AGENDA SOCIOECONOMICS BUSINESS
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1. Board of Trustees Report 11 – Principles for Community-Based Accountable Care Organization
6. Committee on Health Information Technology Report 2 – Sunset Policy Review
7. Board of Trustees Report 13 – Compensation to Physicians for Activities Other Than Direct Patient Care

Agenda Items Tabled to 2021
The following items of business are tabled to the 2021 HOD meeting. However, one may make two motions: ‘Referral to the BOT for Action and report back’ (allowing TMA BOT to adopt policy and address the item and report back to the TMA 2021 HOD) or ‘Referral to the BOT and report back’ (allowing the BOT to consider the item and report back to the TMA 2021 HOD). Your Speakers strongly encourage the use of referral (of tabled items) be limited to urgent and essential items.

9. Patient-Physician Advocacy Committee Report 3 – Legislative Changes Regarding Vacating Orders
10. Resolution 401 – Insurance Coverage Transparency
11. Resolution 402 – Need for and Funding of Level I and II Trauma Centers
12. Resolution 403 – Taxes on Medical Billing Services
13. Resolution 404 – Individual Physicians Be Paid While Awaiting Credentialing Approval
14. Resolution 405 – Physicians to Retain Payment During Credentialing
15. Resolution 406 – Physicians’ Salary Survey
16. Resolution 407 – Compensation to Physicians for Activities Other Than Direct Patient Care
17. Resolution 408 – Contracted Health Plans Must Apply the Same Level of Benefits Concerning Patient Responsibility
18. Resolution 409 – School Physicals Should Be Conducted by Physicians or Their Supervised Designee
20. Resolution 411 – Prior Authorizations
21. Resolution 412 – Step-Edit Therapy Contributes to Denial of Care and Has Not Demonstrated Improved Patient Outcomes or Overall Cost Savings
22. Resolution 413 – Caps on Insulin Copayments with Insurance
24. Resolution 415 – Promotion of LGBTQ+ friendly and Gender-Neutral Options on Medical Documentation and Intake Forms
25. Resolution 416 – Interstate Medical Malpractice Tort Protection for Physicians Treating Patients in Neighboring States
26. Resolution 417 – Insurance Promotion of Preventive Care Services via Incentive-Based Programs
27. Resolution 418 – Paid Parental Leave
28. Resolution 419 – Placing Medicaid Expansion on a Statewide Voting Ballot
29. Resolution 420 – Training Requirements Imposed by Insurance Companies Preventing Patients’ Access to Quality Medical Care
30. Resolution 421 – Physician Societies to Create a Self-Funded, Balanced and Nonpartisan Center for the Study of Healthcare Reform
31. Resolution 422 – Develop Guidelines for Proper Oversight and Collaboration of Mid-Level Providers by Physicians
32. Resolution 423 – A Push for Mobile-First Design Principles within Medical IOT (Internet of Things) Interfaces
33. Resolution 424 – Adoption of Principles of Physician Value-Based Decision-Making in Medical Practice and Professionalism
34. Resolution 425 – Plastic Surgery Board-Certification
35. Resolution 426 – Results and Regulation of Freestanding Birthing Centers and at Home Birthing Services
36. Resolution 427 – Adjustments to Hospice Dementia Enrollment Criteria
Subject: Principles for Community-Based Accountable Care Organizations

Presented by: Linda Villarreal, MD, Chair, Board of Trustees

Referred to: Reference Committee on Socioeconomics

Background

In communities across Texas, a new approach to caring for vulnerable patients – Medicaid patients, uninsured, and seniors – and is gaining strong support among local physician leaders, hospitals, and patient advocates – the community-based accountable care organization (ACO). Other states, including Oregon, Washington, Colorado, and North Carolina, have paved the way for such programs, demonstrating that entities with strong physician leadership and integrated networks of physicians and providers can design, launch, and operate cost-effective health care delivery models that improve patient outcomes while slowing cost growth.

A community ACO model organizes a network of health care safety net physicians and providers, in both inpatient and outpatient settings, working under the direction of a single community-based board that uses value-based payment approaches to improve health outcomes for the population(s) served.

