TMA 2014 Physician Survey

Research Findings
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Low/Declining pay</td>
<td>15%</td>
<td>32%</td>
<td>28%</td>
<td>31%</td>
<td>43%</td>
<td>33%</td>
<td>38%</td>
<td>21%</td>
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<tr>
<td>Health system reform</td>
<td>&lt;1%</td>
<td>3%</td>
<td>&lt;1%</td>
<td>3%</td>
<td>2%</td>
<td>18%</td>
<td>11%</td>
<td>16%</td>
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<tr>
<td>Admin burden</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Third-party interference</td>
<td>2%</td>
<td>9%</td>
<td>6%</td>
<td>7%</td>
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<td>11%</td>
<td>15%</td>
<td>10%</td>
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<tr>
<td>Health info tech</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Economic survival</td>
<td>&lt;1%</td>
<td>3%</td>
<td>9%</td>
<td>13%</td>
<td>15%</td>
<td>16%</td>
<td>12%</td>
<td>7%</td>
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<tr>
<td>Corporate practice</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6%</td>
</tr>
<tr>
<td>Quality/Access</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
<td>7%</td>
<td>2%</td>
<td>4%</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Uninsured/Underinsured</td>
<td>3%</td>
<td>2%</td>
<td>6%</td>
<td>11%</td>
<td>10%</td>
<td>5%</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>Managed care/insurers</td>
<td>44%</td>
<td>16%</td>
<td>9%</td>
<td>9%</td>
<td>7%</td>
<td>2%</td>
<td>2%</td>
<td>3%</td>
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<tr>
<td>Scope</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Supply</td>
<td>2%</td>
<td>2%</td>
<td>3%</td>
<td>3%</td>
<td>2%</td>
<td>3%</td>
<td>1%</td>
<td>1%</td>
</tr>
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<td>6%</td>
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<td>2%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>TX Med Board</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>5%</td>
<td>3%</td>
<td>2%</td>
<td>6%</td>
<td>8%</td>
<td>5%</td>
<td>6%</td>
<td>6%</td>
</tr>
</tbody>
</table>
Practice Viability

- Findings specific to the economic and business issues faced by physician practices.
Two Year Change in Personal Income from Medical Practice

- Decreased
- Stayed the same
- Increased

Yearly Breakdown:
- 2006: 55% Decreased, 29% Stayed the same, 16% Increased
- 2008: 61% Decreased, 28% Stayed the same, 11% Increased
- 2010: 61% Decreased, 27% Stayed the same, 12% Increased
- 2012: 60% Decreased, 27% Stayed the same, 14% Increased
- 2014: 61% Decreased, 27% Stayed the same, 13% Increased
Cash Flow Problems Due to Slow Pay, Nonpay, or Underpayment of Claims by Insurers or Government Payers

- Yes, 61%
- No, 21%
- Don't know, 18%
<table>
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<tr>
<th>Response to Cash Flow Problems</th>
<th>2002 %</th>
<th>2004 %</th>
<th>2006 %</th>
<th>2008 %</th>
<th>2010 %</th>
<th>2012 %</th>
<th>2014 %</th>
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<tbody>
<tr>
<td>Reduce employees/hours/benefits</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>33</td>
<td>27</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Draw from personal funds</td>
<td>46</td>
<td>68</td>
<td>39</td>
<td>33</td>
<td>51</td>
<td>52</td>
<td>40</td>
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<td>Reduce services to gov’t payers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>20</td>
<td>28</td>
<td>27</td>
</tr>
<tr>
<td>Terminate/Renegotiate contracts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>23</td>
<td>21</td>
<td>27</td>
</tr>
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<td>Secure commercial loans</td>
<td>33</td>
<td>46</td>
<td>32</td>
<td>22</td>
<td>33</td>
<td>26</td>
<td>23</td>
</tr>
<tr>
<td>Close/Sell practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>19</td>
<td>17</td>
<td>14</td>
</tr>
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<td>---------------------------------------------</td>
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</tr>
<tr>
<td>Solo</td>
<td>50%</td>
<td>32%</td>
<td>42%</td>
<td>40%</td>
<td>44%</td>
<td>40%</td>
<td>34%</td>
</tr>
<tr>
<td>Grp practice owner, co-owner, or shareholder</td>
<td>24%</td>
<td>20%</td>
<td>28%</td>
<td>24%</td>
<td>25%</td>
<td>28%</td>
<td>28%</td>
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<tr>
<td>Grp practice employee</td>
<td>20%</td>
<td>13%</td>
<td>15%</td>
<td>13%</td>
<td>14%</td>
<td>18%</td>
<td>13%</td>
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<tr>
<td>Partner</td>
<td>10%</td>
<td>9%</td>
<td>9%</td>
<td>11%</td>
<td>7%</td>
<td>9%</td>
<td>8%</td>
</tr>
<tr>
<td>Teach/Admin/Research</td>
<td>7%</td>
<td>5%</td>
<td>5%</td>
<td>7%</td>
<td>6%</td>
<td>7%</td>
<td>5%</td>
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<tr>
<td>Hospital employee</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Resident</td>
<td>7%</td>
<td>0.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>16%</td>
<td>5%</td>
<td>4%</td>
<td>6%</td>
<td>4%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>Grp prac owner</td>
<td>Grp prac employee</td>
<td>Hosp employee</td>
<td>Partner</td>
<td>Solo</td>
<td>Resident</td>
<td>Teach/Admin/Research</td>
</tr>
<tr>
<td>----------------</td>
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<td>---------------</td>
<td>---------</td>
<td>------</td>
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<td>----------------------</td>
</tr>
<tr>
<td>Total</td>
<td>22%</td>
<td>22%</td>
<td>7%</td>
<td>4%</td>
<td>29%</td>
<td>1%</td>
<td>8%</td>
</tr>
<tr>
<td>Bexar</td>
<td>22%</td>
<td>21%</td>
<td>5%</td>
<td>3%</td>
<td>31%</td>
<td>1%</td>
<td>12%</td>
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<tr>
<td>Dallas</td>
<td>27%</td>
<td>18%</td>
<td>5%</td>
<td>5%</td>
<td>26%</td>
<td>1%</td>
<td>12%</td>
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<tr>
<td>Harris</td>
<td>19%</td>
<td>22%</td>
<td>7%</td>
<td>3%</td>
<td>30%</td>
<td>3%</td>
<td>11%</td>
</tr>
<tr>
<td>Tarrant</td>
<td>22%</td>
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<td>6%</td>
<td>30%</td>
<td>0%</td>
<td>8%</td>
</tr>
<tr>
<td>Travis</td>
<td>23%</td>
<td>32%</td>
<td>5%</td>
<td>6%</td>
<td>23%</td>
<td>0%</td>
<td>7%</td>
</tr>
<tr>
<td>Rural</td>
<td>16%</td>
<td>22%</td>
<td>15%</td>
<td>6%</td>
<td>34%</td>
<td>0%</td>
<td>7%</td>
</tr>
<tr>
<td>Metro</td>
<td>21%</td>
<td>21%</td>
<td>10%</td>
<td>4%</td>
<td>29%</td>
<td>1%</td>
<td>6%</td>
</tr>
<tr>
<td>Rio Grande Valley</td>
<td>25%</td>
<td>15%</td>
<td>5%</td>
<td>3%</td>
<td>48%</td>
<td>0%</td>
<td>3%</td>
</tr>
</tbody>
</table>
Practice Size

