Late Items
LATE ITEMS AND POLICY ADDITIONS TO RESOLUTIONS
DISTRIBUTED AT MEETING
2019 Annual Session

At Elections Tab:
Replace Texas Medical Association Councilor Districts with Revised Texas Medical Association Councilor Districts
Replace Attachment A Related Entities with Revised Attachment A Related Entities

At Agendas Tab:
Replace Revised Order of Business with Late Business Order of Business
Replace Saturday Opening Session Agenda with Revised Saturday Opening Session Agenda

At Financial and Organizational Affairs Tab:
Replace Revised agenda with Late Business agenda
Insert PRES Report 1-A-19 after the agenda
Insert Revised Resolution 112-A-19 after Resolution 111

At Medical Education Tab:
Replace Revised agenda with Late Business agenda
Insert PRES Report 2-A-19 after Late Business agenda

At Science and Public Health Tab:
Replace agenda with Late Business Agenda

At Socioeconomics Tab:
Replace Revised agenda with Late Business Agenda
Remove Resolution 406-A-19
# AMA DELEGATION ELECTIONS

May 2019

## DELEGATES

<table>
<thead>
<tr>
<th>Delegates</th>
<th>Incumbent</th>
<th>Eligible for Reelection</th>
<th>Term (2 Years) Jan. 1-Dec. 31</th>
<th>Candidates Announced as of April 26</th>
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<tr>
<td>1</td>
<td>Diana L. Fite</td>
<td>Yes</td>
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<td>Diana L. Fite</td>
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<td>2</td>
<td>Gary W. Floyd</td>
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<td>Jayesh Shah</td>
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<td>Jayesh Shah</td>
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<td>7</td>
<td>Lyle S. Thorstenson</td>
<td>Yes</td>
<td>2020-21</td>
<td>Lyle S. Thorstenson</td>
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## ALTERNATE DELEGATES

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<th>Alternate Delegates</th>
<th>Incumbent</th>
<th>Eligible for Reelection</th>
<th>Term (2 Years) Jan. 1-Dec. 31</th>
<th>Candidates Announced as of April 26</th>
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<td>Matthew G. Brooker</td>
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<td>Bryan G. Johnson</td>
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<td></td>
<td></td>
<td></td>
<td>Ezequiel Silva III</td>
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<td>5</td>
<td>John G. Flores</td>
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<td>2020-21</td>
<td>John G. Flores</td>
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<tr>
<td>6</td>
<td>Steven R. Hays</td>
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<td>Steven R. Hays</td>
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<td>Theresa Phan*</td>
<td>Yes</td>
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<td>Faith C. Mason*</td>
<td>Yes</td>
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<td>Faith C. Mason</td>
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</tbody>
</table>

Delegates and alternate delegates serve two-year terms, Jan. 1, 2020-Dec. 31, 2021; except that the terms for alternate delegate Places 9 and 10, which are designated for a resident and medical student, are May 19, 2019-May 18, 2020.

*Nominations are made by the Resident and Fellow Section and Medical Student Section.
ATTACHMENT A

RELATED ENTITIES

Two non-profit corporations for which the TMA Board of Trustees serves as the **Board of Trustees**.

- **TEXAS MEDICAL ASSOCIATION LIBRARY dba TMA KNOWLEDGE CENTER**
  - Ervin E. and Gertrude K. Baden Trust (Baden fund)

- **TEXAS MEDICAL ASSOCIATION SPECIAL FUNDS FOUNDATION**
  - Durham Endowment
  - Durham Student Loan Fund
  - Harriet Cunningham Memorial Graduate Fellowship in Medical Writing
  - Medical Student Loan Fund
  - Harris County Medical Society Alliance Scholarship Fund
  - Overton Annual Lectureship
  - Young Physician Section Rural Student Scholarship Fund
  - TMA Minority Scholarship Program
  - Patricia Lee Palmer, MD, Memorial Resident Loan Fund
  - directed public health and educational program funds
  - History of Medicine fund
  - Texas Medical Association Alliance Student Loan Fund

Two for-profit corporations for which members of the TMA Board of Trustees serve on the **Board of Trustees**.

- **TMA PRACTICE EDGE, LLC**
  *The TMA Board of Trustees designates four of the seven Board of Managers members, two primary care physicians, a board member, and the TMA CEO.*

- **TMA PRACTICE MANAGEMENT HOLDINGS, LLC**
  *The TMA Board of Trustees selects three managers by virtue of their office-holder positions in TMA: TMA President, TMA Secretary/Treasurer, and the TMA CEO (Oversees TMASS and National PSO).*
  **TMA SPECIALTY SERVICES, LLC**
  *Governance has seven slots appointed by the Managers of Practice Management Holdings, LLC. TMA CEO is chair. The majority of managers are current or former board members.*

One unincorporated nonprofit association for which the TMA Board of Trustees is denominated as the **Board of Trustees**.

- **THE PHYSICIANS BENEVOLENT FUND**

Three trusts for which members of the TMA Board of Trustees serve as **Trustees**.

- **ANNIE LEE THOMPSON LIBRARY TRUST FUND**
- **DR. S. E. THOMPSON SCHOLARSHIP FUND**
  *Trustees of the Dr. S. E. Thompson Scholarship Fund, in addition to the members of the TMA Board of Trustees, include “Dean of the Medical Department of the University of Texas,” now assumed to be Executive Vice Chancellor, Health Affairs, UT System, a position currently held by Kenneth I. Shine, MD.*

- **MAY OWEN IRREVOCABLE TRUST**
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES
ORDER OF BUSINESS
2019 ANNUAL SESSION
May 17-18, 2019

Reference Committee Key:
Financial and Organizational Affairs = FOA
Medical Education and Health Care Quality = MEHCQ
Science and Public Health = SPH
Socioeconomics = SOCIO

REPORTS:
1. Report of President
   1. Nominations for Board of Governors, Texas Medical Liability Trust
   2. Improving the Quality Payment Program and Preserving Patient Access

2. Report of Speakers
   1. Wireless Handheld Voting/Election System

3. Reports of Board of Trustees
   1. TMA Leadership College
   2. Disclosure of Affiliations
   3. TMAIT, TMFHQI, and TMLT
   4. Pending Lawsuits Involving Texas Medical Association and Audit Trail
   5. Investments
   6. Audit of 2017 Financial Statements and 2018-19 Operating Budgets
   7. 2018-19 Board Officers and Committees
   8. Medical Student and Resident Physician Loan Funds
   9. Minority Scholarship Program
   10. Revision of Section 165.155(a) of the Texas Occupations Code, Res. 105-A-18
   11. TMA Education Center
   12. Celebration of Louis J. Goodman, PhD
   13. Compensation to Physicians for Authorizations and Preauthorizations, Res. 405-A-18
   14. Inactive County Medical Societies
   15. Sunset Policy Review

4. Report of Executive Vice President
   1. 2018-19 Update

5. Report of Interspecialty Society Committee
   1. Informational Update

6. Report of Committee on Membership
   1. Membership Development
   2. Women in Medicine Section

7. Reports of Board of Councilors
   1. Distinguished Service Award – Don R. Read, MD
   2. Opinions of the Board of Councilors
   3. County Medical Societies Constitution and Bylaws and Name Change
   4. Emeritus Nominations
   5. Honorary Nominations

REferred To:
   1. Nominations for Board of Governors, Texas Medical Liability Trust
   2. Improving the Quality Payment Program and Preserving Patient Access

Informational

FOA

MEHCQ

8. **Reports of Committee on Physician Health and Wellness**
   1. Policy Review and Amendment to Committee Charge  
   2. Sunset Policy Review

9. **Reports of Texas Delegation to the AMA**
   1. AMA House of Delegates Meetings in 2018  
   2. AMA Membership, Representation, and Delegation Leadership  
   3. Texas Delegation Operating Procedure Changes

10. **Report of International Medical Graduate Section**
    1. International Medical Graduate Section Update

11. **Report of Medical Student Section**
    1. Medical Student Section Operating Procedures Update

12. **Report of Resident and Fellow Section**
    1. Resident and Fellow Section Update

13. **Report of Young Physician Section**
    1. Young Physician Section Update

14. **Reports of Council on Constitution and Bylaws**
    1. Inactive Specialty Societies