Why a community-based ACO? Texas’ state and local elected officials continue to struggle with how best to provide meaningful coverage to uninsured and underinsured Texans while constraining health care costs and improving patient outcomes. But top-down approaches to care delivery have not always yielded better health outcomes or lower costs. Community ACOs are predicated on developing a shared mission and vision among the physicians and providers within a community as well as shared accountability.

Moreover, Texas lawmakers, facing the withdrawal of billions of federal funds over the next few years as the state’s Medicaid 1115 Transformation Waiver winds down, will need to craft a novel strategy to replace or extend those dollars to prevent a potentially catastrophic financial impact on the state’s health care safety net. However, the Centers for Medicare & Medicaid Services has signaled that for it to approve any additional dollars, Texas must deploy a health care delivery model that will provide a return on investment.

Regardless of whether state lawmakers act, local communities will continue to test new health care delivery options. This mean even if Texas fails to find a statewide coverage solution, a local solution, or some combination, physicians must be at the table to design local patient-centered systems of care.

Given that TMA is the voice of Texas physicians and its mission is to improve the health of all Texans, TMA has an opportunity to promote the development of sustainable physician-led delivery systems. The TMA Workgroup on Value-Based Payment Initiatives and Physician-Led Community Health Care Delivery Models, formed at the behest of the Board of Trustees, believes TMA should advance the community ACO model by articulating key principles communities should consider when designing such models. Additionally, TMA should evaluate the development of physician education, training, and services to help prepare practices to participate in such models. When implemented with physician leadership, such models can provide a seamless network of physician practices, inclusive of the full spectrum of primary and specialty care, enabling greater access to health care for low-income and uninsured individuals.
To that end, the workgroup has developed policy principles to guide county medical societies and individual physician leaders on the formation of community-based ACOs.

**Workgroup on Value-Based Payment Initiatives and Physician-Led Community Health Care Delivery Models**

The board requested appointment of the workgroup in 2018 and charged it with the following goals:

- Support implementation of community-based health care delivery models and collaborate with county medical societies to advocate for the adoption of such models;
- Survey Texas’ value-based payment landscape, particularly pertaining to models serving low-income, uninsured, or other vulnerable populations;
- Develop TMA policy, education, and toolkits not only to spur formation of physician-led, community-based organizations but also to help physicians who serve low-income populations successfully transition their practices to participate in new payment arrangements; and
- Advise the TMA-Texas Hospital Association Task Force on Medicaid Physician Payments and Accountable Care on formation of regional, risk-based, community-care collaboratives that may become the underpinnings of the state’s efforts to amend and extend the Medicaid 1115 waiver.

Per the board’s direction, the workgroup consisted of the chairs or designees of TMA councils and committees with overlapping interest in the workgroup’s charge and representatives from large county medical societies with an interest in advancing local community-based ACOs. TMA Trustee Sue Bornstein, MD, chaired the workgroup.

The workgroup met twice, with its work culminating in a report on the challenges facing physicians who care for vulnerable, uninsured Texans; an overview of Medicaid’s rapidly evolving value-based payment landscape; discussion of the benefits and drawbacks of Texas’ Medicaid 1115 Transformation Waiver; a high-level survey of existing community-based ACO activities; and a set of guiding principles for physicians seeking to develop or promote locally driven, community-based ACOs.

The workgroup went dormant for 11 months, largely due to the demands of the legislative session. However, in late 2019, the board revived the workgroup in response to the confluence of a number of advocacy, regulatory, and educational opportunities, including the impending cessation of Texas’ current Medicaid 1115 waiver and initiation of state planning for its replacement; proliferation of value-based payment models among Medicaid, Medicare, and commercial payers; increased interest in expanding use of value-based payment arrangements by policymakers and employers seeking constructive means to reduce health care costs; and a growing number of physicians participating in value-based payment arrangements.

Helping physicians transition successfully to and thrive within these models must be a priority for the association over the next several years.

The revived workgroup will continue where it left off:

- Survey Texas’ value-based payment landscape,
- Refine proposed community-based ACO principles to meet Texas’ diverse geographic and specialty needs,
- Develop a community-based ACO concept paper for consideration by the Texas Health and Human Services Commission (HHSC),
• Recommend potential educational, training, and technical assistance tools to help TMA members transition to and succeed in a value-based payment arena, and

• Identify potential value-based payment policy recommendations for consideration by the TMA House of Delegates.

