could happen to you?

- ☐ Yes
- ☐ No

24. Please rate the desirability, in your opinion, of the following practice types for most NEW physicians:

	5 (Least Desirable)	4	3	2	1 (Most Desirable)
Solo practice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Immediate buy-in to an established medical practice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Employment in an established physician practice, with a subsequent option to buy in to ownership	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Employment by a nonprofit health organization partially owned by a hospital and run by physicians	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Employment by a hospital	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Employment by a state or federal agency	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Employment in academia or research	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## Electronic Health Records - February 2014

1. Which statement best describes the current status of your practice?

- ☐ We do not plan to implement an EHR.
- ☐ We want to implement or plan to implement an EHR.
- ☐ We currently use an EHR.

2. Why are you not planning to implement an EHR? (Check all that apply).

- ☐ Near retirement
- ☐ Cost-prohibitive
- ☐ No time for implementation and training
- ☐ Concerns about electronic system reliability
- ☐ Difficulty entering data
- ☐ No national standards
- ☐ Security, privacy, and liability concerns for myself or my patients
- ☐ Uncertainty regarding Medicare and/or Medicaid fees
- ☐ Uncertainty regarding the economy
- ☐ Uncertainty regarding the impact of health care reform
- ☐ Other (please specify): \_\_\_\_\_

3. Would any of the following convince you to implement an EHR? (Check all that apply).

- ☐ Less direct data entry or more versatile user interface (i.e., voice recognition or PDA entry)
- ☐ Greater flexibility in where and how I document
- ☐ Better/more efficient retrieval of needed information
- ☐ Grants or loans to help with implementation cost
- ☐ Health care payment plan reimbursement incentives (i.e., stimulus package, pay-for-performance)
- ☐ Help in selecting the appropriate system for my office
- ☐ Assistance in implementation and training
- ☐ Evidence that it would help improve the quality of patient care
- ☐ Evidence that it would reduce my liability risk
- ☐ Evidence that it would improve my practice operations
- ☐ A better EHR product than the ones I've seen so far
- ☐ Formal or informal standards that ensure that all systems can share information
- ☐ Help from the local hospital to implement a system that will interface with theirs
- ☐ Certainty regarding Medicare and/or Medicaid fees
- ☐ Other (please specify): \_\_\_\_\_

4. If you want to implement an EHR, how soon do you anticipate doing so?

- ☐ Between zero and six months
- ☐ Between six months and one year
- ☐ Between one and two years
- ☐ More than two years

Answer If you want to implement an EHR, how soon do you anticipate... More than two years is selected

5. Why will it take you more than two years to implement an EHR?

- ☐ Cost-prohibitive
- ☐ No time
- ☐ Uncertainty regarding Medicare and/or Medicaid fees
- ☐ Uncertainty regarding the economy
- ☐ Uncertainty regarding the impact of health care reform
- ☐ Other (please specify): \_\_\_\_\_

6. Which of the following services would you find helpful? (Check all that apply).

- ☐ A technology readiness assessment of my practice
- ☐ Suggestions of appropriate and effective EHR products
- ☐ Analysis of purchase and implementation costs
- ☐ A process to screen vendors
- ☐ Assistance to optimize new system efficiency and effectiveness
- ☐ Financial assistance
- ☐ Other (please specify): \_\_\_\_\_

7. Did your practice apply for Stage 1 Meaningful Use incentives?

- ☐ Yes, and we received them.
- ☐ Yes, and we expect to receive them.
- ☐ No, but we plan to apply.
- ☐ No, and we don't plan to apply.
- ☐ I don't know.

Answer If Did your practice apply for Stage 1 Meaningful Use incentives? Yes, and we received them. Is Selected or Did your practice apply for Stage 1 Meaningful Use incentives? Yes, and we expect to receive them. Is Selected or Did your practice apply for Stage 1 Meaningful Use incentives? No, but we plan to apply. Is Selected

8. Is your practice planning to advance to Stage 2 Meaningful Use?

- ☐ Yes
- ☐ No
- ☐ Don't know

9. Were you involved in the initial EHR selection for your practice?

☐ Yes

☐ No

If No Is Selected, Then Skip to Which type of EHR does your practice...

10. What resources did your practice use to make your EHR decision? (Check all that apply).

☐ National specialty societies

☐ Regional Extension Centers (RECs)

☐ American Medical Association (AMA)

☐ Certified product list

☐ TMA's EHR adoption tools

☐ TMA's Practice Consulting

☐ TMA's seminars

☐ EHR vendors

☐ Other physicians and colleagues

☐ Other (please specify): \_\_\_\_\_

☐ Don't know

11. When you implemented your EHR, from which of the following types of assistance would you have benefited? (Check all that apply).

☐ A technology readiness assessment of my practice

☐ Suggestions of appropriate and effective EHR products

☐ Analysis of purchase and implementation costs

☐ A process to screen vendors

☐ Assistance to optimize new system efficiency and effectiveness

☐ Financial assistance

☐ Other (please specify): \_\_\_\_\_

☐ Don't know

12. Which type of EHR does your practice use?

☐ Office-based only

☐ Office and hospital system

☐ Hospital system only

13. How long has your EHR been implemented?

- ☐ Between zero and six months
- ☐ Between six months and one year
- ☐ Between one and two years
- ☐ More than two years

14. Are you currently or do you plan to participate in a local health information exchange (HIE) in order to share EHR data among health care providers?

- ☐ Yes, we are participating now.
- ☐ Yes, we plan to participate.
- ☐ No.
- ☐ I don't know.