15. **Reports of Council on Health Care Quality**
    1. Council on Health Care Quality Update


17. **Reports of Council on Health Service Organizations**
    1. Supportive Palliative Care Policy
    2. Identification Bracelets for Patients With Hearing Loss, Resolution 312-A-18
    3. Sunset Policy Review


19. **Reports of Council on Medical Education**
    1. Sunset Policy Review
    2. *Support of Expanded Eligibility for Inpatient Medicaid GME Funding to Teaching Hospitals*  
    3. Fixing the Inequity in Medicare GME Funding for Texas Teaching Hospitals Compared to Other States
    4. Study of Projected Need for More Medical Schools in Texas
    5. *Medical Students in Natural Disaster/Emergency Situations and Related Liability Coverage, Resolution 108-A-18*

20. **Reports of Committee on Continuing Education**
    1. TMA CME Program Update
    2. Sunset Policy Review
21. **Reports of Committee on Physician Distribution and Health Care Access**
   1. Improving Access to Care in Medically Underserved Areas through Project ECHO and the Child Psychiatry Access Project Model

22. **Reports of Council on Practice Management Services**
   1. Patient-Centered Medical Responsibilities, Resolution 101-A-18
   2. Improving Health Technology Products to Address the Issues of Sex and Gender
   3. Establish a Standing Committee on Health Information Technology

23. **Reports of Council on Science and Public Health**
   2. Support of Evidence-Based Medicine, Resolution 107-A-17
   3. Raising the Minimum Purchase Age for Guns, Resolution 313-A-18
   4. Early Childhood Adversity and Health
   5. Sunset Policy Review
   6. Task Force on Behavioral Health

24. **Report of Committee on Cancer**
   1. Sunset Policy Review

25. **Reports of Committee on Child and Adolescent Health**
   2. Sunset Policy Review

26. **Report of Committee on Emergency Medical Services and Trauma**
   1. EMS and Trauma Activities Update
   3. Sunset Policy Review

27. **Report of Committee on Infectious Diseases**
   1. Sunset Policy Review

28. **Report of Committee on Reproductive, Women’s, and Perinatal Health** (no report)

29. **Reports of Council on Socioeconomics**
   1. Health Plan Claim Auditing Programs
   2. Sunset Policy Review
   3. Gender Disparities in Physician Compensation
   4. Establishing the Standing Committee on Medicaid, CHIP, and the Uninsured

30. **Report of Committee on Medical Home and Primary Care**
   1. Medical Home and Primary Care Activities Update

31. **Reports of Patient-Physician Advocacy Committee**
   1. Patient-Physician Advocacy Update
   2. Sunset Policy Review

32. **Report of Committee on Rural Health**
   1. Expand Availability of Broadband Internet Access to Rural Texas
2. Rural Health Activities Update
3. Sunset Policy Review

33. Report of TEXPAC (no report)

34. Report of Texas Medical Association Insurance Trust
   1. Texas Medical Association Insurance Trust 2018 Annual Report

35. Report of Texas Medical Association Foundation
   1. TMF Health Quality Institute Annual Report

36. Report of Texas Medical Association Alliance
   1. TMA Alliance Activities and Accomplishments

37. Report of TMF Health Quality Institute
   1. TMF Health Quality Institute Annual Report

RESOLUTIONS:

REferred TO:

101. Saturday-Sunday Meeting Schedule for the Texas Medical Association
     FOA
102. Written Testimony at TMA Reference Committees
     FOA
103. Gratitude for Continuing Medical Education Courses
     FOA
104. Alternate Delegates May Address the House of Delegates
     FOA
105. Pharmacies Practicing Medicine
     FOA
106. Establish a Coalition of Medical Societies to Protect Competition and Sustainability in the Health Insurance Marketplace
     FOA
107. Physician Dispensing of Prescriptions
     FOA
108. Initial Assessment and Treatment Recommendation by Specialists
     FOA
109. Licensure Status on TMA Membership Applications
     FOA
110. Blue Cross and Blue Shield of Texas Charitable Requirements as a Not-for-Profit Corporation
     FOA
111. Opposing Legislation that Mandates Physician Discrimination
     FOA
112. Equal Pay for Equal Work
     FOA
201. Alternative Maintenance of Certification (MOC) Pathways to Comply with Antitrust Rulings
     MEHCQ
202. Clarification of Physician Protection From Maintenance of Certification (MOC) in Facility Bylaws
     MEHCQ
203. Restrictions to Requirements of Maintenance of Certification
     MEHCQ
205. Eliminating Professional and Colloquial Use of the Term “Mental Retardation” by Physicians in a Clinical Setting
     MEHCQ
206. Considerations for Care of Individuals with Autism Spectrum Disorder (ASD)
     MEHCQ
207. Increasing Access to Service Learning Opportunities in Undergraduate Medical Education
     MEHCQ
208. Integration and Maintenance of Wellness Initiatives in Texas Undergraduate and Graduate Medical Education
     MEHCQ
209. Promoting Health Insurance and Health Policy Education Prior to Residency
     MEHCQ
210. Recommendation for Hemorrhage Control Training of Healthcare Professionals
     MEHCQ
211. The Integration of LGBTQ Health Topics into Medical Education
     MEHCQ
212. Improve Physician-Hospital Relations
     MEHCQ
213. Complying with Value-Based Care Quality Measures for Medication Adherence
     MEHCQ
301. Distribution and Display of Human Trafficking Aid Information in Public Places
     SPH
302. Statement on Personhood Measures
     SPH
303. Improving Medical Clearance Policies for Traumatic Brain Injury Patients
     SPH
304. Requirement for Food Allergy Posters and Employee Training in Food Establishments
     SPH
305. Allow the Possession and Administration of an Epinephrine Auto-injector in Certain Entities
     SPH
306. Opposition to Limiting the Physician’s Role in the End-of-Life Process
     SPH
307. Regulatory Recommendations for Bed Bugs
308. Regulation of Electric Scooters
309. Factoring Adolescent Sleep Patterns into Middle and High School Start Times
310. Amending TMA Policy 315.031, Restricting the Sale of Electronic Cigarettes to Minors
311. Identifying Trauma and Mental Health Susceptibilities in Schools
312. Opposition to Increasing Work Requirements for the Supplemental Nutrition Assistance Program (SNAP)
313. Physicians Counseling Patients About the Risks of Direct-to-Consumer Genetic Testing
314. Support of Mandatory Paid Parental Leave
315. Notification of Generic Drug Manufacturing Changes
316. Determinants of Health
401. Participation in Government Programs when Receiving Payment for Uncompensated Care
402. Prescription Monitoring Program Integration Into Electronic Medical Records
403. Prior Authorization Approval
404. Medicare Part B Coverage of Vaccines
405. Lower Drug Costs
407. Compensation to Physicians for Activities Other Than Direct Patient Care
408. Managing Patient-Physician Relations Within Medicare Advantage Plans
409. Update Practice Expense Component of Relative Value Units
410. Laboratory Benefit Managers
411. Data Migration Responsibilities of Electronic Health Record Vendors in Client Contract Termination
412. Medical Necessity Tax Exemption for Feminine Hygiene Products
413. The Benefits of Importation of International Pharmaceutical Medications
414. Studying Financial Barriers of Rural Hospitals
415. Improving Buprenorphine Access for Opioid Substance Use Disorder Treatment
416. Revising the Texas Department of Insurance Division of Workers’ Compensation Designated Doctor Training and Education Process
TEXAS MEDICAL ASSOCIATION
2019 HOUSE OF DELEGATES ANNUAL SESSION

OPENING SESSION
Saturday, May 18, 8:30 am, Hilton Anatole
(The speakers may take items out of order.)