- 1 to 3, 63%
- 4 to 8, 12%
- 9 to 49, 14%
- 50 or more, 11%
Current Practice Ownership

- Wholly owned by one or more physicians in the practice, 66%
- Wholly owned by a hospital, including a NPHC, 11%
- Jointly owned between physicians in the practice and a hospital, including a NPHC, 2%
- Wholly owned by a for-profit org, 6%
- Wholly owned by a not-for-profit org, 9%
- Other, 6%

Wholly owned by one or more physicians in the practice, 66%
Practice Management Authority

- One or more physicians in the practice: 76%
- A practice manager/administrator employed by the practice: 22%
- A hospital or hospital system: 14%
- A not-for-profit organization: 6%
- A practice management organization or PSO not owned by the practice: 3%
- A HMO/managed care organization: 1%
- Other: 4%
Physician Practice Type and Productivity-based Compensation

<table>
<thead>
<tr>
<th>Category</th>
<th>None</th>
<th>Some</th>
<th>All</th>
</tr>
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<tbody>
<tr>
<td>Total</td>
<td>25%</td>
<td>32%</td>
<td>43%</td>
</tr>
<tr>
<td>Solo</td>
<td>23%</td>
<td>11%</td>
<td>66%</td>
</tr>
<tr>
<td>Partner</td>
<td>20%</td>
<td>22%</td>
<td>58%</td>
</tr>
<tr>
<td>Grp prac owner</td>
<td>12%</td>
<td>33%</td>
<td>55%</td>
</tr>
<tr>
<td>Grp prac employee</td>
<td>26%</td>
<td>45%</td>
<td>29%</td>
</tr>
<tr>
<td>Other</td>
<td>57%</td>
<td>29%</td>
<td>15%</td>
</tr>
<tr>
<td>Hosp employee</td>
<td>32%</td>
<td>57%</td>
<td>11%</td>
</tr>
<tr>
<td>Teach/Admin/Research</td>
<td>33%</td>
<td>65%</td>
<td>2%</td>
</tr>
<tr>
<td>Resident</td>
<td>81%</td>
<td>19%</td>
<td>0%</td>
</tr>
</tbody>
</table>
ACO Participation in the Medicare Shared Savings Program

- Yes, 55%
- No, 8%
- Don’t know, 37%

Note: 18 percent practice in an ACO or clinical co-management arrangement.
Note: 52 percent of physicians feel they are at risk of losing their independence in clinical decision-making and 98 percent agree if they lose their ability to make independent clinical decisions, it is bad for physicians and patients.
Percentage of Practices Planning to Hire a New Physician in the Next Year
(Among the 55 percent of physicians whose practice has not hired in the past year.)

- Yes, 16%
- Don't know, 18%
- No, 66%
Economic Factors Important in Practice Decision Not to Hire a New Physician

<table>
<thead>
<tr>
<th>Factor</th>
<th>Not at all Important</th>
<th>Somewhat Unimportant</th>
<th>Somewhat Important</th>
<th>Very Important</th>
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<tr>
<td>Cost of maintaining an employed physician</td>
<td></td>
<td>4%</td>
<td>15%</td>
<td>76%</td>
</tr>
<tr>
<td>Uncertainty regarding health system reform</td>
<td></td>
<td>4%</td>
<td>18%</td>
<td>74%</td>
</tr>
<tr>
<td>Uncertainty regarding Medicare and/or Medicaid fees</td>
<td></td>
<td>7%</td>
<td>6%</td>
<td>20%</td>
</tr>
<tr>
<td>Increasing prevalence of high deductible health plans and patient responsibility</td>
<td></td>
<td>13%</td>
<td>11%</td>
<td>30%</td>
</tr>
<tr>
<td>Recruitment expense</td>
<td></td>
<td>19%</td>
<td>15%</td>
<td>31%</td>
</tr>
<tr>
<td>Decline in patient demand</td>
<td></td>
<td>25%</td>
<td>15%</td>
<td>26%</td>
</tr>
<tr>
<td>Few physicians interested in group practice employment</td>
<td></td>
<td>28%</td>
<td>24%</td>
<td>30%</td>
</tr>
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</table>
### Desirability of Practice Types for Most New Physicians

<table>
<thead>
<tr>
<th>Practice Type</th>
<th>5 (Least Desirable)</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1 (Most Desirable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment in established phys prac with subsequent option to buy in</td>
<td>4%</td>
<td>7%</td>
<td>19%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Immediate buy-in to an established medical practice</td>
<td>13%</td>
<td>18%</td>
<td>29%</td>
<td>26%</td>
<td>15%</td>
</tr>
<tr>
<td>Employment by a NPHC partially owned and run by physicians</td>
<td>10%</td>
<td>17%</td>
<td>33%</td>
<td>28%</td>
<td>12%</td>
</tr>
<tr>
<td>Solo practice</td>
<td>36%</td>
<td>21%</td>
<td>19%</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>Employment in academia or research</td>
<td>9%</td>
<td>20%</td>
<td>40%</td>
<td>23%</td>
<td>9%</td>
</tr>
<tr>
<td>Employment by a hospital</td>
<td>22%</td>
<td>19%</td>
<td>29%</td>
<td>22%</td>
<td>8%</td>
</tr>
<tr>
<td>Employment by a state or federal agency</td>
<td>30%</td>
<td>23%</td>
<td>29%</td>
<td>13%</td>
<td>5%</td>
</tr>
</tbody>
</table>