15. Which EHR system are you using?

- ☐ Allscripts
- ☐ Amazing Charts
- ☐ Athenahealth
- ☐ Centricity (GE)
- ☐ Cerner
- ☐ e-MDs
- ☐ eClinicalWorks
- ☐ EPIC
- ☐ Greenway/Vitera
- ☐ NextGen
- ☐ Practice Fusion
- ☐ Practice Partner (McKesson)
- ☐ Sevocity (Conceptual Mindworks)
- ☐ SpringCharts
- ☐ I only use a practice management system, e-prescribing system, hospital system, or home-grown system.
- ☐ Other (please specify vendor below): \_\_\_\_\_

16. How satisfied are you with your EHR system on the following:

	Very satisfied	Somewhat satisfied	Somewhat dissatisfied	Very dissatisfied
Reports and reporting ability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Effect on productivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Effect on patient care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Data entry and retrieval	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
EHR vendor support	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

17. Would you recommend this system to another practice?

- ☐ Yes  
☐ No

18. Does your practice use scribes for EHR data entry?

- ☐ Yes  
☐ No

Answer If Does your practice use scribes for EHR data entry? Yes Is Selected

19. Did your practice hire new staff as scribes, retrain existing staff, or do both?

- ☐ Hired new staff  
☐ Retrained existing staff  
☐ Both

20. Indicate your agreement with each of the following:

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
Data entry at the point of care disrupts a physician's diagnostic thought process	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Data entry process disrupts formation of the differential diagnosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Use of the EHR decreases attentiveness to the patient's presentation of signs and symptoms.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using an EHR creates data retrieval problems in reviewing patient's history	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



21. To what extent has your EHR saved you money?

- ☐ Significant losses
- ☐ Some losses
- ☐ Neither losses nor savings
- ☐ Some savings
- ☐ Significant savings

22. To what extent has your EHR improved the quality of patient care?

- ☐ Significantly worse
- ☐ Somewhat worse
- ☐ Neither worse nor improved
- ☐ Somewhat improved
- ☐ Significantly improved

23. Has your EHR been worth the effort, resources, and cost?

- ☐ Yes
- ☐ No

24. Were there unanticipated costs related to EHR implementation and use?

- ☐ Yes
- ☐ No
- ☐ Don't know

25. Have you used more than one EHR in your entire medical career?

- ☐ Yes
- ☐ No

Answer If Have you used more than one EHR in your entire medical career? Yes Is Selected

26. If so, please specify the make and/or the model of the best EHR you have used?

27. Are you currently reporting quality data for Medicare's Physician Quality Reporting System (PQRS) program from your EHR?

- ☐ Yes
- ☐ No
- ☐ Don't know

Access to Care - March 2014

1. In your opinion, what is the biggest challenge currently facing Texas physicians?

2. Do you currently treat patients in active medical practice?

☐ Yes

☐ No

If No Is Selected, Then Skip to Do you believe Texas should expand the...

3. In the past two years, how has your personal income from medical practice changed?

☐ Increased

☐ Decreased

☐ Stayed the same

4. In the past year, has your practice experienced any cash-flow problems due to slow payment, nonpayment, or underpayment of claims by insurers or government payers?

☐ Yes

☐ No

☐ Don't know

Answer If In the past year, has your practice experienced any cash-... Yes Is Selected

5. Did these cash-flow problems cause you to take any of the following actions? (Check all that apply.)

☐ Draw from personal funds to fund current practice operations

☐ Secure commercial loans to fund current practice operations

☐ Close or sell a practice

☐ Lay off or reduce employees, employee hours, or employee benefits

☐ Terminate or renegotiate plan contracts

☐ Reduce or terminate services to government payers

☐ Other (please specify): \_\_\_\_\_

6. Are you currently accepting any new patients?

☐ Yes

☐ No

Answer If Are you currently accepting any new patients? Yes Is Selected

7. For patients covered by the following payers, does your practice currently (1) accept all new patients, (2) limit new patients you will accept, or (3) accept no new patients?

	Accept All	Limit	Accept None
Medicare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medicare HMOs or Advantage plans	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medicare-Medicaid dual eligible	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medicaid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HMOs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PPOs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Uninsured or self-pay patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The military health care plan, TRICARE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CHIP plans	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Workers' compensation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. As a result of the ongoing problems with Medicare fee schedule updates, what actions are you taking, planning, or considering?

	Have Done	Will Do	Considering	Will Not Do
Place new or additional limits on Medicare acceptance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Accept no new Medicare patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Terminate existing Medicare patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Change status to Medicare nonparticipating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Formally opt out of Medicare and require direct payment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Place new or additional limits on MEDICAID acceptance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reduce the amount of charity care I deliver	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increase standard fees charged to other patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Delay information technology implementation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Renegotiate or terminate some health plan contracts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reduce staff compensation or benefits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9. Omitted

10. What is your practice policy regarding patients covered by the new Affordable Care Act (ACA) exchange plans?

- ☐ We will accept all exchange plan-covered patients.
- ☐ We will limit our acceptance of exchange plan patients.
- ☐ We will not accept new exchange plan patients.

Answer If What is your practice policy regarding patients covered by the new Affordable Care Act (ACA) exchange plans? We will limit our acceptance of exchange plan patients. Is Selected

11. What types of limits will your practice impose on acceptance of ACA exchange plans? (Check all that apply.)

- ☐ We will accept all patients enrolled in a plan with which we are contracted.
- ☐ We will keep our existing patients who enroll in exchange plans but will not take new exchange plan patients.
- ☐ We will accept patients out of network if we are not contracted with their plan but may not take assignment on claims.
- ☐ Other (please describe): \_\_\_\_\_

12. If you treat ACA exchange patients out of network, will you:

- ☐ Always bill patient directly
- ☐ Always take assignment on the claim
- ☐ Sometimes bill directly and sometimes take assignment

13. Are you aware of the 90-day grace period rule for health plans in the exchanges, which does not require health plans to pay claims for some enrolled patients who fail to pay their premiums?

- ☐ Yes
- ☐ No

14. Have you changed (or are you changing) your eligibility verification procedures for exchange plan enrollees?

- ☐ Yes (Please describe changes): \_\_\_\_\_
- ☐ No

15. Approximately what percentage of your practice revenues are derived from each of the following payers? (If you cannot estimate, you may leave this question blank, but please complete the rest of the survey.)

