**FINAL REFERENCE COMMITTEE REPORT**  
**REFERENCE COMMITTEE ON SOCIOECONOMICS**

Summary *(Highlighted text indicates changes from the interim report)*

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The Reference Committee on Socioeconomics, having met on Saturday, May 8, 2021, with all members present, submits the following report:

(1) Council on Socioeconomics Report 2 – Sunset Policy Review

RECOMMENDATION A:

Mr. Speaker, your reference committee recommends that the recommendations in Council on Socioeconomics Report 2 be amended by substituting the word “payment” for “reimbursement” in the title of policy 30.001 and adding “VBP model” after “ACO” throughout policy 115.015 as follows:

30.001 CRNA Direct Reimbursement Payment: To maintain quality anesthesia care, the Texas Medical Association believes that certified registered nurse anesthetists should be under the medical direction of an anesthesiologist or other appropriate physician direction (CSE p 159, A-90; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

115.015 Accountable Care Organizations and Value-Based Care Models: Accountable Care Organizations will develop into complex organizations tailored to meet the health care needs of a local community. The Texas Medical Association supports accountable care organizations (ACOs) and other value-based care models as a tool in the delivery of medical care if the following safeguards and elements are present:

Physician Outreach and Education. Texas physicians must be informed, receive guidance, tools, and education about value-based care models accountable care organizations. Toolkits that provide the information necessary for physicians to make informed decisions about establishing, affiliating, or joining, or participating in an ACOs or other value-based payment (VBP) arrangement, must be developed and disseminated. Educational materials should address Physician Outreach and Education. Texas physicians must be informed, receive guidance, tools, and education about value-based care models accountable care organizations. Toolkits that provide the information necessary for physicians to make informed decisions about establishing, affiliating, or joining, or participating in an ACOs or other value-based payment (VBP) arrangement, must be developed and disseminated. Educational materials should address In addition, the development and dissemination of information about the ACO governance and participation issues, payment distribution methods models, as well as economic and quality measures, data collection, financing, and patient care management strategies, including evolving expectations for ACO/VBP initiatives to address social determinants of health (including strategies to meet them) should be undertaken. Various methods of outreach should be utilized including webinars, podcasts, seminars, and publications.

ACO-Governance.

Physician Led. Must be physician-led and encourage an environment of collaboration and professionalism among physicians and other health care team members. This ensures that health care delivered under these ACO models is patient-centric and that a physician’s medical decisions are not based on commercial interests but rather on professional medical judgment that puts patients’ interests first. Physician-led and encourage an environment of collaboration and professionalism among physicians and other health care team members. This ensures that health care delivered under these ACO models is patient-centric and that a physician’s medical decisions are not based on commercial interests but rather on professional medical judgment that puts patients’ interests first. Primary care and subspecialty Physicians must be actively engaged in the organization’s design, implementation, monitoring, and evaluation.

Physicians Retain Independent Medical Judgment. Medical decisions should be made by physicians. ACOs/VBP models must be operationally structured and governed by an appropriate number of physicians (rather than lay entities) and place patients’ interests first. Physicians are the medical professionals best qualified by training, education, and experience to provide diagnosis and treatment of patients. Clinical decisions must be made by the physician or physician-controlled entity in an environment where they are free to exercise independent medical judgment free from commercial influence.
(1) Policies and Procedures. ACOs/VBP models must have any policies and procedures that serve to impede a physician’s primary ethical obligation to the well-being and safety of his or her patients. Any time period for an appeal of an alleged breach of conduct must be heard in a clinically appropriate time frame.

(2) Whistleblowing Protections. Physicians should be afforded the right to whistleblow to ACO/VBP model leadership and/or to the appropriate regulatory authority if the ACO/VBP model acts in any way contrary to the patient’s best interests. No retaliation should be permitted by the ACO/VBP model or associated hospital/parent entity for such whistleblowing. For an ACO/VBP model to truly be patient-centric, physicians must be free to advocate for their patients. The physician’s ethical obligations to the patient must supersede the physician’s employment or contractual obligations to the ACO/VBP model or an associated hospital.

(3) Medical Record Ownership. To aid in continuity of care and to ensure the highest quality of treatment, there should be joint ownership of the medical records by the ACO/VBP model and the participating physician. In the alternative, ACOs/VBP models should provide participating physicians (including upon their departure from the ACO/VBP model) with a right of access to the medical record in the same form in which the medical record is typically maintained.

Physician Board of Directors. The ACO/VBP model should be governed by a physician board of directors that is elected by the ACO/VBP model professionals. The governing board is ultimately responsible for the care and well-being of patients. The ACO/VBP model must adopt a conflicts of interest policy and conflicts of interest disclosure policy to ensure that the board of directors appropriately represents the interests of the ACO/VBP model. Any physician-entity (e.g., independent physician association (IPA), medical group, and so on) that contracts with, or is otherwise part of, the ACO/VBP model should be physician-controlled and governed by an elected board of directors.

Hospital-participating ACOs/VBP Models. Where a hospital is part of an ACO/VBP model:
(1) The governing board of the ACO/VBP model, whose majority shall represent physicians participating in the ACO/VBP model, which is comprised of physicians, should be separate and independent from the hospital governing board; and
(2) The Physician privileges and credentialing at the hospitals should not be conditioned on the physician’s exclusive participation in the hospital’s ACO or value-based care contracts, nor should the physician’s privileges at the hospital automatically cease upon the termination of the physician’s agreement with the ACO.

Physician Leadership Licensure/Practice. The ACO/VBP model’s physician leaders, including the medical directors, should be licensed to practice medicine in Texas the state in which the ACO operates and in the active practice of medicine. To ensure local accountability and oversight, any medical director(s) must report to the physician governing board that is who will be actively engaged in the development and oversight of the ACO/VBP model’s medical policy, utilization review, quality improvement, and performance measurement.

ACO State Regulation. Existing state laws offer appropriate means for organization of ACOs without the need for further ACO-specific legislation in Texas. Depending upon an ACO’s structure and scope of activities, various state agencies should have oversight authority over an ACOs/VBP models organized and/or operating in Texas. For example, the Texas Medical Board should appropriately regulate the practice of medicine (i.e., clinical aspects) associated with an ACO/VBP model. If an ACO/VBP model takes on insurance risk (e.g., capitation), the Texas Department of Insurance (TDI) should appropriately regulate that function. TDI has the
background and expertise to deal with the financial and risk-bearing aspects of ACO/VBP model operations. ACOs/VBP models should maintain appropriate and adequate reserves and risk-based capital requirements in the same manner as licensed health insurance carriers.

Physician Participation. Physician participation in an ACO/VBP model generally should be voluntary unless they are a member of a preexisting physician group that elects to participate. Physicians should not be required to join an ACO/VBP model as a condition of contracting with Medicare, Medicaid, or a private payer or being admitted to a hospital medical staff.

Patient Participation. Patient participation in an ACO/VBP model must be voluntary. Patients must be free to choose whether or not to enroll participate in an ACO or value-based payment model.

Marketplace Limiting Agreements. As the purpose of an ACO is to promote community-based care, an ACOs and value-based payment models must not impose marketplace limiting agreements (e.g., covenants not to compete and exclusivity provisions) upon physicians or physician practices. Further, they ACO must not interfere with the internal management of physician practices regarding covenants not to compete.

Due Process. Physician participants in an ACO/VBP model should have due process (consisting of, at a minimum, the right to notice, a hearing, and an appeal to the physician board of directors) to challenge:

- The physician’s (or his or her group) involuntary termination from participation in an ACO/VBP model;
- The physician’s satisfaction of clinical, utilization, or financial performance standards (with an opportunity to explain and/or cure any alleged departures from performance standards);
- The physician’s eligibility to receive savings or distributions from the ACO/VBP model;
- The amount of the distribution of savings and/or revenue received by the physician from the ACO/VBP model (i.e., the appropriate distribution of savings and revenue of an ACO);
- The patients assigned attributed to the physician’s care under by the ACO payer;
- The measurements used to determine the quality of care/efficiency of care provided to patients under the ACO/VBP model; and
- The ACO/VBP model’s assessment of the quality of care provided to patients by the physician under the ACO/VBP model.

