

Survey of Texas Physicians 2016

Research Findings



Physicians Caring for Texans.

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TMA 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 from January through August 2016.

Biggest Challenges

- Texas physicians' reported that **inadequate payment, economic survival, and changes in payment** were the biggest challenges currently facing them (25 percent). Administrative burden coupled with increasing rules and regulations further threatened the economic viability of physician practices and was a top concern among 17 percent of physicians.
- Ten percent of physicians were frustrated with the **increasing interference in the practice of medicine by third parties**, particularly government and insurers. Eight percent of physicians identified dealing with managed care and insurers as a top challenge for physicians. Physicians mentioned frustration with both payment delays and denials from managed care companies, and difficulty with contract negotiations, with concern that negotiations would become increasingly difficult with the proposed health plan mergers. Increasing administrative burden, intrusion by government, and insurers negatively affected quality of and access to care.
- **Quality and access** were a top concern for 7 percent of physicians. Increased paperwork and intrusion by third parties interfered in the patient-physician relationship. Furthermore, inadequate insurance and prescription drug coverage was a concern even for those patients with commercial insurance. Five percent of physicians reported the Affordable Care Act (ACA) remained a top challenge for physicians. Some paired this comment with fear Texas would ultimately expand Medicaid, while others expressed frustration and disappointment that the state did not expand it. Five percent of physicians were concerned about the corporate practice of medicine. These physicians worried increasing overhead costs would drive solo and small group physicians into large and hospital-owned groups.
- **Health information technology** (HIT), particularly electronic health records (EHRs), were a concern for 4 percent of physicians. Physicians reported EHRs and reporting programs, such as meaningful use (MU), were increasing overhead costs and administrative burden, and interfering in the patient-physician relationship.
- Finally, increasing **physician burnout and decreasing morale** made the list this year as top challenge for 1 percent of Texas physicians.

Practice Viability

- For the sixth biennial period, a majority of physicians reported their income from medical practice decreased in the past two years (54 percent).
- A majority of physicians experienced cash flow problems due to slow payment, nonpayment, or underpayment of claims by insurers or government payers in the past year (57 percent).

Practice Description

- The number of solo practitioners (26 percent), consistently below the 1990 high, decreased once again while the number of group practice employees increased (24 percent).

- Among physicians who practiced in a group or partnership, 44 percent were in groups with eight or fewer physicians. When analyzed with solo practitioners, a majority were in practices with eight or fewer physicians (73 percent).
- A majority of physicians described their current practice as wholly owned by one or more physicians in the practice (64 percent) and reported the physician or physicians in the practice had authority for making practice management decisions (57 percent).
- The percentage of physicians who reported a hospital or nonphysician organization owned/employed/provided office space (40 percent), support staff (35 percent), office equipment (32 percent), other practice equipment, or professional liability insurance (29 percent) decreased since 2014.
- Twenty-eight percent of physicians were in an accountable care organization (ACO). Fifty-seven percent reported their ACO participated in the Medicare Shared Savings Program.
- Few physicians (11 percent) participated in alternative payment models (e.g., bundled payments).
- Physicians did not feel the structure, policies, and relationships of their medical practice impaired their independence in making clinical decisions (54 percent) or practice management decisions (43 percent). However, these numbers have decreased since 2014. Furthermore, an increasing percentage of physicians felt they were at risk of losing their independence in clinical decisionmaking (62 percent). Physicians agreed if they lose their ability to make independent clinical decisions, it is bad for physicians and patients (98 percent).
- Fifty-one percent of physicians reported their practice hired a new physician in the past year or will hire a new physician in the next year. Physicians whose practice has not hired and has no plans to do so would hire a new physician if the economic environment was different (42 percent). These physicians ranked the cost of maintaining an employed physician (78 percent) and inadequate Medicare/Medicaid fees (74 percent) as very important in their decision not to hire.
- A small percentage of Texas physicians practiced concierge (3 percent) or cash-based (8 percent) medicine.
- Sixty-five percent of physicians rated employment in an established physician practice with a subsequent option to buy in to ownership as the first or second most desirable practice type for most new physicians.

EHRs

- The percentage of physicians using an EHR increased (76 percent) as those who planned to implement one decreased. The percentage of physicians who did not plan to implement an EHR remained steady at 18 percent. These physicians reported the cost as prohibitive (63 percent).
- Among physicians currently using an EHR, 36 percent participated in a health information exchange (HIE). Those who did not participate were unfamiliar with HIEs (38 percent) or had a system not enabled to participate (23 percent).
- Thirty percent used e-prescribing for controlled substances (EPCS). Those who did not reported it was not supported by their EHR (41 percent).
- Forty-nine percent reported improved patient care due to an EHR including better (i.e., more thorough and legible) records (27 percent). Thirty-four percent reported damage or poor care quality due to an EHR, primarily inaccurate data that is carried forward (40 percent).

- Four percent of physicians experienced a ransomware attack, which cost their practice a median of \$1,000. Four percent of physicians experienced a data breach, which cost their practice a median of \$20,000.
- Twenty-eight percent reported their liability carrier offered cyber liability coverage.

Patient Billing and Practice Revenues

- Physicians reported taking several actions to promote price transparency and help patients determine their out-of-pocket costs, primarily directing them to their administrative or billing staff (59 percent) who are most likely to know charges and payment ranges.
- Sixty-nine percent of physicians reported their practice gives out-of-network or uninsured patients a “prompt payment” discount.
- The mean amount of charity care reported for each physician in practice in 2015 was \$76,620, and uncollectible debts per physician was \$156,170.

Health Plan Contracts

- The majority of physicians were contracted with at least one of the five major payers: Blue Cross and Blue Shield of Texas (BCBSTX) (87 percent), UnitedHealthcare (85 percent), Aetna (84 percent), Cigna (84 percent), and Humana (81 percent).
- Physician felt they must contract with BCBSTX to have a financially viable practice (56 percent). Few physicians (16 percent) felt they did not need to contract with at least one major commercial payer to have a financially viable practice.
- In the past two years, 52 percent of physicians attempted to negotiate the terms of a health plan contract. Success varied by payer, but approximately two-fifths of physicians were successful in securing changes in contracts.
- Twenty percent of respondents terminated a managed care contract in the past two years.
- Physicians had a median of six PPO contracts and two HMO contracts.
- In the past two years, 29 percent of physicians approached a plan with which they were not contracted in an attempt to join its network. Of those respondents, 35 percent received no response from the plan, and 32 percent of respondents received an unacceptable offer.
- Sixty percent of physicians experienced payers asserting assignment of benefits, which imposed a prohibition on balance billing, and 66 percent experienced payers refusing to honor assignment, which resulted in the plan paying patients instead of physicians.

Availability of Care

- A low percentage of physicians accepted all new Medicaid patients (41 percent).
- The percentage of physicians who accepted all new Medicare patients (65 percent) remains significantly less than the percentage of physicians who accepted all new Medicare patients in 2000.
- Approximately half of physicians participated in Medicare’s The Physician Quality Reporting System program in 2015 (51 percent) and in 2016 (52 percent).
- Eighteen percent reported penalties subtracted from their 2016 Medicare fees.
- A large minority of physicians who submitted data on quality measures used their EHR (49 percent).
- Physicians who paid to submit their data on quality measures reported paying an annual per-physician median amount of \$325.

- Eighteen percent experienced data submission errors made by their vendor, and the majority were not refunded their fees (82 percent). Thirty percent were penalized by Medicare for the error(s).
- Seventeen percent downloaded or attempted to download their Quality and Resource Use Report (QRUR). Among those who successfully downloaded it, 44 percent were able to determine why they received incentives or penalties, and 36 percent made changes to their practice as a result.
- Forty-six percent of physicians participated in MU in 2014 and 2015. Nineteen percent reported penalties subtracted from the 2016 fees.
- The average dollar value of Medicare revenue for services delivered personally or the per-physician average amount for physician practices in 2015 was \$175,753.
- Seven percent of physicians estimated the cost to comply with the Merit-Based Incentive Payment System (MIPS). These physicians estimated an average of \$20,490 per physician in practice.
- Thirty-two percent planned to participate in MIPS in 2017.
- Nineteen percent were interested in joining a virtual group for the purpose of group MIPS scoring for incentives and penalties.
- As a result of the requirements of MIPS and value-based care, 43 percent of physicians have or will limit their Medicare patients or opt out of Medicare altogether.

Medicaid Managed Care

- Forty-five percent of physicians treated Medicaid managed care organization (MCO) patients.
- The most frequently reported reason for not treating Medicaid MCO patients was inadequate payment (60 percent).
- Twenty percent would accept more Medicaid MCO patients if rates increased by five to 10 percent.
- Fifty-five percent of physicians were likely to accept more Medicaid patients if the program were reformed to decrease administrative burden, including a simplified preferred drug list.
- Thirty-seven percent reported prescription drugs were issue an in the Medicaid MCO program. These physicians reported consuming prior approvals (89 percent), difficulty getting prior approvals for nonpreferred prescription drugs (76 percent), and unclear when prescription drugs or drug classes require prior approval (74 percent).
- Twenty percent of physicians participated in a Medicaid STAR HMO, primarily Amerigroup (61 percent) and Superior (55 percent).
- Nine percent planned to terminate one or more of their existing STAR HMO contracts in the next year due to payment problems (80 percent), inadequate payments (73 percent), administrative burden (67 percent), and quality-of-care concerns (60 percent).
- Twenty percent of physicians participated in a Medicaid STAR+PLUS HMO, primarily Amerigroup (66 percent) and Superior (58 percent).
- Nine percent planned to terminate one or more of their existing STAR+PLUS HMO contracts due to administrative burdens (77 percent), inadequate payments (71 percent), payment problems (59 percent), and quality-of-care concerns (53 percent).

Damage to Care Quality

- Seventy-three percent of physicians reported 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 adversely affected patient care quality. The most frequently reported causes of poor care quality from private-sector health plans included formulary limitations and treatment denials (55 percent).
- Thirty-six percent of physicians with practice privileges in a hospital reported 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 adversely affected patient care. The most frequently reported causes of poor care quality included inadequate and inconsistent facility staffing (64 and 54 percent respectively).
- A majority of physicians reported their medical staff privileges required them to accept patients who reported to the emergency department without a physician (52 percent). Few physicians were reimbursed for being on call or responding to emergency call (28 percent).
- Eighty-one percent of physicians reported there were hospitals, Ambulatory Surgical Centers (ASCs), or imaging centers in their area that were physician-owned. Twenty-seven percent practiced in a hospital, ASC, or facility that was physician-owned and less than half were owners or investors in the facility (46 percent).
- Physicians agreed the physician-owned facility was a more convenient place for patients than others in the community (52 percent).
- Twenty-three percent of respondents saw cases where physicians lost employment, contracts, or hospital privileges because they raised issues about hospital regulatory compliance or patient care quality and 35 percent of physicians were concerned it could happen to them.

Legislative Issues

- Physicians' top state legislative priorities were defending Texas' liability reforms (83 percent), opposing commercial payer intrusion in medical decisions (80 percent), opposing government intrusion in medical decisions (78 percent), and reducing administrative and regulatory burdens in practice (76 percent).
- Physicians' top federal legislative priorities were opposing government intrusion in and reducing administrative burdens in medical practice (79 percent).
- Top public health legislative priorities included clean water (63 percent), vaccines (60 percent), and reducing obesity (57 percent).
- If the ACA had never passed and physicians could start over to design solutions for individuals who are uninsured, physicians were most likely to support a federal income tax deduction for all medical expenses and funding or subsidies for physicians who provide charity care (86 percent).
- Sixteen percent of physicians used telemedicine as part or all of their practice, and 35 percent envisioned using it in the next five years. Physicians agreed a physician who provides medical care to a patient in Texas using telemedicine should be required to be licensed in Texas (88 percent) and medical services should adhere to the same standards of care as services provided in person (89 percent).
- Thirty-nine percent of physicians delegated prescription drug privileges to advanced practice registered nurses (APRNs) or physician assistants (PAs). Primarily, physicians delegated based on individual experience or education (38 percent).
- Few physicians (11 percent) believed midlevel practitioners should be permitted to diagnose patients and prescribe medicine independently.

- Seventy-six percent of physicians had end-of-life-care discussions with patients.
- Eleven percent were familiar with the Physician Orders for Life-Sustaining Treatment (POLST) or the Medical Orders for Scope of Treatment (MOST) form. Among them, 15 percent used the POLST or the MOST form to document end-of-life conversations, and 69 percent would support wider dissemination of the form.
- Forty-three percent were aware Medicare now pays for end-of-life discussions.

Summary of Findings

Biggest Challenge (March Question 1)

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 were low and declining payment (19 percent); the squeeze between decreasing payments and increasing practice expenses, severe enough to threaten the economic survival of their practice (4 percent); and changes in and uncertainty over value-based payment (2 percent).

An increasing percentage of physicians were overwhelmed with the administrative burdens in practice including increasing rules and regulations (17 percent). Ten percent of physicians specified intrusion in medical practice by third-parties, particularly insurers and government. Eight percent of physicians' specified dealing with managed care and insurers was the biggest challenge, including difficulty with contract negotiations that would worsen with the proposed health plan mergers. For 5 percent of physicians, the consolidation of health practices and threats to the ban on the corporate practice of medicine remained a top concern. These physicians worried solo and small group physicians can't afford increasing overhead and will be forced to sell their practice to larger groups and to hospitals or health care systems.

<i>Biggest Challenge</i>									
	<u>2000</u>	<u>2002</u>	<u>2004</u>	<u>2006</u>	<u>2008</u>	<u>2010</u>	<u>2012</u>	<u>2014</u>	<u>2016</u>
	%	%	%	%	%	%	%	%	%
Low/Declining pay	15	32	28	31	43	33	38	21	19
Admin burden								12	17
Third-party interference	2	9	6	7	5	11	15	10	10
Managed care/insurers	44	16	9	9	7	2	2	3	8
Quality/Access	4	4	4	7	2	4	4	6	7
Reform/ACA	<1	3	<1	3	2	18	11	16	5
Corporate practice								6	5
Health IT							2	7	4
Economic survival	<1	3	9	13	15	16	12	7	4
Uninsured/Underinsured	3	2	6	11	10	5	5	3	4
Balance billing/narrow networks									3

Uncertain reimbursement									2
Scope of practice							2	1	2
Physician supply	2	2	3	3	2	3	1	1	2
Morale									1
Texas Medical Board					2	0	1	1	1
Liability	6	25	33	5	4	2	1	1	1
Other	5	3	2	6	8	5	6	6	6

Quality and access to care were a top concern for 7 percent of physicians. Access to care concerns often were referenced with regards to insured patients who lacked adequate and affordable coverage including prescription drug coverage. An additional 4 percent of physicians mentioned the uninsured or underinsured (i.e., patients covered by government payers.) Three percent of physicians' specified balance billing concerns and insurer's narrow networks, which further decreased access and quality of care for patients.

Five percent of physicians reported the Affordable Care Act continued to be a challenge for physicians. Some physicians paired comments about the ACA with frustration because the state did not expand Medicaid while others paired comments about the ACA with fear that the state yet may do so.

Health information technology decreased as a top-of-the-mind concern now that ICD-10 has been implemented. However, EHRs continued to be a source of frustration for 4 percent of physicians, who reported they were time consuming, detrimental to patient care, and increasing practice overhead.

One percent of physicians were concerned about scope-of-practice expansions. These physicians were concerned payers were using midlevel practitioners in place of physicians to save on costs at the expense of care quality. One percent of physicians were concerned about physician supply. While comments regarding a physician workforce shortage were frequently paired with concerns about specific specialties or geographic areas, some comments expressed a concern these shortages would be exacerbated in the current environment of rules, regulations, intrusion in medical practice, and uncertainty over payment.

One percent of physicians' reported burnout and low morale.

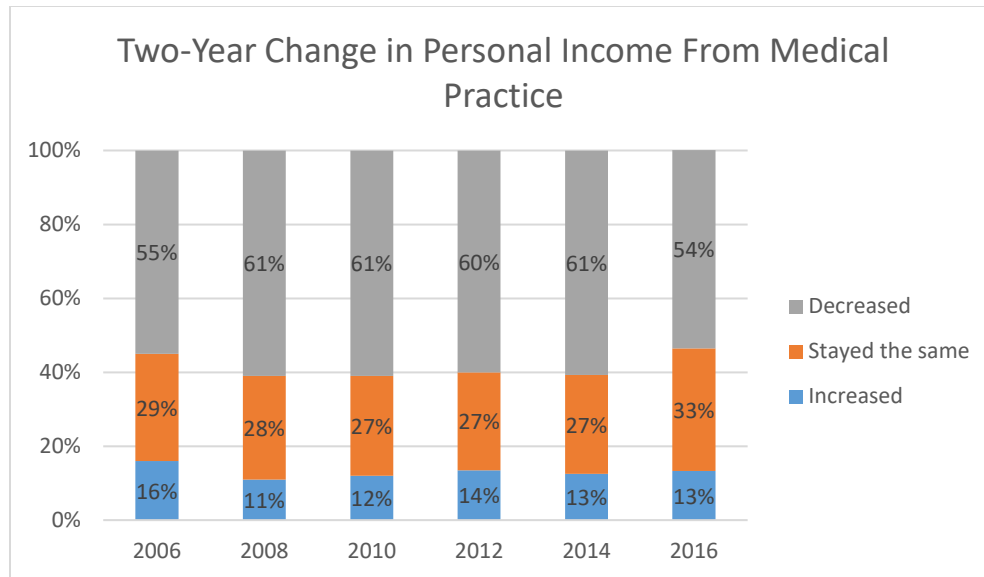
One percent of physicians continued to report threats to overturn liability reform and an overreaching Texas Medical Board were a top concern. Other concerns included the economy, health care costs, politics, and public health issues (e.g., obesity and dealing with emerging viruses).

Practice Viability

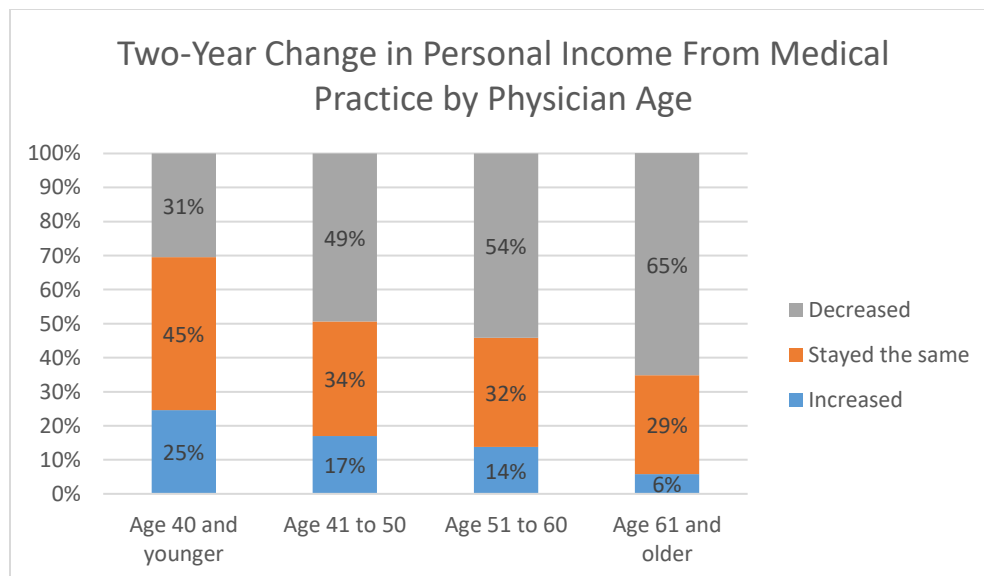
A large section of survey findings were specific to the economic and business issues faced by physician practices.

Physician Income (March Question 3)

For the sixth biennial period, a majority of physicians saw their income from medical practice decrease (54 percent).

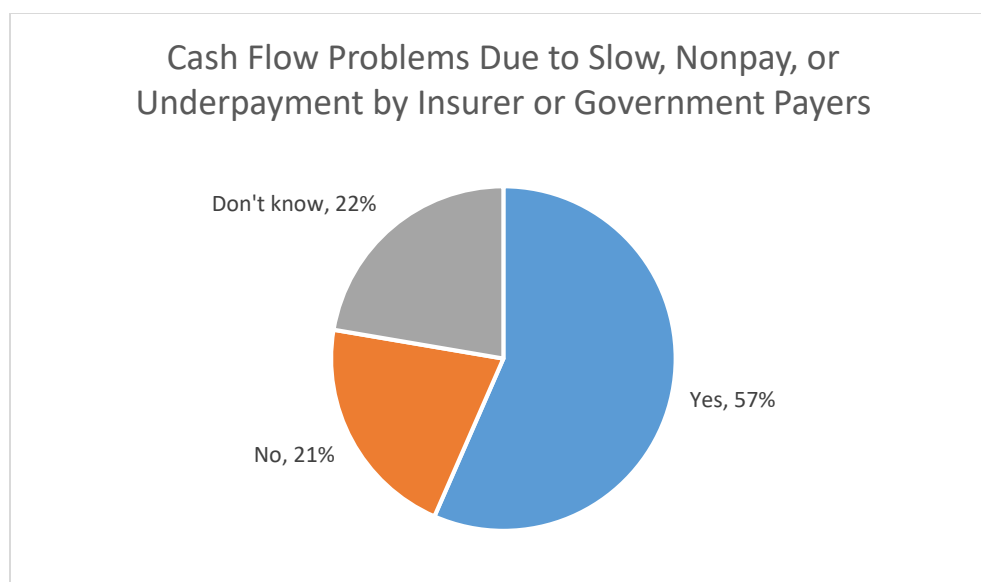


Of particular concern were the physicians' aged 41 to 60 who reported their income decreased. This is a concern because these physicians are in their prime income earning years.



Cash Flow Problems (March Question 4)

Fifty-seven percent of physicians reported 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 Question 5)

In response to cash flow problems, physicians reduced their own or other physician compensation (54 percent).

<i>Response to Cash Flow Problems</i>	2002	2004	2006	2008	2010	2012	2014	2016
	%	%	%	%	%	%	%	%
Reduce physician compensation/benefits								54
Reduce staff/hours/benefits					33	27	44	35
Draw from personal funds	46	68	39	33	51	52	40	31
Terminate/Renegotiate plan contracts					23	21	27	23
Reduce services to gov't payers					20	28	27	19
Secure commercial loans	33	46	32	22	33	26	23	17
Close/Sell practice					5	4	8	9
Other					19	17	14	7

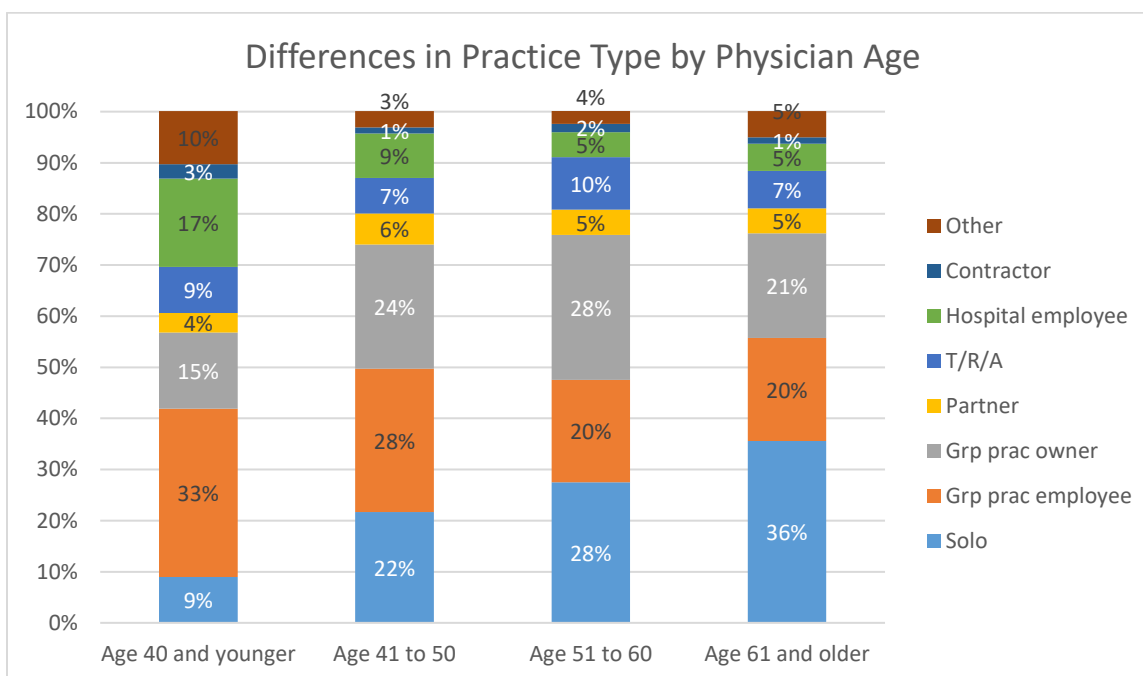
Practice Description

Type of Practice (February Question 2)

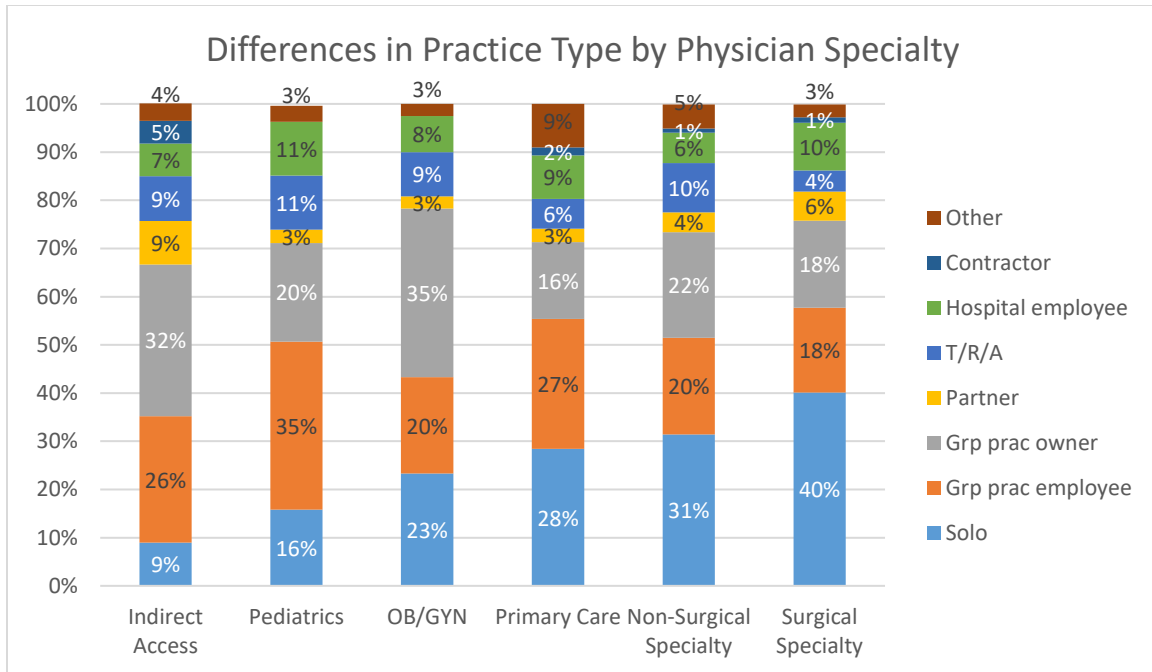
The percentage of solo practitioners decreased again this year. However, it did not appear that large percentages of physicians moved into hospital or health system employment. While the percentage of physicians employed by a hospital increased from 2012 to 2014, it was low at 7 percent, and it did not significantly increase from 2014 to 2016. The percentage of group practice employees continued to increase, which could be because new physicians were more likely to start in this practice arrangement or because fewer experienced physicians left this type of practice to begin their own practice. Overall, 53 percent report some type of ownership in their main practice.

<i>Type of Practice</i>	<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>	<u>2016</u>
	%	%	%	%	%	%	%	%	%	%
Solo	50	32	42	40	44	40	34	44	29	26
Group practice employee		20	13	15	13	14	18	13	22	24
Group practice owner, co-owner or shareholder	24	20	28	24	25	27	28	24	22	22
Partnership	10	9	9	11	7	9	8	5	4	5
Teach/Admin/Research		7	5	5	7	6	7	5	8	8
Hospital employee								4	7	8
Independent Contractor										2
Resident		7		0.1			1	0.3	1	1
Other	16	5	4	6	4	5	5	5	7	4

An analysis of practice type by physician age showed physicians in the youngest age group were more likely than other physicians to describe themselves as a group practice employees (33 percent) or a hospital employee (17 percent). It is possible fewer physician practices hiring new physicians forced new physicians into hospital practice arrangements. This will need to be monitored.

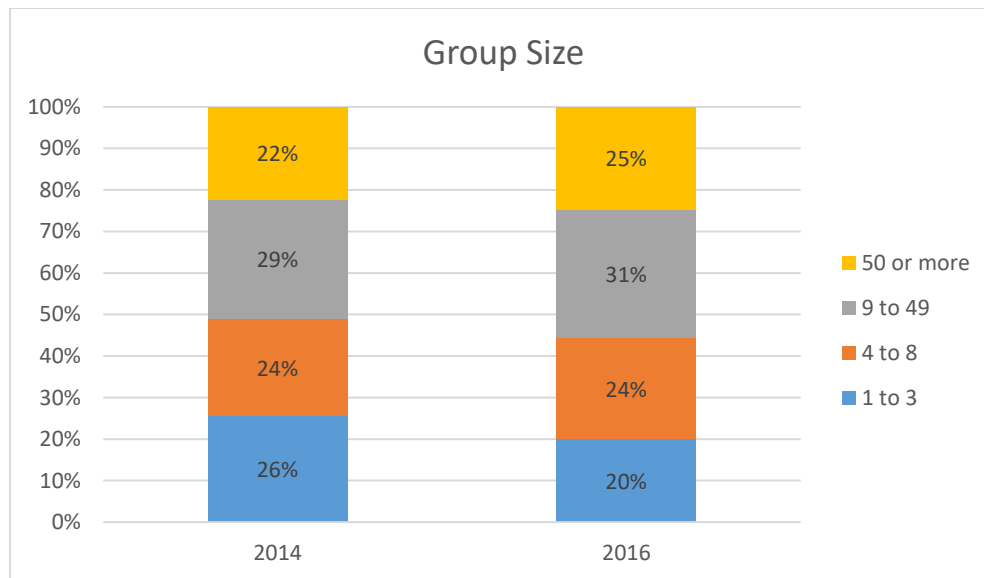


Physicians in surgical specialties were more likely to practice solo (40 percent). Pediatricians were more likely to be group practice employees (35 percent). Obstetrician-gynecologists (35 percent) followed by indirect-access physicians (32 percent) were more likely to be group practice owners.

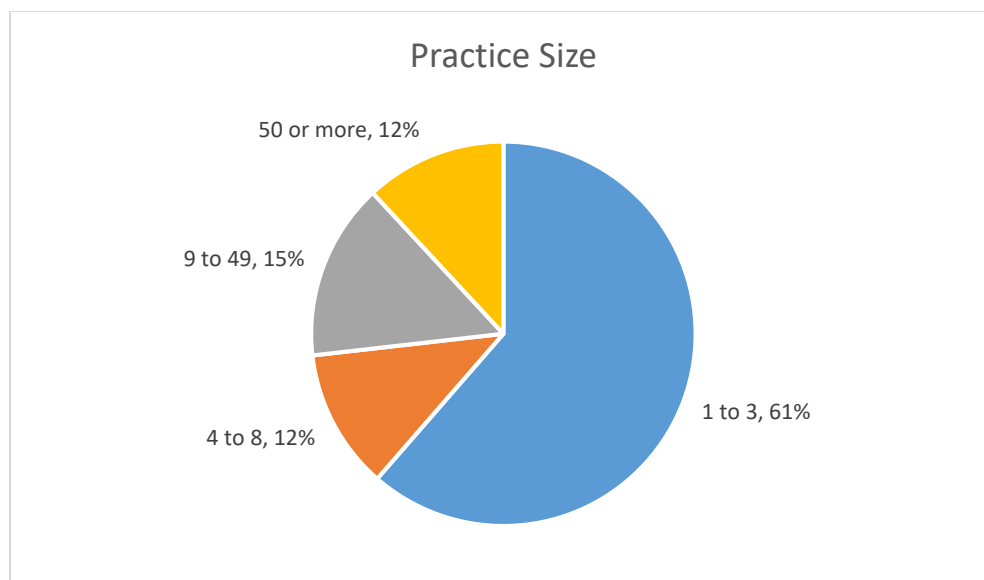


Group Size (February Question 3)

Physicians in groups or partnerships were asked about the number of physicians in their practice. Forty-four percent of physicians practiced in groups with eight or fewer physicians.

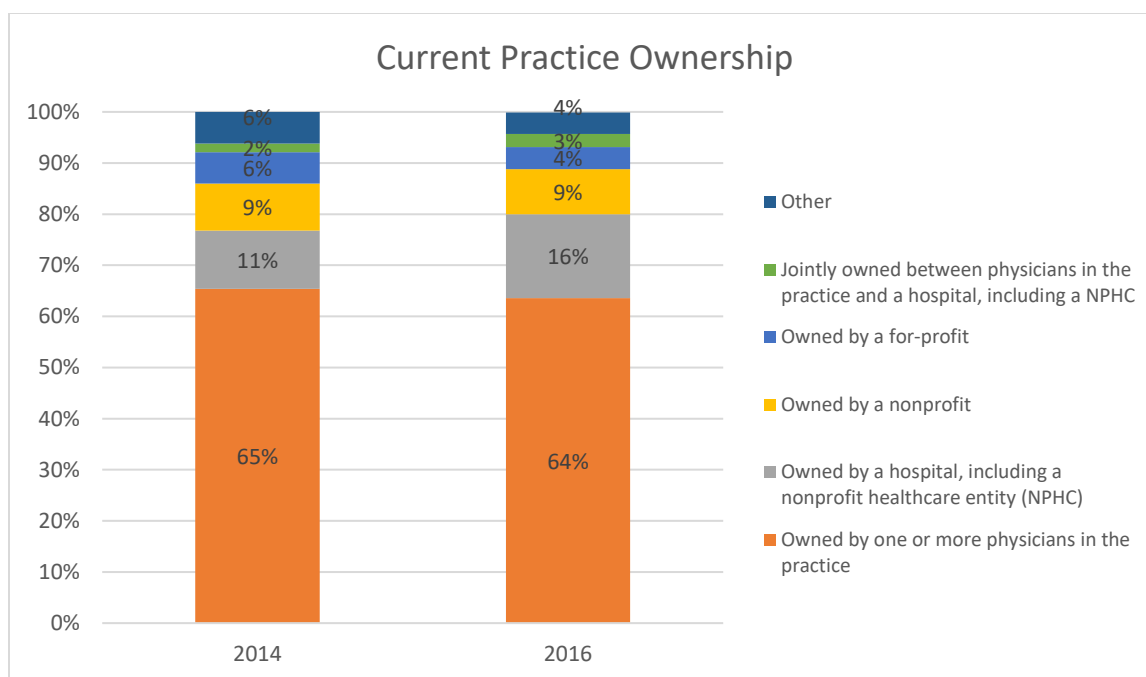


When analyzed with solo and independent contractors, nearly three-fourths of physicians (73 percent) were in practices comprising of eight or fewer physicians.



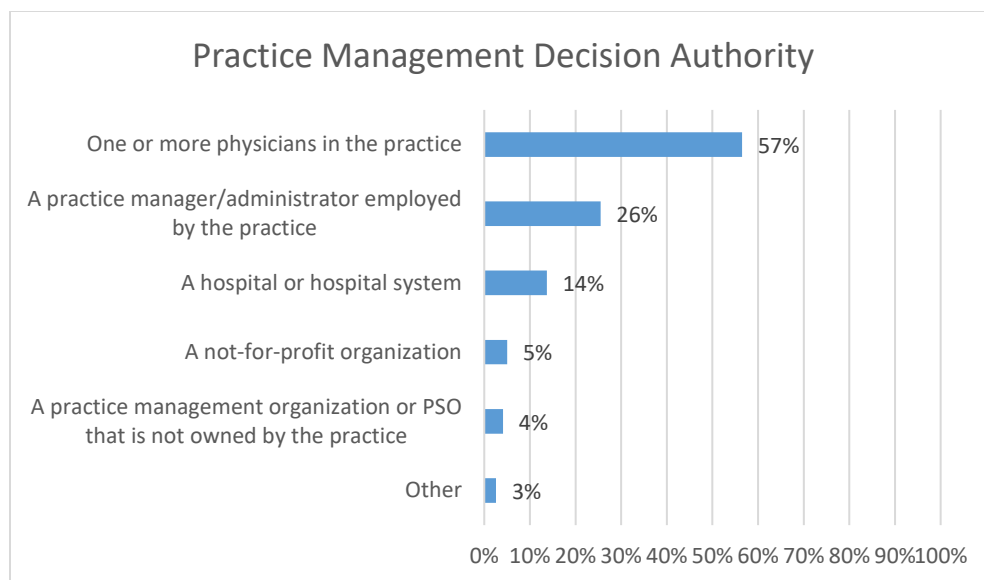
Practice Ownership (July Question 6)

The majority of physicians reported their practice is wholly owned by one or more physicians (64 percent).



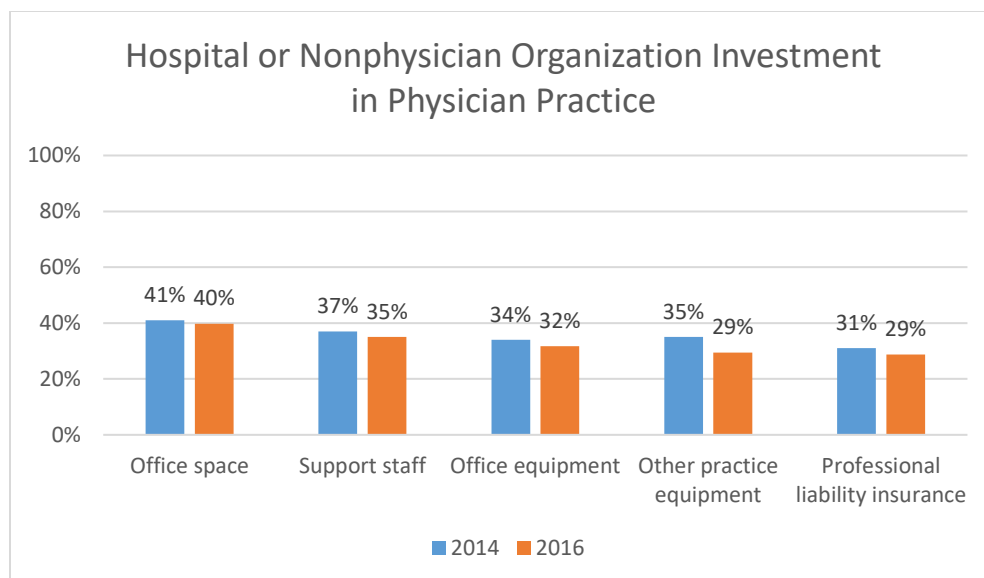
Practice Management Authority (June Question 19)

Primarily one or more physicians in a practice (57 percent) have authority for making practice management decisions.



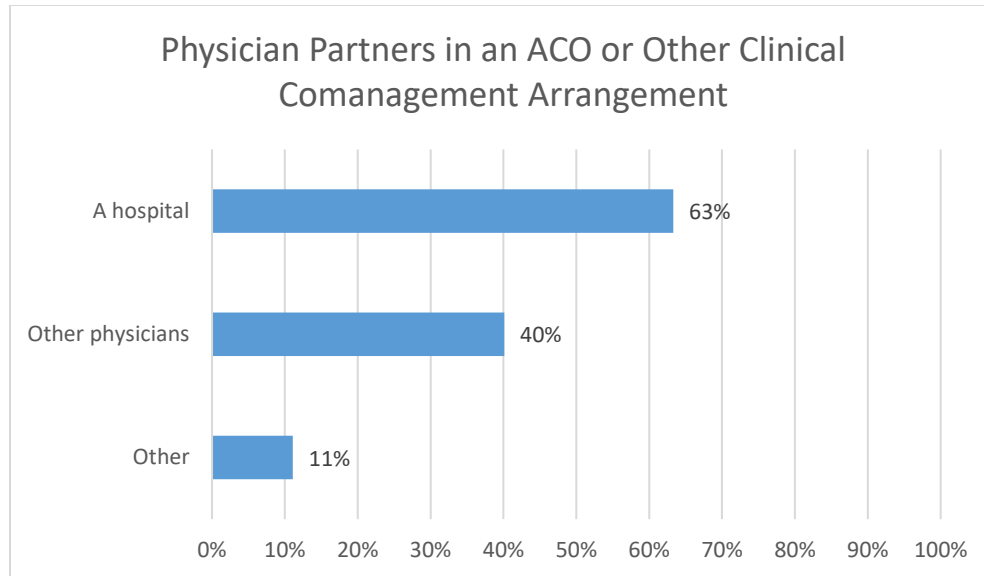
Hospital Investment in Physician Practice (July Question 7)

There was a decrease in the percentage of physicians who reported hospital- or nonphysician organization-provided office space (40 percent), support staff (35 percent), office equipment (32 percent), other practice equipment, or professional liability insurance (29 percent).