1. Call to Order
   Susan M. Strate, MD, Speaker
   Arlo F. Weltge, MD, Vice Speaker

2. Report of Reference Committee on Credentials
   Nefertiti C. Dupont, MD, Chair, Reference Committee on Credentials

3. Board of Trustees, Annual Association Finances Report
   Diana Fite, MD, Chair, Board of Trustees

4. Council on Legislation Update
   Jason Terk, MD, Chair, Council on Legislation

5. Section Awards
   Justin Bishop, MD, RFS Board of Trustees Member, Resident Fellow Section
   Sejal S. Mehta, MD, Chair, International Medical Graduates Section
   Gates Colbert, MD, Chair-Elect, Young Physician Section

6. Announcements

7. Moment of Silence for Deceased Physicians

8. Video Taped Presentation of TMA-Established Organizations
   Texas Medical Liability Trust
   Texas Medical Association Foundation
   TEXPAC

9. Initial Extractions from Reference Committee Reports

10. Elections (9:30 am)

11. Installation of TMA and TMAA Presidents (10:45 am)

12. Call for Reference Committee Reports

13. Adjourn
AGENDA
REFERENCE COMMITTEE ON FINANCIAL AND ORGANIZATIONAL AFFAIRS
Friday, May 17, 2019
Tower Lobby, Topaz - Hilton Anatole

1. TMA President Report 1 – Nominations for Board of Governors, Texas Medical Liability Trust
2. Board of Councilors Report 4 – Emeritus Nomination
3. *Board of Councilors Report 5 – Honorary Nominations*
4. Board of Councilors Report 6 – Sunset Policy Review
5. Board of Trustees Report 14 – Inactive County Medical Societies
7. Council on Constitution and Bylaws Report 1 – Inactive Specialty Societies
8. Committee on Membership Report 2 – Women in Medicine Section
9. Committee on Physician Health and Wellness Report 1 – Policy Review and Amendment to Committee Charge
15. Council on Socioeconomics Report 4 – Establishing a Standing Committee on Medicaid, CHIP, and the Uninsured
17. Texas Delegation to the AMA Report 3 – Texas Delegation Operating Procedures Changes
18. Resolution 101 - Saturday-Sunday Meeting Schedule for the Texas Medical Association
19. Resolution 102 - Written Testimony at TMA Reference Committees
20. Resolution 103 – Gratitude for Continuing Medical Education Courses
21. Resolution 104 – Alternate Delegates May Address the House of Delegates
22. Resolution 105 – Pharmacies Practicing Medicine
23. Resolution 106 – Establish a Coalition of Medical Societies to Protect Competition and Sustainability in the Health Insurance Marketplace
24. Resolution 107 – Physician Dispensing of Prescriptions
25. Resolution 108 – Initial Assessment and Treatment Recommendation by Specialists
26. Resolution 109 – Licensure Status on TMA Membership Applications
27. Resolution 110 – Blue Cross and Blue Shield of Texas Charitable Requirements as a Not-for-Profit Corporation
29. Resolution 112 – Equal Pay for Equal Work
Subject: Nominations for Board of Governors, Texas Medical Liability Trust

Presented by: Douglas W. Curran, MD, President

Referred to: Reference Committee on Financial and Organizational Affairs

The trust instrument that controls the operations of the Texas Medical Liability Trust (TMLT) requires that nominations for the Board of Governors be made by the TMLT board and submitted to the Texas Medical Association House of Delegates by the TMA president. When the house approves the nominations, they will be placed before TMLT policyholders for election.

Positions on the TMLT board are slotted.

John Holcomb, MD, will fulfill his term and board tenure at the end of 2019. The TMLT Board of Governors recommends the following nomination for one three-year term beginning in 2020:

Luis M. Benavides, MD, Laredo, family medicine, for election to Place 6.

Recommendation: Approval of Dr. Luis M. Benavides, nominee of the TMLT Board of Governors, to be placed before TMLT policyholders for election.
Texas Medical Liability Trust – 2020 Board Election Candidate

Luis M. Benavides, MD
Laredo, TX
Nomination for TMLT Board Place 6

Dr. Luis M. Benavides graduated Cum Laude from the University of Texas at Austin with a bachelor’s degree in microbiology in 1974. He then attended the University of Texas Health Science Center at San Antonio and obtained his MD in 1978.

Upon graduation, Dr. Benavides began his residency training in Family Practice at the Memorial Hospital in Corpus Christi, Texas. He completed his residency and obtained his board certification in 1982.

Along with his board certification, Dr. Benavides has certifications in Geriatric Medicine and Hospice & Palliative Medicine.

Dr. Benavides has been serving the Laredo area since 1982. He has hospital affiliations with Doctors Hospital of Laredo, Providence Hospital, Laredo Nursing & Rehab Center and Laredo Specialty Hospital.

Dr. Benavides also holds the position of medical directorship at the Regent Care Nursing Home and Nurses on Wheels Hospice.
REPORT OF BOARD OF COUNCILORS

Subject: Honorary Nominations

Presented by: Steven M. Petak, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

The Texas Medical Association Board of Councilors has approved the nominations of Richard M. Holt, MD; Wesley Stafford, MD; Jane Stafford, MD; Harris M. Hauser, MD; Milton Altschuler, MD; and John D. Milam, MD for honorary membership and recommends their election by the House of Delegates. A brief sketch follows for each member.

Richard M. Holt, MD (Travis County Medical Society)

Dr. Holt received his undergraduate education at Yale University before receiving his medical degree at The University of Texas Medical Branch at Galveston. Upon completion of his postgraduate training, Dr. Holt and his family moved to Austin, where he entered private practice in 1973. Dr. Holt has served in various leadership positions, including the Central Texas Medical Foundation Board, the Travis County Medical Society Community and Public Health Committee, the Disaster Preparedness Committee, and the Wrong Site Wrong Procedure Committee. Dr. Holt’s 44-year career has been characterized by his devotion to his profession and his patients.

Wesley Stafford, MD (Nueces County Medical Society)

Dr. Stafford received his medical degree from The University of Texas Medical Branch at Galveston. He has served as Nueces County Medical Society president, a TMA delegate, a member of the TMA Council Scientific Program, and as chair of the TMA Continuing Education committee. Dr. Stafford has written several scientific papers and publications.

Jane Stafford, MD (Nueces County Medical Society)

Dr. Stafford received her medical degree from The University of Texas Medical Branch at Galveston and her Bachelor of Arts in Biology and English from Southwestern University. She has been a member of TMA, the American Medical Association, and the Nueces County Medical Society for 30 years. Dr. Stafford served as the Nueces County Medical Society president and within the TMA House of Delegates. She is an associate medical director with a demonstrated history of working in the hospital and health care industry.

Harris M. Hauser, MD (Harris County Medical Society)

Dr. Hauser received medical degree with honors at Baylor College of Medicine. Upon completion of his postgraduate training, Dr. Hauser entered private practice in 1962 as co-founder of the Hauser Clinic in Houston. Dr. Hauser has served in numerous leadership positions, including president of the Houston Academy of Medicine, Vice President of the Harris County Medical Society, and HCMS Delegate to the TMA. He has had numerous administrative and civic appointments and many professional memberships including president of the Houston Psychiatric Society. He has been a member of the Texas Medical Association, American Medical Association and Harris County Medical Society for 63 years. Dr. Hauser has had a career of distinguished service and outstanding achievements in medicine.

Milton Altschuler, MD (Harris County Medical Society)

Dr. Altschuler received his medical degree from the University of Texas Branch at Galveston. He has served on the TMA Physicians Benevolent Fund Committee, Houston Psychiatric Society, and the Steering
Committee of the HCMS Retired Physicians Organization. He has been a member of the Texas Medical Association and Harris County Medical Society for 59 years. Dr. Altschuler has written several scientific papers and publications.

John D. Milam, MD (Harris County Medical Society)

Dr. Milam received his medical degree from the Louisiana State University School of Medicine and had a teaching appointment at the University of Texas Health Science Center at Houston. Dr. Milam has been a member of the Texas Medical Association and Harris County Medical Society for 53 years. Dr. Milam served as an HCMS alternate delegate to the TMA, HCMS Membership Committee and president of the Texas Society of Pathologists. Dr. Milam has also received several medical awards, including the George T. Caldwell Distinguished Service Award. He has written numerous scientific papers and publications.