- \_\_\_\_\_ Medicare
- \_\_\_\_\_ Medicare HMOs or Advantage plans
- \_\_\_\_\_ Medicare capitated
- \_\_\_\_\_ Medicaid
- \_\_\_\_\_ Medicare-Medicaid dual eligible
- \_\_\_\_\_ CHIP
- \_\_\_\_\_ HMOs
- \_\_\_\_\_ PPOs - in network
- \_\_\_\_\_ PPO members out of network
- \_\_\_\_\_ Commercial capitated
- \_\_\_\_\_ Uninsured or self-pay patients
- \_\_\_\_\_ Workers' compensation plans

16. Does your practice belong to any of the following categories? (Check all that apply.)

- ☐ All or mostly cash or self-pay
- ☐ Concierge medicine
- ☐ Medicare opted-out
- ☐ Heavy Medicaid (i.e., population of 50 percent or greater)
- ☐ None of the above

17. Omitted

18. Omitted

19. Do you believe Texas should expand the Medicaid program to cover individuals earning up to \$14,856 (133 percent of poverty)?

- ☐ Yes, Texas should expand Medicaid.
- ☐ No, Texas should not expand Medicaid.
- ☐ Don't know/No opinion.

If Yes, Texas should expand Medicaid... Is Selected, Then Skip to End of Survey

Answer If Do you believe Texas should expand the Medicaid program to cover individuals earning up to \$14,856 (133 percent of poverty)? No, Texas should not expand Medicaid. Is Selected

20. In your opinion, what is the most important reason Texas should not expand the Medicaid program?

- ☐ Texas needs less government intrusion.
- ☐ There is too much fraud and abuse within the program.
- ☐ Texas Medicaid pay is inadequate.
- ☐ There is too much hassle and red tape within the program.
- ☐ There is too much waste in the program.
- ☐ The program is bankrupt.
- ☐ Expansion will increase health care costs.
- ☐ Expansion will increase government debt.
- ☐ Texas Medicaid does not provide essential health services or quality care.
- ☐ Expanding the program will raise taxes.
- ☐ There are not enough participating physicians in the program.
- ☐ Expansion will increase emergency department use and costs.
- ☐ Other (please specify): \_\_\_\_\_

21. If the Texas Medicaid program were reformed to reduce administrative burden and increase physician fees to Medicare parity, would you support the Medicaid expansion?

- ☐ Yes
- ☐ No
- ☐ Don't know/No opinion

If Yes Is Selected, Then Skip to End of Survey

22. Omitted

23. Omitted

## Contracts - April 2014

The physician or the practice administrator can complete this section. Please forward the survey email with corresponding link to the person best able to answer questions about practice contracts. Before starting, it will be helpful to collect the following data about your practice: The approximate number of health plan contracts

1. Is this section being completed by:

- ☐ Physician
- ☐ Practice administrator/ manager
- ☐ Other (please specify): \_\_\_\_\_

2. How many of the following do you have: (Please enter approximate numbers.)

HMO contracts?

PPO contracts?

Workers' comp contracts?

Medicare Advantage plan contracts?

Medicaid Managed Care contracts?

3. In 2013, were you contracted with?

	Yes	No	Don't know
Aetna	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blue Cross/Blue Shield	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cigna	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Community Health Choice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Community First	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
FirstCare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Humana	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Molina	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Scott & White	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sendero	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Superior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
United Healthcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. In the past two years, have you approached a plan with which you are not contracted in an attempt to join their network?

- ☐ Yes
- ☐ No
- ☐ Don't know

Answer If In the past two years, have you approached a plan with... Yes Is Selected

5. If yes, how have they responded to your request?

- ☐ No response
- ☐ Received an offer, but it was unacceptable
- ☐ Received a contract

6. In the past two years, have you or your representative attempted to negotiate the terms of any health plan contracts?

- ☐ Yes
- ☐ No
- ☐ Not applicable because I have no contracts
- ☐ Don't know

If Choice - No, Is Selected Then Skip to Have you terminated any health plan contracts in the past two years? \*If Not applicable because I ha... Is Selected, Then Skip to Have you terminated any health plan c... If Don't know Is Selected, Then Skip to Have you terminated any health plan c...

7. Who has attempted to negotiate the terms of a health plan contract? (Check all that apply.)

- ☐ Practice physician(s)
- ☐ Practice staff
- ☐ A consultant
- ☐ An Independent Physician Association (IPA) or a Physician's Hospital Organization (PHO)
- ☐ Other (please specify): \_\_\_\_\_

8. In the past two years, how often have you or your representative been successful in negotiating changes in a plan's contract language or payment terms?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always
- ☐ Don't know



9. In your most recent effort, what was the outcome of the attempt to get contract changes?

- ☐ Secured changes in contract payments
- ☐ Secured changes in contract terms
- ☐ Secured changes in both payments and contract terms
- ☐ No change in the contract
- ☐ Don't know

10. Have you terminated any health plan contracts in the past two years?

- ☐ Yes
- ☐ No
- ☐ Not applicable - I have no contracts
- ☐ Don't know

If No Is Selected, Then Skip To Are you participating in any new heal...If Not applicable - I have no ... Is Selected, Then Skip To Are you participating in any new heal...If Don't know Is Selected, Then Skip To Are you participating in any new heal...

11. If you have terminated health plan contracts, what was the reason? (Check all that apply.)

- ☐ Payment rate cuts imposed by the plan
- ☐ Payments that had not increased enough to cover practice costs
- ☐ Other payment problems such as claim denials, incorrect or late payment, or bundling
- ☐ Administrative burden imposed on practice by plan
- ☐ Requirements to participate in health insurance exchange plans
- ☐ Other (please specify): \_\_\_\_\_

12. If you have terminated health plan contracts, did your termination notice result in new or renewed contract negotiations that ultimately produced a new contract with no lapse in coverage?