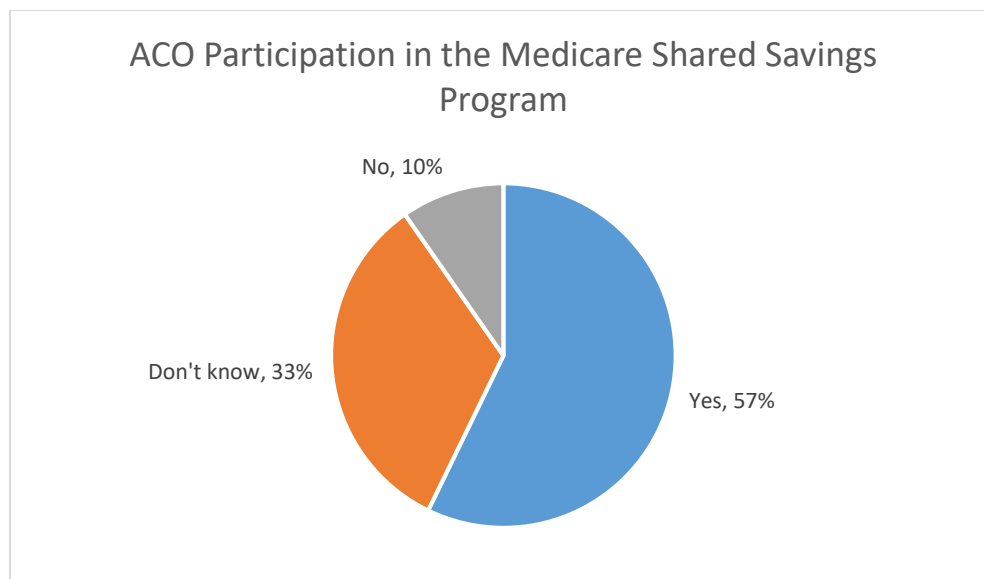


Accountable Care Organizations (March Question 12-16)

Twenty-eight percent of physicians practiced in an accountable care organization (ACO) or other clinical co-management arrangement, primarily with a hospital (63 percent).



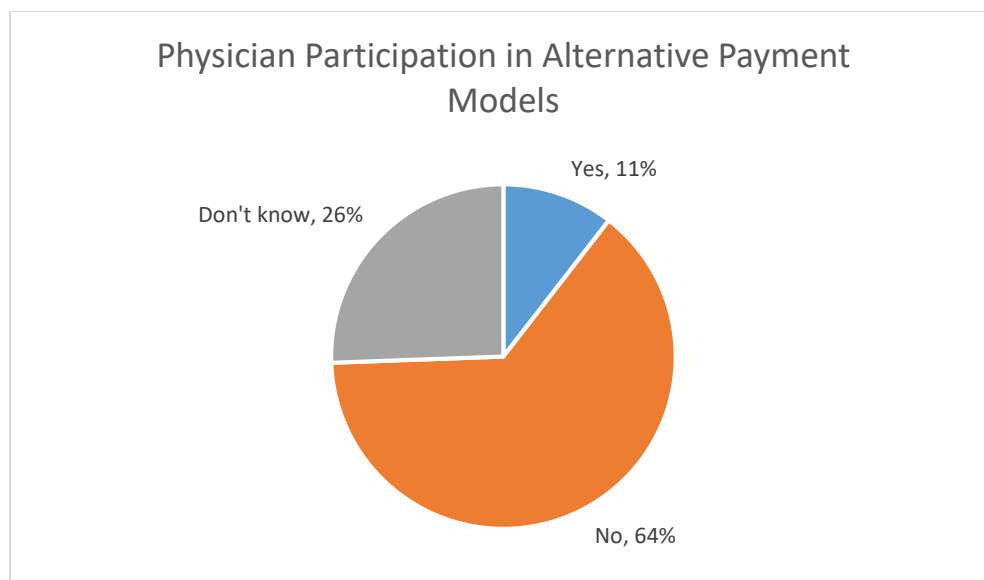
Among physicians who participated in an ACO, 57 percent reported their ACO was in the Medicare Shared Savings Program.



Among physicians not in an ACO, 47 percent reported there was an ACO in their area and it had no effect (74 percent) or a negative effect (24 percent) on their practice. Physicians who reported a negative effect described a loss of referrals, patients, and restricted networks.

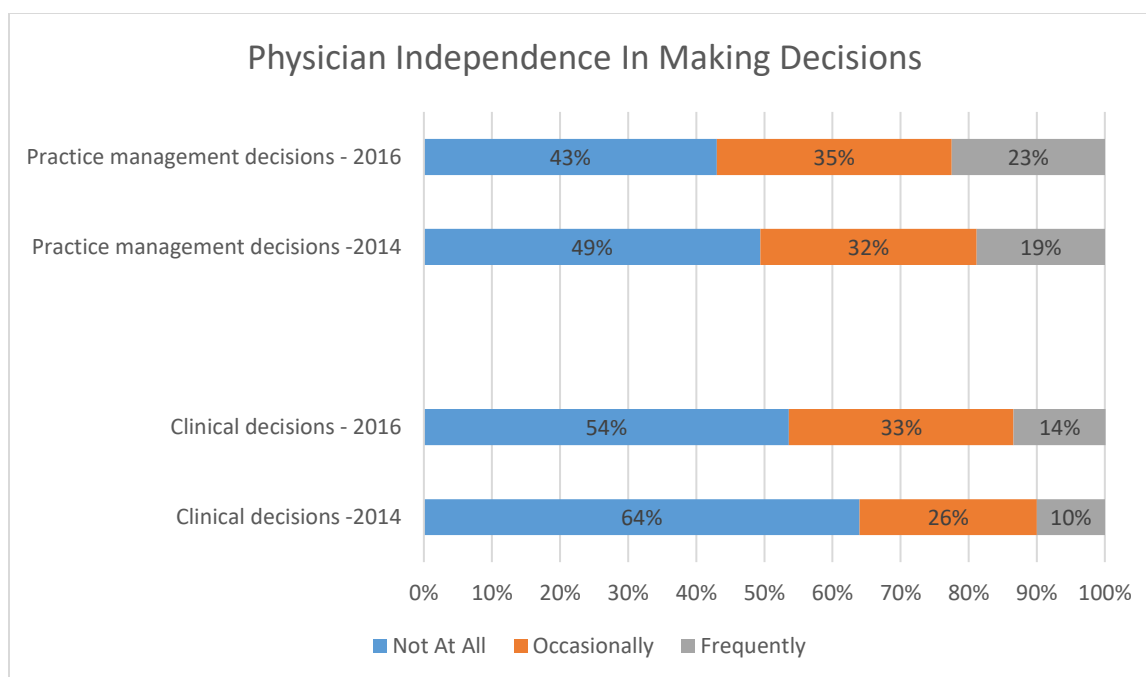
Alternative Payment Models (March Question 17)

Few physicians (11 percent) participated in alternative payment models (e.g., bundled payments).

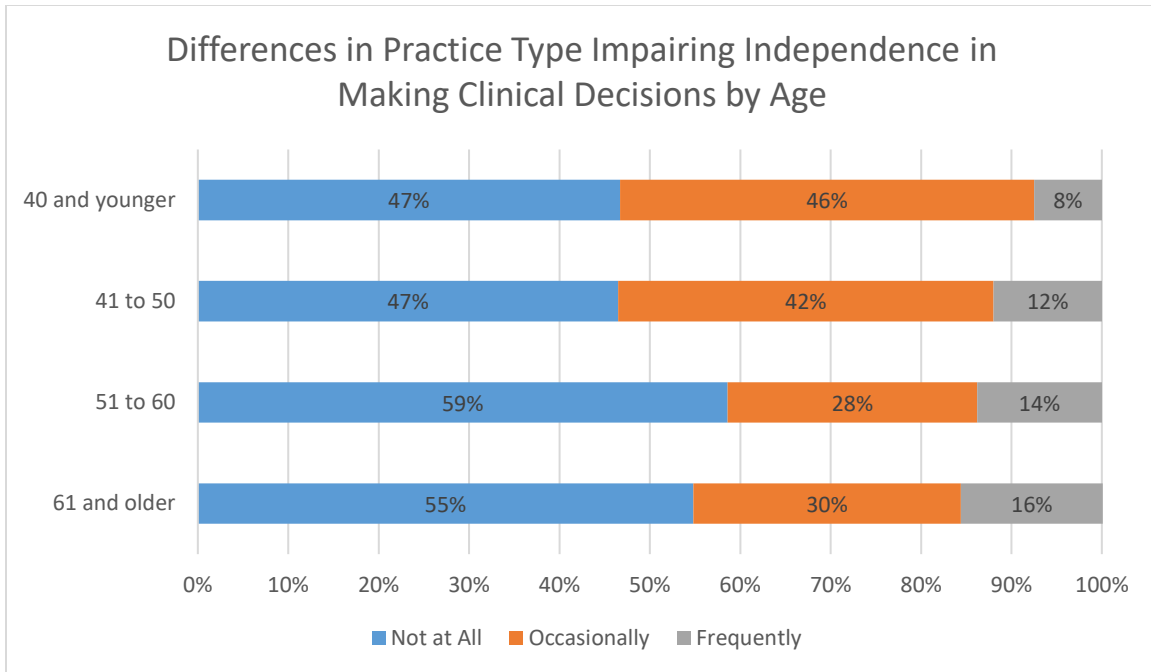


Independent Decisionmaking (July Question 15-17)

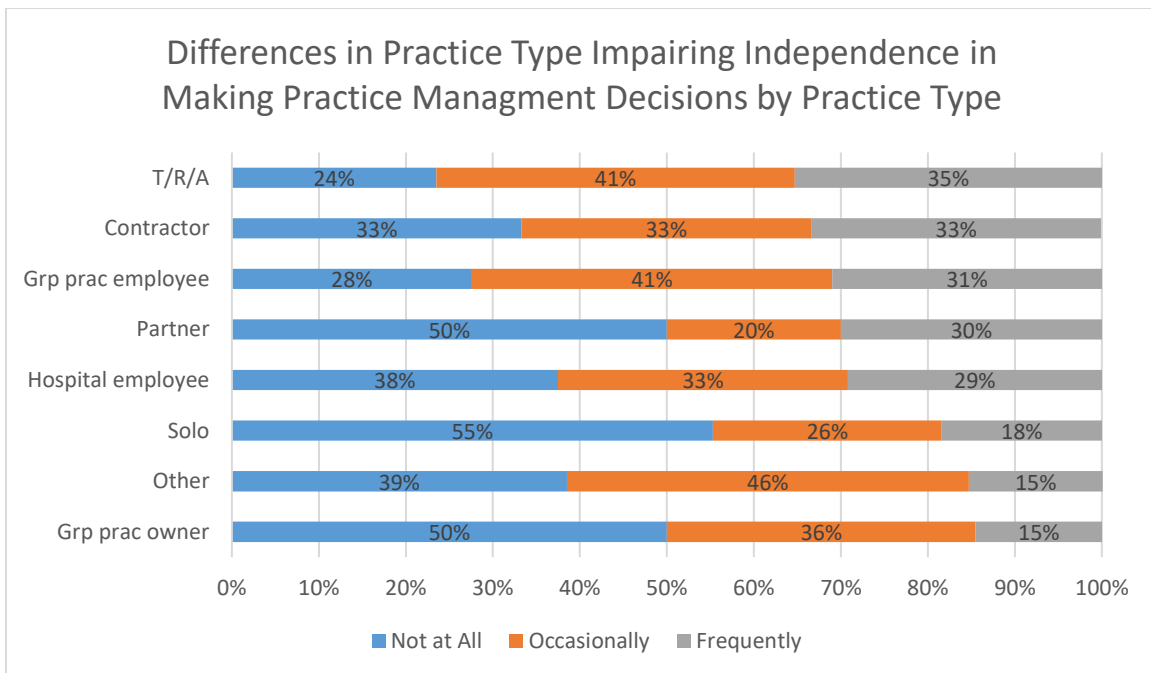
Physicians felt the structure, policies, and relationships of their medical practice frequently impaired their independence in making clinical (14 percent) and practice management (23 percent) decisions. Both these percentages have increased since 2014.



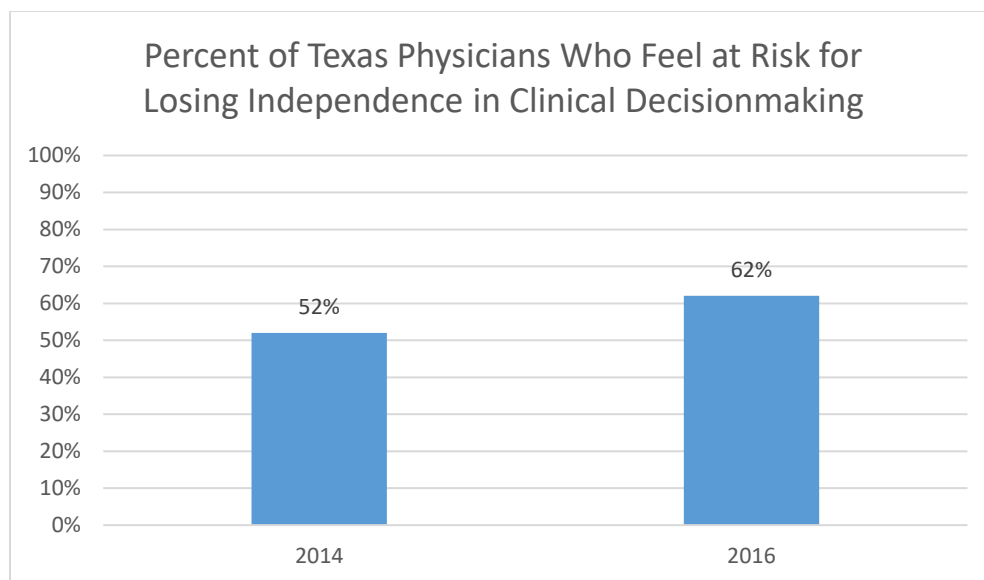
Younger physicians were less likely to report their practice type frequently impaired their independence in making clinical decisions.



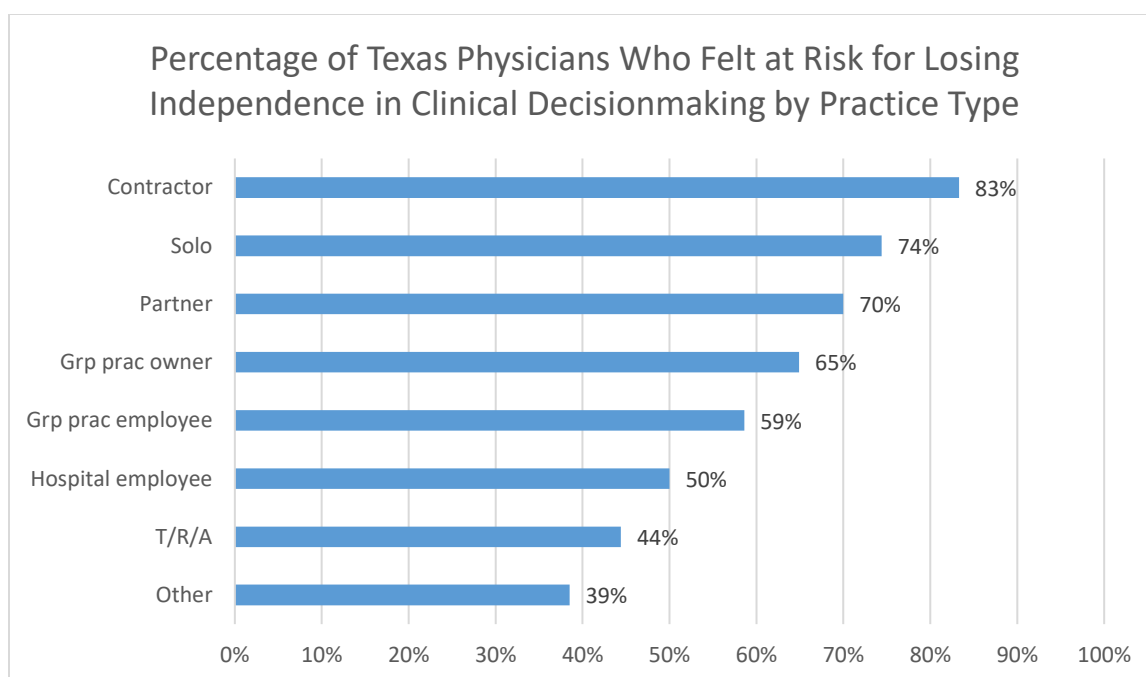
Physicians who practiced in teaching, research, or administration were more likely to report their practice type frequently impaired their independence in making practice management decisions.



There were no statistically significant differences by physician practice type and independence in making clinical decisions. Sixty-two percent of physicians felt they were at risk of losing their independence in clinical decisionmaking, an increase since 2014.



Independent contractors (83 percent) and solo physicians (74 percent) felt most at risk for losing their independence in making clinical decisions.

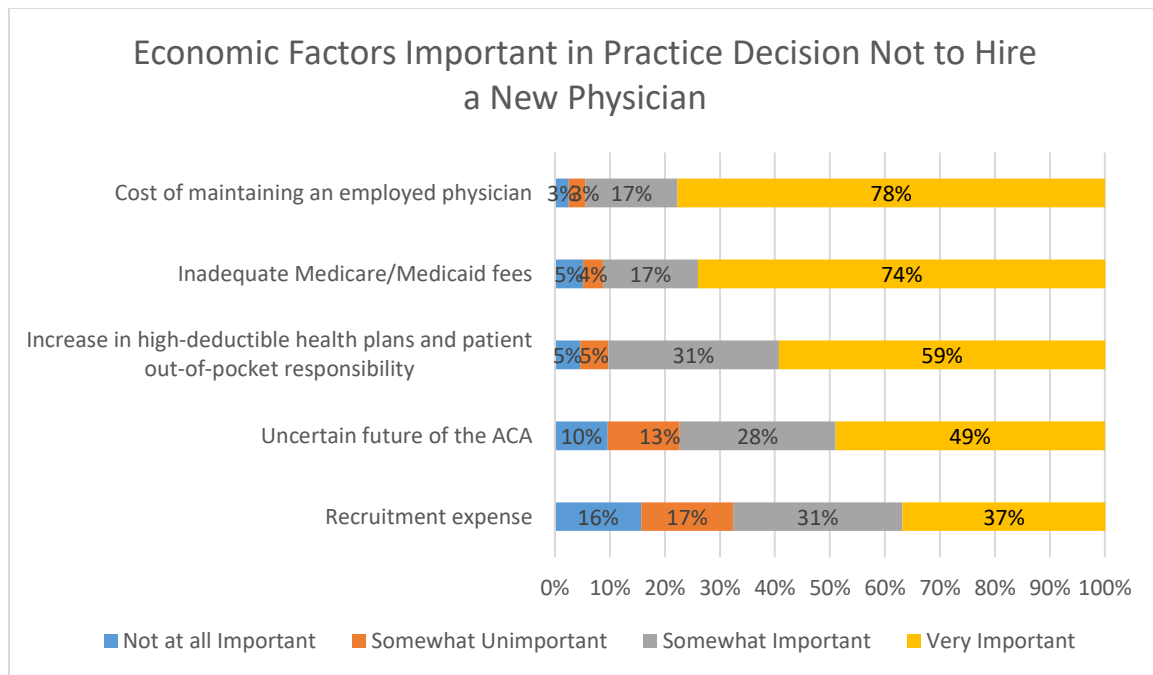


Physicians agreed losing their ability to make independent clinical decisions is bad for physicians and patients (98 percent).

Physician Recruitment (March Question 21-23)

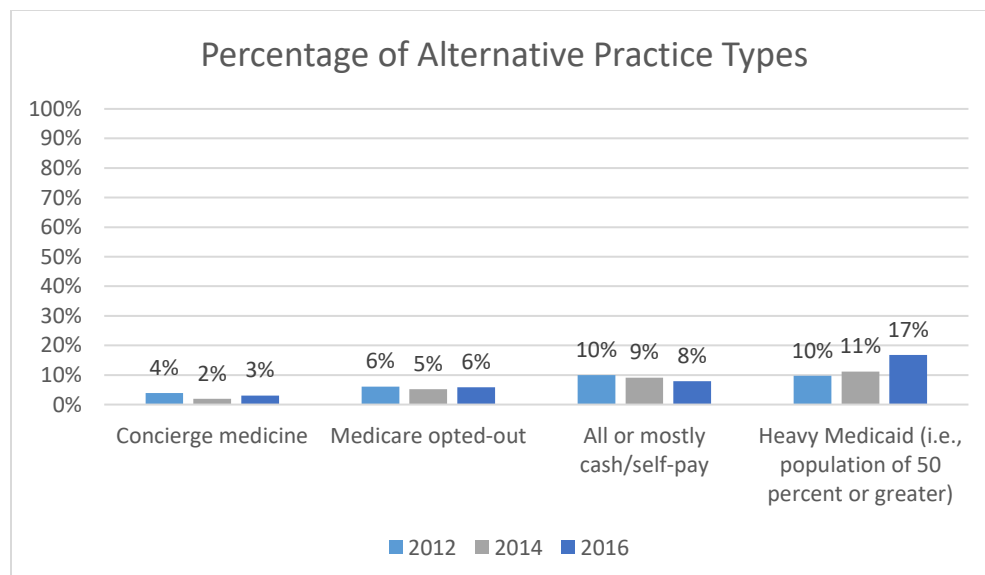
A little more than half of physicians reported their practice hired a new physician in the past year or will do so in the next year (51 percent). Physicians whose practice has not hired a new physician and has no plans to do so would hire a new physician if the economic environment was different (42 percent, up from 35 percent in 2014). These physicians rank the cost of maintaining an employed

physician (78 percent) and inadequate Medicare and/or Medicaid fees (74 percent) as very important in their decision not to hire a new physician.



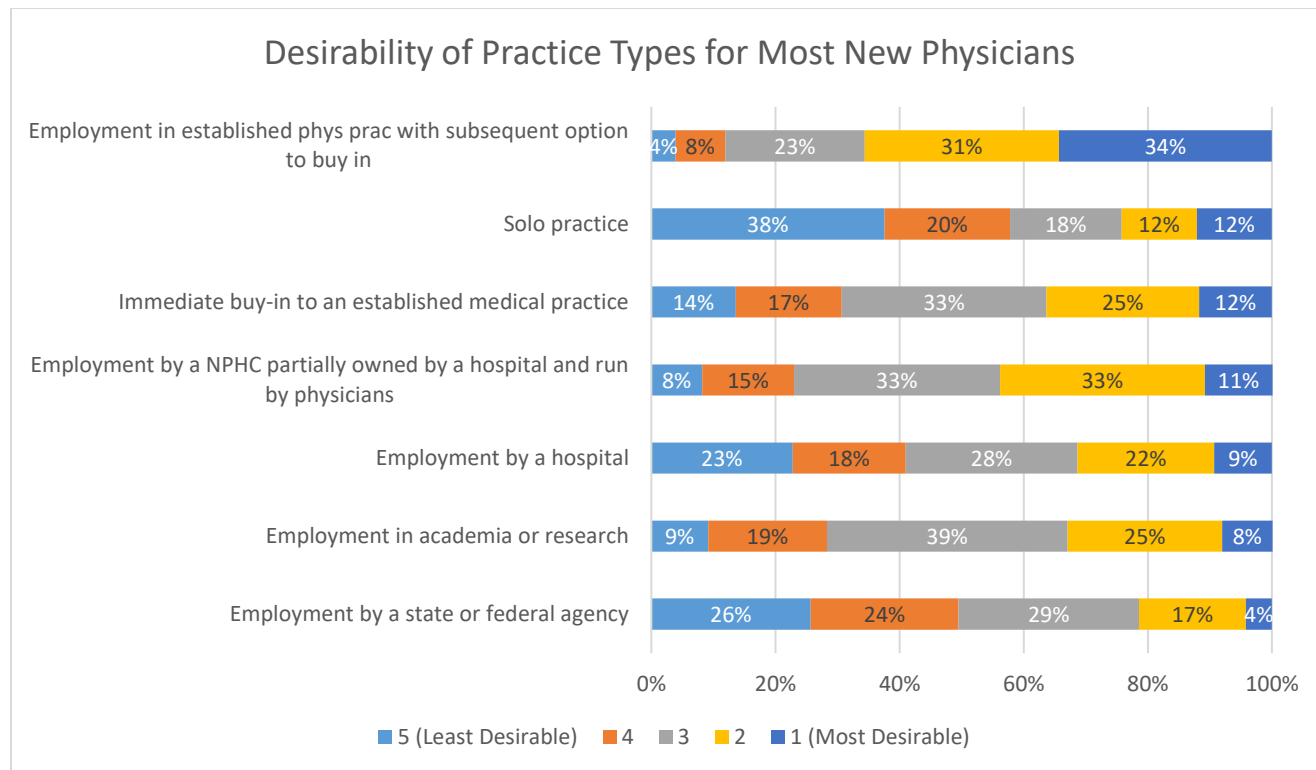
Alternative Practice Types (April Question 19)

Despite increasing attention to concierge and cash-based practices, there was no indication these practice types were growing in Texas.

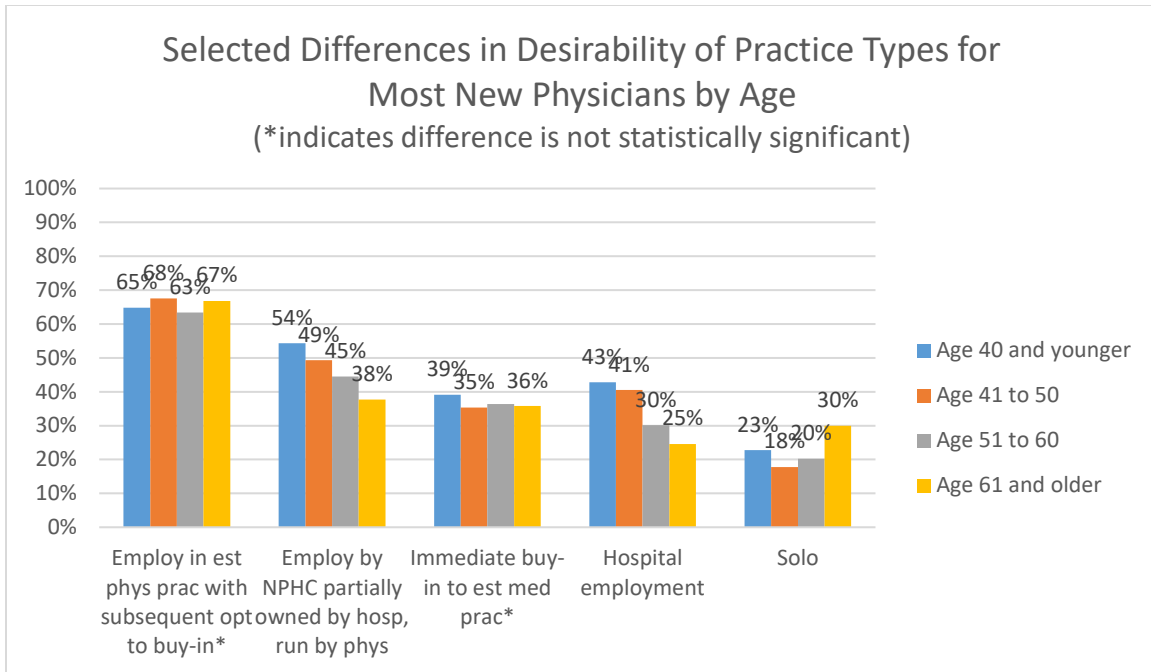


Practice Type Desirability (July Question 31)

Sixty-five percent of physicians rated employment in an established physician practice with a subsequent option to buy in to ownership as the first or second most desirable practice type for most new physicians.



There were statistically significant differences in physicians' rating of the one or two most desirable practice types by age. Younger physicians were more likely to rate employment by a nonprofit health corporation (NPHC) partially owned by a hospital and run by physicians, and employment by a hospital as desirable.

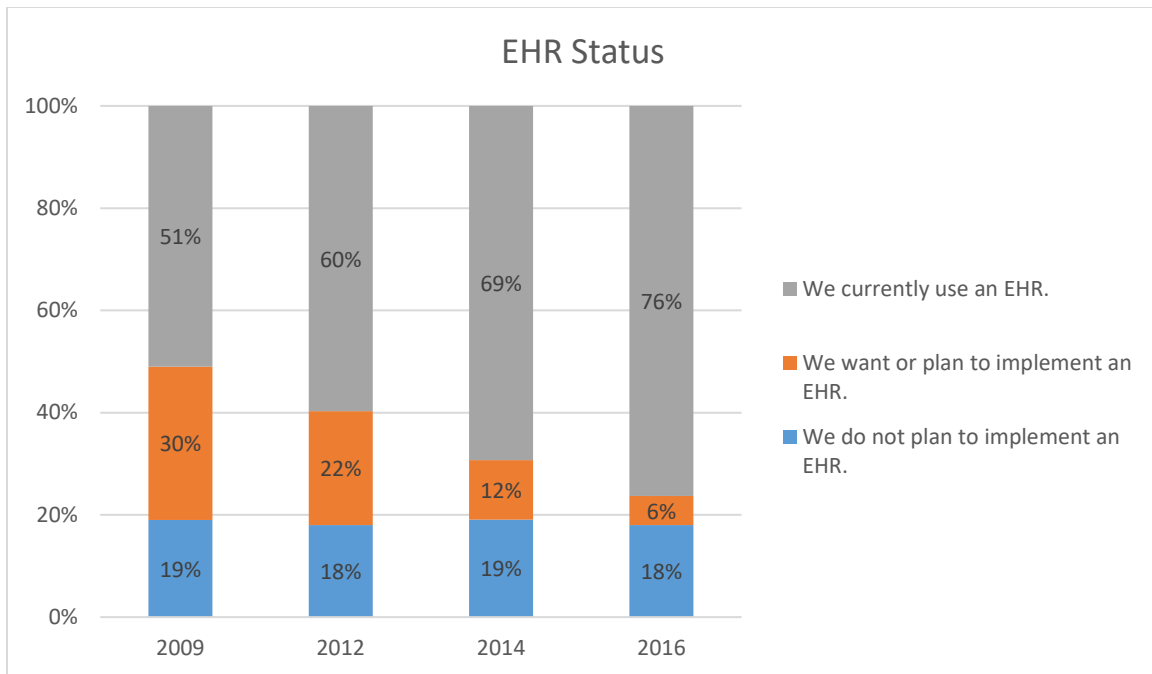


Electronic Health Records

Health information technology, such as electronic health records, e-prescribing, and health information exchange, has the potential to improve patient quality of care. TMA's goal is to help ensure HIT has a positive impact on physicians, patients, and practices by enhancing quality of care, patient safety, and practice viability. The current questions served as a benchmark of physician needs and experiences with EHRs and are especially important as TMA tailors services and resources to help physicians with meaningful use of an EHR.

EHR Status (May Question 1)

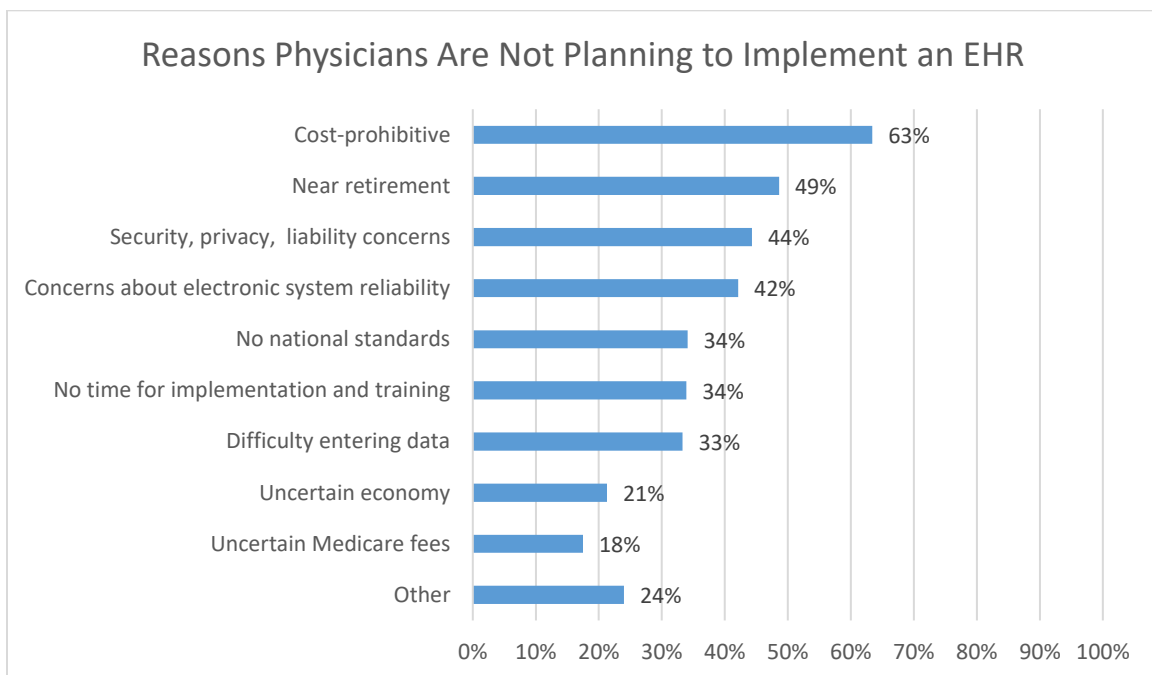
The percentage of physicians using an EHR (76 percent) increased while the percentage of physicians who planned to implement an EHR decreased (6 percent). The percentage of physicians who do not plan to implement an EHR remained steady at 18 percent.



Practices With No Plans to Implement an EHR

Reasons for Not Implementing an EHR (May Question 2)

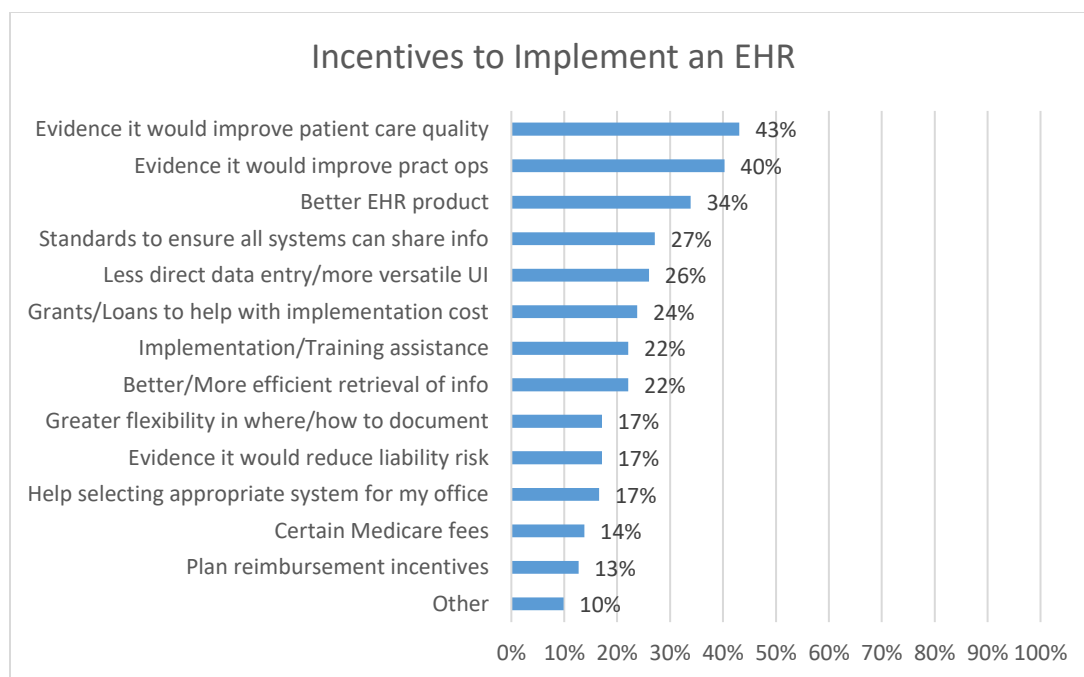
Physicians who did not plan to implement an EHR continued to report it was cost-prohibitive (63 percent).



A percentage of physicians (24 percent) listed “other” reasons why they were not planning to implement an EHR, primarily that there was no evidence it improved patient care but there was evidence it decreased patient care quality.

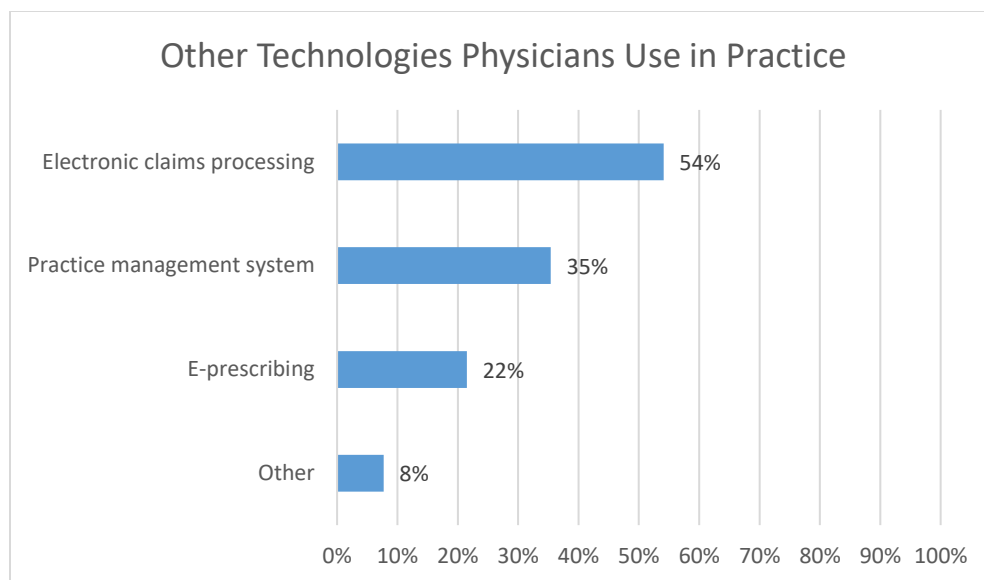
Incentives to Implement an EHR (May Question 3)

Physicians would be more likely to implement an EHR if they saw evidence it improved the quality of patient care (43 percent) or practice operations (40 percent).



Other Technology in Practice (May Question 4)

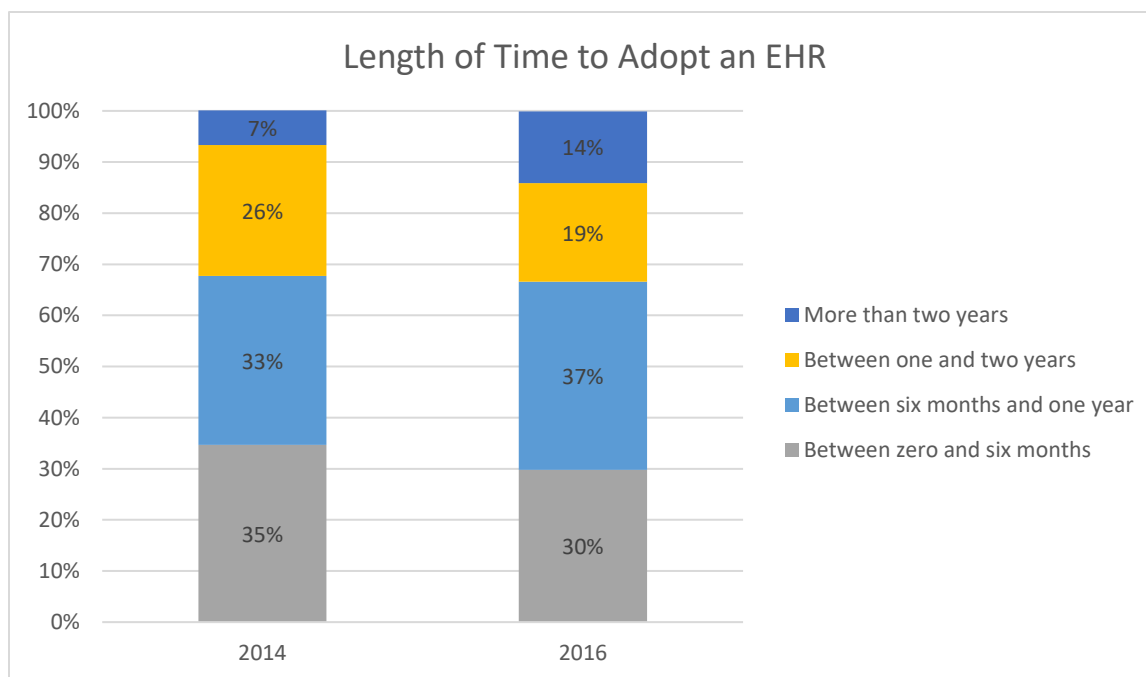
Although 20 percent of physicians were not using an EHR in their practice, they were using other technology, particularly electronic claims processing (54 percent).