Additionally, the workgroup will examine best practices for addressing social drivers of health within value-based payment arrangements. As health care costs continue to rise, there is considerable interest in whether better management of nonmedical factors, such as food security, safe housing, care coordination, and transportation, can help bend the cost curve while also improving health outcomes. As a result, community-based entities must evaluate how to incorporate such services into their models in a way meaningful to patients without creating undue burden or additional costs for physicians.

Caring for Vulnerable Patients – Texas’ Landscape

According to the September 2019 Census Bureau report, Texas’ overall poverty rate dropped modestly in 2018, from a two-year average of 14.3% (2015-16) to 13.7% (2017-18). The national average is 12.3%. For a family of four, this means living on an annual income of about $33,000. Yet, a growing body of evidence shows that living in poverty contributes to poorer health outcomes. Social drivers of health – access to safe, affordable housing; reliable transportation; and nutritious foods – play a major factor. So does the lack of health care coverage. From 2013 to 2016, Texas’ rate of uninsured dropped considerably, from 22.1% to 16.6%. But in 2017, the trend took an unfortunate U-turn. Today nearly 5 million Texans – 17.7% – lack coverage, double the national average. Some one-third of parents earning less than 138% of the federal poverty level ($46,575 for a family of four) lack health care coverage. One out of five uninsured children in the country live in Texas, though most are eligible for Medicaid or the Children’s Health Insurance Program. And among low-income women, 25% lack comprehensive health insurance coverage.

Going without health care coverage can have serious health consequences. Patients without coverage are less likely to receive cost-saving preventive, primary, and specialty care. Early identification and treatment of chronic illnesses like high blood pressure or diabetes can greatly reduce the likelihood of serious illness, yet without affordable health coverage, patients, particularly low-incomes ones, often forgo treatment. Uninsured people are up to four times more likely not to have a regular source of health care, often relying on overcrowded emergency departments for basic medical services. Moreover, being uninsured exposes individuals to the potential for catastrophic financial loss if unexpected medical care should arise, as in the case of a car accident or a cancer diagnosis.

By law, Texas counties must provide indigent health care. Yet the magnitude of uninsured Texans strains community resources, resulting in an overall economic impact felt by everyone. Large urban communities, with larger tax bases, fund hospitals and health systems to provide health care to the uninsured. But this also means taxpayers in these communities defray the rising costs of this care through increased property taxes. Business owners experience rising health insurance premiums to maintain health insurance benefits for their employees, thereby impacting their bottom line. Individuals who do not have access to health insurance from their employers find only unaffordable monthly premiums when shopping for health plans.

Federal dollars remain available to Texas to extend coverage to the working poor. To date, Texas has elected to forgo these funds, though 36 other states, including Arkansas, Indiana, Ohio, and Utah, have accepted the federal funds. However, in late January 2020, the Centers for Medicaid & Medicare Services announced a new initiative called the Healthy Adult Opportunities – a block grant for the so-called
Medicaid expansion population – that might entice Texas to pursue coverage for this population. As of this writing, TMA is evaluating the implications of the program.

Regardless of whether Texas pursues coverage for low-income, uninsured adults, Texas counties must find new ways to deliver affordable, effective care at a more affordable cost.

**Future of the Texas Medicaid 1115 Transformation Waiver**

Texas’ Medicaid 1115 Transformation Waiver will expire September 2022, resulting in the loss of billions of needed federal dollars unless Texas obtains a new waiver. Under the waiver terms and conditions, the Texas Health and Human Service Commission must develop a waiver transition plan, including opportunities for future waiver proposals. TMA learned in a recent meeting with HHSC that the current waiver, as designed, will not continue. However, HHSC and CMS have begun exploring new waiver opportunities, including targeted coverage initiatives for certain low-income Texans, such as those with chronic diseases or severe behavioral health disorders. At the meeting TMA and specialty society leadership offered the community-based ACO concept as a potential framework for organizing any new waiver – an idea the agency liked. HHSC invited TMA to more fully design the concept and submit a concept paper to it by next summer.

