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It has been four years since the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which repealed the Sustainable Growth Rate (SGR) formula used to determine Medicare physician fee-for-service payments.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.

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

Late Business

REPORT OF TMA PRESIDENT

PRES Report 2-A-19

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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 are required to participate in the QPP, but choose not to, face an automatic negative adjustment (penalty) to their Medicare Part B payments that stands for an entire calendar year. Those who do participate, however, may receive a positive (bonus), neutral (no change in payment), or negative payment adjustment depending on how they score on the MIPS 0-100-point scale relevant to that year’s performance target. 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.

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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>62,901</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>
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*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.
- 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.

1. 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.

2. 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.

3. 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.

4. 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:


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

The committee recommends retention of the following policy:


Recommendation: Retain.
Subject: Sunset Policy Review

Presented by: Ronald L. Cook, DO, Chair

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

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

The council recommends retaining Policy 185.018 and Policy 200.031.

185.018 Mitigating the Texas Physician Shortage: To keep pace with the state’s vigorous population growth, Texas needs significant increases in physician numbers, as well as maintenance of a stable practice environment to enhance physician retention. Both segments of the physician pipeline, medical education and graduate medical education (GME), need to be expanded and funded in order to educate and train more physicians for Texas. Further, GME numbers need to be aligned with medical school expansions to retain the Texas medical graduates who want to train in the state and to prepare physicians in the specialties most needed for Texas (Council on Medical Education Rep. 1-A-09).

Texas has achieved the target ratio of 1 to 1 entry-level residency positions for every Texas medical school graduate; however, three new medical schools opened since 2016, and there are plans for three more through 2020. The increased enrollments will require the creation of more than 500 residency positions through 2024 to maintain the 1:1 ratio. The council strongly endorses the continued emphasis in Policy 185.018 on the need to grow GME in sync with medical school enrollments.

Given recent and planned medical schools, the council considered the reference in the policy that supports the establishment and funding of new medical schools. Ultimately, the council made the decision to support the retention of this policy based on future physician workforce needs. This decision was based on the following assessments:

- Physician supply in Texas is growing at a healthy rate, with annual increases ranging from 3 to 5 percent over the past decade. The state’s population, however, continues to grow at a vigorous rate. This trend is expected to continue, with projected gains of 22 percent by 2030. This high rate of increase has constrained growth in the ratio of physicians per capita, and Texas ranks 41st for the ratio of physicians per 100,000 population. There remains the need to continue to recruit and train more physicians for Texas.

- The council also looked at long-term trends for medical school development in the state. It became obvious that the recent cluster of new medical schools followed four decades of extremely limited growth. From 1978 to 2016, only four new medical schools opened, with changes in medical school enrollments greatly lagging behind population gains. Texas has led the nation in net population growth since at least the year 2000. In the latest state ranking, Texas ranked at the bottom of the third quartile – at 36th – in a comparison of ratios for medical students per 100,000 population. The Texas ratio of 27.4 was considerably below the national ratio of 35.4. In a comparison of the five most-populous states, Texas ranked fourth in the ratio of students per capita.

- The council believes it would be beneficial to the state for the Texas Higher Education Coordinating Board to commission a comprehensive assessment of the projected need for more medical schools, as outlined in CME Report 4-A-19.
Because of the extremely small growth in medical schools for almost four decades and the expectation that Texas will likely experience exceptional population growth through 2030, the council recommends that Policy 185.018 be retained as written to plan for future physician workforce needs. Should the study referenced in CME Report 4-A-19 be completed, the council will monitor the outcomes and offer future updates to this policy as warranted.

200.031 Medical School Admissions: The Texas Medical Association reaffirms its current policy supporting medical schools’ efforts to recruit, enroll, and retain qualified underrepresented minorities and strongly supports a diverse, qualified medical student body for Texas medical schools. In addition, TMA strongly supports the State of Texas partnership with Texas medical schools in efforts to increase the representation of Hispanic and African American medical students attending Texas medical schools toward the goal of reaching their proportion in the Texas population (Council on Medical Education, p 73, I-96; reaffirmed BOT Rep. 11-I-99; reaffirmed CME Rep. 2-A-09).

Recommendation: Retain.
Subject: Support of Expanded Eligibility for Inpatient Medicaid GME Funding to Teaching Hospitals

Presented by: Ronald L. Cook, DO, Chair

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

Before 2005, the Texas Medicaid program provided graduate medical education (GME) supplemental payments to a broad group of teaching hospitals. The supplemental payments stopped in 2005 due to a state budget shortfall. In 2008, the program was restored to a narrowly defined group, the five teaching hospitals owned by the state. These hospitals now had to put up their own money through an intergovernmental transfer to qualify for the 130-percent federal match. This means only an extremely limited number of teaching hospitals are eligible to seek matching federal funds for the inpatient Medicaid GME program, to the exclusion of hundreds of teaching hospitals. Since the loss of the broader eligibility for Medicaid GME funding in 2005, the Texas Medical Association has searched, in partnership with others, for ways to expand the program, with no success. The potential benefits to GME are significant, particularly at a time of great need for the expansion of GME capacity in the state.

In response to a state legislative directive, the Texas Health and Human Services Commission (HHSC), the state’s Medicaid authority, reevaluated the state’s Medicaid GME funding program in 2018. Because of this study, HHSC made the decision to begin the process of expanding eligibility to include additional types of teaching hospitals. The expansion is proposed to be rolled out in three phases, pending federal approval, as described below.

The first two phases would allow teaching hospitals to put up their own money as the non-federal share in order to draw down the federal match, similar to the current arrangement for state-owned hospitals. No state dollars would be used, which means no additional state appropriations are needed to implement this provision.

In the first phase, HHSC modified its rules to expand eligibility to include at least nine teaching hospitals that are owned and managed by non-state governmental entities. This amendment to the Medicaid State Plan is pending federal approval. For the second phase, HHSC will explore the potential for extending eligibility to teaching hospitals that are owned and managed by non-governmental organizations. This would enable at least 59 private hospitals, including 11 children’s hospitals, to qualify for the federal match.

In the third phase, HHSC is proposing an adjustment in the process used for determining the “medical education add-on” payments to teaching hospitals for inpatient Medicaid services. Currently, 57 hospitals are receiving these payments, for a state total of $109.3 million in FY 2018, and this program has not been updated to reflect current costs. HHSC’s proposal could require additional state appropriations, depending on how it is implemented, and this determination will be made during the 2019 state legislative session.

These proposals could serve as attractive incentives for eligible teaching hospitals to maintain and even grow their GME programs, in most cases without requiring additional state funds. The council is proposing new policy in support of all three proposals.
Recommendation: Adopt the following as new policy:

The Texas Medical Association supports expansion of the eligibility for the state’s inpatient Medicaid graduate medical education (GME) supplemental payments to include additional types of teaching hospitals. These monies can play a critical role in incentivizing hospitals to maintain and expand existing residency programs, as well as develop new programs. TMA recognizes that this growth is needed to maintain an adequate GME capacity that will accommodate the growing number of medical school graduates. TMA supports the specific use of the additional Medicaid GME payments for the support of GME programs.

TMA supports the proposed Medicaid GME expansion initiatives developed by the Texas Health and Human Services Commission, including:

- Extending eligibility for the inpatient Medicaid GME supplemental payments to teaching hospitals owned and managed by non-state governmental entities, such as cities or counties;
- Extending eligibility of teaching hospitals owned and managed by nongovernmental organizations, such as private hospitals; and
- Updating the inpatient Medicaid GME add-on payments to teaching hospitals based on current costs.
Before 2005, the Texas Medicaid program provided graduate medical education (GME) supplemental payments to a broad group of teaching hospitals. The supplemental payments stopped in 2005 due to a state budget shortfall. In 2008, the program was restored to a narrowly defined group, the five teaching hospitals owned by the state. These hospitals now had to put up their own money through an intergovernmental transfer to qualify for the 130-percent federal match. This means only an extremely limited number of teaching hospitals are eligible to seek matching federal funds for the inpatient Medicaid GME program, to the exclusion of hundreds of teaching hospitals. Since the loss of the broader eligibility for Medicaid GME funding in 2005, the Texas Medical Association has searched, in partnership with others, for ways to expand the program, with no success. The potential benefits to GME are significant, particularly at a time of great need for the expansion of GME capacity in the state.

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Recommendation: Adopt the following as new policy:

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- Extending eligibility of teaching hospitals owned and managed by nongovernmental organizations, such as private hospitals; and
- Updating the inpatient Medicaid GME add-on payments to teaching hospitals based on current costs.
Subject: Fixing the Inequity in Medicare GME Funding for Texas Teaching Hospitals Compared to Other States

Presented by: Ronald L. Cook, DO, Chair

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

Texas teaching hospitals receive significantly less Medicare graduate medical education (GME) funding than similar hospitals across the country. To demonstrate the extreme disparity, the average Medicare payment per resident for Texas is $65,496 – less than half the state average of $155,135 for Connecticut or $139,126 for New York. (The Geography of GME: Imbalances Signal Need for New Distribution Policies, Mullan, F, et al, Health Affairs (Millwood), 2013.)

Recognizing that Medicare provides the largest amount of financial support for training the future physician workforce, by far, this disparity has a major detrimental impact on GME in Texas. The council believes this extreme discrepancy among states cannot be justified. States with high population increases such as Texas have a great need to grow their GME capacity, and Medicare GME funding can play a critically important role in improving the financial status of teaching hospitals, better enabling them to add residency positions.

The basis for the discrepancies in the average Medicare GME payment amounts by state is the “per resident base year cost amount” determined for each hospital by the Centers for Medicare & Medicaid Services. The council believes it is important for Texas teaching hospitals to seize opportunities as they arise for the recalculation of these base amounts to achieve greater equity in the distribution of GME funding across states. Further, the council believes the American Medical Association is uniquely positioned to advocate for teaching hospitals through its policies such as Policy D-305.973(c), which calls for the Medicare direct medical education per resident figure to be more equitable across teaching hospitals while ensuring adequate funding of all residency programs.

Recommendation: The council recommends adopting the following as new policy:

The Texas Medical Association supports equity in the “hospital-specific per resident base year cost amount” used by the Centers for Medicare & Medicaid Services to determine Medicare GME funding for teaching hospitals in Texas. Achieving equity in Medicare GME payments is particularly important to states with high population growth rates, such as Texas, to further enable expansion of the state’s GME capacity to meet the state’s growing demand for physicians’ services. This payment equity is needed for teaching hospitals that have Medicare GME funding caps as well as new teaching hospitals that are in their Medicare GME cap-building phase.

TMA urges the AMA to act on AMA Policy D-305.973(c) to make the Medicare direct medical education per resident figure more equitable across teaching hospitals while ensuring adequate funding of all residency programs.
Subject: Study of Projected Need for More Medical Schools in Texas

Presented by: Ronald L. Cook, DO, Chair

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

Three new medical schools have opened in Texas since 2016 and three more are in development, with planned openings by 2020. Raymund Paredes, PhD, Texas Higher Education Coordinating Board commissioner, and state legislators have questioned the affordability of additional medical schools and the potential imbalance that could result between the rising number of medical school graduates and the state’s graduate medical education capacity. With the recent opening or planning of six medical schools and the talk of even more, the question arises as to when the state will know when the number of schools has met its needs.

In the past, the coordinating board commissioned comprehensive assessments of the need for medical schools in the state. The last assessment was released in 2002. Recognizing the extraordinary amount of resources required to build and maintain a new medical school, including financing, physical space, faculty and staff, clinical clerkship training needs, teaching hospital partners, and residency programs, the council believes it is imperative for the state to have a comprehensive plan of the projected need for more medical schools.

Recommendation: Adopt the following as new policy:

The Texas Medical Association recognizes that medical schools require extraordinary resources to meet national accreditation standards and to maintain educational excellence. With the increasing number of medical schools under development in Texas, it is in the best interest of the state for a comprehensive study to be done on the projected need for additional medical schools. The study should be commissioned by the Texas Higher Education Coordinating Board, similar to this agency’s work in 2002, which evaluated the projected need the people of Texas have for physicians’ services and the need for opportunities in the state to become a physician.

TMA supports the coordinating board’s use of the study in evaluating future proposals for the establishment of new medical schools in the state.
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.
Resolution 205-A-18, Graduate Associate Physician (International Medical Graduate [IMG] Section) was adopted as substituted by the House of Delegates as follows:

That the Council on Medical Education study the issue of unmatched candidates for U.S. residency programs and report back in 2019.

The resolution originally asked the Texas Medical Association to draft legislation for a state licensing program for “graduate associate physicians” in Texas in 2019 that would permit medical school graduates who have no residency training to practice in patient care under physician supervision. The Reference Committee on Medical Education and Health Care Quality did not support this proposal. In response, the IMG Section proposed a revision to Res. 205 to substitute the original language with a study of unmatched candidates for U.S. residency programs. The council supported this and the house adopted the revised resolution.

The council welcomed the opportunity to study the causal factors for physicians who fail to match to a residency position. This career interruption is traumatic and life-altering for physicians, and the council feels it is important to have a better understanding of how and why it happens and what can be done to prevent it.

As a first step, the council conducted a literature search on physicians who do not match and determined there was little available research. The council then compiled information on match outcomes at national and state levels to help understand the extent of the problem and the latest trends. The council devoted the majority of its meeting at the 2019 TMA Winter Conference to panel discussions with experts from the National Resident Matching Program® (NRMP® or The Match®). Small group discussions were held to identify methods for maximizing Match outcomes. The results of that meeting were incorporated into this report. An executive summary and the council’s study are provided in this report, with recommendations to adopt new policy and amend current policy.

**Recommendation 1:** Adopt new policy as follows:

**Maximizing Match Rates for Candidates to U.S. Residency Programs:** The Texas Medical Association:

1. Should continue to set as a priority advocating for graduate medical education (GME) capacity that maintains the state’s goal of 1.1 to 1 for the ratio of entry-level GME positions per Texas medical school graduate.
2. Supports data collection and projections by the Texas Higher Education Coordinating Board that monitor and project the state’s aggregate GME needs for graduates of existing and new medical schools. The outcomes should continue to be provided to state policymakers and medical school leadership.
3. Supports activities by Texas medical schools to reduce the number of graduates who do not match. This includes periodic assessments of the processes used for advising and counseling
medical students in developing their strategic plans for participation in the match, as well as back-up plans, which should be strongly encouraged for students with lower academic performance.

4. Through its Council on Medical Education, will look for opportunities to promote additional research on match outcomes, including statistical analysis and reporting of final match outcomes.

5. Should continue to serve as a convener of the state’s medical school leadership in efforts to maximize match outcomes for every Texas medical school graduate and reduce the number who do not match. This activity should include:

   a. Collecting statistical information on annual match outcomes for the state’s medical school graduates and tracking the annual aggregate number of graduates who:
      i. Match only to preliminary positions without a corresponding categorical residency position.
      ii. Secure a training position after reapplication in the second year following medical school graduation, or
      iii. Do not match in the second year following graduation; and

   b. Collaborating with medical schools to identify effective methods for achieving high match rates and monitoring career outcomes for Texas medical school graduates who fail to match.

6. Supports effective financial planning resources for medical students.

   a. Medical schools are encouraged to carefully consider the potential for high tuition rates that result in high education-related debt for graduates.

   b. There should be adequate funding for loan repayment programs such as the federal Public Service Loan Forgiveness Program, the state Physician Education Loan Repayment Program, and state Loan Repayment Program for Mental Health Professionals, which includes psychiatrists.

   c. Repayment amounts for these programs need to correlate to rising levels of physician loan obligations.

**Recommendation 2:** Amend the title of TMA Policy 30.036, New Licensing Category for Assistant Physicians to more accurately reflect the policy statement, as follows: **Opposition to New State Licensing Category for Assistant Physicians Who Do Not Complete Residency Training.**
COUNCIL ON MEDICAL EDUCATION
STUDY OF UNMATCHED CANDIDATES FOR U.S. RESIDENCY PROGRAMS, 2019

The Council on Medical Education was charged to study the issue of unmatched candidates for U.S. residency programs and to report back in 2019.

Executive Summary
Currently, only a very small percentage of U.S. medical school graduates are unable to secure a residency position – about 2 percent – and the number and proportion of unmatched graduates has been stable in recent years. There are common misconceptions that the number is growing, and the growth is a result of a shortage of residency training positions. There are presently 60 percent more residency positions than U.S. allopathic medical school seniors in the national match and 10 percent more in Texas than medical school graduates. But given the recent openings of medical schools and plans for additional schools, it is a valid concern that due diligence is needed to maintain the current ratio of 1.1 to 1 in Texas for entry-level residency positions per medical school graduate. Growth in GME capacity must be commensurate with medical school enrollment increases to maintain the state’s target ratio.

Even if the number of unmatched graduates is not increasing, the council strongly believes every effort should be made to prevent an avoidable non-match. In most cases, graduating medical students fail to secure a match due to lower scores on Step/Level 1 of the United States Medical Licensing Exam (USMLE) or Comprehensive Osteopathic Medical Licensing Exam of the United States (COMLEX). This is often a reflection of a poor strategy for the Match, including not having a back-up plan in place before Match Day. It is expected that medical schools have made substantial and sustained commitments to guide and assist students in preparing for the Match. It may be that more can be done to help students prepare for potential participation in the post-Match process.

Although few do not match as a result of nonacademic issues, this small group may have the greatest challenges to finding success as a physician. Texas medical schools are asked to consider whether there are sufficient processes in place, including an exit plan from medical school when needed, to achieve the best possible outcomes.

There is a need for better data collection and research on match outcomes and for ready access to final match statistics in order to prevent misconceptions about the extent of the problem. The circulation of inflated numbers is resulting in pressures to create alternative practice models, such as state licensing programs for graduate associate physicians, as presented in the original version of Res. 205. It is important to consider whether it is good public policy to advocate for a new state licensing program for the greatly limited number of medical students in Texas who do not match each year – an average of 37 medical students in the year of graduation from medical school and 13 in the second year after graduation.

Finally, it is hoped that medical schools in Texas will collaborate to share best practices for maximizing the match for each medical student, including the prevention of non-matches; participate in state efforts to collect and report statistics on match outcomes; and work together to achieve the common goal of producing well-qualified physicians for the state.