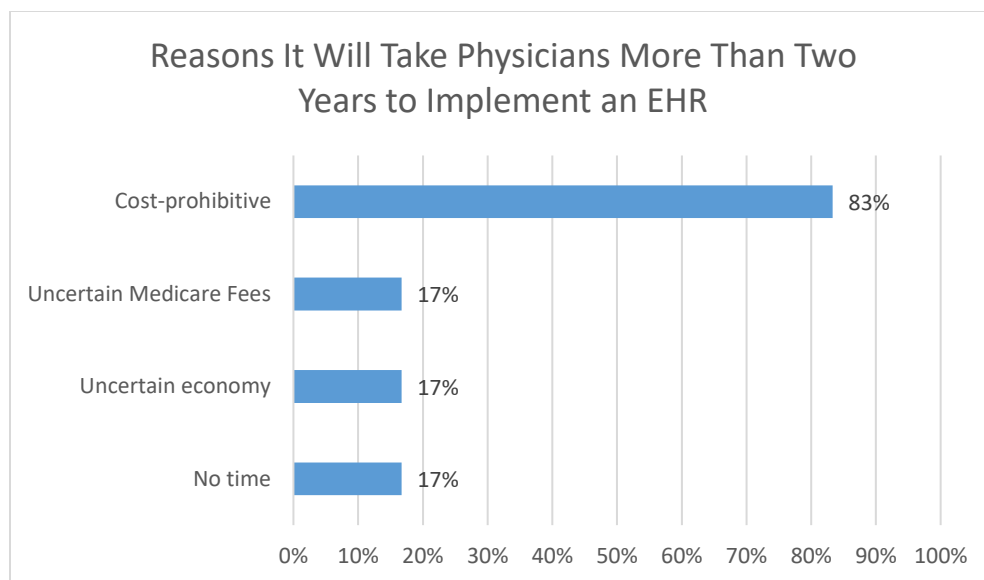
Practices With Plans to Implement an EHR

Time Until EHR Implementation (May Question 5-6)

Practices that wanted to or planned to implement an EHR anticipated doing so within one year (67 percent).

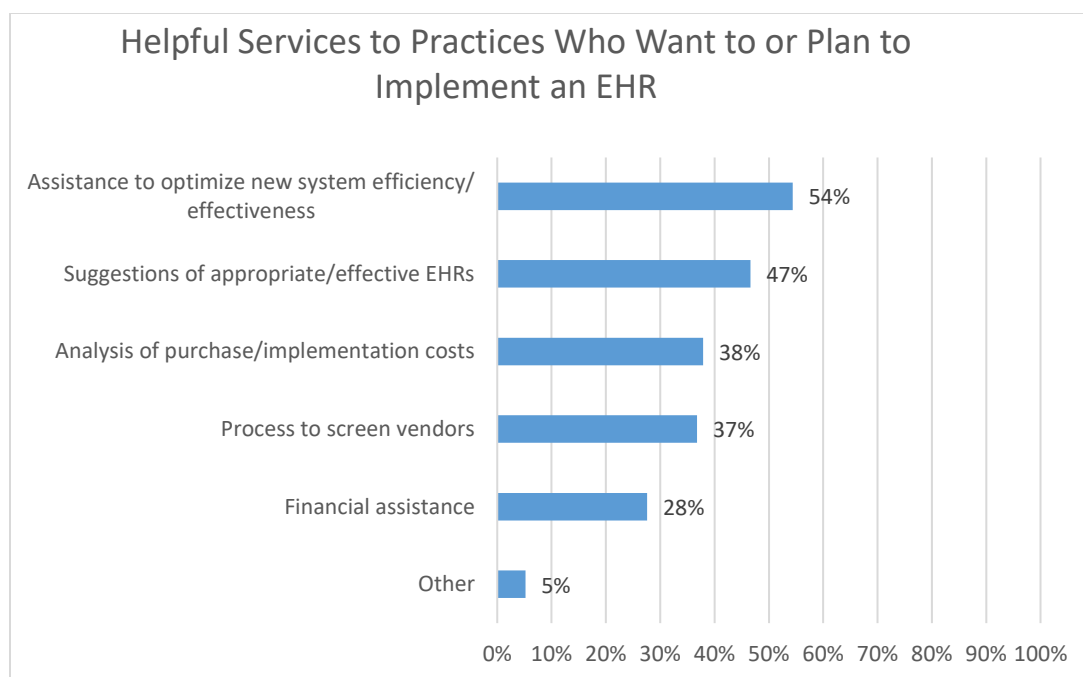


Physicians who reported it will take their practice more than two years to implement an EHR reported the cost was prohibitive (83 percent).



Helpful Services for Implementation (May Question 7)

Physicians who want or plan to implement an EHR reported assistance optimizing new system efficiency and effectiveness (54 percent) would be most helpful to their practice.

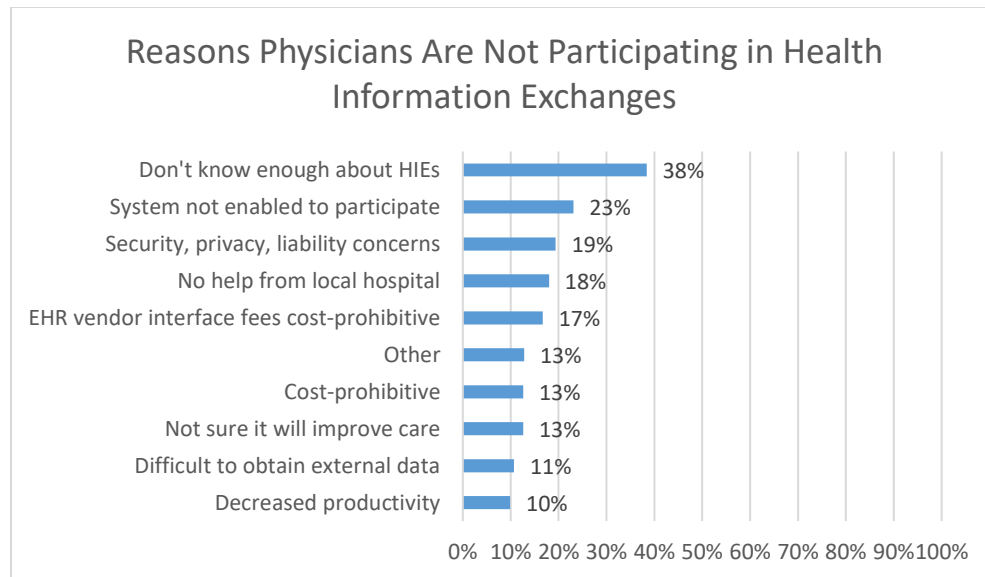


A small percentage of physicians specified other services that would be helpful to their practice, including assistance with security concerns.

Practices That Have Implemented an EHR

Health Information Exchange (February Question 8-9)

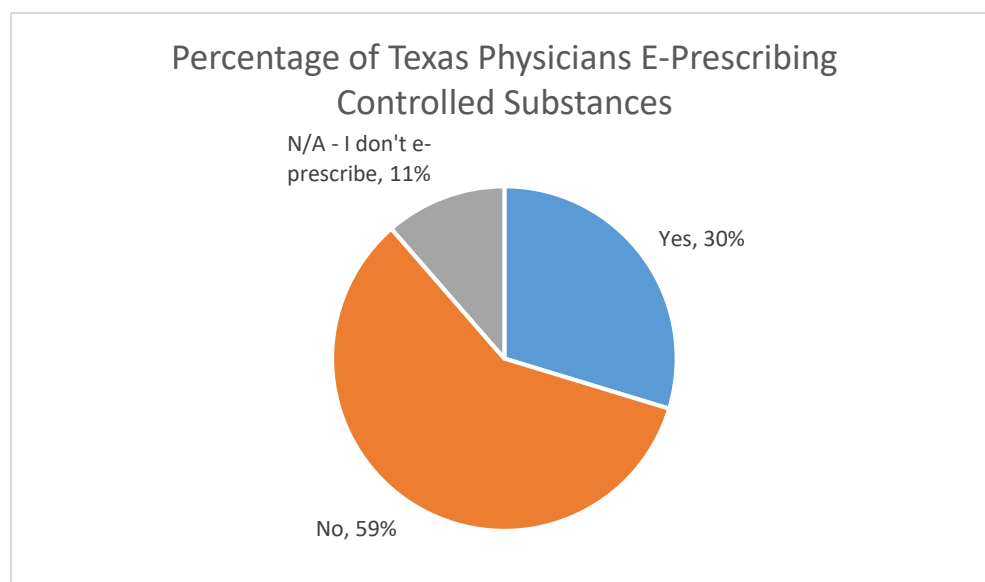
Thirty-six percent of physicians participated in a local HIE to share EHR data among health care providers. Physicians who were not participating in a HIE were unfamiliar with them (38 percent) or their system was not enabled to participate (23 percent).



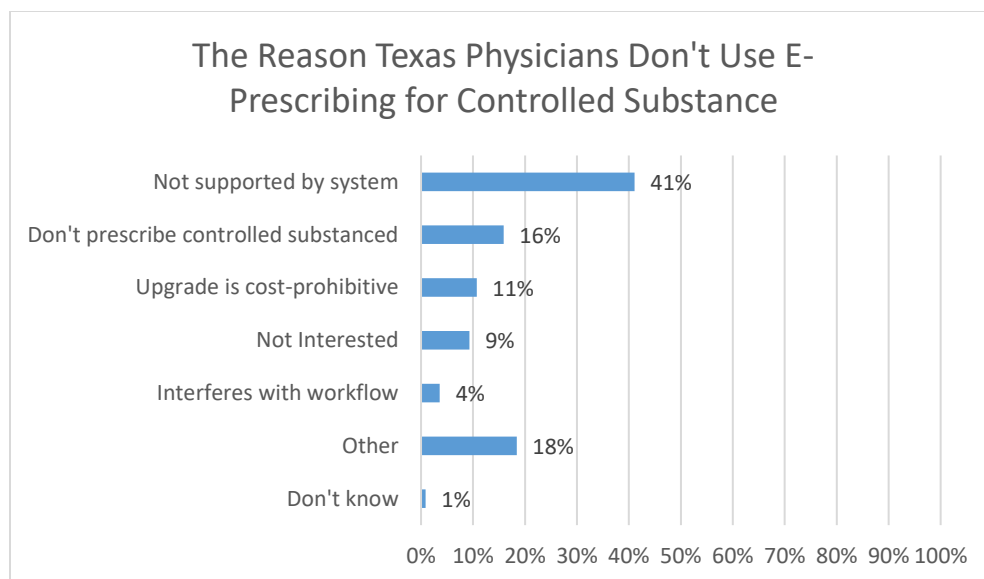
Other reasons physicians specified as to why they were not participating in a local HIE included there were none in their area or it was not their decision.

E-Prescribing Controlled Substances (May Question 10-11)

Thirty percent of physicians used e-prescribing for controlled substances.



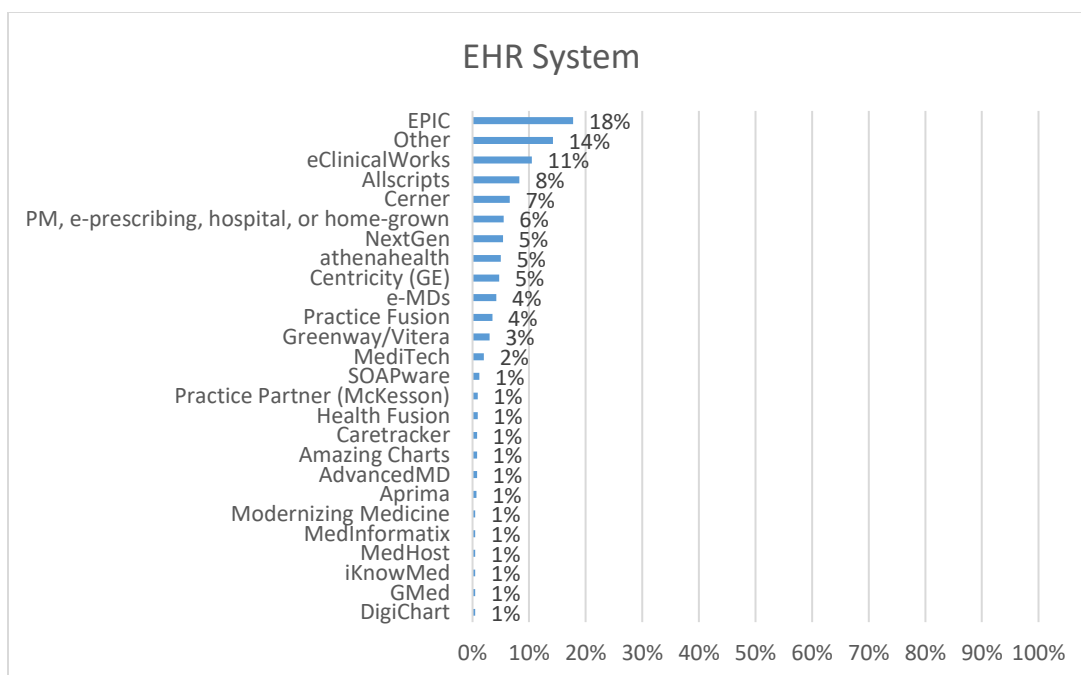
Physicians who didn't use EPCS reported it was not supported by their EHR (41 percent).



Eighteen percent reported other reasons why they didn't use EPCS: They didn't know about it, were told it was not available, or found the process difficult to set up.

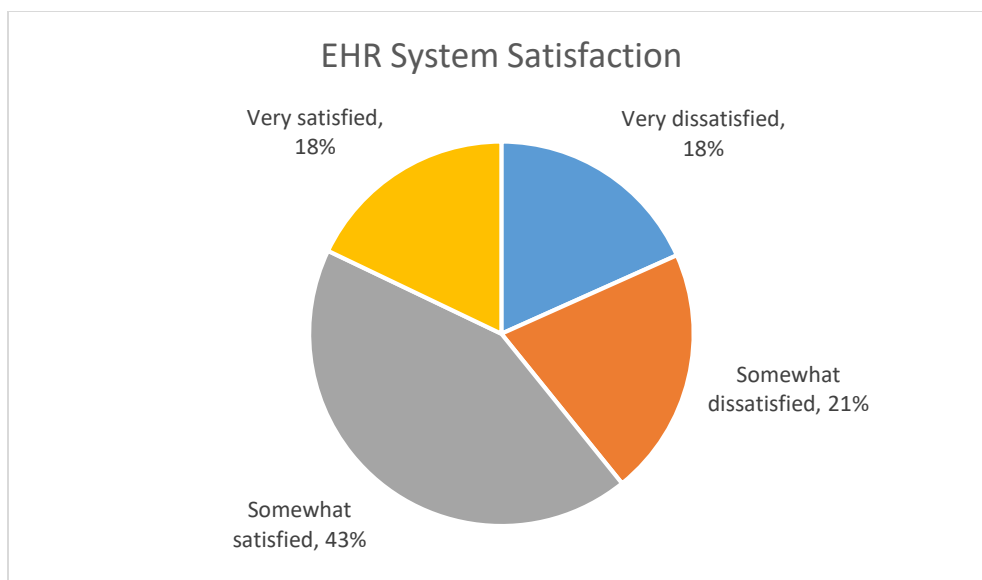
EHR System (May Question 12)

In years past the largest percentage of physicians used “other” EHR systems, too numerous to quantify. This year the percentage of physicians who used “other” systems decreased to 14 percent with EPIC now the system with the largest percentage of users (18 percent).

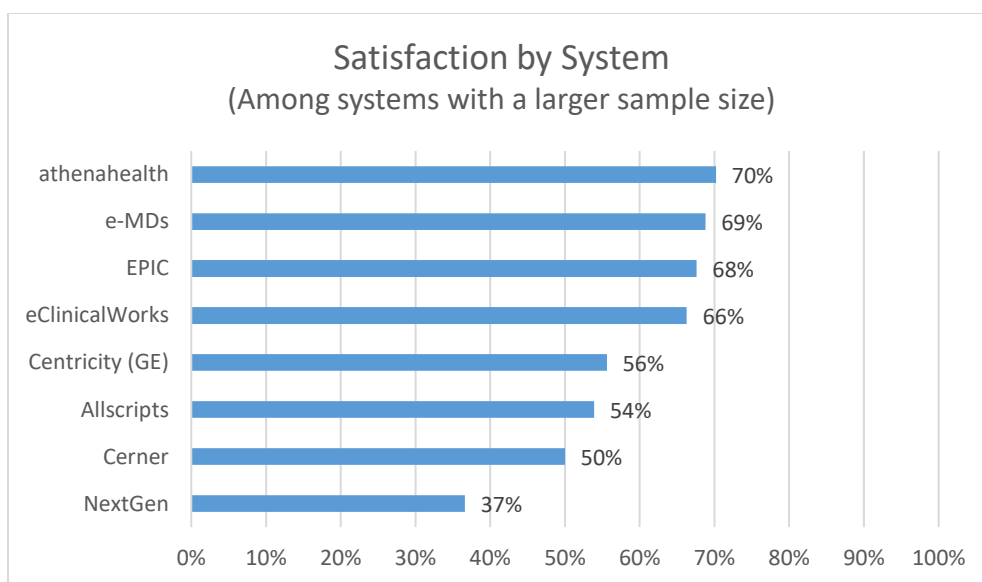


EHR Satisfaction (May Question 13)

Users were asked to rate their satisfaction with their system. Overall, physicians were satisfied with their EHR (61 percent).

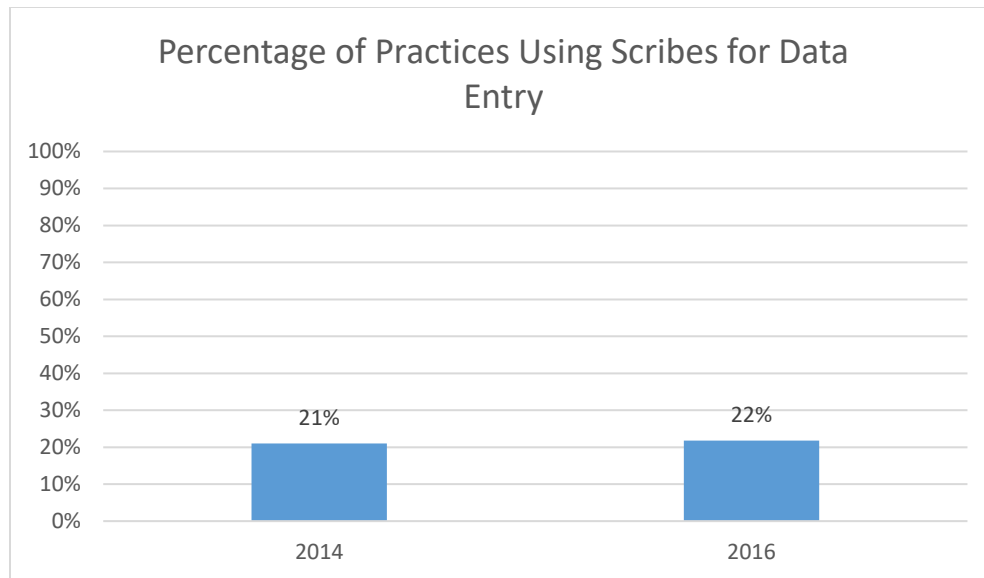


Among systems with a larger percentage of users, an analysis of physician satisfaction showed physicians most likely to be satisfied with athenahealth (70 percent) followed by e-MDs (69 percent).



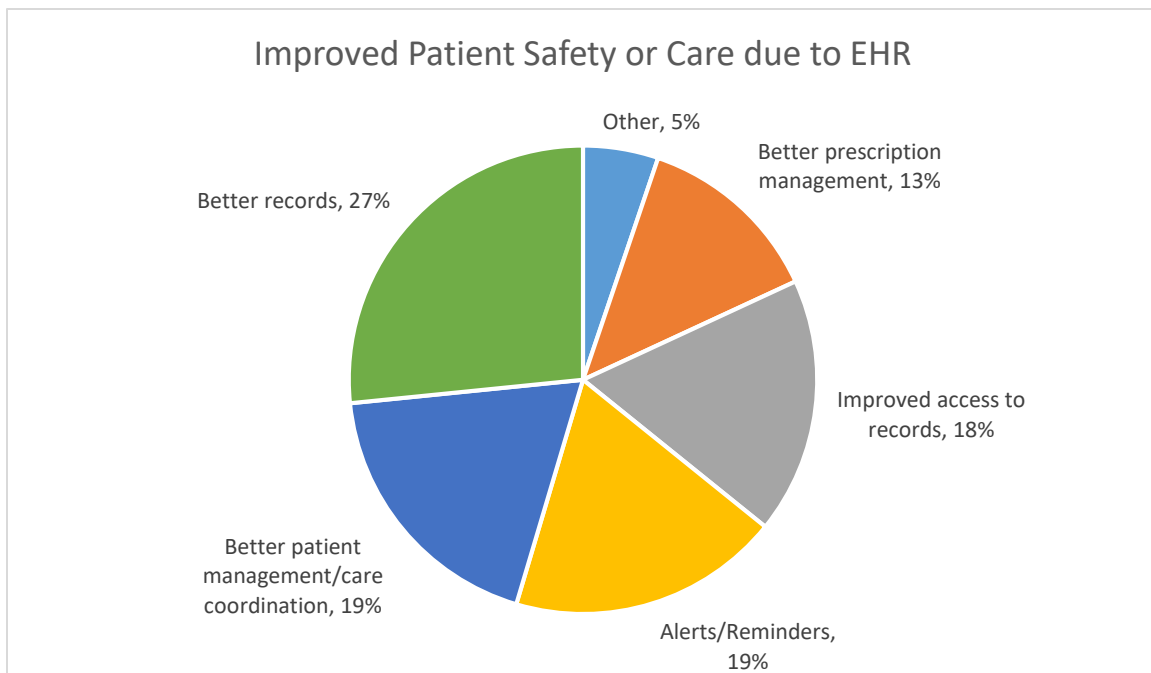
Scribes (May Question 14)

Twenty-two percent of physicians reported their practice used scribes for EHR data entry.



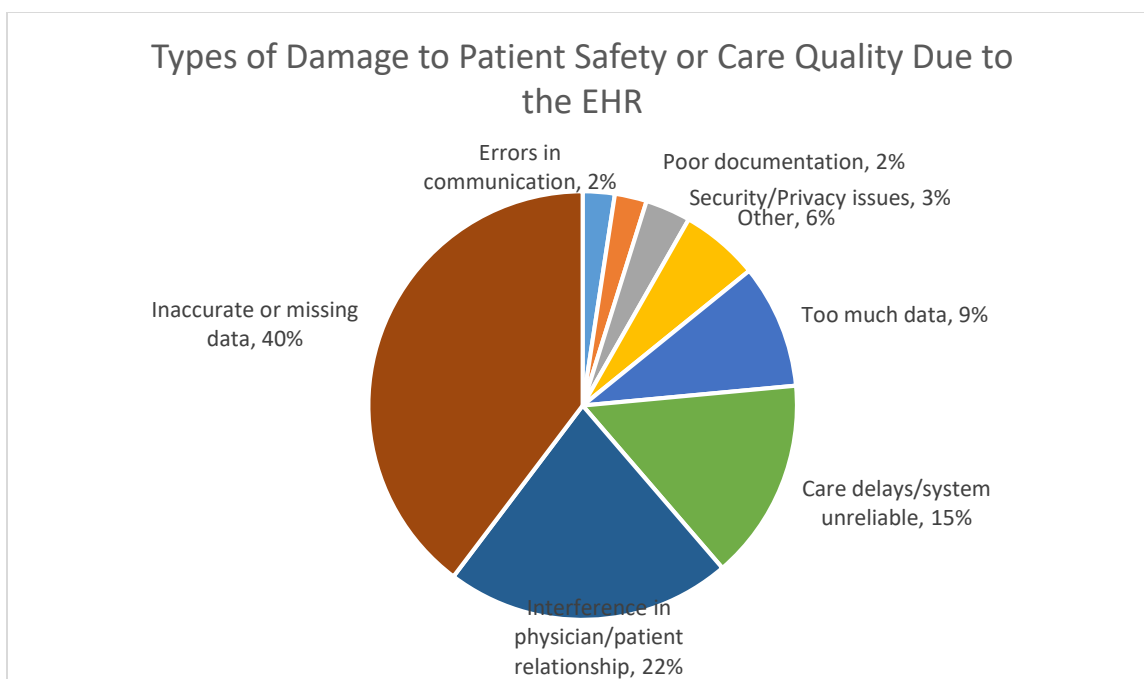
EHR Effect on Patient Safety and Quality of Care (Question 15-18)

EHRs have the potential to improve patient safety and care, but they can introduce new types of errors or escalate small errors into larger ones. Forty-nine percent of physicians saw improved patient safety and care as a result of using an EHR, including more thorough and legible records (27 percent), improved care coordination, and alerts or reminders (19 percent).



Thirty-four percent of physicians experienced damage to patient safety and care due to an EHR, primarily missing or inaccurate data, which was seemingly carried forward into perpetuity (40 percent). An additional 9 percent of physician experienced too much data, much of which was

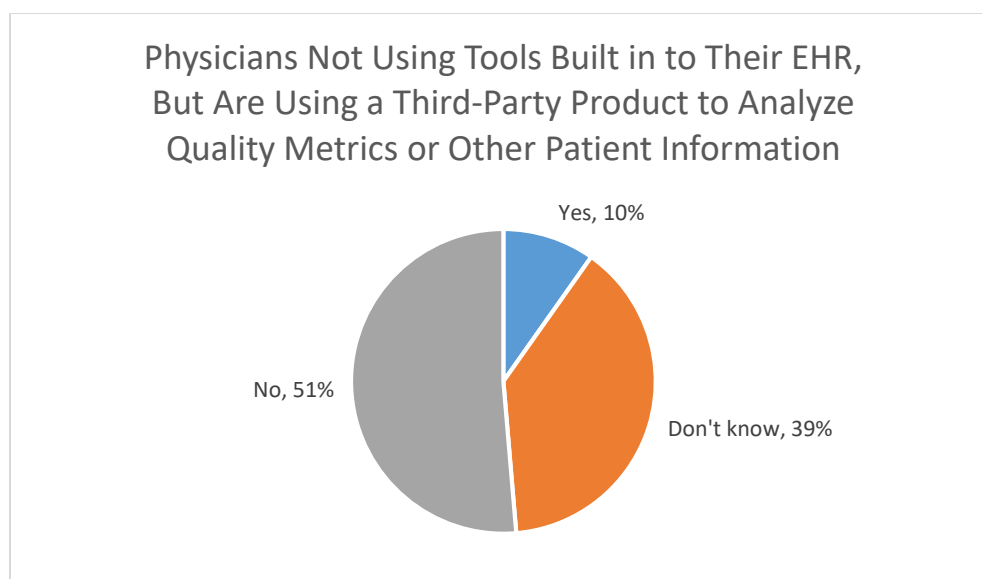
irrelevant and obscured important information. Twenty-two percent reported interference in the patient-physician relationship, and 15 percent of physicians reported delays in care, frequently as a result of system crashes and downtime.



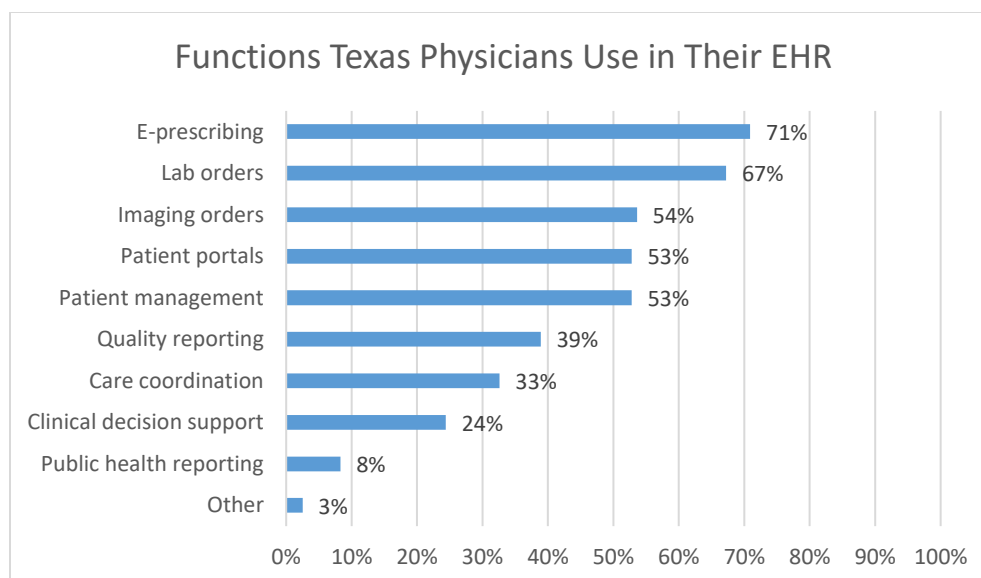
Fifty-two percent disagreed improvements in patient safety and care quality due to an EHR outweighed risks.

EHR Tools (May Question 19-21)

Sixty percent of physicians used tools built in to their EHR to analyze quality metrics or other information about their patient population. Among the 40 percent of physicians not using tools built in to their HER, 10 percent are using a third-party product.

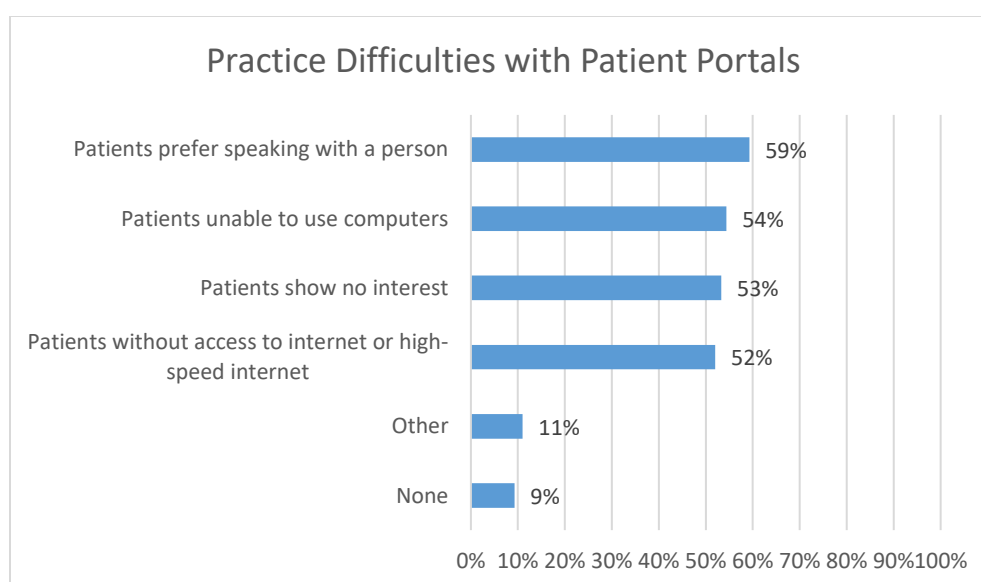


A large majority physicians used e-prescribing (71 percent) and ordered labs (67 percent) through their EHR.



Patient Portals (May Question 22-23)

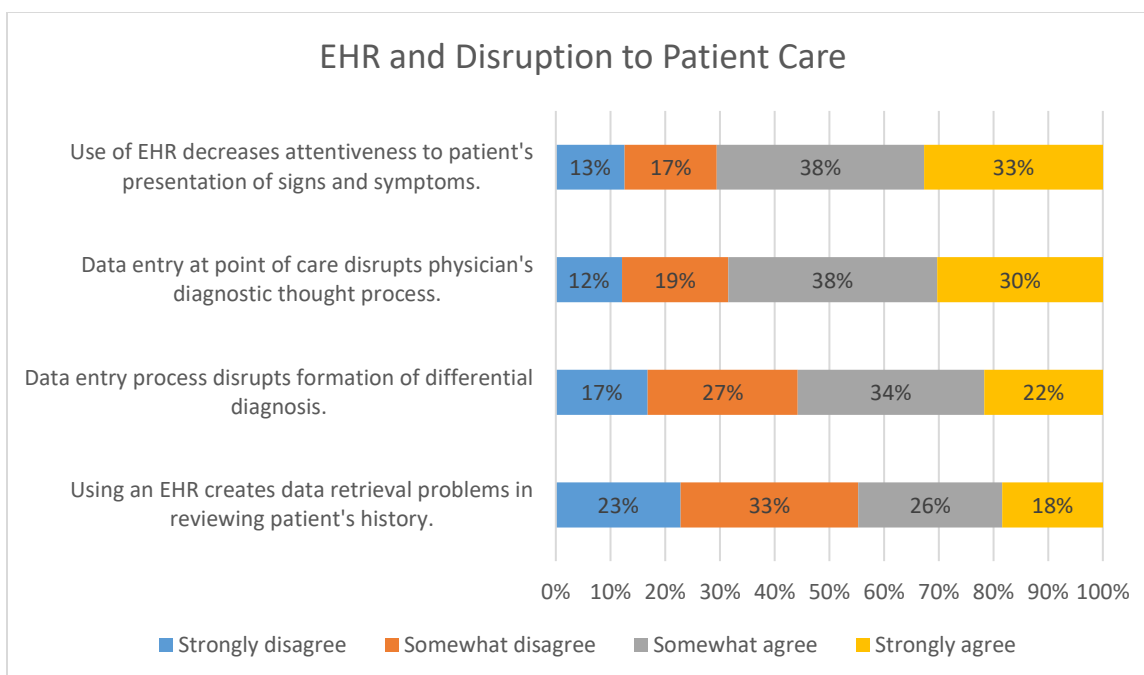
Patient portals are online websites which give patients access to their personal health information. They are also the primary way in which practices demonstrated patient engagement in the meaningful use program. Seventy-three percent of physicians had a patient portal. However, the majority of physicians experienced challenges using their patient portal, including low patient adoption rates because patients preferred speaking with a practice physician or staff (59 percent), patients unable to use or without a computer (54 percent), patients with no interest in using a portal (53 percent), and patients without internet or high-speed internet (52 percent). Other problems physicians experienced were patients with limited English proficiency and patients frequently forgetting their password and diverting staff time from other practice activities.



Given that these factors are beyond a physician's or practice's control, basing payment on patient use of portals may discourage practices from seeing older patients or patients with limited resources and may not be best from a policy or patient care standpoint.

EHR Disruption to Patient Care (May Question 24)

Physicians agreed use of the EHR decreased attentiveness to the patient's presentation of signs and symptoms (71 percent), and data entry at the point of care disrupted a physician's diagnostic thought process (68 percent).



Use of More Than One EHR (May Question 25)

Sixteen percent of physicians switched EHRs because their EHR was ineffective and 5 percent because their EHR went out of business. Seven percent listed other reasons for switching EHRs including cost.

Cyber Security (May Question 26-28)

Four percent of physicians' practices experienced a ransomware attack (data encrypted until ransom paid), which cost a median of \$1,000 to unencrypt their data, and 4 percent experienced a data breach, which cost a median of \$20,000 including IT support, notifying patients, and updating policies.

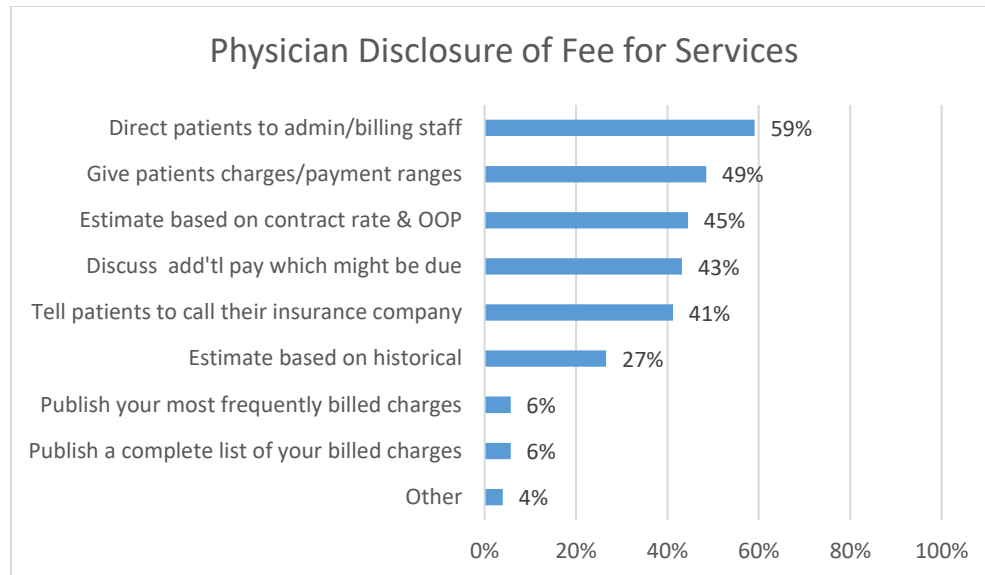
Cyber Liability Coverage (May Question 29)

Twenty-eight percent of physicians reported their liability insurance carrier offered cyber liability coverage.

Patient Billing

Fee Transparency (January Question 11)

Health care price transparency or disclosure has emerged as a hot topic in state legislatures as a method of containing health care costs and protecting patients from “surprise” bills. Physicians reported several actions to promote transparency and assist patients who are trying to determine their out-of-pocket costs, frequently directing patients to their administrative or billing department or staff (59 percent) to discuss charges or payment ranges.



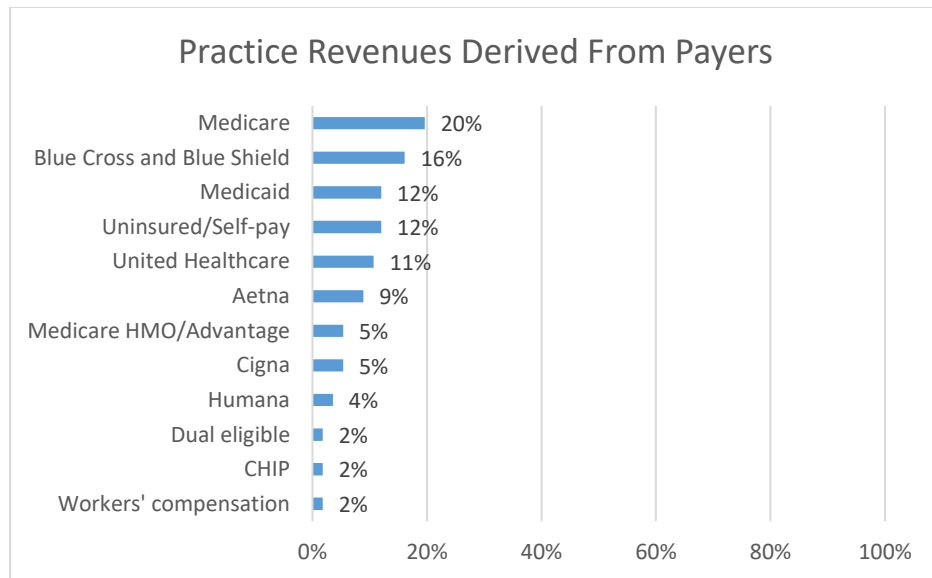
Prompt Payment Discounts (January Question 21)

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 offered discounts to those patients when they pay promptly for the services they receive (69 percent).

Practice Revenues

Sources of Practice Revenues (February Question 4)

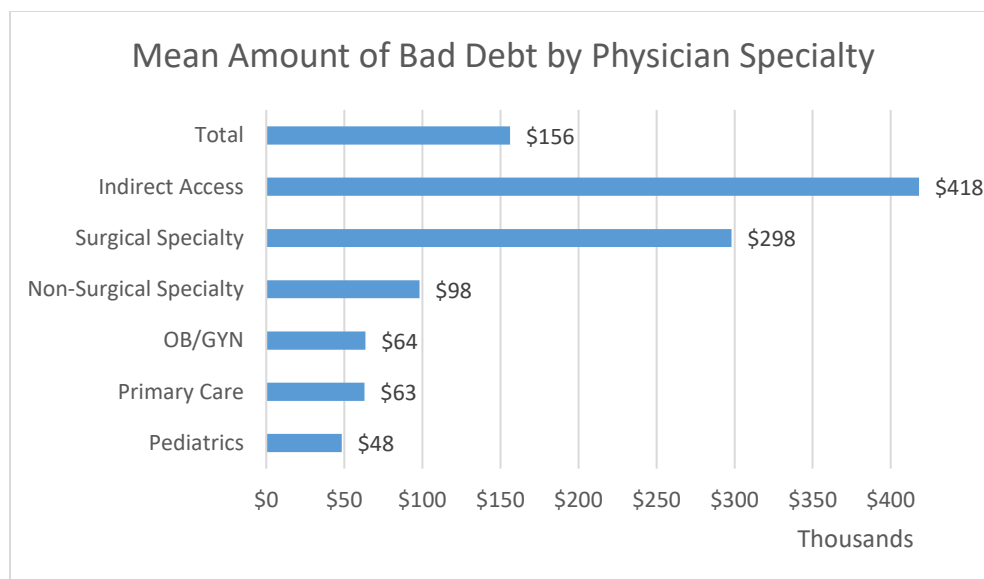
Physicians were asked to estimate their revenue percentages by payer type. Forty-three percent of average practice revenues were derived from programs funded and regulated by state or federal government: 20 percent from Medicare, 12 percent from Medicaid, 5 percent from Medicare HMO or Advantage plans, 2 percent from payments for dual-eligible patients, 2 percent from workers' compensation plans, and 2 percent from the Children's Health Insurance Program (CHIP). Revenues for commercially insured patients constituted 45 percent of physician practice receipts: Blue Cross and Blue Shield of Texas (16 percent), UnitedHealthcare (11 percent), Aetna (9 percent), Cigna (5 percent), and Humana (4 percent).