TMA has strongly supported Texas’ waiver since its inception in 2011 and continues to do so. Undoubtedly, thousands of low-income Texans have benefitted from it. The waiver has:

- Stabilized financial solvency for safety net hospitals, particularly rural hospitals;
- Expanded availability of behavioral health care;
- Allowed Texas to test innovative health care delivery models to determine what models will work or not, such as medical home programs designed to increase use of prenatal care or to better serve children and adolescents with special health care needs; and
- Improved access to health and dental care services for low-income, uninsured Texans.

Yet, the current waiver design also has a fundamental flaw – namely, a hospital-centric approach to organizing health care delivery rather than a community-focused one. As HHSC evaluates the future of the waiver, TMA has strongly advocated for designing a new approach that will more fairly distribute funding throughout the health care delivery system, including to community-based physicians unaffiliated with hospitals or academic health systems. These physicians have no means to participate in innovative health care delivery models or funding despite also playing a vital role in the care of low-income patients.

Finding physicians who will care for Medicaid patients is a daily struggle across the state, though the situation is far worse in underserved communities. Most of Texas Medicaid’s physician fee-for-service payment rates – which are what most Medicaid managed care organizations pay physicians, too – have not received a meaningful, *enduring* increase in more than two decades.¹

For any future waiver, there must be an inclusive, community-based approach, such as establishment of a “medical neighborhood” or community-based ACO that will allow all physicians, hospitals, and providers who treat Medicaid and low-income, uninsured Texans to participate, regardless of their affiliation with a particular system.

¹ In 2007, lawmakers allocated funds to increase payment rates for select preventive health services for children, including well-child visits. From 2013 to 2014, federal funding temporarily boosted select primary care physician payment rates to Medicare parity.
Primary care physicians, in particular, are the foundation of a robust, cost-effective health care delivery system. Studies show that systems built around a strong primary care model have better health care outcomes, higher patient satisfaction, and lower costs. If a future waiver request doesn’t benefit the array of primary care practices — hospital-affiliated or not — Texas’ primary care system will wither, impacting all Texans.

In addition to finding a fairer funding mechanism for any future waiver, TMA supports using any new waiver as a means to achieve two other vital goals: (1) reduce the number of Texans without health insurance and (2) implement innovative strategies to address the nonmedical factors that impact health care outcomes and costs.

Ultimately, all Texans benefit when their neighbors, colleagues, family, and friends have health care coverage. Insured children are healthier children, missing less school and contributing to their future socioeconomic success. Insured parents miss less work, increasing economic productivity, a win for employers and the state economy. Insured women have healthier pregnancies and maternal and infant health outcomes, reducing Medicaid costs. And more insured Texans contribute to lower health care premiums for everyone.

**Community Solutions**
Across Texas, physician leaders have devised or informed the creation of new health care delivery models organized to provide more efficient and effective health care for the uninsured. Several hospital associations and health-care foundations also have designed community-based initiatives. Examples of models include:

- **Project Access Dallas (discontinued):** This initiative connected physicians to low-income and uninsured patients to provide patient-centered care within an office setting. Important collaborations with local hospitals, businesses, and faith-based community organizations enabled Project Access to provide comprehensive primary care, access to specialists, hospital care, prescription drugs, and social services at minimal cost to eligible patients. In 2013, Dallas County Medical Society discontinued Project Access because of funding changes related to the Texas 1115 Medicaid waiver.

- **911 Telehealth Triage:** Developed with input from Harris County Medical Society, this program connects Harris County 911 callers with local clinics and physician services to reduce inappropriate ambulance dispatches and emergency department use for conditions better treated within a physician office.

- **Project Access Travis and Tarrant counties (extant):** Both models provide coordinated care for low-income residents by connecting patients with volunteer physicians from a range of specialties.

- **Travis County Community-Care Collaborative:** Operated by Central Health, the local hospital district, this program works through a network of clinics, system-affiliated physicians, and private physician practices to connect uninsured, underinsured, and low-income residents to high-quality, low-cost health care.

