Dear all:

Please allow this to be an update of MAG activities over the last two weeks. As always, previous updates can be found at [http://www.mag.org/resources/executive-directors-message](http://www.mag.org/resources/executive-directors-message).

**American Medical Association Federation CEO Advisory Committee**

I want to thank James Madara, MD, (AMA CEO) for bringing together leaders of a dozen state and national specialty societies to Chicago for the Federation CEO Advisory Committee. We spent much of our time discussing how organized medicine can better help our members with MACRA, ACO’s, physician burnout and satisfaction. Also, we had preliminary discussions on the next steps involving the health insurance mergers. In fact, AMA will be testifying against the Anthem/CIGNA mergers in New York before their state regulator.

**House of Delegates**

The MAG House of Delegates is rapidly approaching. In addition to policy positions being taken at this meeting, this is your opportunity to elect your leadership. Please take a moment and review the candidates for office, along with any statements that have been submitted which can be found at [http://www.mag.org/about-us/house-of-delegates](http://www.mag.org/about-us/house-of-delegates).

**James Magazine “Top Lobbyists” – Vote Now**


Specifically, I encourage you to vote for…

- MAG in the “Top Trade or Business Associations” category (question 4)
- MAG Government Relations Director Derek Norton in the “Top Male Lobbyists” category (question 5)
- MAG Contract Lobbyist Travis Lindley in the “Top Male Lobbyists” category (question 5)
- MAG Government Associate Kimberly Ramseur in the “Top Female Lobbyists” category (question 6)
- MAG’s new Government Relations Associate and GAMPAC Manager Bethany Sherrer in the “Rising Stars” category (question 7)

There are several additional categories that are included in the survey, but you can simply skip those if you don’t have an opinion or simply wish to expedite the process.

**Physician Advocacy Institute**

Please see attached a recent study by Avalere Health on the acquisition of physician practices by health systems. As noted by the study, the data simply reflects what we have seen in the marketplace over the last few years – more physicians moving into employment settings due to increased administrative burdens. Avalere researchers studied the rate of acquisitions of physician practices by hospitals and health systems and changes in physician employment status between July 2012 and July 2015. The research confirms a nationwide increase in the number of physicians leaving private practice and entering into employment arrangements with hospitals and health systems.

The study found that between 2012-2015:

- The number of practices owned by hospitals and health systems rose nearly 90%
- One of out every four practices was owned by a hospital or health system, up from one in seven in 2012.
- 38% of U.S. physicians were employed by hospital or health systems, up from one in four in 2012.
- This rise in physician employment and growth in physician practice acquisitions occurred in every region of the country.
This study confirms the strategic direction MAG has taken since 2011 on the emphasis to represent all physicians which has resulted in over a 35% growth in MAG during that time period.

**Georgia Solution to the Uninsured**
MAG has worked very closely with the Georgia Chamber of Commerce on finding a solution to the uninsured. This is a great first step in finding a solution for the uninsured in this state. Your Council on Legislation will meet next week to discuss whether this should be a MAG legislative priority for the 2017 General Assembly. If you have any questions about this solution, please contact me directly.

**MAG Foundation “Think About It” Campaign**
Please see the link (http://ksulifestyle.com/2016/09/06/prescription-drug-use-take-back-initiative/) to an article promoting a drop box the MAG Foundation placed at Kennesaw University. The placing of drop boxes on the college campuses is part of the “Think About It” campaign and a grant we received from Kaiser Permanente. Again, we want to thank Kaiser Permanente and Ali Rahimi, MD (MAG Foundation board member) for supporting the “Think About It” campaign. Also, a great job by Lori Murphy for her work on the campaign.

If you should have any questions, please do not hesitate to call.

Donald

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*MAG: The leading voice for the medical profession in Georgia...every physician in every specialty and practice setting.*
Physician Practice Acquisition Study:
National and Regional Employment Changes

September 2016
About the Physicians Advocacy Institute

The Physicians Advocacy Institute (PAI) is a not-for-profit organization that was established to advance fair and transparent policies in the health care system to sustain the profession of medicine for the benefit of patients.

As part of this mission, PAI seeks to better understand the challenges facing physicians and their patients and also educate policymakers about these challenges.

PAI also develops tools to help physicians prepare for and respond to policies and marketplace trends that impact their ability to practice medicine.

Information about PAI can be found at physiciansadvocacyinstitute.org.
PAI: Committed to Researching Topics Important to Physicians and Patients

Through a research collaboration with Avalere Health, PAI is working to gain a more complete picture of the potential impact that various marketplace forces and private and public sector policies have on physicians and patients.