Recommendation: Elect Richard M. Holt, MD; Wesley Stafford, MD; Jane Stafford, MD; Harris M. Hauser, MD; Milton Altschuler, MD; and John D. Milam, MD to honorary membership in TMA.
Whereas, The principle of equanimity is a firmly held virtue in the practice of medicine; and

Whereas, Inasmuch as we are called as physicians to be equitable in our approach to provision of care to our patients, we are expected to uphold this same respect for colleagues; and

Whereas, The Texas Medical Association prides itself in being at the forefront in advancements in medicine, whether scientific, political, or social; and

Whereas, TMA has a firm and clear nondiscrimination policy that guides its practices in issues of nondiscrimination based on factors including sex, ethnicity, and religion; and

Whereas, Gender pay gaps exist in a variety of settings as borne out in the literature and, in some instances, as much as a 20 percent for the equal amount of work being performed by women vs. men; and

Whereas, As Texas physicians, we understand that the way we move forward, together, as a strong and unified house, is by being united by equanimity; therefore be it

RESOLVED, That the Texas Medical Association promote the principle of equal pay for equal work, regardless of sex, ethnicity, and religious preference; and be it further

RESOLVED, That in upholding the principle of equal pay for equal work, TMA lends its strength and affirmation to the efforts underway by the American Medical Association to address this issue of inequality.

Related TMA Policy:
60.005 Equal Rights: All individuals should have access to equal social, economic, and professional opportunities (Medical Student Section, p 123, A-95; reaffirmed BOC Rep. 3-A-05; reaffirmed BOC Rep. 4-A-15).

Related AMA Policy:
D-65.989 Advancing Gender Equity in Medicine:
1. Our AMA will draft and disseminate a report detailing its positions and recommendations for gender equity in medicine, including clarifying principles for state and specialty societies, academic medical centers and other entities that employ physicians, to be submitted to the House for consideration at the 2019 Annual Meeting.

2. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral objective criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation
determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.

3. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.

4. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.

5. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.
AGENDA
REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HEALTH CARE QUALITY
Friday, May 17, 2019
Tower Lobby, Senator's Lecture Hall - Hilton Anatole

1. TMA President Report 2 – Improving the Quality Payment Program and Preserving Patient Access

2. Committee on Continuing Education Report 2 - Sunset Policy Review


4. Council on Medical Education Report 2 - Support of Expanded Eligibility for Inpatient Medicaid GME Funding to Teaching Hospitals

5. Council on Medical Education Report 3 - Fixing the Inequity in Medicare GME Funding for Texas Teaching Hospitals Compared to Other States

6. Council on Medical Education Report 4 - Study of Projected Need for More Medical Schools in Texas


9. Council on Health Service Organizations Report 1 - Supportive Palliative Care Policy


12. Committee on Physician Distribution and Health Care Access Report 1 - Improving Access to Care in Medically Underserved Areas through Project ECHO and the Child Psychiatry Access Project Model


18. Resolution 207-A-19 - Increasing Access to Service Learning Opportunities in Undergraduate Medical Education

19. Resolution 208-A-19 - Integration and Maintenance of Wellness Initiatives in Texas Undergraduate and Graduate Medical Education


22. Resolution 211-A-19 - The Integration of LGBTQ Health Topics into Medical Education


*Resolution 204 was moved to the Reference Committee on Financial and Organizational Affairs and renamed Resolution 112*
Subject: Improving the Quality Payment Program and Preserving Patient Access

Introduced by: Douglas W. Curran, MD, President

Referred to: Reference Committee on Medical Education and Health Care Quality

**Quality Payment Program**

It has been four years since the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which repealed the Sustainable Growth Rate (SGR) formula used to determine Medicare physician fee-for-service payments. In SGR’s place, MACRA requires physicians to choose between two major payment tracks that transition physicians to a value-based payment system: the Merit-Based Incentive Payment System (MIPS) and alternative payment models (APMs). These two payment tracks began in 2017 under the Quality Payment Program (QPP) framework, which the Centers for Medicare & Medicare Services (CMS) uses to implement the MIPS and APM tracks as required by law. Using this framework, physicians either participate in an advanced APM or default to the MIPS track, unless they are exempt under the low-volume threshold policy.

Simply put, the premise of the QPP is to improve the care and population health of Medicare beneficiaries, lower Medicare costs, and minimize burdens on practicing physicians. Physicians and other clinicians who participate in the APM and MIPS tracks are subject to performance measurement based on various quality, technology use, and cost metrics. Physicians can switch between the two tracks from one year to the next. Participation in the QPP requires annual quality reporting to CMS through various data collection and submission methods. Data submitted for a given performance year affect Medicare payments two years later.

It is important to note MACRA requires that MIPS be a budget-neutral program. This means bonuses are funded by practices who receive payment penalties. (Bonuses for exceptional performance come from a separate pool of funds.) This provision of the law creates winners and losers among physicians and other clinicians who participate in the APM and MIPS tracks are subject to performance measurement based on various quality, technology use, and cost metrics. Physicians can switch between the two tracks from one year to the next. Participation in the QPP requires annual quality reporting to CMS through various data collection and submission methods. Data submitted for a given performance year affect Medicare payments two years later.

Payment adjustments increase incrementally every year beginning at +/-4% in 2019 and capping at +/-9% in 2022 and beyond. Physicians and other clinicians who participate in a risk-based advanced APM receive a 5% incentive payment in addition to APM-specific rewards. The first QPP performance year was 2017, and the first payment year was 2019. Of note, the program undergoes updates through federal rulemaking every year resulting in changes to program policies, data requirements, and other rules and regulations.

**Issues**

MIPS replaced three previous CMS quality programs: Physician Quality Reporting System, Electronic Health Record Incentive Program (meaningful use), and Value-Based Payment Modifier Program. Through MIPS, CMS was supposed to create policies that would streamline data requirements and reduce reporting burdens. However, those hoped-for improvements did not materialize. Other than inflicting
smaller payment penalties, MIPS after three years has not proven to be any better than the programs it replaced.

TMA analysis shows that for practices with a low volume of Medicare payments, compliance costs may exceed any likely financial return on investment through incentives and avoided penalties. Further, much of the clinical quality and cost metrics that physicians are scored on is not in physician control. Factors not in physician control often are not evenly distributed in the population, resulting in physicians being penalized if they serve disproportionate numbers of disadvantaged or high-risk patient populations. MACRA requires that CMS, based on individuals’ health status and other risk factors, assess and implement appropriate adjustments. But after three years, the agency has not yet proposed any methodology for properly risk adjusting MIPS cost and quality measures, resulting in inadequate and/or unfair scoring methodologies. These issues may have the unintended consequence of physicians deciding not to treat certain patients.

TMA disagrees with MIPS’ one-size-fits-all approach. CMS has recognized this in past proposed rules, where it stated, “[W]e recognize that individual MIPS-eligible clinicians and groups that are small practices or practicing in designated rural areas face unique dynamics and challenges such as fiscal limitations and workforce shortages, but serve as a critical access point for care and provide a safety net for vulnerable patient populations.” Additionally, CMS has acknowledged concerns in its past proposed rules that “physicians in these practices tend to have patient populations with a higher proportion of older adults, as well as higher rates of poor health outcomes, co-morbidities, chronic conditions, and other social risk factors, which can result in the costs of providing care and services being significantly higher, compared to physicians in other areas.” CMS also has noted that “physicians may be disproportionately more susceptible to lower performance scores across all performance categories and negative MIPS payments adjustments, and as a result, such outcomes may further strain already limited resources and workforce shortages, and negatively impact access to care (reduction and/or elimination of available services).”

Moreover, because small practices are the most adversely affected by the negative cost/benefit relationship, TMA has had longstanding concerns that the budget neutrality requirement would result in a shift of Medicare payments away from small, often rural, physician practices to large, mostly urban, physician organizations and health care systems. This creates financial incentives for a massive restructuring of ambulatory care delivery systems, potentially eliminating many small practices that currently comprise 73% of physician practices in Texas per the TMA 2018 Survey of Texas Physicians (small groups defined as eight physicians or less).

It is clear that through the enactment of MACRA, Congress did not intend to penalize physicians who care for large numbers of disadvantaged or high-risk Medicare patient populations, who provide care in rural areas, or who choose to practice as solo practitioners or in small groups, but the current QPP creates incentives for physicians not to serve certain patients and not to locate their practices in areas where poverty or other specific characteristics are prevalent. For these reasons, TMA continues to advocate for improvements and a fair program for all physicians.