- ☐ Yes, every time
- ☐ Yes, sometimes
- ☐ No

13. Are you participating in any new health insurance products sold on the exchange?

- ☐ Yes
- ☐ No
- ☐ Don't know

If No Is Selected, Then Skip to In your practice, do you have a method...If Don't know Is Selected, Then Skip to In your practice, do you have a method...

14. Which health insurance exchange plans are you participating in?

	None	Some	All	Don't know
Aetna	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blue Cross/Blue Shield	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cigna	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Community Health Choice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CommunityFirst	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
FirstCare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Humana HMO	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Humana EPO	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Molina	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Scott & White	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sendero	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Superior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
United Healthcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

15. Is the hospital you normally refer to in-network for the health insurance exchange plans you participate in?

- ☐ Yes
- ☐ No
- ☐ Don't know

16. In your practice, do you have a method to detect whether your contractual discounts have been accessed without your consent, as in a silent PPO?

- ☐ Yes
- ☐ No
- ☐ Not applicable - I have no contracts
- ☐ Don't know

Answer If In your practice, do you have a method to detect whether ... Yes Is Selected

17. If you have a method to detect unauthorized access to your contracted discounts, have you ever actually detected such activity?

- ☐ Yes
- ☐ No
- ☐ Don't know

18. Does your practice give out-of-network or uninsured patients a “prompt payment” discount if they pay in full for their services at the time of their visit or within some specific time frame?

- ☐ Yes
- ☐ No

19. When patients have some financial responsibility to pay for services (such as high deductibles or out-of-network payments), physicians and patients need specific information about the patient’s share of payment at the time of the service or in advance. How often is the necessary information available from the insurer?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

20. Have you detected cases where you are listed incorrectly in a health plan’s directory? (Check all that apply.)

- ☐ I was listed as a participating provider when I was not participating.
- ☐ I was not listed as a participating provider when I was participating.

Answer If Have you detected cases where you are listed incorrectly in a health plan’s directory? (Check all that apply.) I was listed as a participating provider when I was not participating. Is Selected or Have

you detected cases where you are listed incorrectly in a health plan's directory? (Check all that apply.) I was not listed as a participating provider when I was participating. Is Selected

21. Which of these health plans has listed you incorrectly in their directory? (Check all that apply.)

- ☐ Aetna
- ☐ Blue Cross/Blue Shield
- ☐ Cigna
- ☐ Community Health Choice
- ☐ Community First
- ☐ FirstCare
- ☐ Humana
- ☐ Molina
- ☐ Scott & White
- ☐ Sendero
- ☐ Superior
- ☐ United Healthcare
- ☐ Other (please specify): \_\_\_\_\_
- ☐ Don't know/ Don't remember

22. Have you experienced any of the following problems with assignment of benefits? (Check all that apply.)

- ☐ Payers refusing to honor assignment, resulting in plans paying patients instead of physicians.
- ☐ Payer asserting that assignment of benefits imposes a prohibition on balance billing.

Legislative Affairs - May 2014

1. What legislative, legal, and regulatory issues are most important to you as a physician?

	Not at all Important	Somewhat Unimportant	Somewhat Important	Very Important
Defending Texas' tort reforms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Opposing government intrusion in medical decisions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Opposing commercial payer intrusion in medical decisions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Opposing hospital management intrusion in medical decisions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Health plan hassles and prompt pay	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medicare payment adequacy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Easing restrictions on private contracting in Medicare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Revising or eliminating some or all provisions of the Affordable Care Act (ACA)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Covering the uninsured	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reducing administrative and regulatory burdens in medical practice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Antitrust protection for physicians	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Texas Medicaid payment adequacy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Texas Medical Board (TMB) regulation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reducing or eliminating state taxes on physician practices	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Preventing government-imposed price controls or balance billing limits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Preventing scope of practice expansion for non-physicians	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Remove the requirements for Medicare and Medicaid re-enrollment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Preserve the current provisions of the Texas Advanced Directive Act (TADA)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. Which of the following federal advocacy positions are most important to you as a physician?

	Very Unimportant	Somewhat Unimportant	Somewhat Important	Very Important
Eliminate bonuses AND penalties in Medicare's value-based payment modifier program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eliminate the federal physician ranking program to be reported on the "Physician Compare" website	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Revise all physician quality-of-care measures to eliminate penalties dependent on patient compliance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Require health plans to simplify verifications of eligibility for preventive care benefits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Require health plans to include "90-day grace period" information in all standard eligibility verifications	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Put ICD-10 on permanent hold	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eliminate penalties for Patient Quality Reporting System (PQRS) non-reporting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ensure that failure to report Medicare or Medicaid over payments is not treated as fraud	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. Do you support or oppose the following advocacy positions?

	Support	Oppose	Don't know
Restore physicians' rights to invest in health care facilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Require employers in Texas to provide workers' comp coverage for their employees	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Regulate e-cigarettes the same as other smoking products and limit minor access	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prohibit Medicaid pharmacies from selling cigarettes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Background checks on firearm purchases in all settings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Require retailers of pregnancy tests to post warnings about the dangers of Fetal Alcohol Syndrome	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Permit physicians to treat patients telephonically without a prior face-to-face visit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Enact a statewide ban on texting while driving	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Permit parents to know how many vaccine exemptions have been filed on their child's school campus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Require physicians to notify patients or surrogates when placing a DNR order	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Require EHR companies to maintain patient data for 7 years	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Repeal the ACA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. Omitted

5. Would you support or oppose the following measures to improve Medicare solvency?

	Support	Oppose	Don't Know
Increase Medicare eligibility age	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increase Medicare premiums for beneficiaries	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increase Medicare coinsurance and/or deductibles	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increase Medicare payroll taxes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cuts to physician fees	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cuts to hospital or other provider fees	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Incentives to physicians and hospitals to reduce total Medicare spending	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Penalties to physicians and hospitals who have high Medicare cost or utilization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provide beneficiaries with vouchers to purchase plans	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (please specify):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. To address high health-care cost and/or utilization of medical care services, do you support or oppose the following measures?