This report, summarizing national and regional changes in physician employment trends, highlights a significant shift in the landscape for practicing medicine in the U.S. Increasingly, physicians practice in the context of employment arrangements with health systems and hospitals. Understanding the extent of this trend provides a better understanding of today’s health care marketplace.

PAI and Avalere are planning a next phase of research in early 2017 to continue to build a better understanding of the implications of this trend.
What Types of Arrangements Contribute to This Trend?

The Avalere researchers’ findings summarized in the following slides show a consistent increase in physician employment stemming from:

1. continued growth in **hospital and health system acquisitions of physician practices**, which typically involve multiple physicians as well as acquisition of the practice’s physical building/equipment; and

2. sustained increases in the number of **individual physicians entering into employment arrangements** with hospitals and health systems.
Methodology
Methodology: Trends in Hospital Ownership of Physician Practices with Medicare-Billing Physicians

- Avalere used an SK&A¹ database that contains physician² and practice location information on hospital/health system ownership:
  - Each record in the database corresponds to a unique physician in a specific practice location
  - The database identifies each physician-practice location combination as “employed”—part of a hospital or health system-owned practice—or “independent”
  - These data include solo and single-location small practices as well as large, multi-specialty multi-location group practices
  - The dataset covers seven different points in time from July 2012 to July 2015 for each physician-practice location combination
  - SK&A develops the physician affiliation flag through conducting bi-annual phone surveys with individual practice locations

¹ SK&A is an organization that provides healthcare provider information and data solutions. [http://www.skainfo.com/about#ims](http://www.skainfo.com/about#ims)
² Physicians are defined as MDs and DOs and does not include nurse practitioners or physicians assistant
Subject to change pending Avalere review.
Haydn, 8/26/2016
Methodology: Trends in Hospital Ownership of Physician Practices with Medicare-Billing Physicians

• Avalere linked the data from SK&A to the CMS National Plan & Provider Enumeration System (NPPES) by NPI\(^3\) to identify the primary address for the providers
  ○ Each record in the database corresponds to a unique physician in a specific practice location

\(^3\) NPI = National Provider Identifier
Highlights of Research Findings

SIGNIFICANT AND CONSISTENT INCREASES IN PHYSICIANS
EMPLOYMENT AND HOSPITAL OWNERSHIP OF PRACTICES

This research confirms a significant, nationwide shift in the number of physicians leaving private practice and entering into employment arrangement with hospitals and health systems.

The results show a dramatic increase in hospitals and health systems employing physicians and acquiring physician practices over a three-year period between July 2012 and July 2015.

National Trend:

• From July 2012 to July 2015, the percent of hospital-employed physicians increased by almost 50 percent, with increases in each six-month time period measured over these three years.

Employment Trend Extends Across All Regions:

• All regions saw an increase in hospital-employed physicians at every measured time period, with a range of total increase from 75-114 percent.
Between July 2012 and July 2015, the Number of Employed Physicians Increased to More Than 140,000

CHANGE IN EMPLOYMENT OF PHYSICIANS
NUMBER OF HOSPITAL-EMPLOYED PHYSICIANS

- Between 2012 and 2015, the number of physicians employed by hospitals grew by 46,000 nationwide.
- Physician employment grew in each of the six-month periods analyzed.
- In the six months from July 2014 to January 2015 alone, nearly 20,000 physicians shifted into employment models.

Avalere analysis of SK&A hospital/health system ownership of physician practice locations data with Medicare 5% Standard Analytic Files
Physician Employment Grew by 49 Percent from 2012 to 2015

**CHANGE IN EMPLOYMENT OF PHYSICIANS**

**PERCENT OF HOSPITAL-EMPLOYED PHYSICIANS**

- In 2012, one in four physicians was employed by a hospital.
- By 2015, 38 percent of physicians were employed by hospitals.
- Growth occurred throughout the three-year period, with some of the fastest acceleration occurring in late 2014.

Avalere analysis of SK&A hospital/health system ownership of physician practice locations data with Medicare 5% Standard Analytic Files
Hospital or Health System Ownership of Physician Practices Grew by 86 Percent From 2012 to 2015

CHANGE IN OWNERSHIP OF PHYSICIAN PRACTICES

NUMBER OF HOSPITAL-OWNED PHYSICIAN PRACTICES (THOUSANDS)

- Between 2012 and 2015, the number of physician practices employed by hospitals grew by 31,000 practices, which is an 86 percent increase over three years.
- By 2015, 67,000 physician practices nationwide were hospital-owned.
- In the six months from July 2014 to January 2015 alone, 13,000 physician practices were acquired.