Framing the Council’s Study
To help frame the council’s study, it is important to understand the goals of the IMG Section in calling for the study as presented in Res. 205. Res. 205 cited:
• The projected national physician shortage;
• The greater number of applicants to the 2018 Match than available entry-level residency positions;
• The many graduates, United States and IMGs, who are unable to secure a match because of limited slots;
The large number of U.S. medical graduates and IMGs with specific U.S. legal status who may be available to provide medical care with appropriate supervision; and

The fact that advanced practice registered nurses (APRNs) are able to practice with only 700 hours of training, while medical graduates with 15,000 hours of medical education are not able to provide medical care.

**Issues Related to Unmatched Graduates**

When a medical student does not match, this type of career interruption has far-reaching consequences for students, medical schools, and society. From an education perspective, residency training is considered an inseverable component of the three-part continuum for the education and training of a physician, between medical school and CME. A minimum of one year of residency training is required for a Texas medical license for graduates of U.S. and Canadian medical schools and two years for IMGs. In addition, board eligibility depends on the completion of residency training, and board eligibility/certification is often required to participate on health plan provider panels, to be hired by physician groups and hospitals, and to qualify for hospital admitting privileges.

There also is a financial impact when a graduate does not match. Students have invested considerably in tuition and have foregone potential income during their extended years in school. Society’s financial investment in the student’s education also will likely see less return. This includes the considerable amount of state support for the infrastructure and operations of health science centers, and the total state formula funding of almost $180,000 per medical student over four years.

Graduates who fail to match do not generally reflect positively on their medical schools. However, as with any educational/training program, it is not reasonable to expect a success rate of 100 percent. Yet, based on the limited amount of research, and what appears to be limited collaboration among medical schools, the question arises whether more can be done to both prevent unmatched graduates and to help students when it does happen.

It is difficult to accurately assess the extent of the problem of unmatched graduates. Data on final match rates are not readily available. These data are not reported by school and are not routinely available in aggregate form at the state level. Given the common misconception that unmatched graduates number in the thousands, it can be expected that there will be continued pressure for the creation of alternative practice models for unmatched graduates, such as state licensing programs for graduate associate physicians as originally proposed in Res. 205.

**Study Questions**

For the study of unmatched candidates to U.S. residency programs, the council sought to answer the following key questions:

1. How many U.S. medical school graduates do not match to a residency position?
2. What are the reasons for not finding a match?
3. What resources are available to facilitate a good match?
4. Can more be done to improve match rates?
5. What happens to those who fail to match?

The council’s efforts to find answers to each of these questions are summarized in the report, followed by policy recommendations. Recognizing the significant role that graduates of medical schools outside of Texas have in the U.S. physician workforce, representing one of four, the council also studied the challenges they face in securing residency positions. The results are presented in Attachment 1.
Question 1: How Many U.S. Medical School Graduates Do Not Match to a Residency Position?

It is a common misperception that thousands of U.S. medical school graduates do not match. The number is considerably less, as shown below.

<table>
<thead>
<tr>
<th># Unmatched U.S. Medical School Graduates</th>
<th>2018</th>
<th>2014-18 (Five-Year Average)</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.:</td>
<td>620</td>
<td>583</td>
</tr>
<tr>
<td>Texas:</td>
<td>39</td>
<td>37</td>
</tr>
</tbody>
</table>

About 2 percent of U.S. medical school seniors (MS4s) do not enter residency training directly after graduation from medical school, and the percentage is the same for Texas seniors. The 2018 NRMP Main Match was one of the most successful ever. Both the number of positions offered and the number of active applicants were the largest in NRMP history.

A total of 33,167 positions were offered in the 2018 Match, and 96.2 percent of these were filled on Match Day. Only 1,268 positions (3.8 percent) were still open after Match Day, and 1,171 of these were offered in the post-Match Day process, called the Match Week Supplemental Offer and Acceptance Program (SOAP). The final fill rate was 99.4 percent. There were 213 unfilled positions at the end of the Match process, and while it is not exactly known how many ultimately filled, anecdotal information indicates only very few did not fill.

**Improved Unmatched Rates for U.S. Allopathic Medical School Seniors, 2004-18**

Although the match rate was strong in 2018, the council also wanted to assess whether the rate has been going up or down in recent years. The council looked at unmatched rates for allopathic MS4s on the Annual Match Days for 2004-18. Match rates for the end of the post-Match processes were preferable but not readily available.

The unmatched rates for allopathic seniors, as shown in Chart 1 below, improved over the 15-year period, from 7.1 percent in 2004 to 5.7 percent in 2018. This occurred despite the increased number of medical school seniors. Rates for unmatched students in the most recent years, at 5.7 percent, are the third lowest in the past 15 years.

![Chart 1: % Unmatched U.S. Allopathic Medical School Seniors on Match Day, 2004-18, NRMP](image)

Note: Match statistics in the chart represent match rates on the first day of Match Week and do not reflect final match results, which were higher.

Prepared by: Texas Medical Association, Medical Education Department, January 2019.
Source: NRMP Results and Data, 2018 Main Residency Match®, 2004-18
All types of applicants who participated in the NRMP Match during this time period also showed improved unmatched rates, including osteopathic medical school seniors and prior graduates, graduates of allopathic medical schools in prior years, and IMGs, both U.S.-born and non-U.S.-born. Osteopathic applicants saw the biggest improvement in match rates for this time period, dropping from 32.1 percent unmatched in 2006 to 18.3 percent in 2017 and 2018.

Research published in the *Journal of the American Medical Association* in 2015 tracked 186,937 U.S. medical school graduates from 2005 to 2015. The percentage of unmatched (during the year of their graduation from medical school) for these cohorts ranged from 2.6 to 3.5 percent, with a mean of 3 percent. African-American, Hispanic, and non-U.S.-citizen U.S. graduates were consistently less likely to enter residency soon after graduation than white graduates were. These distinctions diminished over time, and within six years, more than 99 percent of all graduates entered GME or were found to be in medical practice in the United States. In this study, the percentage of U.S. allopathic graduates who entered residency training in the year of their graduation remained stable, despite the increase in the number of graduates. Differences in residency start time by race/ethnicity diminished over time.

**Texas Match Rates**

TMA’s ad hoc Council of Medical School Deans has had a longstanding interest in monitoring match rates and maximizing match outcomes. This council has been working with TMA for five years to collect data on the number of Texas MS4s who do not match. There is no other known source for this data.

The ad hoc council reviews and discusses unmatched statistics for Texas each year; these data are distributed to the deans of student affairs at each medical school. The survey results are reported using an anonymous format because there is no interest in calling out individual schools. Rather, the goals are to gain a better understanding of match outcomes for Texas medical schools for the purposes of monitoring the number of unmatched and partial matches, and harnessing the collective wisdom of Texas medical schools in identifying effective methods for maximizing match outcomes.

The five-year annual average for Texas MS4s who did not match on the first day of Match Week for 2014-18 was 112. (Survey results for 2014-18 are provided in Attachment 2.) Two-thirds of the 112 were able to secure a residency position through the post-Match processes each year, and the five-year annual average number of those who were unmatched at the end of Match Week in Texas was only 37. The numbers of unmatched by school were quite small; most Texas schools each had less than five graduates per year who went unmatched.

**Question 2: What Are the Reasons for Not Finding a Match?**

When students do not match to a residency position, they are not required to report the potential reasons. National surveys are conducted to allow medical students to provide this information on a voluntary basis. TMA conducted the first-ever survey for Texas in November 2018 of the perceptions of deans of student affairs at Texas medical schools on why students did not match. Both the national and Texas surveys had similar outcomes: Lower academic performance was cited most often, primarily lower scores for Step/Level 1 of the USMLE and COMLEX.

Graph 2 shows the responses to the survey for Texas (six of nine schools reported). The deans reported 60.5 percent likely did not match due to lower academic performance. The second most likely reason was other factors, such as a medical condition and deferral of residency due to childrearing (19.5 percent). This was followed by unsuccessful decisionmaking by seniors in the Match, such as applying to only one specialty or one residency program for which they were not sufficiently competitive and without a solid back-up plan (15.8 percent). Small percentages likely did not match due to poor interviewing skills (3.3 percent), and nonacademic issues, such as professionalism (1 percent).
Emphasis on Test Scores by Residency Program Directors

The number of applications for residency positions, particularly in highly competitive specialties, has increased to levels that limit the feasibility of in-depth reviews by residency program directors. To demonstrate this, NRMP reported an average of 129 applications per offered residency position for 2018. This has influenced residency program directors to rely more heavily on objective indicators such as board scores. In fact, 98 percent of program directors reported in a 2018 NRMP survey that they use USMLE Step 1 scores for identifying applicants for interviews, and 88 percent of program directors said they would seldom/never consider an applicant who failed Step 1 on the first attempt. In addition, program directors said they rejected 48 percent of applications.

Other Factors Used by Residency Program Directors in Selecting Interview Candidates

Residency program directors are increasingly placing an emphasis on the medical student performance evaluation, or dean’s letter, in selecting candidates for interviews, as reported in the biennial NRMP Program Director Survey. The directors stressed that the letters need to be meaningful and should reflect specifics about each graduate. Some specialties, for example, emergency medicine, are using standardized video interviews to assist in the selection of candidates. A 2017 study in *Academic Medicine* found that program directors are considering additional measures to assess an applicant’s degree of interest in the specialties and programs they apply to, and are looking for indices of maturity, patient commitment, and a sense of team spirit.

Controversy About Emphasis on USMLE and COMLEX Step/Level 1 Scores for Selection of Residency Interview Candidates

Some academic leaders question the heavy reliance on exam scores as objective criteria for selecting residency interview candidates. In a commentary in *Academic Medicine* in January 2016, the authors take the position that the exams were developed for use by individual medical licensing authorities in evaluating applicants for licensure and were “not designed to be a primary determinant of the likelihood of success in residency.” They believe evidence is lacking of its potential predictive value, and the argument is made that many other factors may be equally or even more predictive of performance during residency. The study finds it is “ill advised” to use the exam scores for a purpose for which they were not developed and have not been validated. It is stressed that the test is intended to differentiate students with adequate knowledge, not to infer substantial differences in knowledge between students. Further, the scores are used to “make career-changing decisions about medical school graduates based on
overweighting a screening test in a manner not supported by strong evidence and for which the test was not specifically designed.”

To reduce the reliance on board scores, some recommend the exams be converted to pass/fail. There are concerns, however, that this would take away the medical school’s ability to use the scores to target needed improvements. Obviously, this would greatly diminish the ability of residency program directors to utilize the scores as a screening tool.

The study suggests that the heavy use of exam scores by residencies influences a student’s specialty choice based on the strength of his or her scores and the perceived likelihood of matching to more or less competitive specialties, even though the student may have other attributes that are suitable for a given specialty.

It is further noted that the overemphasis on Step/Level 1 scores adds another layer of stress for students. The authors argue that the “undue emphasis” on the scores “could distort faculty perceptions of the relative importance of the medical knowledge competency over the other five important general competencies, potentially creating an adverse impact on curriculum change.”

Critics emphasize that exams do not measure many clinical aptitudes and skills, qualities of professionalism, or competencies specific to the planned training program. Alternatively, it is recommended that more attention be given to clinical reasoning, patient care, professionalism, and ability to function as a member of a health care team. Further, weight should be given to factors shown empirically to predict performance in the relevant specialty, such as evaluation during the core clerkship, performance during specialty-specific subinternships and electives, and other activities, such as research. The authors argue this information needs to be made available to program directors.

**Emphasis on Life-Style Specialties**

While the competitiveness of a select number of specialties has likely always played a role in the challenges of matching to a residency program, the current “squeeze” appears to be heavily influenced by the recent focus on lifestyle specialties, those specialties with work schedules that are likely to give physicians more work/life balance. Although not within the purview of TMA nor the council, this raises the question whether more could be done to improve the work schedules for additional specialties. The growing amount of concern about physician burnout and physician health and wellness are another motivating factor for improving work/life balance for all physicians.

**Potential Influence of Debt Levels**

High levels of medical education debt have been cited as influencing medical student specialty choice, with those with large loans being drawn to higher paying specialties. The median medical education-related debt for allopathic medical students reached $195,000 in 2018, with a growing number (9.5 percent) having debt above $300,000. Osteopathic graduates have even higher average debt, at $240,000. Sources: Association of American Medical Colleges 2018 Medical School Graduation Questionnaire, All Schools Report; and 2015-16, American Association of Colleges of Osteopathic Medicine.

**More Training Slots Than Medical School Seniors**

Res. 205 states “many graduates, U.S. and IMGs, are unable to secure a match because of limited slots.” With the recent opening of new medical schools, this is a common concern. It is not borne out, however, by historic NRMP Match statistics, which show a consistently high ratio of GME positions per MS4. In fact, since 2003, there have been at least 5,000 more slots each year than MS4s. The ratio of first-year GME positions per U.S. MS4 in 2018 was 1.6 to 1 – the highest on record. This means there were 60 percent more offered positions than MS4s. Recent U.S. trends are shown in Graph 3.
Note: Osteopathic medical school graduates cannot be identified separately in NRMP reports.
Sources: First-Year Graduate Medical Education in the U.S., 2002-2017, NRMP; and Results and Data, 2018 Main Residency Match®, April 2018.
Prepared by: Texas Medical Association, Medical Education Department, January 2019.

Texas
The ratio of entry-level GME positions to medical school graduates for Texas reached the state target of 1.1 to 1 in 2018, with a total of 1,904 GME positions (allopathic and osteopathic) for 1,734 graduates. Entry-level GME positions grew by 34.5 percent, while graduates increased 26 percent from 2010 to 2018. (See Graph 4.) With three new medical schools since 2016 and plans for three more through 2020, a net increase of 433 (25 percent) is projected for total graduates from 2018 to 2024. Unless GME grows at a commensurate rate, there will be fewer entry-level residency positions than the number of Texas medical school graduates.

Note: Includes Texas osteopathic medical graduates.
Sources: NRMP Main Residency Match®, 2010-18; American Osteopathic Medical Association; and Texas Higher Education Coordinating Board.
Prepared by: Texas Medical Association, Medical Education Department, January 2019
GME Expansions

A total of 237 new GME positions were created in the state from 2014 to 2017 through state grants to residency programs by the Texas Higher Education Coordinating Board (THECB). Both initial state budget bills for 2020-21, House Bill 1 and Senate Bill 1, show a proposed total of $157.2 million for the GME Expansion Grant program. This is an increase of $60.15 million (62 percent) over the previous state appropriation and reflects the amount requested by THECB to maintain the state’s target ratio of 1.1 to 1 for entry-level residency positions per Texas medical school graduate.

Additional residency positions have been created in the state in recent years with funding sources other than state grants. As shown in Graph 4, the number of entry-level GME match positions grew from 1,416 in 2010 to 1,904 in 2018, a net increase of 488 (34.5 percent).

Question 3: What Resources Are Available to Facilitate a Good Match?

Obviously, medical students are not alone in navigating the pathway to residency. Their goal of maximizing a successful match is shared by medical schools, residency programs, match programs, and other organizations. All are committed to achieving high match rates and the best possible outcomes.

Medical School Accreditation Standards Related to Match Outcomes

It is fully expected that each medical school dedicates considerable resources to help students maximize their potential in preparing for the transition to residency training, including preparation for exams, and selecting and matching to residency positions. (See Council on Medical Education’s Principles on Medical School and Medical Student Responsibilities in Regard to Maximizing Match Potential in Attachment 3.)

The two U.S. medical school accrediting bodies, Liaison Committee on Medical Education (LCME) and American Osteopathic Association’s Commission on Osteopathic College Accreditation (COCA), do not have specific accreditation standards on match outcomes for graduates. There are standards on preparing students for the match and providing related career counseling. The standards are not specific to a targeted number of matched graduates (the previous osteopathic accreditation standard for a 100-percent match has been rescinded), or for how long a school should assist a physician in securing a residency position after graduation.

The schools’ responsibilities in preparing students for the match are defined in the following accreditation standards:

• LCME Accreditation Standard 11.2 Career Advising
  A medical school has an effective career advising system in place that integrates the efforts of faculty members, clerkship directors, and student affairs staff to assist medical students in choosing elective courses, evaluating career options, and applying to residency programs.

• COCA Accreditation Element 9.6: Career Counseling
  A college of medicine must provide career counseling to assist its students in evaluating career options and applying to GME training programs.

• COCA Accreditation Standard 10: GME
  The faculty of a college of medicine must ensure that the curriculum provides content of sufficient breadth and depth to prepare students for entry into a GME program for the subsequent practice of medicine. The college of medicine must strive to develop GME to meet the needs of its graduates within the defined service area, consistent with the mission of the school.

Several national organizations, including the Association of American Medical Colleges (AAMC), NRMP, and AMA also offer resources for students, as summarized below.
AAMC
Careers in Medicine® Online Guide
This extensive resource helps students maximize the match, including the following examples (with hyperlinks):

1. Understanding the wide range of specialty and practice options available to physicians.
2. Gauging their competitiveness and candidacy.
3. Determining which specialty or specialties are right for them.
4. Researching residency programs in their preferred specialty or specialties.
5. Determining how many and to which residency programs they should apply.
6. Creating an effective residency application and preparing for interviews.

Optimizing GME Initiative: Transition to Residency
This initiative offers resources and tools for all key players in the Match process, including medical students, medical school advisors, and residency program directors.

NRMP
NRMP provides technical guidance on the Match and a series of videos designed to inform students and maximize Match outcomes, as well as an extensive series of historical reports on Match statistics and surveys of residency program directors.

AMA
The association’s Career Planning Resource provides guidance on selecting clinical clerkships, applying for residency, choosing a specialty, finding a residency program, and interviewing for residency positions.

All fellowship and residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) are searchable on the AMA’s Fellowship and Residency Electronic Interactive Database Access system (FREIDA™). Descriptive information is available for each program, and tools are available to help students and physicians make a program selection.

Question 4: Can More Be Done to Improve Match Rates?
To answer this question, the council looked at the reasons students did not match. In the TMA ad hoc council survey of Texas medical schools in 2018, the following reasons were identified (in order), with similar findings at the national level, as presented in more detail under question 2.