	Support	Oppose
Fee cuts to physicians whose Medicare patients use more medical services	<input type="radio"/>	<input type="radio"/>
Allow high-deductible insurance with spending accounts like Health Saving Accounts (HSAs)	<input type="radio"/>	<input type="radio"/>
Financial incentives for medical homes	<input type="radio"/>	<input type="radio"/>
Limits on the use of imaging equipment by physician specialty	<input type="radio"/>	<input type="radio"/>
Payment incentives and penalties based on reported clinical data on quality of care	<input type="radio"/>	<input type="radio"/>



7. Omitted
8. Omitted
9. Omitted

10. If the ACA had never been passed and you could start over to design solutions for individuals who are uninsured, would you support or oppose the following government measures?

	Support	Oppose
Expand Medicare to cover more people	<input type="radio"/>	<input type="radio"/>
Expand the Children's Health Insurance Program (CHIP) to cover more children	<input type="radio"/>	<input type="radio"/>
Expand Medicaid to cover low-income adults	<input type="radio"/>	<input type="radio"/>
Encourage greater enrollment in Medicaid or CHIP for children who currently are eligible	<input type="radio"/>	<input type="radio"/>
Provide financial assistance (like vouchers, tax credits, or subsidies) to help uninsured individuals buy coverage	<input type="radio"/>	<input type="radio"/>
Provide subsidies for high-risk pool premiums for individuals who are not insurable	<input type="radio"/>	<input type="radio"/>
More funding for outpatient charity clinics to provide free or reduced-price care	<input type="radio"/>	<input type="radio"/>
More direct funding for hospitals that provide charity care	<input type="radio"/>	<input type="radio"/>
Direct funding or subsidies for physicians who provide charity care	<input type="radio"/>	<input type="radio"/>
Federal income tax deductible for all medical expenses	<input type="radio"/>	<input type="radio"/>
Federal single-payer health insurance plan	<input type="radio"/>	<input type="radio"/>
A penalty or tax on individuals who do not purchase health insurance	<input type="radio"/>	<input type="radio"/>
A penalty or tax on employers who do not offer adequate health insurance	<input type="radio"/>	<input type="radio"/>

11. To assist patients with their out of pocket costs, do you currently: (Check all that apply.)

- ☐ Publish a complete list on your website or in patient information materials
- ☐ Publish your most frequently billed charges on your website or in patient information materials
- ☐ Give patients individual charges or possible payment ranges when they ask for them
- ☐ Routinely discuss with patients information about additional payment amounts that might be due when planning future tests or procedures
- ☐ Try to provide an estimate in advance based on your contract rate and the patient's out of pocket responsibility
- ☐ Tell patients to call their insurance company
- ☐ Have the patient discuss what they need to do with your administrative/billing staff
- ☐ Try to provide an estimate based on what the patient's insurance has historically paid you for the service(s) as the maximum allowed for your out of network services
- ☐ Other (please specify): \_\_\_\_\_

12. The Texas Legislature is likely to pass a bill next session requiring disclosure of prices of health care providers. Previous efforts to do so have included onerous provisions like prohibitions on balance billing. In an effort to avoid requirements that could be more intrusive and financially or administratively burdensome, would you support or oppose a requirement that you post or otherwise disclose your standard charges (not contract rates) for services that you frequently perform, retaining the right to offer discounts?

- ☐ Strongly oppose
- ☐ Somewhat oppose
- ☐ Somewhat support
- ☐ Strongly support

13. Omitted

14. Has your practice had a Medicare Recovery Audit Contractor (RAC) review?

- ☐ Yes
- ☐ No

If No Is Selected, Then Skip to Have you had problems with the Texas...

15. If so, how many?

16. What has been the impact of the RAC (financial recoupment of dollars, costly appeals process, and increased administrative burden) on your practice?

- ☐ No impact
- ☐ Cutbacks because of financial hardships due to RAC (e.g., limited services, reduced staff)
- ☐ Additional administrative responsibilities of clinical staff to respond to RAC
- ☐ Increased administrative costs to manage responses to RAC requests and/or appeals
- ☐ Employed additional staff or hired external resources to manage the RAC process
- ☐ Purchased or modified practice software
- ☐ Training and education
- ☐ Other (please specify): \_\_\_\_\_

17. Have you had problems with the Texas Medical Board (TMB)?

- ☐ Yes
- ☐ No

Answer If Have you had problems with the Texas Medical Board (TMB)? Yes Is Selected

18. If so, briefly describe the problems you have had:

19. Do you have end-of life-care discussions with patients? (Check all that apply.)

- ☐ Yes, I initiate them with all or most patients.
- ☐ Yes, I initiate them with some or certain patients.
- ☐ Yes, when a patient initiates them.
- ☐ No.

20. If a patient has advance directives, do you keep a copy or note its existence in the medical record?

- ☐ Yes
- ☐ No

21. Currently, there is a process that allows health care physicians and facilities to withdraw medically inappropriate treatment for patients. There are legislative proposals to require physicians and facilities to continue treatment indefinitely if

requested by the family or until transfer can be arranged to another health care facility and physician. Please rate the following statements regarding this legislation.

	Strongly Disagree (1)	2	3	4	Strongly Agree (5)
This legislation will increase health care costs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This legislation will increase patient suffering.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I support this legislation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

22. According to Texas law, if artificial means of support preclude a determination that a person's spontaneous respiratory and circulatory functions have ceased, the person is dead when, in the announced opinion of a physician, according to ordinary standards of medical practice, there is irreversible cessation of all spontaneous brain function. Should Texas revise the definition of brain death?