Low-Volume Threshold
MACRA requires the secretary of health and human services (HHS) to select the low-volume threshold(s) for CMS to use in defining MIPS-eligible clinicians. The law also outlines criteria CMS may use to exclude clinicians from mandatory participation. They include one or more of the following: (1) the minimum amount of Medicare Part-B allowed charges, (2) the minimum number of Medicare Part B-enrolled individuals seen, and (3) the minimum number of items and services furnished to Medicare Part B-enrolled individuals.
Prior to the first QPP performance year, TMA advocated for a low-volume threshold high enough to alleviate the threat to practice viability, particularly for small and rural practices, and to preserve patient access. The low-volume threshold policy in 2017 exempted physicians who submitted Medicare charges of less than $30,000 or saw fewer than 100 Medicare patients, but this was not sufficient for TMA. For the 2018 performance year, TMA and other medical societies around the country advocated for an even higher threshold. This advocacy resulted in an increase to $90,000 or 200 patients. For the 2019 performance year, the low-volume threshold policy changed once again because of continued advocacy and as a result of the Bipartisan Budget Act of 2018. To be excluded from MIPS in 2019, physicians and other clinicians need to meet one or more of the following three criteria.

1. Have ≤ $90,000 in Medicare Part B allowed charges for covered professional services,
2. Provide care to ≤ 200 Medicare Part B-enrolled beneficiaries, OR
3. Provide ≤ 200 covered professional services under the Medicare Physician Fee Schedule (new criterion).

The new criterion for the 2019 performance year simply allows clinicians who otherwise would have been exempt the opportunity to opt in, voluntarily report, or not report at all. Physicians who “opt in” receive a MIPS payment adjustment, and physicians who “voluntarily” report do not. TMA supported these policy changes during the last rulemaking cycle because the association supports physician choice. However, while the low-volume threshold policy decreases the percentage of physicians in small practices who have to participate in the program, it does not exempt all physicians who continue to face administrative, technological, and financial challenges. Recognizing these ongoing challenges, TMA remains vigilant in keeping the low-volume threshold policy in place while advocating for continued improvements and simplification of the program, and recommending that participation in the QPP be completely voluntary.

Some national organizations are calling on Congress, HHS, and CMS to reduce or eliminate the low-volume threshold policy because, under budget neutrality, it reduces the amount of incentive payments available. While TMA acknowledges this issue, the association maintains that even if the threshold criteria were reduced or eliminated, which would require more clinicians to participate and also boost incentive payments under budget neutrality, the current MIPS program would continue to harm small and rural practices, and many physician practices would continue to see no return on investment. TMA supports the current opt-in and voluntary participation options for practices that want to participate in MIPS, but the association strongly opposes reducing or eliminating the low-volume threshold. The solution is not to further harm small and rural practices but to make the program more clinically relevant and administratively easier to participate in. Budget neutrality in MIPS must be reformed not only to protect small and rural practices but also to provide an appropriate return on the significant investments many physicians have made to meet program compliance. For these reasons, TMA should advocate for Congress to eliminate budget neutrality and to finance payment incentives from supplemental funds that do not come from Medicare Part B payment cuts to physicians and other clinicians.

QPP Experience Report
Given that CMS had published experience reports for past quality programs two years after each performance year, TMA had been anticipating the complete publication of the 2017 QPP Experience Report since the beginning of 2019 to evaluate the first-year outcomes of budget neutrality and the overall program. On March 21, 2019, CMS published the 2017 QPP Experience Report with an accompanying appendix purportedly to provide a full account of clinicians’ experience, as well as to illustrate the successes and challenges in 2017. However, across the 30-page report and appendix, TMA found a lack of clarity for several data elements, numerous holes in CMS’ assessment and evaluation of the 2017 QPP, alarming results for physician practices in our state, and potentially flawed data. Analyses by staff experts
led TMA to question the overall accuracy of the report. If left unchallenged, CMS could use the report to serve as the basis for undermining the low-volume threshold and other policies that protect physicians in small and rural practices from Medicare payment cuts in coming years.

National results showed that while some clinicians achieved full or partial qualifying APM participant status in advanced APMs (99,128), an overwhelming majority of clinicians participated in MIPS (1,006,319), either directly or as part of a MIPS APM. Because the overall performance target was set low, at three points out of 100 points in 2017, the maximum bonus to Medicare Part B payments this year is 1.88%, and the maximum payment penalty is 4%. Overall, CMS reported a 95% participation rate. Among those who participated, 71% of practices earned a positive payment adjustment and a bonus for exceptional performance, 22% earned a positive payment adjustment only, 2% received a neutral payment adjustment (no change in payment), whereas, 5% received a negative payment adjustment for nonparticipation. However, while the bonus may appear like an incentive, TMA asserts that the ongoing 2% Medicare sequestration effectively erases it.

TMA questions CMS’ claim of a 95% overall participation rate in the QPP, noting that the report showed even higher rates in Texas and several other states where large portions of the physician workforce were exempted from reporting because of natural disasters like Hurricane Harvey. Regardless, this percentage reflects the number of clinicians who simply reported the minimum amount of data or were exempt under the Extreme and Uncontrollable Circumstances Policy. The true measure of success for “overall participation” would have been the percentage of clinicians who met full data requirements across all MIPS categories, but CMS did not report that percentage.

<table>
<thead>
<tr>
<th>State</th>
<th>Eligible Clinicians</th>
<th>Participated</th>
<th>Participation Rate %</th>
<th>Participated as Individual</th>
<th>Participated as Group</th>
<th>Participated in MIPS APM</th>
<th>Did Not Participate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas</td>
<td>62,731</td>
<td>63,901</td>
<td>97.08%</td>
<td>12,142</td>
<td>32,684</td>
<td>16,072</td>
<td>1,830</td>
</tr>
<tr>
<td>National Total</td>
<td>1,057,824</td>
<td>1,006,319</td>
<td>95.13%</td>
<td>122,897</td>
<td>542,200</td>
<td>341,221</td>
<td>51,505</td>
</tr>
</tbody>
</table>

*Number of MIPS-eligible clinicians who did not participate in the 2017 QPP and are receiving a 4% negative payment adjustment (penalty) in 2019. Source: 2017 Quality Payment Program Experience Report – Appendix

CMS Administrator Seema Verma stated that 2017 data “show significant success in the QPP.” However, when data are further broken down by practice designation, performance results show a different picture, even though CMS’ low-volume threshold policy exempted many physicians in small practices in 2017. Mean and median final scores for physicians and other clinicians who submitted data at the individual level, including physicians in solo practice, were lower than for group practices, and scores for small and rural practices were significantly lower than for large practices and MIPS APM participants. Most notably, among all practices, small practices fared the worst.

<table>
<thead>
<tr>
<th>Practice Designation</th>
<th>Small Practices (1-15 clinicians)</th>
<th>Small and Rural Practices</th>
<th>Rural Practices</th>
<th>Large Practices (16 or more clinicians)</th>
<th>MIPS APMs (e.g., ACOs)</th>
<th>2017 MIPS Overall National Total*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>43.46</td>
<td>44.66</td>
<td>63.08</td>
<td>74.37</td>
<td>87.64</td>
<td>74.01</td>
</tr>
<tr>
<td>Median</td>
<td>37.87</td>
<td>42.00</td>
<td>75.29</td>
<td>90.29</td>
<td>91.76</td>
<td>88.97</td>
</tr>
</tbody>
</table>

*For the 2022 QPP performance year and future years, CMS will set the overall performance target (number of points needed to avoid a 9% payment penalty) at either the national mean or median of the final scores for all MIPS-eligible clinicians from a prior performance period. 
Sources: 2017 Quality Payment Program Experience Report and 2017 Quality Payment Program Performance Year Data At-A-Glance
State results showed that of the 62,731 MIPS-eligible clinicians in Texas, 44,829 participated directly in MIPS and 16,072 participated in MIPS through a MIPS APM, while 1,830 did not participate at all. CMS did not provide the number of Texas clinicians who took part in an advanced APM or the number of Texas clinicians who were exempt from participation. TMA was unable to assess how Texas physicians fared compared with the rest of the nation because CMS provided limited state data. More alarming, TMA found harm to small and rural practices as evidenced by the fact that the majority of clinicians who are actively receiving the 4% payment penalty this year and funding the MIPS incentive payment for the rest of the country are from small and rural practices nationwide and in our state. Questionable, misleading, and incomplete data, along with selection bias, lack of meaningful clinical data, poor electronic health record participation, Medicare payment shift, limited to no return on investment, no data insights on vendors, and an inaccurate definition of physician are among the numerous flaws and/or troubling results found in TMA’s analysis of the 2017 QPP Experience Report. Frankly, it is disturbing that CMS had conducted such poor analyses and evaluation of the first year of MACRA implementation and did so without any regard to the serious threat the payment penalties pose to physician practices or to the potential harm to continued physician participation in Medicare and access to care. As the QPP evolves over time and as the program becomes more complex with more rigorous, yet flawed, performance measurement methodologies that do not account for factors out of physician control, TMA foresees future outcomes in which potentially thousands of Texas physician practices receive the 9% payment penalty every year.