Avalere analysis of SK&A hospital/health system ownership of physician practice locations data with Medicare 5% Standard Analytic Files
As of 2015, One in Four Physician Practices Was Hospital-Owned

CHANGE IN OWNERSHIP OF PHYSICIAN PRACTICES
PERCENT OF HOSPITAL-OWNED PHYSICIAN PRACTICES

- In 2012, one in seven physician practices was owned by a hospital.
- Hospital ownership of practices increased to 1 in 4 by 2015.
- Growth occurred throughout the three-year period, with some of the fastest acceleration occurring in late 2014.

Avalere analysis of SK&A hospital/health system ownership of physician practice locations data with Medicare 5% Standard Analytic Files
Avalere also studied these trends by region. While there are differences across regions, there is a steady trend toward increased employment and hospital ownership of practices in every region of the nation.
Almost half of all physicians in the Midwest are employed by hospitals. Rates of employment are lowest in the South, where one-third of physicians are employed by hospitals, and in Alaska and Hawaii.
In Every Region, Hospital Ownership Increased From 2012-2015

More than one-third of Midwest physician practices were hospital-owned in 2015. Rates of practice ownership increased in every region over the entire time period.

Avalere analysis of SK&A hospital/health system ownership of physician practice locations data with Medicare 5% Standard Analytic Files
All Regions Have Seen Rapid Growth in Hospital Employment and Practice Ownership

PERCENT INCREASE BETWEEN JULY 2012 AND JULY 2015

Avalere analysis of SK&A hospital/health system ownership of physician practice locations data with National Plan & Provider Enumeration System (NPPES) data on primary practice location by NPI

Northeast: +57.9%
South: +58.6%
Midwest Region: +43.9%
West (ex AK & HI): +33.2%
AK & HI: +118.3%

Percentage Change

- Physicians
- Practice Locations
Impact of Increase in Physician Employment

The shift towards employment has significant implications for physicians, but also impacts patients and the system as a whole.

- For physicians, the trend brings challenges but can alleviate certain burdens of independent practice. Government and private payer payment policies increasingly favor integrated health systems and make it challenging for physician practices to remain independent.

- For patients, this trend may impact where they receive care and also how much they will pay in cost-sharing.

- Overall system costs can increase as well.
How does the site of service delivery impact spending?

Medicare Payment Differentials Across Outpatient Settings of Care

In 2016, Avalere released a study in collaboration with PAI that documented the differential in Medicare payment for services routinely performed in hospital outpatient department (HOPD) and physician office settings.

This study underscores the impact that the ongoing shift towards hospital employment/hospital ownership of physician practices could have on spending, should this payment differential persist.

For the three types of services studied—cardiac imaging, colonoscopy, and evaluation and management services—Medicare pays more across an episode of care when patients receive services in a HOPD setting (even when it is in an stand-alone or “off-campus” building) than in a physician-owned office.

Data reflects 22-day episodes for cardiac imaging and colonoscopy and profile 2 for E&M. For detailed results and methodology please see complete paper.
www.PhysiciansAdvocacyInstitute.org
Georgia Chamber of Commerce – Health and Wellness Policy Committee

Quality Healthcare Access Study

Proposed Policy Alternatives

August 2016
Introduction

In November 2015 the Georgia Chamber of Commerce – Health and Wellness Policy Committee’s Healthcare Access Task Force initiated a nine month study to develop policy options to increase quality healthcare access for Georgians.
The Case to Increase Healthcare Access in Georgia?

Georgia’s healthcare system is getting squeezed, and with Washington’s dysfunction and gridlock, the state must act.

This problem affects every Georgian; patients with health coverage in Georgia today are already paying increased premiums to cover the cost of uncompensated care.

Four rural hospitals have closed in Georgia since the beginning of 2013.

Regions where a hospital closes and family doctors leave not only lose a major part of their tax base, but they also have no hope of attracting new high-paying jobs.

Georgia is Ranked 48th in Uninsured Rate.

Rural Hospitals are scaling back by reducing service offerings, including critical services like labor and delivery. Physicians’ practices will not locate in a community where hospital privileges are limited or do not exist.

26% Of the total population lives below 138% FPL
29% Of those below 138% FPL are uninsured

The “Georgia Way” should present the most conservative, most sustainable pathway under U.S. law to close the coverage gap and to save or improve our healthcare provider network.

Source: America’s Health Rankings
National View of Medicaid Expansion

32 states have elected to expand Medicaid, six of which have taken alternative approaches through an 1115 waiver.