- ☐ Yes
- ☐ No

## Practice Description - June 2014

1. Did your practice pay the Texas franchise tax (also known as business or margins tax) in 2013?

- Yes
- No

Answer If Did your practice pay the Texas franchise tax (also known as business or margins tax) in 2013? Yes Is Selected

2. If yes, what was the total franchise tax liability per physician?  
\$

3. "Charity care" is medical care provided with prior knowledge that the patient will be unable to pay for services. Last year, what was the approximate dollar value of the charity care that you delivered personally, or was the per-physician average amount delivered in your practice? (Enter approximate dollar amount.)  
\$

4. Last year, what was the approximate dollar value of non-collectible debts, over and above charity care, attributable to medical services that you delivered personally, or were delivered per physician on average in your practice? (Enter approximate dollar amount.)  
\$

5. Do you believe mid-level practitioners (APNs and PAs) should be permitted to independently diagnose patients and prescribe medicine?

- Yes
- No

6. Does your practice use mid-level practitioners?

- Yes
- No

If No Is Selected, Then Skip to Have you experienced or seen cases where...

7. If so, how does your practice use them? (Select all that apply.)

	APNs	PAs
Patient care coordination	<input type="checkbox"/>	<input type="checkbox"/>
Patient education	<input type="checkbox"/>	<input type="checkbox"/>
Routine exams	<input type="checkbox"/>	<input type="checkbox"/>
Sick visits	<input type="checkbox"/>	<input type="checkbox"/>
Assistance with procedures	<input type="checkbox"/>	<input type="checkbox"/>
Performing tests	<input type="checkbox"/>	<input type="checkbox"/>
Follow-up care	<input type="checkbox"/>	<input type="checkbox"/>
EHR scribes	<input type="checkbox"/>	<input type="checkbox"/>
Prescription privileges	<input type="checkbox"/>	<input type="checkbox"/>
Hospital rounds	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify):	<input type="checkbox"/>	<input type="checkbox"/>

8. Are the mid-level practitioners in your practice responsible for more or less practice management and administrative duties than the physicians?

- More
- About the same
- Less
- None

9. Do your mid-level practitioners supervise other practice staff?

- Yes
- No

10. If you delegate prescription privileges to APRNs and/or PAs, do you place any limitations? (Select all that apply.)

- I do not delegate controlled substances.
- I delegate controlled substances, but I exclude certain specific drugs. (Please specify which drugs below): \_\_\_\_\_
- I delegate without limitation.
- I delegate only for certain diagnoses.
- I delegate only for certain patients.
- I delegate only for specific circumstances.
- I delegate based on individual APRN or PA training or experience.

11. Have you experienced or seen cases where physician supervision of mid-level practitioners has improved patient quality of care or prevented problems? If so, please describe:

If Have you experienced or see... Is Empty, Then Skip to End of Survey

12. Omitted  
13. Omitted

## Care Quality - July 2014

1. In the past year, has your practice experienced any specific cases in which the quality of patient care was adversely affected by the operating policies or utilization controls of a government program or private-sector health plan? (Check all that apply.)
  - Medicare
  - Medicaid
  - Health plans
  - Workers' compensation

Answer If In the past year, has your practice experienced any specific...? Medicare Is selected or In the past year, has your practice experienced any specific... Medicaid Is selected or In the past year, has your practice experienced any specific... Health plans Is Selected or In the past year, has your practice experienced any specific... Workers' compensation is selected

2. If you have seen damage to care quality, what were the causes? (Check all that apply.)

	Medicare	Medicaid	Managed Care	Workers' Comp
Inadequate access to primary care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inadequate specialist access	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delays in treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limited or tiered formularies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Denials or non-coverage for some procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limited or tiered networks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify below):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Has your practice participated in a quality improvement program for a carrier?
  - Yes
  - No

If No Is Selected, Then Skip To Novitas Solutions Inc. took over from...

4. If so, how much was the per physician bonus payment?
5. Which health plan is running the quality improvement program?
6. Novitas Solutions Inc. took over from TrailBlazer Enterprises as Texas' Medicare carrier in 2011. Has your practice experienced in problems with Novitas?
  - Yes
  - No



Answer If Novitas Solutions Inc. took over from TrailBlazer Enterprises as Texas' Medicare carrier in 2011.... Yes Is Selected

7. If so, what were the causes of problems your practice encountered with Novitas? (Check all that apply.)

- Enrollment problems
- Telephone support line busy or unavailable
- Excessive telephone hold times
- Heavy prepayment audits
- Administrative burden and paperwork
- Payment problems
- Inability to find answers to questions on Novitas website
- Excessive document requests
- Excessive payment recoupments
- Other (please specify): \_\_\_\_\_

8. Have you attempted to contact Novitas customer support by telephone?

- Yes
- No

If No Is Selected, Then Skip to Did you attempt to use the Novitas we...

9. In your most recent effort, how quickly did you get through?

- Immediately
- Under 30 seconds
- About 1 minute
- 2 - 5 minutes
- More than 5 minutes
- Not At All

10. In your most recent effort, how many times did you have to contact customer service before the problem was corrected?

- 1 time
- 2 times
- 3 times
- More than 3 times
- The problem is still not corrected

11. Please take a few minutes to evaluate the customer service representative from your most recent effort?

	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree
The Novitas representative quickly identified the problem.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The Novitas representative appeared knowledgeable and competent.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The Novitas representative helped me understand the cause(s) and solution to my problem.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The Novitas representative handled my problems with courtesy and professionalism.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The waiting time for having my question addressed was satisfactory.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My phone call was transferred to the person who could best answer my question.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12. What is your overall satisfaction with Novitas phone support?

- Very Dissatisfied
- Somewhat Dissatisfied
- Neutral
- Somewhat Satisfied
- Very Satisfied

13. Have you attempted to use the Novitas website?

- Yes
- No

Answer If Did you attempt to use the Novitas website? Yes Is Selected

14. Was sufficient information available on the Novitas website to answer your question?

- Yes
- No

15. Do you think the Center for Medicare & Medicaid Services (CMS) should re-evaluate Novitas as the Medicare Administrative Contractor?