**Legend:**
- 5 (Least Desirable)
- 4
- 3
- 2
- 1 (Most Desirable)
Physician Ratings of Desirability of Selected Practice Types for Most New Physicians by Age

- **Employ in est phys prac, with opt to buy-in**
  - Age 40 and younger: 76%
  - Age 41 to 50: 70%
  - Age 51 to 60: 69%
  - Age 61 and older: 65%

- **Immediate buy-in to an est prac**
  - Age 40 and younger: 47%
  - Age 41 to 50: 42%
  - Age 51 to 60: 38%
  - Age 61 and older: 42%

- **Employ by NPHC partially owned by hosp, run by phys**
  - Age 40 and younger: 41%
  - Age 41 to 50: 42%
  - Age 51 to 60: 42%
  - Age 61 and older: 36%

- **Hosp employ**
  - Age 40 and younger: 41%
  - Age 41 to 50: 32%
  - Age 51 to 60: 29%
  - Age 61 and older: 25%

- **Solo**
  - Age 40 and younger: 26%
  - Age 41 to 50: 27%
  - Age 51 to 60: 21%
  - Age 61 and older: 17%
Electronic Health Records

EHR Status

2014
- 19% We do not plan to implement an EHR.
- 12% We want or plan to implement an EHR.
- 69% We currently use an EHR.

2012
- 18% We do not plan to implement an EHR.
- 22% We want or plan to implement an EHR.
- 60% We currently use an EHR.

2009
- 19% We do not plan to implement an EHR.
- 30% We want or plan to implement an EHR.
- 51% We currently use an EHR.
Practices with No Plans to Implement an EHR
Reasons Physicians Are Not Planning to Implement an EHR

- Cost-prohibitive: 64%
- Near retirement: 55%
- Security, privacy, and liability concerns: 42%
- Concerns about electronic system reliability: 35%
- Difficulty entering data: 34%
- No national standards: 33%
- Not time for implementation and training: 31%
- Uncertainty regarding the economy: 30%
- Uncertainty regarding health care reform: 28%
- Uncertain Medicare/Medicaid fees: 23%
Incentives to Implement an EHR

- Evidence it would improve pract ops: 46%
- Evidence it would improve patient care quality: 46%
- A better EHR product than ones I've seen so far: 36%
- Less direct data entry/more versatile user interface: 29%
- Greater flexibility in where/how document: 26%
- Grants/Loans to help with implementation cost: 25%
- Standards to ensure all systems can share info: 24%
- Implementation/Training assistance: 23%
- Evidence it would reduce liability risk: 23%
- Help selecting appropriate system for my office: 21%
- Certainty regarding Medicare/Medicaid fees: 20%
- Better/More efficient retrieval of information: 19%
- Plan reimbursement incentives: 17%
- Help from hospital...a system that will interface with theirs: 16%
Practices with Plans to Implement an EHR
Between 0 and 6 months, 35%

Between 1 and 2 years, 26%

Between 6 months and 1 year, 33%

More than 2 years, 7%

Time Physicians Anticipate Their Practice Will Implement an EHR
Reason It Will Take Some Practices More Than Two Years to Implement an EHR

- Cost-prohibitive: 55%
- Uncertainty regarding the impact of health care reform: 9%
- No time: 9%
Helpful Services to Physician Practices With Plans to Implement an EHR

- Suggestions of appropriate and effective EHR products: 61%
- Assistance to optimize new system efficiency/effectiveness: 52%
- Analysis of purchase and implementation costs: 46%
- A process to screen vendors: 40%
- Financial assistance: 39%
- A tech readiness assessment of my practice: 31%
Practices Which Have Implemented an EHR
Practice Application for Stage 1 Meaningful Use Incentives

- Yes, and we received them., 43%
- Yes, and we expect to receive them., 16%
- No, but we plan to apply., 5%
- No and we don't plan to apply., 11%
- I don't know., 25%
Practice Plans to Advance to Stage 2 Meaningful Use

- Yes, 80%
- No, 4%
- Don’t know, 16%
Resources Physician Practices Used to Make EHR Decision

- EHR vendors: 56%
- Physicians and colleagues: 53%
- Certified product list: 22%
- National specialty societies: 16%
- TMA's EHR adoption tools: 7%
- TMA's seminars: 6%
- Regional extension centers: 3%
- American Medical Association: 2%
- TMA's Practice Consulting: 2%
- Other: 17%
- Don't know: 4%
Types of Assistance Beneficial When Implementing an EHR

- Suggestions of appropriate and effective EHR products: 48%
- Assistance to optimize new system efficiency and effectiveness: 47%
- Analysis of purchase and implementation costs: 41%
- A process to screen vendors: 35%
- Financial assistance: 33%
- A tech readiness assessment of practice: 30%
- Don't know: 9%
Type of EHR Used by Practice

- Office-based only, 62%
- Office and hospital system, 25%
- Hospital system only, 13%
Between 0 and 6 months, 7%
Between 6 months and 1 year, 10%
Between 1 and 2 years, 17%
More than 2 years, 67%
Yes, we are participating now., 15%
Yes, we plan to participate., 22%
No., 22%
I don't know., 42%
Physician Satisfaction with EHR

- Date entry and retrieval: 23% Very satisfied, 41% Somewhat satisfied, 21% Somewhat dissatisfied, 14% Very dissatisfied
- Reports and reporting ability: 23% Very satisfied, 43% Somewhat satisfied, 22% Somewhat dissatisfied, 12% Very dissatisfied
- Effect on patient care: 22% Very satisfied, 43% Somewhat satisfied, 21% Somewhat dissatisfied, 15% Very dissatisfied
- EHR vendor support: 21% Very satisfied, 42% Somewhat satisfied, 21% Somewhat dissatisfied, 16% Very dissatisfied
- Effect on productivity: 17% Very satisfied, 30% Somewhat satisfied, 24% Somewhat dissatisfied, 29% Very dissatisfied
Practice Staff As Scribes
(Among 21 percent of practices which use scribes)

- Hired new staff, 19%
- Retrained existing staff, 47%
- Both, 34%
Data entry process disrupts formation of differential diagnosis.