Charity Care and Bad Debt (January Question 22-23)

Charity care is defined as medical care provided with prior knowledge 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 2015 was \$76,620.

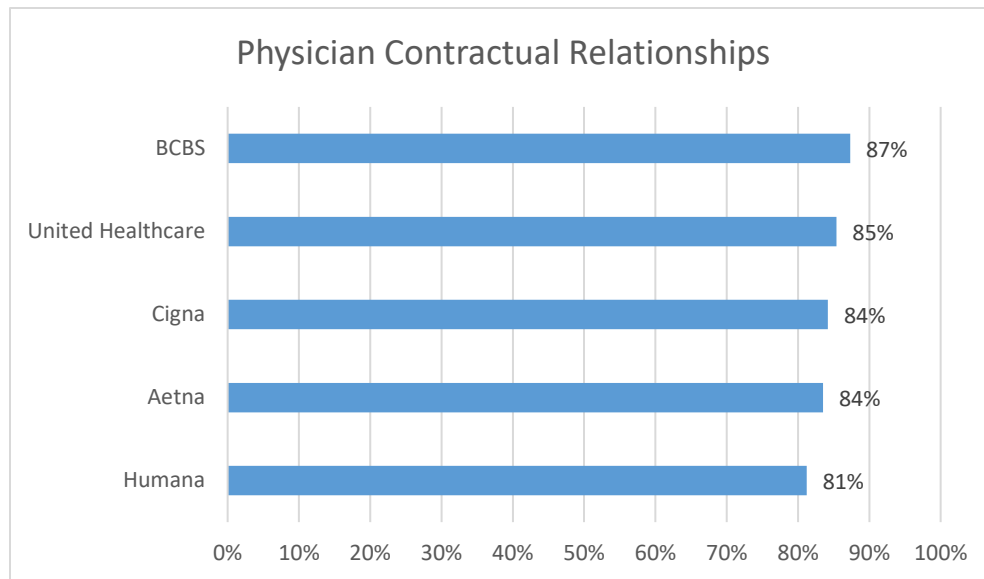
Bad debt is the uncollectible debts over and above charity care. The mean amount of uncollectible debts per physician in 2015 was \$156,170. Physicians in the indirect-access specialties reported an average amount of \$418,080.



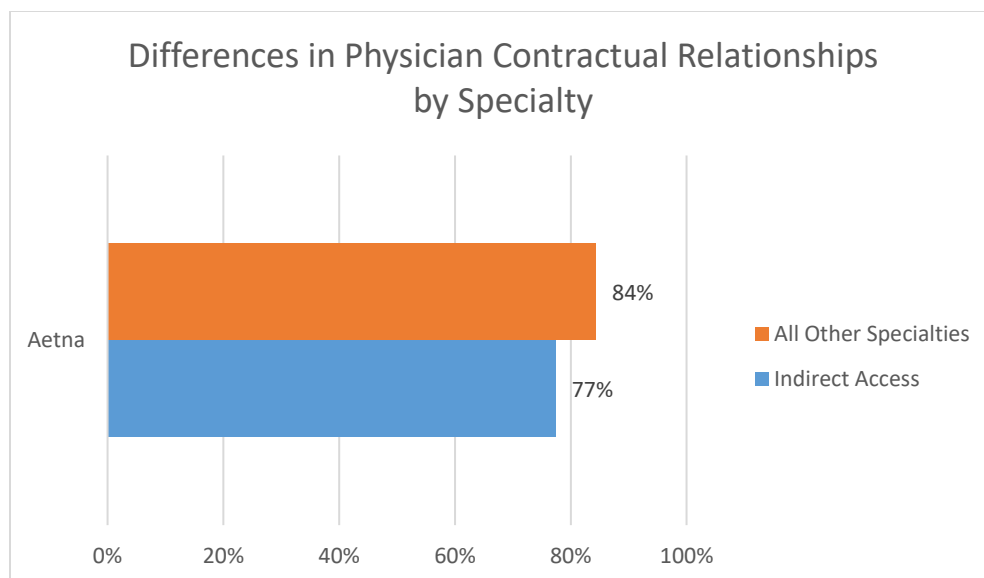
Health Plans

Contract Status (February Question 5)

A large majority of physicians were contracted with Blue Cross and Blue Shield of Texas (87 percent), UnitedHealthcare (85 percent), Cigna (84 percent), Aetna (84 percent), and Humana (81 percent) in 2015.

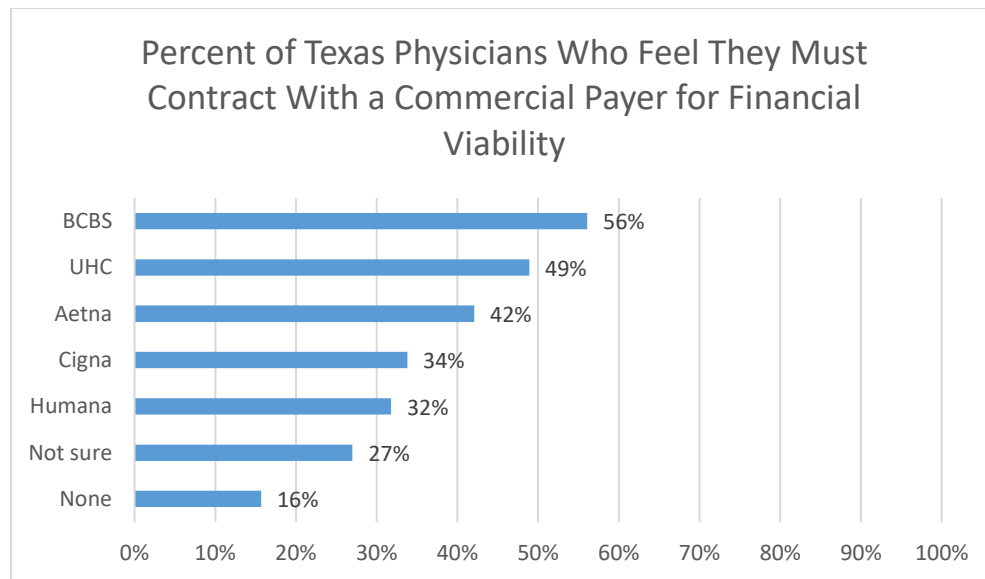


Physicians in the indirect-access specialties were less likely to be contracted with Aetna in 2015, but there were no statistically significant differences in contract relationships with the other four major payers by physician specialty.



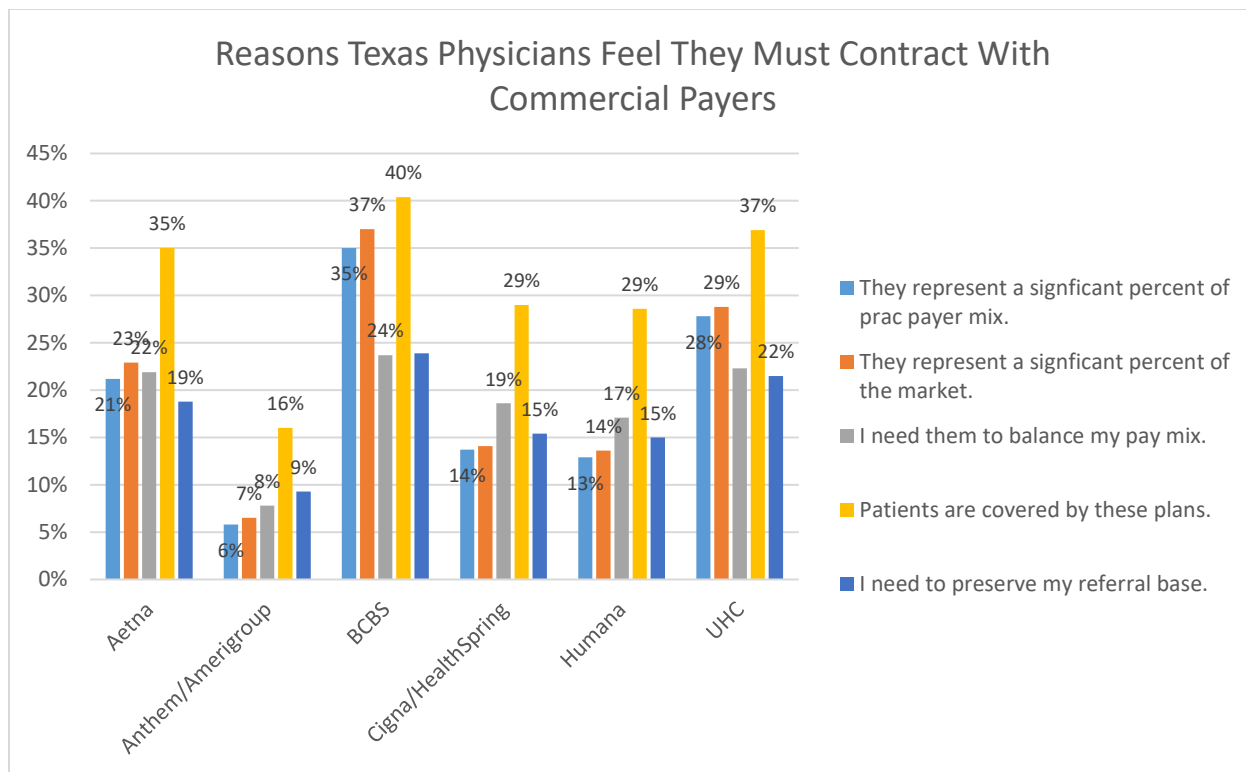
Contract Status and Financial Viability (February Question 6)

Physicians were asked if they feel they must contract with the one of the five major payers to have a financially viable practice. The majority of physicians (56 percent) felt they must contract with BCBSTX to have a financially viable practice. Few physicians (16 percent) felt they didn't have to contract with at least one of the five major payers to have a financially viable contract.



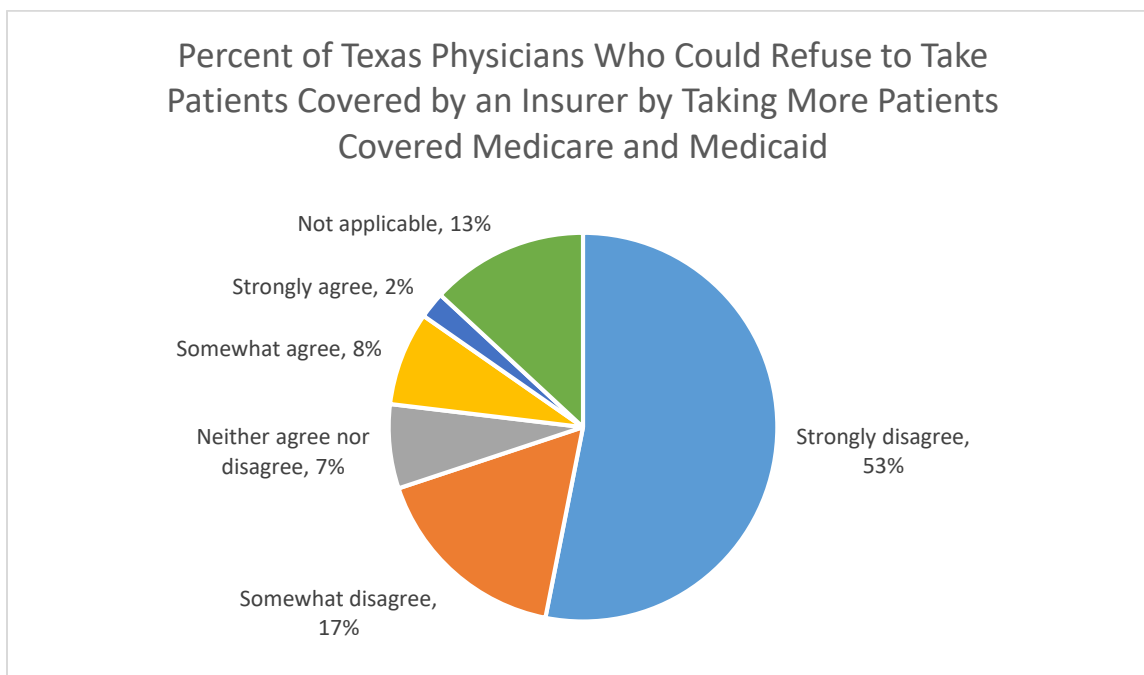
Reasons Physicians Must Contract With a Commercial Payer (February Question 7)

Physicians who felt they must contract with BCBSTX to have a financially viable practice felt they must preserve access to care for patients (40 percent), and BCBSTX represents a significant percentage of the market (37 percent).



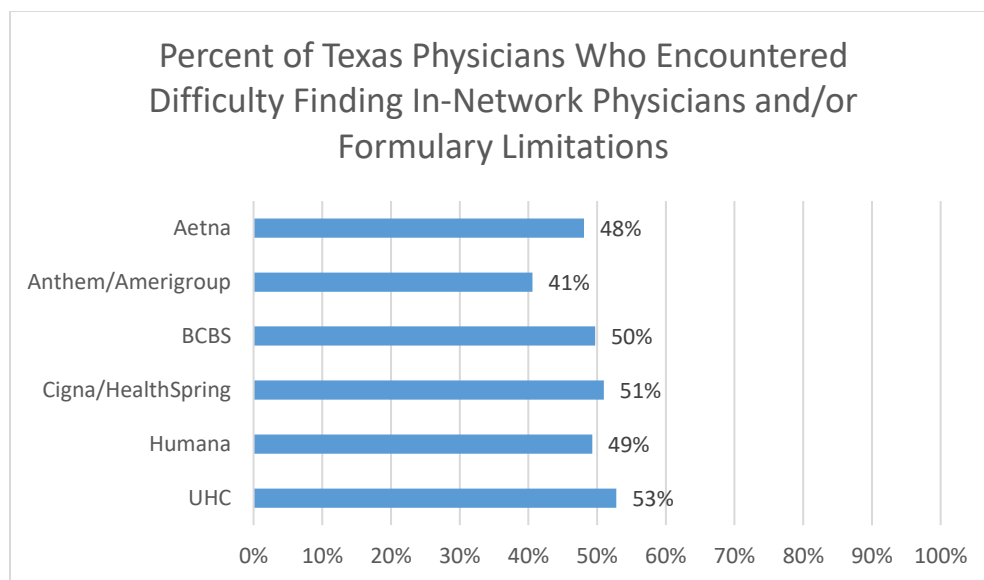
Physicians Ability to Replace Commercial Insurers with Government Payers (Question 8)

Physicians disagree (59 percent) they can refuse to take patients covered by commercial insurers and recover the lost revenue by treating more Medicare and Medicaid patients.



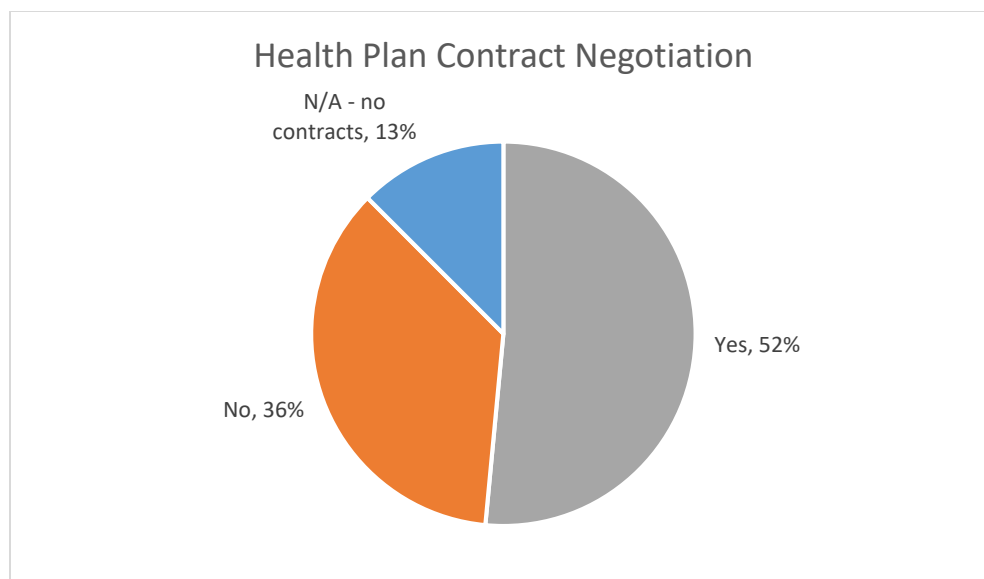
Network Adequacy and Formulary Limitations (February Question 9)

Physicians encountered difficulty finding in-network physicians who accepted new patients for referrals and/or formulary limitations which prevented optimal treatment from UnitedHealthcare (53 percent), Cigna/HealthSpring (51 percent), and BCBSTX (50 percent).

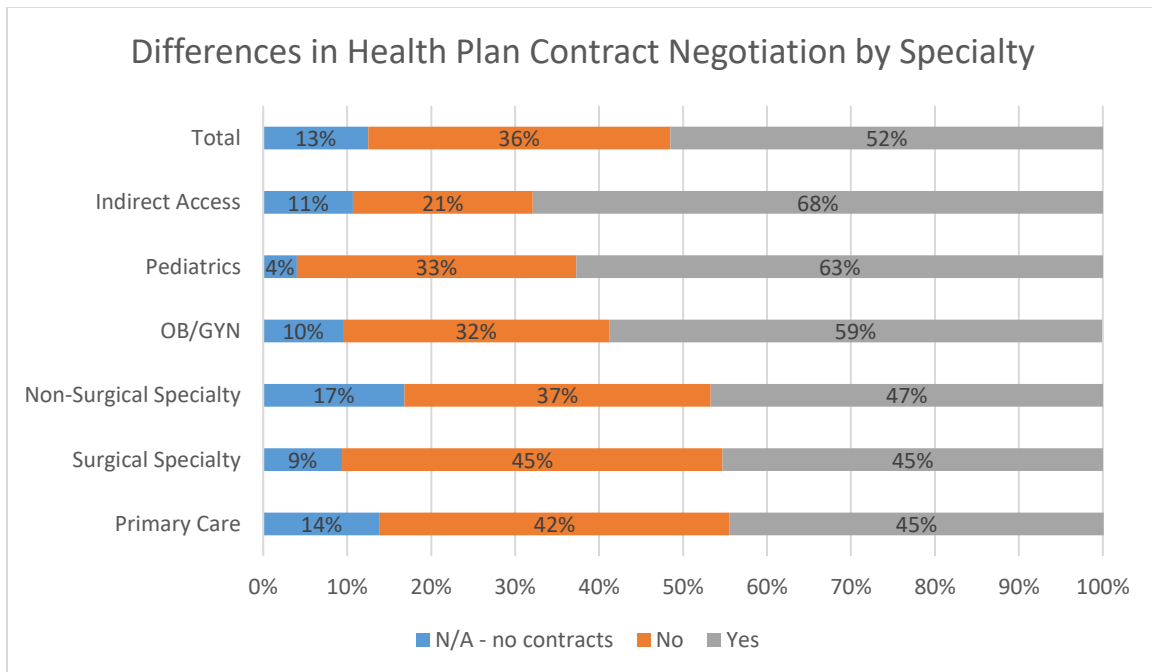


Health Plan Contract Negotiation (February Question 11-13)

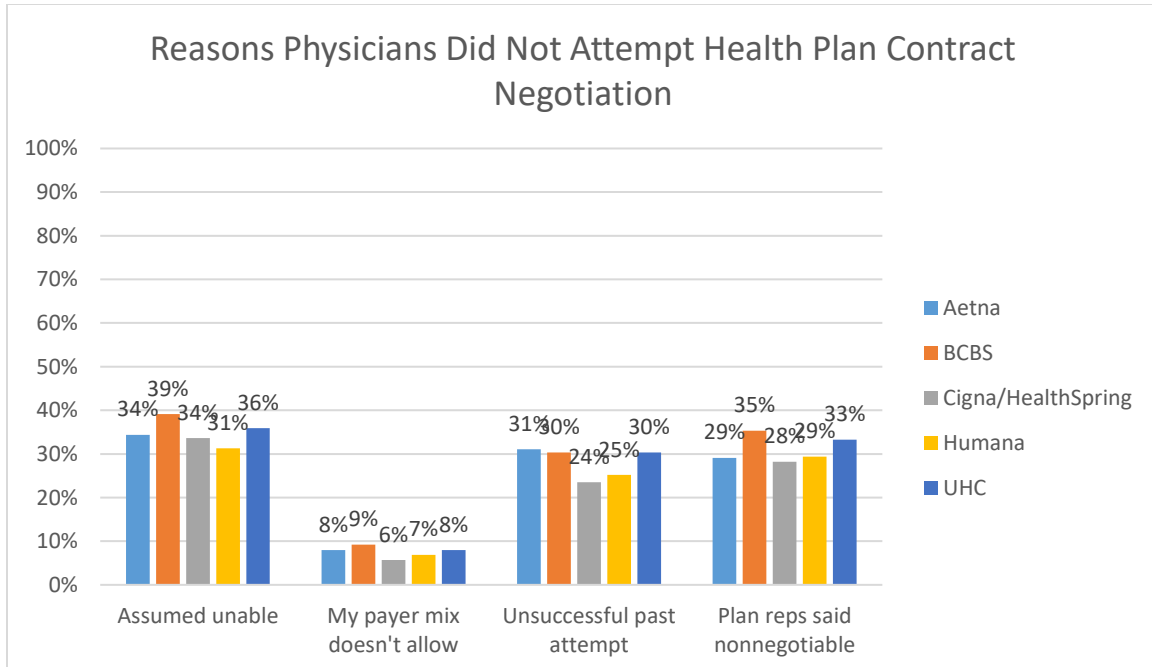
Respondents were asked about their experience in managed care contract negotiations. The majority of physicians attempted to negotiate the terms of a health plan contract in the past two years (52 percent).



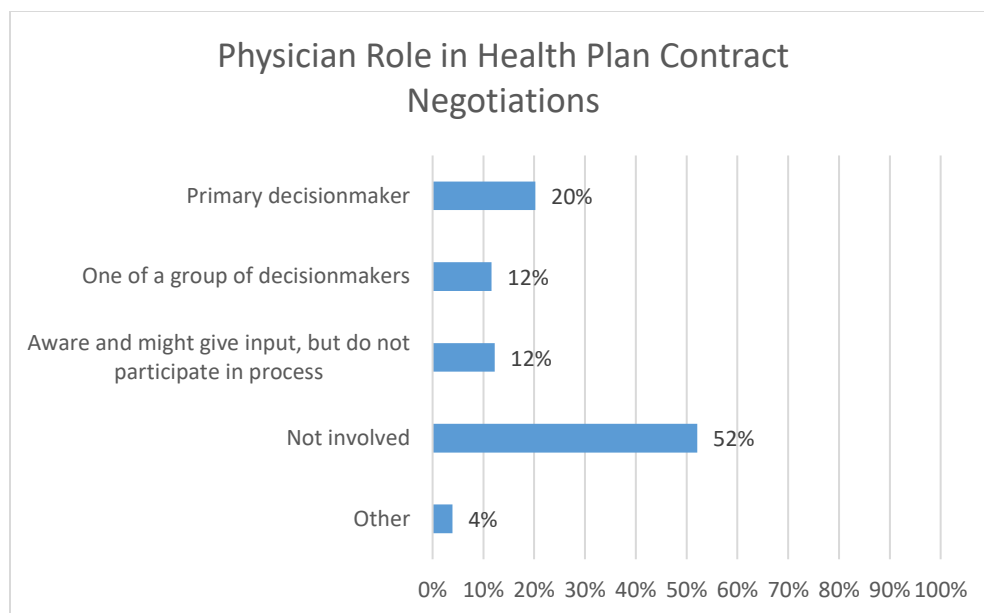
Indirect-access physicians were most likely to attempt to negotiate the terms of a health plan contract in the past two years (68 percent).



Physicians who did not attempt to negotiate the terms of a health plan contract in the past two years were asked why not. Reasons varied by payer, although a large minority of physicians assumed they were unable to do so.

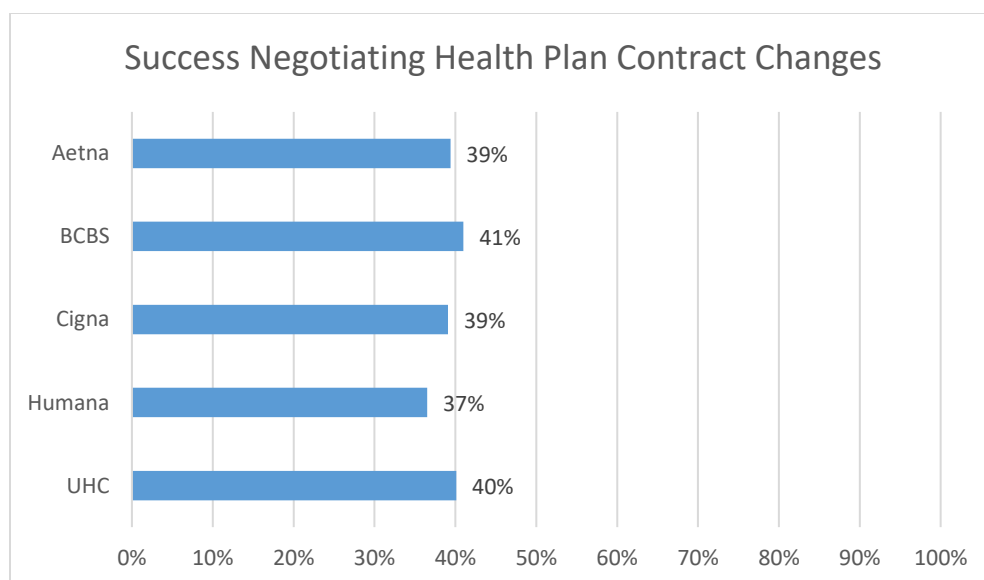


Forty-four percent were involved in some way in health plan contract negotiations.

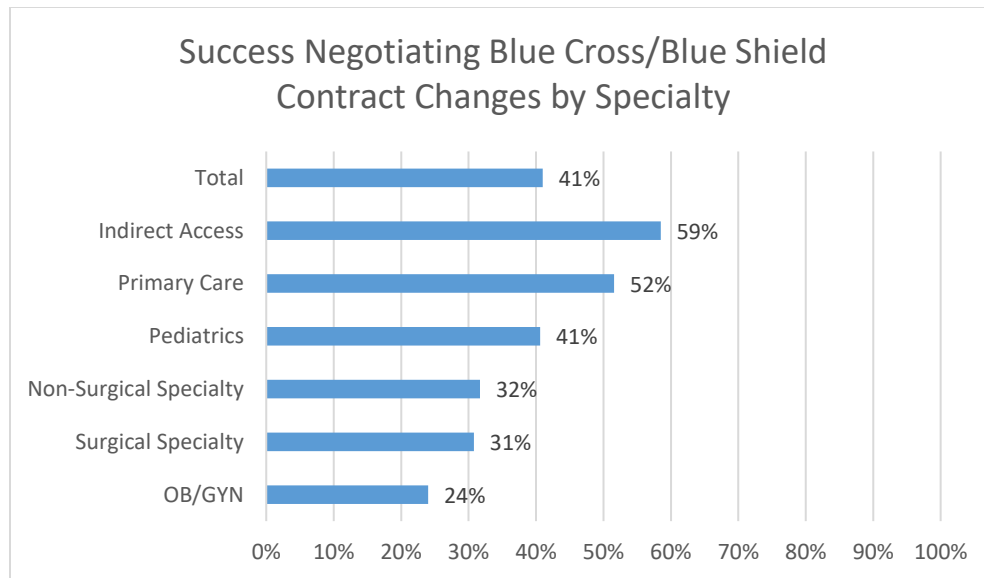


Success Negotiating Contract Changes (February Question 14)

Respondents who attempted contract negotiations were asked to report on the success of those efforts. Success varied by payer, but approximately two-fifths physicians reported some success with each one of the five major payers.

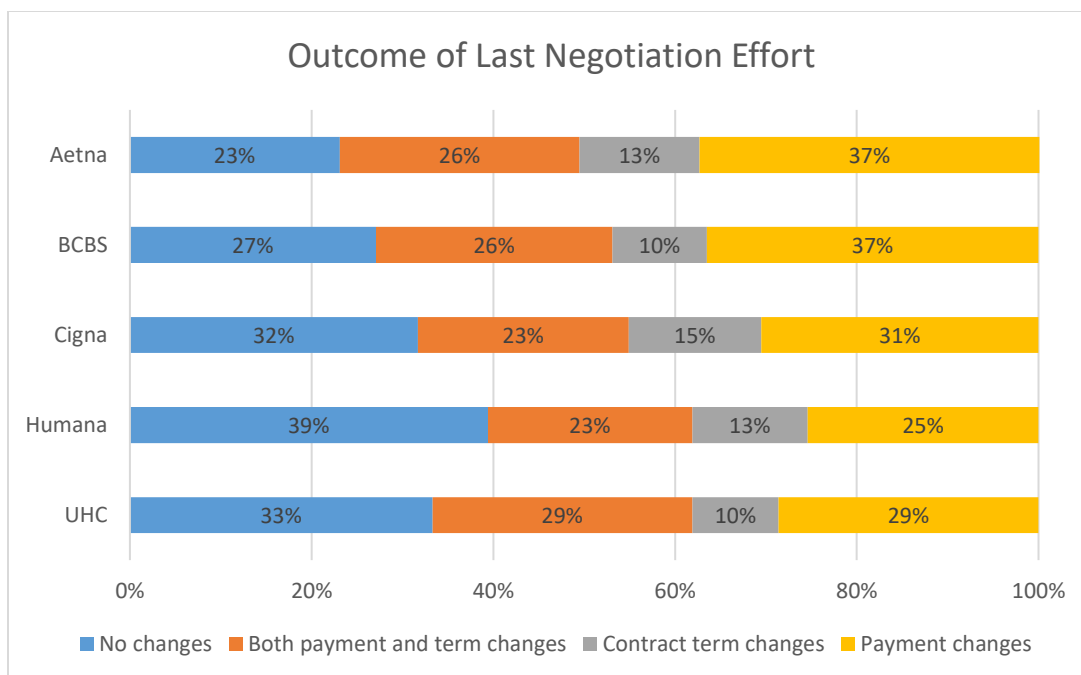


Indirect-access (59 percent) followed by primary care (52 percent) physicians were most likely to report success negotiating contract changes with BCBS.



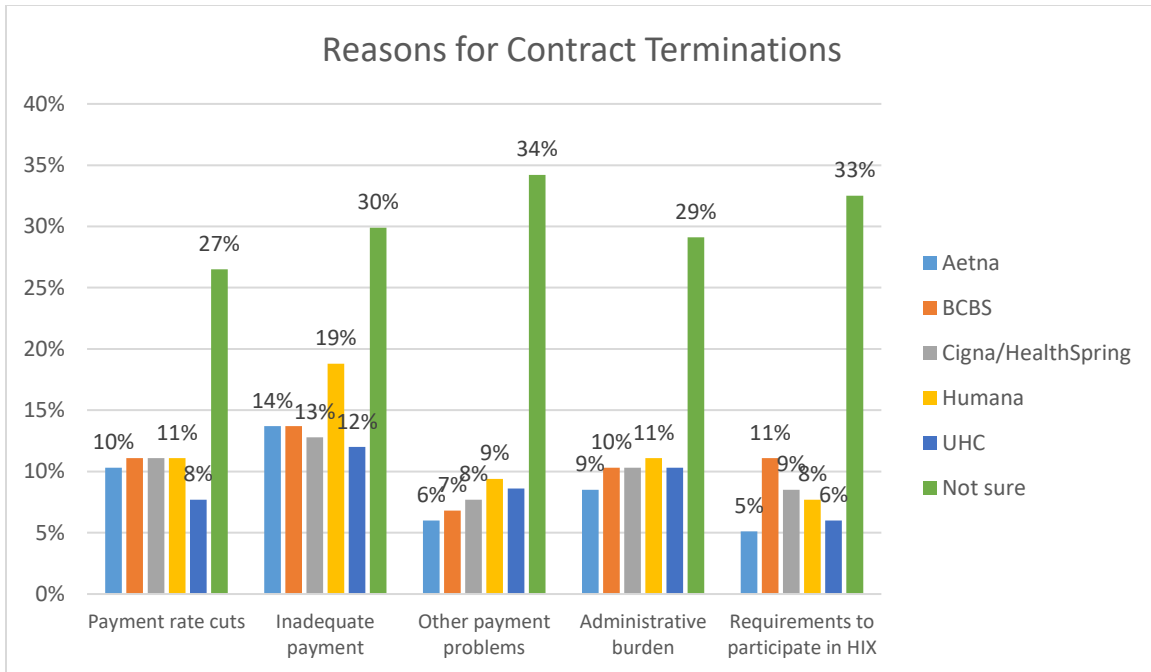
Outcome of Last Negotiation Effort (February Question 15)

The percentage of respondents who secured changes in contract payment, terms, or both varied by payer, but the majority received changes either in payment, contract terms, or both



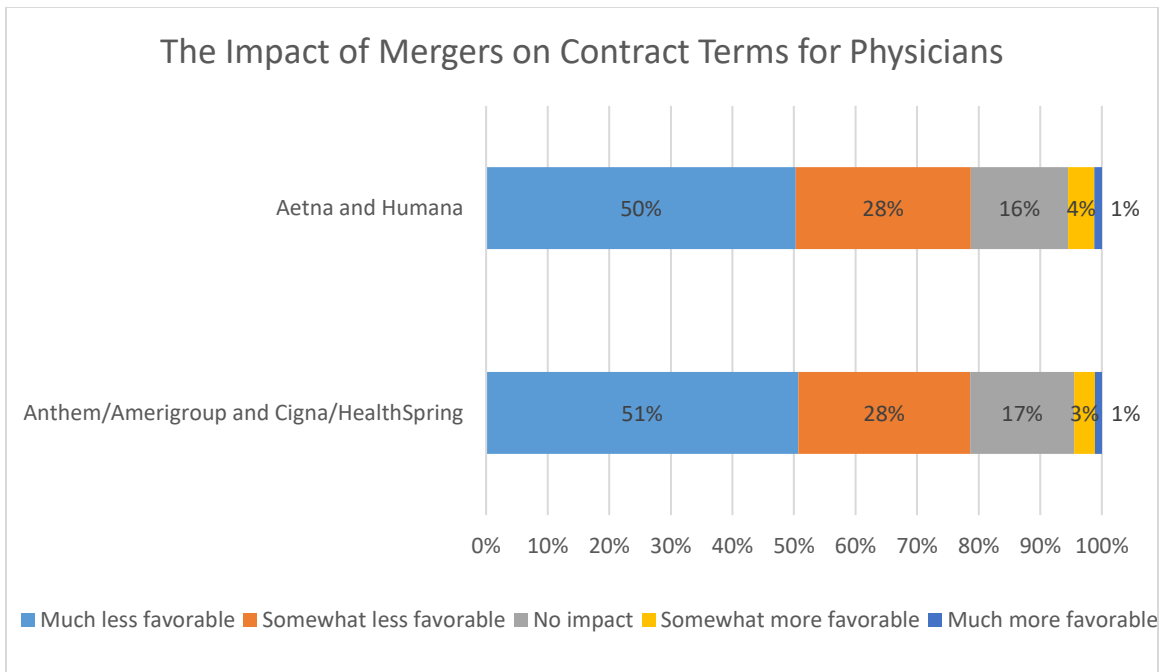
Contract Terminations (February Question 18-19)

Twenty percent of respondents terminated a health plan contract in the past two years. Reasons varied by payer, and the large minority of physicians were not sure why plan contracts were terminated.



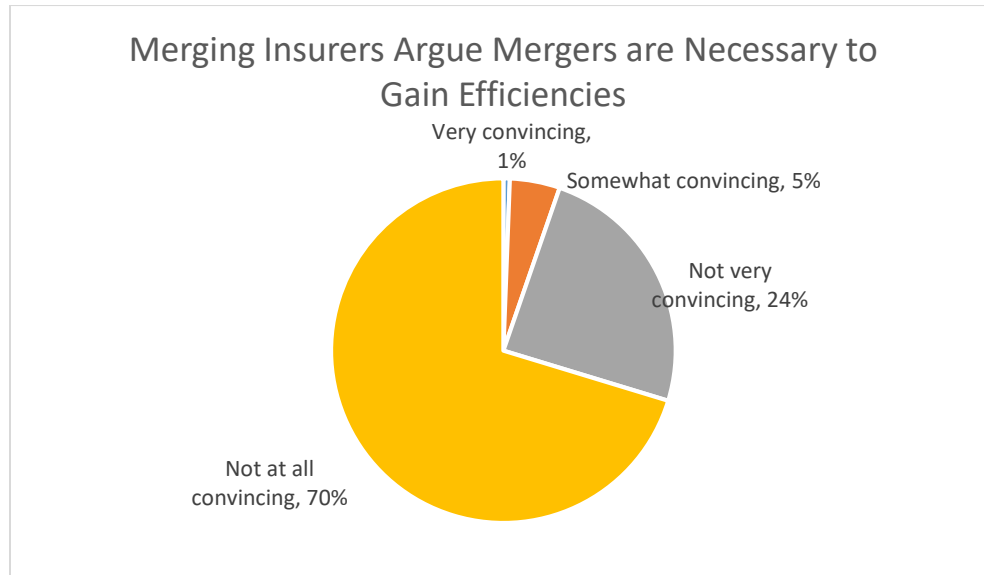
The Effect of Health Plan Mergers on Contracts (February Question 21-22)

In physicians' view, the merger of Aetna and Humana (78 percent) and Anthem/Amerigroup and Cigna/HealthSpring (79 percent) would have a less favorable impact on contract terms for them as physicians.



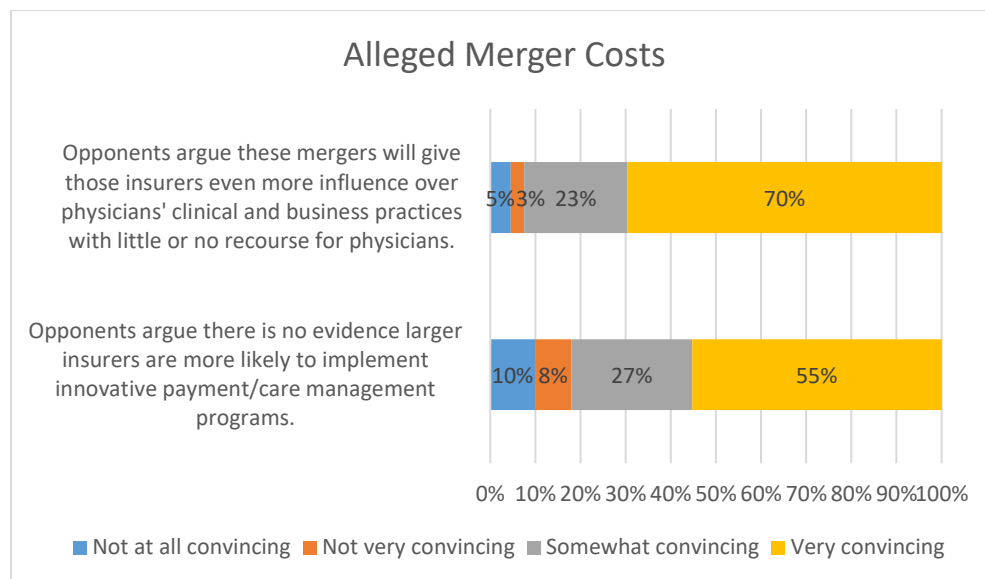
Alleged Merger Efficiencies (February Question 26)

Merging insurers argue mergers are necessary to gain efficiencies in areas such as innovative payment programs and care management strategies that will benefit patients. Physicians report this argument is not convincing (94 percent).