- Yes
- No

16. Do you have practice privileges at a hospital?

- Yes
- No

If No Is Selected, Then Skip to Are there hospitals, Ambulatory Surgical...

17. Is the hospital in which you primarily practice owned partially or entirely by physicians?

- Yes
- No

18. Thinking about the hospital in which you primarily practice, please indicate your agreement with the following statements:

	Strongly Disagree (1)	2	3	4	Strongly Agree (5)
Hospital and medical staff work together to solve patient safety problems.	•	•	•	•	•
Hospital and medical staff work together to solve economic problems.	•	•	•	•	•
The hospital takes efforts to address physician concerns.	•	•	•	•	•
The working relationship between hospital and medical staff is cooperative.	•	•	•	•	•
Timely on-call coverage is generally available for all specialties.	•	•	•	•	•

19. In the past year, have there been any specific cases in your practice in which the quality of patient care was adversely affected by the policies or operations of a hospital or surgical facility?

- Yes
- No

Answer If In the past year, have there been any specific cases in... Yes Is Selected

20. If you have seen damage to care quality, what were the causes? (Check all that apply.)

- Scheduling delays
- Delays in implementing physician orders
- Errors in implementing physician orders
- Inadequate facility staffing
- Inconsistent facility staffing
- Inconsistencies in surgical settings or equipment
- Inadequate call coverage
- Other (please specify below): \_\_\_\_\_

21. Do your medical staff privileges at any hospital require you to accept patients who report to the emergency room without a physician?

- Yes
- No

22. Does the hospital reimburse you in some fashion for being on call or responding to emergency call for medically indigent patients?

- Yes
- No

23. Are there hospitals, Ambulatory Surgical Centers (ASCs), or other facilities in your area that are physician-owned?

- Yes
- No

If No Is Selected, Then Skip to End of Survey

24. Do you practice in any hospital, ASC, or other facility that is physician-owned?

- Yes
- No

Answer If Do you practice in any hospital, ASC, or other facility that is physician-owned? Yes Is Selected

25. Are you an owner or investor in the facility?

- Yes
- No

26. Please indicate your agreement with each of the following statements regarding physician-owned facilities in your community in comparison to other facilities offering comparable services:

	Strongly Disagree (1)	2	3	4	Strongly Agree (5)
The facility is a safer place for patients than others in the community.	•	•	•	•	•
The facility is a more convenient place for patients than others in the community.	•	•	•	•	•
The facility is less expensive for patients than others in the community.	•	•	•	•	•
The facility has improved the efficiency of my practice.	•	•	•	•	•

Omitted - August 2014

## Medicaid MCOs - September 2014

The following questions pertain to your experiences with Medicaid managed care. If you do not accept Medicaid, you may skip questions, but please continue through to the end of the survey. The more responses we receive, the better able we can evaluate differences by specialty and by region. Further, by completing the survey, you will be eligible for our incentives. As always, individual responses are confidential, and only aggregate results will be reported. Thank you in advance for your time and effort.

1. Do you treat Medicaid Health Maintenance Organization (HMO) patients?

Yes

No

Answer If Do you treat Medicaid Health Maintenance Organization (HMO) patients? No Is Selected

2. Why do you not treat Medicaid HMO patients?

Have not had the opportunity to contract or finalize a contract with a HMO

Efforts to contract with a HMO are rejected

Inadequate fees

Administrative complexity/burden

Prefer Medicaid fee-for-service

Practice does not accept Medicaid (fee-for-service or managed care)

Other (please specify): \_\_\_\_\_

3. What percentage of your patients are in

Medicaid HMOs?

Medicaid fee-for-service (FFS)?

4. Would you accept more Medicaid HMO patients if rates increased by 5 to 10 percent?

Yes

Maybe

No

Answer If Would you accept more Medicaid HMO patients if rates increased by 5 to 10 percent? No Is Selected

5. Would you accept more Medicaid HMO patients if rates increased by 10 percent or more?

Yes

No

6. How likely are you to accept more Medicaid HMO and/or Medicaid FFS patients if the following reforms are made?

	Very Unlikely	Somewhat Unlikely	Somewhat Likely	Very Likely
Incentive payments (e.g., becoming a medical home, achieving quality metrics, etc.)				
Decreased administrative burden (e.g., simplified Preferred Drug List, Prior Approval Process)				
Standardized Credentialing				
Other (please specify):				

7. What do you like about Medicaid HMOs? (Check all that apply.)

Certain or specific types of disease management (specify which):

\_\_\_\_\_

Care coordinators for patients with complex, chronic conditions

Alerts when certain patients are admitted to a hospital or an emergency department

Enhanced payment for quality of care or care management

Enhanced payments for after-hours care

Value added services for patients

Other (please specify): \_\_\_\_\_

None of the above

8. Do any Medicaid HMOs offer you fees that are:

	No	Yes	Don't know
Above the Medicaid FFS schedule			
Below the Medicaid FFS schedule			



9. Administrative burden has been identified as an issue when participating in Medicaid HMOs (STAR and STAR+PLUS). Rate how burdensome the following issues are when dealing with Medicaid HMOs.

	None	Some	Quite a Bit	An Extreme Amount
Eligibility verification				
Prior-authorization for medical services				
Recoupments				
Prescription drug process				
Coordination of benefits				
Paperwork				
Difficulty finding in-network specialty care (which specialties):				
HMO credentialing process				
Other (please specify):				

Answer If Administrative burden has been identified as an issue when participating in Medicaid HMOs (STAR... Prescription drug process - Some Is Selected or Administrative burden has been identified as an issue when participating in Medicaid HMOs (STAR... Prescription drug process - Quite a Bit Is Selected Or Administrative burden has been identified as an issue when participating in Medicaid HMOs (STAR... Prescription drug process - An Extreme Amount Is Selected

10. If obtaining prescription drugs are an issue, please specify which of the following are problematic. (Check all that apply.)