- **Outside of organized medicine,** several groups are also working on models to address the health care needs of low-income Texans. The Teaching Hospitals of Texas, with input from TMA and other physician organizations, modeled a new program called TCARE (Texas Community Access, Reform, and Engagement). This model sustains and redirects some federal funds into physician and community systems. It includes incentive payments to physicians and providers as well as per-member per-month care management fees, behavioral health care management, and performance sharing. The proposal embraces local innovation predicated on the involvement of public and private physicians.
There also is budding interest among the state’s executive leadership and rural lawmakers to revisit the dormant, but visionary, Rural Community Health System (RCHS) statute, which more than 20 years ago authorized formation of a community-led insurance entity. TMA, the Texas Academy of Family Physicians, and the Texas Organization of Rural and Community Hospitals helped design the model as a means for rural physicians and hospitals to better compete in a swiftly evolving Medicaid and commercial health care delivery landscape. Back then, RCHS was ahead of its time. Health plans refused to contract with it, and its community-led board eventually disbanded. But today it is a potential vehicle for rural physicians and hospitals to organize into community-led systems of care.

There is undeniable interest among community leaders and policymakers in developing local delivery systems for vulnerable patients. However, devising a single blueprint for the design and implementation of these models is challenging because of the variation in communities’ size, resources, and demographic characteristics. After reviewing extant, emerging, and discontinued community-based initiatives as well as out-of-state community-based ACOs, the workgroup identified key characteristics and principles critical to building and maintaining a successful community-based accountable care organization.

To succeed, community-based ACOs should adhere to the following principles:

- Ensure the establishment of a community-based board to govern the entity, comprising diverse representatives from primary care and specialty physicians, public and private hospitals, health care providers, social service agencies, faith-based and community organizations, and community members;
- Articulate a clear mission and vision and the ACO’s short-term and long-range community goals;
- Engage local physician leaders with a mix of practice size and employment status in the model’s design and implementation to ensure widespread support and participation;
- Foster transparent governance, decisionmaking processes, and operations to nurture and sustain trust among all stakeholders and funding entities;
- Foster initiatives to proactively address health disparities, including outreach and engagement of community leaders;
- Partner with local public health departments and social service organizations, such as food banks and affordable housing programs, to address social determinants of health that contribute to poorer health outcomes;
- Build and maintain robust physician and provider networks that include private practice physicians, employed physicians (e.g., those who work for federally qualified health centers or hospital systems), and other key partners – hospitals, post-acute care providers, and so forth;
- Establish competitive, fair, and reasonable payment rates for physicians and providers while also using population-health payment models that reward improved patient outcomes and practice transformation;
- Establish realistic, standardized, actionable, and validated performance measures;
- Leverage all available funding streams to support the ACO, including public and private payers as well as grants;
- Engage Medicaid managed care organizations serving Medicaid patients within the community to develop collaborative models; low-income patients frequently transition between having Medicaid coverage and being uninsured (e.g., Medicaid covers pregnancy for low-income women, but that coverage ends 60 days postpartum), so it is essential they have the opportunity to participate in an organized system of care regardless of insurance status;
- Establish a robust and meaningful health information exchange for both clinical and social service information exchange, using the latest technological tools to ensure seamless patient navigation.
across the network, reduce costs by eliminating redundant tests or procedures, and maintain a high
degree of population health metrics and evaluations;
• Ensure primary care is the cornerstone of each ACO network, and locate patient-centered primary
care sites in historically medically underserved areas to ensure ready access to services for eligible
patients;
• Ensure participating physicians retain their independence to advocate on behalf of their patients’
health needs;
• Incorporate patient risk assessment into the ACO’s essential activities to help participating physicians
more quickly identify and address patients’ medical and social needs that impact health quality,
outcomes, and costs;
• Ensure that care coordination is a core function of the ACO to ensure participating physicians can
quickly and easily facilitate referrals to medical, social, and supportive services based on a patient’s
individual needs;
• Build partnerships with state agencies and local social service entities, such as food banks, to allow
the ACO-participating physicians to easily and quickly obtain nonmedical interventions for patients; and
• Engage physician practices regardless of their degree of practice transformation, particularly in the
early stages of an ACO’s formation, while promoting activities that support practice evolution.