Economic and Quality Measures. Rather than payers selecting measures, practicing physicians currently in clinical practice must be actively involved in the development of economic and quality measures used by ACOs for performance measurement in value-based care contracts. Such measures and methodologies must be transparent, valid, and agreed to by the ACO/VBP model’s governing board or the contracted physician group, approved by the physician governing board. The economic and quality performance standards must meet the TMA principles for reporting, including the use of nationally accepted, physician specialty- validated clinical measures; the inclusion of a sufficient number of patients to produce statistically valid quality information; appropriate attribution methodology; risk adjustment; reflection of geographic costs; and the right for physicians to appeal inaccurate quality/efficiency reports and have them corrected. There also must be timely notification and feedback provided to physicians regarding the economic and quality measures and results. Physicians should must be provided all economic and quality measures prior to the evaluation period. ACOs/VBP models should periodically conduct assessments of patients’ satisfaction with the timeliness and availability of care.
Flexibility in Patient Referral and Antitrust Laws. The federal and state antikickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible (with bright-line exemptions) to allow physicians to collaborate with hospitals in forming ACOs/VBP models without being employed by the hospitals or ACOs/VBP models or in legal jeopardy. This is particularly important for physicians in small- and medium-size practices who may want to remain independent but otherwise integrate and collaborate with other physicians (i.e., so-called virtual integration) for purposes of participating in the ACO/VBP model. The Patient Protection and Affordable Care Act explicitly authorizes the secretary to waive requirements under the Civil Monetary Penalties statute, the Antikickback statute, and the Ethics in Patient Referrals (Stark) law for Medicare ACOs/VBP models. The secretary should establish a full range of waivers and safe harbors that will enable independent physicians to use existing or new organizational structures to participate as Medicare ACOs/VBP models. In addition, the secretary should work with the Federal Trade Commission to provide explicit exceptions to the antitrust laws for ACO/VBP model participants in Medicare, Medicaid, other state-based programs, and commercial markets. Physicians cannot completely transform their practices only for the Medicare patients, and antitrust enforcement could prevent them from creating clinical integration structures involving their privately insured patients. These waivers and safe harbors should be allowed where appropriate to exist beyond the end of the initial agreement between the ACO/VBP model and Centers for Medicare & Medicaid Services (CMS) so that any new organizational structures that are created to participate in the program do not suddenly become illegal simply because the shared savings program does not continue.

CMS Provision of ACO/VBP Model Resources. Additional resources should be provided up front to encourage ACO/VBP model development. CMS’s Center for Medicare & Medicaid Innovation (CMI: the Innovation Center) should provide grants to physicians in order to finance up-front costs of creating an ACO/VBP model. ACO/VBP model incentives must be aligned with the physician or physician group’s risks (e.g., start-up costs, systems investments, culture changes, and financial uncertainty). Developing this capacity for physicians practicing in rural communities and solo-small group practices requires time and resources, and the outcome is unknown. Providing additional resources for the up-front costs will encourage the development of ACOs/VBP models since the “shared savings” model only provides for potential savings at the back-end, which may discourage the creation of ACOs/VBP models by (particularly among independent physicians and practicing in rural underserved communities).

ACO Spending or Efficiency Benchmarks in Medicare Shared Savings Program, Medicaid, and Commercial ACOs/VBP Models. The ACO Spending benchmarks for all value-based care arrangements should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.

(1) The ACO/VBP model spending benchmark, which will be based on historical spending patterns by the ACO/VBP model and/or in the ACO/VBP model’s service area and negotiated between Medicare and the ACO, must be risk adjusted to incentivize ensure physicians who treat sicker patients with higher clinical and/or socioeconomic risk factors, including patients residing in low-wealth communities, who are uninsured and/or who have higher disease burden, will be able to successfully participate. Studies show that patients with these factors are more likely to experience barriers to care and are more costly and difficult to treat. To participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill.

(2) Federal, state, and commercial payers should adopt the use of standardized risk-adjustment mechanisms across different types of ACOs to minimize the administrative complexity and
costs of physicians participating in an ACO/VBP model and make it easier to analyze ACO/VBP model performance across multiple populations.

(3) Prior to assignment to an ACO/VBP model, benchmark should be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating factors (i.e., hospital wage index) and physician health information technology (HIT) costs.

(4) The ACO/VBP model benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating factors (i.e., hospital wage index) and physician health information technology (HIT) costs.

(5) The ACO/VBP model benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient socioeconomic and health status factors.

(6) There shall be a determination that access to care is not compromised in fragile medical environments (e.g., inner city and rural settings).

Medicare Shared Savings Procedural Due Process. An ACO/VBP model must be afforded procedural due process with respect to the secretary’s discretion to terminate an agreement with an ACO/VBP model for failure to meet the quality performance standard.

Medicaid ACO Spending Benchmark. Any ACO spending benchmarks established under the Medicaid program should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.

The ACO spending benchmarks must be risk adjusted to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill. The use of standardized mechanisms across different types of ACOs will minimize the administrative complexity and costs of physicians participating in an ACO and make it easier to analyze ACO performance across multiple populations.

The ACO benchmark should be risk adjusted for the socioeconomic and health status of the patients that are assigned to each ACO, such as income/poverty level, insurance status prior to Medicaid enrollment, race, and ethnicity, and health status. Studies show that patients with these factors have experienced barriers to care and are more costly and difficult to treat once they reach Medicare eligibility.

The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating factors (i.e., hospital wage index) and physician HIT costs.
The ACO benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient socioeconomic and health status factors.

Medicaid ACOs and Value-Based Payment Arrangements.

If Medicaid tests the ACO concept, the Texas Medicaid state should seek ongoing input from practicing physicians and providers on the pilot’s design regarding the state’s value-based payment and quality roadmap, including the pilot’s quality and financial benchmarks, the mechanisms for collecting and reporting data, and how data will be shared with ACO physician participants, patients, and the public. Any ACO pilot tested in the Medicaid system must be of sufficient length to ensure valid and reliable evaluation of the pilot’s impact on health outcomes and spending— including ensuring any required performance measures for Medicaid managed care organizations and network physicians be relevant, practical, and meaningful. Texas Medicaid should collaborate with practicing physicians, providers, and Medicaid managed care organizations to develop a menu of standardized value-based payment options that promote innovation, while also minimizing complexity stemming from the proliferation of similar but divergent models.

There shall be a determination that access to care is not compromised in fragile medical environments (e.g., inner city, rural settings).

State ACO/VBP Model Pilot Initiatives [e.g., Employee Retirement System (ERS)/Teachers Retirement System (TRS)] Spending Benchmarks. Any ACO/VBP model spending benchmarks established under a direct contract state with a state-funded insurance program and an ACO pilot initiative should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.

The ACO spending benchmarks must be risk adjusted to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill. Texas Medicaid, ERS, and other state-administered health systems whose contacted health plans contract with ACOs/VBP models should require the use of standardized risk-adjustment mechanisms across different types of ACOs will to minimize the administrative complexity and costs of physicians participating in an ACO/VBP model and make it easier to analyze ACO/VBP model performance across multiple populations.

The ACO benchmark should be risk adjusted for the socioeconomic and health status of the patients that are covered by the ERS/TRS ACO, such as income/poverty level, insurance status prior to ERS/TRS enrollment or ACO assignment, race and ethnicity, and health status. Studies show that patients without health coverage have experienced barriers to care and are more costly and difficult to treat once they do have coverage due to pent up demand.

The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating factors (i.e., hospital wage index) and physician HIT costs.

The ACO benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient socioeconomic and health status factors.
If ERS tests a direct contract option with a statewide or regional the ACO/VBP model, concept, the state should seek input from practicing physicians and providers on the pilot’s design, including the pilot’s quality and financial benchmarks, the mechanisms for collecting and reporting data, and how data will be shared with ACO/VBP model physician participants, patients, and the public. Any ACO/VBP model pilot tested in the ERS system must be of sufficient length to ensure valid and reliable evaluation of the pilot’s impact on health outcomes and spending.

There shall be a determination that access to care is not compromised in fragile medical environments (e.g., inner city, rural settings).

Financial Incentives.
Public and private payers who partner with ACO/VBP models must invest sufficient resources to monitor and evaluate the ACO/VBP model’s compliance with financial and quality benchmarks, including mechanisms to ensure the entity is not withholding medically necessary care to achieve financial gain.

ACO/VBP models should have the flexibility to use a variety of payment methods alone or simultaneously, including fee-for-service, care management fees, shared savings, partial capitation, or global capitation.

ACO/VBP models must have the flexibility to develop a mix of financial and other incentives designed to foster safe, high quality and cost-effective patient care. However, to ensure that incentives are fair and reasonable, and not intended to promote the inappropriate denial of medically necessary care or unfair restraint of trade, the ACO/VBP model’s local physician governing board shall develop and oversee the incentive structure. Further, the ACO shall publicly disclose the types of incentives to avoid appearance of impropriety.

As ACOs organizations gain expertise in patient care management under value-based care models, they may realize and become more cost-effective, there will be a diminishing rate of achievable savings over time. Financial incentives must be designed to recognize that successful ACOs will eventually achieve efficiencies that will not offer ever increasing savings. To impose penalties where there is little or no opportunity to increase savings may create an improper incentives that may adversely affect patient care. To that end, and to ensure an ACO maintains a patient-centered focus, value-based contracts must include a broad set of performance-based measures and benchmarks that recognize and reward incremental and enduring quality improvement. ACOs that perform at or below a national or state spending benchmark should continue to be rewarded for maintaining cost-effective, high quality care.

There shall be a determination that access to care must is not compromised in fragile medical environments (e.g., inner city, rural settings).

Transparency. ACO/VBP models should be required to annually disclose administrative expenditures as well as the organization’s aggregate payments to physicians and providers (to permit comparison of payments to physicians versus facilities).