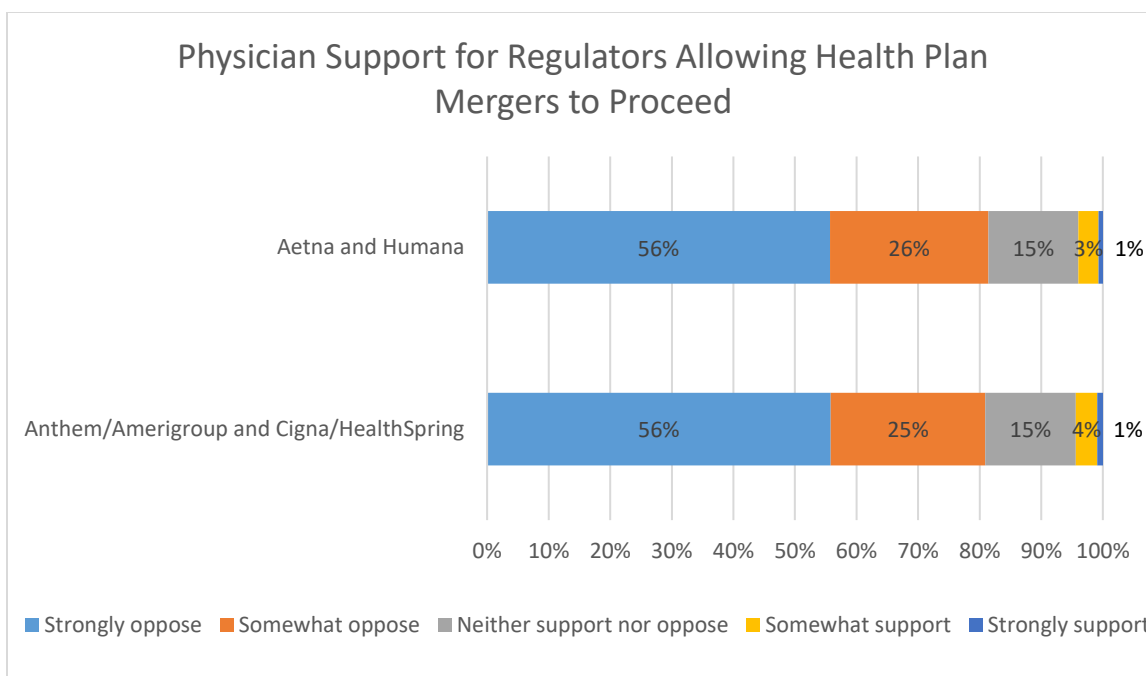
Alleged Merger Costs (February Question 27)

Opponents argue mergers will give insurers even more influence over physicians' clinical and business practices with little or no recourse for physicians and physicians will be forced to cut costs so deeply that we will see a significant degradation of their ability to provide the care that the consumers value and need. Physicians find this argument a convincing reason to oppose these mergers (93 percent). Opponents argue there is no evidence larger insurers are more likely to implement innovative payment or care management programs and more dominant insurers have less incentive to invest in reform, and peer-reviewed studies have concluded concerted delivery system efforts have emerged from sources such as provider systems, not insurers. Physicians find this argument a convincing reason to oppose health plan mergers (82 percent).



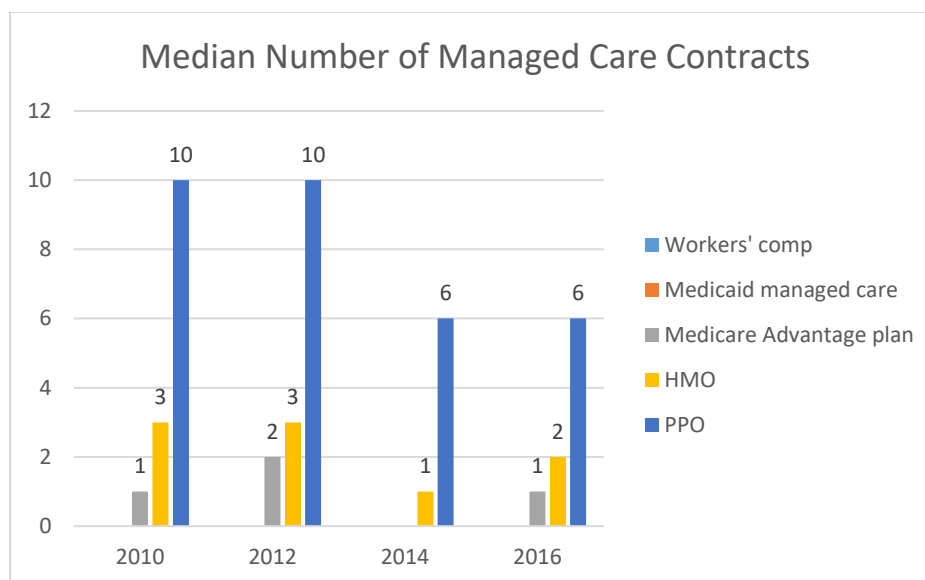
Opposition to Mergers (February Question 28-29)

Physicians oppose regulators allowing the Aetna-Humana merger (82 percent) and the Anthem/Amerigroup-Cigna/HealthSpring merger (81 percent) to proceed.



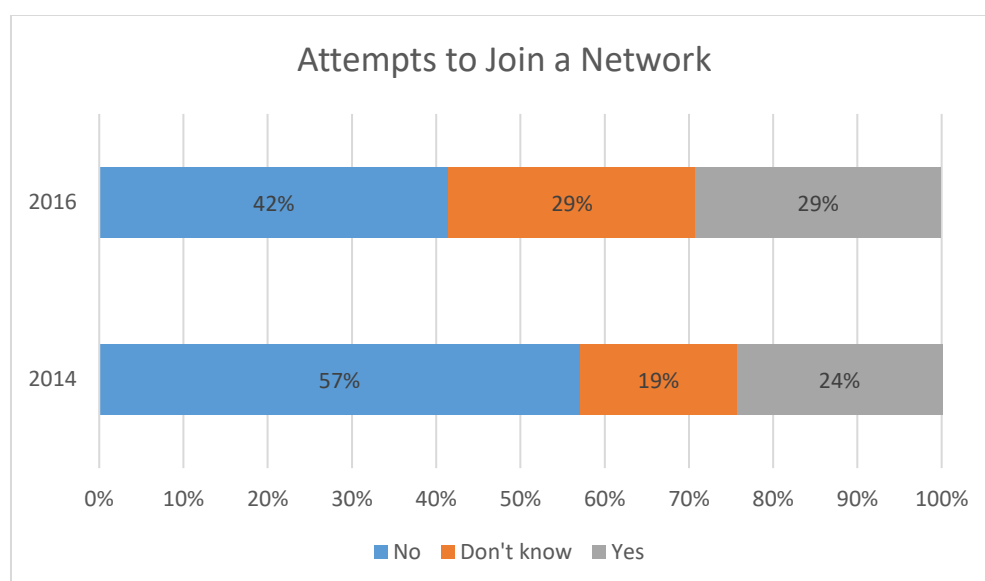
Managed Care Contracts (March Question 9)

Respondents had a median of six PPO contracts and two HMO contracts.

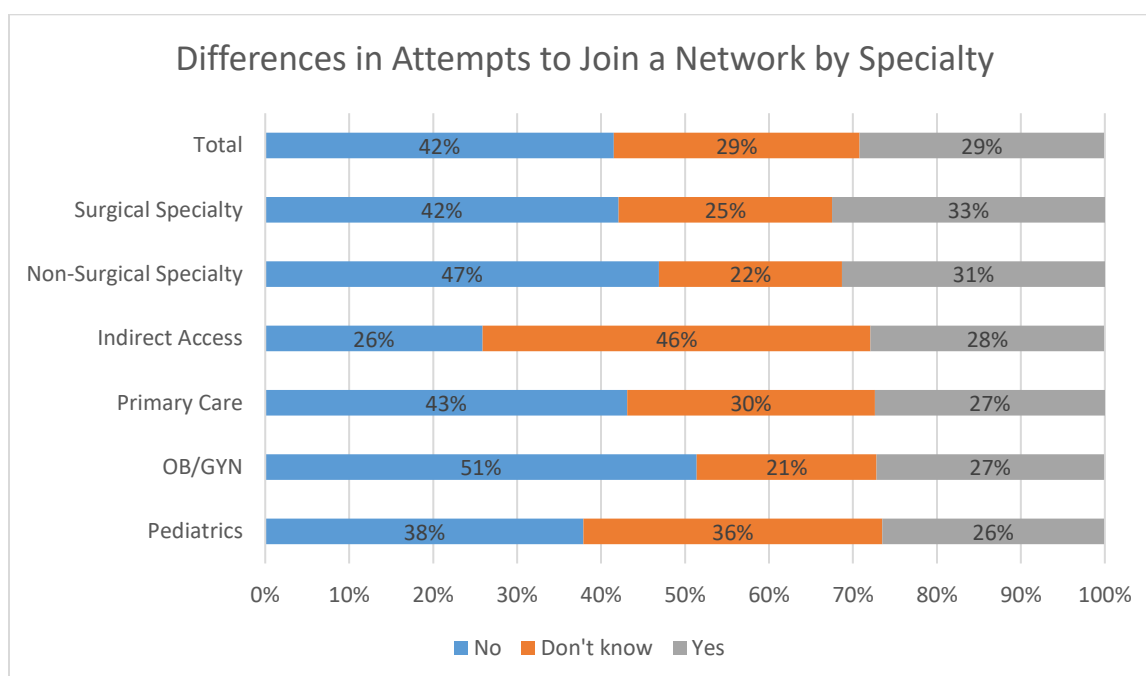


Physician Attempts to Join a Network (March Question 10)

An increasing percentage of physicians approached a plan with which they are not contracted with in an attempt to join its network in the past two years (29 percent).

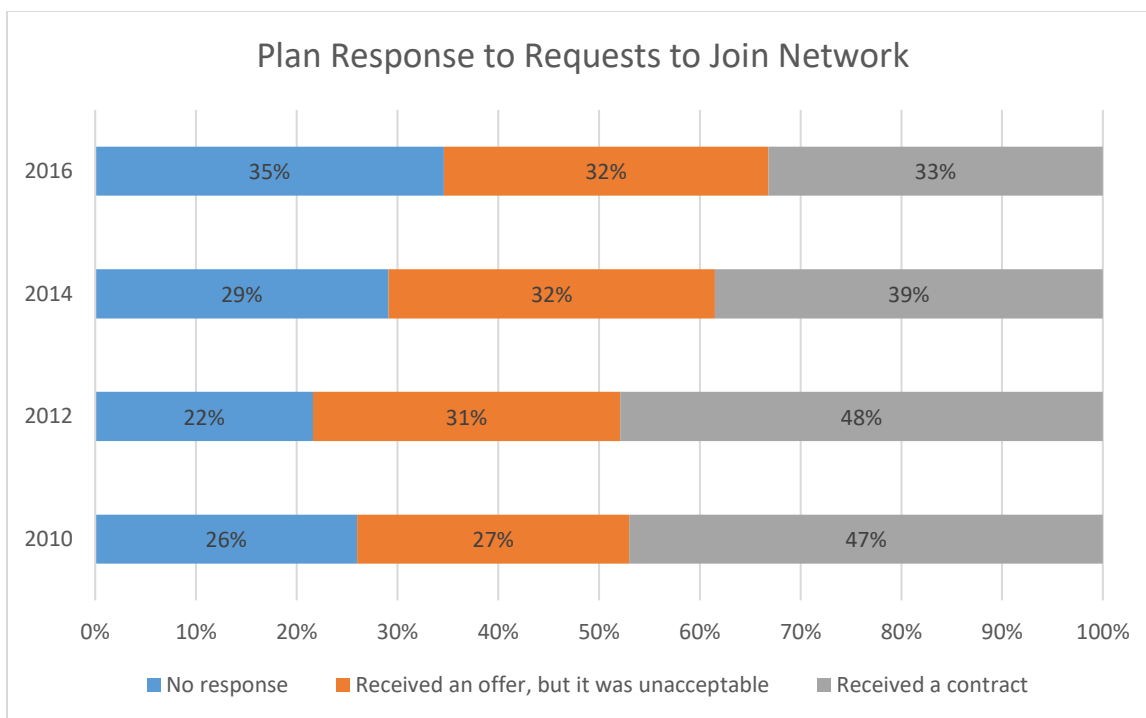


Surgical specialists were more likely to approach a plan with which they are not contracted with in an attempt to join its network in the past two years (33 percent).



Outcome of Attempt to Join a Network (March Question 11)

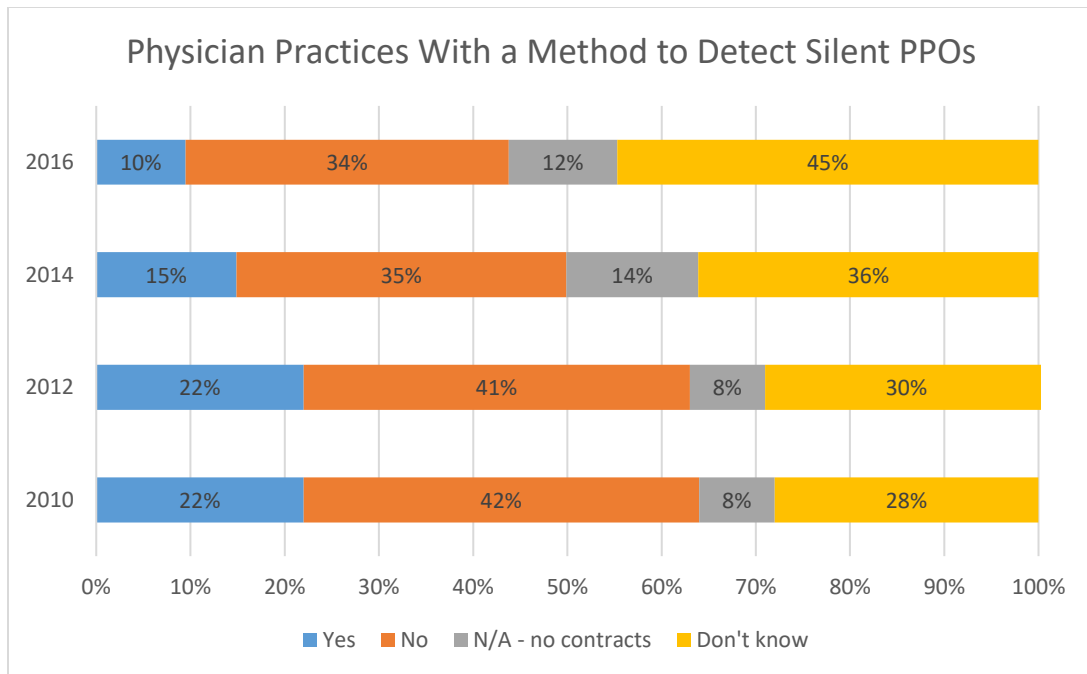
Among physicians who approached a plan in an attempt to join its network, 35 percent received no response from the plan (up from 29 percent in 2014 and 22 percent in 2012).



There were no statistically significant differences by physician specialty and response from the plan.

Silent PPOs (July Question 3-4)

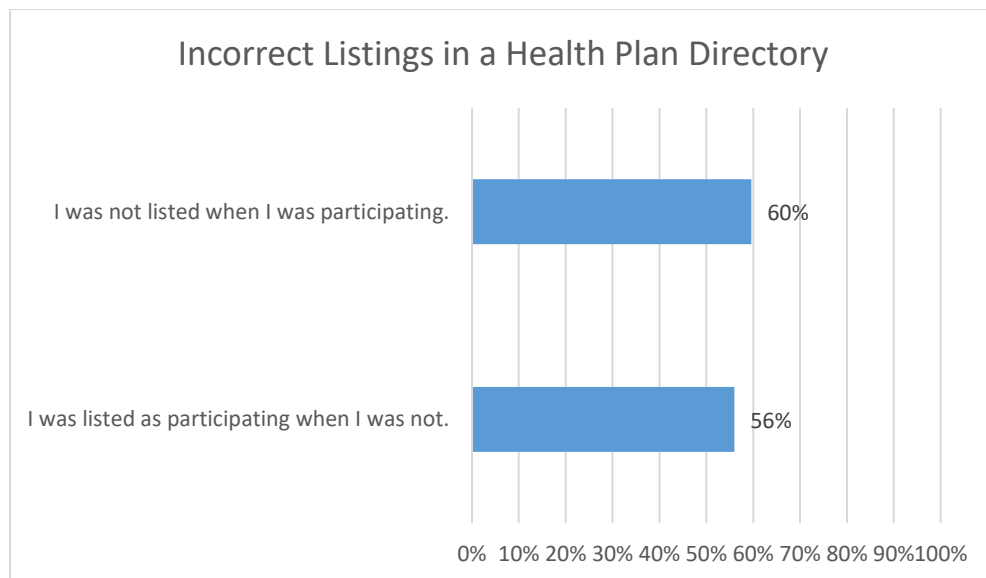
Ten percent of physician practices have a method to detect unauthorized access to contracted discounts, as in a silent PPO.



Among practices with a method to detect a silent PPO, 49 percent have detected such activity.

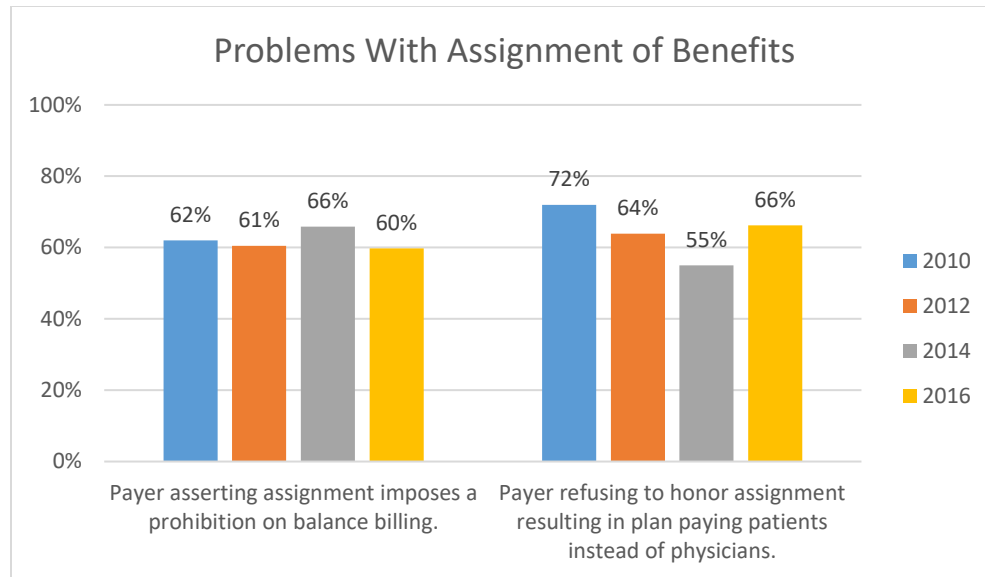
Incorrect Listings in Health Plan Directories (July Question 5)

A majority of physicians have detected cases where they were listed incorrectly in a health plan's directory. Sixty percent of physicians were not listed as a participating provider when they were participating, and 56 percent of physicians were listed when they were not 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 (February Question 20)

Respondents frequently experienced problems with payers refusing to honor assignment resulting in plans paying patients instead of physicians (66 percent) and payers asserting assignment of benefits, which imposed a prohibition on balance billing (60 percent).



Healthy Environment

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

Availability of Care

Acceptance of New Patients (March Question 6-7)

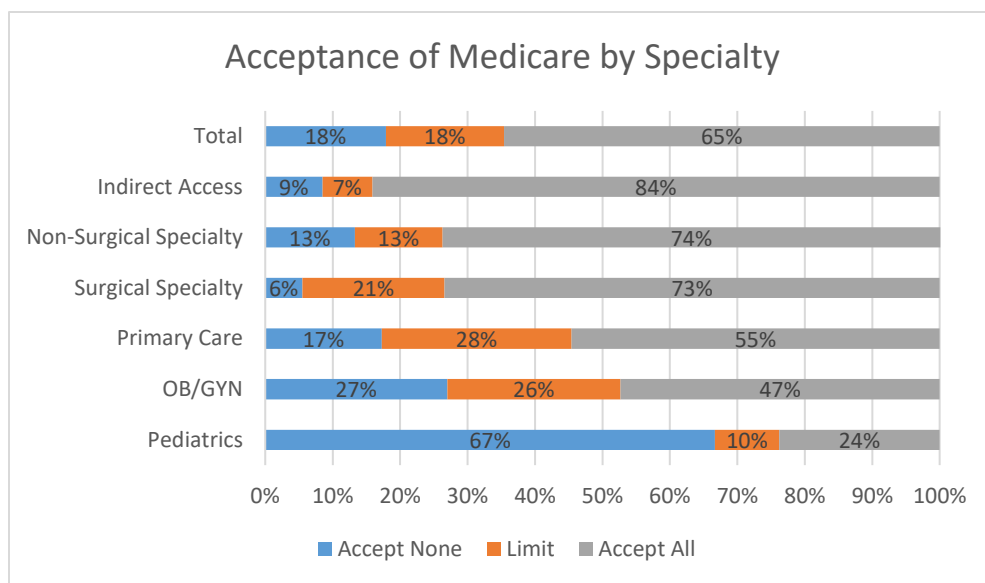
Ninety-three percent of physicians indicated their practice is accepting new patients. Physicians who were accepting new patients were asked about their specific policies towards new patients covered by various payers. The results are reported as percentages of the physicians whose practices were not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

Acceptance of New Patients by Payer Type

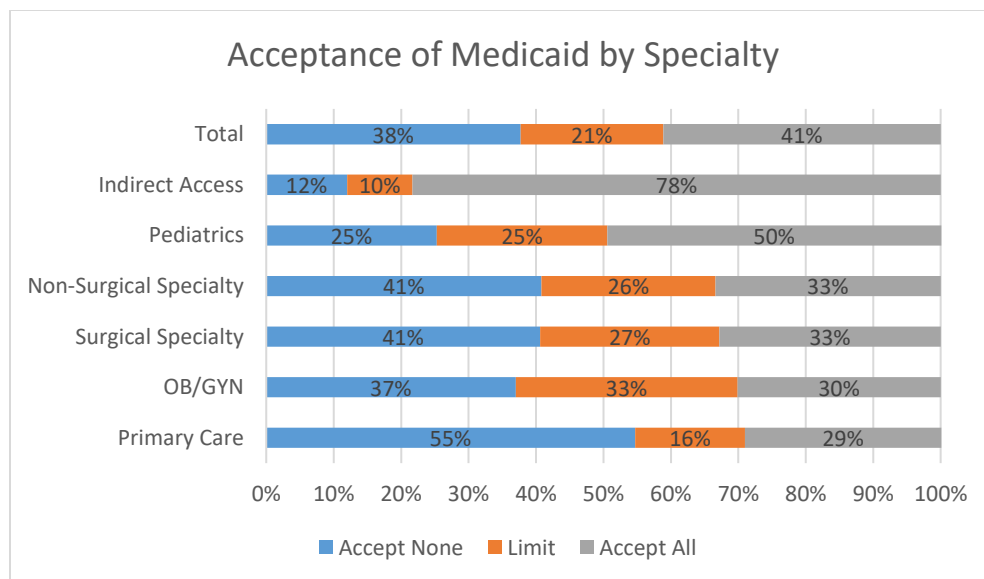
	2014			2016		
	Accept	Decline	Limit	Accept	Decline	Limit
	%	%	%	%	%	%
PPOs	78	5	16	82	5	12
Uninsured	68	4	28	70	5	25
Medicare	63	18	19	65	18	18
The military health care plan, TRICARE	64	19	17	63	20	18
HMOs	50	21	29	56	16	29
Medicare-Medicaid dual-eligible	47	33	20	50	31	19
Medicare Advantage plans	43	27	31	48	25	27

Medicaid	37	39	24	41	38	21
ACA exchange plans				40	31	30
CHIP	36	49	15	40	46	14
Workers' compensation	28	59	13	34	55	12

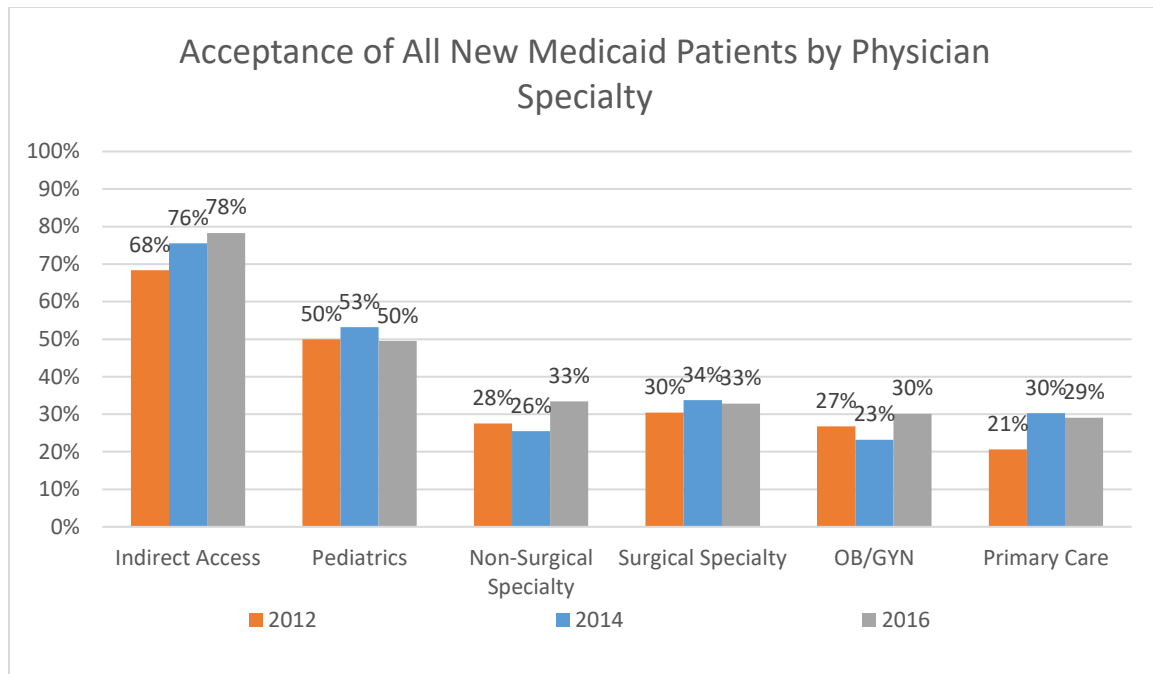
Medicare: Although the percentage of physicians accepting new Medicare patients increased somewhat since 2014, it remained significantly reduced from the levels recorded in 2000. Further uncertainty in Medicare payment may damage future access and will need to be closely monitored.



Medicaid: The federally required payment increases to primary care physicians continued to have a positive effect on the percentage of physicians accepting all new Medicaid patients, despite those payment increases being temporary.

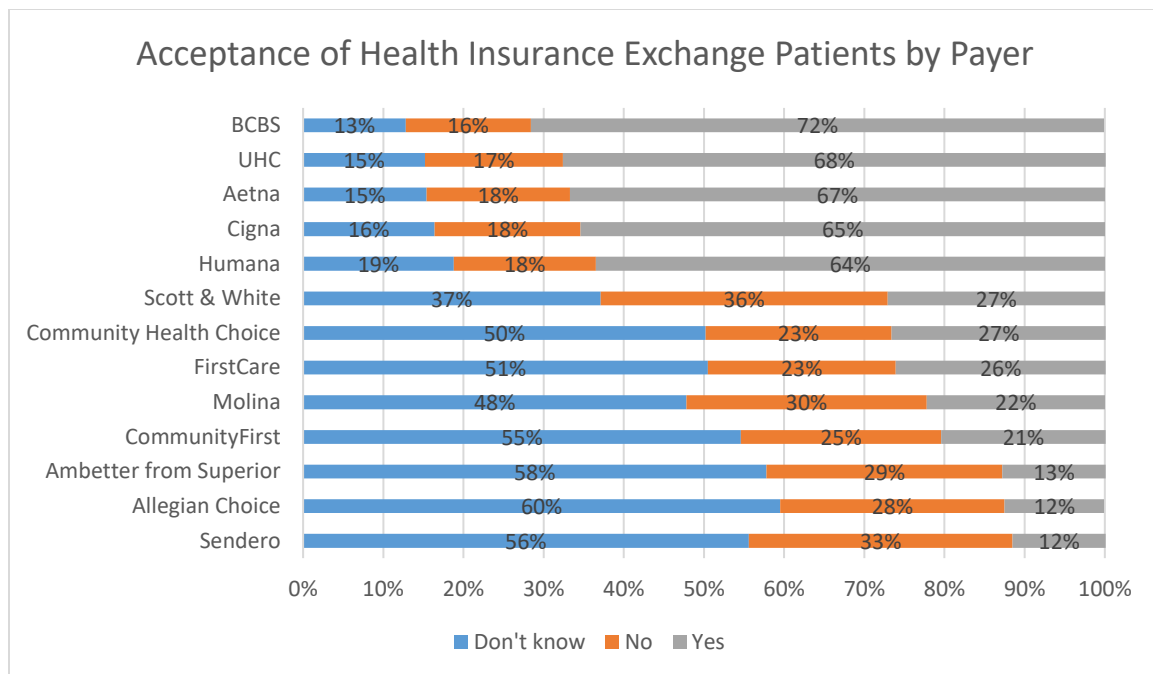


Indirect-access physicians were most likely to accept all new Medicaid patients (78 percent). The percentage of primary care physicians accepting these patients increased after the primary care payment increased, but appears to be back on the decline since payment increases were not maintained.



Acceptance of Health Insurance Exchange Patients (March Question 8)

Physicians were asked about their specific policies towards health insurance exchange patients covered by various payers. The majority of physicians accepted health insurance exchange patients covered by the five major payers.



Medicare Fees

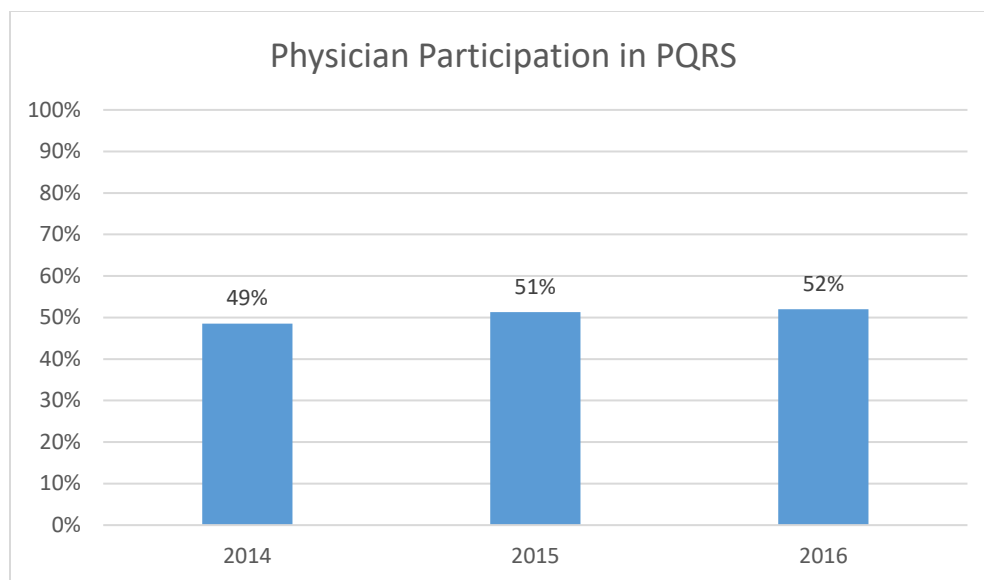
Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015. The law repealed the Sustainable Growth Rate formula used to calculate Medicare physician fee-for-service payments and attempted to simplify and improve Medicare's physician penalty and incentive programs by consolidating and revising them. The following questions were asked to help TMA support the physicians who provide the medical care to Medicare beneficiaries.

Medicare Participation (August Question 1)

Eighty-five percent of physicians treated at least one Medicare patient since 2011.

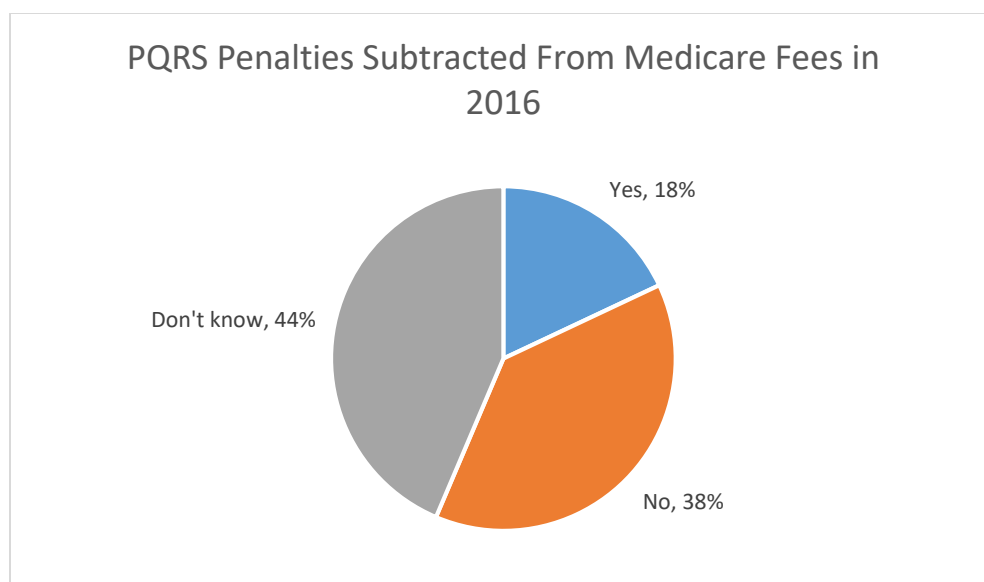
PQRS Participation (August Question 2-3)

Approximately half of physicians (51 percent) reported quality data in Medicare's Physician Quality Reporting System in 2015 and are reporting or will report for the 2016 performance period (52 percent).



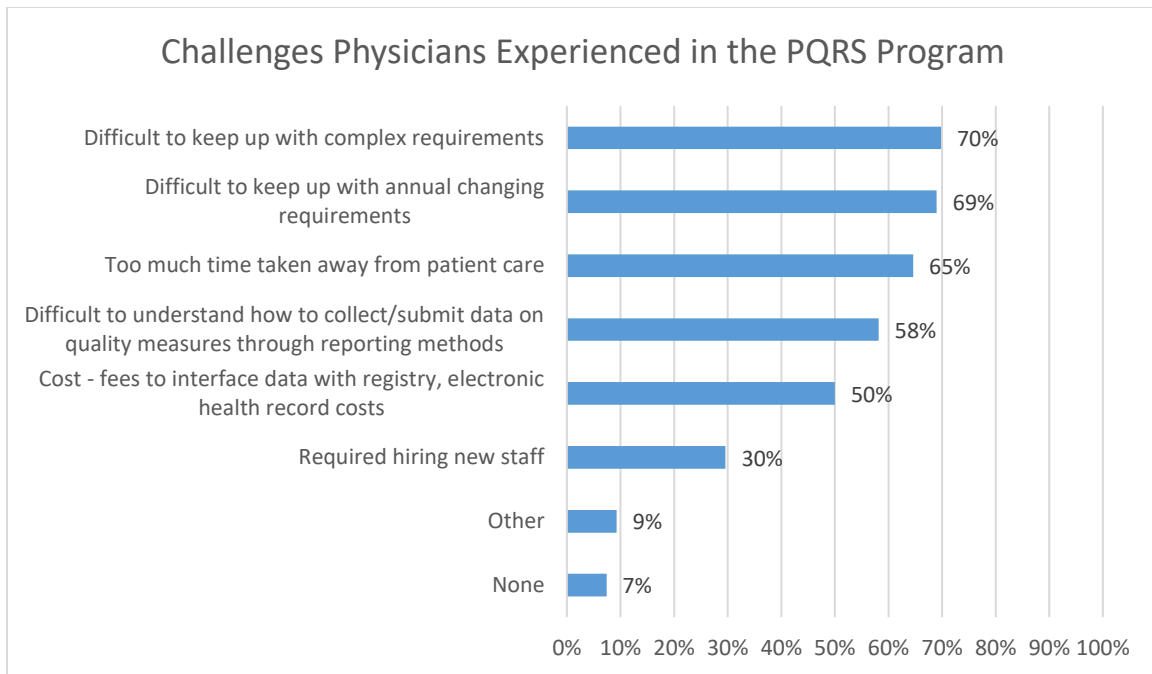
PQRS Penalties (August Question 4)

Eighteen percent of physicians reported PQRS penalties were subtracted from their Medicare fees in 2016.



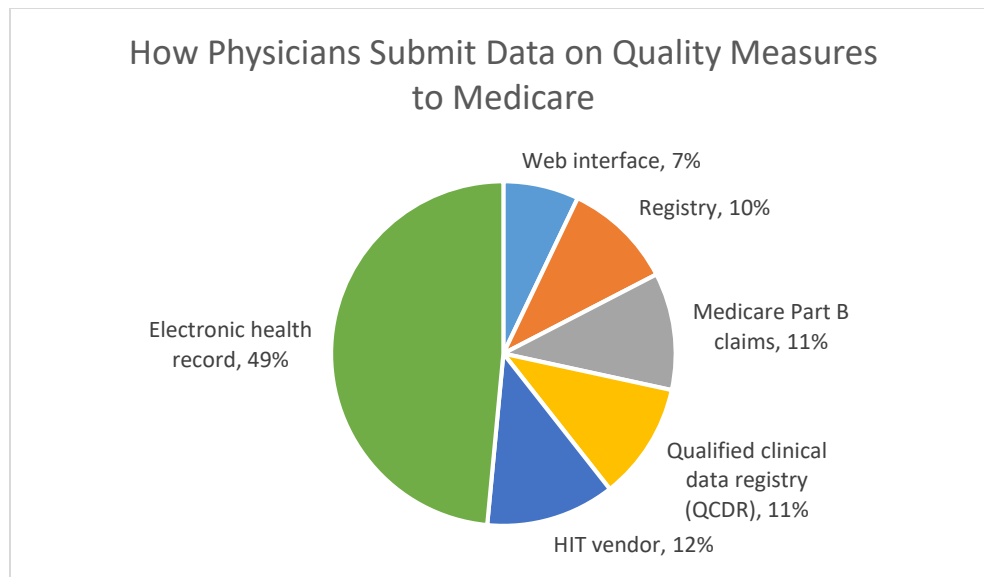
Challenges to PQRS Participation (August Question 5)

Physicians who participated in or attempted to participate in PQRS were asked to describe any challenges they experienced with the program. Physicians reported it was difficult to keep up with complex and changing requirements (70 and 69 percent).



Physician Submission of Quality Measures (August Question 6)

Among physicians who submitted data on quality measures to Medicare, the large minority used their EHR (49 percent).

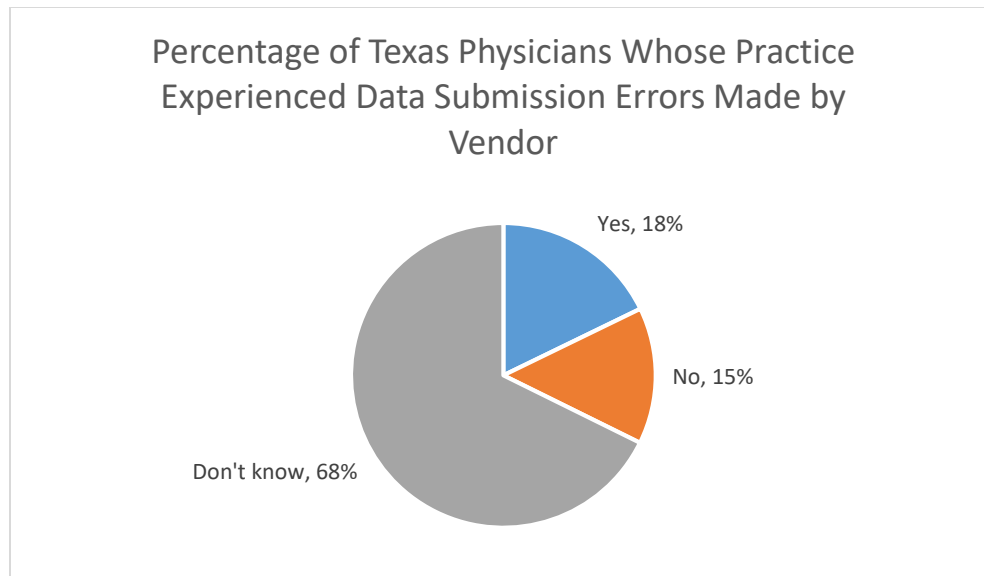


Payment for Data Submission on Quality Measures (August Question 7)

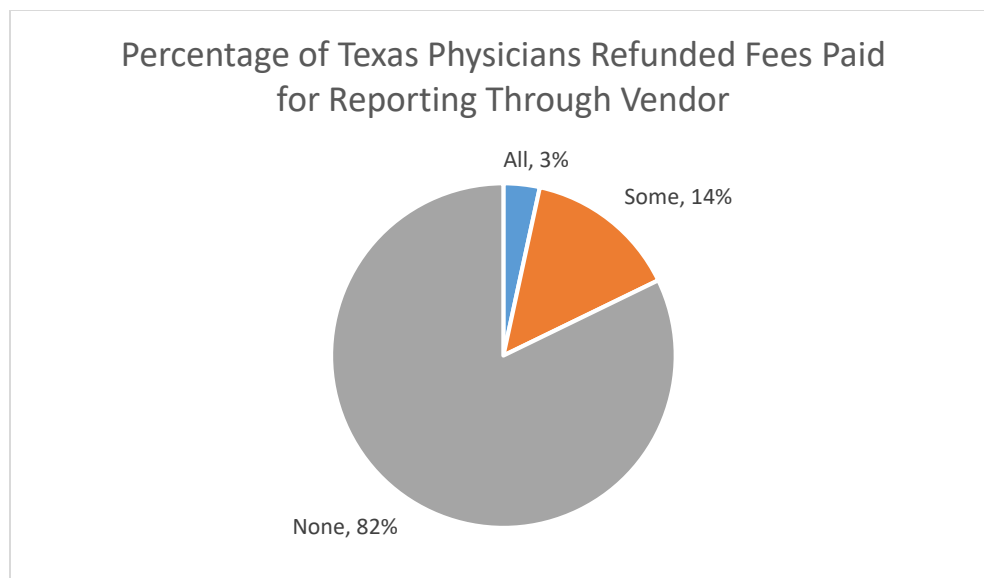
Physicians who paid to submit data on quality measures to Medicare reported an annual median amount of \$325 per physician.