Action
Because TMA’s mission is to represent the voice of all Texas physicians, whose vision is health
improvement of all Texans, TMA is in a strategic position to introduce and advocate for the necessary
policy changes to promote sustainable health care financing and delivery systems for Texas. A
community ACO can reduce the “cost transfers” of uncompensated health care, address the health care
needs of historically marginalized populations, reduce the need for more complex and expensive health
care, and create a sustainable delivery and financing model for Texas.

Furthermore, as Texas explores options to transition from the current Medicaid 1115 Transformation
Waiver to a new one, Texas will need to submit a compelling, innovative health care delivery model to
CMS to gain approval. The community-ACO model fits that criteria by promoting a proactive, integrated,
transparent, and cost-effective approach to improving patient health outcomes.

Recommendation 1: That the Texas Medical Association adopt the following Principles for
Community-Based Accountable Care Organizations:

Principles for Community-Based Accountable Care Organizations

• Require establishment of a community-based board to govern the entity, composed of diverse
representatives from primary care and specialty physicians, public and private hospitals, health care
providers, social service agencies, faith-based and community organizations, and community
members.
• Articulate a clear mission and vision and the ACO’s short-term and long-range community goals.
• Engage local physician leaders with a mix of practice size and employment status in the model’s
design and implementation to ensure widespread support and participation.
• Foster transparent governance, decisionmaking processes, and operations to nurture and sustain trust
among all stakeholders and funding entities.
• Implement initiatives to proactively address health disparities, including outreach and engagement of
community leaders.
• Partner with local public health departments, state agencies, and social service organizations to address nonmedical factors, such as food and housing insecurity, that contribute to poorer health outcomes and to connect eligible low-income patients to available services.

• Build and maintain robust physician and provider networks that include private practice physicians, employed physicians (e.g., those who work for federally qualified health centers or hospital systems), and other key partners — hospitals, post-acute care providers, and so forth — with any interest in serving the population.

• Establish competitive, fair, and reasonable payment rates for physicians and providers while also using population-health payment models that reward improved patient outcomes and practice transformation.

• Establish realistic, standardized, actionable, and validated performance measures and ensure that measures are periodically reviewed to confirm their continued relevance and utility.

• Leverage all available funding streams to support the ACO, including funding from public and private payers as well as foundation and community grants.

• Engage Medicaid managed care organizations serving Medicaid patients within the community to develop collaborative models. Low-income patients frequently transition between having Medicaid coverage and being uninsured (e.g., Medicaid covers pregnancy for low-income women, but that coverage ends 60 days postpartum), so it is essential they have the opportunity to participate in an organized system of care regardless of insurance status.

• Establish a robust and meaningful health information exchange for both clinical and social service information exchange, using the latest technological tools to ensure seamless patient navigation across the network, reduce costs by eliminating redundant tests or procedures, and maintain a high degree of population health metrics and evaluations.

• Ensure primary care is the cornerstone of each ACO network, and locate patient-centered primary care sites in historically medically underserved areas to ensure ready access to services for eligible patients and to address health equity.

• Ensure participating physicians retain their independence to advocate on behalf of their patients’ health needs.

• Incorporate patient risk assessment into the ACO’s essential activities to help participating physicians more quickly identify and address the medical and social needs that impact a patient’s health quality, outcomes, and costs;

• Make care coordination a core function of the ACO to prevent gaps in care by allowing participating physicians and providers to quickly and easily obtain assistance in arranging and coordinating a patient’s medical, social, and long-term care services.

• Engage physician practices regardless of their degree of practice transformation, particularly in the early stages of an ACO’s formation, while promoting activities that support practice evolution.

**Recommendation 2:** That the Texas Medical Association actively promote use of a community-based accountable care organization(s) as the foundation of any future Medicaid 1115 waiver.
The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The Council on Health Service Organizations recommends retention of the following policy:

85.012 **Advance Directives**: The Texas Medical Association encourages physicians who staff hospitals to attempt to obtain appropriate advance directives before discharging a patient (CM-EMS Rep. 4-A-00; reaffirmed CHSO Rep. 1-A-10).