- ☐ Difficult to get prior-approval for non-preferred prescription drugs
- ☐ Time consuming to get prior-approval when required for prescription drugs
- ☐ Lack of communication between pharmacy, plan, and/or the agency
- ☐ Unclear with prescription drugs or drug classes require prior approval
- ☐ Pharmacies do not honor 72-hour emergency supply requirement
- ☐ Inability to communicate with a medical director when a non-preferred prescription drug is denied
- ☐ Other (please specify): \_\_\_\_\_

11. While there are differences among Medicaid HMOs, please provide an overall rating for Medicaid managed care with respect to the following:

	Very Unsatisfied	Somewhat Unsatisfied	Somewhat Satisfied	Very Satisfied
Access to specialists (please specify which):				
Coordination of care				
Reimbursement rates				
Ease of contract negotiation				
Other (please specify):				

12. Do you participate in any STAR HMOs? (STAR HMOs primarily cover pregnant women and children.)

Yes

No

If No Is Selected, Then Skip to Do you intend to contract with any ad...?

13. Please indicate which STAR HMOs you participate in. (Select all that apply.)

- ☐ Aetna Better Health
- ☐ Amerigroup
- ☐ Blue Cross Blue Shield of Texas
- ☐ CHRISTUS Health Plan
- ☐ Community First Health Plans
- ☐ Community Health Choice
- ☐ Cook Children's Health Plan
- ☐ Driscoll Children's Health Plan
- ☐ El Paso First
- ☐ FirstCare
- ☐ Molina Healthcare of Texas
- ☐ Parkland
- ☐ Right Care from Scott & White Health Plan
- ☐ Sendero Health Plans
- ☐ Seton Health Plan
- ☐ Superior Health Plan
- ☐ Texas Children's Health Plan
- ☐ United Community Health Plan
- ☐ UnitedHealthcare Community Plan

14. In the next year, do you plan to terminate one or more of your existing STAR HMO contracts?

Yes

No

If No Is Selected, Then Skip to Do you intend to contract with any additional...?

15. If you intend to terminate a Medicaid STAR HMO contract, please select the reason(s) why? (Check all that apply.)

☐ Inadequate payments

☐ Payment problems (i.e., claim denials, incorrect or late payments)

☐ Administrative burden (i.e., paperwork)

☐ Quality of care concerns (i.e., inadequate provider network, delays in treatment)

☐ Other (please specify): \_\_\_\_\_

16. With which STAR HMO(s) do you intend to terminate your contract?

17. Do you intend to contract with any Medicaid STAR HMOs in the next year?

Yes

Maybe

No

Answer If Do you intend to contract with any additional Medicaid STAR HMOs in the next year? Yes Is Selected or Do you intend to contract with any additional Medicaid STAR HMOs in the next year? Maybe Is Selected

18. Which one(s)?

19. Do you participate in STAR+PLUS HMOs? (STAR+PLUS HMOs primarily cover adults with disabilities.)

Yes

No

If No Is Selected, Then Skip to Do you intend to contract with any ad...?

20. Please indicate if you participate in STAR+PLUS HMOs, which primarily cover adults with disabilities. (Select all that apply.)

- ☐ Amerigroup
- ☐ Bravo Health
- ☐ HealthSpring
- ☐ Molina Healthcare of Texas
- ☐ Superior Health Plan
- ☐ United Community Health Plan

21. In the next year, do you intend to terminate one or more of your existing STAR+PLUS HMO contracts?

Yes

No

If No Is Selected, Then Skip to Do you intend to contract with any ad...?

22. If you intend to terminate a Medicaid STAR+PLUS HMO contract, please select the reason(s) why? (Check all that apply.)

- ☐ Inadequate payments
- ☐ Payment problems (i.e., claim denials, incorrect or late payments)
- ☐ Administrative burdens (i.e., paperwork)
- ☐ Quality of care concerns (i.e., inadequate provider network, delays in treatment)
- ☐ Other (please specify): \_\_\_\_\_

23. With which Medicaid STAR+HMO(s) do you intend to terminate your contract?

24. Do you intend to contract with any Medicaid STAR+PLUS HMOs in the next year?

Yes

Maybe

No

Answer If Do you intend to contract with any additional Medicaid STAR+PLUS HMOs in the next year? Yes Is Selected or Do you intend to contract with any additional Medicaid STAR+PLUS HMOs in the next year? Maybe Is Selected

25. Which one(s)?

26. Texas Medicaid managed care provide this definition for a service coordinator: a nurse, social worker, or other staff member who will work directly with plan members, family members, doctors, and community supports to make sure all health

care and long-term services and support needs are met. Has your practice used the STAR+PLUS service coordinators?

Yes

No

I don't know

I didn't know STAR+PLUS plans offered service coordination.

If No Is Selected, Then Skip to Do you have practice privileges in an emergency...If I don't know Is Selected, Then Skip to Do you have practice privileges in an emergency...If I didn't know STAR+PLUS plan... Is Selected, Then Skip to Do you have practice privileges in an emergency...?

27. How do you use the service coordinators? (Check all that apply.)

- ☐ The service coordinator initiated contact with the practice on behalf of the patient.
- ☐ The practice initiated contact with the service coordinator on behalf of the patient.
- ☐ A patient initiated contact with the service coordinator.
- ☐ I don't know
- ☐ Other (please specify): \_\_\_\_\_

28. Did the service coordinator result in improved patient care?

Yes

No

Don't know

29. Do you have practice privileges in an emergency department (ED)?

Yes

No

Answer If Do you have practice privileges in an emergency department (ED)? Yes Is Selected

30. If so, does the ED have staff, policies, and/or programs in place to direct patients to community providers when emergency care is not appropriate?

Yes

No

Don't know