Use of EHR decreases attentiveness to patient’s presentation of signs and symptoms.

Data entry at point of care disrupts physician’s diagnostic thought process.

Using an EHR creates data retrieval problems in reviewing patient’s history.
Significant losses, 22%
Some losses, 25%
Neither losses nor savings, 36%
Some savings, 12%
Significant savings, 6%
Significantly worse, 8%

Somewhat worse, 17%

Neither worse nor improved, 39%

Somewhat improved, 27%

Significantly improved, 9%
Unanticipated Costs Related to EHR Implementation and Use

- Yes, 60%
- No, 11%
- Don't know, 29%
Physician Participation in Medicare's PQRS Program

- Yes, 46%
- No, 23%
- Don't know, 31%
The majority of physicians offer discounts to uninsured patients when they pay promptly for the services they receive (63 percent).
<table>
<thead>
<tr>
<th>Item</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give patients charges/pay ranges when they ask for them.</td>
<td>64%</td>
</tr>
<tr>
<td>Have patients discuss what they need to do with billing/admin staff</td>
<td>64%</td>
</tr>
<tr>
<td>Try to estimate insurance payment and net patient liability in advance.</td>
<td>53%</td>
</tr>
<tr>
<td>Provide an estimate in advance based on contract rate and patient’s out-of-pocket</td>
<td>53%</td>
</tr>
<tr>
<td>Discuss with patients information about amounts that might be due when planning future tests/procs</td>
<td>49%</td>
</tr>
<tr>
<td>Tell patients to call insurance company</td>
<td>48%</td>
</tr>
<tr>
<td>Provide estimate based on patient's insurance has historically paid you for service(s)</td>
<td>37%</td>
</tr>
<tr>
<td>Publish most frequently billed charges.</td>
<td>6%</td>
</tr>
<tr>
<td>Publish a complete list.</td>
<td>6%</td>
</tr>
</tbody>
</table>
Practice Revenues by Payer

- PPOs — in network: 18%
- Medicare: 16%
- Uninsured or self-pay patients: 8%
- Medicaid: 7%
- HMOs: 5%
- Medicare HMOs or Advantage plans: 4%
- PPO members out of network: 2%
- Medicare-Medicaid dual eligible: 2%
- Commercial cap: 2%
- Workers’ compensation plans: 2%
- CHIP: 1%
- Medicare capitated: 1%
Health Plans
Median Number of Managed Care Contracts

<table>
<thead>
<tr>
<th>Service Type</th>
<th>2010</th>
<th>2012</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers' comp</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medicaid Managed Care</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medicare Advantage plan</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>HMO</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>PPO</td>
<td>10</td>
<td>10</td>
<td>6</td>
</tr>
</tbody>
</table>
Percentage of Texas Physicians with Contracts with Payers

- **Blue Cross/Blue Shield**
  - 2007: 88%
  - 2009: 87%
  - 2011: 86%
  - 2013: 89%

- **United Healthcare**
  - 2007: 83%
  - 2009: 83%
  - 2011: 84%
  - 2013: 81%

- **Cigna**
  - 2007: 75%
  - 2009: 78%
  - 2011: 81%
  - 2013: 78%

- **Aetna**
  - 2007: 78%
  - 2009: 81%
  - 2011: 82%
  - 2013: 81%

- **Humana**
  - 2007: 75%
  - 2009: 77%
  - 2011: 77%
  - 2013: 75%
Attempts to Contract

No, 57%

Yes, 24%

Don't know, 19%
Plan Response to Requests to Join a Network

- **2010**
  - No response: 26%
  - Received an offer, but it was unacceptable: 27%
  - Received a contract: 47%

- **2012**
  - No response: 22%
  - Received an offer, but it was unacceptable: 31%
  - Received a contract: 48%

- **2014**
  - No response: 29%
  - Received an offer, but it was unacceptable: 32%
  - Received a contract: 39%

Legend:
- Red: No response
- Orange: Received an offer, but it was unacceptable
- Blue: Received a contract
Attempts to Negotiate a Health Plan Contract

- Yes, 49%
- No, 41%
- N/A - no contracts, 10%
Attempts to Negotiate the Terms of a Health Plan Contract Mady

By

- Practice staff: 54%
- Practice physician(s): 32%
- An independent physician association or physician's hospital organization: 28%
- A consultant: 12%
Success Negotiation Contract Changes

Always, 2%

Never, 19%

Rarely, 26%

Sometimes, 33%

Often, 19%
Reasons for Contract Terminations
(Among 27 percent of who terminated a health plan contract in the past two years)

- Payment rate cuts imposed by plan: 55% (2010), 57% (2014)
- Administrative burden imposed on practice by plan: 40% (2010), 43% (2012), 43% (2014)
- Other payment problems such as claim denials, incorrect or late payment, or bundling: 45% (2010), 43% (2012), 38% (2014)
- Payments that had not increased enough to cover practice costs: 36% (2010), 35% (2012)
- Requirement to participate in health insurance exchange plan: 12% (2010)
Termination Notice Resulted in Re/New Negotiations with Contract and No Lapse in Coverage

- Every time, 3%
- Sometimes, 21%
- No, 77%
Physician Practices with a Method to Detect a Silent PPO

2014:
- Yes: 15%
- No: 35%
- N/A: 14%
- Don't know: 36%

2012:
- Yes: 22%
- No: 41%
- N/A: 8%
- Don't know: 30%

2010:
- Yes: 22%
- No: 42%
- N/A: 8%
- Don't know: 28%
Physician Practices Which Have Detected Silent PPO Activity

Yes, 46%

No, 32%

Don't know, 22%
Frequency with Which Patient Payment Information is Available from Health Plan

- Always, 7%
- Never, 10%
- Rarely, 17%
- Sometimes, 40%
- Often, 26%
Incorrect Listings in a Health Plan Directory

- Listed as participating, not: 61%
- Not listed when participating: 56%
Payers asserting assignment imposes a prohibition on balance billing.

Payers refusing to honor assignment, resulting in plans paying patients instead of physicians.