20.005 **Long-Term Care Insurance**: The Texas Medical Association will develop an educational awareness program for physicians relevant to evolving federal laws and regulations on the benefits of long-term care insurance and the inadequacy of Medicare and Medicaid for that purpose (Substitute Committee on Aging and Long-Term Care, p 68, I-96; amended CHSO Rep. 1-A-10).

260.001 **Infectious Waste Management**: The Texas Medical Association, through the American Medical Association, supports the use of the Centers for Disease Control and Prevention’s standard precautions and the Environmental Protection Agency’s Model Guidelines for State Medical Waste Management as models for other federal agencies’ rules, and opposes adoption of rules that conflict with these generally accepted standards (Council on Health Facilities, p 105, A-90; amended CM-ID Rep. 2-I-00; reaffirmed CHSO Rep. 1-A-10).

**Recommendation 1**: Retain.

The Council on Health Service Organizations recommends amending of the following policy:

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).

**Recommendation 2**: Retain as amended.
The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The Council on Socioeconomics recommends retention of the following policies:

30.007 Prescribing by Pharmacists: The Texas Medical Association reaffirms its position in opposition to independent prescribing by pharmacists. TMA affirms its readiness to work with the Texas Pharmaceutical Association and the American Medical Association to review prescription drugs for appropriate transfers to “over the counter” status (Board of Councilors, p 44, A-93; reaffirmed BOC Rep. 5-A-10).

145.007 Competitive Insurance Models: A system of health care delivery free of burdensome and unnecessary government regulations is a goal which all patients and physicians should support. No national competitive health insurance model should be implemented irrevocable prior to pilot test studies which would identify and minimize problems of any new system. The Texas Department of Insurance should control the state’s insurance industry and its insurance policies and programs. Health care expenditures should remain tax deductible (Council on Socioeconomics, p 177, I-94; amended CSE Rep. 1-A-10).

145.011 Plan Responsibility for Patient Education: For the benefit of patient understanding, state health plans and insurers should use plain language in information on plan operating policies and procedures (Res. 411-A-99; reaffirmed CSE Rep. 1-A-10).

145.013 Private Healthcare System Impact of Uninsured: The Texas Medical Association supports continued efforts to address the issue of health care for the uninsured including input from all segments of the association with an emphasis on private sector solutions (Sub. Res. 403-A-99; reaffirmed CSE Rep. 1-A-10).

145.014 Texas Department of Insurance: The Texas Medical Association supports continued efforts to fund the Texas Department of Insurance (TDI) adequately and require that TDI resolve complaints and ensure insurance companies pay claims within the state-mandated statutory time frame (Amended Res. 406-I-00; amended CSE Rep. 1-A-10).

155.006 Laboratory Personnel: All clinical laboratory personnel should remain under the control and supervision of a physician (Council on Socioeconomics, p 179, I-94; reaffirmed CSE Rep. 1-A-10).

170.007 Professional Liability: To ensure access to medical care for Texans, the Texas Medical Association will continue efforts to (1) reduce or limit frivolous professional liability claims; (2) continue to examine the causes of claims frequency; (3) monitor claims data collected by the Texas Department of Insurance and the Texas Medical Board and make the aggregate data available to the membership; (4) advocate for judicial enforcement of current expert witness and cost bond provisions; and (5) allow the right to countersue (Substitute Res. 102, 103, 108-I-00; amended CSE Rep. 1-A-10).
180.001 **Managed Care Truth in Advertising Standards:** The Texas Medical Association favors legislation which would provide that managed health care plans in Texas meet high standards of truth in advertising and legal safeguards to assure that high quality medical care is not compromised by deceptive marketing activities, unsubstantiated claims about so-called “quality assurance” activities, and disruptive precertification and concurrent review practices (Resolution 27L, p 189, A-90; reaffirmed CSE Rep. 1-A-10).

180.026 **Health Insurance Plans:** The Texas Medical Association approves continued aggressive advocacy for members in dealing with health insurance plan issues and will expand where appropriate its cooperative, collaborative initiatives with health insurers to address issues and problems of mutual concern (BOT Rep. 22-A-99; amended CSE Rep. 1-A-10).