HIT. Health information technology, including use of interoperable electronic medical records, is a desirable feature of an ACO, but should not be a required element (CSE Rep. 6-A-11).

RECOMMENDATION B:
Mr. Speaker, your reference committee recommends that Council on Socioeconomics Report 2 be adopted as amended.

This report recommends retention of policies: 30.001 CRNA Direct Reimbursement, 115.014 Out-of-Network Referral Requirements, 115.016 “A Modest Proposal” to Save our Health Care System, 130.001 Hospital Contracts, 145.015 Mandatory Referral and Precertification of Chronic Renal Failure Treatment, 190.002 Medicaid Medications, 190.003 Medicaid Payments to Increase Participation, 195.009 Medicare Hospital Incentive Payments, 230.006 Physician Charge Transparency, 235.033 Coordination of Benefits, and 240.001 Geographic Practice Cost Indices (GPCIs).

This report also recommends amending the follow policies: 100.003 Patient Transfers, 115.001 Indigent Care, 115.015 Accountable Care Organizations, 180.002 Managed Care Incentive Withholds, 190.020 Sterilization Services, 190.030 Physician Enrollment in Medicaid HMOs, 195.002 Medicare HMO Disclosure of Limitations on Choice of Physicians, 195.004 Disproportionate Share Fund, 195.006 Medicare Program Cutbacks, 235.001 Fee for Service, 235.002 Individual Responsibility for Health Care and Funding, 235.003 Reimbursement Based on Years in Practice, 235.004 Third-Party Payer Physician Payment Reductions, 235.006 Bundled Payment Proposals, 235.008 Surgical Assistants, 235.023 Reimbursement for Uncompensated Services to the Uninsured or Underinsured, 240.004 Medicare Reimbursement for Emergencies, and 280.002 Insurance Coverage for New Medical Procedures.

This report also recommends deletion of the following policies: 95.036 Tax-Deferred Health Benefits Mandate on Over-the-Counter Medication, 190.004 Medicaid Allowance for Preterm Labor, 235.007 Reimbursement of Preventive Health Care, and 95.001 Prescription Triplicate Forms.

Your reference committee received testimony supporting this report and suggesting amendments. Testimony strongly supported retaining policy 30.001, upholding CRNA supervision by an anesthesiologist or other appropriate physician. Recommended amendments were to replace the term “reimbursement” with “payment” and to add “VBP model” after “ACO” throughout policy 115.015 to broaden the policy and improve consistency.

Your reference committee agreed with the written testimony and agrees with adopting the recommended amendments to improve consistency throughout the document. At the virtual hearing, your reference committee did not hear testimony on this report. The reference committee maintains a recommendation for Report 2 be adopted as amended.

(2) Council on Socioeconomics Report 3 – Opposition to New Federal Public Charge Definition

RECOMMENDATION:

Mr. Speaker, your reference committee recommends that the recommendations in Council on Socioeconomics Report 3 be adopted.

This report recommends that TMA (1) adopt new policy opposing revisions to the federal definition of public charge that penalize legal immigrants or their children for using local, state, or national health, nutrition, and housing services, including Medicaid and the Children’s Health
Insurance Program; (2) continue to advocate that the new federal rules be rescinded to protect the health of all Texans; and (3) develop resources to help physicians accurately and concisely convey to their patients what federal rules relating to public charge do and do not say.

Your reference committee received testimony supporting this report. It noted the current presidential administration invalidated this regulation, which was issued by the previous administration. Testimony called for TMA to still define clear policy that objects to penalizing legal immigrants or their children for the use of local, state, or national health, nutrition, or housing services.

Your reference committee agreed with the written testimony and the need to establish related TMA policy. At the virtual hearing, your reference committee did not hear any testimony on this report and maintains the recommendation for the report to be adopted.

Patient-Physician Advocacy Committee Report 3 – Legislative Changes Regarding Vacating Orders

RECOMMENDATION A:

Mr. Speaker, your reference committee recommends that the recommendations in Patient-Physician Advocacy Committee Report 3, page 2, lines 9-10, be amended as follows:

That the Texas Medical Association seek legislation that would provide that: (1) should an administrative law judge find that the Texas Medical Board (TMB) failed to meet its burden of proof on charges that served as the basis for a temporary suspension or restriction of a physician’s license, the TMB shall overturn and vacate the temporary suspension or restriction as soon as practicable and dismiss the case; (2) the effect of an overturned and vacated temporary suspension or restriction, unless specifically appealed by the TMB to district court, shall be that the suspension or restriction never happened and never should have happened; and (3) any mention of charges against a physician related to the temporary suspension or restriction shall be removed from the physician’s TMB profile, all parties shall be notified that the temporary restriction or suspension is void, any related report to the National Practitioner Data Bank shall be voided, and the case dismissed, unless and until the TMB appeals the case to district court and that court reverses the administrative law judge’s findings of facts and conclusion of law.

RECOMMENDATION B:

Mr. Speaker, your reference committee recommends that Patient-Physician Advocacy Committee Report 3 be adopted as amended.

Your reference committee heard testimony supporting the report’s recommendations, but concern was expressed with recommendation three since the Texas Medical Board has neither the authority nor the ability to void a report made to the National Practitioner Data Base. Testimony recommended deleting that section.

Your reference committee agreed with the written testimony and recommends adoption as amended. At the virtual hearing, your reference committee heard additional testimony opposing the amendment indicating that the TMB does have the ability to make a report to the National
Practitioner Data Bank (NPDB) voiding the order, although there is a dispute as to whether or not it is required. The testifier indicated there is a lawsuit pending that may clarify the TMB’s requirement. Additional input from TMA’s Office of the General Counsel states that the NPDB regularly accepts modified and void reports and that the amended language is acceptable since the NPDB is one of the parties that would be notified by the TMB. In a case before the Texas Supreme Court, the TMA argued in an amicus brief that the TMB should have sent a report voiding the previous report of a temporary restriction to the NPDB because, ultimately, after a full hearing, the charges were not proven, and the case was dismissed. Your reference committee appreciates the additional information but stands behind its decision to amend the recommendation.

(4) Board of Trustees Report 18 – Compensation to Physicians for Activities Other Than Direct Patient Care (Tabled BOT Report 13 2020)

RECOMMENDATION:

Mr. Speaker, your reference committee recommends that the recommendations in Board of Trustees Report 18 be adopted.

This report recommends that TMA advocate for significant legislative and/or regulatory reforms to lessen (1) the negative impact of state-regulated health plan prior authorization requirements on patients and (2) the burden of state-regulated health plan prior authorization requirements on physician practices.

Your reference committee received testimony supporting this report that noted prior authorizations have become increasingly burdensome for physicians and their staff. Testimony noted there is little benefit from prior authorization for patients, but care is routinely complicated and delayed by the requirements.

Your reference committee agreed with the written testimony, concurs with the frustrations associated with prior authorizations, and calls for the resolution to be adopted. At the virtual hearing, your reference committee did not hear any testimony on this report. The reference committee recommends for it to be adopted.

(5) Committee on Medical Home and Primary Care Report 1 – Sunset Policy Review

RECOMMENDATION:

Mr. Speaker, your reference committee recommends that the recommendation in Committee on Medical Home and Primary Care Report 1 be adopted.

This report recommends that policy 260.005 Community and Migrant Health Centers be retained.

Your reference committee received testimony from the Council on Socioeconomics supporting the retention of the policy.
Your reference committee agreed with the written testimony and recommends adoption. At the virtual hearing, your reference committee did not receive any testimony on this report and calls for it to be adopted.

(6) Committee on Rural Health Report 1 – Sunset Policy Review

RECOMMENDATION:

Mr. Speaker, your reference committee recommends that the recommendation in Committee on Rural Health Report 1 be adopted.

This report retention of policy 55.003 School Career Programs in Rural Areas.

Your reference committee received testimony from the Council on Socioeconomics strongly supporting the retention of the policy.

Your reference committee agreed with the written testimony and recommends adoption. At the virtual hearing, your reference committee did not hear any testimony on this report and calls for it to be adopted.

(7) Resolution 401 – Caps on Insulin Copayments with Insurance (Tabled Res 413 2020)

RECOMMENDATION A:

Mr. Speaker, your reference committee recommends that Resolution 401 be amended by amending the first resolve on line 37 and adding a second resolve as follows:

(1) That TMA support a limiting the copayments insured on the patient cost sharing amount patients pay per month for prescribed insulin, and

(2) That the TMA Delegation to the AMA take a similar resolution to the AMA House of Delegates.

RECOMMENDATION B:

Mr. Speaker, your reference committee recommends that Resolution 401 be adopted as amended.

Your reference committee received testimony generally supporting this resolution, but amendments were offered. One testifier encouraged the reference committee to consider replacing “copayments” with “patient cost sharing” to include deductibles, copayments, and coinsurance. Another testifier urged the reference committee to consider not limiting the resolution to copayments but to also include the total cost of insulin and the cap on copayments. This testifier added that while many states implemented caps at $100 for a 30-day supply, that is still cost-prohibitive for many patients, and mentioned active Texas legislation that would create a $50 cap. Finally, this testifier suggested strengthening the resolution by adding a resolved clause that directs the Texas Delegation to the AMA to take a similar resolution to the AMA House of
Delegates. Doing so would address Employee Retirement Income Security Act (ERISA) plans that could be excluded by state-specific legislation.