Problems with Assignment of Benefits:

- 2010: 62%
- 2012: 61%
- 2014: 66%
- 2010: 72%
- 2012: 64%
- 2014: 55%
Acceptance of New Health Insurance Exchange Patients

- BCBS: 15% None, 56% Some, 30% All
- Cigna: 42% None, 35% Some, 23% All
- Aetna: 42% None, 36% Some, 22% All
- UHC: 45% None, 35% Some, 20% All
- Humana HMO: 59% None, 26% Some, 16% All
- Superior: 73% None, 12% Some, 15% All
- Humana EPO: 70% None, 18% Some, 13% All
- Molina: 79% None, 9% Some, 11% All
- CHC: 81% None, 8% Some, 11% All
- Scott & White: 85% None, 5% Some, 10% All
- FirstCare: 85% None, 7% Some, 8% All
- Sendero: 90% None, 3% Some, 7% All
- CommunityFirst: 89% None, 5% Some, 6% All
Healthy Environment

- Availability of Care
Percent of Texas Physicians Who Accept All New Medicare Patients

- 2000: 78%
- 2002: 74%
- 2004: 67%
- 2006: 62%
- 2008: 64%
- 2010: 66%
- 2012: 59%
- 2014: 63%
Percent of Texas Physicians Who Will Accept All New Medicaid Patients

- 2000: 67%
- 2002: 49%
- 2004: 45%
- 2006: 38%
- 2008: 42%
- 2010: 42%
- 2012: 32%
- 2014: 37%
Acceptance of All New Medicaid Patients by Physician Specialty

- **Indirect Access**: 2014 - 76%, 2012 - 68%
- **Pediatrics**: 2014 - 53%, 2012 - 50%
- **Surgical Specialty**: 2014 - 34%, 2012 - 30%
- **Primary Care**: 2014 - 30%, 2012 - 21%
- **Non-surgical Specialty**: 2014 - 26%, 2012 - 28%
- **Obstetrics/Gynecology**: 2014 - 23%, 2012 - 27%
### Physician Response to Problems with the Medicare Fee Schedule

<table>
<thead>
<tr>
<th>Action</th>
<th>Have done (%)</th>
<th>Will do (%)</th>
<th>Considering (%)</th>
<th>Will not do (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New MEDICAID limits</td>
<td>39</td>
<td>9</td>
<td>22</td>
<td>31</td>
</tr>
<tr>
<td>New Medicare limits</td>
<td>24</td>
<td>12</td>
<td>29</td>
<td>34</td>
</tr>
<tr>
<td>Reduce charity</td>
<td>23</td>
<td>8</td>
<td>27</td>
<td>42</td>
</tr>
<tr>
<td>Accept no new Medicare patients</td>
<td>18</td>
<td>5</td>
<td>31</td>
<td>46</td>
</tr>
<tr>
<td>Reduce staff compensation or benefits</td>
<td>17</td>
<td>8</td>
<td>33</td>
<td>42</td>
</tr>
<tr>
<td>Delay IT</td>
<td>16</td>
<td>8</td>
<td>21</td>
<td>55</td>
</tr>
<tr>
<td>Renegotiate/terminate some contracts</td>
<td>15</td>
<td>15</td>
<td>46</td>
<td>24</td>
</tr>
<tr>
<td>Increase fees</td>
<td>12</td>
<td>7</td>
<td>36</td>
<td>45</td>
</tr>
<tr>
<td>Change status to Medicare nonpar</td>
<td>10</td>
<td>4</td>
<td>33</td>
<td>54</td>
</tr>
<tr>
<td>Opt out</td>
<td>7</td>
<td>3</td>
<td>33</td>
<td>57</td>
</tr>
<tr>
<td>Terminate existing Medicare patients</td>
<td>6</td>
<td>18</td>
<td>74</td>
<td>22</td>
</tr>
</tbody>
</table>
We will accept all exchange plan-covered patients, 36%

We will limit our acceptance of exchange plan patients, 41%

We will not accept new exchange plan patients, 22%
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 out of network if we are not contracted with their plans, but may not take assignment on claims.

Other
Billing ACA Exchange Patients Out of Network

- Always bill patient directly, 46%
- Sometimes bill directly and sometimes take assignment, 39%
- Always take assignment on the claim, 15%
Medicaid Managed Care

- Forty-two percent of physicians treat Medicaid HMO patients
Efforts to contract with a HMO are rejected

Not had the opportunity to contract/finalize a contract with a HMO

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

Prefer Medicaid fee-for-service

Inadequate fees

Admin complexity/burden

Reasons Physicians Do Not Treat Medicaid HMO Patients
Practice Patients by Payer

Medicaid HMO: 14%
Medicaid FFS: 13%
Percentage of Texas Physicians Who Would Accept More Medicaid HMO Patients if Rates Increased by 5 to 10 Percent

- Yes, 21%
- No, 47%
- Maybe, 33%

Note: 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.
Percent of Texas Physicians Who Would Accept More Medicaid if the Program Was Reformed

- **Decreased administrative burden**
  - Very Unlikely: 29%
  - Somewhat Unlikely: 15%
  - Somewhat Likely: 36%
  - Very Likely: 21%

- **Standardized Credentialing**
  - Very Unlikely: 36%
  - Somewhat Unlikely: 18%
  - Somewhat Likely: 32%
  - Very Likely: 14%

- **Incentive payments**
  - Very Unlikely: 45%
  - Somewhat Unlikely: 16%
  - Somewhat Likely: 24%
  - Very Likely: 14%
What Physicians Like About Medicaid HMOs

- None: 67%
- Care coordinators for patients with complex/chronic conditions: 17%
- Enhanced pay for quality of care/care management: 13%
- Value added services for patients: 12%
- Enhanced payments for after-hours care: 11%
- Alerts when certain patients are admitted to a hospital or an ED: 9%
- Certain/Specific types of disease management: 3%
Above the Medicaid FFS schedule

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>4%</td>
<td>28%</td>
<td>68%</td>
</tr>
</tbody>
</table>

Below the Medicaid FFS schedule

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>16%</td>
<td>15%</td>
<td>69%</td>
</tr>
</tbody>
</table>
### Administrative Burden in Medicaid HMOs