**States' Choices**

<table>
<thead>
<tr>
<th>Choices</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional *</td>
<td>26 states (including DC)</td>
</tr>
<tr>
<td>Alternative Model*</td>
<td>6 states</td>
</tr>
<tr>
<td>Under Discussion*</td>
<td>3 states</td>
</tr>
</tbody>
</table>

**States that Have Made or are Making Proposals**

9 states

**States without a Decision at this Time**

7 states

**Alternative States – Key Observations**

**Market Design**

- States have leveraged existing infrastructure – managed care and qualified health plans (QHPs).
- Montana is uniquely providing care through fee-for-service (FFS), leveraging a third-party administrator (TPA).

**Member Responsibility**

- States are using premium contributions to health savings accounts (HSAs) and cost-sharing to promote member responsibility and financial sustainability.
- States have greater flexibility for enrollees over 100% of the federal poverty level (FPL).

**Incentives**

- Michigan is using provisions to incentivize healthy behavior.
- Indiana and Montana have included penalties for lack of contribution.

**Benefits**

- Due to federal requirements, states are offering wraparound benefits beyond the 10 essential health benefits (EHBs).
- States are leveraging their waiver authority to limit non-emergency medical transportation (NEMT) to help reduce costs.
Georgia Healthcare Landscape Summary

Georgia is below the national average on health, poverty, and insurance rankings, while fairly comparable to other states in terms of its Medicaid program.

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Medicaid Program Design</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Uninsured Rates</strong> – Rates are 6% higher than the national average and 3% higher than other non-expansion states</td>
<td><strong>Service Delivery</strong> – Care Management Organizations (CMO) service the majority of the Medicaid Population</td>
</tr>
<tr>
<td><strong>Population Distribution</strong> – Predominately a geographically rural state with most of its population living in urban areas</td>
<td><strong>Cost Sharing</strong> – Requires co-payments for specific categories of service</td>
</tr>
<tr>
<td><strong>Income and Unemployment</strong> – Generally lower rankings than other states</td>
<td><strong>Benefits</strong> – Set of base benefits and additional benefits</td>
</tr>
<tr>
<td><strong>Cost of Care</strong> – Higher in urban counties</td>
<td><strong>Eligibility</strong> – Provides limited eligibility to adults with low-income and more generous eligibility for children</td>
</tr>
<tr>
<td><strong>Medicaid Inpatient Hospital Utilization</strong> – Higher in urban counties</td>
<td><strong>By Group</strong> – The Aged, Blind, and Disabled (ABD) group accounts for the majority of payments while LIM accounts for majority of membership</td>
</tr>
<tr>
<td><strong>Emergency Room (ER) Utilization</strong> – Higher in rural counties</td>
<td><strong>Total</strong> – Total expenditures have been growing at a rate of 4% since 2000; lagging behind the growth of total Medicaid membership</td>
</tr>
</tbody>
</table>

**Hospital Costs and Utilization**

**Medicaid Expenditures**

**Medicaid Inpatient Hospital Utilization** – Higher in urban counties

**Payments** – The vast majority of Indigent Care Trust Fund (ICTF) payments are from federal non-disproportionate share hospital (DSH) program payments
Policy Alternatives
Development Approach
Policy Alternatives Development Approach

Building the alternatives followed an iterative approach, based on data, that stressed collaboration and incorporated feedback throughout the process.

Collaboration
- Leverage subject matter expertise
- Consider impact on key stakeholders
- Receive constructive feedback to meet objectives

Setting Baselines
- Strategic decision criteria to help focus brainstorming
- Consolidated documentation of input to date
- Initial alternatives with potential core designs and additional components for consideration

Data Analysis
Alternatives Lab
Task Force Input
Policy Objectives
Guiding Principles

Policy Alternatives
Policy Alternatives Lab Overview

Members of the Task Force participated in a Policy Lab to solicit input for policy alternatives to increase healthcare access in Georgia

**Act I: Setting the Scene**

- A facilitated panel reviewed perspectives and challenged conventional perceptions, centered around eight “suits” or policy themes
- During the panel discussions, ThinkTank was used as an anonymous brainstorming tool to gather thoughts and new ideas from participants that would be leveraged during breakout groups

**Act II: Exploring Concepts**

- Attendees participated in breakout groups to develop alternatives from four Georgia stakeholder perspectives:
  - Patient
  - State
  - Industry
  - Employer
- Groups were then asked to create a “sales pitch” of their concept

**Act III: The Path Forward**

- Each breakout group’s chosen representative defended his/her healthcare concept in a “CNN style debate,” reviewing a high-level summary of the alternative and key value statements, and answering questions
The Georgia Way to Increase Healthcare Access