1. Weak academic performance, including USMLE/COMLEX exam scores:
   Schools are encouraged to consider sharing methods they have found effective for identifying contributing factors to a student’s poor performance or even failure of a Step/Level exam. It is important to catch students who are struggling early in medical school and apply specialized support services and counseling. The literature further suggests that students with weak scores should have a strategic plan for the match and a well-thought-out advance back-up plan. In particular, they should be advised about selecting a highly competitive specialty. (See more under #3.)

2. Personal reasons, such as medical conditions or childrearing responsibilities:
   Life events are to be expected. These are individual cases, but often the delay in entering residency training is short term.

3. Unsuccessful decisionmaking in the Match:
   Medical students need to be coached on specialty selection beginning in the first year, not the third year, of medical school. Further, they need to be aware of the cadre of resources that are available to them within their medical school as well as external organizations to help them develop an effective match strategy.
4. Poor interviewing/interpersonal skills:
   This category applied to only 3.3 percent of Texas MS4s. Data should be available to medical schools and students about the screening criteria used by residency program directors/faculty in the resident selection process. Regular advisor meetings are critical, along with individualized counseling and mock interviews.

5. Non-academic issues, e.g., professionalism:
   Only 1 percent of students likely did not match due to non-academic issues, but this represents the most challenging impediment to success. The literature indicates most, if not all, students with non-academic issues, such as professionalism or maturity concerns, were known to the medical schools prior to the match. The council encourages the medical schools to evaluate whether processes should be refined to determine when a medical student does not have the needed qualifications for a career in patient care.

LCME Accreditation Standards include a description of the characteristics of accepted applicants, as follows:

   LCME Accreditation Standard 10.4 Characteristics of Accepted Applicants
   A medical school selects applicants for admission who possess the intelligence, integrity, and personal and emotional characteristics necessary for them to become competent physicians.

   In the rare event remediation is not feasible or is unsuccessful, although difficult for all involved, the literature suggests promotion policies at medical schools should include an exit plan and counseling for alternative careers. Resources are available, including information on nonclinical careers for physicians. An example is AAMC’s web-based Careers in Medicine, with references on careers in public health and service, public policy and government, communications and journalism, informatics, pharmaceutical research, and consulting.

   A study referenced in multiple professional journals, including New England Journal of Medicine (2005) and Virtual Mentor (2007), presents data on the potential correlation between unprofessional behavior during medical school and disciplinary issues for physicians in later years.

   In this case–control study, disciplinary action among practicing physicians by medical boards was strongly associated with unprofessional behavior in medical school. Students with the strongest association were those who were described as irresponsible or as having diminished ability to improve their behavior. Professionalism should have a central role in medical academics and throughout one’s medical career.

   Physicians who were disciplined by a medical board were three times more likely to have a record of unprofessional behavior during medical school than were the controls [in the study]. In particular, they were more likely to have demonstrated irresponsibility, diminished capacity for self-improvement, poor initiative, impaired relationships with students, residents and faculty, impaired relationships with nurses, and unprofessional behavior associated with being anxious, insecure, or nervous.

   MCAT scores appeared to be loosely linked with disciplinary behavior, with a trend towards lower test scores in physicians disciplined by the board. Furthermore, disciplined physicians were also twice as likely to have failed at least one course on their first attempt during medical school…but the association with these variables was less strong than that with unprofessional behavior.
Divergent Trends Toward Holistic Evaluations Between Some Medical Schools and Residency Programs

Residency program directors appear to be placing a heavy emphasis on USMLE/COMLEX test scores at a time when an increasing number of medical schools are de-emphasizing standardized scores as part of their admissions criteria. Some schools have moved to a more holistic assessment process that places less priority on GPAs and MCAT scores. This raises the question whether the medical school admissions trends are potentially divergent from the high priority being placed on test scores in the residency application process.

Increased Need for Understanding COMLEX Exam Scores by Allopathic Residency Program Directors

Given that the ACGME will become the single national accrediting body for GME in 2020 and the resulting increase in the number of osteopathic medical students participating in the NRMP, it is increasingly important for allopathic residency program directors to have an understanding of the COMLEX testing series and the correlation between COMLEX and USMLE scores.

Question 5: What Happens to Those Who Fail to Match?

For graduates who fail to match the first year:

1. Those who continue to search for a residency position: 67.1%
2. Those who seek employment, such as a research position: 22.7%

Similar patterns were seen at the national level and in Texas, with a majority of unmatched MS4s reporting plans to continue their search for an open position. Additionally, almost a quarter said they planned to work in paid research positions or to pursue additional degrees.

United States

In the survey conducted by LCME of U.S. medical schools in 2016-17 (most recent available), the majority of MS4s who did not match reported plans to continue looking for an open residency position (67.1 percent), as shown below:

Post-Match Plans for Unmatched U.S. MS4s (2017):

1. 44.4% (246) continue to search for a residency position in 2017;
2. 22.7% (120) continue to search for a residency position in 2016;
3. 5.8% (32) seek an additional degree;
4. 5.4% (30) not known by the medical school; and
5. 0.1% (5) seek a career outside of medicine.

In addition, 28.5 percent reported plans to either seek employment, such as a research position, or an additional degree. Less than 1 percent planned to seek a career outside of medicine.

Texas

Data for Texas MS4s is similar to the national statistics. In the TMA ad hoc council survey for 2018, it was learned that the majority of the 2017 Texas medical school graduates who did not match (21 of 34, or 62 percent) were able to secure a match a year later in 2018. (See Attachment 2.) This indicates that almost two-thirds of those who did not match were able to find a residency position a year later. In fact, four of the nine schools participating in the survey reported that 100 percent of their 2017 graduates were matched by 2018 (one year later). Only 13 graduates remained unmatched in the second year following graduation.
Preparing for Match Reapplication

To improve their competitiveness for reapplying to the Match, the literature suggests physicians should look for opportunities to allow them to:

- Stay in touch with their medical school,
- Obtain letters of recommendation in their specialty,
- Enhance their personal statement,
- Demonstrate commitment to the specialty,
- Gain personal knowledge of faculty,
- Demonstrate leadership qualities,
- Demonstrate interest in a program,
- Gain volunteer experiences,
- Demonstrate involvement in research,
- Gain fluency in another language,
- Take USMLE Step 3/COMLEX Level 3, and
- Stay involved in a clinical environment.

There may be a need to offer financial counseling to unmatched students in cases where they are not able to defer student loans.

Employment of Unmatched Graduates as Graduate Associate Physicians

The original wording of Res. 205 sought TMA policy that would have required TMA to draft legislation for a state licensing program for graduate associate physicians. At least five states have such programs that authorize unmatched medical school graduates to engage in direct patient care under the supervision of a licensed physician. Two of these states extend eligibility to physicians who had some amount of residency training, and Missouri extends eligibility to certain IMGs.

Some programs are limited to certain specialties and medically underserved areas while others are not. In some states, there is a maximum number of license renewals while others are unlimited. Most programs authorize delegated prescriptive authority. After four months of practice with continuous supervision, Missouri allows “assistant physicians” to practice up to 50 miles away from their “collaborating” physician.

Assistant physicians are paid by their collaborating physicians in Missouri at a level similar to a resident’s stipend, $50-60,000 a year. The Centers for Medicare & Medicaid Services provided confirmation that patient care services by graduate associate physicians (or their equivalents with other titles) cannot be paid by Medicare as “incident-to” a physician’s services as is done for APRNs and physician assistants. Graduate associate physicians are not an “acceptable enrollment non-physician specialty type,” and there has been no request to add them and no plans to do so. Given the inability to bill for the services of graduate associate physicians, there are questions about both the affordability and sustainability of this employment model for the supervising physician as well as the graduate. Further, it is likely graduates would not be able to defer payment on their medical school-related loans, which raises a question as to how long they could remain in a position at that salary level.

TMA has policy in opposition to creation of a licensing program for assistant physicians in Texas, as follows:

**30.036 New Licensing Category for Assistant Physicians:** TMA opposes the creation of special licensing pathways for physicians who have not completed a year of residency training. Further, TMA recognizes primary care as encompassing specialties that require the completion of a full residency training process in the relevant specialties. TMA opposes lower standards of licensing for physicians and other health professions in medically underserved areas (CM-PDHCA Rep. 2-A-15).
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The council also has concerns that a state initiative for a new licensing program for assistant physicians would likely hurt TMA’s advocacy efforts to maintain state support for GME expansions. Texas legislators may view assistant physicians as a less expensive alternative to funding GME positions. Further, such an initiative could undermine TMA’s efforts to advocate for appropriate staffing models that recognize the considerable differences in the education and training model for physicians in comparison to APRNs, optometrists, etc.

Opposition to Lower Standards for Medically Underserved Communities
TMA’s vision is “To Improve the Health of All Texans,” and the council has consistently held the position that establishing a lower standard for physicians or any other health care practitioner or system in medically underserved areas is not in keeping with this vision. That principle is specifically referenced in TMA Policy 30.036.

Related TMA Policy:
200.027 GME Training Positions: TMA supports the right of each graduate medical education program to select the best qualified candidates to fill available training positions (Board of Trustees, p 20, A-96; reaffirmed CME Rep. 1-A-08, and Rep. 2-A-18).

Sources:
MATCH RATES FOR INTERNATIONAL MEDICAL GRADUATES

International medical graduates (IMGs) have an important role in the U.S. physician workforce, representing 1 of 4. The numbers are likely increasing, as IMGs made up 29 percent of the newly licensed physicians in Texas in 2017.

Res. 205 expressed concerns about the ability of IMGs to secure residency training positions in the United States. IMGs do have considerably lower match rates than graduating U.S. medical school students (57.1 percent IMG compared with 94.3 percent U.S. MS4s); however, their match rates are higher than U.S. physicians who graduated before 2018 (43.8 percent).

The number of U.S.-citizen IMGs participating in the National Resident Matching Program® (NRMP®) Main Match has grown rapidly in recent years as a reflection of the greater numbers of U.S. citizens graduating from Caribbean medical schools. For 2018, there was little difference in the match rate for the two IMG groups, with U.S.-citizen IMGs matching at 57.1 percent and non-U.S. at 56.1 percent.

Findings
In the 2018 NRMP Main Match, on Match Day:

- More non-U.S.-citizen IMGs matched to an entry-level residency position than any other year in the NRMP history; and
- Match rates for both U.S.-Citizen and non-U.S. were the highest in 25 years.

Educational Commission for Foreign Medical Graduates
IMGs are required to obtain certification from the Educational Commission for Foreign Medical Graduates (ECFMG) to qualify for the NRMP Main Match. To be eligible, IMGs must pass both the USMLE Steps 1 and 2, and a test of English proficiency. This certificate is time unlimited, which raises the question about the length of time an IMG should be considered eligible for residency training following graduation from medical school or years out of medical practice, as further discussed below.

Match Resources for IMGs
IMGs have access to the same Match-related resources as U.S. medical school students, such as NRMP’s technical guidance and extensive match statistics and surveys, and the considerable array of information and self-assessment tools on the Association of American Medical Colleges’ Careers in Medicine® Online Guide. NRMP also publishes reports on Match characteristics of IMGs. Further, the American Medical Association IMG Section has online resources and webinars developed in partnership with ECFMG to assist IMGs in seeking residency positions. IMGs can participate in the NRMP post-Match process, called the Supplemental Offer and Acceptance Program (SOAP) and have access to post-Match websites that identify open residency positions, such as Association of American Medical Colleges’ FindaResident™ at https://services.aamc.org/findaresident/.

To help IMGs improve their potential competitiveness for the match, the AMA-IMG Section developed guidelines for the development of observerships. These are programs that provide an opportunity for IMGs to learn more about the U.S. health care delivery system by observing clinical practice. The AMA offers a web-based listing of observerships.

TMA’s IMG Section offers information about a variety of topics of interest to IMGs on its website at https://www.texmed.org/template.aspx?id=456, including links to the ECFMG, NRMP, and the Texas Medical Board. In addition, the section provides an opportunity for IMGs to connect with an IMG Section physician leader for mentorship on a variety of topics, through an online registration system.
Potential Challenges
U.S.-citizen and non-U.S.-citizen IMGs have different challenges in securing a match. For some IMGs, U.S. residency program directors have difficulty in assessing the prior education and training experience and overall credentials, particularly for graduates of medical schools for which accreditation or U.S. medical school/training equivalence has not been established. Further, cultural differences may influence an IMG’s interviewing skills, including use of eye contact or even customs related to handshakes.

Time Limits for Years Out-of-Training/Medical Practice for Residency Program Candidates
For any residency candidate, there is a question about continued eligibility in the years moving forward after graduation from medical school. How many years, post-graduate, should a physician maintain eligibility for residency training if he or she has not been active in medicine during those years? Should additional assessments be required to demonstrate “fit” for residency, such as Texas A&M University Health Science Center’s KSTAR (Knowledge, Skills, Training, Assessment, and Research) program, which offers assessments for physicians who have a lapse in medical licensure and/or an active practice in medicine prior to application for a Texas medical license? For an initial Texas medical license, a physician must have been engaged in active patient care for 12 months of the previous 24 months. What standard (or time limit) should be applied to physicians who are inactive in medicine for extended periods before applying for the Match?

Related TMA Policies
TMA has policies that support equitable treatment of IMGs in the residency selection process, as shown below, and the council has consistently supported awareness of these policies. Further, the council supports the retention of Policy 245.010 during the 2019 policy sunset process.

200.027 GME Training Positions: TMA supports the right of each graduate medical education program to select the best qualified candidates to fill available training positions (Board of Trustees, p 20, A-96; reaffirmed CME Rep. 1-A-08; reaffirmed CME Rep. 2-A-18).

245.010 Discrimination against IMGs: TMA supports and promotes the right of every licensed physician to be treated meritoriously without discrimination based on national origin or geographic location of medical school (Amended Res. 301-I-99; amended BOC Rep. 6-A-09).

Alternative Careers for IMGs
In cases where it is not feasible for IMGs to match to a residency position, there are resources to assist them in identifying alternative careers. As an example, the non-profit Welcome Back Initiative is described as an international health worker assistance center. There are a number of centers located throughout the United States to help IMGs find employment in health professions, particularly in medically underserved areas that are a good fit for their language skills and cultural competencies. The center assists IMGs in understanding the educational, licensing, or certificate requirements for specific professions, and services are provided at no cost.

Improving Match Outcomes for IMGs
IMGs represent the largest number that do not match to residency positions each year. Efforts should be made to ensure that IMGs are aware of the resources available to help them prepare for the Match and maximize match outcomes. It is also critically important that IMG physicians are fully aware of the options that may be available to them in the post-Match processes, including how to access listings of open positions.
ANNUAL TMA MATCH SURVEY
2018 National Resident Matching Program (NRMP) and American Osteopathic Association Match Week Results by School, Statistics for Fourth-Year Texas Medical Students
Who Did Not Match to an Entry-Level Training Position on First Day of 2018 Match Week
Reported in an Anonymous Format by School

MATCH RESULTS ON MATCH DAY
FIRST DAY OF 2018 MATCH WEEK
(INITIAL MATCH RESULTS)

<table>
<thead>
<tr>
<th>By Medical School</th>
<th># Did not Match to Residency Position</th>
<th>Texas Medical School Seniors who Matched in the Post-Match Processes</th>
<th>Seniors who Ultimately Did Not Match During Match Week</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>1</td>
<td>6</td>
<td>83%</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>10</td>
<td>60%</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>6</td>
<td>33%</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>14</td>
<td>71.4%</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>23</td>
<td>95.7%</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>15</td>
<td>67%</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>7</td>
<td>71.4%</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>13</td>
<td>84.6%</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>25</td>
<td>36%</td>
<td>16</td>
</tr>
<tr>
<td><strong>Texas Total</strong></td>
<td><strong>119</strong></td>
<td><strong>67%</strong></td>
<td><strong>39</strong></td>
</tr>
</tbody>
</table>

119 did not match to entry-level residency positions on Match Day, the first day of the 2018 Match Week. 80 (67%) of the 119 matched in the post-Match processes. 39 (33%) of the 119 ultimately did not match to an entry-level residency position during Match Week, representing 2.2 percent of the 1,734 Texas medical school graduates for 2018.

MOST DIFFICULT SPECIALTIES TO MATCH TO IN 2018

1. #1: Psychiatry was cited most often (by five medical schools).
2. #2: Orthopedic Surgery was cited by four schools.
3. #3: General Surgery was noted by three schools.

For comparison:
Specialties Most Commonly Identified as Difficult to Secure a Match, Prior Years
2017
#1 Orthopedic Surgery
#2 Psychiatry and Emergency Medicine
2016
#1 Emergency Medicine
#2 Orthopedic Surgery and General Surgery
#3 Psychiatry

2015
#1 Emergency Medicine
#2 Ob/Gyn and Pediatrics
#3 Orthopedic Surgery

2014
#1 Orthopedic Surgery
#2 Surgery and Otolaryngology
#3 Dermatology, OB/Gyn, and Ophthalmology

Follow-Up on 2017 Graduates Who Did Not Match, by Medical School

<table>
<thead>
<tr>
<th>Medical School</th>
<th>2017 graduates, as reported in 2018, who:</th>
<th>Did NOT match in 2017 but DID match in 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Matched to a preliminary program in 2017 but NOT a PGY-2 position in 2018</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>1 (25% of 2017 unmatched)</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>2 (67% of 2017 unmatched)</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>1 (50% of 2017 unmatched)</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>2 (100% of 2017 unmatched)</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>3 (100% of 2017 unmatched)</td>
</tr>
<tr>
<td>6</td>
<td>0</td>
<td>1 (25% of 2017 unmatched)</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>1 (100% of 2017 unmatched)</td>
</tr>
<tr>
<td>8</td>
<td>0</td>
<td>3 (100% of 2017 unmatched)</td>
</tr>
<tr>
<td>9</td>
<td>Not available</td>
<td>7 (58% of 2017 unmatched)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>10</td>
<td>21* (62% of 2017 unmatched)</td>
</tr>
</tbody>
</table>

*In the 2017 medical school survey, a total of 34 fourth-year students were reported as not matched to a residency position. In 2018, the medical schools reported that 21 of the 34 did secure a match in 2018, for a second-year match rate of 62 percent for this group, with 13 unmatched in the second year after medical school graduation.