Your reference committee agreed with the resolution’s intent and recommends to adopt as amended.

At the virtual hearing, your reference committee did not receive any testimony on this resolution.


RECOMMENDATION A:

Mr. Speaker, your reference committee recommends that Resolution 402 be amended by addition of a second resolve as follows:

(1) That the Texas Medical Association work with relevant stakeholders to support coverage of and payment for postpartum maternal health care for at least 12 months postpartum under the newborn child’s health insurance plan, including Children’s Medicaid and Children’s Health Insurance Program plans for women who are otherwise uninsured or ineligible for Medicaid; and

(2) That the TMA Delegation to the AMA take a similar resolution to the AMA House of Delegates.

RECOMMENDATION B:

Mr. Speaker, your reference committee recommends that Resolution 402 be adopted as amended.

Your reference committee received testimony strongly supporting the resolution. Testimony also suggested an amendment that the TMA delegation take a similar resolution to the AMA House of Delegates.

Your reference committee agreed with the written testimony. The reference committee understands that CHIP Perinatal Program is the correct mechanism for this policy change. At the virtual hearing, your reference committee heard testimony in support of the resolution and discussion on how the AMA is extensively studying the topic the resolution addresses. Testimony noted that the AMA may adopt similar policy independent of the proposed amendment, reducing the need to adopt the amendment. Testimony also advocated for adopting the resolution as amended to increase the number of reports submitted to the AMA on this topic, highlighting the importance of this issue, and increasingly the probability of AMA policy adoption. Your reference committee maintains its recommendation to adopt as amended.

(9) Resolution 403 – Insurance Promotion of Preventive Care Services via Incentive-Based Program (Tabled Res 417 2020)

RECOMMENDATION:
Mr. Speaker, your reference committee recommends that Resolution 403 be amended by addition of a second resolve as follows:

(1) That the Texas Medical Association advocate for health insurance companies to adopt cash-based incentive programs similar to the Medicare Incentives for Prevention of Chronic Disease program to promote usage of preventive care services and that TMA support further research on health care initiatives that increase usage of preventive care services, and

(2) That the TMA Delegation to the AMA take a similar resolution to the AMA House of Delegates.

RECOMMENDATION B:

Mr. Speaker, your reference committee recommends that Resolution 403 be adopted as amended.

This resolution resolves that the Texas Medical Association advocate for health insurance companies to adopt cash-based incentive programs similar to the Medicare Incentives for Prevention of Chronic Disease program to promote usage of preventive care services and that TMA support further research on health care initiatives that increase usage of preventive care services.

Your reference committee received testimony generally supporting this resolution. One testifier noted that any program encouraging patients to use preventive health services is beneficial. Another testifier supported the goals of the resolution but recommend strengthening its impact by adding a resolved clause that directs the Texas Delegation to the AMA to take a similar resolution to the AMA House of Delegates for consideration.

Your reference committee agreed with the written testimony and recommends adoption as amended. At the virtual hearing, your reference committee heard testimony discussing the need to study incentive programs. The Reference Committee maintains the recommendation for Resolution 403 be adopted as amended.

(10) Resolution 404 – Training Requirements Imposed by Insurance Companies Preventing Patients’ Access to Quality Medical Care (Tabled Res 420 2020)

RECOMMENDATION:

Mr. Speaker, your reference committee recommends that Resolution 404 be adopted.

This resolution resolves (1) that the Texas Medical Association urge insurance companies to cease and desist from requiring physicians to spend time – in addition to their extensive professional training – in training in each companies’ requirements for patient care; (2) that TMA urge the Texas Medical Board to condemn such practice by insurance companies as beyond the companies’ purview of physician training responsibilities; (3) that TMA urge the Texas insurance commissioner to investigate the appropriateness of insurance companies imposing on physicians the onerous and unnecessary burden of web-based or otherwise administered training; and (4) that TMA urge the Texas Legislature to take adequate measures to prevent insurance companies from interfering with the education of physicians by engaging in the wasteful exercise of requiring physicians to train in the companies’ preferences, objectives, and/or goals.
Your reference committee received testimony supporting this resolution. One testifier shared that the resolution was inspired by a health plan requiring physicians to complete a web-based course to be allowed to treat its enrollees. The course pertained to the plan's referral requirements, and the resolution is designed to prevent the practice of steering patients to certain physicians or medical groups. Finally, a concern was shared that all insurance companies might demand that physicians complete company-specific online or written training as a prerequisite to seeing enrollees, which quickly would overwhelm physicians.

Your reference committee agreed with the written testimony and understands that such training could be both overwhelming for physicians and unnecessary. At the virtual hearing, your reference committee did not hear any testimony on this resolution and recommends it be adopted.

(11) Resolution 405 – Ensuring Medical Practice Viability Through Reallocation of Insurance Savings During the COVID-19 Pandemic

RECOMMENDATION:

Mr. Speaker, your reference committee recommends that Resolution 405 be referred for study.

This resolution resolves (1) that the Texas Medical Association advocate for full transparency regarding Medicaid expenditures relative to allocated funds, as well as expenditures relative to gross income for all commercial payers during the pandemic; (2) that TMA urge adoption of legislation that would mandate a review of the difference between the current physician financial deficit created by the COVID-19 pandemic and subsequent profits the insurance companies have reaped due to the government shutdowns and mandates; (3) That a fair and equitable formula be implemented to divide and allocate the savings directly resulting from decreased patient encounters among patients/employers who paid their premiums, physicians who have been impacted directly by government mandates and shutdowns, and the insurance companies; and (4) That the Texas Delegation to the American Medical Association take a similar resolution to the AMA House of Delegates for consideration.

Your reference committee received testimony generally supporting this resolution. A concern was noted over the optics of physicians seeking to profit from clinical work that did not actually occur. The reference committee was encouraged to shape this resolution more closely to support practice viability. Another testifier noted that although patient volume is down due to the public health emergency, physician and staff workloads have increased due to uncompensated care. Furthermore, canceled in-office visits due to patient fears of exposure to COVID-19 negatively impact practices. This testifier noted that many payers have seen significant declines in expenditures in the past year but have not yet disclosed this; thus the resolution asks that the savings be shared in a fair manner with the patient and employers who paid the insurance premiums, the physicians who provide uncompensated care to patients covered by the plan, and the payers.

Your reference committee agreed with the written testimony and understands that practices have experienced financial difficulties due to the COVID-19 pandemic but recommends this resolution be referred for further study. The reference committee discussed how the Medicare sustainable growth rate formula, which was repealed in 2015, would have enabled increased physician payments when overall Medicare expenditures decreased. The reference committee
acknowledged that current Medicare physician payment updates are based on the Medicare Access and CHIP Reauthorization Act and do not allow payment increases regardless of Medicare utilization and expenditures. Finally, the reference committee agreed with the need to address practice viability but remained concerned with the perception of physicians financially benefiting when medical services have not been rendered. At the virtual hearing, your reference committee heard testimony opposing the recommendation to refer for study since practices are experiencing financial difficulties due to the COVID-19 pandemic. Other testimony discussed the importance of further studying the financial impact of COVID-19, but that it is premature to carry this resolution to the AMA since the pandemic has not concluded. The reference committee maintains the recommendation that Resolution 405 be referred for study.

(12) Resolution 406 – Medicaid-Medicare Parity Needed for Patient Access Exacerbated by COVID-19

RECOMMENDATION:

Mr. Speaker, your reference committee recommends that Resolution 406 be adopted.

This resolution resolves that the Texas Medical Association advocate to increase Texas Medicaid reimbursement rates to physicians at least equal to Medicare rates, as the COVID-19 pandemic has made operating a physician practice financially impossible for many practices with a large Medicaid population.

Your reference committee received testimony supporting the report and suggesting it be reaffirmed as existing policy in place of adoption. Testimony detailed the experience of primary care physicians serving the Medicaid population and financial difficulties the COVID-19 pandemic has exacerbated. Testimony also supported the increase in Medicaid payment rates and noted that related TMA policy (190.003) exists and this resolution could be reaffirmed.

Your reference committee agreed with the written testimony, though understands that the report differs from existing TMA policy by recognizing the pandemic’s impact on physician practice viability. The pandemic exacerbated financial strains caused by inadequate Medicaid payments. The reference committee discussed the profound importance of the report and the need to act swiftly to support physician practices; thus the reference committee encourages adoption of the report in addition to existing policy to increase focus on the issue. At the virtual hearing, your reference committee did not receive any testimony on this resolution. The committee recommends adoption.