Conclusion

After TMA’s analysis, the association led a call to action among the Coalition of State Medical Societies, and on April 25, 2019, TMA spearheaded a sign-on letter to HHS Secretary Alex M. Azar II and CMS Administrator Verma. Joining TMA on the letter were the medical societies of California, Florida, Louisiana, New York, North Carolina, Oklahoma, and South Carolina. The letter, which was also circulated to Congress and the American Medical Association, called on CMS “to rescind the report; establish a transparent approach to your analysis and reporting; and issue a revised, unbiased, and complete report that truly captures the full breadth of the 2017 QPP.” The letter further urged HHS and CMS not to use the report as the basis for future QPP changes that could harm physicians’ practices. The complete letter can be found in the TMA MACRA Resource Center at www.texmed.org/MACRA.

Recommendation 1: That the Texas Medical Association strongly advocate for Congress to make participation in the Merit-Based Incentive Payment System and alternative payment models under the Quality Payment Program completely voluntary.

Recommendation 2: That TMA strongly advocate for Congress to eliminate budget neutrality in the Merit-Based Incentive Payment System and to finance incentive payments with supplemental funds that do not come from Medicare Part B payment cuts to physicians and other clinicians.

Recommendation 3: That TMA call on the Centers for Medicare & Medicaid Services to provide a transparent, accurate, and complete Quality Payment Program Experience Report on an annual basis so the association can analyze the data to advocate for additional exemptions; flexibilities; and reductions in reporting burdens, administrative hassles, and costs.

Recommendation 4: That TMA establish formal policy that the Centers for Medicare & Medicaid Services increase the low-volume threshold for the 2020 Quality Payment Program and future years of the program for all physicians but continue to offer them the opportunity to opt in or voluntarily report.

Recommendation 5: That TMA establish formal policy that the Centers for Medicare & Medicaid Services preserve patient access by exempting small practices (one to 15 clinicians) from required
participation in the Merit-Based Incentive Payment System but continue to offer them the opportunity to opt in or voluntarily report.

**Recommendation 6:** That the Texas Delegation to the American Medical Association ask the AMA House of Delegates to adopt similar policy and calls to action.

**Related TMA Policies:**

195.033 Medicare Payment Incentives and Penalties: The Texas Medical Association advocates that any Medicare penalty or incentive program including the Value-Based Payment Modifier program and the Merit-Based Incentive Payment System be designed so that: (1) the measures and standards used do not result in financial penalties for physicians when their patients do not comply with orders or recommendations for testing and treatment; (2) physicians are not penalized for providing services to disadvantaged patients; (3) physicians are not penalized for noncompliance with obsolete or superseded guidelines and standards; and (4) both cost and quality measures are adequately risk adjusted to eliminate the effects of poverty, poor educational attainment, and cultural differences from the measures used to adjust payment. Until all of the above are implemented, Medicare payments should not be adjusted using these measures (CSE Rep. 2-A-12; amended CSE Rep. 6-A-17).

265.017 Pay-for-Performance Principles and Guidelines: Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the American Medical Association Guidelines for Pay-for-Performance Programs and the following five American Medical Association Principles for Pay-for-Performance Programs:

1. Ensure quality of care. Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality-of-care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician’s sound clinical judgment and should not adversely affect PFP program rewards.

2. Foster the patient-physician relationship. Fair and ethical PFP programs support the patient-physician relationship and overcome obstacles to physicians treating patients, regardless of patients’ health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.

3. Offer voluntary physician participation. Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of nonparticipating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.

4. Use accurate data and fair reporting. Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment, and appeal results prior to the use of the results for programmatic reasons and any type of reporting.

5. Provide fair and equitable program incentives. Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

Guidelines for Pay-for-Performance Programs
Safe, effective, and affordable health care for all Americans is the American Medical Association’s goal for our health care delivery system. AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment AMA’s Principles for Pay-for-Performance Programs and provide AMA leaders, staff, and members operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.
- Evidence-based quality-of-care measures must be the primary measures used in any program.

1. All performance measures used in the program must be defined prospectively and developed collaboratively across physician specialties.
2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
4. Performance measures should be scored against both absolute values and relative improvement in those values.
5. Performance measures must be subject to the best available risk adjustment for patient demographics, severity of illness, and comorbidities.
6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
7. Performance measures must be selected for clinical areas that have significant promise for improvement.

- Physician adherence to PFP program requirements must conform with improved patient care, quality, and safety.
- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.
- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing also should analyze for patient deselection. If implemented, the program must be phased in over an appropriate period of time to enable participation by any willing physician in affected specialties.
- Plans that sponsor PFP programs must explain these programs prospectively to the patients and communities covered by them.

Patient-Physician Relationship

- Programs must be designed to support the patient-physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not cause conditions that limit access to improved care.
1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socioeconomic groups, as well as those with specific medical conditions, or the physicians who serve these patients.

2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).

- Programs must neither directly nor indirectly encourage patient deselection.
- Programs must recognize outcome limitations caused by patient nonadherence, and sponsors of PFP programs should attempt to minimize noncompliance through plan design.

Physician Participation

- Physician participation in any PFP program must be completely voluntary.
- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.
- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
- Programs should be available to any physicians and specialties wishing to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.
- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).

1. Programs should provide physicians tools to facilitate participation.
2. Programs should be designed to minimize financial and technological barriers to physician participation.

- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act.
- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not cause financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a nonpunitive manner.
1. Programs should use accurate administrative data and data abstracted from medical records.
2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.
3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.

- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.
- Physicians should be assessed in groups and/or across health care systems, rather than individually when feasible.
- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.

1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.
2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.
- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.
- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards

- Programs must be based on rewards and not on penalties.
- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.
- Programs must offer financial support to physician practices that implement IT systems or software that interacts with aspects of the PFP program.
- Programs must finance bonus payments based on specified performance measures with supplemental funds.
- Programs must reward all physicians who actively participate in the program and who achieve prespecified absolute program goals or demonstrate prespecified relative improvement toward program goals.
- Programs must not reward physicians based on ranking compared with other physicians in the program.
- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.
- Programs must not penalize physicians financially based on factors outside of the physician’s control.
- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.
• Programs must not penalize physicians financially when they follow current, accepted clinical
guidelines that are different from measures adopted by payers, especially when measures have not
been updated to meet currently accepted guidelines.

TMA opposes private payer, congressional, or Centers for Medicare & Medicaid Services pay-for-
performance initiatives if they do not meet the AMA’s Principles and Guidelines for Pay for Performance

Related AMA Policies:

H-390.837 MACRA and the Independent Practice of Medicine: 1. Our AMA, in the interest of
patients and physicians, encourages the Centers for Medicare and Medicaid Services and Congress to
revise the Merit-Based Incentive Payment System to a simplified quality and payment system with
significant input from practicing physicians, that focuses on easing regulatory burden on physicians,
allowing physicians to focus on quality patient care. 2. Our AMA will advocate for appropriate scoring
adjustments for physicians treating high-risk beneficiaries in the MACRA program. 3. Our AMA will
urge CMS to continue studying whether MACRA creates a disincentive for physicians to provide care to
sicker Medicare patients (Alt. Res. 206, A-17; Reaffirmed: BOT Action in response to referred for
decision: Res. 237, I-17).