Data Submission Errors (August Question 8-10)

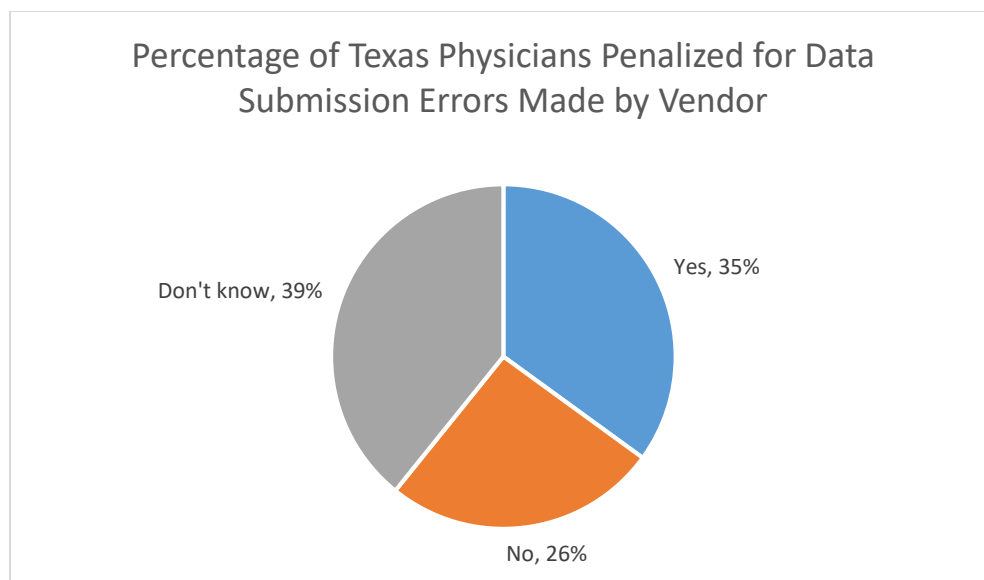
The majority of physicians didn't know if their practice experienced data submission errors made by their vendor (68 percent).



Among physicians whose practice experienced data submission errors made by their vendor, few were refunded their fees (17 percent).

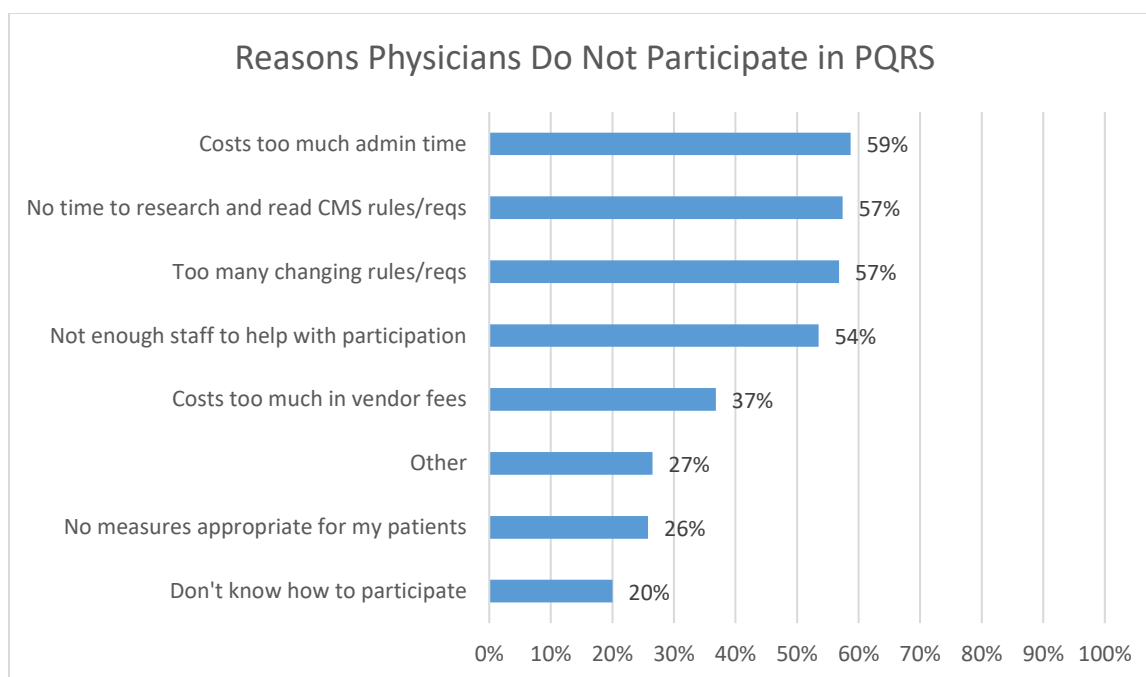


Thirty percent were penalized by Medicare for the error or errors.



Reasons Physicians Do Not Participate in PQRS (August Question 11)

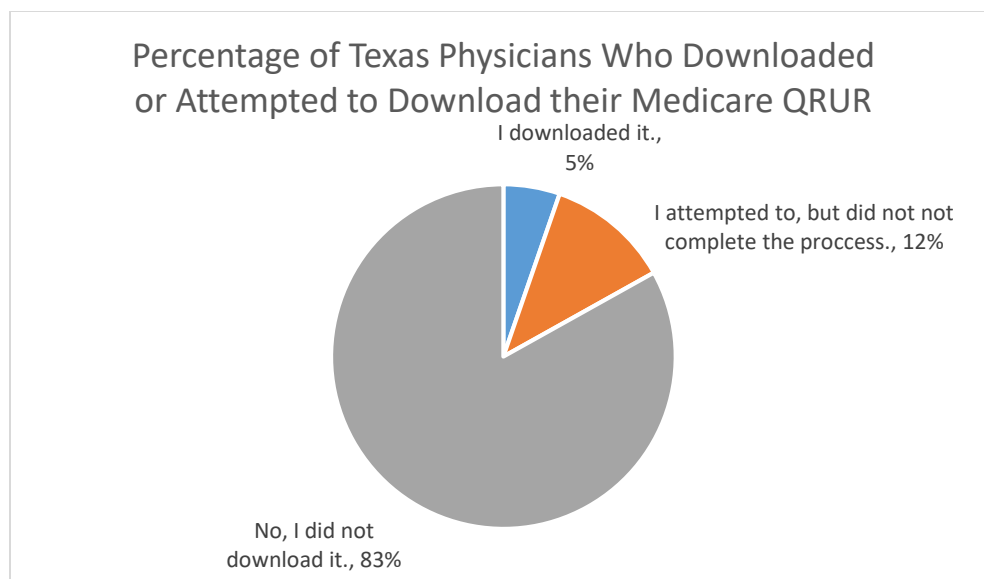
Physicians were asked why they didn't participate in PQRS. The majority of physicians reported it cost too much in administrative time (64 percent), they didn't have time to research and read through all the rules and requirements (55 percent), the rules and requirements were continually changing (54 percent), and they didn't have the staff to help participate (53 percent).



Other reasons physicians gave for not participating in PQRS included having opted out of Medicare.

Medicare Quality and Resource Use Reports (August Question 12-16)

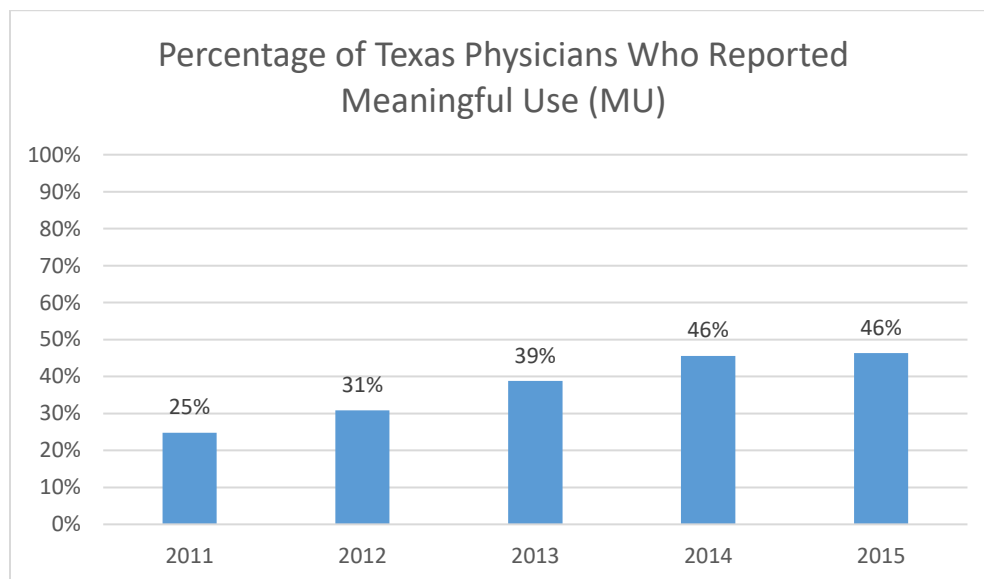
Seventeen percent of physicians downloaded their Medicare quality and resource use report (QRUR) or attempted to download it.



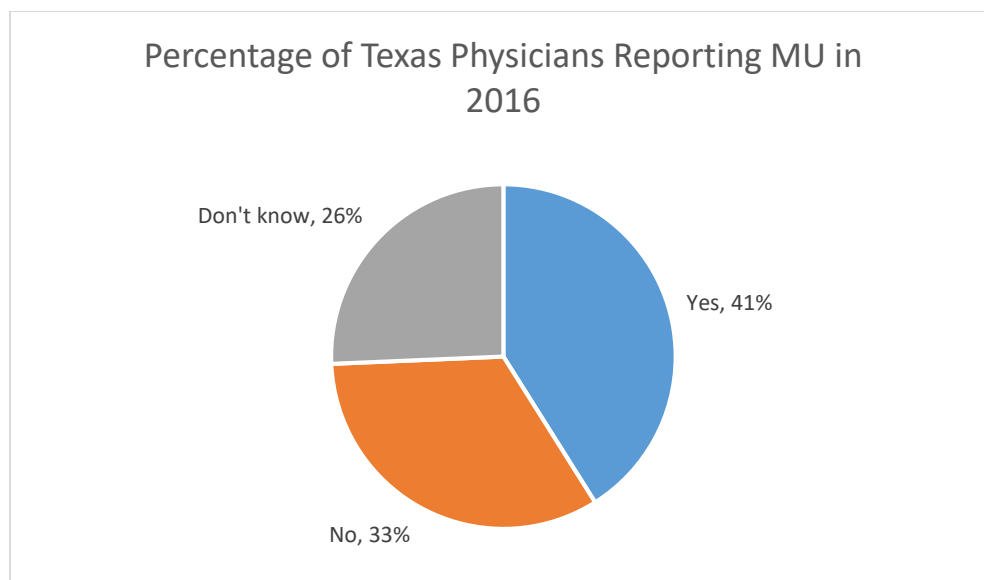
Eighty percent had difficulty accessing their QRUR in the portal. Among physicians who successfully downloaded it, 44 percent were not able to determine why they received incentives or penalties. Few physicians (36 percent) made changes to their practice as a result of their report.

Practice Participation in Meaningful Use (August Question 17-19)

Forty-six percent of respondents participated in MU in 2014 and 2015.

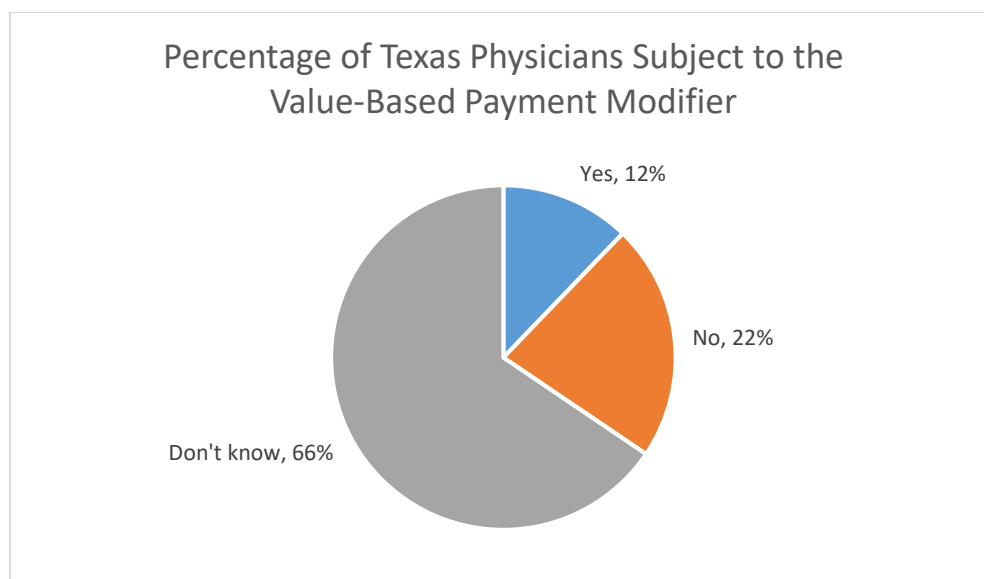


Nineteen percent of physicians received MU penalties subtracted from their fees in 2016. Forty-eight percent didn't know if they received penalties. Forty-one percent will report MU in 2016.

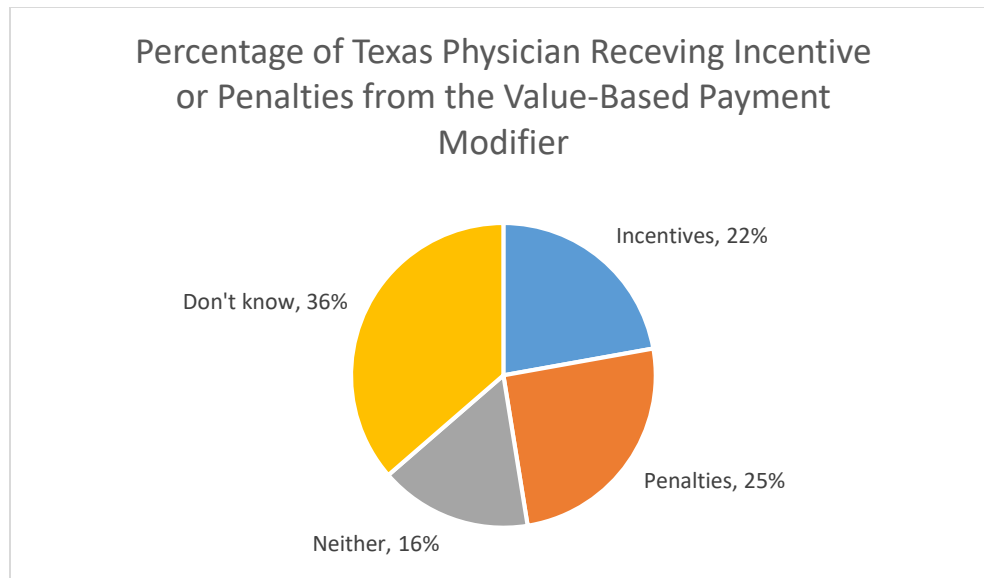


Value-Based Payment Modifier (August Question 20-21)

Twelve percent of physicians were subject to the value-based payment modifier.

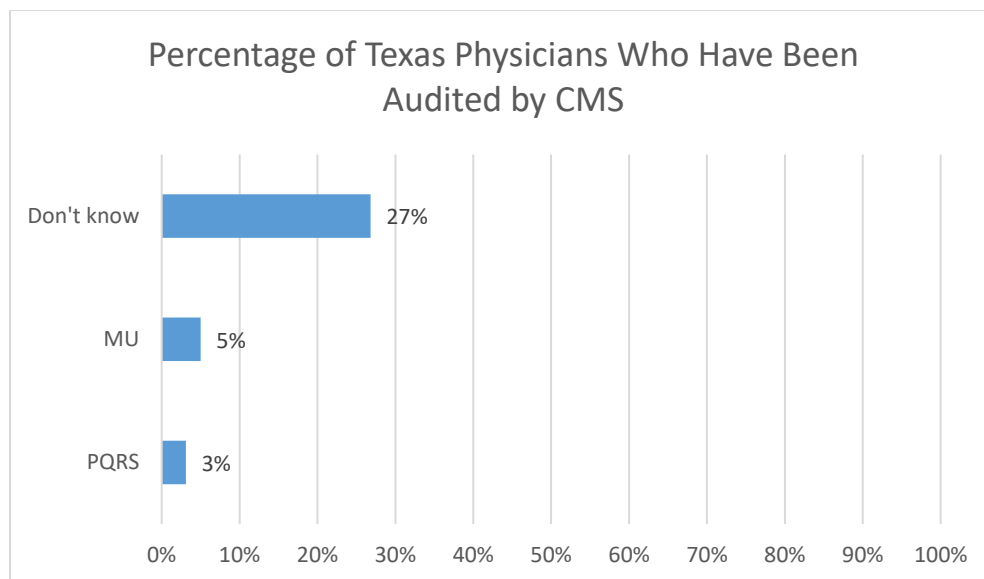


Among them, 22 percent received incentives, and 25 percent received penalties.



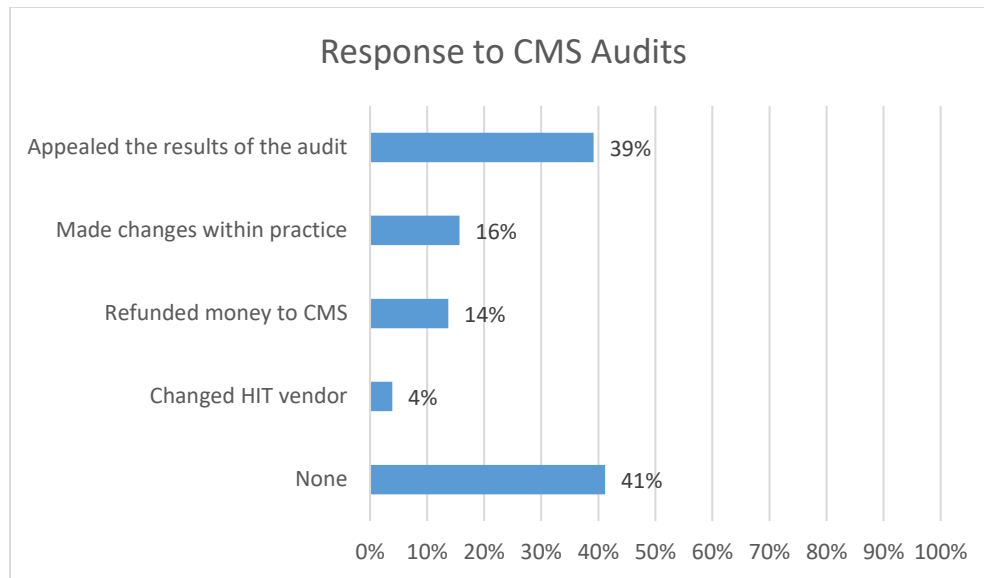
Audits by CMS (August Question 22)

Eight percent of physicians were audited by the Centers for Medicare & Medicaid Services (CMS) on PQRS, MU, or both.



Response to CMS Audits (August Question 23)

In response to audits by CMS, a large minority of physicians made no changes (41 percent) or appealed the results (39 percent).



Medicare Revenue (August Question 24)

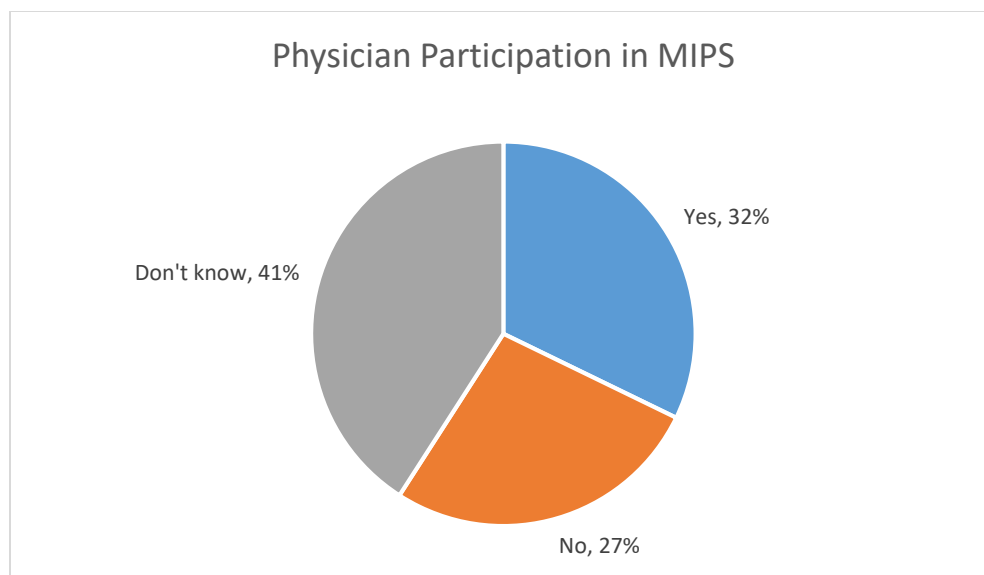
In 2015, the average dollar value of the Medicare revenue for services delivered personally or the per-physician average amount for physician practices was \$175,753.

Medicare MIPS Compliance Cost (August Question 25-26)

Avoiding Medicare payment penalties in the Merit-Based Incentive Payment System will require reporting data on quality measures (PQRS), MU, and participation in clinical practice improvement activities in 2017. Few physicians (7 percent) have estimate how much it will cost their practice to comply. Those who had estimated an average of \$20,490 per physician.

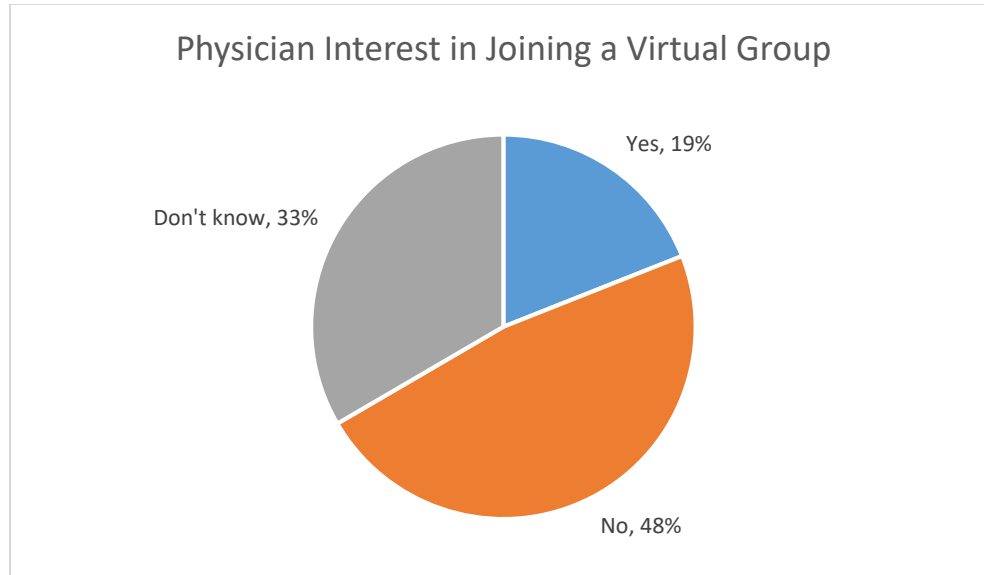
Participation in Medicare MIPS Program (August Question 27)

Thirty-two percent of physicians reported they will report data on quality measures, MU, and clinical practice improvement activities for the MIPS program in 2017.



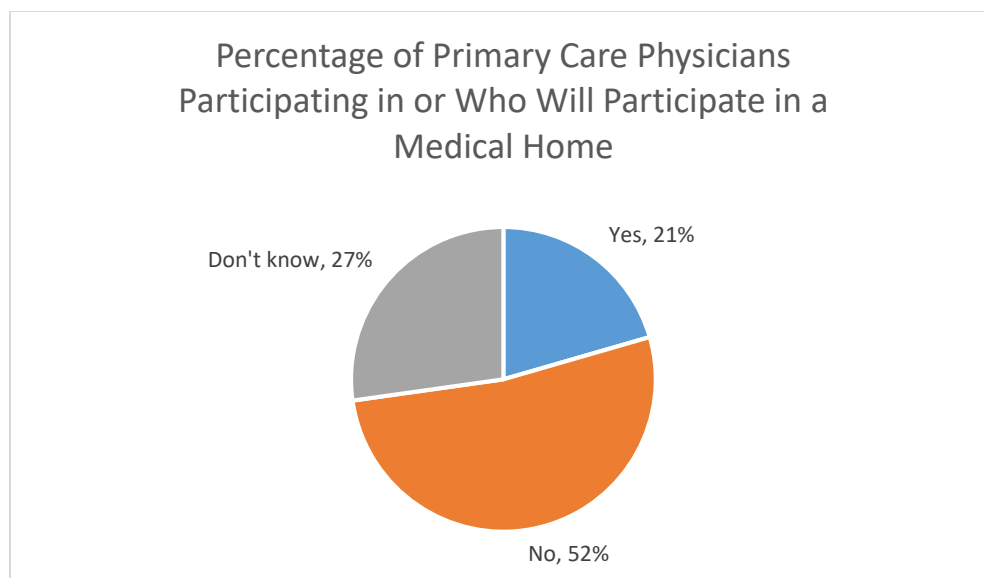
Physician Interest in a Virtual Group (August Question 28)

A virtual group is a group of nonaffiliated physicians formed for the purposes of group MIPS scoring for incentives and penalties. Nineteen percent of physicians were interested in joining one.



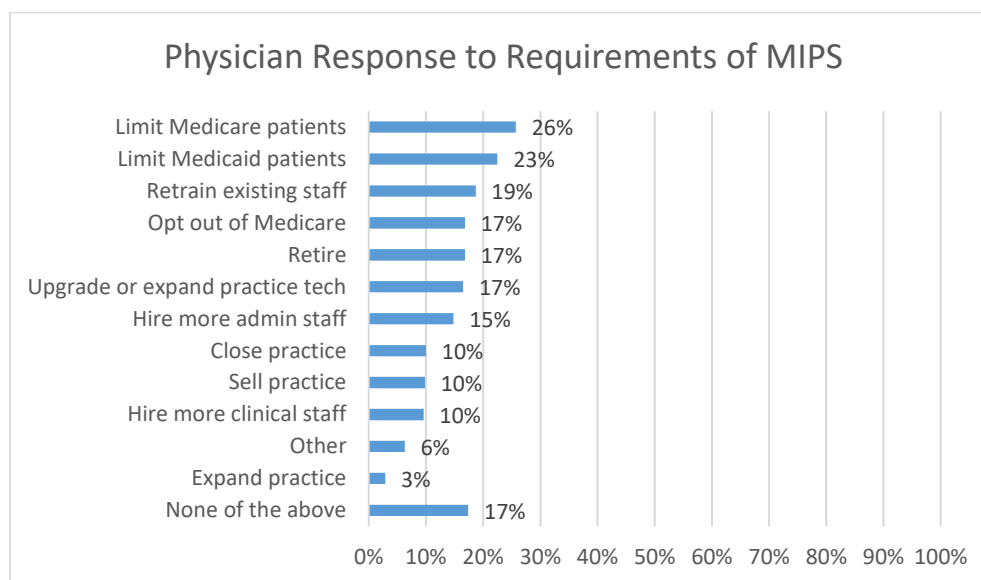
Participation in a Medical Home (August Question 29)

Physicians were asked if they were a primary care physician whether they were participating in or will participate in a medical home. After excluding physicians who responded “not applicable,” 21 percent reported they were participating or will participate in a medical home.



Response to MIPS and Value-Based Care (August Question 30)

As a result of the requirements of MIPS and value-based care, 43 percent of physicians have limited or will limit their Medicare patients or opt out of Medicare.



Medicaid Managed Care

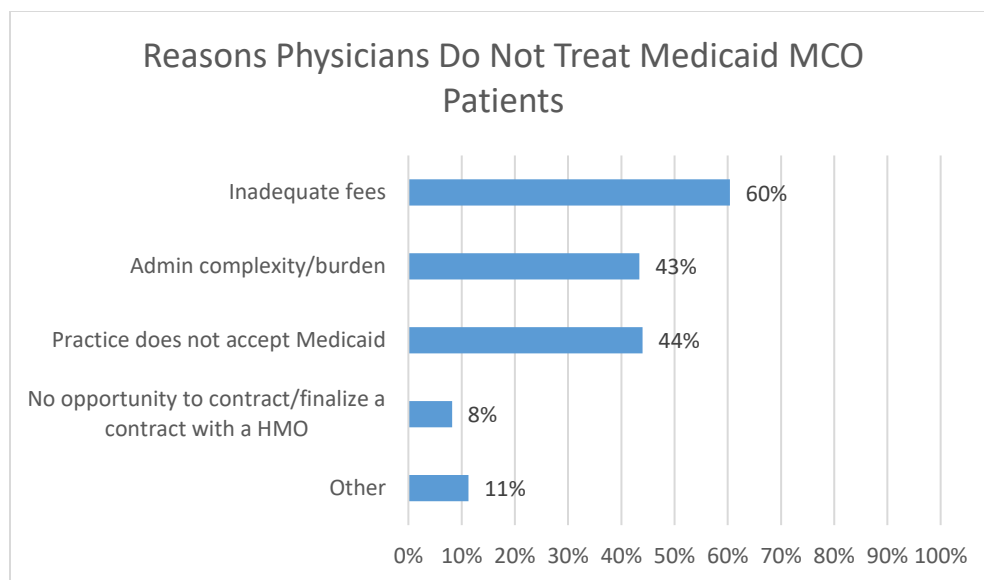
Increasing physician participation in Medicaid is a high priority for TMA. Physicians were asked questions about their participation in Medicaid managed care organizations.

Acceptance of Medicaid MCO Patients (Question 32)

Forty-five percent of physicians treated Medicaid MCO patients.

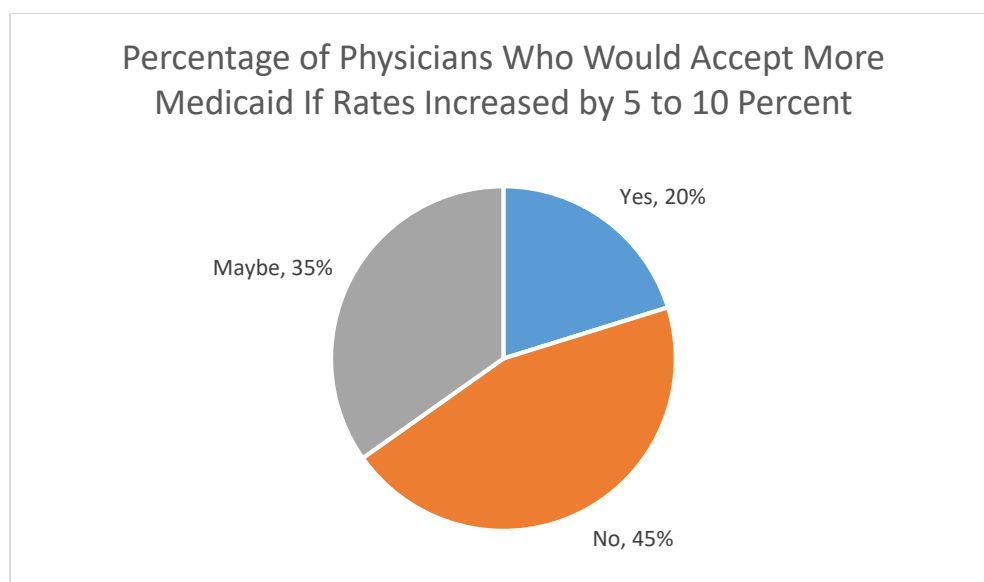
Reasons Physician Do Not Accept Medicaid MCO Patients (Question 33)

Physicians who did not treat Medicaid MCO patients were asked the reason or reasons why not. Primarily, physicians did not treat Medicaid MCO patients because payment was too low to cover the cost of providing services (60 percent).

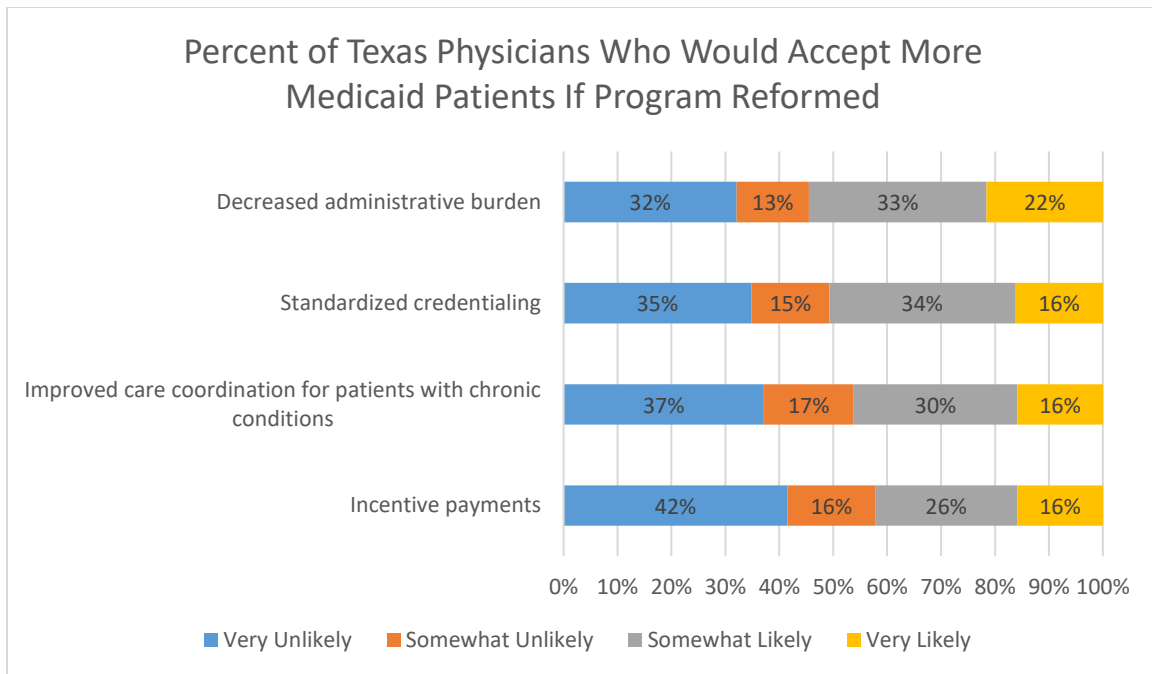


Increased Acceptance of Medicaid MCOs (Question 34-35)

Twenty percent of physicians would accept more Medicaid MCO patients if rates increased by 5 to 10 percent, and an additional 35 percent would consider doing so.

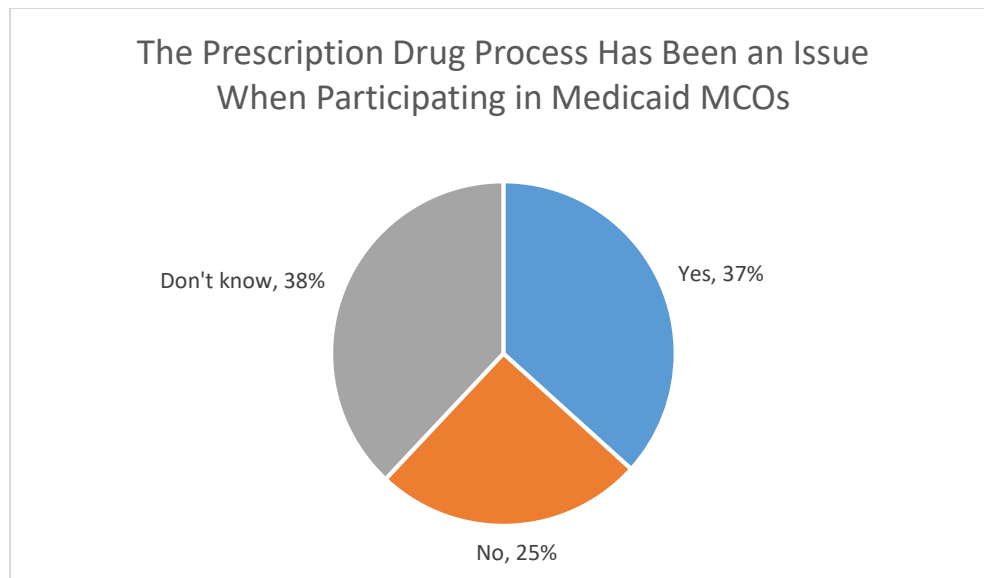


The majority (55 percent) of physicians were likely to accept more Medicaid patients if the program was reformed to decrease administrative burden (e.g., simplified preferred drug list, prior approval processes).

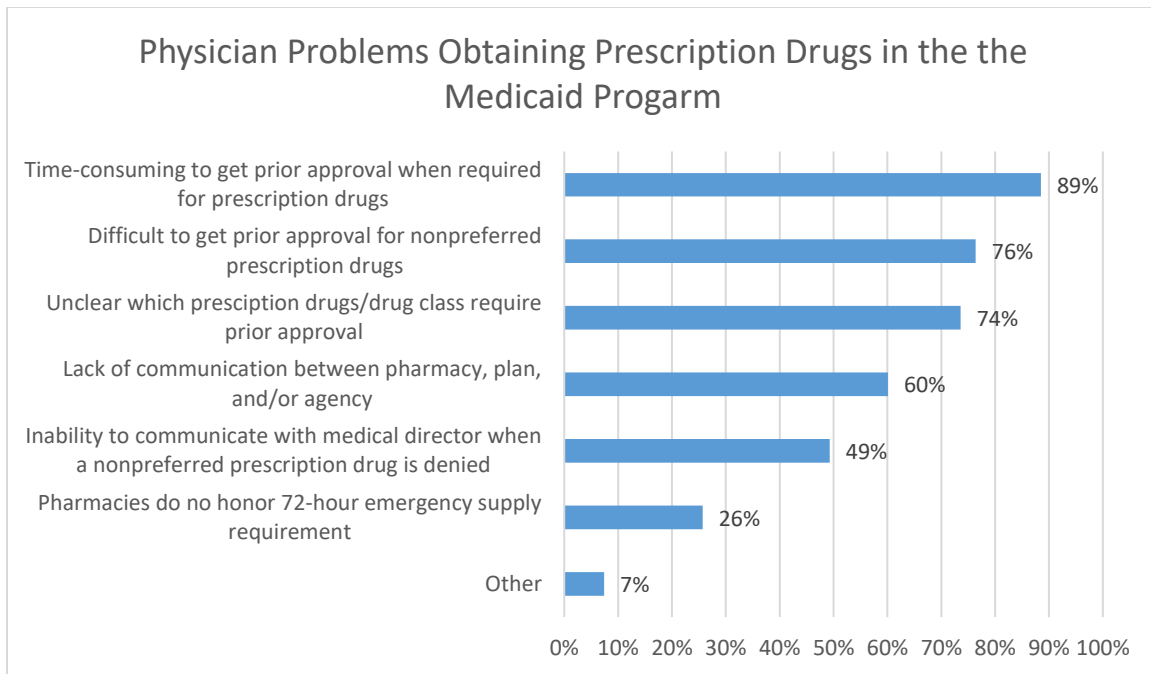


Prescription Drug Issues in Medicaid MCO (August Question 36-37)

Thirty-seven percent of physicians reported prescription drugs were an issue when participating in Medicaid MCOs, either STAR or STAR+PLUS.