Source: Survey of student affairs deans at Texas medical schools, conducted by email April 2018.
Prepared by: Texas Medical Association, Medical Education Department, May 2018.
TMA COUNCIL ON MEDICAL EDUCATION’S PRINCIPLES ON MEDICAL SCHOOL AND MEDICAL STUDENT RESPONSIBILITIES WITH REGARD TO MAXIMIZING MATCH POTENTIAL

TMA’s Council on Medical Education believes medical schools can reasonably be expected to have responsibility for:

1. Ensuring every medical student is well prepared for the match process.
2. Providing guidance, counseling, and mentoring to each student to help them have a reasonable assessment and awareness of their individual skills, competencies, “fit,” and competitiveness for their preferred specialties and residency programs. Schools should ensure students are aware of the tools and resources available to assist them in selecting a residency program.
3. Making every effort to ensure students are fully informed about their training options and have a thorough understanding of the match and post-match processes.
4. Providing information on medical students to a residency program that can be considered “reasonably pertinent to a program’s decision, whether to rank an applicant, determine an applicant’s ability to satisfy program requirements, or identify circumstances that might adversely affect the applicant’s ability to satisfy program, licensure, or visa requirements or to start training on time.”
5. Informing residency programs if a student will not graduate in time to enter residency training on July 1.
6. Assisting medical students in coping with the emotional aspects of an unsuccessful match.

And, further that medical students can reasonably have responsibility:

1. For being as prepared as possible in order to maximize their opportunities in the match. This requires a student to familiarize themselves with the match process.
2. To select residency programs and specialties that are a good fit for their demonstrated competencies and aptitude.
3. To have an awareness of their “competitiveness” and “ranking” within the applicant pool with special attention to their preferred specialties and residency programs. Resources are available to students to assist them in making a reasonable assessment of their competitiveness for individual specialties.
The 84th Texas Legislature in 2015 established the Palliative Care Interdisciplinary Advisory Council to assess the availability of patient-centered and family-focused palliative care in Texas. The Council on Health Service Organizations acknowledges that supportive palliative care (SPC), a recognized specialty in the medical field, is available to people of all ages at any stage of a serious illness and offers a team-based approach to care focusing on controlling pain and improving comfort levels to provide a better quality of life for patients with life-limiting illnesses. Texas has a statutory framework regarding hospice palliative care (HPC) in Texas Health and Safety Code Chapter 142, but lacks a statutory scheme to define “supportive palliative care” as distinct from HPC.

After discussion and debate, the Council on Health Service Organizations recommends TMA adopt policy to support legislation that would enact distinct statutory language for SPC in a new chapter in the Health and Safety Code so that Texas may leverage any new statutory language through collaborative efforts with health plans and other stakeholders to develop a value-based SPC pilot focused on the most vulnerable Texans with serious, life-limiting illness.

**Recommendation:** That the Texas Medical Association develop policy to advocate for legislation that defines “supportive palliative care” as a distinct and different term from “hospice palliative care” under Texas Health and Safety Code Chapter 142.
Resolution 312-A-18, Identification Bracelets for Patients With Hearing Loss: That the Texas Medical Association adopt as policy a recommendation for medical care settings, especially hospitals and emergency departments, to provide identification bracelets on patients with hearing loss indicating their hearing status.

The Council on Health Service Organizations recognizes that many individuals, including physicians, nurses, and other medical staff, are not aware that hearing loss in patients can hinder effective communication, particularly in acute care facilities. The council recommends TMA adopt policy that enables acute care facilities to identify patients with hearing loss while avoiding the labeling of patients and maintaining patient dignity.

The Council on Health Service Organizations recommends the House of Delegates approve Resolution 312-A-18 as policy.

Recommendation: Adopt.
Subject: Sunset Policy Review

Presented by: Hattie E. Henderson, MD, Chair

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

The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness. Following are policies the Committee on Health Services Organization reviewed, with recommendations for retention, amendment, and deletion.

The Committee on Health Services Organization recommends retention of the following policies:

20.008 **Minimum Disaster Preparedness Standards for Assisted Living Action:** The Texas Medical Association will request the State of Texas to enact minimum standards of operation during a disaster for licensed assisted living facilities, including provision of emergency power to operate all life-sustaining equipment and services required by current residents, and to make those standards part of the requirement to obtain a license to operate an assisted living facility in Texas (Amended Res. 206-A-09).

20.007 **Behavior Evaluation in Long-Term Care Facilities Action:** Behavior disorders of dementing illnesses are clinical complications that should not be classified and labeled as regulatory violations. Clinical complications are medical issues that should only be evaluated by qualified facility surveyors. Surveyors should be educated about the differences between sexual behavior as a result of mental illness or dementia and sexual abuse. Long-term care facilities should not be cited for patient sexual behavior as a result of mental illness or dementia. The Texas Medical Association in no way supports any form of sexual abuse (Amended Res. 405-I-99; reaffirmed CHSO Rep. 1-A-09).

**Recommendation:** Retain.
The committee is submitting this report in collaboration with the Committee on Medical Home and Primary Care and the Committee on Rural Health. Policy recommendations presented in this report touch on areas of responsibility for all three committees and were approved by all.

The committees learned about two innovative models that have the potential for improving access to care in medically underserved communities of the state. Project ECHO has proven to be successful in other states and other countries. The model has been implemented in Texas – only in a limited manner, however, and the committees believe there is considerable potential for broader implementation. The committees also learned about the proposed development of a Texas version of the Child Psychiatry Access Project model, which seeks to increase the availability of mental health services for children across the state. This model has the potential for improving access to care, and the committees support the development of such a program for Texas.

**Project ECHO**

The University of New Mexico established the Project ECHO (Extension for Community Healthcare Outcomes) model in 2003. It is an educational model that offers a unique form of continuing medical education in certain specialty services for community-based primary care physicians. It is accomplished using teleconferencing between physician specialists at academic health centers and primary care physicians who voluntarily seek the training. The goal of the program is to enable primary care physicians in physician shortage areas and medically underserved areas to manage their patients with certain complex medical conditions. Because of the void of physicians who felt qualified to treat hepatitis C, the initial program in New Mexico in 2003 offered mentorship in treating patients with this condition. Since then, the program has grown, now offering mentorships in more than 100 specialty services, including HIV-AIDS, tuberculosis, opioid use disorder, pain management, behavioral health, palliative care, and cervical cancer.

Typically, the training is provided through regularly scheduled videoconferences on a weekly or bimonthly basis for six to eight weeks. They are structured as two-part sessions: a didactic educational program, followed by virtual grand rounds where primary care clinicians from multiple sites present patient cases to the specialist teams and to each other. Patient cases and treatment options are discussed in a HIPAA-compliant way. (For example, the case presentation models use deidentified information.) Most programs offer CME credit to the community physicians, and all programs are free of charge.

Research has shown the model can improve professional satisfaction and reduce isolation among rural physicians. These benefits may help in recruiting and retaining physicians in rural areas.

To quote the Project ECHO website: “As the ECHO model expands, it is helping to address some of the health care system’s most intractable problems, including inadequate or disparities in access to care, rising costs, systemic inefficiencies, and unequal or slow diffusion of best practices. Across the United States and globally, policymakers are recognizing the potential of ECHO to exponentially expand
workforce capacity to treat more patients sooner, using existing resources. At a time when the health care system is under mounting pressure to do more without spending more, this is critical.”

Currently, 154 partners offer 402 individual programs in 45 states, including Texas, as do 80 global partners in 31 countries. The average cost of implementing an ECHO program is about $200,000 a year. Although sizeable, this is far less than most efforts to transform components of the health care delivery system.

A federal law enacted in December 2016, the Expanding Capacity for Health Outcomes (ECHO) Act, calls for research on the potential benefits of “technology-enabled collaborative learning and capacity building models,” with a report on the findings to be issued by the U.S. Department of Health and Human Services (HHS) before December 2018. The report is still unpublished.

Project ECHO in Texas
In Texas, eight academic health center hubs, including the five health-related institutions below, participate in Project ECHO.

1. Baylor College of Medicine and Baylor St. Luke’s Medical Center, Houston;
2. Texas Tech University Health Sciences Center, Lubbock;
3. UT Health San Antonio;
4. The University of Texas MD Anderson Cancer Center; and
5. TMF Health Quality Institute, Austin, in partnership with UT Austin Dell Medical School/Seton Healthcare.

MD Anderson Cancer Center serves as the state’s only “superhub,” which allows it to offer training on the model to physician specialists as an extension of the central program at The University of New Mexico; it offers training in multiple cancer specialties. It is one of few hubs that offers training to physicians in residency, such as a program on cancer survivorship for family medicine residents.

Project ECHO is being widely used by federally qualified health centers (FQHCs) in Texas and other states to fill the void of specialty services in the medically underserved areas where the clinics are located. Texas has more than 400 FQHCs distributed across the state.

Relevant Grant Funding
At the state level, the Cancer Prevention and Research Institute of Texas (CPRIT) has provided grant funding for ECHO projects at MD Anderson Cancer Center. Nationally, grants have been provided to Project ECHO projects by the General Electric Foundation, Robert Wood Johnson Foundation, and the Center for Medicare and Medicaid Innovation.

Proposed Texas Version of Child Psychiatry Access Project in Massachusetts
The Massachusetts Child Psychiatry Access Project has strong similarities to Project ECHO in that it is designed to fill a gap in the availability of specialty services, in this case child and adolescent psychiatry, through the training and mentoring of primary care pediatricians using telephone consultations. In Texas, child and adolescent psychiatry has one of the highest levels of physician shortages, with a ratio of 14,465 children per physician. The Massachusetts program started in 2004, and it is different from Project ECHO in the sense that it is not limited to mentoring. It serves as a statewide system of regional children’s behavioral health consultation hubs that reaches 95 percent of the children in the state. Its intent is to help pediatricians meet the needs of children with behavioral health problems.
The Texas Medical Association, the Federation of Texas Psychiatry, and the Texas Pediatric Society are all in support of establishing a similar program to expand psychiatric services for children in Texas with telemedicine. Several bills have been filed in the 2019 Texas Legislature to expand access to child/adolescent psychiatry services in Texas, and TMA is monitoring these bills.

Potential Benefit to Texas
In assessing the state’s physician workforce needs, the committees recognize the extensive challenges to producing adequate numbers of physician specialists to meet demands. The Texas physician workforce is growing at a rapid rate, but given the degree of physician specialty shortages, it is not expected that enough have been recruited to meet the state’s needs and to address geographic maldistribution. Neither Project ECHO nor the Child Psychiatry Access Project model have been designed to produce more physicians. Both focus on the existing primary care physician workforce by expanding their expertise in response to a defined, unmet need among their patient populations. The committees believe there is a need for such innovative models to improve access to care by maximizing the existing workforce.

Project ECHO has been established long enough to show outcomes. A prospective cohort study published in the New England Journal of Medicine in June 2011 found that hepatitis C patients in New Mexico treated by ECHO-trained primary care physicians had better outcomes than patients treated at a specialty clinic.

Policy Recommendations
Recognizing the limited implementation and awareness of Project ECHO, there is a need to promote greater awareness and voluntary participation among health-related institutions and community-based primary care physicians as a means of improving access to care in underserved areas of the state. Further, given the limited awareness of the Child Psychiatry Access Project model, as implemented in Massachusetts, the committees also support greater awareness of the potential benefits of such a program for Texas.

Recommendation 1: Adopt of new policy, as follows:

Improving Access to Care Through Project ECHO and Promoting Awareness of Potential Benefits of the Child Psychiatry Access Project Model for Texas: The Texas Medical Association should promote awareness of Project ECHO and the Child Psychiatry Access Network and encourage broad implementation and participation in the state by:

A. Promoting broader participation among Texas’ health-related institutions as hubs to provide training in the specialty services most needed in rural and medically underserved areas of the state;
B. Promoting awareness and voluntary participation by physicians as a method for expanding their knowledge and skills in specialty care otherwise not readily available to their patient populations;
C. Ensuring stakeholders strive to identify and mitigate barriers to full implementation of physician education and mentoring models in Texas;
D. Promoting awareness among state governmental agencies, such as the Texas Health and Human Services Commission as the state Medicaid authority, and the Texas Department of Agriculture’s State Office of Rural Health;
E. Promoting these programs in underserved areas in partnership with state specialty societies, such as the Texas Academy of Family Physicians, Texas Pediatric Society, Texas Chapter of the American College of Physicians, Texas Association of Obstetricians and Gynecologists,
and Federation of Texas Psychiatry, and state professional organizations such as the Texas Organization of Rural and Community Hospitals;

F. Promoting awareness among physicians of the continuing medical education opportunities provided through Project ECHO;

G. Promoting awareness of national, federal, and state grant opportunities as they are identified;

H. Should state legislation pass that directs the establishment of the Child Psychiatry Access Network in Texas, monitoring the progress of implementing the network in the state and promoting awareness among physicians;

I. Monitoring whether payers offer additional payment or incentive payments for community-based physicians who engage in clinical practice improvement activities as a result of their participation in Project ECHO programs; and if confirmed, promoting awareness among physicians;

J. Evaluating the use of the Project ECHO model to provide not only clinical training to interested physicians but also training to support practice transformation for physicians seeking to adapt to new health care delivery and payment models; and

K. Enabling the implementation of these programs in rural Texas through advocacy of the availability of broadband connectivity in rural areas.

Recommendation 2: Direct the Texas Delegation to the AMA to advocate for these policies at the national level:

• Promote awareness and greater implementation of the Project ECHO and Child Psychiatry Access Project models among both academic health centers and community-based primary care physicians;

• Work with stakeholders to identify and mitigate barriers to broader implementation of the models in the United States;

• Monitor whether payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in Project ECHO programs and if confirmed, promote awareness among physicians;

• Support broadband connectivity in all rural areas; and

• Encourage the U.S. Department of Health and Human Services to publish its findings on the potential benefits of the Project ECHO model, as required by the federal ECHO Act of December 2016 (P.L. 114-270, 114th Congress).

Sources:
3. Partnering Urban Academic Medical Centers and Rural Primary Care Clinicians to Provide Complex Chronic Disease Care, Sanjeev A., et al., Health Affairs (Millwood), June 2011; 30(6).
Subject: Alternative Maintenance of Certification (MOC) Pathways to Comply with Antitrust Rulings

Introduced by: Harris County Medical Society

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

Whereas, Texas law provides some protection to physicians from maintenance of certification (MOC) by certifying boards as it requires that the physicians of each facility must vote whether to require MOC; and

Whereas, Texas law allows some institutions to require MOC; and

Whereas, History has proven that when free-market competition exists in providers of a service or product, then quality increases and price decreases; and

Whereas, Antitrust legislation and regulations prevent monopolies; therefore be it

RESOLVED, That any facility or medical staff in Texas that has complied with Texas law in requiring maintenance of certification (MOC) must accept proof of MOC from one of multiple recertifying entities.

Related TMA Policy:

175.018 Maintenance of Certification: The maintenance of certification (MOC) process should become substantially more physician friendly, offered at a reasonable cost to physicians and requiring no more than one missed day of patient care per recertification cycle. Time spent preparing for MOC should count as AMA PRA Category 1 Credit™. Use of ongoing educational processes, such as annual board certification, should be an option for practitioners in all specialties. There should be greater coordination between American Board of Medical Specialties’ boards to ensure that the demands of MOC processes are similar across all specialties (Amended Res. 305-A-07; amended CME Rep. 6-A-17).

175.021 Maintenance of Certification Requirement: The Texas Medical Association supports the American Medical Association’s Principles of Maintenance of Certification (MOC) H-275.924 to ensure physician’s choice of lifelong learning, and will pursue legislation that eliminates discrimination by the State of Texas, employers, hospitals, and payers based on the American Board of Medical Specialties’ proprietary MOC program as a requirement for licensure, employment, hospital staff membership, and payments for medical care in Texas (Res. 206-A-16).

175.023 Initial Guiding Principles on Maintenance of Certification: The Texas Medical Association believes in the following guiding principles regarding maintenance of certification:

1. Good medical practice necessitates a commitment by each physician to life-long learning.

2. Physicians have a social contract to maintain professional competency throughout their professional careers.

3. Action is needed to maintain the privilege of self-governance and decrease the potential for governmental interference.

4. Maintenance of certification (MOC) should be a meaningful process deeply rooted in best practices, responsive to participating physicians, and highly valued by physicians and the public.
Impact of MOC

5. MOC should not be a mandated requirement for licensure, credentialing, hospital privileging, payment, network participation, or employment (TMA Policy 175.021).

6. MOC should not be a revenue-generating enterprise for the specialty boards but rather a service provided to its diplomates. MOC programs should have fiduciary responsibility to their diplomates.

7. The American Medical Association should continue to monitor MOC processes to ensure they do not have a detrimental impact on the physician workforce, resulting in shortages and access barriers, due to a high loss rate of physicians unwilling or unable to participate in the MOC process (current AMA policy).

MOC Operational Characteristics

8. The MOC process should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.

9. The MOC process should use multiple options to recognize and accommodate different learning styles for physicians.

10. The MOC process should be designed with sufficient flexibility to accommodate the broad variety of physician practice characteristics, including nonclinical activities such as teaching, leadership roles, administrative, and research.

11. Physicians with lifetime board certification should not be required to seek recertification but should be afforded the opportunity for voluntary recertification.

12. High-stakes exams, including closed-book exams, should not be mandated as part of the MOC process.

13. Charges to physicians in relation to the MOC process should not be cost prohibitive but should be reasonable, not resulting in a barrier to practice.

14. Changes to the MOC process should undergo a vigorous evaluation to ensure the requirements are relevant, feasible, reasonably affordable, and accessible.

15. Individual boards should develop MOC requirements in conjunction with evaluation and feedback from its diplomates.

16. ABMS boards should make a diligent effort to inform diplomates about changes in MOC requirements, including the rationale or evidence behind the changes, and allow sufficient time for diplomates to make any changes necessary to comply with those requirements.

17. MOC requirements should be updated to reflect ongoing changes in health care delivery systems and medical practice, including the establishment of new fields of medicine.

18. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake, intent to maintain or change practice, and assess the impact on individual practices and the specialty as a whole.

19. Diplomates should have flexibility in selecting sources of MOC-related continuing medical education (CME) programming and should not be mandated or limited to participation in CME provided by American Board of Medical Specialties member boards.

20. Physicians should be exempted from MOC for no less than five years after attainment of initial board certification.

21. Patient satisfaction programs such as the Consumer Assessment of Healthcare Providers and Systems patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties and should not be part of the MOC process.