H-390.838 MIPS and MACRA Exemption: Our AMA will advocate for an exemption from the Merit-
Based Incentive Payment System (MIPS) and Medicare Access and CHIP Reauthorization Act of 2015
(MACRA) for small practices (Res. 208, I-16 Reaffirmation: A-17 Reaffirmation: I-17 Reaffirmation: A-
18).

D-390.949 Preserving Patient Access to Small Practices Under MACRA: 1. Our AMA will urge the
Centers for Medicare and Medicaid Services to protect access to care by significantly increasing the low
volume threshold to expand the MACRA MIPS exemptions for small practices (on a voluntary basis), and
to further reduce the MACRA requirements for ALL physicians' practices to provide additional
flexibility, reduce the reporting burdens and administrative hassles and costs. 2. Our AMA will advocate
for additional exemptions or flexibilities for physicians who practice in health professional shortage areas.
3. Our AMA will determine if there are other fragile practices that are threatened by MACRA and seek
additional exemptions or flexibilities for those practices (Res. 243, A-16; Reaffirmation: I-17;

D-390.950 Preserving a Period of Stability in Implementation of the Medicare Access and
Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA): 1. Our AMA will
advocate that Centers for Medicare and Medicaid Services (CMS) implement the Merit-Based Payment
Incentive Payment System (MIPS) and Alternative Payment Models (APMs) as is consistent with
congressional intent when the Medicare Access and Children's Health Insurance Program (CHIP)
Reauthorization Act (MACRA) was enacted. 2. Our AMA will advocate that CMS provide for a stable
transition period for the implementation of MACRA, which includes assurances that CMS has conducted
appropriate testing, including physicians' ability to participate and validation of accuracy of scores or
ratings, and has necessary resources to implement provisions regarding MIPS and APMs. 3. Our AMA
will advocate that CMS provide for a stable transition period for the implementation of MACRA that
includes a suitable reporting period (Res. 242, A-16).

D-395.999 Reducing MIPS Reporting Burden: Our AMA will work with the Centers for Medicare and
Medicaid Services (CMS) to advocate for improvements to Merit-Based Incentive Payment System
(MIPS) that have significant input from practicing physicians and reduce regulatory and paperwork
burdens on physicians. In the interim, our AMA will work with CMS to shorten the yearly MIPS data reporting period from one-year to a minimum of 90-days (of the physician’s choosing) within the calendar year (Res. 236, A-18).

**H-390.849 Physician Payment Reform:** 1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles: a) promote improved patient access to high-quality, cost-effective care; b) be designed with input from the physician community; c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions; d) not require budget neutrality within Medicare Part B; e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice; f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process; g) make participation options available for varying practice sizes, patient mixes, specialties, and locales; h) use adequate risk adjustment methodologies; i) incorporate incentives large enough to merit additional investments by physicians; j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols; k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization; l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services. 2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients. 3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data. 4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives. 5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment (CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12; Modified: CMS Rep. 6, A-13; Reaffirmation I-15; Reaffirmation: A-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17).

**Sources:**


Resolution 108-A-18, Inclusion of Medical Students in Good Samaritan Laws and Policies for Disaster Settings (Medical Student Section) was adopted as amended by the house as follows:

That TMA: (1) support medical students volunteering inside of their institutional affiliations during times of disaster and emergency, due to both the need for and the competency of medical students, as demonstrated by previous research and disaster situations; and (2) study the involvement of medical students in natural disaster and emergency situations in order to develop TMA policy regarding medical student roles in disaster situations.

The council was asked to address the second part of Resolution 108-A-18.

Framing the Council’s Study
The council reached out to the author of the resolution to inquire about the motivation and goals in order to frame the council’s study of the issues. This resolution was drafted following medical student experiences in volunteer activities as part of the disaster response to Hurricane Harvey in Houston in 2017. From this discussion, the council identified two primary goals:

1. Scope of Medical Student Competencies in Volunteer Work
   - A. The resolution, as originally written, sought support for allowing students to volunteer in disaster response activities that do not require supervision by faculty members from their respective schools due to “both the need for and the competency of medical students.”
   - B. The resolution identified concerns that medical student education had not been recognized in their role as volunteers. For example, the resolution notes that medical students have the competency to perform triage activities but have not been utilized in this way.

2. Professional Liability Coverage/Indemnification for Medical Students During Volunteer Work/Emergency Response
The resolution seeks TMA’s support for applying the Good Samaritan Law to medical students as unlicensed providers of care in emergency settings.

The Council’s Study
The council focused its study on the resolution’s two primary goals, as summarized below:

Goal #1: Scope of Medical Student Competencies in Volunteer Work. There was broad consensus that medical students have the potential for serving in a highly valued role in volunteer work. TMA Policy 200.055, Maximizing Participation of Medical Students in Natural Disaster and Emergency Situations, adopted by the house in 2018, supports medical student volunteering inside their institutional affiliations during times of disaster and emergency. Students’ altruistic nature, empathy, and high energy often
motivate them to help others in times of great need. Whether that role should involve medical care such as triage activities, however, was not supported by others.

The council reached out to several physicians for their perspectives on the appropriate role of medical students in a disaster/emergency response. This included a physician who has overseen five post-hurricane relief operations in the state, including Harvey in 2017. In addition, a medical school and several faculty members at various academic health centers were consulted. When asked about the ability of medical students to perform triage activities, none of the physicians were of the opinion that medical students have the competencies to function in this role. There could be exceptions, such as students who are also certified paramedics. In that case, however, they would be acting in their role as a certified paramedic and not as a medical student.

The following comment was provided by a Texas medical school:

It is [the medical school’s] view that generally medical students prior to 4th year would not have the demonstrated competency to provide medical services in a disaster since competency of medical students isn’t measured until after completion of the third year of medical school. Proper supervision is critical and medical students of any year should not be authorized to practice independently or supervised by physicians who are not faculty members within their institution, even in a disaster.

There was broad agreement, however, that medical students can perform many other needed and important volunteer activities that do not involve medical care. For example, medical students were highly effective in assisting with credentialing and orienting new volunteer physicians as part of the post-Harvey response in Dallas in 2017. Medical students could also seek other important leadership roles within organizations such as the American Red Cross, Medical Reserve Corps, or other key organizations that provide disaster response. These activities not only nurture altruism but also can provide greater exposure and enriching learning opportunities outside of medical school.

Texas academic health centers and medical schools in particular are encouraged to promote awareness among their students of the state’s centralized volunteer registry for disaster or public health emergency response efforts (www.texasdisastervolunteerregistry.org). Students can select their preferred responder organizations through this online process. The registry is maintained by the Texas Department of State Health Services but is used by local responder organizations as a volunteer registration and management tool. This program is designed to match a volunteer’s skills and abilities with the needs of particular emergency situations.

**Goal #2: Professional Liability Coverage/Indemnification for Medical Students During Volunteer Work/Emergency Response.** Legal officials from a prominent state university system provided information to the council about the status of professional liability coverage for medical students, confirming that medical schools provide this coverage through their self-insured plans. This coverage, however, is limited to certain settings and does not follow medical students outside of their roles as students. This means activities overseen by the medical schools, including volunteer work at student-run health clinics must be supervised by a medical school faculty member of the respective school in order to retain liability coverage. The coverage does not extend to activities that are not supervised by medical school faculty.

Further, based on input from various sources, including the TMA Office of the General Counsel, the state’s Good Samaritan Law does not apply to disaster response and is therefore not applicable to students volunteering in disaster response programs.
Medical students who provide aid in emergency situations as Good Samaritans, such as a car accident, would be indemnified by the provisions of the Good Samaritan law, the same as anyone else. This applies to “emergency services provided after the sudden onset of a medical or traumatic condition manifesting itself by acute symptoms of sufficient severity.”

The state’s Charitable Immunity and Liability law establishes indemnity for volunteer services by “direct service volunteers” to charitable organizations that are tax exempt under Section 501(c)(3) or (4) of the IRS Code of 1986 and meet certain other criteria. This provision includes medical students who volunteer to provide nonmedical care services with charitable organizations. This law also provides indemnity for “volunteer health care providers” at charitable organizations, which is defined to include physicians but not medical students.