(13) Resolution 407 – Ensuring That Telehealth Coverage Does Not Discourage Use of Local Physicians

RECOMMENDATION:

Mr. Speaker, your reference committee recommends that Resolution 407 be referred for study.
This resolution resolves (1) that the Texas Medical Association recognize that a benefit of having local physicians and their team of local health care providers provide telemedicine services is that they have the ability to ask the patient to switch to an in-person visit if circumstances warrant this approach, (2) that TMA advocate for legislation that requires insurance carriers not to establish cost-sharing policies that encourage patients to use nonlocal physicians and providers instead of local physicians, and (3) That the Texas Delegation to the American Medical Association take a similar resolution to the AMA House of Delegates for consideration.

Your reference committee received testimony both supporting the resolution conceptually and suggesting further study is needed. There was agreement that patients should have continuity of care and be encouraged to be treated by their own physician familiar with their health needs. However, concern was expressed about (1) taking away patient choice, (2) the lack of definition of a local physician, and (3) the unintended consequence of not supporting physician-directed telemedicine to reach specialists outside of the patient’s region.

Your reference committee agreed with the written testimony and noted that telemedicine utilization and policies are rapidly evolving. The committee discussed how some payers are using telemedicine to satisfy their network adequacy requirements. Acknowledging that TMA needs robust and thorough consideration, the reference committee recommends this be referred for further study.

At the virtual hearing, your reference committee heard additional testimony disagreeing with the refer-for-study decision. The reference committee received a recommendation to amend the second resolve:

“RESOLVED, That TMA advocate for legislation preventing insurance carriers from establishing cost-sharing policies that encourage patients to seek medical care from corporate entities that are unable to provide comprehensive care (such as in-office visits) instead of from their personal physicians who can provide a full range of visit options; and be it further”

The reference committee discussed at length and still recognizes the need to empower patients and their choice of where and how care is received. The reference committee stood by its decision to refer for study.

(14) Resolution 408 – Need for and Funding of Level I and Level II Trauma Centers (Tabled Res 402 2020)

RECOMMENDATION:

Mr. Speaker, your reference committee recommends that Resolution 408 be adopted.

This resolution resolves that the Texas Medical Association work with state officials to determine the number of Level I and Level II trauma centers needed to support communities throughout Texas and to provide funding to make Level I and Level II trauma centers viable for all other service lines.

Your reference committee received testimony supporting this resolution. Testimony emphasized the importance to emergency physicians and their patients of funding trauma centers.
Your reference committee agreed with the written testimony and noted that assessing and properly funding emergency facilities must occur immediately to prevent loss of life. Determining the emergency facility needs of all Texas communities is critical to making emergency care accessible. **At the virtual hearing, your reference committee did not hear any testimony on this resolution and calls for it to be adopted.**

(15) Resolution 409 – Taxes on Medical Billing Services (Tabled Res 403 2020)

**RECOMMENDATION:**

Mr. Speaker, your reference committee recommends that Resolution 409 be adopted.

This resolution resolves that the Texas Medical Association oppose the imposition of service and use taxes on processes that are not actually part of delivering a medical service and TMA work with the Texas Comptroller of Public Accounts and state legislators to resolve and clarify that medical billing, including outsourced billing services, is not the adjudication or practice of insurance, and thus should not be subject to insurance-related sales taxes.

Your reference committee received testimony supporting this resolution. It was noted that Texas House Bill 1445, supported by the TMA and passed by the House and Senate this session, also prohibits a tax on medical billing services.

Your reference committee agreed with the written testimony and recommends adopting this resolution. **At the virtual hearing, your reference committee did not hear any testimony on this resolution and calls for it to be adopted.**

(16) Resolution 410 – Individual Physicians Be Paid While Awaiting Credentialing Approval (Tabled Res 404 2021)

**RECOMMENDATION:**

Mr. Speaker, your reference committee recommends that Resolution 410 be adopted.

This resolution resolves that the Texas Medical Association adopt as policy that individual physicians should be paid the contracted rate while awaiting approval of their credentials by a health plan and That TMA advocate for legislation that individual physicians be paid by health plans for their services while they are awaiting formal approval of their credentials.

Your reference committee received testimony supporting this resolution. It was noted that TMA and other physician organizations work to improve the unreasonable delays in credentialing. One testifier stated the belief that all physicians, whether joining a group or seeking to establish their own practice, should be able to benefit from the same process whereby a health plan treats them as a participating physician during credentialing. Further, it was noted that the insurance industry benefits from unnecessary delays in completing the credentialing process that lead to payment denial because the physician is not credentialed on the date of service. Another testifier supported the resolution and noted the credentialing process is tedious and time-consuming for all physicians but especially burdensome for those practicing in rural and underserved areas.
Your reference committee agreed with the written testimony and calls for the resolution to be adopted. At the virtual hearing, your reference committee did not hear any testimony on this resolution and calls for it to be adopted.

(17) Resolution 411 – Physicians to Retain Payment During Credentialing (Tabled Res 405 2020)

RECOMMENDATION:

Mr. Speaker, your reference committee recommends that Resolution 411 be adopted.

This resolution resolves that the Texas Medical Association adopt as policy that physicians should not be required to refund the contracted rate should credentialing be denied by a health plan and That TMA advocate to amend, by changing “may cover” to “may not cover,” Texas Insurance Code, Title 8, Health Insurance and Other Health Coverages, Subtitle F. Physicians and Health Care Providers, Chapter 1452 Physician and Provider Credentials, Sect. 1452.106 Effect of Failure to Meet Credentialing Requirements, to state “the managed care plan issuer may not recover from the applicant physician or the physician’s medical group an amount equal to the difference between payments for in-network benefits and out-of-network benefits.”

Your reference committee received testimony supporting this resolution. This testimony noted the resolution’s intent is to encourage insurers and other payers to expedite and improve the credentialing process and to make appropriate payment for services rendered by physicians or providers while those processes are ongoing.

Your reference committee agreed with the written testimony, discussed the frustrations with the credentialing process, and calls for this resolution to be adopted. At the virtual hearing, your reference committee did not hear any testimony on this resolution and calls for it to be adopted.

(18) Resolution 412 – Maintaining the Integrity of Physicians Orders in an Electronic Environment

RECOMMENDATION A:

Mr. Speaker, your reference committee recommends that Resolution 412, lines 14-15, be amended as follows:

RESOLVED, that the Texas Medical Association support legislation stating that altering physician orders in the inpatient setting, without the approval of the order’s original author or the covering physician is practicing medicine and is prohibited except in an emergency (i.e., a patient safety situation). Orders and order sets approved by the medical executive committee and/or the medical staff should be exempt, with those altered orders permitted.

RECOMMENDATION B:

Mr. Speaker, your reference committee recommends that Resolution 412 be adopted as amended.
Your reference committee received testimony supporting the resolution with suggested amendments that clarify the resolution is intended only for inpatient settings and that protocols approved by a medical executive committee or by the medical staff should be permitted.

Your reference committee agreed with the written testimony and recommends adoption as amended. At the virtual hearing, your reference committee did not hear any testimony on this resolution and calls for it to be adopted.

(19) Resolution 413 – Compensation to Physicians for Activities Other Than Direct Patient Care
(Tabled Res 407 2020)

RECOMMENDATION:

Mr. Speaker, your reference committee recommends that Resolution 413 be adopted. This resolution resolves that adopt a Funding for Physician Noncare Services policy as follows:

The Texas Medical Association advocates for payers – insurance companies and managed care companies, including companies managing governmental insurance plans – to compensate physicians for the time physicians and their staff spend on services outside of direct patient care (noncare services), such as authorization and preauthorization for coverage and payment for prescriptions, laboratory tests, radiology tests, procedures, surgeries, hospitalizations, and physician visits, as well as gathering, compiling, and submitting medical records and data.

TMA also recommends such compensation be promptly paid in full by payers to physicians at a level commensurate with their education, training, and expertise, and at a rate comparable to that of the most highly trained professionals.

Physicians shall bill the payers for time spent by them and their staff to perform noncare services including, but not limited to, time spent filling out forms, reviewing the patient’s medical record, gathering patient-related data, making telephone calls (including time spent negotiating “phone trees” and hold time), documenting in the patient’s medical record, communicating with the patient, altering treatment plans (such as changing medications to comply with formularies), printing, copying, and faxing.

Upon receiving such a bill, payers shall pay the physician promptly, with significant interest penalties assessed for payment delays. Because noncare services benefit payers, compensation to physicians for these services should not be billable to patients.

Your reference committee received testimony supporting this resolution. One testifier noted that a substantial proportion of activities are nondirect patient care and should be valued and paid appropriately. Another testifier supported this resolution and noted the burden of prior authorization and approval processes is a threat to the viability of practices, and the time and hassles associated with prior authorizations and other administrative inefficiencies should be borne by the payers.

Your reference committee agreed with the written testimony and understands the financial and time frustrations associated with services outside of direct patient care. Thus the reference committee recommends this resolution be adopted. At the virtual hearing, your reference committee did not hear any testimony on this resolution and calls for it to be adopted.
(20) Resolution 414 – Contracted Health Plans Must Apply the Same Level of Benefits Concerning Patient Responsibility (Tabled Res 408 2020)

RECOMMENDATION:

Mr. Speaker, your reference committee recommends that the recommendation in Resolution 414 be adopted.