22. The MOC program should be a tool for process improvement and should not be constructed as a punitive measure to the detriment of physicians’ practices. Careful consideration should be given to the use of physician-specific data to be publicly released regarding MOC participation.

23. The MOC program should use commonly accepted practices for identifying core competencies applicable across specialties but also should provide the flexibility necessary to reasonably reflect the distinct characteristics of each specialty.

24. The MOC process should be streamlined to prevent overburdening physicians with more than one board certification by removing duplicative requirements. MOC requirements for diplomates with added qualifications should be applicable to the diplomat’s primary area of practice (CME Rep. 6-A-17).
175.024 Monitoring Maintenance of Certification Reforms: The Texas Medical Association will: (1) monitor the American Board of Medical Specialties (ABMS’) Program for Maintenance of Certification (MOC), American Osteopathic Association’s Osteopathic Continuous Certification Program, and other MOC providers in direct correlation to adopted TMA Initial Guiding Principles on MOC; (2) continue to monitor the American Medical Association’s efforts as the national liaison with ABMS and other MOC providers, with particular focus on AMA’s work to address physician concerns and calls for MOC reform; (3) inform AMA and ABMS of adopted TMA Initial Guiding Principles on MOC; and (4) continue to assess physician views and experiences with MOC and Osteopathic Continuous Certification through activities by the Council on Medical Education as these programs incorporate reforms and communicate these findings to AMA, ABMS, and other appropriate MOC providers (CME Rep. 6-A-17).

175.025 Freedom from Maintenance of Certification: The Texas Medical Association will: (1) take the position in its advocacy efforts that all requirements for maintenance of board certification in medical staff bylaws for Texas health-related facilities, institutions, and programs that fall within the differentiation prohibition of Senate Bill 1148 (2017) should be considered null and void effective Jan. 1, 2018; (2) take the position in its advocacy efforts that any requirements for maintenance of board certification in medical staff bylaws for Texas health-related facilities, institutions, and programs that fall within the differentiation prohibition of Senate Bill 1148 (2017) require the vote of the medical staff (or satisfaction of another exception under the law); (3) take the position in its advocacy efforts that any vote for requiring maintenance of board certification in medical staff bylaws for Texas health-related facilities, institutions, and programs that fall within the differentiation prohibition under Senate Bill 1148 taken before the effective date of the bill should be considered null and void effective Jan. 1, 2018; and (4) be actively and immediately engaged in the rule-making process of SB 1148. (Res. 203-A-18)

Related AMA Policy:

H-275.924 Maintenance of Certification: AMA Principles on Maintenance of Certification (MOC)

1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.

2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.

3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.

4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).

5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.

6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.

7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.

9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit™, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."

10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.

11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.

13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.

14. MOC should be used as a tool for continuous improvement.

15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.

16. Actively practicing physicians should be well-represented on specialty boards developing MOC.

17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.

18. MOC activities and measurement should be relevant to clinical practice.

19. The MOC process should be reflective of and consistent with the cost of development and administration of the MOC components, ensure a fair fee structure, and not present a barrier to patient care.

20. Any assessment should be used to guide physicians' self-directed study.

21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.

23. Physicians with lifetime board certification should not be required to seek recertification.

24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.

25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards’ websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards’ websites or physician certification databases even if the diplomate chooses not to participate in MOC.

27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Maintenance of Certification from their specialty boards. Value in MOC should include cost effectiveness with full financial transparency, respect for physicians’ time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 202  
A-19

Subject: Clarification of Physician Protection From Maintenance of Certification (MOC) in Facility Bylaws

Introduced by: Harris County Medical Society

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

Whereas, Texas law provides some protection to physicians from maintenance of certification (MOC) by certifying boards as it requires that the physicians of each facility must vote whether to require MOC; and

Whereas, Physicians of certain medical staff categories may be disenfranchised, penalized, and restricted in practice by not being allowed to vote on the question of MOC requirements in medical staff bylaws; and

Whereas, Certain institutions in Texas have disenfranchised physicians and violated Texas law by keeping or including MOC requirements in the medical staff bylaws without putting the question of such requirements to a vote of the medical staff; and

Whereas, Certain institutions in Texas have disenfranchised physicians and violated Texas law by keeping or including MOC requirements in the medical staff bylaws by ignoring a vote of the medical staff; and

Whereas, Certain institutions in Texas have disenfranchised physicians and violated Texas law by keeping or including MOC requirements in the medical staff bylaws by accepting the decision of institutional boards, such as a Medical Executive Committee, in lieu of putting the question of such requirements to a vote of the medical staff; and

Whereas, Certain institutions in Texas have disenfranchised physicians by restricting voting to a single time and place when and where physicians may be unavailable to vote; and

Whereas, Certain institutions in Texas have disenfranchised physicians by creating system-wide bylaws that can prevent or impede changes to medical staff bylaws; therefore be it

RESOLVED, That, unless statutorily exempted, every facility in Texas must conduct a vote (over a timeframe of two to four weeks) of the entire medical staff, regardless of medical staff appointment category, prior to including or allowing to remain in the medical staff bylaws any requirement of MOC; and be it further

RESOLVED, That, regardless of the existence of any system-wide medical staff bylaws, MOC requirements and voting shall be facility-specific, with each facility providing proof of receipt of a notice to each physician when the facility plans to conduct such a vote; and be it further

RESOLVED, That this vote must ignore any wishes of the facility system, administration, or medical staff representatives and under no circumstances should there be any reprisals against any physician by the facility system, administration, or medical staff representatives over any activity involving matters pertaining to MOC.
Related TMA Policy:

**130.006 Hospital Medical Staff Bylaws**: The Texas Medical Association supports changes in current laws to make established hospital medical staff bylaws binding upon and enforceable by the hospital medical staff and the board.

TMA policy is for Hospital Accrediting Organizations to include in its standards a provision which would require that medical staff bylaws, when formally approved by a hospital governing board, be mutually and equally binding on both the governing board and the medical staff.

TMA endorses the following principles for inclusion in future drafts of the Medical Staff Chapter of the Accreditation Manual for Healthcare Organizations:

1. Continue the use of the term “medical staff” in the title of the chapter and throughout the manual;
2. Provide consideration of qualified limited licensed practitioners when authorized by state laws and approved by the executive committee of the medical staff and the governing board;
3. Require that 100 percent of the voting members of the executive committee be fully licensed physicians actively practicing; and
4. Ensure that all hospitalized patients receive the same standard of care through appropriate language relating to admissions and the responsibility for the medical care of patients (Hospital Medical Staff Section, p 151-152, A-93; reaffirmed CHSO Rep. 1-A-03; amended CHSO Rep. 1-A-13).

**130.008 Medical Staff Privileges**: Rules, regulations, or bylaws of hospitals in Texas should include the following or similar phrase: “No physician may be denied staff privileges for political reasons or because of accepting or not accepting mandated assignments for payment for fee-for-service” (Hospital Medical Staff Section, p 151, A-93; reaffirmed CHSO Rep. 1-A-03; reaffirmed CHSO Rep. 1-A-13).

**130.011 Medical Staffs**: The need for continued community-based hospital care and the potential threat posed by the failure of governing and policymaking bodies to request, receive, and heed the advice and counsel of local medical staffs are causes for community and statewide concern. Medical staffs should foster cooperative and effective communication with their governing boards and should adopt bylaws that promote medical staff credentialing policies and procedures intended to assure a competent medical staff. Medical staffs should establish the capability to assist in resolution of conflicts between their members, hospital administration, and governing boards (Council on Socioeconomics, p 180, I-94; reaffirmed CHSO Rep. 2-A-05; reaffirmed CHSO Rep. 1-A-15).

**130.015 Physician Participation in Medical Staff Affairs**: The Texas Medical Association supports the principle that a hospital may not contract to limit physician participation or staff privileges or the participation or the staff privileges of a partner, associate, or employee of the physician at a different hospital or hospital system. TMA stands opposed to placing conditions on medical staff privileges to physician members by limiting their participation in medical staff matters through such conditions and limitations (Substitute Res. 29GG, p 177D, I-97; reaffirmed CHSO Rep. 1-A-08; reaffirmed CHSO Rep. 1-A-18).

**130.026 Medical Staff Rights and Responsibilities Bill of Rights**: The Texas Medical Association adopts the following medical staff rights and responsibilities as TMA policy:

TMA recognizes the following fundamental responsibilities of the medical staff:

- The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the hospital’s governing body;
- The responsibility to provide leadership and work collaboratively with the hospital’s administration and governing body to continuously improve patient care and outcomes;
- The responsibility to participate in the hospital’s operational and strategic planning to safeguard the interest of patients, the community, the hospital, and the medical staff and its members;
• The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation;
• The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct; and
• The responsibility to make appropriate recommendations to the hospital’s governing body regarding membership, privileging, patient care, and peer review.

TMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff’s ability to fulfill its responsibilities:

• The right to be self-governed, which includes but is not limited to (1) initiating, developing, and approving or disapproving of medical staff bylaws, rules, and regulations; (2) selecting and removing medical staff leaders; (3) controlling the use of medical staff funds; (4) being advised by independent legal counsel; and (5) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for nonphysician members;
• The right to advocate for its members and their patients without fear of retaliation by the hospital’s administration or governing body;
• The right to be provided with the resources necessary to continuously improve patient care and outcomes;
• The right to be well informed and share in the decisionmaking of the hospital’s operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments;
• The right to be represented and heard, regardless of the voting rights of the physician as outlined by the medical staff bylaws, at all meetings of the hospital’s governing body; and
• The right to engage the hospital’s administration and governing body on professional matters involving their own interests.

TMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of contractual or independent status:

• The responsibility to work collaboratively with other members and with the hospital’s administration to improve quality and safety;
• The responsibility to provide patient care that meets the professional standards established by the medical staff;
• The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff;
• The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the hospital;
• The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff;
• The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.

TMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of contractual or independent status, and are essential to each member’s ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the hospital:

• The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws, which right may not be waived as a condition of employment or medical staff privileges;
The right to make treatment decisions, including referrals, based on the best interest of the patient, subject only to review by peers;

The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the hospital’s administration or governing body;

The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty;

The right to full due process before the medical staff or hospital takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments;

The right to immunity from civil damages, injunctive or equitable relief, and criminal liability when participating in good faith peer review activities; and

The right to be free of “sham peer reviews” and manipulation of medical staff bylaws by hospitals attempting to silence or inhibit the voicing of physician concerns regarding the advocacy of their patients. (CHSO Rep. 2-A-18).

175.018 Maintenance of Certification: The maintenance of certification (MOC) process should become substantially more physician friendly, offered at a reasonable cost to physicians and requiring no more than one missed day of patient care per recertification cycle. Time spent preparing for MOC should count as AMA PRA Category 1 Credit™. Use of ongoing educational processes, such as annual board certification, should be an option for practitioners in all specialties. There should be greater coordination between American Board of Medical Specialties’ boards to ensure that the demands of MOC processes are similar across all specialties (Amended Res. 305-A-07; amended CME Rep. 6-A-17).

175.021 Maintenance of Certification Requirement: The Texas Medical Association supports the American Medical Association’s Principles of Maintenance of Certification (MOC) H-275.924 to ensure physician’s choice of lifelong learning, and will pursue legislation that eliminates discrimination by the State of Texas, employers, hospitals, and payers based on the American Board of Medical Specialties’ proprietary MOC program as a requirement for licensure, employment, hospital staff membership, and payments for medical care in Texas (Res. 206-A-16).

175.023 Initial Guiding Principles on Maintenance of Certification: The Texas Medical Association believes in the following guiding principles regarding maintenance of certification:

1. Good medical practice necessitates a commitment by each physician to life-long learning.

2. Physicians have a social contract to maintain professional competency throughout their professional careers.

3. Action is needed to maintain the privilege of self-governance and decrease the potential for governmental interference.

4. Maintenance of certification (MOC) should be a meaningful process deeply rooted in best practices, responsive to participating physicians, and highly valued by physicians and the public.

Impact of MOC

5. MOC should not be a mandated requirement for licensure, credentialing, hospital privileging, payment, network participation, or employment (TMA Policy 175.021).

6. MOC should not be a revenue-generating enterprise for the specialty boards but rather a service provided to its diplomates. MOC programs should have fiduciary responsibility to their diplomates.

7. The American Medical Association should continue to monitor MOC processes to ensure they do not have a detrimental impact on the physician workforce, resulting in shortages and access barriers, due to a high loss rate of physicians unwilling or unable to participate in the MOC process (current AMA policy).

MOC Operational Characteristics

8. The MOC process should be based on evidence and designed to identify performance gaps and unmet
needs, providing direction and guidance for improvement in physician performance and delivery of care.
9. The MOC process should use multiple options to recognize and accommodate different learning styles for physicians.
10. The MOC process should be designed with sufficient flexibility to accommodate the broad variety of physician practice characteristics, including nonclinical activities such as teaching, leadership roles, administrative, and research.
11. Physicians with lifetime board certification should not be required to seek recertification but should be afforded the opportunity for voluntary recertification.
12. High-stakes exams, including closed-book exams, should not be mandated as part of the MOC process.
13. Charges to physicians in relation to the MOC process should not be cost prohibitive but should be reasonable, not resulting in a barrier to practice.
14. Changes to the MOC process should undergo a vigorous evaluation to ensure the requirements are relevant, feasible, reasonably affordable, and accessible.
15. Individual boards should develop MOC requirements in conjunction with evaluation and feedback from its diplomates.
16. ABMS boards should make a diligent effort to inform diplomates about changes in MOC requirements, including the rationale or evidence behind the changes, and allow sufficient time for diplomates to make any changes necessary to comply with those requirements.
17. MOC requirements should be updated to reflect ongoing changes in health care delivery systems and medical practice, including the establishment of new fields of medicine.
18. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake, intent to maintain or change practice, and assess the impact on individual practices and the specialty as a whole.
19. Diplomates should have flexibility in selecting sources of MOC-related continuing medical education (CME) programming and should not be mandated or limited to participation in CME provided by American Board of Medical Specialties member boards.
20. Physicians should be exempted from MOC for no less than five years after attainment of initial board certification.
21. Patient satisfaction programs such as the Consumer Assessment of Healthcare Providers and Systems patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties and should not be part of the MOC process.
22. The MOC program should be a tool for process improvement and should not be constructed as a punitive measure to the detriment of physicians’ practices. Careful consideration should be given to the use of physician-specific data to be publicly released regarding MOC participation.
23. The MOC program should use commonly accepted practices for identifying core competencies applicable across specialties but also should provide the flexibility necessary to reasonably reflect the distinct characteristics of each specialty.
24. The MOC process should be streamlined to prevent overburdening physicians with more than one board certification by removing duplicative requirements. MOC requirements for diplomates with added qualifications should be applicable to the diplomate’s primary area of practice (CME Rep. 6-A-17).

175.024 Monitoring Maintenance of Certification Reforms: The Texas Medical Association will: (1) monitor the American Board of Medical Specialties’ (ABMS’) Program for Maintenance of Certification (MOC), American Osteopathic Association’s Osteopathic Continuous Certification Program, and other MOC providers in direct correlation to adopted TMA Initial Guiding Principles on MOC; (2) continue to monitor the American Medical Association’s efforts as the national liaison with ABMS and other MOC providers, with particular focus on AMA’s work to address physician concerns and calls for MOC reform; (3) inform AMA and ABMS of adopted TMA Initial Guiding Principles on MOC; and (4) continue to assess physician views and experiences with MOC and Osteopathic Continuous Certification through activities by the Council on Medical Education as these programs incorporate reforms and communicate these findings to AMA, ABMS, and other appropriate MOC providers (CME Rep. 6-A-17).
175.025 Freedom from Maintenance of Certification: The Texas Medical Association will: (1) take the
position in its advocacy efforts that all requirements for maintenance of board certification in medical
staff bylaws for Texas health-related facilities, institutions, and programs that fall within the
differentiation prohibition of Senate Bill 1148 (2017) should be considered null and void effective Jan. 1,
2018; (2) take the position in its advocacy efforts that any requirements for maintenance of board
certification in medical staff bylaws for Texas health-related facilities, institutions, and programs that fall
within the differentiation prohibition of Senate Bill 1148 (2017) require the vote of the medical staff (or
satisfaction of another exception under the law); (3) take the position in its advocacy efforts that any vote
for requiring maintenance of board certification in medical staff bylaws for Texas health-related facilities,
institutions, and programs that fall within the differentiation prohibition under Senate Bill 1148 taken
before the effective date of the bill should be considered null and void effective Jan. 1, 2018; and (4) be
actively and immediately engaged in the rule-making process of SB 1148 (Res. 203-A-18).
Subject: Restrictions to Requirements of Maintenance of Certification

Introduced by: Harris County Medical Society

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

Whereas, Texas law provides some protection to physicians from maintenance of certification (MOC) by certifying boards; and

Whereas, MOC requirements such as licensing verification can be performed easily online by any board without wasting physician resources; and

Whereas, Adequate CME requirements already exist for licensure and oversight by the Texas Medical Board; and

Whereas, Many MOC requirements have proven to be unfair; needlessly time-consuming; irrelevant to a physician’s scope of practice; costly in time away from patient care, in expenses of testing and preparation, and in personal time; and needless in data collection, possibly for the sole benefit of the certifying board; and

Whereas, MOC has never proven to improve the quality of patient care, prevent medical malpractice, provide protection to patients, nor provide value to physicians who endure the time, expense, sacrifice, and stress of the recertification process; therefore be it

RESOLVED, That the Texas Medical Association oppose mandatory maintenance of certification; and be it further

RESOLVED, That what constitutes life-long learning remain under the purview of state medical boards; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association take this resolution to the AMA House of Delegates.

Related TMA Policy:

175.018 Maintenance of Certification: The maintenance of certification (MOC) process should become substantially more physician friendly, offered at a reasonable cost to physicians and requiring no more than one missed day of patient care per recertification cycle. Time spent preparing for MOC should count as AMA PRA Category 1 Credit™. Use of ongoing educational processes, such as annual board certification, should be an option for practitioners in all specialties. There should be greater coordination between American Board of Medical Specialties’ boards to ensure that the demands of MOC processes are similar across all specialties (Amended Res. 305-A-07; amended CME Rep. 6-A-17).