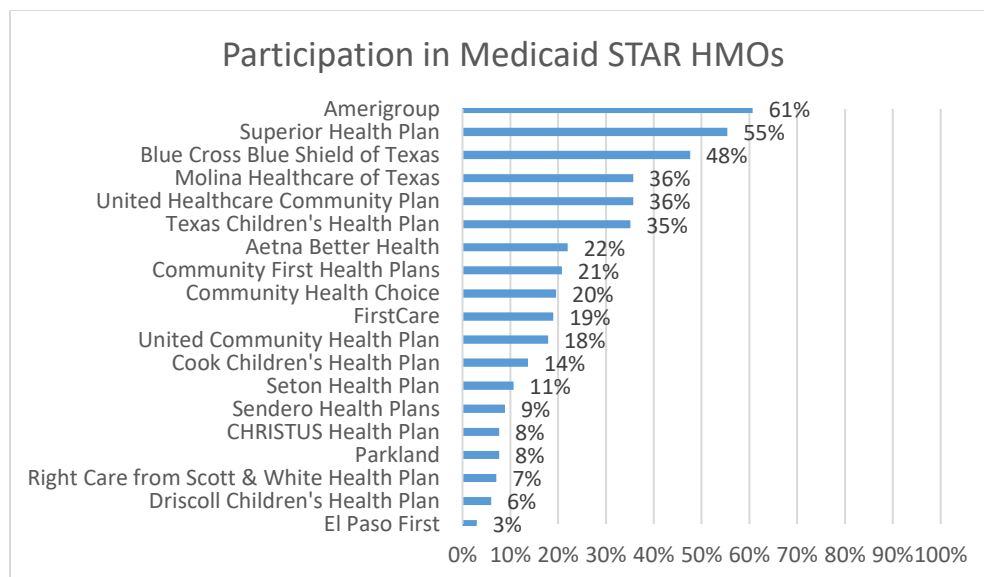
Physicians who found prescription drugs an issue reported time-consuming prior approvals (89 percent), difficulty in getting prior approvals for nonpreferred prescription drugs (76 percent), and lack of clarity about when prescription drugs or drug classes require prior approval (74 percent).



Other problems physicians experienced included the approved drugs changing frequently and without notification.

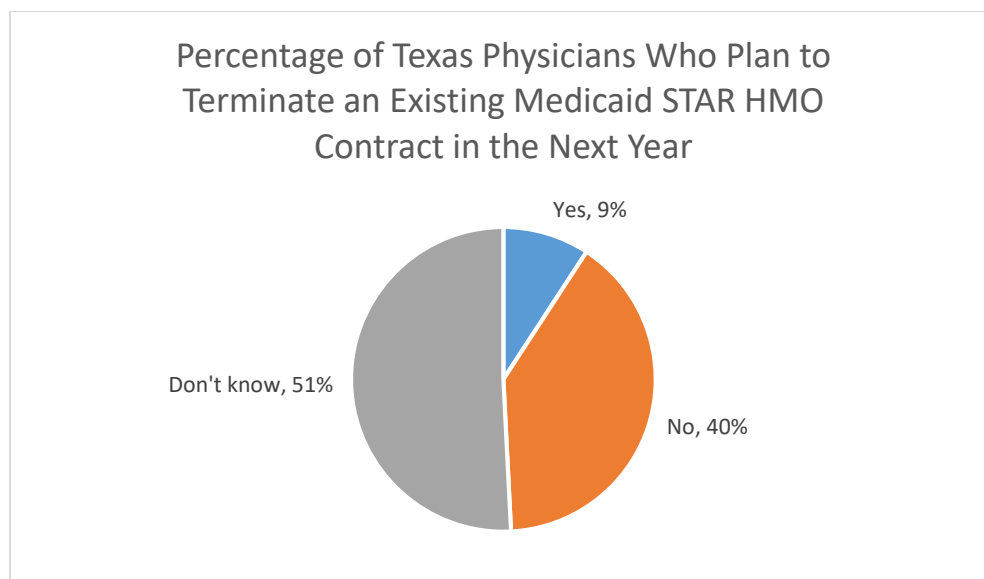
Participation in Medicaid STAR HMOs (August Question 38-39)

Medicaid STAR HMOs primarily cover pregnant women and children. Twenty percent of physicians participated in a STAR HMO, primarily Amerigroup (61 percent) and Superior (55 percent).

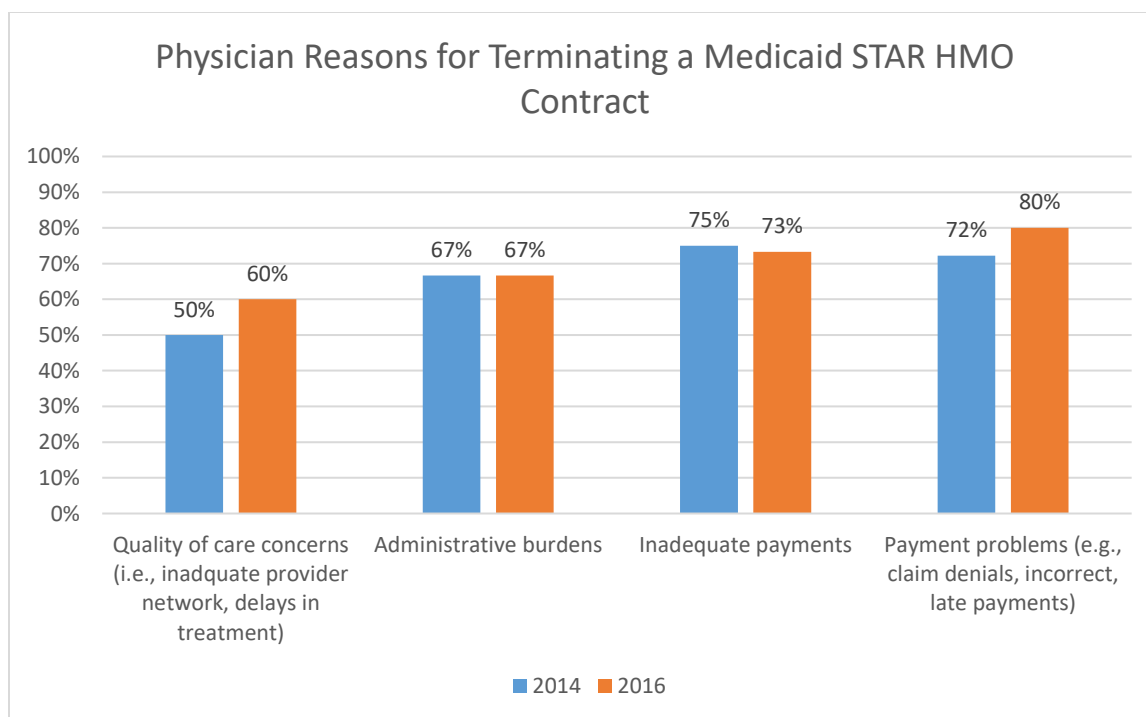


Termination of Medicaid STAR HMO Contracts (August Question 40-41)

Nine percent of physicians planned to terminate one or more of their existing STAR HMO contracts in the next year.

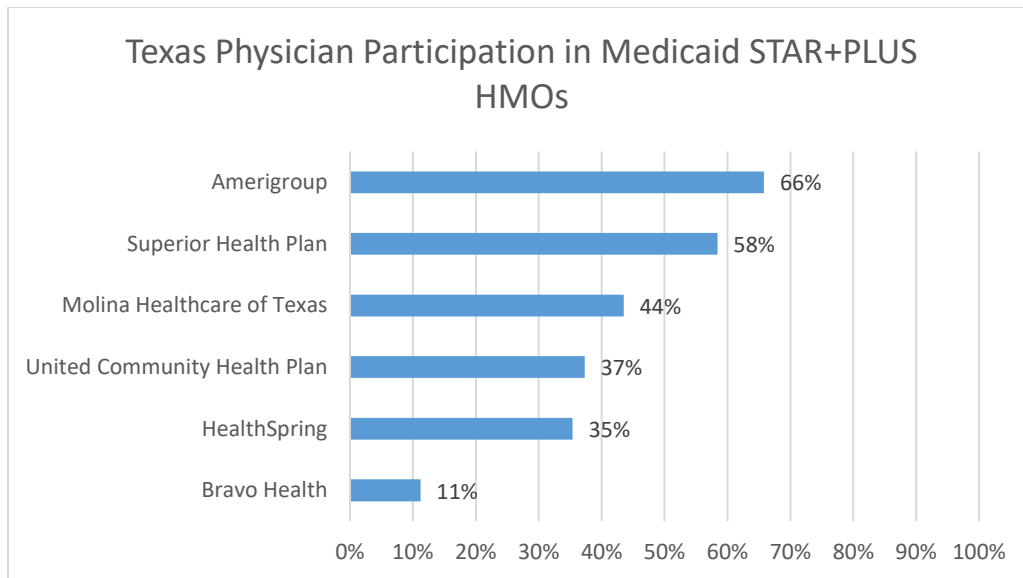


Physicians planned to terminate a Medicaid STAR HMO contract due to payment problems (80 percent), inadequate payment (73 percent), administrative burdens (67 percent), and quality of care concerns (60 percent).



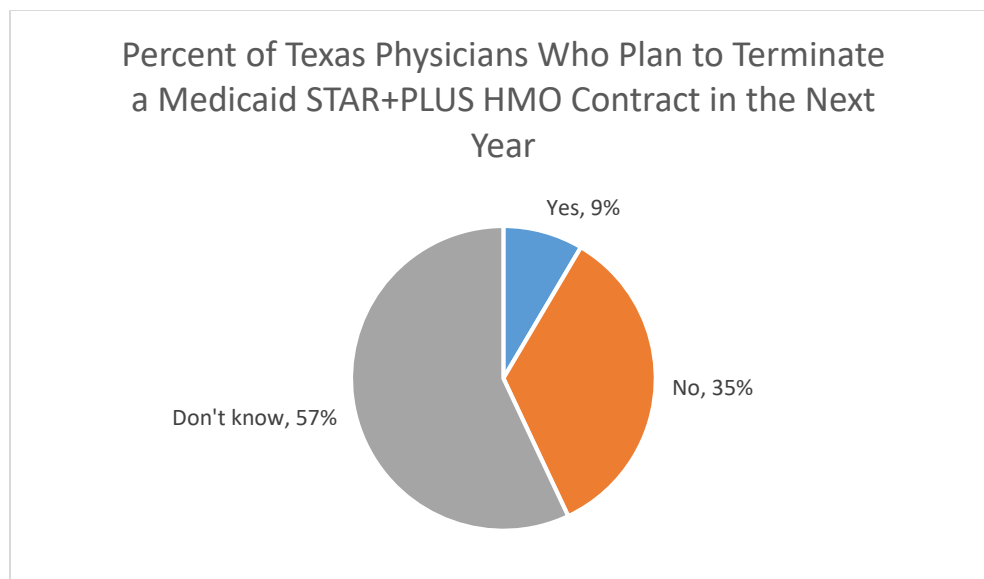
Participation in Medicaid STAR+PLUS HMOs (August Question 42-43)

The Medicaid STAR+PLUS HMOs primarily cover adults with disabilities and seniors. Twenty percent of physicians participated in a Medicaid STAR+PLUS HMO, primarily Amerigroup (66 percent) and Superior (58 percent).

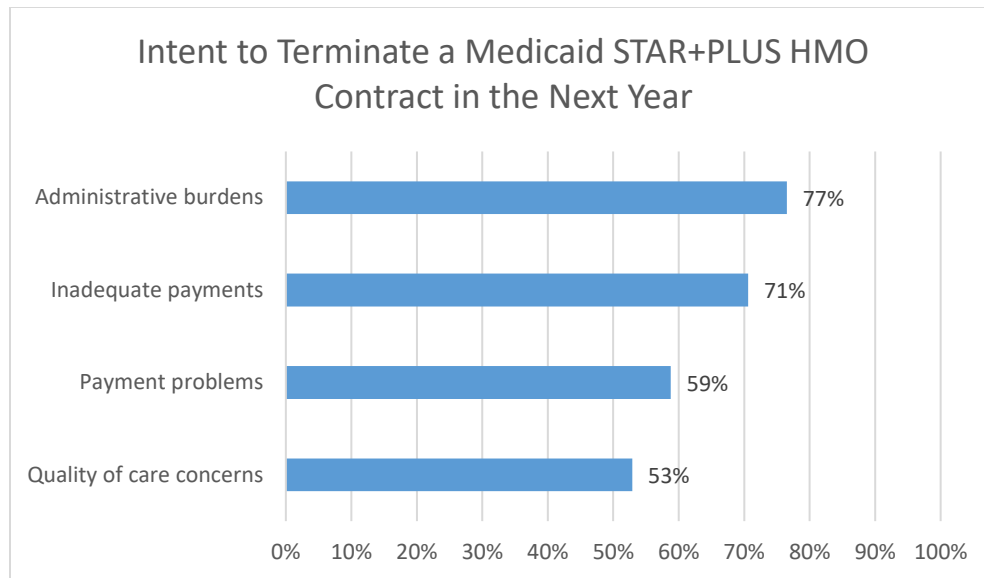


Termination of Medicaid STAR+PLUS HMO Contracts (August Question 44-45)

Among physicians who participated in a STAR+PLUS HMO, 9 percent planned to terminate one or more of their existing contracts in the next year



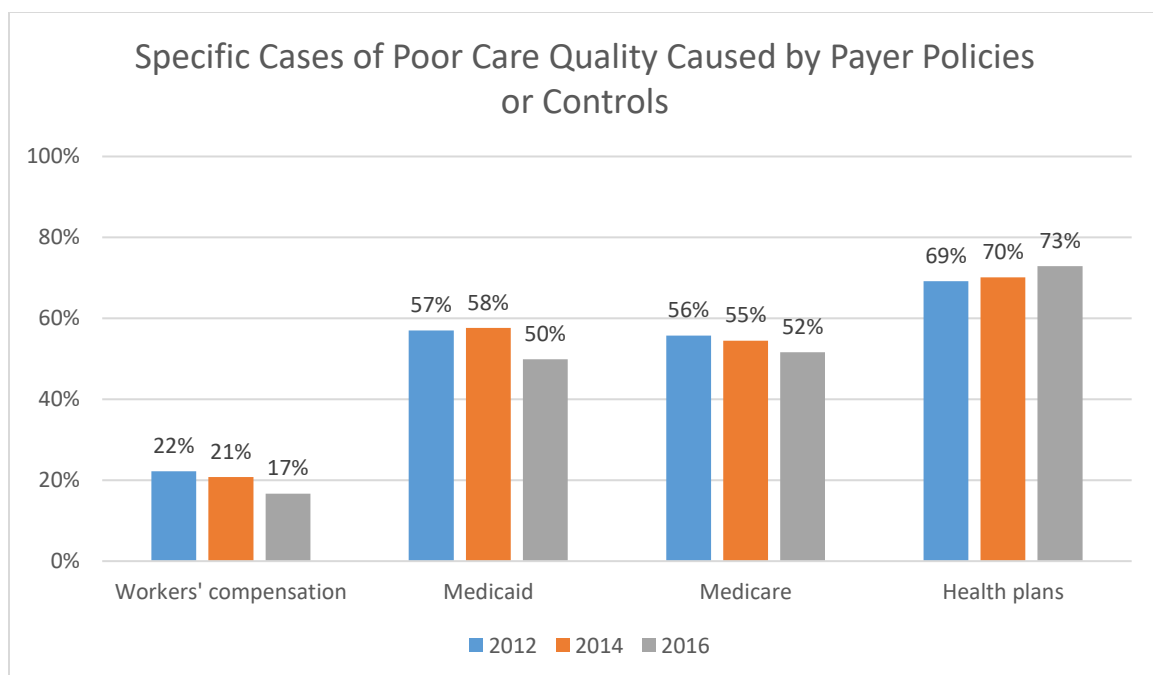
Physicians planned to terminate a Medicaid STAR+PLUS contract because of administrative burdens (77 percent) and inadequate payments (71 percent).



Care Quality Impact — Payers

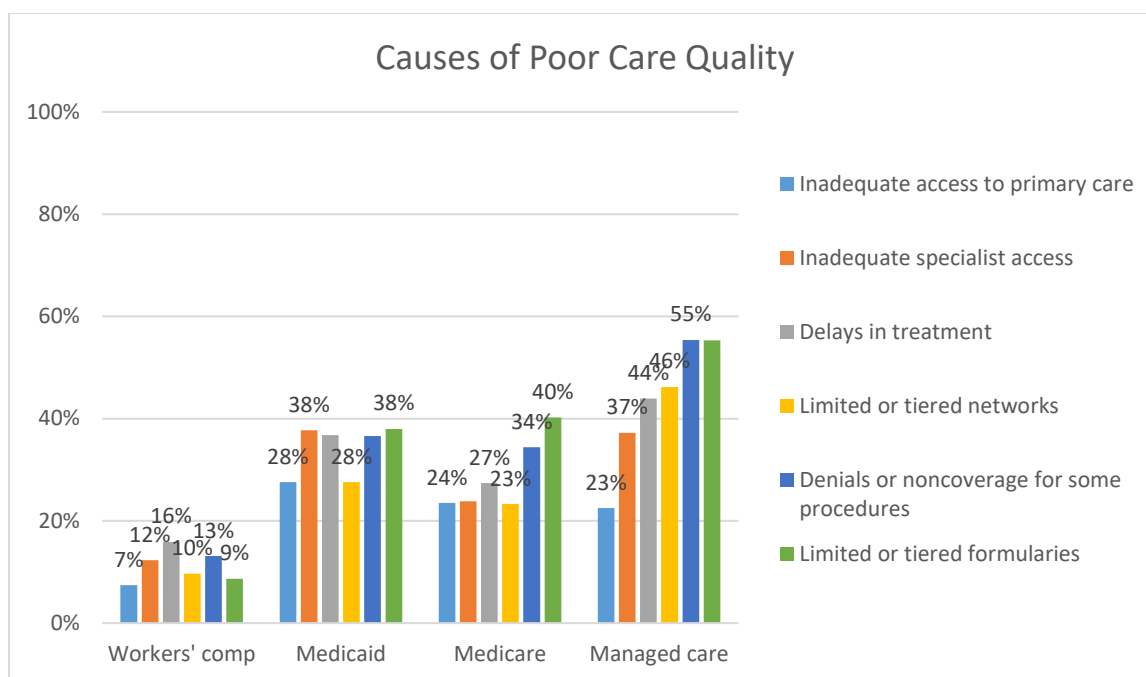
Poor Care Quality Due to Third-Party Payer Practices (July Question 1)

Respondents were asked to report whether they saw 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 indicated in the past year there was at least one instance in their practice in which patient care quality was adversely impacted by a health plan (73 percent) or Medicare (52 percent).



Cause of Adverse Impact by Third-Party Payers (July Question 2)

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 reported problems were caused by formulary limitations and treatment denials (55 percent).

Medicare: Medicare quality problems were most frequently attributed to limited or tiered formularies (40 percent) and treatment denials (34 percent).

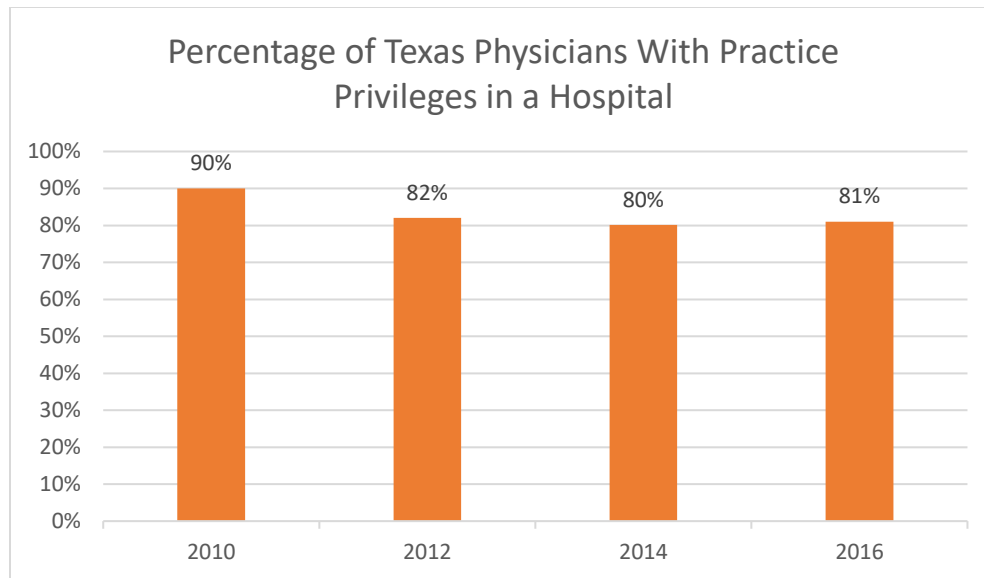
Medicaid: Quality problems in Medicaid were most frequently attributed to formulary limitations and inadequate access to specialists (38 percent).

Workers' compensation: Among physicians who saw specific cases of care quality problems in workers' compensation, treatment delays were the most frequently listed reason (16 percent).

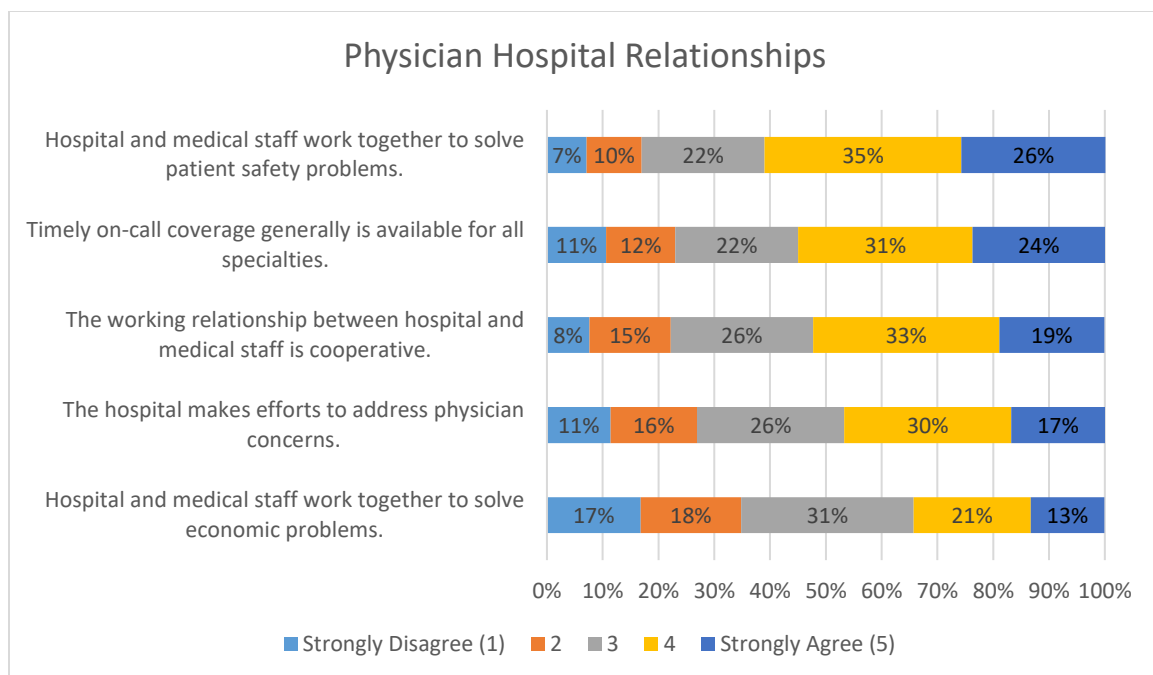
Physicians and Hospitals

Hospital Practice (July Question 18-20)

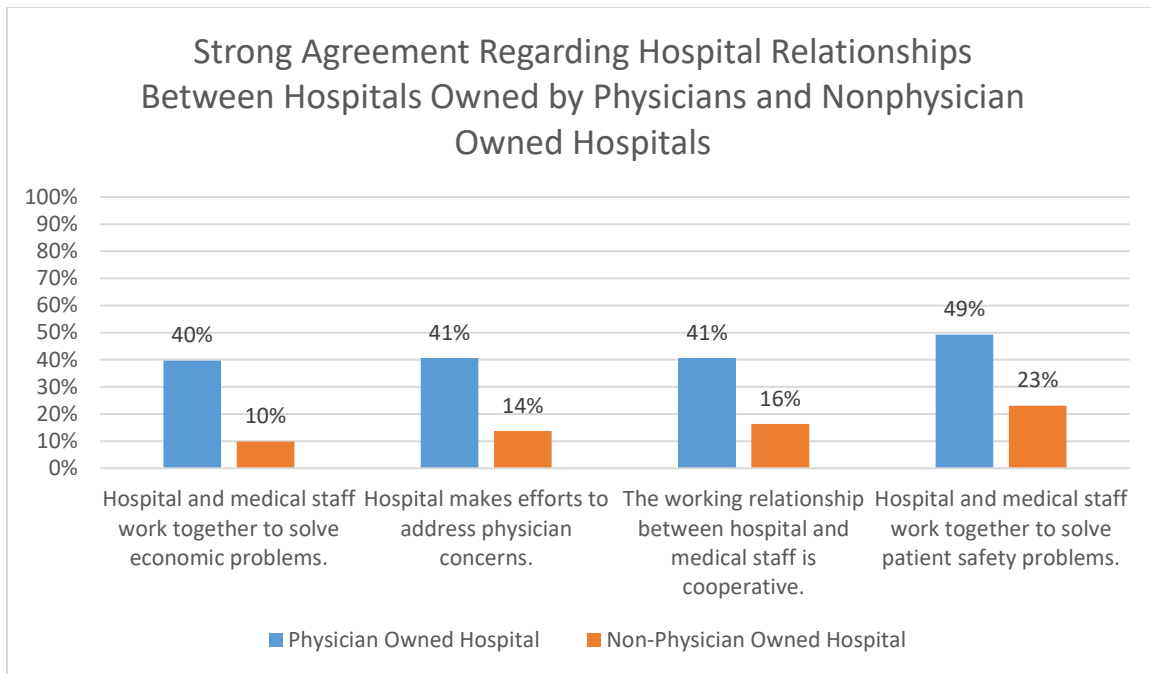
Eighty-one percent of physicians had practice privileges at a hospital.



Ten percent of physicians reported the hospital in which they primarily practiced in was owned partially or entirely by physicians, unchanged from 2014. Thinking about the hospital in which they primarily practice, physicians agreed hospital and medical staff work together to solve patient safety problems (61 percent), timely on-call coverage is available for all specialties (55 percent), and the working relationship between hospital and medical staff is cooperative (52 percent).

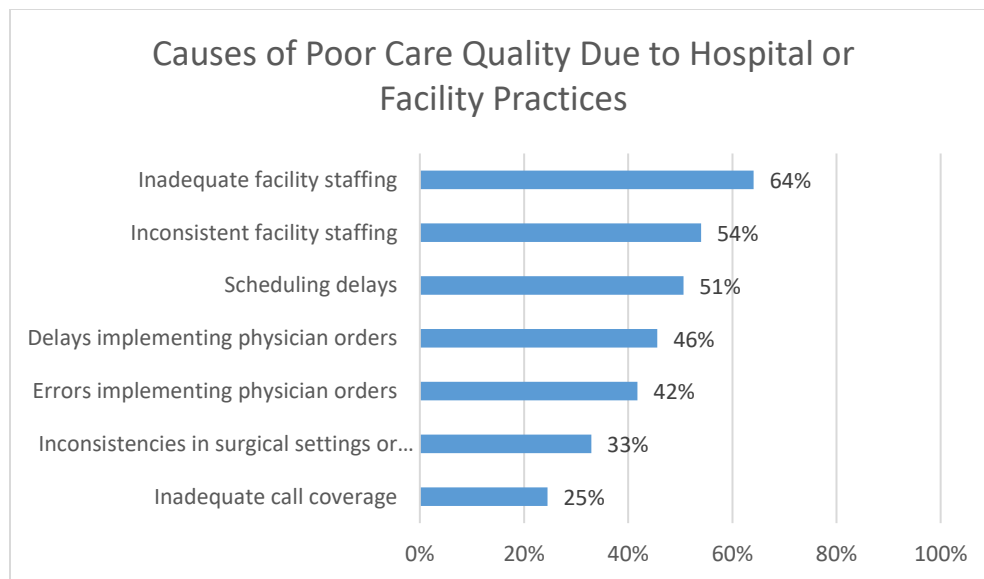


Physicians who primarily practiced in a hospital owned partially or entirely by physicians were more likely to strongly agree hospital and medical staff worked together to solve patient safety problems (49 percent).



Poor Care Quality Due to Hospital or Facility Practices (July Question 21-22)

Thirty-six 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. Physicians who saw damage to care quality were most likely to report inadequate and inconsistent facility staffing (64 and 54 percent respectively).

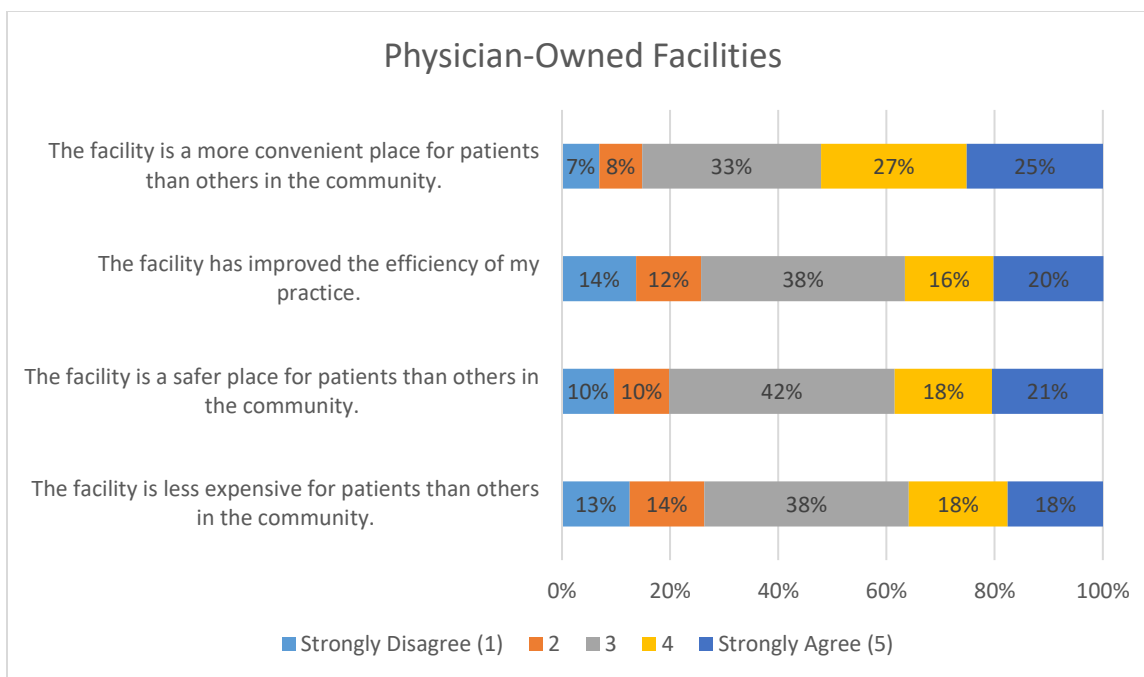


Hospitals and Call Coverage (July Question 23-24)

Among physicians with practice privileges at a hospital, 52 percent were required to accept patients without a physician who report to the emergency department, and 28 percent were compensated in some manner by the hospital for caring for medically indigent patients.

Physician-Owned Hospitals (July Question 25-28)

Eighty-one percent of physicians reported there were physician-owned specialty hospitals, ASCs, or imaging centers in their area. Twenty-seven percent practiced in a physician-owned facility, but less than half (46 percent) were owners or investors in the facility. Physicians agreed the facility is a more convenient place for patients than others in the community (52 percent).



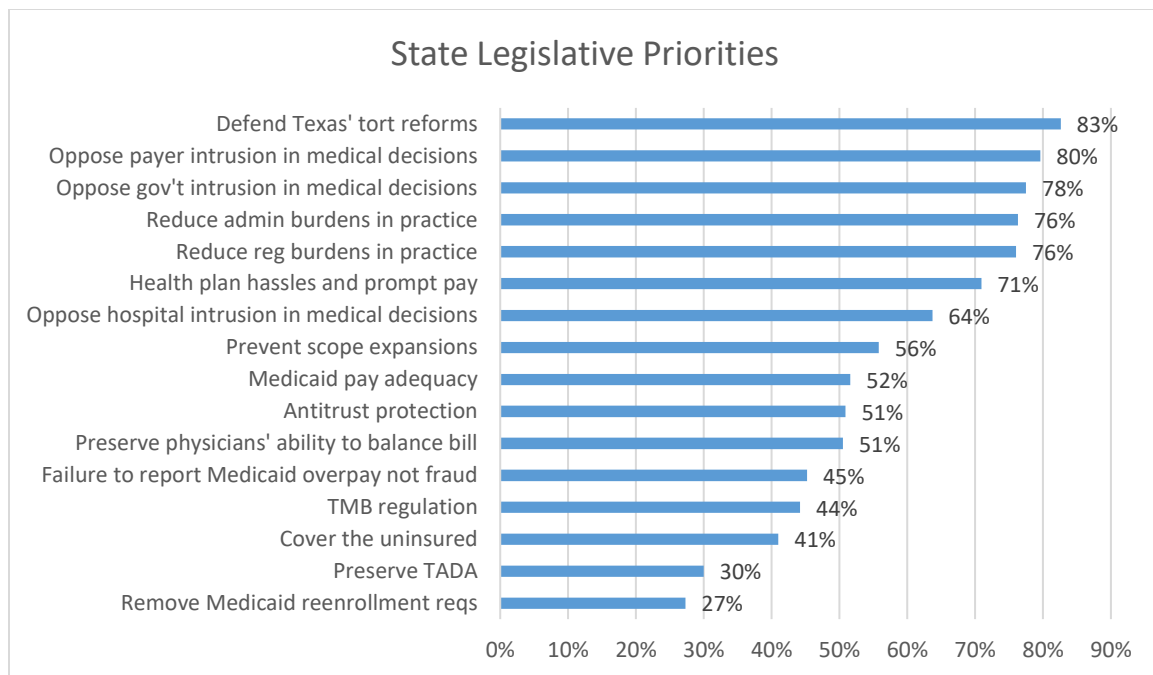
Adverse Quality of Care and Physician Employment (July Question 29-30)

Twenty-three percent of respondents saw cases where physicians lost employment, contracts, or hospital privileges after raising issues about hospital regulatory compliance or patient care quality, and 35 percent of physicians were concerned it could happen to them.

One Voice — Legislative Issues

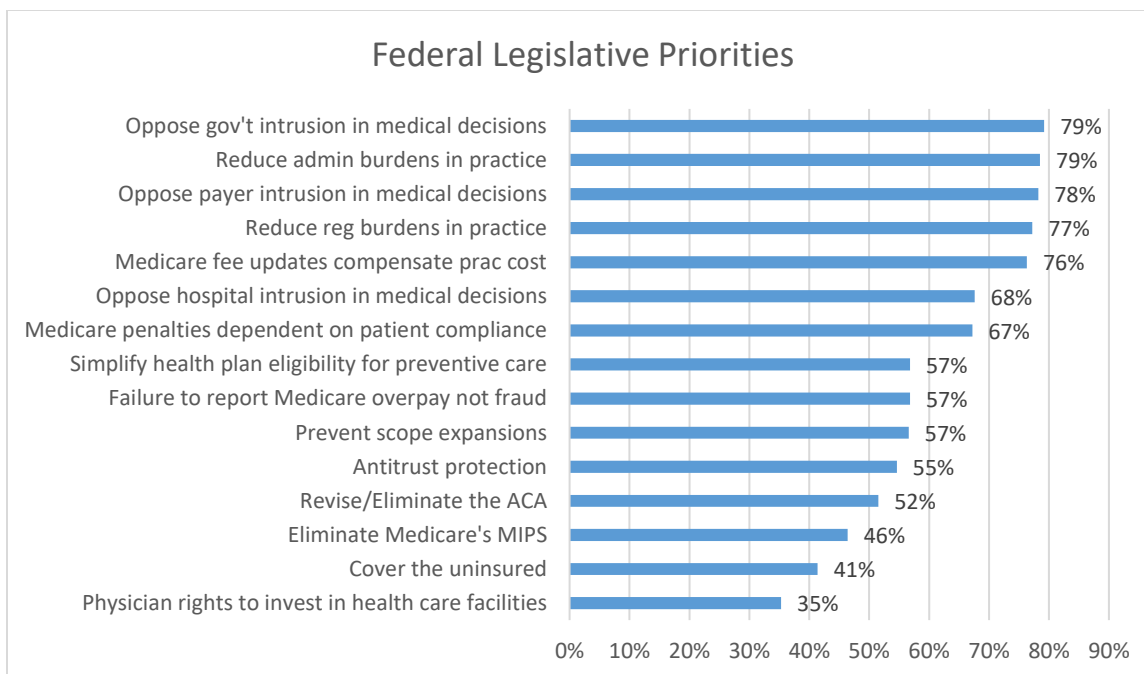
State Legislative Priorities (April Question 1)

Physicians' top state legislative priorities were defending Texas' liability reforms (83 percent), opposing commercial payer intrusion in medical decisions (80 percent), opposing government intrusion in medical decisions (78 percent), and reducing administrative and regulatory burdens in practice (76 percent).



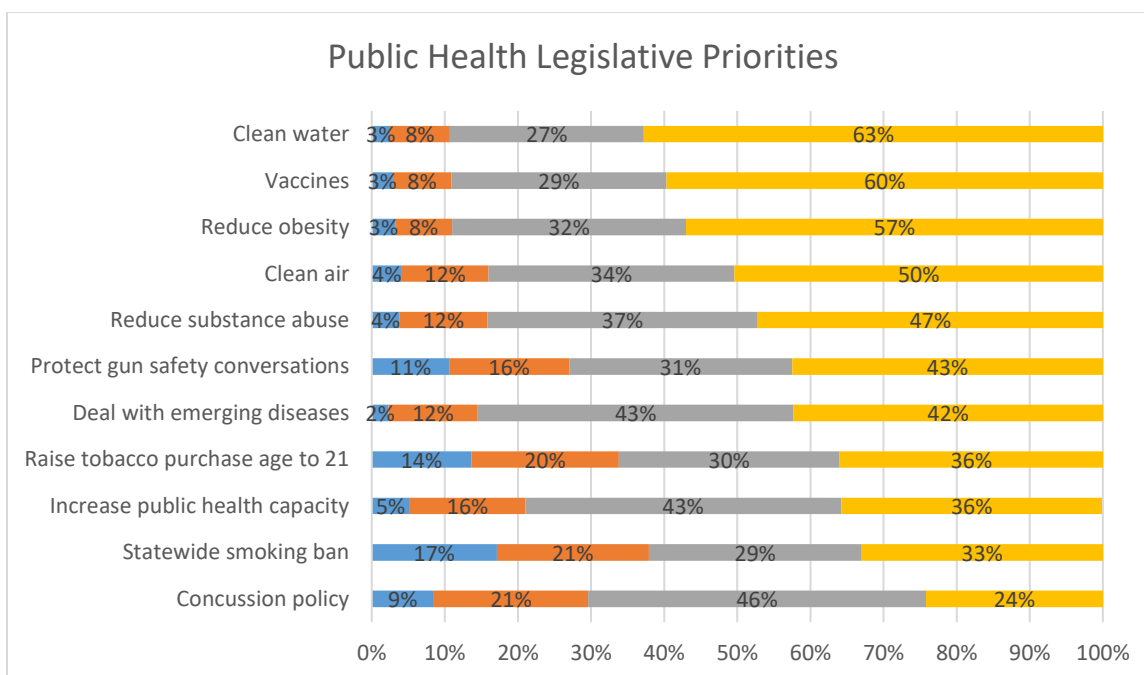
Federal Legislative Priorities (April Question 2)

The top federal legislative priorities were opposing government intrusion in medical decisions and reducing administrative burdens in medical practice (79 percent).



Public Health Priorities (April Question 3)

Top public health legislative priorities included clean water (63 percent), vaccines (60 percent), and reducing obesity (57 percent).



Support for Uninsured Initiatives (March Question 24)

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 included federal tax law changes, direct charity subsidies, and subsidies for high-risk pool premiums.