This resolution resolves (1) that the Texas Medical Association adopt as policy that health plans in a binding contract with a physician must apply the same level of benefits concerning patient responsibility (copay, coinsurance) regardless of the contracted physician or provider rendering the service, (2) that TMA take this issue to the state legislature for potential statutory action, and (3) that the Texas Delegation to the American Medical Association carry a similar resolution to the AMA House of Delegates for policy development and legislative action.

Your reference committee received written testimony supporting this resolution. Your reference committee agreed with the intent of the resolution and encourages adoption of the resolution.

At the virtual hearing, your reference committee heard testimony suggesting Resolution 414 be combined with Resolution 407. Additional testimony was heard regarding the AMA’s extensive policy on network protections and a question if the resolution pertained to both in- and out-of-network coverage. As such, the testimony recommended the resolution be refined further within TMA before advancing to the AMA. Your reference committee discussed the suggestion to combine the resolution but deems them as independent resolutions. Your reference committee maintains the recommendation to adopt to show the importance of the resolution’s intent.

(21) Resolution 415 – Paper Medical Record Chart Preparedness for Electronic Health Record Interruptions

RECOMMENDATION A:

Mr. Speaker, your reference committee recommends that Resolution 415 be amended by amending the first resolve and deleting the second resolve as follows:

(1) That the Texas Medical Association encourage all users of electronic health records (EHRs) in all health care environments to have an easily accessible training manual instructing clinical staff on how to maintain paper medical records during planned and unplanned EHR downtimes and interruptions, option available at the time of EHR interruptions, such as those from cyber attacks, 

(2) RESOLVED, That TMA encourage all health care entities to conduct training at least annually on the use of these emergency paper medical records

(3) That the Texas Delegation to the American Medical Association take a similar resolution to the AMA House of Delegates for consideration.

RECOMMENDATION B:
Mr. Speaker, your reference committee recommends that Resolution 415 be adopted as amended.

Your reference committee received testimony supporting and opposing Resolution 415, with the majority supporting it with the following recommended amendments: (1) Remove the annual training requirement, and (2) instead, have an easily accessible training manual. The opposing testifier indicated annual training would place an administrative burden on practices.

Your reference committee agreed with the written testimony and recommends adoption as amended. At the virtual hearing, your reference committee heard additional virtual testimony expressing concern over how this resolution would be implemented. An additional testifier and the submitting caucus expressed support of adoption as amended. Your reference committee maintains the recommendation to adopt as amended.

(22) Resolution 416 – Physician Societies to Create a Self-Funded, Balanced, and Nonpartisan Center for the Study of Health Care Reform (Tabled Res 421 2020)

RECOMMENDATION:

Mr. Speaker, your reference committee recommends that Resolution 416 be not adopted.

This resolution resolves that the Texas Medical Association, in collaboration with other medical societies, create and support a permanent, physician-led, independently funded “center” for the balanced, nonpartisan study of health care reform; and that this entity maintain and promote an online platform to provide for balanced critique about general and specific policy proposals, health care reports, and national health care systems for the benefit of the general public and That the Texas Delegation to the American Medical Association carry a similar resolution to the AMA House of Delegates, calling upon AMA to support the aforementioned permanent, physician-led, independently funded center for balanced, nonpartisan study of health care reform.

Your reference committee received testimony predominately against this resolution. Several testifiers spoke against its significant fiscal note. They also noted that several Texas physicians are on the boards of two similar organizations formed for the same purpose as the resolution. In addition, it was noted that several national and state entities are conducting work on health care reform.

One testifier spoke in support of the resolution, noting that nongovernmental organizations are successful in altering public opinion and policy, and suggested physicians do not have a dedicated think tank for an objective study of health care reform proposals. This testifier argued that a physician-led, evidence-based center for study of health care can show the public that TMA is engaged and interested in improving the system. Finally, the fiscal note was challenged with the statement that only seed funding is needed, and TMA could solicit external funding.

Your reference committee discussed the written testimony and recognized that organizations already exist and operate in this space with Texas physicians’ input. Given the considerable fiscal note, the reference committee recommended the resolution be not adopted.

At the virtual hearing, your reference committee received an amendment by the author for a resolved clause to state:
RESOLVED, That the Texas Medical Association, in collaboration with other medical societies, create and support a permanent, physician-led, independently funded “center” for the balanced, nonpartisan study of health care reform; and that this entity maintain and promote an online platform to provide for balanced critique about general and specific policy proposals, health care reports, and national health care systems for the benefit of the general public to improve health literacy and fundamental knowledge necessary to evaluate proposed healthcare legislation; and be it further

The Reference Committee discussed how the amendment is an improvement but maintains the recommendation to not adopt.

(23) Resolution 417 – Verbal Physicians Orders

RECOMMENDATION A:

Mr. Speaker, your reference committee recommends that Resolution 417 be amended by amending the first resolve on lines 17-18 and deleting the second resolve as follows:

(1) That the Texas Medical Association encourage for legislation or Texas Medical Board rules that require medical staff approval facilities to allow for physician orders to be given in the most efficient manner to accommodate patient care safely and in a timely manner, any limitations on the types of physician orders that are permissible; and

(2) That TMA advocate for inclusion of “how to give, receive, and document verbal orders” in the training material for clinical staff in health care facilities prior to their matriculation, as well as inclusion of the same material and procedures and their subsequent modifications in the staff’s continuing education.

RECOMMENDATION B:

Mr. Speaker, your reference committee recommends that Resolution 417 be adopted as amended.

Your reference committee received testimony in support of this resolution but with the limitation of encouraging facilities rather making than a legislative request, as these decisions are made locally. There was also a recommendation that it not be limited to verbal orders as there may be other efficient ways to give orders rather than verbal.

Your reference committee agreed with the written testimony and recommendations provided and additionally noted that the resolution as written is out of TMA’s purview. Your reference committee recommends adoption as amended. At the virtual hearing, your reference committee did not hear any testimony on this resolution and calls for it to be adopted as amended.

(24) Resolution 418 – Electronic Prescribing of Controlled Substances (EPCS) Unfunded Mandate and Pharma Financial Settlements

RECOMMENDATION A:
Mr. Speaker, your reference committee recommends that Resolution 418 be amended by deletion of the third resolve as follows:

(1) That the Texas Medical Association work with the American Medical Association to initiate a request to the federal government to use the dollars from the Purdue Pharma settlement, and other such settlements, to help pay for the electronic prescribing of controlled substances financial unfunded mandate;

(2) That the Texas Delegation to the American Medical Association take a resolution to the AMA House of Delegates to lobby the federal government to require certified electronic health record companies to provide electronic prescribing of controlled substances as standard basic service, and

(3) That the Texas Delegation to the AMA take a resolution to the AMA House of Delegates to initiate movement on the request, and

(4) That TMA review the electronic prescribing of controlled substances laws in other states to inquire on their implementation of this law to see if their law(s) have implicated dollars to cover this cost and better waiver language.

RECOMMENDATION B:

Mr. Speaker, your reference committee recommends that Resolution 418 be adopted as amended.

Your reference committee received testimony supporting the resolution but noting the third resolved clause is redundant.

Your reference committee agreed with the written testimony, agrees with the recommendation to remove the redundant third resolve clause, and recommends adoption as amended. At the virtual hearing, your reference committee did not hear any testimony on this resolution. The committee recommends adoption.

Resolution 419 – Advocating for Increased Capacity of Local State Mental Health Facilities and Coordination of Behavioral Health Services (Tabled Res 313 2020)

RECOMMENDATION:

Mr. Speaker, your reference committee recommends that the recommendation in Resolution 419 be adopted.

This resolution resolves (1) that the Texas Medical Association advocate for increased funding and capacity for inpatient psychiatric beds throughout Texas with a priority emphasis in areas that lack local access to mental health facilities, and (2) that TMA policy 215.019 Public Mental Health Care Funding be amended as follows:

Public Mental Health Care Funding: Despite increases in funding from the Texas Legislature for the mental health care system, Texas still struggles to provide optimal psychiatric care for those in need. The Texas Medical Association therefore supports: (1) state efforts to provide the public mental health system with funding sufficient to address
common severe mental illness across the lifespan for all in need; (2) state efforts to
effectively ensure that appropriated funds are used to provide best practices for patients in a cost-
efficient manner for taxpayers; (3) equity of reimbursement for primary care providers
offering behavioral health care in a primary care setting as a way of improving access to
mental health care; (4) innovative and evidence-based approaches for the early detection
and prevention of mental illness; and (5) comprehensive and coordinated approaches that
create more seamless transitions in psychiatric care, resulting in fewer readmissions and
better utilization of available resources.

Your reference committee received testimony supporting the resolution and emphasizing the
importance of coordinated and comprehensive mental health care. Testimony noted that mental
health facilities must be available statewide. They are critical to patients’ access to specialty
services, and going to jail is often the alternative when conditions are left untreated.