175.021 Maintenance of Certification Requirement: The Texas Medical Association supports the American Medical Association’s Principles of Maintenance of Certification (MOC) H-275.924 to ensure physician’s choice of lifelong learning, and will pursue legislation that eliminates discrimination by the State of Texas, employers, hospitals, and payers based on the American Board of Medical Specialties’
proprietary MOC program as a requirement for licensure, employment, hospital staff membership, and payments for medical care in Texas (Res. 206-A-16).

175.023 Initial Guiding Principles on Maintenance of Certification: The Texas Medical Association believes in the following guiding principles regarding maintenance of certification:

1. Good medical practice necessitates a commitment by each physician to life-long learning.  
2. Physicians have a social contract to maintain professional competency throughout their professional careers.  
3. Action is needed to maintain the privilege of self-governance and decrease the potential for governmental interference.  
4. Maintenance of certification (MOC) should be a meaningful process deeply rooted in best practices, responsive to participating physicians, and highly valued by physicians and the public.

Impact of MOC

5. MOC should not be a mandated requirement for licensure, credentialing, hospital privileging, payment, network participation, or employment (TMA Policy 175.021).  
6. MOC should not be a revenue-generating enterprise for the specialty boards but rather a service provided to its diplomates. MOC programs should have fiduciary responsibility to their diplomates.  
7. The American Medical Association should continue to monitor MOC processes to ensure they do not have a detrimental impact on the physician workforce, resulting in shortages and access barriers, due to a high loss rate of physicians unwilling or unable to participate in the MOC process (current AMA policy).

MOC Operational Characteristics

8. The MOC process should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.  
9. The MOC process should use multiple options to recognize and accommodate different learning styles for physicians.  
10. The MOC process should be designed with sufficient flexibility to accommodate the broad variety of physician practice characteristics, including nonclinical activities such as teaching, leadership roles, administrative, and research.  
11. Physicians with lifetime board certification should not be required to seek recertification but should be afforded the opportunity for voluntary recertification.  
12. High-stakes exams, including closed-book exams, should not be mandated as part of the MOC process.  
13. Charges to physicians in relation to the MOC process should not be cost prohibitive but should be reasonable, not resulting in a barrier to practice.  
14. Changes to the MOC process should undergo a vigorous evaluation to ensure the requirements are relevant, feasible, reasonably affordable, and accessible.  
15. Individual boards should develop MOC requirements in conjunction with evaluation and feedback from its diplomates.  
16. ABMS boards should make a diligent effort to inform diplomates about changes in MOC requirements, including the rationale or evidence behind the changes, and allow sufficient time for diplomates to make any changes necessary to comply with those requirements.  
17. MOC requirements should be updated to reflect ongoing changes in health care delivery systems and medical practice, including the establishment of new fields of medicine.  
18. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake, intent to maintain or change practice, and assess the impact on individual practices and the specialty as a whole.  
19. Diplomates should have flexibility in selecting sources of MOC-related continuing medical education (CME) programming and should not be mandated or limited to participation in CME provided by American Board of Medical Specialties member boards.  
20. Physicians should be exempted from MOC for no less than five years after attainment of initial board
certification.

21. Patient satisfaction programs such as the Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties and should not be part of the MOC process.

22. The MOC program should be a tool for process improvement and should not be constructed as a punitive measure to the detriment of physicians' practices. Careful consideration should be given to the use of physician-specific data to be publicly released regarding MOC participation.

23. The MOC program should use commonly accepted practices for identifying core competencies applicable across specialties but also should provide the flexibility necessary to reasonably reflect the distinct characteristics of each specialty.

24. The MOC process should be streamlined to prevent overburdening physicians with more than one board certification by removing duplicative requirements. MOC requirements for diplomates with added qualifications should be applicable to the diplomate's primary area of practice (CME Rep. 6-A-17).

175.024 Monitoring Maintenance of Certification Reforms: The Texas Medical Association will: (1) monitor the American Board of Medical Specialties (ABMS') Program for Maintenance of Certification (MOC), American Osteopathic Association's Osteopathic Continuous Certification Program, and other MOC providers in direct correlation to adopted TMA Initial Guiding Principles on MOC; (2) continue to monitor the American Medical Association's efforts as the national liaison with ABMS and other MOC providers, with particular focus on AMA's work to address physician concerns and calls for MOC reform; (3) inform AMA and ABMS of adopted TMA Initial Guiding Principles on MOC; and (4) continue to assess physician views and experiences with MOC and Osteopathic Continuous Certification through activities by the Council on Medical Education as these programs incorporate reforms and communicate these findings to AMA, ABMS, and other appropriate MOC providers (CME Rep. 6-A-17).

175.025 Freedom from Maintenance of Certification: The Texas Medical Association will: (1) take the position in its advocacy efforts that all requirements for maintenance of board certification in medical staff bylaws for Texas health-related facilities, institutions, and programs that fall within the differentiation prohibition of Senate Bill 1148 (2017) should be considered null and void effective Jan. 1, 2018; (2) take the position in its advocacy efforts that any requirements for maintenance of board certification in medical staff bylaws for Texas health-related facilities, institutions, and programs that fall within the differentiation prohibition of Senate Bill 1148 (2017) require the vote of the medical staff (or satisfaction of another exception under the law); (3) take the position in its advocacy efforts that any vote for requiring maintenance of board certification in medical staff bylaws for Texas health-related facilities, institutions, and programs that fall within the differentiation prohibition of Senate Bill 1148 (2017) take before the effective date of the bill should be considered null and void effective Jan. 1, 2018; and (4) be actively and immediately engaged in the rule-making process of SB 1148 (Res. 203-A-18).

Related AMA Policy:

Maintenance of Certification and Osteopathic Continuous Certification D-275.954

Our AMA will:

1. Continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the House of Delegates regarding the MOC and OCC process.

2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOC and OCC issues.

3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of MOC, and encourage the ABMS to report its research findings on the issues surrounding certification and MOC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC.

5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of MOC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.

6. Work with interested parties to ensure that MOC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that MOC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.

7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.

8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from MOC requirements.

9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting MOC and certifying examinations.

10. Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.

11. Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, particularly to ensure that MOC is specifically relevant to the physician’s current practice.

12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for MOC; (b) support ABMS member board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet MOC requirements.

13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.

14. Work with the ABMS to study whether MOC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.

15. Encourage the ABMS to use data from MOC to track whether physicians are maintaining certification and share this data with the AMA.

16. Encourage AMA members to be proactive in shaping MOC and OCC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and MOC Committees.

17. Continue to monitor the actions of professional societies regarding recommendations for modification of MOC.

18. Encourage medical specialty societies’ leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members.

19. Continue to work with the ABMS to ensure that physicians are clearly informed of the MOC requirements for their specific board and the timelines for accomplishing those requirements.

20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.

21. Recommend to the ABMS that all physician members of those boards governing the MOC process be required to participate in MOC.

22. Continue to participate in the National Alliance for Physician Competence forums.

23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC.

24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's MOC and associated processes.

26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the MOC program.

27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Maintenance of Certification.

28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on maintenance of certification activities relevant to their practice.

29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.

30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.

31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.

32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.

33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.

34. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.

35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for MOC Part IV.

36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.

37. Through its Council on Medical Education, continue to be actively engaged in following the work of the ABMS Continuing Board Certification: Vision for the Future Commission.

38. (a) Submit commentary to the American Board of Medical Specialties (ABMS) Continuing Board Certification: Vision for the Future initiative, asking that junior diplomates be given equal opportunity to serve on ABMS and its member boards; and (b) work with the ABMS and member boards to encourage the inclusion of younger physicians on the ABMS and its member boards.

39. Continue studying the certifying bodies that compete with the American Board of Medical Specialties and provide an update in the Council on Medical Education’s annual report on maintenance of certification at the 2019 Annual Meeting.

An Update on Maintenance of Licensure D-275.957

Our American Medical Association will: 1. Continue to monitor the evolution of Maintenance of Licensure (MOL), continue its active engagement in discussions regarding MOL implementation, and report back to the House of Delegates on this issue.

2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOL issues.

3. Work with the Federation of State Medical Boards (FSMB) to study whether the principles of MOL are important factors in a physician's decision to retire or have a direct impact on the U.S. physician.
workforce.

4. Work with interested state medical societies and support collaboration with state specialty medical societies and state medical boards on establishing criteria and regulations for the implementation of MOL that reflect AMA guidelines for implementation of state MOL programs and the FSMB’s Guiding Principles for MOL.

5. Explore the feasibility of developing, in collaboration with other stakeholders, AMA products and services that may help shape and support MOL for physicians.

6. Encourage the FSMB to continue to work with state medical boards to accept physician participation in the American Board of Medical Specialties maintenance of certification (MOC) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and advocate that MOC or OCC not be the only pathway to MOL for physicians.

7. Continue to work with the FSMB to establish and assess MOL principles, with the AMA to assess the impact of MOL on the practicing physician and the FSMB to study its impact on state medical boards.

8. Encourage rigorous evaluation of the impact on physicians of any future proposed changes to MOL processes, including cost, staffing, and time.

An Update on Maintenance of Licensure H-275.917

AMA Principles on Maintenance of Licensure (MOL):

1. Our American Medical Association (AMA) established the following guidelines for implementation of state MOL programs:

   A. Any MOL activity should be able to be integrated into the existing infrastructure of the health care environment.
   
   B. Any MOL educational activity under consideration should be developed in collaboration with physicians, should be evidence-based and should be practice-specific. Accountability for physicians should be led by physicians.
   
   C. Any proposed MOL activity should undergo an in-depth analysis of the direct and indirect costs, including physicians' time and the impact on patient access to care, as well as a risk/benefit analysis, with particular attention to unintended consequences.
   
   D. Any MOL activity should be flexible and offer a variety of compliance options for all physicians, practicing or non-practicing, which may vary depending on their roles (e.g., clinical care, research, administration, education).
   
   E. Any MOL activity should be designed for quality improvement and lifelong learning.
   
   F. Participation in quality improvement activities, such as chart review, should be an option as an MOL activity.

2. Our AMA supports the Federation of State Medical Boards Guiding Principles for MOL (current as of June 2015), which state that:

   A. Maintenance of licensure should support physicians' commitment to lifelong learning and facilitate improvement in physician practice.
   
   B. Maintenance of licensure systems should be administratively feasible and should be developed in collaboration with other stakeholders. The authority for establishing MOL requirements should remain within the purview of state medical boards.
   
   C. Maintenance of licensure should not compromise patient care or create barriers to physician practice.
   
   D. The infrastructure to support physician compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements.
   
   E. Maintenance of licensure processes should balance transparency with privacy protections (e.g., should capture what most physicians are already doing, not be onerous, etc.).

3. Our AMA will:

   A. Continue to support and promote the AMA Physician's Recognition Award (PRA) Credit system as
one of the three major CME credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format, and continue to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME as part of the process for MOL.

B. Advocate that if state medical boards move forward with a more intense or rigorous MOL program, each state medical board be required to accept evidence of successful ongoing participation in the ABMS MOC and AOA-Bureau of Osteopathic Specialists Osteopathic Continuous Certification to have fulfilled all three components of the MOL, if performed,

C. Advocate that state medical boards accept programs created by specialty societies as evidence that the physician is participating in continuous lifelong learning and allow physicians to choose which programs they participate in to fulfill their MOL criteria.

D. Oppose any MOL initiative that creates barriers to practice, is administratively unfeasible, is inflexible with regard to how physicians practice (clinically or not), does not protect physician privacy, or is used to promote policy initiatives about physician competence.

**Maintenance of Certification H-275.924**

AMA Principles on Maintenance of Certification (MOC)

1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.

2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.

3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.

4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).

5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.

6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.

7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.

8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.

9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (**AMA PRA Category 1 Credit™**, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."

10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards.
accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.

11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.

13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.

14. MOC should be used as a tool for continuous improvement.

15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.

16. Actively practicing physicians should be well-represented on specialty boards developing MOC.

17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.

18. MOC activities and measurement should be relevant to clinical practice.

19. The MOC process should be reflective of and consistent with the cost of development and administration of the MOC components, ensure a fair fee structure, and not present a barrier to patient care.

20. Any assessment should be used to guide physicians' self-directed study.

21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.

22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.

23. Physicians with lifetime board certification should not be required to seek recertification.

24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.

25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards’ websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards’ websites or physician certification databases even if the diplomate chooses not to participate in MOC.

27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Maintenance of Certification from their specialty boards. Value in MOC should include cost effectiveness with full financial transparency, respect for physicians’ time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes.
Subject: Eliminating Professional and Colloquial Use of the Term “Mental Retardation” by Physicians in a Clinical Setting

Introduced by: Medical Student Section

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

Whereas, The diagnostic and statistical manual of mental disorders (DSM-V) replaced the diagnosis of “mental retardation” with that of “intellectual disability” (intellectual developmental disorder) in 2013; and

Whereas, The updated DSM-V terminology more specifically reflects an affected individual’s condition, its impact on his or her intellectual and adaptive functioning, and encourages a more in-depth comprehension of a patient’s diagnosis; and

Whereas, In 2013, the Social Security Administration published a rule in the Federal Register to use the term “intellectual disability” in place of “mental retardation” for claims involving mental disorders; and

Whereas, In 2017, Public Law 111–256, also known as Rosa’s Law, was amended to eliminate the use of the term “mental retardation” in federal law and replace it with “intellectual disability” without changing the definition, coverage, eligibility, rights, and responsibilities of the affected individuals; and

Whereas, A 2012 study showed that while there has been an increase in the use of the terms “intellectual disability” or “developmental delay” in the past several years in primary literature, the term “mental retardation” remains the most commonly used clinical term in written publications and continues to be used regularly by physicians in clinical settings; and

Whereas, The same 2012 study surveyed parents and physicians regarding the use of the term “mental retardation” and the vast majority of both groups agreed that the term should not be utilized when talking to patients or their families about their diagnoses; and

Whereas, The campaign “Spread the Word to End the Word” is led by the Special Olympics organization and other organizations who seek to eliminate the pejorative and dehumanizing word “retarded” from public vernacular in order to promote the shift in focus from the disability to the individual and his or her accomplishments; and

Whereas, The term “mental retardation” promotes the stigma and negative treatment of people with intellectual disabilities, which also is associated with diminished access and poorer health, employment, and quality of life outcomes; and

Whereas, The World Health Organization has used diagnostic identification to update its International Classification of Diseases to expand the term “intellectual disability” to include a variety of disorders that are on the same developmental spectrum as “mental retardation,” thereby removing a core classification and implementing a more effective, parent category for developmental disorders; therefore be it
RESOLVED, That the Texas Medical Association support the elimination of the term “mental retardation” from its professional and colloquial use by physicians in a clinical setting, to be replaced with more widely accepted terminology, such as “intellectual disability” or “developmental disorder;” and be it further

RESOLVED, That the Texas Delegation carry this, or a similar resolution, to the American Medical Association that the term “mental retardation” be replaced with more widely accepted terminology by all United States physicians in a clinical setting.

Related TMA Policy:

254.014 Physicians and Substance Use Disorder: Physicians and Substance Use Disorder: The Texas Medical Association recommended that physicians adopt the term "substance use disorder" terminology instead of "addiction."

215.009 Mental Health Institutions Community Mental Health Care Centers: Community mental health and intellectual and developmental disability centers, community mental retardation centers, are providing diagnostic, therapeutic, rehabilitative, preventive, and/or educational services to a large number of persons with mental, behavioral, emotional, and/or adjustment problems, or with intellectual disabilities and/or with related disorders. Such centers are and should be classified as mental health care facilities, and the clinical director of all such centers should be required to be a licensed physician, preferably a psychiatrist, experienced in mental health care.

215.014 Texas Health and Human Services Advisory Councils: The Texas Medical Association supports representation by licensed psychiatrists on Health and Human Services Advisory Councils for services that impact the care of people with mental illness and/or developmental disabilities, including the Drug Utilization Board, the State Medicaid Advisory Committee, and the State Health Services Council.

Related AMA Policy:

H-90.968 Medical Care of Persons with Developmental Disabilities: The American Medical Association encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with developmental disabilities; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability can impact the physical and mental health of persons with Developmental Disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports for patients with developmental disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound developmental disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the developmentally disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with developmental disabilities.

Sources:


TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 206
A-19

Subject: Considerations for Care of Individuals With Autism Spectrum Disorder (ASD)

Introduced by: Medical Student Section

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

Whereas, Autism Spectrum Disorder (ASD) is a range of neurodevelopmental disorders characterized by limited interests, social impairment, and repetitive behaviors; and

Whereas, Adults with ASD have higher rates of chronic medical illnesses, and increased exposure to violence and abuse; and

Whereas, Adults with ASD are more likely to be hospitalized or visit the emergency room due to barriers preventing them from accessing care, such as difficulty waiting in the waiting room, tolerating vital signs, and intolerance to needles or to being touched; and

Whereas, Youth with ASD are less likely to receive specific preventative services, such as vaccination; and

Whereas, Physicians have a responsibility to recognize caregiver burden; and

Whereas, Caregiver burden is prevalent in parents of children with autism, who have a greater risk for developing depression, stress, anxiety, and distress; and

Whereas, Parents of individuals with autism report that they receive “passive or decreased” reassurance about their child’s condition; and

Whereas, Staff in the health care field often lack the time and training to adapt to the communication and care needs of individuals with autism; and

Whereas, Physicians are aware of medical home deficiencies for children with autism, and acknowledge that they feel less competent providing primary care for children with autism compared to children with other neurodevelopmental conditions; and

Whereas, Applied Behavioral Analysis (ABA) therapy is the treatment approach with the best evidence to have a positive impact on child behavior, particularly in individuals with ASD; and

Whereas, Children receiving center-based ABA therapy made further gains than those receiving home-based ABA therapy; and

Whereas, The Texas Health and Human Services Commission Children’s Autism Program provides focused ABA services through local community agencies and organizations; and

Whereas, Autism Speaks is a global organization providing free autism information and resources to over 18 million people; and
Whereas, Telehealth services provide rural communities with effective and easily accessible services for ASD, such as ABA and Cognitive Behavioral Therapy (CBT); therefore be it
RESOLVED, That the Texas Medical Association support the provision of resources in the community to individuals with autism and to their families in order to provide a more comprehensive spectrum of primary and preventative care to individuals with autism; and be it further
RESOLVED, That TMA encourage Texas medical schools to educate students using a holistic and practical approach to treatment, management, and care for their patients with ASD; and be it further
RESOLVED, That TMA encourage physicians to become more aware of state and local demographics and promote existing resources in order to better accommodate patients with ASD in rural or underserved communities.