<table>
<thead>
<tr>
<th>Administrative Burden</th>
<th>None</th>
<th>Some</th>
<th>Quite a Bit</th>
<th>An Extreme Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty finding in-network specialty care</td>
<td>12%</td>
<td>11%</td>
<td>25%</td>
<td>53%</td>
</tr>
<tr>
<td>Prior-authorization for medical services</td>
<td>10%</td>
<td>11%</td>
<td>32%</td>
<td>47%</td>
</tr>
<tr>
<td>Paperwork</td>
<td>9%</td>
<td>13%</td>
<td>32%</td>
<td>46%</td>
</tr>
<tr>
<td>Recoupments</td>
<td>13%</td>
<td>19%</td>
<td>28%</td>
<td>40%</td>
</tr>
<tr>
<td>Coordination of benefits</td>
<td>12%</td>
<td>20%</td>
<td>32%</td>
<td>36%</td>
</tr>
<tr>
<td>Prescription drug process</td>
<td>13%</td>
<td>21%</td>
<td>31%</td>
<td>34%</td>
</tr>
<tr>
<td>Eligibility verification</td>
<td>13%</td>
<td>24%</td>
<td>31%</td>
<td>33%</td>
</tr>
<tr>
<td>HMO credentialing process</td>
<td>16%</td>
<td>24%</td>
<td>30%</td>
<td>30%</td>
</tr>
</tbody>
</table>
## Problems Obtaining Prescription Drugs in Medicaid HMOs

<table>
<thead>
<tr>
<th>Issue</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time consuming to get prior-approval when required for prescription drugs</td>
<td>77%</td>
</tr>
<tr>
<td>Difficult to get prior-approval for non-preferred prescription drugs</td>
<td>69%</td>
</tr>
<tr>
<td>Unclear which prescription drugs/drug classes require prior-approval</td>
<td>64%</td>
</tr>
<tr>
<td>Lack of communication between pharmacy, plan, and/or agency</td>
<td>47%</td>
</tr>
<tr>
<td>Inability to communicate with a medical director when a non-preferred prescription drug is denied</td>
<td>43%</td>
</tr>
<tr>
<td>Pharmacies do not honor the 72-hour emergency supply requirement</td>
<td>21%</td>
</tr>
<tr>
<td>Other</td>
<td>6%</td>
</tr>
</tbody>
</table>
Physician Satisfaction with Medicaid HMOs

- **Reimbursement rates**: 70% Very Unsatisfied, 23% Somewhat Unsatisfied, 7% Very Satisfied
- **Access to specialists**: 59% Very Unsatisfied, 29% Somewhat Unsatisfied, 10% Somewhat Satisfied, 3% Very Satisfied
- **Ease of contract negotiation**: 56% Very Unsatisfied, 33% Somewhat Unsatisfied, 9% Somewhat Satisfied, 1% Very Satisfied
- **Coordination of care**: 45% Very Unsatisfied, 38% Somewhat Unsatisfied, 16% Somewhat Satisfied, 1% Very Satisfied
Physician Participation in STAR HMOs
(Among 23 percent of physicians who participate in a Medicaid STAR HMO)

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

- 60% Amerigroup
- 55% Superior Health Plan
- 50% Blue Cross Blue Shield of Texas
- 39% Molina Healthcare of Texas
- 35% United Healthcare Community Plan
- 21% Aetna Better Health
- 21% Community First Health Plans
- 21% Texas Children's Health Plan
- 21% Community Health Choice
- 17% United Community Health Plan
- 17% FirstCare
- 13% CHRISTUS Health Plan
- 13% Seton Health Plan
- 12% Cook Children's Health Plan
- 12% Parkland
- 11% Sendero Health Plans
- 9% Driscoll Children's Health Plan
- 7% El Paso First
- 6% Right Care from Scott & White Health Plan
Physician Reasons for Medicaid HMO Contract Termination
(Among physicians who treat Medicaid STAR HMO patients, 25 percent plan to terminate one or more of their existing contracts)

- Inadequate payments: 75%
- Payment problems (i.e., claim denials, incorrect, late payments): 72%
- Administrative burdens: 67%
- Quality of care concerns (i.e., inadequate provider network, delays in treatment): 50%

Note: Physicians who intend to terminate a contract specified Amerigroup, Community First, Molina, and Superior.
Physician Intent to Contract with Any Medicaid STAR HMOs in the next year

- Yes, 6%
- Maybe, 22%
- No, 72%
Physician Participation in Medicaid STAR+PLUS HMOs
(Among the 20 percent of physicians who treat STAR+PLUS HMO patients)

- Amerigroup: 71%
- Superior Health Plan: 62%
- Molina Healthcare of Texas: 46%
- HealthSpring: 44%
- United Community Health Plan: 34%
- Bravo Health: 16%
Reasons Physicians Intend To Terminate a Medicaid STAR+PLUS HMO Contract in the Next Year
(Among 28 percent who plan to terminate one or more of their existing contracts)

- Inadequate payments: 83%
- Administrative burdens: 79%
- Payment problems: 71%
- Quality-of-care concerns: 67%

Note: Physicians who intend to terminate a Medicaid STAR+PLUS contract specify Amerigroup, Molina, and Superior.
Physician Intent to Contract with Any Medicaid STAR+PLUS HMOs in the Next Year

- Yes, 4%
- Maybe, 21%
- No, 75%

Note: Physicians who intend to contract with a Medicaid STAR+PLUS HMO specify Amerigroup, Superior, or United.
Percentage of Texas Physicians Whose Practice Has Used the STAR+PLUS Service Coordinators

- Yes., 16%
- No., 23%
- I didn't know STAR+PLUS plans offered service coordination., 19%
- I don't know., 42%
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.

The service coordinator initiated contact with the practice on behalf of the patient.
Service Coordinators Improved Patient Care

- No, 83%
- Don't know, 17%
The ED Has Staff, Policies, Program in Place to Direct Patients to Community Providers
(Among Physicians with Practice Privileges in an Emergency Department)
Payers
Specific Cases of Poor Care Quality Caused By Payer Policies or Controls

- Workers' compensation: 22% (2012), 21% (2014)
- Medicare: 56% (2012), 55% (2014)
- Medicaid: 57% (2012), 58% (2014)
- Health plans: 69% (2012), 70% (2014)
Causes of Poor Care Quality

- Inadequate access to primary care
- Inadequate specialist access
- Delays in treatment
- Denials or noncoverage for some procedures
- Limited or tiered formularies
- Limited or tiered networks

Workers' comp: 19%
Medicare: 57%
Medicaid: 73%
Managed care: 75%

Medicare: 60%
Medicaid: 62%
Managed care: 70%

Medicare: 62%
Medicaid: 53%
Managed care: 59%

Workers' comp: 24%
Medicare: 43%
Medicaid: 52%
Managed care: 75%

Workers' comp: 26%
Medicare: 47%
Medicaid: 53%
Managed care: 76%

Workers' comp: 16%
Medicare: 44%
Medicaid: 62%
Managed care: 76%

Workers' comp: 20%
Medicare: 43%
Medicaid: 69%
Managed care: 75%

Workers' comp: 20%
Medicare: 43%
Medicaid: 62%
Managed care: 76%

Workers' comp: 20%
Medicare: 43%
Medicaid: 62%
Managed care: 76%
Novitas Solutions Inc. took over from Trailblazer Enterprises as Texas’ Medicare carrier in 2011.