This objective of this effort is to develop up to three policy alternatives to increase healthcare access in Georgia in a fiscally sustainable manner

<table>
<thead>
<tr>
<th>Guiding Principles</th>
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<tbody>
<tr>
<td>• Develop a plan that is administratively feasible</td>
</tr>
<tr>
<td>• Modernize healthcare delivery for this population</td>
</tr>
<tr>
<td>• Support sustainability of the provider network</td>
</tr>
<tr>
<td>• Focus on improved health outcomes</td>
</tr>
<tr>
<td>• Create a sustainable pathway to closing the coverage gap</td>
</tr>
<tr>
<td>• Emphasize using private plans, keeping as many people as possible on employer-provided plans</td>
</tr>
<tr>
<td>• Support individuals’ transition to the commercial market</td>
</tr>
<tr>
<td>• Take advantage of all federal dollars available</td>
</tr>
<tr>
<td>• Reduce regulatory barriers</td>
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<tr>
<td>• Emphasize member responsibility</td>
</tr>
<tr>
<td>• Promote consumerism - employee/member engagement</td>
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<tr>
<td>• Implement in a way that builds local capacity</td>
</tr>
<tr>
<td>• Emphasize economic development</td>
</tr>
<tr>
<td>• Encourage provider innovation</td>
</tr>
<tr>
<td>• Promote provider participation</td>
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</tbody>
</table>
Proposed Policy Alternatives
Policy Alternatives Summary

The Taskforce has proposed three policy alternatives that maximize affordability, sustainability and member responsibility

<table>
<thead>
<tr>
<th>Market Design</th>
<th>Alternative 1</th>
<th>Alternative 2</th>
<th>Alternative 3</th>
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<tbody>
<tr>
<td>CMO</td>
<td>CMO</td>
<td>CMO and QHP</td>
<td></td>
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<table>
<thead>
<tr>
<th>Eligibility</th>
<th>Alternative 1</th>
<th>Alternative 2</th>
<th>Alternative 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;100% FPL covered through CMO</td>
<td>&lt;138% FPL covered through CMO</td>
<td>&lt;100% FPL through CMO and &lt;138% FPL through QHP</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Federal Match</th>
<th>Alternative 1</th>
<th>Alternative 2</th>
<th>Alternative 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A: Enhanced FMAP</td>
<td>Enhanced FMAP</td>
<td>Enhanced FMAP</td>
<td></td>
</tr>
<tr>
<td>1B: Standard FMAP</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Employer-sponsored Insurance (ESI)</th>
<th>Alternative 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimize ESI crowd-out by requiring eligible individuals and their family members to enroll in employer coverage when cost effective</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Work Requirement</th>
<th>Alternative 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand SNAP (Food Stamp) work requirement pilot statewide</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Premiums and Cost-Sharing</th>
<th>Alternative 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every member contributes towards premium at maximum allowable amount for eligibility group;</td>
<td></td>
</tr>
<tr>
<td>Require disenrollment due to non-payment of member premiums</td>
<td></td>
</tr>
<tr>
<td>Maintain member copayments for applicable encounters</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Design</th>
<th>Alternative 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial-style benefit package that is “skinniest” Medicaid benchmark criteria will allow</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Delivery System Reform</th>
<th>Alternative 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement Delivery System Reform Incentive Payment (DSRIP) across Low Income Medicaid</td>
<td></td>
</tr>
</tbody>
</table>
Policy Alternatives Summary *(continued)*

The Taskforce has proposed three policy alternatives that maximize affordability, sustainability and member responsibility

<table>
<thead>
<tr>
<th>Alternative 1</th>
<th>Alternative 2</th>
<th>Alternative 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordination with Corrections</td>
<td>Strengthen Criminal Justice Reform through “warm handoff” and intensive behavioral health care coordination for released inmates with aim to prevent recidivism</td>
<td></td>
</tr>
<tr>
<td>Improve Rural Access to Care</td>
<td>Stabilize rural provider infrastructure and incentivize providers to practice in Health Shortage Areas</td>
<td></td>
</tr>
<tr>
<td>Personal Responsibility &amp; Consumerism</td>
<td>Establish HSA-style account to promote consumerism and personal responsibility; use funds to pay Cost-sharing and/or purchase additional coverage (i.e., vision and/or dental coverage)</td>
<td></td>
</tr>
<tr>
<td>Additional Components</td>
<td>Value-Based Care, Commercial-style Open Enrollment cycles, waive retroactive eligibility, Coordinated Incentives for payers, providers and members, Population Transition and Preventable Event Oversight and Avoidance</td>
<td></td>
</tr>
</tbody>
</table>