Related TMA Policy:

**200.049 Advocacy Education in Medical School Curricula:** The Texas Medical Association supports medical school efforts to provide advocacy education for medical students (Amended Res. 205-A-13; originally numbered 200.050).

**200.054 High-Value Care in Undergraduate and Graduate Medical Education:** The Texas Medical Association supports the inclusion and integration of topics of health care value in medical education (Res. 201-A-18).

**55.033 Children's Mental and Behavioral Health:** Texas has a relatively young population, with about 28 percent of Texans under the age of 18. TMA recognizes that many mental health disorders of childhood are the basis of both physical and mental disease throughout an entire lifespan. Childhood and adolescence are critical times for brain development; consequently, many mental disorders develop during these periods. Managing mental health disorders among children requires multiple strategies.

**Physician Education.** All physicians should have adequate information that enables them to recognize common mental disorders. Primary care physicians should be provided educational tools regarding the screening, diagnosis, and current available treatment modalities for mental disorders such as attention deficit disorder, mild depression, and mild anxiety. TMA can provide resources for physicians on national screening and treatment guidelines, and billing and coding information.

**Practice.** Access to care remains a critical issue for children and adolescents with mental health disorders, especially underserved children. A physician-led medical home, therefore, can play an important role in recognizing, consulting, and treating children with mental health disorders by following the United States Preventive Services Task Force (USPSTF) recommendations for screening children and adolescents for mental health disorders.

All physicians who see and treat children should be able to recognize and either treat or refer children with obvious mental illness including substance abuse disorder.

Because school is the "workplace of the child," primary care physicians should have knowledge of the demands and resources of their local school districts.

**Advocacy.** TMA should facilitate and advocate for:

- Continuing mental health education programs for physicians and mental health care providers regarding child and adolescent mental health and substance abuse,
b. Medical schools and graduate medical education programs that recognize the role of primary care physicians and provide effective training and research in all aspects of child and adolescent mental health and substance abuse,
c. Continuing dialogue and networking with the public mental health community on these issues,
d. Minimizing youth exposure to advertisements for legal addicting substances,
e. Positive mental health messages that counteract tobacco and alcohol advertisements,
f. Strong children's mental health networks throughout the state,
g. Emphasizing pediatric mental health education for all physicians who see children,
h. Adequate numbers and quality of mental health professionals throughout the state,
i. Coordinating with the educational system for mentally healthy schools, and

Related AMA Policy: None.

Sources:

Whereas, Service learning combines community service engagement with structured academic learning by facilitating long-term community partnerships aimed towards fulfilling the needs of community members; and

Whereas, Service learning programs are successful when there are established and studied frameworks in place to support engaged volunteers, which then cater to intrinsic motivations within students, making the time spent both worthwhile and targeted in impact; and

Whereas, There is no existing study on the current state of service learning opportunities offered within Texas medical schools and their impact; and

Whereas, Engaging in service learning allows students to reflect on their contributions, focus on their communities, contextually synthesize academic concepts, and promote a deeper level of care for patients; and

Whereas, Service learning can allow students to establish long-term relationships with patients from an underserved population in their community, exposing students to the complex medical and social conditions that contribute to the health outcomes among the underserved; and

Whereas, Studies have shown that service learning experiences can significantly improve a student’s ability to determine the health literacy status of patients and communicate with patients; and

Whereas, Qualitative interviews have shown that engaging in service learning promotes interdisciplinary work in the fields of public health and allows students and trainees to identify the health needs of their community; and

Whereas, Service learning is significantly correlated with improving students’ ability to obtain a history and perform a physical exam following volunteer experience in free clinics; and

Whereas, The Liaison Committee on Medical Education Competencies and the Association of American Medical Colleges recognize the benefits of structured service learning experiences and mandate that medical schools provide support for service learning and projects that benefit communities in competency 6.6 of the LCME’s Functions and Structure of a Medical School guide; and

Whereas, Service learning opportunities are well studied and there are multiple established frameworks for developing and implementing them into the existing framework of medical education institutions; and

Whereas, Schools who use service learning models have stronger ties to their local communities and faculty members and students alike have increased opportunities to conduct research and take action to improve health outcomes; and
Whereas, The American Medical Association supports the inclusion of service learning in medical education and the Texas Medical Association supports community-based medical education as a viable model; therefore be it

RESOLVED, That the Texas Medical Association study the impact of existing service learning programs and opportunities undergraduate medical education; and be it further

RESOLVED, That TMA collaborate with appropriate parties to identify evidence-based strategies to increase service learning opportunities for Texas undergraduate medical students.

Related TMA Policy:

115.005 Charity Care: Recognizing the problems of access to medical and health care for the indigent, Texas physicians should voluntarily provide charity care to those who are unable to pay and to donate time to public clinics. Existing community facilities should be utilized to provide care for the medically indigent, and state agencies should augment existing community resources to provide primary care services where such assistance is necessary (Council on Medical Education, p 89, A-94; reaffirmed CME Rep. 4-A-04; reaffirmed CM-PDHCA Rep. 2-A-14).

200.036 Community Based Medical Education: The Texas Medical Association believes that community-based medical education is a viable model that should be evaluated in each community (BOT Rep. 6-I-00; reaffirmed CME Rep. 2-A-10).

260.005 Community and Migrant Health Centers: The Texas Medical Association reaffirms the importance of funding for comprehensive primary care, access and public health partnership through community and migrant health center programs (YPS, p 139-140, A-91; amended CPH Rep. 4-A-01; reaffirmed CSPH Rep. 3-A-11).

200.044 Community-Based Physicians as Educators and Mentors: The Texas Medical Association recognizes the important role of community physicians in educating and mentoring medical students and residents. TMA believes clerkships and other learning experiences in community-based physician practices afford medical students and residents greater exposure to different practice environments and real-world medicine. These experiences can enable medical students to be better informed when making decisions about a medical specialty as well as a preferred practice location and setting. TMA encourages the continued development and retention of partnerships between academic health centers and community-based physicians (CME Rep. 4-A-07; amended CME Rep. 7-A-17).

115.020 Supporting Community-Based Health Care Delivery Models for Vulnerable Patients: The Texas Medical Association supports the concept and implementation of community-based health care delivery models emphasizing meaningful access for vulnerable patients throughout Texas. TMA will collaborate with the county medical societies to advocate before the Texas Health and Human Services Commission, elected officials, and the Centers for Medicare & Medicaid Services for adoption of community-based health care delivery models (Res. 403-A-17).

260.037 Essential Public Health Services: The Texas Medical Association adopted the Essential Public Health Services Work Group's definition of public health and essential public health services: (1) monitor health status to identify community health problems; (2) diagnose and investigate health problems and health hazards in the community; (3) inform, educate, and empower people about health issues; (4) mobilize community partnerships to identify and solve health problems; (5) develop policies and plans that support individual and community health efforts; (6) enforce laws and regulations that protect health and ensure safety; (7) link people to needed personal health services and assure the provision of health care when
otherwise unavailable; (8) assure a competent public health and personal health care workforce; (9) evaluate
effectiveness, accessibility, and quality of personal and population-based health services; and (10) research
for new insights and innovative solutions to health problems. In addition, in accordance with stated principles,
TMA affirms that public health departments should be adequately funded in order to provide these essential
services in every Texas community deliberately and apart from indigent care. TMA supports efforts to arrive
at agreeable solutions to ensuring a stable public health system capable of adapting to health systems reform
and the challenges of addressing emerging public health issues (CPH, p 80, I-95; reaffirmed CPH Rep. 2-A-
05; amended CSPH Rep. 3-A-13).

Related AMA Policy:

**H-295.916 Improving Medical School/Community Practice:**

1. Medical schools should be encouraged to include community physicians who serve as volunteer faculty in
medical school activities and in committees and other decision-making bodies related to the student
educational program, such as the curriculum committee and the admission committee, and in search
committees for medical school deans and department chairs.
2. County/state medical societies should be encouraged to include medical school administrators and faculty
members in committees and other society activities, and to consider creating a seat for medical school deans
in the state society house of delegates.
3. There should be mechanisms established at local or state levels to address tensions arising between the
academic and practice communities, such as problems associated with the granting of faculty appointment or
hospital staff privileges.
4. Medical schools and other academic continuing medical education providers should work with community
physicians to develop continuing education programs that address local needs.
5. Community physician groups and schools of medicine should be encouraged to communicate during the
initial stages of discussions about the formation of patient care networks.

**H-295.880 Service Learning in Medical Education:** Our AMA will support the concept of service learning
as a key component in medical school and residency curricula, and that these experiences should include
student and resident collaboration with a community partner to improve the health of the population.

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5. Gardner, Janet, and Jan Emory. “Changing Students’ Perceptions of the Homeless: A Community Service
https://doi.org/10.1016/j.nepr.2018.01.001.
https://www.ama-assn.org/education/accelerating-change-medical-education/treating-community-your-
patient.

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 208
A-19

Subject: Integration and Maintenance of Wellness Initiatives in Texas Undergraduate and Graduate Medical Education

Introduced by: Medical Student Section

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

Whereas, The current medical education system has unintended, yet significantly negative, effects on student well-being and personal development; and

Whereas, Inadequate sleep, decreased exercise frequency, and a positive depression screen are associated with burnout risk in medical students; and

Whereas, Stress, burnout, and depression are significant manifestations of distress experienced by students from the time of matriculation through the completion of residency training, and at least 24 percent of first and second year students are considered depressed or dysphoric based on the Beck Depression Inventory; and

Whereas, Assessment of students at the Albert Einstein College of Medicine indicated an increase in perceived stress and risk for depression (a Center for Epidemiologic Studies Depression Scale Score greater than 16) in third year medical students when compared to first year students, with the number of students at risk for depression increasing from 28.4 percent in the first year to 39 percent in the third year; and

Whereas, Research indicates a need for improved learning environments and systems to support physicians in training who have comparatively higher rates of suicide and depression (22 to 35 percent) compared to the general population (17 percent); and

Whereas, Regulation of duty hours alone is not sufficient to improve overall resident well-being, indicating that greater flexibility to accommodate resident training needs is required; and

Whereas, The St. Louis University School of Medicine reports a decrease in depression rates from 27 percent to 11 percent following implementation of prevention-focused wellness initiatives which identify the suboptimal aspects of the learning environment and address the source of student distress rather than viewing stress as an inevitable outcome; and

Whereas, 82 percent of students at Northwestern University’s Feinberg School of Medicine, who reported that their well-being suffered due to the rigors of medical school, were better able to recognize their limitations and were more willing to seek help without experiencing guilt after implementation of wellness courses into the curriculum; and

Whereas, Research findings suggest that students who practice positive lifestyle habits and behaviors are more confident in their ability to counsel patients on wellness and achieve better patient outcomes; and

Whereas, 75 percent of students at the Vanderbilt University School of Medicine demonstrated improved perceptions of wellness and career counseling following implementation of an Advisory College Program
which supported productivity and professional satisfaction through group-based faculty engagement with
students; and

Whereas, Review of institutional wellness programs such as the trainee-specific patient-centered medical
home model developed as part of The University of Texas Southwestern Housestaff Health and Wellness
Initiative suggests that coordinated care and scheduling accommodations improve student health, safety, and
performance; and

Whereas, Integration of wellness initiatives into medical education can be achieved through efficient changes
to the existing infrastructure and includes transition to a pass/fail grading system, increased elective
opportunities, and emphasis on team-based learning; and

Whereas, The University of Texas System’s Transformation in Medical Education initiative addresses
resiliency and promotes student well-being by integrating wellness into medical education during the initial
stages of professional identity formation; and

Whereas, Self-evaluation of wellness through an Integrative Health and Wellness Assessment (IHWA) is a
potential tool for students to assess health behaviors and identify sources of distress; and

Whereas, Standardized definitions of student wellness, quality of life, and burnout in addition to assessments
such as the IHWA are necessary for the establishment of evidence-based interventions to improve the welfare
of medical trainees; therefore be it

RESOLVED, That the Texas Medical Association supports research on a systematic and standardized
approach to wellness in order to establish common terminology and a basic framework for wellness programs
in Texas undergraduate and graduate medical education; and be it further

RESOLVED, That TMA advocates for the integration of a standard multidimensional wellness model into
Texas undergraduate and graduate medical education and encourages those institutions in their efforts to
routinely monitor and assess student well-being.

Related TMA Policy:

130.025 Healthy Food in Hospitals Healthy Food in Hospitals:

Texas Medical Association encourages hospitals to: (1) offer and promote healthy, reasonably priced, and easily accessible food options; and (2) work towards providing food options in accordance with Food and Drug Administration Dietary Guidelines for Americans 2015-2020, such as increased fruits and vegetables and decreased added sugar, saturated fats, and sodium consumption (Res. 310-A-17).

Related AMA Policy:

H-405.959 Physicians and Physicians-in-Training as Examples for Their Patients to Promote Wellness and Healthy Lifestyles:

Our AMA will: (1) establish a program that recognizes physicians and physicians-in-training who model wellness and healthy lifestyles in their practice and communities or establish programs that contribute to the wellness of their patients and/or community; and (2) will aid in the development of a health and wellness component in conjunction with the Doctors Back to School Program

9.3.1 Physician Health and Wellness:

When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress. To fulfill this responsibility individually, physicians should: (a) Maintain their own health and wellness by: (i) following healthy lifestyle
habits; (ii) ensuring that they have a personal physician whose objectivity is not compromised. (b) Take appropriate action when their health or wellness is compromised, including: (i) engaging in honest assessment of their ability to continue practicing safely; (ii) taking measures to mitigate the problem; (iii) taking appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease; (iv) seeking appropriate help as needed, including help in addressing substance abuse. Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition. Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.

H-295.993 Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs: Our AMA: (1) recognizes the need for appropriate mechanisms to include medical students and resident physicians in the monitoring and advocacy services of state physician health programs and wellness and other programs to prevent impairment and burnout; and (2) encourages medical school administration and students to work together to develop creative ways to inform students concerning available student assistance programs and other related services.

H-405.961 Physician Health Programs: Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness.

Sources:
10. Sastre, Elizabeth Ann, Erin E. Burke, Evan Silverstein, Asher Kupperman, Jennifer A. Rymer, Mario A. Davidson, Scott M. Rodgers, and Amy E. Fleming. "Improvements in Medical School Wellness and


Subject: Promoting Health Insurance and Health Policy Education Prior to Residency

Introduced by: Medical Student Section

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

Whereas, 17 percent of Texans lack health insurance, which is twice the state average in the United States; and

Whereas, By 2040, more than 6.1 million Texans will be uninsured, which translates to an estimated total loss of $178.5 billion, justifying the need to address health uninsurance in Texas by improving patient health insurance literacy; and

Whereas, The Centers for Disease Control and Prevention’s Healthy People 2020 identified health literacy as a priority in disease prevention and health promotion, which encompasses supporting changes to improve health professionals’ knowledge of the U.S. health care system, including the role of health insurance; and

Whereas, A U.S. national study reported that 29.6 percent of insured adults had delayed or foregone care because they do not understand their health insurance, in part due to a lack of patient-provider communication about their benefits and the function of insurance; and

Whereas, Only 41 percent of surveyed medical students at a U.S. medical school in 2012 could pass an introductory exam on the basics of health policy, including the function of health insurance within the health care system; and

Whereas, 96 percent of U.S. medical students surveyed believed that health policy education was important; however, 54 percent of students felt dissatisfied with their curriculum, demonstrating a student demand for improved health policy education; and

Whereas, The three main barriers to medical students becoming involved in health policy advocacy include a lack of knowledge about health policy (57 percent), an unawareness of opportunities available (56 percent), and a lack of time (43 percent); and

Whereas, 58 percent of U.S. medical school deans agree that there is not enough health policy education in medical schools; and

Whereas, The updated 2019-20 Liaison Committee on Medical Education accreditation standards do not mandate health insurance education in undergraduate medical curriculum; and

Whereas, A number of Texas medical schools have successfully included more comprehensive health insurance electives in their curriculum, but these courses have limited student capacity and are not mandatory; and
Whereas, After medical schools integrated health system education into their core curriculum, which
encompassed topics such as health insurance, health care costs, and access to health care, 96 percent of
graduating medical students reported being prepared for successful medical practice; and

Whereas, The American Medical Association has requested that undergraduate and graduate medical
education incorporate topics related to health care policy; and

Whereas, TMA currently does not have policy on undergraduate and graduate medical education on
health insurance or health policy; therefore be it

RESOLVED, That the Texas Medical Association support the availability of educational resources for
medical students on health insurance and health policy to improve readiness for understanding the role of
insurance in health care.

Related TMA Policy:

200.020 Medical Education Curriculum: Medical schools should incorporate in their curricula a broad
range of educational opportunities and perspectives, not exclusively related to the basic sciences (Council

Related AMA Policy:

H-295.864 Systems-Based Practice Education for Medical Students and Resident/Fellow
Physicians: Our AMA: (1) supports the availability of educational resources and elective rotations for
medical students and resident/fellow physicians on all aspects of systems-based practice, to improve
awareness of and responsiveness to the larger context and system of health care and to aid in developing
our next generation of physician leaders; (2) encourages development of model guidelines and curricular
goals for elective courses and rotations and fellowships in systems-based practice, to be used by state and
specialty societies, and explore developing an educational module on this topic as part of its Introduction
to the Practice of Medicine (IPM) product; and (3) will request that undergraduate and graduate medical
education accrediting bodies consider incorporation into their requirements for systems-based practice
education such topics as health care policy and patient care advocacy; insurance, especially pertaining to
policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and
Medicaid; the physician's role in obtaining affordable care for patients; cost awareness and risk benefit
analysis in patient care; inter-professional teamwork in a physician-led team to enhance patient safety and
improve patient care quality; and identification of system errors and implementation of potential systems
solutions for enhanced patient safety and improved patient outcomes.