Texas physicians think the CMS should re-evaluate Novitas as the MAC (58 percent).
Causes of Problems with Novitas
(Among the 29 percent of respondents who experienced problems with Novitas.)

- Payment problems: 69%
- Administrative burden and paperwork: 68%
- Excessive document requests: 64%
- Excessive telephone hold times: 53%
- Inability to find answers to questions on Novitas website: 47%
- Telephone support line busy or unavailable: 46%
- Excessive payment recoupments: 35%
- Enrollment problems: 28%
- Heavy prepayment audits: 25%
Length of Time to Get Through to Novitas Telephone Support In Most Recent Effort

(Among the 27 percent of respondents who tried to contact customer support by telephone.)

- Not At All, 10%
- Immediately, 0%
- Under 30 seconds, 2%
- About 1 minute, 5%
- More than 5 minutes, 57%
- 2 to 5 minutes, 26%
Number of Times Contact Novitas Customer Service Before Problem Resolved

- 1 time, 13%
- 2 times, 28%
- 3 times, 20%
- More than 3 times, 21%
- The problem is still not corrected, 18%
The Novitas representative handled my problems with courtesy and professionalism.

My phone call was transferred to the person who could best answer my questions.

The Novitas representative appeared knowledgable and competent.

The waiting time for having my question addressed was satisfactory.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Novitas representative handled my problems with courtesy and professionalism.</td>
<td>26%</td>
<td>31%</td>
<td>43%</td>
</tr>
<tr>
<td>My phone call was transferred to the person who could best answer my questions.</td>
<td>46%</td>
<td>27%</td>
<td>27%</td>
</tr>
<tr>
<td>The Novitas representative appeared knowledgable and competent.</td>
<td>47%</td>
<td>20%</td>
<td>32%</td>
</tr>
<tr>
<td>The Novitas representative quickly identified the problem.</td>
<td>51%</td>
<td>19%</td>
<td>30%</td>
</tr>
<tr>
<td>The waiting time for having my question addressed was satisfactory.</td>
<td>60%</td>
<td>19%</td>
<td>21%</td>
</tr>
</tbody>
</table>
Percent of Texas Physicians Satisfied with Novitas Phone Support

- Very Satisfied, 7%
- Very Dissatisfied, 27%
- Somewhat Satisfied, 16%
- Somewhat Dissatisfied, 31%
- Neutral, 18%
Ten percent of physicians’ report the hospital in which they primarily practice is owned partially or entirely by physicians.
Hospital and medical staff work together to solve economic problems.

Timely on-call coverage is generally available for all specialties.

Hospital and medical staff work together to solve patient safety problems.

The working relationship between hospital and medical staff is cooperative.

The hospital takes efforts to address physician concerns.

Physician Hospital Relationships

- Strongly Disagree (1)
- 2
- 3
- 4
- Strongly Agree (5)
Percent of Texas Physicians Who Witnessed Specific Cases In Which Patient Care Was Adversely Affected by the Policies or Operations of a Hospital or Surgical Facility

- 2012: 32%
- 2014: 37%
Inadequate call coverage: 18%
Inconsistencies in surgical settings or equipment: 32%
Scheduling delays: 42%
Errors implementing physician orders: 46%
Delays implementing physician orders: 46%
Inconsistent facility staffing: 58%
Inadequate facility staffing: 64%
The facility is less expensive for patients than others in the community.

The facility has improved the efficiency of my practice.

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.

Note: Eighty percent of physicians report there are physician-owned specialty hospitals, ASCs, or imaging centers in their area. Among them, 31 percent practice in a physician-owned facility and 53 percent owners or investors in the facility.
Texas Physicians Who Have Seen Cases Where Physicians Lost Employment, Contracts, or Privileges for Raising Issues about Hospital Regulatory Compliance or Patient Care Quality

Thirty-eight percent of physicians are concerned it could happened to them.
Legislative Issues
Preserve TADA
Medicare private contracting
Medicare/Medicaid re-enrollment
Cover the uninsured
TMB regulation
Medicaid pay adequacy
Antitrust protection
Revise/Eliminate provisions of the ACA
Reduce taxes on practices
Prevent scope expansions
Reduce admin/reg burdens in practice
Health plan hassles and prompt pay
Medicare pay adequacy
Prevent balance billing limits
Oppose hospital intrusion in medical decisions
Prevent scope expansions
Reduce taxes on practices
Revise/Eliminate provisions of the ACA
Antitrust protection
Medicaid pay adequacy
TMB regulation
Cover the uninsured
Medicare/Medicaid re-enrollment
Medicare private contracting
Preserve TADA
Federal Legislative Priorities