Your reference committee agreed with the written testimony, discussed the importance and
timeliness of the resolution, and recommends adoption. At the virtual hearing, your reference
committee did not hear any testimony on this resolution and calls for it to be adopted.

Resolution 420 – Step-Edit Therapy Contributes to Denial of Care and Has Not Demonstrated
Improved Patient Outcomes or Overall Cost Savings (Tabled Res 412 2020)

RECOMMENDATION:

Mr. Speaker, your reference committee recommends that the recommendation in Resolution 420
be adopted.

This resolution resolves that the Texas Medical Association (TMA) urge our legislators to review
and make transparent the “fail-first” policy of step-edit therapy and study how it affects patient
outcomes and that TMA ask the American Medical Association to review the ethical implication
of step-edit therapy and make further recommendations on its use.

Your reference committee received testimony supporting this resolution. It was noted that step-
therapy policies negatively impact the health of many patients, create confusion and unnecessary
additional work for patients and physicians, and do so without improvement in outcomes or cost
savings. Another testifier commended the resolution and suggested that the AMA policies cited
contain important principles that could be shared with legislators at the state level to strengthen
the impact of the resolution. They also noted that given strong AMA policy around step-edit
therapy, further discussion at AMA may not be needed per the second resolved clause.

Your reference committee agreed with the written testimony, discussed how step-therapy harms
patients and is time consuming for physicians, and recommends adoption of the resolution. At the
virtual hearing, your reference committee did not hear any testimony on this resolution and calls
for it to be adopted.

Resolution 421 – Augmented Intelligence (AI) in Health Care (Tabled Res 201 2020)

RECOMMENDATION A:
Mr. Speaker, your reference committee recommends that Resolution 421 be amended by amending the first resolve on lines 16-17 and deleting the second resolve as follows:

(1) That the Texas Medical Association Council on Socioeconomics, TMA Committee on Health Information Technology, and TMA Council on Medical Education collaboratively develop study the effects of augmented intelligence (AI) policy on health care in Texas, and

(2) That TMA ensure this effort includes guidance on how physicians may be affected and how physicians may prepare for the challenges and the opportunities AI creates.

RECOMMENDATION B:

Mr. Speaker, your reference committee recommends that Resolution 421 be adopted as amended.

Your reference committee received supporting and opposing testimony. Those supporting the resolution recommended amending it to remove the study and instead ask TMA to develop AI policy.

Your reference committee agreed with the supporting testimony and understands that AI policy should be developed by TMA. The reference committee recommends adoption as amended. At the virtual hearing, your reference committee did not hear any testimony on this resolution and calls for it to be adopted as amended.

Resolution 422 – Adjustments to Hospice Dementia Enrollment Criteria (Tabled Res 427 2020)

RECOMMENDATION:

Mr. Speaker, your reference committee recommends that Resolution 422 be referred for study.

This resolution resolves that the Texas Medical Association collaborate with the American Medical Association in advocating for the Centers for Medicare & Medicaid Services (CMS) to adjust the secondary hospice enrollment criteria for dementia. Specifically, CMS should incorporate dementia patients who are Functional Assessment Staging Test Stage 6e, who, or their families on their behalf, have chosen not to receive medications or interventions for acute illnesses and that TMA collaborate with AMA in advocating for CMS to expand the coverage and availability of other, novel provisions of care for dementia patients, such as expanding the Medicare Care Choices model that allows palliative services to be provided in the home setting, as a bridge to hospice care.

Your reference committee received testimony generally supporting this resolution. The sponsor of the resolution argued the importance of supporting changes to the hospice dementia enrollment criteria to ensure TMA policy is consistent with current best practices. The sponsor also called on TMA to advocate with the Centers for Medicare & Medicaid Services to incorporate into the criteria dementia patients who are at Functional Assessment Staging Test Stage 6e, and who – or their families on their behalf – have chosen not to receive medications or interventions for acute illnesses. Another testifier offered full support for expanding coverage for dementia patients and discussed how hospice enrollment criteria were developed in a different era with a different
understanding of what might be appropriate for hospice benefits, and thus revising the enrollment
criteria for hospice is needed.

Another testifier commended the authors and agreed with both resolved clauses. It was noted that,
given the prevalence of dementia in older adults and the increasing costs to Medicare, the
reference committee should support referral for further evaluation of how to strengthen and
increase the scope of interventions to address these growing concerns. A concern was raised that
the problems outlined in the resolution are larger than what the resolution covers, and that it
would be helpful to ensure the concern is fully addressed if additional interventions could be
recommended.

Your reference committee discussed the written testimony and agreed with the intent of the
resolution. However, the reference committee did not think changing enrollment criteria
fundamentally addresses many issues with dementia in hospice care settings. To more thoroughly
address dementia issues, the reference committee recommends this resolution be referred for
further study.

At the virtual hearing, your reference committee heard testimony in support of the resolution and
opposition to it being referred for study. The reference committee discussed the testimony and the
importance of the resolution, but concluded that for a resolution to be effective, it should be
comprehensive. The reference committee maintains the recommendation to refer for study.

(29) Resolution 423 – Insurance Coverage for Fertility Preservation Procedures for Cancer Patients
Undergoing Gonadotoxic Therapy

RECOMMENDATION:

Mr. Speaker, your reference committee recommends that Resolution 423 be adopted.

This resolution resolves that the Texas Medical Association advocate for payment of fertility
preservation therapy services by all payers when iatrogenic infertility may be caused directly or
indirectly by necessary medical treatments as determined by a licensed physician.

Your reference committee received testimony unanimously supporting this resolution. It was
noted that TMA sometimes is concerned with mandates and specific services, but this is a limited
resolution regarding fertility treatments in the setting of patients undergoing cancer treatment and
does not concern general fertility treatments. Another testifier supported the resolution as part of
broader comprehensive cancer care planning. The sponsor argued it is critically important to
provide coverage for the medically necessary treatment of fertility preservation and discussed
remarkable improvements in treating cancer, which have enabled many younger people with
cancer to survive.

Your reference committee agreed with the written testimony, discussed how this resolution does
not cover many individuals and is not expensive, and calls for the resolution to be adopted. At the
virtual hearing, your reference committee did not hear any testimony on this resolution and calls
for it to be adopted.
Resolution 424 – Encourage the Establishment of an Express Lane Eligibility (ELE) Program in Texas

RECOMMENDATION:

Mr. Speaker, your reference committee recommends that Resolution 424 be adopted.

This resolution resolves that our Texas Medical Association encourage the establishment of an express lane eligibility (ELE) program in Texas that permits the use of income, household size, or other eligibility information previously collected from an Express Lane Agency (ELA), as described by the Centers for Medicare & Medicaid Services, to facilitate enrollment in Medicaid and the Children’s Health Insurance Program (CHIP).

Your reference committee received testimony supporting the resolution. Testimony emphasized the importance of the health care safety net, detailed the complexity of navigating benefit programs, and supported ELE as a means of streamlining enrollment in Medicaid and CHIP programs by using financial data already available to the state. Testimony discussed how ELE will expedite and facilitate enrollment in critical health care benefits and encourage communications between state agencies to streamline programs and increase efficiency.

Your reference committee agreed with the written testimony and the importance of expedient enrollment in these programs. The committee recommends adoption. At the virtual hearing, your reference committee did not hear any testimony on this resolution. The committee recommends adoption.

Resolution 425 – Making COVID-19 Emergency Telehealth Policies Permanent

RECOMMENDATION:

Mr. Speaker, your reference committee recommends that Resolution 425 be not adopted.

This resolution resolves that the Texas Medical Association support policy for payment parity, as initiated by the COVID-19 PHE declaration and 28 TAC §35.1 enacted by Governor Abbott, for the same covered service provided to an enrolled patient by a contracted physician via telemedicine and That TMA support research on the use of telemedicine services in rural settings in response to 28 TAC §35.1 to determine its effect on increasing access to health care services across the state.

Your reference committee received testimony supporting this resolution but questioned the necessity since TMA already has telemedicine payment parity policy. Your reference committee agreed with the written testimony. Your reference committee recommends not adoption and instead reaffirmation of existing telemedicine payment parity policy. At the virtual hearing, your reference committee did not hear any testimony on this resolution. The committee supports adoption as amended.
Resolution 426 – Support for Rural Labor and Delivery Departments

RECOMMENDATION A:

Mr. Speaker, your reference committee recommends that Resolution 426 be amended by addition of a third resolve as follows:

(1) That the Texas Medical Association support legislation and advocate for increased funding for rural labor and delivery departments under financial strain to allow for improved access to intrapartum care;

(2) That TMA promote awareness to the general public, policy-makers, and physicians about the challenges rural women face when seeking obstetric care that result from decreased access to local labor and delivery departments; and

(3) That TMA explore incentivizing physicians to practice obstetrics in rural settings in addition to Texas’ existing rural primary care recruitment programs.

RECOMMENDATION B:

Mr. Speaker, your reference committee recommends that Resolution 426 be adopted as amended.