Sources:
1. Texas Alliance for Health Care, “The Impact of Uninsurance on Texas’ Economy,” Texas Alliance
   for Health Care (2019), http://wrgh.org/docs/TheImpactofUninsurance
2. onTexasEconomy20190108.pdf.
3. Texas Alliance for Health Care, “The Impact of Uninsurance on Texas’ Economy.”
4. “Health Literacy for Public Health Professionals," Centers for Disease Control and Prevention,
5. Renuka Tipirneni, Mary C. Politi, Jeffrey T. Kullgren, Edith C. Kieffer, Susan D. Goold, and Aaron
   M. Scherer, "Association Between Health Insurance Literacy and Avoidance of Health Care Services
   Sarah S. Nouri, and Rima E. Rudd, "Health Literacy in the “oral Exchange”: An Important Element
10. Liaison Committee on Medical Education, Function and Structure of a Medical School (American Medical Association, 2018).
Whereas, With increased attention given to mass casualty preparation, training in proper, safe, and effective use of tourniquets has been shown to be of significant benefit in reducing mortality; and

Whereas, The use of correctly placed prehospital tourniquets has shown a positive risk-benefit ratio, with the overall morbidity remaining low; and

Whereas, Collaborations between the American College of Surgeons (ACS) and the Department of Homeland Security have helped create such programs as Stop the Bleed and bleedingcontrol.org, which teach bystanders how to identify and treat life-threatening hemorrhage with direct pressure, tourniquets, and wound packing; and

Whereas, Studies have shown that a standard hemorrhage control course can improve civilian willingness to respond quickly in an emergency by as much as 31.4 percent; and

Whereas, Studies of real-world usage have shown that tourniquets in hemorrhage control situations are most effective when used prior to the onset of shock, and can increase survival rates by as much as 80 percent, so education supporting immediate prehospital response is of key importance; and

Whereas, Despite this bystander education effort, hemorrhage control is not mandatory training in the majority of medical schools or for attending physicians, but cardiopulmonary resuscitation/basic life support training is often required before matriculating or receiving hospital privileges; and

Whereas, The American Medical Association (AMA) supports state and medical societies in promoting training of both lay public and professional responders in essential techniques of bleeding control; and

Whereas, AMA and ACS support increased availability of bleeding control supplies in schools, places of employment, and public buildings; therefore be it

RESOLVED, That the Texas Medical Association support initiatives that promote the training of health care professionals in hemorrhage control, such as Stop the Bleed, at Texas medical schools; and be it further

RESOLVED, That TMA support the inclusion of hemorrhage control supplies in first aid kits in public spaces, including medical schools and hospitals.

Related TMA Policy: None.

Related AMA Policy:
H-130.935 Support for Hemorrhage Control Training:
1. Our AMA encourages state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control.

2. Our AMA encourages, through state medical and specialty societies, the inclusion of hemorrhage control kits (including pressure bandages, hemostatic dressings, tourniquets and gloves) for all first responders.

Sources:


Subject: The Integration of LGBTQ Health Topics Into Medical Education

Introduced by: Medical Student Section

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

Whereas, LGBTQ patients experience an increased risk of physical (e.g., HIV, hepatitis, breast cancer) and mental health (e.g., anxiety, depression, suicide) problems, as well as barriers to health care (e.g., discrimination); and

Whereas, The Texas Medical Association recognizes that LGBTQ patients have unique health needs and face barriers to health care; and

Whereas, Only about five hours are allocated to LGBTQ health care topics during a physician’s training; and

Whereas, A survey asking physicians how many hours of medical school were dedicated to LGBT health care topics revealed that 61 percent received no lesbian content, 49 percent had no gay male content, 78 percent had no bisexual content, and 76 percent had no transgender content; and

Whereas, The Association of American Medical Colleges (AAMC) reported in 2014 that only 35.8 percent of medical students surveyed felt adequately trained to care for the LGBT population, and only 9.3 percent felt comfortable directing LGBT patients to LGBT health care professionals and services; and

Whereas, The American Medical Association’s Advisory Committee on LGBTQ Issues acknowledges the urgent need to provide better training to physicians to be able to deliver a higher quality of care to LGBTQ patients; and

Whereas, The AAMC concludes that understanding LGBTQ experiences and their impact on the patient-physician relationship is of the utmost importance in order to provide comprehensive, sensitive, and optimal health care; and

Whereas, the AMA supports the inclusion of LGBTQ health issues in the cultural competency curriculum for medical school and residency training; therefore be it

RESOLVED, That the Texas Medical Association support the integration of LGBTQ health care topics into undergraduate and graduate medical education; and be it further

RESOLVED, That TMA work with the appropriate parties to develop best practices for the integration of LGBTQ health care education into undergraduate and graduate medical education as well as CME.

Related TMA Policy:

265.028 Improving LGBTQ Health Care Access: The Texas Medical Association recognizes that lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) individuals have unique health care needs and suffer significant barriers in access to care that result in health care disparities. TMA will provide educational opportunities for physicians on LGBTQ health issues to increase physician awareness of the importance of
building trust so LGBTQ patients feel comfortable voluntarily providing information on their sexual orientation and gender identity, thus improving their quality of care. TMA also will continue to study how best to reduce barriers to care and increase access to physicians and public health services to improve the health of the LGBTQ population (CSPH Rep. 8-A-18).

Related AMA Policy:
H-295.878 Eliminating Health Disparities: Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education: Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, Transgender and Queer communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include LGBTQ health issues in the cultural competency curriculum for both undergraduate and graduate medical education; and (4) encourages the LCME, AOA, and ACGME to assess the current status of curricula for medical student and residency education addressing the needs of pediatric and adolescent LGBTQ patients.

Sources:
Subject: Improve Physician-Hospital Relations

Introduced by: Harris County Medical Society

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

Whereas, The number of hospital-employed and academic-employed physicians is increasing; and

Whereas, Independent physicians have unique issues that differ from their hospital or academic-employed colleagues; and

Whereas, Independent physicians have voiced that hospitals and medical executive boards are not giving their issues appropriate weight; and

Whereas, Inpatient hospital referrals and issues regarding medical staff bylaws have become two issues of greatest concern; therefore be it

RESOLVED, That the Texas Medical Association study ways to protect the relationship of physicians and their patients after inpatient hospital referrals and report back to the TMA House of Delegates at its annual 2020 meeting; and be it further

RESOLVED, That TMA study ways to improve the representation of all practice types of physicians through hospital medical staff bylaws.

Related TMA Policy:

115.008 Hospitalists and Intensivists: The Texas Medical Association opposes the mandatory utilization of hospitalists and intensivists in Texas hospitals and recommends that no hospital medical staff bylaws prohibit the patient from choosing to have his or her principal physician provide for continuity and coordination of care (Res. 407-I-98; reaffirmed CHSO Rep. 1-A-08; reaffirmed CHSO Rep. 1-A-18).

115.010 Hospitalists: The Texas Medical Association opposes the mandatory use of hospitalists proposed by health plans, institutions, or other entities, continues to support the voluntary use of hospitalists as deemed appropriate by physician-led policymaking bodies advising health plans, institutions, and other entities, and will continue to monitor hospitalist programs and assist members in dealing with the business and practice impacts associated with the use of hospitalists (Amended CSE Rep. 8-A-99; reaffirmed CSE Rep. 1-A-10).

130.001 Hospital Contracts: The Texas Medical Association voted to seek legislation to prohibit hospitals from extracting payments from physicians for patient referrals or for the right to serve patients in hospitals for utilizing space, supplies, equipment, utilities, hospital employees, and obtaining billing information (Res. 27CC, p 206, A-90; reaffirmed CSE Rep. 5-I-01; amended CSE Rep. 8-A-11).

130.006 Hospital Medical Staff Bylaws: The Texas Medical Association supports changes in current laws to make established hospital medical staff bylaws binding upon and enforceable by the hospital medical staff and the board.
TMA policy is for Hospital Accrediting Organizations to include in its standards a provision which would require that medical staff bylaws, when formally approved by a hospital governing board, be mutually and equally binding on both the governing board and the medical staff.

TMA endorses the following principles for inclusion in future drafts of the Medical Staff Chapter of the Accreditation Manual for Healthcare Organizations:

1. Continue the use of the term “medical staff” in the title of the chapter and throughout the manual;
2. Provide consideration of qualified limited licensed practitioners when authorized by state laws and approved by the executive committee of the medical staff and the governing board;
3. Require that 100 percent of the voting members of the executive committee be fully licensed physicians actively practicing; and
4. Ensure that all hospitalized patients receive the same standard of care through appropriate language relating to admissions and the responsibility for the medical care of patients (Hospital Medical Staff Section, p 151-152, A-93; reaffirmed CHSO Rep. 1-A-03; amended CHSO Rep. 1-A-13).

**130.008 Medical Staff Privileges:** Rules, regulations, or bylaws of hospitals in Texas should include the following or similar phrase: “No physician may be denied staff privileges for political reasons or because of accepting or not accepting mandated assignments for payment for fee-for-service” (Hospital Medical Staff Section, p 151, A-93; reaffirmed CHSO Rep. 1-A-03; reaffirmed CHSO Rep. 1-A-13).

**130.011 Medical Staffs:** The need for continued community-based hospital care and the potential threat posed by the failure of governing and policymaking bodies to request, receive, and heed the advice and counsel of local medical staffs are causes for community and statewide concern. Medical staffs should foster cooperative and effective communication with their governing boards and should adopt bylaws that promote medical staff credentialing policies and procedures intended to assure a competent medical staff. Medical staffs should establish the capability to assist in resolution of conflicts between their members, hospital administration, and governing boards (Council on Socioeconomics, p 180, I-94; reaffirmed CHSO Rep. 2-A-05; reaffirmed CHSO Rep. 1-A-15).

**130.015 Physician Participation in Medical Staff Affairs:** The Texas Medical Association supports the principle that a hospital may not contract to limit physician participation or staff privileges or the participation of the staff privileges of a partner, associate, or employee of the physician at a different hospital or hospital system. TMA stands opposed to placing conditions on medical staff privileges to physician members by limiting their participation in medical staff matters through such conditions and limitations (Substitute Res. 29GG, p 177D, I-97; reaffirmed CHSO Rep. 1-A-08; reaffirmed CHSO Rep. 1-A-18).

**130.021 Hospital-Based Emergency Department Referral Patterns:** The Texas Medical Association work with the Texas Hospital Association (THA) and the Texas Legislature, if necessary, to (1) develop policy that requires a hospital to make a reasonable attempt to notify a patient’s own physician for direction on further care when that patient is admitted to the hospital via the emergency department; (2) work with THA and the Texas Legislature, if necessary, to develop policy to allow the referring physician, if that physician has privileges in the hospital, to have his or her patient assigned to his or her service or his or her designated proxy in the hospital, as opposed to the patient being preferentially referred to the hospital’s affiliated group; and (3) condemn the practice of steering a patient away from his or her physician to another physician because of affiliation or loyalty to the hospital (Res. 408-A-11).
130.022 **Avoiding Bias in Medical Executive Committees:** The Texas Medical Association strongly encourages adoption of medical staff bylaws that ensure hospital medical staff committees, particularly executive committees are composed of a majority of physician members elected by the medical staff (Amended Res. 411-A-12).

130.026 **Medical Staff Rights and Responsibilities Bill of Rights:** The Texas Medical Association adopts the following medical staff rights and responsibilities as TMA policy:

TMA recognizes the following fundamental responsibilities of the medical staff:
- The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the hospital’s governing body;
- The responsibility to provide leadership and work collaboratively with the hospital’s administration and governing body to continuously improve patient care and outcomes;
- The responsibility to participate in the hospital’s operational and strategic planning to safeguard the interest of patients, the community, the hospital, and the medical staff and its members;
- The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation;
- The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct; and
- The responsibility to make appropriate recommendations to the hospital’s governing body regarding membership, privileging, patient care, and peer review.

TMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff’s ability to fulfill its responsibilities:
- The right to be self-governed, which includes but is not limited to (1) initiating, developing, and approving or disapproving of medical staff bylaws, rules, and regulations; (2) selecting and removing medical staff leaders; (3) controlling the use of medical staff funds; (4) being advised by independent legal counsel; and (5) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for nonphysician members;
- The right to advocate for its members and their patients without fear of retaliation by the hospital’s administration or governing body;
- The right to be provided with the resources necessary to continuously improve patient care and outcomes;
- The right to be well informed and share in the decisionmaking of the hospital’s operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments;
- The right to be represented and heard, regardless of the voting rights of the physician as outlined by the medical staff bylaws, at all meetings of the hospital’s governing body; and
- The right to engage the hospital’s administration and governing body on professional matters involving their own interests.

TMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of contractual or independent status:
- The responsibility to work collaboratively with other members and with the hospital’s administration to improve quality and safety;
- The responsibility to provide patient care that meets the professional standards established by the medical staff;
- The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff;
- The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the hospital;
- The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff;
• The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.

TMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of contractual or independent status, and are essential to each member’s ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the hospital:

• The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws, which right may not be waived as a condition of employment or medical staff privileges;

• The right to make treatment decisions, including referrals, based on the best interest of the patient, subject only to review by peers;

• The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the hospital’s administration or governing body;

• The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty;

• The right to full due process before the medical staff or hospital takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments;

• The right to immunity from civil damages, injunctive or equitable relief, and criminal liability when participating in good faith peer review activities; and

• The right to be free of “sham peer reviews” and manipulation of medical staff bylaws by hospitals attempting to silence or inhibit the voicing of physician concerns regarding the advocacy of their patients. (CHSO Rep. 2-A-18).
Supplement

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 213
A-19

Subject: Complying with Value-Based Care Quality Measures for Medication Adherence

Introduced by: Elizabeth Torres, MD

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

Whereas, medication non-adherence is linked to an estimated 125,000 deaths, 10% of hospitalizations, and health care costs up to $289 billion annually; and

Whereas, Value-based care payment models are becoming more prevalent in the health care marketplace with 1,000-plus Accountable Care Organizations (ACOs) in value-based care contracts covering an estimated 32.7 million patients in the U.S. at the end of the first quarter of 2018; and

Whereas, 53 ACOs participated in Medicare’s Shared Savings Program in 2018, and an estimated additional 50 to 75 organizations participate in other value-based care contracts or pay-for-performance opportunities in Texas; and

Whereas, Many value-based care contracts offer financial incentives and shared savings opportunities to physicians and organizations based on reducing the cost of care, and most include performance on quality measures as a gating mechanism to earn the shared savings or pay-for-performance incentives; and

Whereas, More than 90% of health payers utilize the Healthcare Effectiveness Data and Information Set (HEDIS), developed and maintained by the National Committee for Quality Assurance, to assess quality performance of physicians and other providers in value-based contracts; and

Whereas, The 2019 HEDIS includes several measures addressing medication adherence such as measures for controlling high blood pressure, persistence of beta-blocker treatment after a heart attack, annual monitoring for patients on persistent medications, and medication reconciliation post-discharge; and

Whereas, Numerous blood pressure medications, such as Valsartan, Losartan, and Irbesartan, have been recalled over the past several months as federal investigators discovered potentially cancer-causing impurities in them leading to patient non-compliance and medication shortages that impede an ACO’s ability to meet quality measures regarding medication adherence and thus performance incentives; and

Whereas, Some patients access medications via pharmaceutical assistance programs, cash payments, and discounted prescription apps, such as GoodRx, which cannot be tracked via the claims submission methods used by payers to capture results for medication adherence; therefore be it

RESOLVED, That the Texas Medical Association work with payers to identify standard methodologies that address quality measure requirements for medication adherence in response to marketplace influences beyond the physician/providers control.
Sources:

https://catalyst.nejm.org/optimize-patients-medication-adherence/

https://www.healthaffairs.org/do/10.1377/hblog20180810.481968/full/?utm_term=Recent+Progress+In+The+Value+Journey%3A+Growth+Of+ACOs+And+Value-Based+Payment+Models+In+2018&utm

4. TMA PracticeEdge Texas Value Based Care Database (2019).

https://www.ncqa.org/hedis/measures/.


Related TMA Policy:
95.043 Prescription Drug Value Based Contracting: In no way should value-based contracting or any other contracting method be a hindrance between the physician and the drugs the physician believes is the best treatment for his or her patient (CSE Rep. 4-A-17).

95.041 Ensuring Patient Access to Affordable Prescription Medications: TMA will: (1) support programs whose purpose is to contain the rising costs of prescription drugs provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to medically indicated prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs; (2) study the issue of drug pricing, including whether large price increases impact patient access to critical medications; (3) support the application of greater oversight to the establishment of closed distribution systems for prescription drugs; (4) support the mandatory provision of samples of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays; (5) work with interested parties to support legislation or regulatory changes that streamline and expedite the FDA approval process for generic drugs; and (6) support measures that increase price transparency for generic and brand-name prescription drugs. (Substitute Res. 405-A-16 and Res. 409-A-16).

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 Principles for Pay-for-Performance Programs:
Quality of Care
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.

Patient-Physician Relationship
Programs must recognize outcome limitations caused by patient nonadherence, and sponsors of PFP programs should attempt to minimize noncompliance through plan design.

Program Rewards
Programs must not penalize physicians financially based on factors outside of the physician’s control.

Related AMA Policy:
H-450.966 Quality Management: The AMA:

(1) continues to advocate for quality management provisions that are consistent with AMA policy;
(2) seeks an active role in any public or private sector efforts to develop national medical quality and performance standards and measures;
(3) continues to facilitate meetings of public and private sector organizations as a means of coordinating public and private sector efforts to develop and evaluate quality and performance standards and measures;
(4) emphasizes the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts;
(5) urges national medical specialty societies and state medical associations to participate in relevant public and private sector efforts to develop, implement, and evaluate quality and performance standards and measures; and
(6) advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts: (a) Standards and measures shall have demonstrated validity and reliability. (b) Standards and measures shall reflect current professional knowledge and available medical technologies. (c) Standards and measures shall be linked to health outcomes and/or access to care. (d) Standards and measures shall be representative of the range of health care services commonly provided by those being measured. (e) Standards and measures shall be representative of episodes of care, as well as team-based care. (f) Standards and measures shall account for the range of settings and practitioners involved in health care delivery. (g) Standards and measures shall recognize the informational needs of patients and physicians. (h) Standards and measures shall recognize variations in the local and regional health care needs of different patient populations. (i) Standards and measures shall recognize the importance and implications of patient choice and preference. (j) Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured. (k) Data collection needs related to standards and measures shall not result in undue administrative burden for those being measured.