- Eliminate penalties in quality of care measures dependent on patient compliance: 66%
- Ensure failure to report Medicare/Medicaid over payments is not treated as fraud: 60%
- Require plans to simplify eligibility verifications for preventive care: 54%
- Put ICD-10 on permanent hold: 50%
- Eliminate penalties for PQRS non-reporting: 47%
- Require plans to include grace period information in all standard verifications: 47%
- Eliminate federal physician ranking to be reported on Physician Compare: 43%
- Eliminate bonuses and penalties in Medicare's VBPM program: 42%
<table>
<thead>
<tr>
<th>Issue</th>
<th>Support (%)</th>
<th>Oppose (%)</th>
<th>Don't know (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Require EHRs to maintain data for 7 yrs.</td>
<td>79%</td>
<td>6%</td>
<td>15%</td>
</tr>
<tr>
<td>Enact a state ban on texting while driving</td>
<td>79%</td>
<td>13%</td>
<td>8%</td>
</tr>
<tr>
<td>Background checks on firearm purchases</td>
<td>72%</td>
<td>22%</td>
<td>7%</td>
</tr>
<tr>
<td>Regulate e-cigs as other smoking products</td>
<td>71%</td>
<td>16%</td>
<td>13%</td>
</tr>
<tr>
<td>Physicians' rights to invest in health facilities</td>
<td>67%</td>
<td>16%</td>
<td>18%</td>
</tr>
<tr>
<td>Medicaid pharmacies from selling cigarettes</td>
<td>69%</td>
<td>20%</td>
<td>15%</td>
</tr>
<tr>
<td>Vaccine exemptions in child's school</td>
<td>69%</td>
<td>12%</td>
<td>23%</td>
</tr>
<tr>
<td>Repeal the ACA</td>
<td>56%</td>
<td>27%</td>
<td>18%</td>
</tr>
<tr>
<td>Pregnancy test retailers warn of FAS</td>
<td>59%</td>
<td>23%</td>
<td>22%</td>
</tr>
<tr>
<td>Physician notification of DNR</td>
<td>54%</td>
<td>22%</td>
<td>24%</td>
</tr>
<tr>
<td>Require work comp coverage</td>
<td>42%</td>
<td>32%</td>
<td>26%</td>
</tr>
<tr>
<td>Treat telephonically without prior face-to-face</td>
<td>32%</td>
<td>50%</td>
<td>18%</td>
</tr>
</tbody>
</table>

- **Support**
- **Oppose**
- **Don't know**
Support for Efforts to Address Medicare Solvency

- Vouchers to purchase plans: 54%
- Incentives to reduce spending: 54%
- Increase co-ins/deductibles: 50%
- Increase eligibility age: 48%
- Increase premiums: 44%
- Increase Medicare payroll taxes: 26%
- Hospital/Provider fee cuts: 21%
- High cost/use penalties: 19%
- Cuts to physician fees: 3%
Support for Efforts to Address High Health Care Cost and Utilization

- Allow high-deductible insurance with spending accounts like HSAs: 85%
- Financial incentives for medical homes: 57%
- Payment incentives and penalties based on reported clinical data on quality of care: 40%
- Limits on the use of imaging equipment by physician specialty: 27%
- Fee cuts to physicians whose Medicare patients use more medical services: 11%
## Support for Uninsured Initiatives

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

*This question was not asked in 2010.*
Yes, Texas should expand Medicaid.

No, Texas should not expand Medicaid.

I don't know.
The Most Important Reason Texas Should Not Expand the Medicaid program

- Inadequate pay/participation, 25%
- Fraud/Abuse, 15%
- Government intrusion, 10%
- Government debt, 9%
- Hassle/Red tape, 8%
- Health care costs, 7%
- Waste, 6%
- Other, 10%
- Services/quality care, 4%
- Raise taxes, 3%
- ED use/costs, 2%

Fraud/Abuse, 15%
Support for Medicaid Expansion if the Program Was Reformed to Reduce Administrative Burden and Increase Physician Fees to Medicare Parity

- Yes, 42%
- No, 30%
- Don't know, 28%
Support for Medicaid Expansion if the Program Was Reformed to Reduce Administrative Burden and Increase Physician Fees to Medicare Parity

- Yes, 42%
- No, 30%
- Don't know, 28%
### Impact of RAC on Practice

(Among 12% of physicians report their practice has had a RAC review.)

<table>
<thead>
<tr>
<th>Impact Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional admin responsibilities of clinical staff to respond to RAC</td>
<td>57%</td>
</tr>
<tr>
<td>Increased admin costs to manage responses to RAC requests/appeals</td>
<td>55%</td>
</tr>
<tr>
<td>Training and education</td>
<td>31%</td>
</tr>
<tr>
<td>Employed additional staff or hired external resources to manage RAC process</td>
<td>20%</td>
</tr>
<tr>
<td>No impact</td>
<td>18%</td>
</tr>
<tr>
<td>Cutbacks because of financial hardships due to RAC (e.g., limited services, reduced staff)</td>
<td>16%</td>
</tr>
<tr>
<td>Purchased/Modified practice software</td>
<td>14%</td>
</tr>
</tbody>
</table>
End-of-Life Care Discussions With Patients

Yes, I initiate them with some or certain patients. 46%

Yes, I initiate them with all or most patients. 16%

Yes, when a patient initiates them. 14%
This legislation will increase health care costs.

This legislation will increase patient suffering.

I support this legislation.
Practice Use of Mid-level Practitioners
(Among 42 percent of physicians whose practice uses mid-level practitioners.)

- Sick visits: 64% (60% PAs, 68% APNs)
- Performing tests: 64% (60% PAs, 68% APNs)
- Patient care coordination: 62% (60% PAs, 68% APNs)
- Prescription privileges: 63% (60% PAs, 68% APNs)
- Routine exams: 63% (60% PAs, 68% APNs)
- Patient education: 60% (60% PAs, 68% APNs)
- Follow-up care: 64% (60% PAs, 68% APNs)
- Assistance with procedures: 65% (60% PAs, 68% APNs)
- Hospital rounds: 60% (60% PAs, 68% APNs)
- EHR scribes: 63% (60% PAs, 67% APNs)
Mid-levels Responsible for More or Less Practice Management and Administrative Duties Than Physicians in Practice

- None, 20%
- About the same, 15%
- More, 2%
- Less, 63%
I do not delegate controlled substances.

I delegate based on individual APRN or PA training or experience.

I delegate without limitation.

I delegate only for specific circumstances.

I delegate controlled substances, but exclude certain specific drugs.

I delegate only for certain diagnoses.

I delegate only for certain patients.
Demographics

- Male. 70%; Female, 30%
- 40 and younger, 18%; 41-50, 22%; 51-60, 27%; 61+, 33%
- Indirect Access, 16%; Primary Care, 30%; Pediatrics, 10%; Ob/Gyn, 7%; Surgical Specialty, 13%; Non-surgical Specialty, 24%
- Bexar, 9%; Dallas, 13%; Harris, 18%; Tarrant, 6%; Travis, 9%; Rural, 6%; Metro, 37%; Rio Grande Valley, 2%
Methodology

- 30,250 Texas physicians with email addresses in the TMA database were emailed a personalized link to the survey. Responses were received by 4,280.

- Survey content was comprehensive, covering a broad range of physician opinion and experience and not limited to specific issues.

- No published links allowed for uninvited responses.