Your reference committee received testimony supporting the report and suggesting an amendment. Testimony noted that because the Texas budget has current funding for rural labor and delivery departments, TMA policy should support increased funding. Additional testimony supported further funding, claiming that current levels are inadequate and exacerbate a fragmented system of care. Testimony supported TMA drawing further attention to this issue to reduce maternal morbidity and mortality. In addition, testimony suggested an amendment to highlight the importance of staffing these facilities. Further, testimony recommended the addition of a resolved clause to explore incentivizing physicians to practice obstetrics in rural settings.

Your reference committee agreed with the written testimony and the importance of drawing attention to this issue, especially in underserved areas. The committee supports adoption as amended. At the virtual hearing, your reference committee did not hear any testimony on this resolution and calls for it to be adopted as amended.

Resolution 427 – Limiting Out-of-Network Ground Ambulance Costs

RECOMMENDATION A:

Mr. Speaker, your reference committee recommends that Resolution 427 be amended by addition of a third resolve as follows:

(1) That the Texas Medical Association support increased data collection and price transparency of ground ambulance providers and services,

(2) That TMA support policies and initiatives to reduce surprise, out-of-network billing related to ground ambulance services, and
(3) That the TMA Delegation to the AMA take this resolution to the AMA House of Delegates.

RECOMMENDATION B:

Mr. Speaker, your reference committee recommends that Resolution 427 be adopted as amended.

Your reference committee received testimony generally supporting this resolution with one testifier offering an amendment. A testifier spoke in strong support, discussing how ambulance transport costs patients thousands of dollars for merely a quarter of a mile when a practice is across the street from a hospital. Another testifier discussed that more than 85% of ground ambulance services are billed as out of network and that the federal government does not limit ambulance charges for patients with private insurance. Thus surprise medical bills related to ground ambulances remain a significant concern. Finally, a testifier wrote in support and discussed how patients do not have enough information to make an informed decision on the service. They suggested bringing this topic to AMA for support at the federal level as well as the state level.

Your reference committee agreed with the written testimony and supports adoption of the resolution as amended. At the virtual hearing, your reference committee heard testimony discussing an AMA report on ambulance costs to patients and AMA policy calling for price transparency and an arbitration model for patients. The Reference Committee maintains the recommendation for the resolution to be adopted as amended.

(34) Resolution 428 – Insurance Coverage Transparency (Tabled Resolution 401 2020)

RECOMMENDATION:

Mr. Speaker, your reference committee recommends that Resolution 428 be adopted.

This resolution resolves (1) that the Texas Medical Association advocate for legislation that requires commercial insurance carriers to provide accurate information regarding the patient’s cost-sharing liability and the insurance plan’s liability when a medical office or facility provides the diagnosis and CPT codes via phone or the internet; (2) that TMA advocate for legislation that requires commercial insurance carriers, during insurance eligibility verification, to provide information regarding factors that may result in denial of the claim, e.g., the insurance carrier is waiting for the primary policyholder to verify whether he or she has other health insurance coverage; (3) that TMA advocate for legislation that requires commercial insurance carriers to respond to telephone inquiries about the patient’s cost-sharing liability by providing accurate information verbally and via fax confirmation; (4) that TMA advocate for legislation that penalizes commercial insurance carriers, via fines and the publication of each carrier’s number of noncompliance complaints, when the above information is inaccurate or not provided in a timely manner; and (5) that the Texas Delegation to the American Medical Association carry a similar resolution to the AMA House of Delegates.

Your reference committee received testimony unanimously supporting this resolution. One testifier spoke in support and called for TMA policy on insurance coverage transparency since these policies are active at the state and federal level. It was noted that for any headway in controlling health care costs, both patients and physicians need to know those costs when making
treatment decisions. To be successful in value-based models, physicians also need such
information. Another testifier noted that insurance plans can quickly determine a patient’s
insurance status, if a CPT code is covered, and what the patient’s financial responsibility will be
if that code is billed. In contrast, insurance plans choose not to share this information. It was
argued that physicians and patients should have the right to know such information.

Your reference committee agreed with the written testimony, discussed how plans should make
pricing information more transparent, and calls for the resolution to be adopted. At the virtual
hearing, your reference committee heard testimony in support of the resolution. It was noted the
AMA has existing policy but that insurers continue to not comply with the policy
recommendations. The Reference Committee maintains the recommendation for this resolution to
be adopted.

(35) Resolution 429 – Adoption of Principles of Physician Value-Based Decisionmaking in Medical
Practice and Professionalism

RECOMMENDATION:

Mr. Speaker, your reference committee recommends that Resolution 429 be referred for study.
This resolution resolves (1) that the Texas Medical Association adopt the American Medical
Association policy Value-Based Decision-Making in the Health Care System H-450.938:

Principles to guide physician value-based decisionmaking:

1. Physicians should encourage their patients to participate in making value-based
   health care decisions.
2. Physicians should have easy access to and consider the best available evidence at the
   point of decisionmaking, to ensure that the chosen intervention is maximally
effective in reducing morbidity and mortality.
3. Physicians should have easy access to and review the best available data associated
   with costs at the point of decisionmaking. This necessitates cost data to be delivered
   in a reasonable and useable manner by third-party payers and purchasers. The cost of
   each alternate intervention, in addition to patient insurance coverage and cost-sharing
   requirements, should be evaluated.
4. Physicians can enhance value by balancing the potential benefits and costs in their
   decisionmaking related to maximizing health outcomes and quality of care for
   patients.
5. Physicians should seek opportunities to improve their information technology
   infrastructures to include new and innovative technologies, such as personal health
   records and other health information technology initiatives, to facilitate increased
   access to needed and useable evidence and information at the point of
   decisionmaking.
6. Physicians should seek opportunities to integrate prevention, including screening,
testing, and lifestyle counseling, into office visits by patients who may be at risk of
developing a preventable chronic disease later in life; and
(2) That TMA adopt policy encouraging physicians to practice value-based decisionmaking, to the best of their ability, as a core tenet of physician professionalism

Your reference committee received testimony generally agreeing with the intent of this resolution. However, one testifier suggested that TMA create Texas-specific policy on value-based decisionmaking instead of following AMA’s policy. Another testifier suggested there is limited benefit in adopting a copy of the AMA policy.

A testifier spoke for the resolution and the importance of value-based health care. The reference committee was urged to adopt formal policy encouraging physicians to practice value-based decisionmaking to the best of their ability as a core tenet of physician professionalism.

Your reference committee discussed the written testimony and how far-reaching value-based decisionmaking policies are. Given the implementation of value-based care models is specified in great detail via regulations, the reference committee concurs with testimony calling for TMA to develop its own value-based decisionmaking policy specific to Texas. At the virtual hearing, your reference committee did not hear any testimony on this resolution and calls for it to be referred for study.

(36) Resolution 430 – Paid Parental Leave (Tabled Res 418 2020)

RECOMMENDATION:

Mr. Speaker, your reference committee recommends that Resolution 430 be referred for study.

This resolution resolves that (1) that the Texas Medical Association promote awareness and education for physicians, legislators, and the public on the importance of adequate parental leave, especially paid leave, in ensuring good maternal and infant health outcomes and promoting the health and well-being of the family; (2) That TMA support federal, state, local, and private parental leave policies that provide adequate time to give birth, recover, and breastfeed, and allow for parental bonding following the birth or adoption of a child; (3) That TMA support policies that provide at least 12 weeks of paid parental leave following the birth or adoption of a child; (4) That TMA support that paid parental leave policies incorporate funding mechanisms that do not put an undue burden on solo or small business owners; and (5) That TMA evaluate how internal policies for employees should be updated to provide paid parental leave following the birth or adoption of a child.

Your reference committee received mixed testimony on this resolution.

A testifier wrote in support of the resolution and discussed the need to support mothers and fathers to maintain healthy pregnancies and postpartum periods. It was argued that without support from an employer, future parents might not be able to obtain appropriate medical care or remain socially and financially supported. Another testifier wrote in support of the resolution but commented that most statements are about mothers’ leave and health, not fully including fathers. Another testifier urged support. Another testifier urged to support it as written and liked the inclusion of the resolved clauses related to small businesses.

Testimony was also received calling for the resolution to be referred, stating large companies already have requirements, and the resolution is therefore applicable only to small businesses that
cannot shoulder this financial burden. It was argued the child tax credit in the stimulus bill should help low-income women in such situations. One testifier contended the resolution should not be adopted via the Reference Committee on Socioeconomics and instead be referred to the Reference Committee on Science and Public Health since the resolution discusses breast-feeding and infant health. Another testifier understood the need of providing 12 weeks off for parental leave but added that it is not financially feasible and would threaten the viability of small businesses.

Your reference committee discussed the mixed testimony and the merits of the resolution and understands the financial implications for small business owners. Given the potential to divide TMA members, the reference committee recommends the resolution be referred for further study. At the virtual hearing, your reference committee did not hear any testimony on this resolution and maintains the recommendation to refer it for study.

Respectfully submitted,

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