Support for Uninsured Initiatives

	<u>2004</u>	<u>2006</u>	<u>2008</u>	<u>2012</u>	<u>2014</u>	<u>2016</u>
Federal tax deduction for all medical expenses	85%	87%	92%	85%	87%	86%
Funding or tax credits for physician charity care		88%	94%	81%	87%	86%
More funding for outpatient charity clinics	78%	80%	82%	76%	81%	80%
Subsidies for high-risk pool premiums				76%	82%	76%
Encourage eligible people to enroll in Medicaid or CHIP		82%	85%	74%	81%	74%
Vouchers or tax credits for purchase of insurance	73%	77%	82%	73%	75%	74%
More direct funding for hospital charity care		81%	81%	75%	77%	72%
Expand CHIP			70%	64%	76%	67%
Expand Medicaid	46%	57%	51%	44%	60%	54%
Expand Medicare	44%	40%	36%	38%	53%	48%
Individual mandate		55%	45%	36%	43%	39%
Federal single-payer health insurance plan	38%	44%	32%	31%	34%	36%
Employer mandate		45%	35%	30%	38%	35%

Telemedicine

Telemedicine in Practice (April Question 4-7)

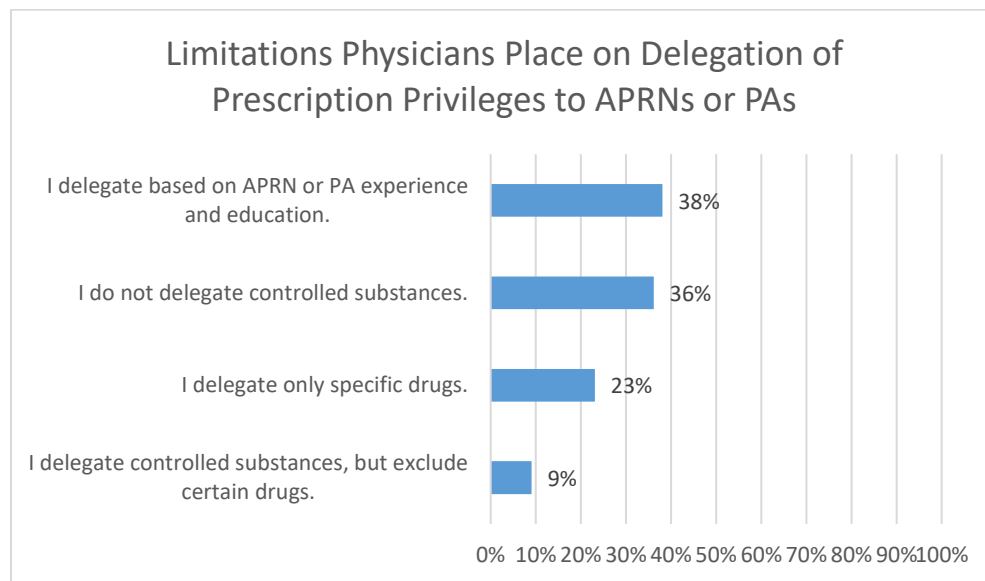
Telemedicine is a modality that provides medical care services for a patient at a remote location by a physician harnessing communications technology — generally audio, video, and store-and-forward technologies — that allow the physician to diagnose and treat the patient's condition in accordance with accepted standards of care. Sixteen percent of physicians used telemedicine as part or all of their practice. Among those not using it, 35 percent envisioned using it in five years. Physicians agreed a physician who provides medical care to a patient in Texas through telemedicine should be required to be licensed in Texas (88 percent), and medical services provided to a patient through

telemedicine should adhere to the same standards of care as services provided in person (89 percent).

Scope of Practice

Delegation of Prescription Privileges to Midlevel Practitioners (April Question 9-11)

Thirty-nine percent of physicians delegated prescription privileges to APRNs and PAs. Physicians who delegated prescription privileges did so based on individual APRN or PA experience and education (38 percent).



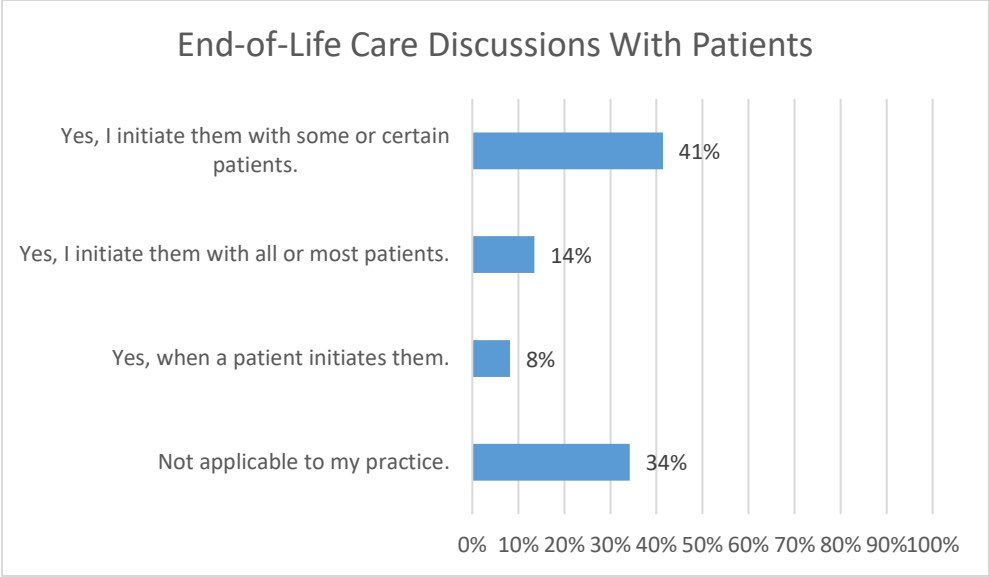
Independent Midlevel Practitioners (April Question 12)

Few physicians (11 percent) believed midlevel practitioners (APRNs and PAs) should be permitted to diagnose patients and prescribe medicine independently.

Advance Directives

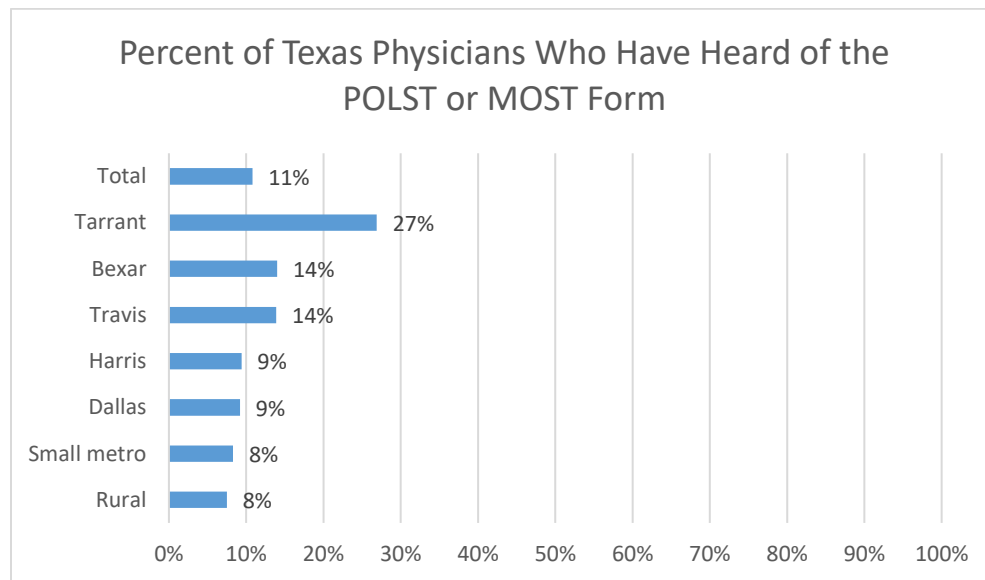
End-of-Life Care Discussions (April Question 13)

Sixty three percent of physicians had end-of-life-care discussions with patients.



POLST or MOST Forms (April Question 14-16)

Eleven percent of physicians' were familiar with the POLST or MOST form.



Among them, 15 percent used a POLST or MOST form to document end-of-life conversations. Sixty-nine percent would support wider dissemination of the forms' use.

Medicare Payment for End-of-Life Discussions (April Question 17)

Forty-three percent of physicians were aware Medicare now pays for end-of-life discussions, suggesting an increased need for outreach and education on this issue.

Physician Demographics

Gender

	<u>2010</u>	<u>2012</u>	<u>2014</u>	<u>2016</u>
	%	%	%	%
Male	75	73	70	67
Female	25	27	30	33

Age

	<u>2010</u>	<u>2012</u>	<u>2014</u>	<u>2016</u>
	%	%	%	%
40 and younger	21	19	18	19
41 to 50	27	23	22	22
51 to 60	33	32	27	27
61 and older	19	25	33	32

Specialty

	<u>2010</u>	<u>2012</u>	<u>2014</u>	<u>2016</u>
	%	%	%	%
Obstetrics-Gynecology	7	7	7	6
Pediatrics	7	8	10	9
Surgical Specialty	13	13	13	11
Indirect Access	14	15	16	18
Primary Care	25	26	30	27
Nonsurgical Specialty	33	32	24	29

County

	<u>2010</u>	<u>2012</u>	<u>2014</u>	<u>2016</u>
	%	%	%	%
Bexar	9	8	9	9
Dallas	13	12	13	14
Harris	19	17	18	20
Tarrant	8	6	6	7
Travis	9	8	9	9
Smaller metro	34	41	37	35
Rural	6	6	6	6
Rio Grande Valley	3	3	2	

TMA Membership Status

	<u>2010</u>	<u>2012</u>	<u>2014</u>	<u>2016</u>
	%	%	%	%
Former				7
Nonmember	13	14	17	12
Member	87	86	83	81

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 Survey of Texas Physicians was conducted by TMA as a monthly email survey. The survey contained a total of 233 questions, many with multiple response items. Not all questions were answered by all respondents due to the monthly design and skip patterns. 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 39,165 Texas physicians and residents with email addresses in the TMA database were emailed a personalized link to the survey each month with an invitation to participate and an incentive to answer the survey for the month along 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. No published links allowed uninvited responses. Each link was unique and carried with it respondent demographic information. Each respondent was allowed to respond only once to the each monthly survey. Reminders requesting participation from physicians who did not answer the survey were emailed one week after the survey was sent at the beginning of the month. Responses were received from 5,845 Texas physicians by the end of the survey year.

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-percent confidence level are reported.

APPENDIX — Survey Instrument

Jan Balance Billing

Balance billing is the term used when physicians and health care providers who are not contracted with an HMO or PPO bill patients for the difference between the amount the health plan pays out of network and the amount the physician or provider charged for the service. Media stories have reported that patients are surprised when they visit an in-network hospital or facility and receive a bill from an out-of-network physician. This has led to other stories about “surprise” billing. The Texas Legislature, with encouragement from consumer groups, business, and health plans, is likely to entertain a number of bills next session to address the issue. Several of these bills likely will propose prohibiting out-of-network billing. (Note that the Texas Legislature cannot regulate employer-sponsored health plans.)

1. Omitted
2. Omitted
3. Omitted
4. Omitted
5. Omitted
6. Omitted
7. Omitted
8. Omitted
9. Omitted

10. To assist patients with their out-of-pocket costs, do you (check all that apply):
- ☐ Publish a complete list of your billed charges 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.
 - ☐ Discuss with patients information about additional payment amounts that might be due when planning tests or procedures.
 - ☐ Try to provide an advance estimate 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 paid you historically for the service(s) as the maximum allowed for your out-of-network services.
 - ☐ Other (please specify): _____
11. Omitted
12. Omitted
13. Omitted
14. Omitted
15. Omitted
16. Omitted
17. Omitted
18. Omitted
19. Have you experienced any of the following problems with assignment of benefits? (Check all that apply.)
- ☐ Payer refusing to honor assignment resulting in plan paying patients instead of physicians.
 - ☐ Payer asserting assignment of benefits imposes a prohibition on balance billing.
20. 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

21. "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.)
22. 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 that were delivered per physician on average in your practice? (Enter approximate dollar amount.)

Feb Mergers

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

Yes

No

If No Is Selected, Then Skip To The merging insurers argue that the m...?

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. Approximately what percent 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.)

Aetna
 Blue Cross and Blue Shield
 Cigna
 Humana
 United Healthcare
 Medicare
 Medicare HMOs or Advantage plans
 Medicaid
 Medicare-Medicaid dual eligible
 CHIP
 Uninsured or self-pay patients
 Workers' compensation plans

5. In 2015, were you contracted with:

	Yes	No	Don't know
Aetna			
Blue Cross and Blue Shield			
Cigna			
Humana			
United Healthcare			

6. Do you feel you must contract with one or more of the following commercial insurers to have a financially viable practice? (Check all that apply.)

☐ Aetna
☐ Blue Cross and Blue Shield
☐ Cigna
☐ Humana
☐ United Healthcare
☐ None of these
☐ Not sure

Answer If Please indicate with respect to each whether you have encountered any of the following: (Check all that apply) Is Selected Or Please indicate with respect to each whether you have encountered any of the following: (Check all that apply) Is Selected Or Please indicate with respect to each whether you have encountered any of the following: (Check all that apply) Is Selected Or Please indicate with respect to each

whether you have encountered any of the following: (Check all that apply) Is Selected Or Please indicate with respect to each whether you have encountered any of the following: (Check all that apply) Is Selected

7. What makes these insurers essential to your financial viability? (Check all that apply.)

	Aetna	Anthem/ Amerigroup	Blue Cross/ Blue Shield	Cigna/ HealthSpring	Humana	United Healthcare	Not sure
They represent a significant percentage of my payer mix.							
They represent a significant percentage of the market.							
I need them to balance my payer mix.							
Our patients are covered by these plans.							
I need them to preserve my referral base.							
I see those patients when I cover the emergency department.							
Other (please specify):							

8. Can you refuse to take patients covered by an insurer and recover the lost revenue by treating more Medicare and Medicaid patients?

- ☐ Strongly disagree
- ☐ Somewhat disagree
- ☐ Neither agree nor disagree
- ☐ Somewhat agree
- ☐ Strongly agree
- ☐ Not sure

9. Please indicate with respect to each whether you have encountered any of the following (check all that apply):

	Aetna	Anthem/ Amerigroup	Blue Cross/ Blue Shield	Cigna/ HealthSpring	Humana	United Healthcare	Not Applicable	Not sure
Difficulty finding available in-network physicians who accept new patients for referrals								
Formulary limitations that prevent optimal treatment.								

10. Omitted

11. 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 Not applicable because I ha... Is Selected, Then Skip to Have you terminated any health plan c...

Answer If In the past two years, have you or your representative attempted to negotiate the terms of any health plan contracts? No Is Selected

12. Why did you or your representative NOT attempt to negotiate the terms of any health plan contracts? (Check all that apply.)

	Aetna	Anthem/ Amerigroup	Blue Cross/ Blue Shield	Cigna/ HealthSpring	Humana	United Healthcare	Not sure
I assumed we could not do so.							
My payer mix does not allow it.							
I have attempted in the past and was unsuccessful.							
The plan representatives told me they were nonnegotiable.							
Other (please specify):							

13. Which of these best describes your role in negotiating contracts with insurance companies that you or your employer contract with?

You are the primary decision maker.

You are one of a group of decision makers.

You are aware and might give input but do not participate in the process.

You are generally not involved in these negotiations.

Other (please specify): _____

Answer If In the past two years, have you or your representative attempted to negotiate the terms of any he...
Yes Is Selected

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

	Yes	No	Not Applicable
Aetna			
Blue Cross/Blue Shield			
Cigna			
Humana			
United Healthcare			

Answer If In the past two years, have you or your representative been successful in negotiating changes in... -
Yes Is Selected

15. 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 terms	No change in the contract	Don't know	Not Applicable
Aetna						
Blue Cross/Blue Shield						
Cigna						
Humana						
United Healthcare						

16. Omitted

17. Omitted

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

Yes

No

Not applicable because I have no contracts

Don't know

If Not applicable because I ha... Is Selected, Then Skip To In your view, how would the merger of...

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

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

	Aetna	Anthem/ Amerigroup	Blue Cross/ Blue Shield	Cigna/HealthSpring	Humana	United Healthcare	Not sure
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							
Other (please specify):							

20. Omitted

21. Omitted

22. In your view, how would the merger of Aetna and Humana impact contract terms?

- ☐ Much more favorable for you as a physician
- ☐ Somewhat more favorable
- ☐ No impact
- ☐ Somewhat less favorable
- ☐ Much less favorable
- ☐ Not sure

23. How would the merger of Anthem/Amerigroup and Cigna/HealthSpring impact contract terms?

- ☐ Much more favorable for you as a physician
- ☐ Somewhat more favorable
- ☐ No impact
- ☐ Somewhat less favorable
- ☐ Much less favorable
- ☐ Not sure

24. Omitted

25. Omitted

26. The merging insurers argue that the mergers are necessary to gain efficiencies in areas such as innovative payment programs and care management strategies that will benefit patients. Is this argument a very convincing, somewhat convincing, not very convincing, or not at all convincing reason to SUPPORT these mergers?

- ☐ Very convincing
- ☐ Somewhat convincing
- ☐ Not very convincing
- ☐ Not at all convincing
- ☐ Not sure

27. Are the following very convincing, somewhat convincing, not very convincing, or not at all convincing reasons to OPPOSE these mergers?

	Very convincing	Somewhat convincing	Not very convincing	Not at all convincing	Not sure
Opponents argue these mergers will give those insurers even more influence over physicians' clinical and business practices with little or no recourse for physicians. Physicians will be forced to cut costs so deeply that we will see a significant degradation of their ability to provide the care that the consumers value and need.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Opponents argue there is no evidence that larger insurers are more likely to implement innovative payment and care management programs. More dominant insurers have less incentive to invest in reform, and peer-reviewed studies have concluded that concerted delivery system reform efforts have emerged from sources such as provider systems, not insurers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

28. Do you support or oppose regulators allowing the Aetna-Humana merger to proceed?

- Strongly support allowing merger to proceed
- Somewhat support
- Neither support nor oppose
- Somewhat oppose
- Strongly oppose allowing merger to proceed
- Not sure

29. Do you support or oppose regulators allowing the Anthem/Amerigroup and Cigna/HealthSpring merger to proceed?

- Strongly support allowing merger to proceed
- Somewhat support
- Neither support nor oppose
- Somewhat oppose
- Strongly oppose allowing merger to proceed
- Not sure

30. Omitted

31. Omitted

32. May we contact you to discuss?

Yes

No

March Availability of Care

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 If the ACA had never been passed and...

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

Reduce physician compensation or 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			
Medicare HMOs or Advantage plans			
Medicare-Medicaid dual eligible			
Medicaid			
HMOs			
PPOs			
Uninsured or self-pay patients			
The military health care plan, TRICARE			
CHIP plans			
Workers' compensation			
ACA exchange plans			

If ACA exchange plans - Accept... Is Selected, Then Skip to How many of the following do you have...

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

	No	Yes	Don't know
Aetna			
Allegian Choice			
Ambetter from Superior			
Blue Cross and Blue Shield			
Cigna			
Community Health Choice			
CommunityFirst			
FirstCare			
Humana			
Molina			
Scott & White			
Sendero			
United Healthcare			

9. 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?

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

Yes

No

Don't know

Answer If In the past two years, have you approached a plan with which you are not contracted in an attempt to join their network? Yes Is Selected

11. If yes, how has it responded to your request?

No response

Received an offer, but it was unacceptable

Received a contract

12. Are you in an accountable care organization (ACO) or other clinical co-management arrangement?

Yes

No

If No Is Selected, Then Skip to Are there ACOs in your area?

13. If yes, with whom? (Check all that apply).

A hospital

Other physicians

Other (please specify): _____

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

Yes

No

Don't know

Answer If Are you in an Accountable Care Organization (ACO) or other clinical co-management arrangement? No Is Selected

15. Are there ACOs in your area?

Yes

No

Don't know

Answer If Are there ACOs in your area? Yes Is Selected

16. Are the ACOs in your area having a positive or negative effect on your practice? Please describe why.

Positive (please specify why): _____

Negative (please specify why): _____

No effect

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

Yes

No

Don't know

18. Omitted

19. Omitted

20. Omitted

21. Has your practice hired a new physician in the past year or is it planning to hire a new physician in the next year?

Yes

No

If Yes Is Selected, Then Skip to If the ACA had never been passed and...

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

Yes

No

Don't know

23. 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
Inadequate Medicare and/or Medicaid fees				
Uncertain future of the ACA				
Expense of recruitment				
Cost of maintaining an employed physician				
Increase in high deductible health plans and patient out-of-pocket responsibility				
Other (please specify):				

24. 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		
Expand CHIP to cover more children		
Expand Medicaid to cover low-income adults		
Encourage greater enrollment in Medicaid or CHIP for children who currently are eligible		
Provide financial assistance (like vouchers, tax credits, or subsidies) to help individuals buy coverage		
Provide subsidies for high-risk-pool premiums for individuals who are not insurable		
More funding for outpatient charity clinics to provide free or reduced-price care		
More direct funding for hospitals that provide charity care		
Direct funding or subsidies for physicians who provide charity care		
Federal income tax deduction for all medical expenses		
Federal single-payer health insurance plan		
A penalty or tax on individuals who do not purchase health insurance		
A penalty or tax on employers who do not offer adequate health insurance		

April Legislative Affairs

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

	Not at all Important	Somewhat Unimportant	Somewhat Important	Very Important
Defend Texas' tort reforms				
Oppose government intrusion in medical decisions				
Oppose commercial payer intrusion in medical decisions				
Oppose hospital management intrusion in medical decisions				
Health plan hassles and prompt pay				
Cover the uninsured				
Reduce administrative burdens in medical practice				
Reduce regulatory burdens in medical practice				
Antitrust protection for physicians				
Texas Medicaid payment adequacy				
Texas Medical Board regulation				
Preserve physicians' ability to balance bill				
Prevent scope of practice expansion for nonphysician				
Remove the requirements for Medicaid reenrollment				
Preserve the current provisions of the Texas Advance Directive Act				
Ensure failure to report Medicaid overpayments is not treated as fraud				
Other (please specify):				

2. Which federal legislative, legal, and regulatory issues are most important to you as a physician?

	Not at all Important	Somewhat Unimportant	Somewhat Important	Very Important
Oppose government intrusion in medical decisions				
Oppose commercial payer intrusion in medical decisions				
Oppose hospital management intrusion in medical decisions				
Revise/Eliminate some or all provisions of the Affordable Care Act				
Cover the uninsured				
Reduce administrative burdens in medical practice				
Reduce regulatory burdens in medical practice				
Antitrust protection for physicians				
Prevent scope of practice expansion for nonphysician				
Revise Medicare quality-of-care measures to eliminate penalties dependent on patient compliance				
Require health plans to simplify verifications of eligibility for preventive care benefits				
Restore physician rights to invest in health care facilities				
Require Medicare fee updates to adequately compensate for increases in practice cost				
Ensure failure to report Medicare overpayments is not treated as fraud				
Eliminate Medicare's Merit-Based Incentive Payment System				
Other (please specify):				

3. Which public health issues are most important to you as a physician?

	Not at all Important	Somewhat Unimportant	Somewhat Important	Very Important
Reducing obesity				
Clean air				
Clean water				
Raising the tobacco purchase age from 18 to 21				
Reducing substance abuse				
Protecting physician conversations on gun safety				
A statewide smoking ban				
Vaccines				
Concussion policy				
Increasing public health capacity				
Dealing with emerging diseases				
Other (please specify):				

4. Telemedicine is a modality that utilizes the provision of medical care services for a patient at a remote location by a physician harnessing communications technology - generally audio, video, and store and forward technologies - that allow the physician to diagnose and treat the patient's condition in accordance with accepted standards of care. Do you utilize telemedicine as part or all of your practice?

Yes

No

Answer If Do you utilize telemedicine as part or all of your practice? No Is Selected

5. Do you envision utilizing telemedicine in five years?

Yes

No

6. Should a physician who provides medical care to a patient in Texas through telemedicine be required to be licensed in Texas?

Yes

No

7. Should medical services provided to a patient through telemedicine adhere to the same standards of care as services provided in person?

Yes

No

8. Omitted

9. Do you delegate prescription privileges to APRNS and PAs

Yes

No

If No Is Selected, Then Skip to Do you believe mid-level practitioner...?

10. In your practice and for your patients, would you be comfortable delegating Schedule II medications to your APRN or PA?

Yes

No

11. If you delegate prescription privileges to APRNs and/or PAs, do you place any limitations on what they may prescribe under your supervision? (Check all that apply.)

I do not delegate controlled substances.

I delegate controlled substances, but exclude certain drugs. (Please specify which drugs): _____

I delegate only specific drugs.

I delegate without limitation.

I delegate based on individual APRN or PA experience and education.

12. Do you believe APRNS and PAs should be permitted to independently diagnose patients and prescribe medicine without physician supervision?

Yes

No

13. 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

Not applicable to my practice

14. Have you heard of the POLST or MOST form?

Yes

No

If No Is Selected, Then Skip To Were you aware Medicare is now...

15. Are you using a POLST or MOST form to document end-of-life conversations?

Yes

No

16. Would you support wider dissemination of the form's use?

Yes

No

Don't know

17. Were you aware Medicare is now paying physicians for end-of-life discussions?

Yes

No

18. Omitted

19. Can your practice be described by any of the following? (Check all that apply.)

All or mostly cash or self-pay

Concierge

Medicare opted-out

Heavy Medicaid (i.e., population of 50 percent or more)

None of the above

20. Would you be willing to speak confidentially with TMA staff about your answers?

Yes

No

May EHRs

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? (Select 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 fees

Uncertainty regarding the economy

Other (please specify): _____

3. Would any of the following convince you to implement an EHR? (Select 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 it would improve the quality of patient care

Evidence it would reduce my liability risk

Evidence it would improve my practice operations

A better EHR product than ones I've seen

Standards to ensure that all systems can share information

Certainty regarding Medicare fees

Other (please specify): _____

4. What technologies do you use in practice? (Select all that apply.)

A practice management system

Electronic claims processing

E-prescribing

Other (please specify): _____

None

5. 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 you anticipate... More than two years is selected

6. Why will it take you more than two years to implement an EHR? (Select all that apply.)

Cost-prohibitive

No time

Uncertainty regarding Medicare fees

Uncertainty regarding the economy

Other (please specify): _____

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

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): _____

8. Are you participating in a local health information exchange (HIE) in order to share EHR data among health care providers?

Yes

No

Answer If Are you participating in a local health information exchange (HIE) in order to share EHR data among healthcare providers? No Is Selected

9. If not, why not? (Select all that apply.)

Don't know enough about HIEs

Security, privacy, and liability concerns

EHR system is not enabled to participate

Decreased productivity

No help from local hospital

Difficult to obtain external data

Not sure it will improve patient care

HIEs are cost-prohibitive

EHR vendor interface fees are cost-prohibitive

Other (please specify): _____

10. Do you use e-prescribing for controlled substances?

Yes

No

Not applicable – I don't use e-prescribing

Answer If Do you use e-prescribing for controlled substances? No Is Selected

11. If you don't use e-prescribing for controlled substances (EPCS), why not?

I'm not interested in using it.

I don't prescribe controlled substances.

The upgrade to EPCS is cost-prohibitive.

It is not supported by my EHR.

It interferes with workflow.

Other (please specify): _____

12. 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)

I only use a practice management system, e-prescribing system, hospital system, or home-grown system.

Other (please specify vendor): _____

13. How satisfied are you with your EHR system?

Very dissatisfied

Somewhat dissatisfied

Somewhat satisfied

Very satisfied

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

Yes

No

15. Have you experienced or witnessed:

	Yes	No
Damage to patient safety or care quality due to use of the EHR?		
Improved patient safety or care quality due to use of the EHR?		

Answer If Instances where an EHR damaged or harmed safety or care quality? - Yes Is Selected

16. If you have seen damage or harm to patient safety or care quality due to an EHR, please describe:

Answer If Have you experienced or witnessed: Improved patient safety or care quality due to use of the EHR? - Yes Is Selected

17. If you have seen an improvement in patient safety or care quality due to use of an EHR, please describe:

18. Do any improvements in patient safety and care quality due to the EHR outweigh risks to patient safety and care quality?

Yes

No

19. Are you using tools built-in to your EHR to analyze quality metrics or other information about your patient population?

Yes

No

Answer If Are you using tools built-in to your EHR to analyze quality metrics or other information about you... No Is Selected

20. Do you use a third-party product to analyze quality metrics or other information about your patient population?

Yes

No

Don't know

21. Which EHR functions do you use? (Select all that apply.)

Quality reporting

Patient management

E-prescribing

Patient portals

Care coordination

Public health reporting

Clinical decision support

Imaging orders

Lab orders

Other (please specify): _____

22. Do you have a patient portal?

Yes

No

Answer If Do you have a patient portal? Yes Is Selected

23. Which problems, if any, have you or your practice experienced with patient portals? (Select all that apply.)

Patients without access to Internet or high speed Internet.

Patients unable to use computers.

Patients prefer speaking with physician or practice staff.

Patients have no interest.

Other (please specify): _____

None

24. Indicate your agreement with each of the following:

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

25. In your current, primary place of practice have you switched EHRs because your former one was:

	No	Yes
Ineffective?		
Went out of business?		
Other (please specify):		

26. Has your practice experienced a ransomware (data encrypted until ransom paid) or data breach?

	Yes	No	Don't know
Ransomware			
Data breach			

Answer If Ransomware - Yes Is Selected

27. How much was the ransom to have your data unencrypted? (If your practice experienced more than one ransomware, answer for the most recent one.)

Answer If Data breach - Yes Is Selected

28. How much did it cost your practice to recover from the data breach including IT support, notifying patients, updating policies, etc.? (If your practice experienced more than one data breach, answer for the most recent one.)

29. Does your liability insurance carrier offer cyber liability coverage?

Yes

No

Don't know

June Membership

1. Omitted
2. Omitted
3. Omitted
4. Omitted
5. Omitted
6. Omitted
7. Omitted
8. Omitted
9. Omitted
10. Omitted
11. Omitted
12. Omitted
13. Omitted
14. Omitted
15. Omitted
16. Omitted
17. Omitted
18. Omitted

19. Who has authority for making practice management decisions (e.g., hiring, firing, business strategy, hardware/software purchases) 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 hospital or hospital system

A not-for-profit organization

Other (please specify): _____

20. Omitted

21. Omitted

22. Omitted

23. Omitted

24. Omitted

25. Omitted

26. Omitted

27. Would you be willing to speak confidentially with TMA staff about your answers?

Yes

No

July Care Quality

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...? Medicare Is selected or In the past year, has your practice experienced any... Medicaid Is selected or In the past year, has your practice experienced any...

Health plans Is Selected or In the past year, has your practice experienced any... 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				
Inadequate specialist access				
Delays in treatment				
Limited or tiered formularies				
Denials or noncoverage for some procedures				
Limited or tiered networks				
Other (please specify):				

3. 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 your contractual discounts have been accessed without your consent, as in a silent PPO Yes Is Selected

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

Yes

No

5. 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.

6. Which of the following best describes the current ownership of your practice?

Wholly owned by one of more physicians in the practice

Wholly owned by a hospital or hospital system including a nonprofit health corporation (NPHC; formerly known as a 5.01[a])

Jointly owned between physicians in the practice and a hospital or hospital system including a NPHC

Wholly owned by a for-profit organization (please specify): _____

Wholly owned by a nonprofit organization (please specify): _____

Other (please specify): _____

I don't know

7. Does a hospital or nonphysician organization own, employ, or provide the following in your practice? (Check all that apply.)

Your office space

Your office equipment

Other equipment in your practice

Professional liability insurance

Support staff

None of the above

8. Omitted

9. Omitted

10. Omitted

11. Omitted

12. Omitted

13. Omitted

14. Omitted

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

	Not at All	Occasionally	Frequently
Clinical decisions			
Practice management decisions			

16. Do you feel you are at risk of losing your independence in clinical decisionmaking?

Yes

No

17. If physicians lose their ability to make independent clinical decisions, do you feel this is bad for (check all that apply):

	No	Yes
Physicians		
Patients		

18. Do you have practice privileges at a hospital?

Yes

No

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

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

Yes

No

20. 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.					
Hospital makes efforts to address physician concerns.					
The working relationship between hospital and medical staff is cooperative.					
Timely on-call coverage generally is available for all specialties.					

21. 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

22. 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): _____

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

Yes

No

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

Yes

No

25. 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 Have you seen cases where physicians...

26. 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

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

Yes

No

28. Please indicate your agreement with each of the following statements regarding physician-owned facilities in your community in comparison with 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.					

29. 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

30. Are you concerned this could happen to you?

Yes

No

31. 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					
Immediate buy-in to an established medical practice					
Employment in an established physician practice with a subsequent option to buy in to ownership					
Employment by a nonprofit health organization partially owned by a hospital and run by physicians					
Employment by a hospital					
Employment by a state or federal agency					
Employment in academia or research					

32. May we contact you to discuss further your answers to the previous questions?

Yes

No

Aug Medicare and Medicaid

Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015. The law repealed the Sustainable Growth Rate (SGR) formula used to calculate Medicare physician fee-for-service payments and attempted to simplify and improve Medicare's physician penalty and incentive programs by consolidating and revising them. TMA is reviewing draft implementing rules and has recommended extensive alterations to the Centers for Medicare & Medicaid Services (CMS). Please answer the following questions and help us support the physicians who provide medical care to Medicare beneficiaries.

1. Have you treated any Medicare patients since 2011?

Yes

No

If No Is Selected, Then Skip to As a result of the requirements of ML...

2. Did your practice report quality data for the Medicare Physician Quality Reporting System (PQRS) program in the past two years? (Check all that apply.)

2014

2015

Don't know

None of the above

3. Are you or will you report quality data to PQRS for the 2016 performance period?

Yes

No

Don't know

4. Are you getting PQRS penalties subtracted from your Medicare fees in 2016?

Yes

No

Don't know

5. Which, if any, challenges have you experienced in the PQRS program? (Check all that apply.)

Too much time taken away from patient care

Cost - fees to interface data with registry, electronic health record (EHR) costs, etc.

Difficult to keep up with annual changing requirements

Difficult to keep up with complex requirements

Difficult to understand how to collect and submit my data on quality measures through the various reporting methods

Required hiring new staff

Other (please specify): _____

None

Not applicable

6. How do you submit your data on quality measures to Medicare?

Medicare Part B claims

EHR

Registry

Qualified clinical data registry (QCDR)

Web interface

Health information technology (HIT) vendor

Don't know

Not applicable - I don't submit my data on quality measures to Medicare

7. If you pay to submit data on quality measures to Medicare, how much do you pay annually or what is the per-physician average amount in your practice? (If you don't pay for submission or can't estimate, please leave this question blank.)

8. Has your practice experienced data submission errors made by your vendor?

Yes

No

Don't know

Not applicable

Answer If Has your practice experienced data submission errors made by your vendor? Yes Is Selected

9. Were you refunded the fees you paid for reporting through the vendor?

All

Some

None

Answer If Has your practice experienced data submission errors made by your vendor? Yes Is Selected

10. Were you penalized by Medicare for the error(s)?

Yes

No

Don't know

Answer If Did your practice report quality data for the Medicare Physician Quality Reporting System (PQRS)... None of the above is selected and Are you reporting quality data for PQRS in 2016? No Is Selected

11. If you do not participate in PQRS, why not? (Check all that apply.)

I don't have time to research and read through CMS rules and program requirements to make a decision to participate.

I don't know how to participate.

I don't have the staff to help with participation.

There are too many changing rules and requirements.

It costs too much in administrative time.

It costs too much in vendor fees.

There are no quality measure appropriate for my patient population.

Other (please specify): _____

12. Have you downloaded or attempted to download your Medicare quality and resource use report (QRUR), which shows your quality and cost scores for the Medicare value-based modifier program?

Yes, I downloaded it.

I attempted to download it but did not complete the process.

No, I did not download it.

Answer If Have you downloaded or attempted to download your Medicare PQRS feedback report? Yes, I downloaded it. Is Selected or Have you downloaded or attempted to download your Medicare PQRS feedback report? I attempted to download it, but did not complete the process. Is Selected

13. Did you have difficulty accessing your QRUR in the portal?

Yes

No

Answer If Have you downloaded or attempted to download your Medicare PQRS feedback report? Yes, I downloaded it. Is Selected

14. Were you able to determine why you received incentives or penalties?

Yes

No

Answer If Have you downloaded or attempted to download your Medicare PQRS feedback report? Yes, I downloaded it. Is Selected

15. Did you make changes to your practice based on the results of your report?

Yes

No

Answer If Did you make changes to your practice based on the results of your report? Yes Is Selected

16. What changes did you make as a result of your report?

17. Did you report meaningful use (MU) in? (Check all that apply.)

2011

2012

2013

2014

2015

None of the above

18. Are you getting MU penalties subtracted from your Medicare fees in 2016?

Yes

No

Don't know

Not applicable

19. Are you reporting MU in 2016?

Yes

No

Don't know

20. Are you currently subject to the value-based payment modifier?

Yes

No

Don't know

Answer If Are you currently subject to the Value-Based Payment Modifier? Yes Is Selected

21. Are you receiving the following?

Incentives

Penalties

Neither

Don't know

22. Have you been audited by CMS on the following? (Check all that apply.)

PQRS

MU

Don't know

Neither

Answer If Have you been audited by CMS on either of the following? (Check all that apply.) PQRS Is selected or Have you been audited by CMS on either of the following? (Check all that apply.) MU Is Selected

23. As a result of the audit, did you do any of the following? (Check all that apply.)

- Refunded money to CMS
- Appealed the results of my audit
- Changed my HIT vendor
- Changed my PQRS vendor
- Made changes within my practice
- None of the above

24. In 2015, what was the approximate dollar value of the Medicare revenue for services you delivered personally or what was the per-physician average amount for your practice? (If you don't know or can't estimate, please leave this question blank.)

25. Avoiding Medicare payment penalties in the Merit-Based Incentive Payment System (MIPS) will require reporting data on quality measures (PQRS), MU, and participating in clinical practice improvement activities in 2017. Have you estimated how much it will cost you per physician in your practice to comply?

- Yes
- No
- Don't know

Answer If Avoiding penalties in MACRA will require reporting MU, quality measures (PQRS), and/or participating in other quality programs. Have you estimated how much it will cost you per physician to comply? Yes Is Selected

26. What is your estimate of the cost per physician?

27. Will you report data on quality measures, MU, and clinical practice improvement activities for the MIPS program in 2017?

- Yes
- No
- Don't know

28. Are you interested in joining a virtual group of nonaffiliated physicians formed for the purpose of group MIPS scoring for incentives/penalties?

- Yes
- No
- Don't know

29. If you are a primary care physician, are you participating in or will you participate in a medical home in 2017?

Yes

No

Don't know

Not applicable

30. As a result of the requirements of Medicare's Merit-Based Incentive Payment System (MIPS) and value-based care, have you or will you do the following? (Check all that apply.)

Close practice

Sell practice to a hospital or larger group

Retire

Limit Medicare patients

Limit Medicaid patients

Opt out of Medicare

Expand practice

Hire more administrative staff

Hire more clinical staff

Retrain existing staff

Upgrade/Expand practice technology

Other (please specify): _____

None of the above

Not applicable

31. We are interested in your perspective. Please share with us your thoughts on MACRA.

32. Do you treat Medicaid managed care organization (MCO) patients?

Yes

No

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

33. Why do you not treat Medicaid MCO patients?

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

Inadequate fees

Administrative complexity/burden

Practice does not accept Medicaid

Other (please specify): _____

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

Yes

Maybe

No

35. TMA is fighting for Medicaid red tape reduction. How likely are you to accept more Medicaid MCO 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)				
Decreased administrative burden (e.g., simplified preferred drug list, prior approval process)				
Standardized credentialing				
Improved care coordination for patients with chronic conditions				
Other administrative/paperwork reforms (please specify):				

Answer If Do you treat Medicaid Managed Care Organization (MCO) patients? Yes Is Selected

36. Has the prescription drug process been an issue when participating in Medicaid MCOs (STAR and STAR+PLUS)?

Yes

No

Don't know

Answer If Has the prescription drug process been an issue when participating in Medicaid MCOs (STAR and STAR+PLUS)? Yes Is Selected

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

Difficult to get prior approval for nonpreferred prescription drugs

Time consuming to get prior approval when required for prescription drugs

Lack of communication between pharmacy, plan, and/or the agency

Unclear which 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 nonpreferred prescription drug is denied

Other (please specify): _____

38. 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 participate in STAR+PLUS HMOs?

39. Please indicate which STAR HMOs you participate in. (Select all that apply.) For a list of STAR health plans by county, visit: STAR_HMO_List.pdf

Aetna Better Health
Amerigroup
Blue Cross and 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

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

Yes
No
Don't know

Answer If In the next year, do you plan to terminate one or more of your existing STAR HMO contracts?
Yes Is Selected

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

Inadequate payments
Payment problems (e.g., claim denials, incorrect or late payments)
Administrative burden (e.g., paperwork)
Quality of care concerns (e.g., inadequate provider network, delays in treatment)
Other (please specify): _____

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

Yes
No

If No Is Selected, Then Skip To At the direction of the Texas Legislature...

43. Please indicate which STAR+PLUS HMOs you participate in. (Select all that apply.) For a list of STAR+PLUS health plans by county, visit: Map.pdf

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

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

Yes
No
Don't know

Answer If In the next year, do you intend to terminate one or more of your existing STAR+PLUS HMO contracts? Yes Is Selected

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

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

46. Omitted

47. May we contact you to discuss your answers to any of the previous questions?

Yes
No