It is important to note, however, that the scope of the services provided by medical students will dictate whether indemnification should be of concern. If a medical student is performing in a volunteer role that does not involve medical care or an activity that is supervised by a faculty member from their respective medical schools, then new state laws are not needed to encompass medical student liability, as suggested by Res. 108. Because of the lack of general support for medical students to be involved in volunteer roles that include medical care, there are not sufficient grounds for TMA to adopt new policy positions in support of indemnification of liability for medical students in volunteer roles.

In conclusion, the council applauds the strong interest of medical students to be extensively involved in volunteer activities in response to natural disaster and emergency situations. Students are encouraged to continue seeking opportunities that are a good match for their skills and interests.

**Recommendation:** Adoption of amended TMA Policy 200.055, Maximizing Participation of Medical Students in Natural Disaster and Emergency Situations, as follows:

The Texas Medical Association: (1) supports medical students volunteering inside of their institutional affiliations during times of disaster and emergency, due to both the need for and the competency of medical students, as demonstrated by previous research and disaster situations; (2) recognizes that medical students often possess the altruistic attributes that are of great benefit during critical times following natural or man-made disasters, catastrophic events, or public health crises. Students are encouraged to pursue their interests and actively participate as fully as their schedules will allow in volunteer activities that best utilize these attributes. TMA encourages participation by medical students in official responder organizations, such as the American Red Cross or Medical Reserve Corps; and (3) encourages academic health centers, and medical schools in particular, to promote awareness among their students of the Texas Department of State Health Services’ online centralized volunteer registry for disaster or public health emergency response efforts. This registry is an effective way to maximize the unique skills possessed by medical students for engaging in organized activities of the state’s responder organizations for disaster or public health emergencies.
AGENDA
REFERENCE COMMITTEE ON SCIENCE AND PUBLIC HEALTH
Friday, May 17, 2019
Tower Lobby, Governor's Lecture Hall - Hilton Anatole


5. Committee on Emergency Medical Services and Trauma Report 3 – Sunset Policy Review

6. Committee on Infectious Diseases Report 1 – Sunset Policy Review

7. Council on Practice Management Services Report 2 – Improving Health Technology Products to Address the Issues of Sex and Gender


13. Resolution 301 - Distribution and Display of Human Trafficking Aid Information in Public Places

14. Resolution 302 - Statement on Personhood Measures

15. Resolution 303 - Improving Medical Clearance Policies for Traumatic Brain Injury Patients

16. Resolution 304 - Requirement for Food Allergy Posters and Employee Training in Food Establishments

17. Resolution 305 - Allow the Possession and Administration of an Epinephrine Auto-injector in Certain Entities

18. Resolution 306 - Opposition to Limiting the Physician’s Role in the End-of-Life Process

19. Resolution 307 - Regulatory Recommendations for Bed Bugs

20. Resolution 308 - Regulation of Electric Scooters

21. Resolution 309 - Factoring Adolescent Sleep Patterns into Middle and High School Start Times
22. **Resolution 310** - Amending TMA Policy 315.031, Restricting the Sale of Electronic Cigarettes to Minors

23. **Resolution 311** - Identifying Trauma and Mental Health Susceptibilities in Schools

24. **Resolution 312** - Opposition to Increasing Work Requirements for the Supplemental Nutrition Assistance Program (SNAP)

25. **Resolution 313** - Physicians Counseling Patients About the Risks of Direct-to-Consumer Genetic Testing

26. **Resolution 314** - Support of Mandatory Paid Parental Leave

27. **Resolution 315** - Notification of Generic Drug Manufacturing Changes

28. **Resolution 316** – Determinants of Health
REPORT OF COMMITTEE ON EMERGENCY MEDICAL SERVICES AND TRAUMA

CM-EMST Report 3-A-19

Subject: Sunset Policy Review

Presented by: Veer Vithalani, MD, Chair

Referred to: Reference Committee on Science and Public Health

The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The committee recommends retaining Policy 100.013.

100.013 Trauma Funding: The Texas Medical Association supports the Texas Department of State Health Services’ efforts to secure a permanent funding source for state funding of emergency medical services and trauma (CM-EMS Rep. 1-I-98; reaffirmed CPH Rep. 2-A-09).

Recommendation 1: Retain.

The committee recommends deletion of the following policies:

205.029 Hurricane Ike and The University of Texas Medical Branch: The Texas Medical Association adopted the following set of principles relating to regional Hurricane Ike recovery issues and The University of Texas Medical Branch at Galveston:

Address a regional crisis regarding access to critical care, with the immediate establishment of a third Level 1 or 2 trauma center, or expansion of existing centers and supporting infrastructure (ICUs, inpatient beds, and the like) for adults and children in the Houston/Galveston/Beaumont area).

Use of emergency state appropriation to establish or expand the above-mentioned centers.

Apply existing trauma care funds, currently in the treasury, or regional tax for the sustainability of at least three Level 1 or 2 trauma centers in the region.

Adequately fund care for the uninsured patients who arrive from other counties. Use state and/or federal funding and/or mandatory uninsured compensation from the counties of residence.

The University of Texas Medical Branch (UTMB) can continue providing these services as part of its mission with state funding, or

Each county can contract with hospitals and physicians or establish hospital districts to obtain these services.

Provide adequate funding and resource capacity, either at UTMB or other facilities, for the care of:
Correctional patients (Texas Department of Criminal Justice)

Burn patients, both pediatric and adult

Mental health/substance abuse patients

Primary and preventive care patients

Chronic disease management patients

The Federal Emergency Management Agency provide 100-percent reimbursement for UTMB recovery costs, as was done for post-Katrina New Orleans.

Promote cost effective care of displaced patients and ensure reimbursement for medical schools/hospitals for costs incurred for medical students and residents transferred from UTMB (Res. 301-A-09).

**Recommendation 2**: Delete.
AGENDA
REFERENCE COMMITTEE ON SOCIOECONOMICS
Friday, May 17, 2019
Tower Lobby, Sapphire Room - Hilton Anatole

1. Committee on Rural Health Report 1 – Expand Availability of Broadband Internet Access to Rural Texas
2. Committee on Rural Health Report 3 – Sunset Policy Review
3. Council on Socioeconomics Report 1 – Health Plan Claim Auditing Programs
5. Resolution 401 - Participation in Government Programs when Receiving Payment for Uncompensated Care
6. Resolution 402 - Prescription Monitoring Program Integration Into Electronic Medical Records
7. Resolution 403 - Prior Authorization Approval
8. Resolution 404 - Medicare Part B Coverage of Vaccines
9. Resolution 405 – Lower Drug Costs
10. Resolution 407 - Compensation to Physicians for Activities Other Than Direct Patient Care
11. Resolution 408 - Managing Patient-Physician Relations Within Medicare Advantage Plans
12. Resolution 409 - Update Practice Expense Component of Relative Value Units
13. Resolution 410 – Laboratory Benefit Managers
14. Resolution 411 - Data Migration Responsibilities of Electronic Health Record Vendors in Client Contract Termination
15. Resolution 412 - Medical Necessity Tax Exemption for Feminine Hygiene Products
16. Resolution 413 - The Benefits of Importation of International Pharmaceutical Medications
17. Resolution 414 - Studying Financial Barriers of Rural Hospitals
18. Resolution 415 - Improving Buprenorphine Access for Opioid Substance Use Disorder Treatment
19. Resolution 416 – Revising the Texas Department of Insurance Division of Worker’s Compensation Designated Doctor Training and Education Process

*Resolution 406 was moved to the Reference Committee on Financial and Organizational Affairs and renamed Resolution 112
The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The committee recommends retaining Policy 100.016.

**100.016 Texas Department of State Health Services Emergency Medical Services Local Projects Grant Program:** The Texas Medical Association supports the DSHS EMS Local Projects Grant program which provides emergency medical services education, training and equipment to rural and frontier areas of Texas (CM-EMS Rep. 2-A-99; reaffirmed CPH Rep. 2-A-09).

**Recommendation:** Retain.