180.027 **Prompt Payment of Claims:** The Texas Medical Association reaffirms ongoing efforts through the TMA Hassle Factor Log initiative, carrier meetings, and regulatory advocacy to address the growing problems medical offices are encountering in obtaining prompt and appropriate payment and continues to support legislative initiatives directed towards streamlining and simplifying health plans' claims processing and administrative requirements (Sub. Res. 405-A-99; amended CSE Rep. 1-A-10).

190.018 **Medicaid Reimbursement for Rehabilitation:** The Medicaid program should provide payment for inpatient and outpatient rehabilitation services provided by community rehabilitation hospitals for treatment of persons aged 21 through 64 who suffer a major trauma or illness (CM-R Rep. 1-A-00; amended CSE Rep. 1-A-10).

195.005 **Medicare Reform:** Because the existing Medicare program has evolved into an overly complex, under-funded system, the Texas Medical Association agreed to seek an honest consensus to address current problems, explore ways to reduce the complexity of regulations, address the program’s “hassles,” develop a plan for future beneficiaries, explore funding alternatives, and examine long-term needs of the Medicare-eligible population (Res. 28U, p 167, A-91; reaffirmed CSE Rep. 1-A-10).

195.030 **Medicare Payment Localities:** The Texas Medical Association supports changes to Medicare payment locality boundaries so that they are defined to reflect measurable differences in local economic conditions and are updated at least every five years to reflect changes in those conditions. Reliance on Metropolitan Statistical Area boundaries and updates would meet this condition. TMA supports, where necessary, revision of federal administrative rules to accommodate locality boundary changes. When locality boundaries have not been updated for more than five years and the needed changes would result in significant fee cuts for some physicians, the Texas Medical Association favors locality revisions that include payment increases sufficient to assure that physicians in revised localities do not suffer fee cuts (CSE Rep. 2-A-10).

195.031 **Health Savings Accounts for Medicare Beneficiaries:** Medicare beneficiaries should be permitted to make tax-free contributions to health savings accounts (Res. 401-A-10).

220.001 **Active Duty Physicians:** The Texas Medical Association supports advocacy on the federal level for adequate compensation for both active duty and reserve physicians to ensure that medical care is available for our military forces (Resolution 27U, p 181B, I-90; amended CSE Rep. 1-A-10).
235.032 **Payment for Services Provided to County Indigent Patients**: When patients who have a payer, including all county indigent health care programs, are provided care, the payer should be responsible for paying for services (Res. 413-A-10).

240.019 **Medicare’s Elimination of Payments for Consultation Codes**: The Texas Medical Association opposes all public and private payer efforts to eliminate payments for inpatient and outpatient consultation service codes and supports legislation to overturn the Centers for Medicare and Medicaid Services action that eliminated payments for consultation codes (Res. 410-A-10).

240.020 **Deactivation of Medicare Billing Privileges**: Lack of Appeal Rights and Harsh Adverse Effects on Physicians: It is Texas Medical Association policy that (1) physicians who legitimately render services to Medicare patients be paid at their current practice’s geographic index without disruption, allowing for backdating the reactivation of the privilege to bill for Medicare and Medicaid covered services to eligible patients; (2) physicians be provided due process and appeals process in order to be compensated for care actually provided to Medicare or Medicaid patients when their billing privileges are deactivated such as for failure to notify the Medicare or Medicaid carrier of change of office address using the proper Centers for Medicare & Medicaid Services (CMS) form; and (3) access issues for Medicare beneficiaries be considered before similar CMS regulations are created (Res. 414-A-10).

265.010 **Medical Care Guidelines**: The Texas Medical Association opposes the use of so-called medical care guidelines (including, but not limited to, those published by Milliman & Robertson) that are based on economic data rather than evidence-based, scientifically sound medical data (Res. 402-A-00; reaffirmed CSE Rep. 1-A-10).

265.011 **Medical Record Review**: Health plans and insurance companies should be required to provide patients and physicians a minimum of two weeks’ notice of an impending review. Appropriate limits should be placed on such reviews (Amended Res. 402-I-00; reaffirmed CSE Rep. 1-A-10).

**Recommendation 1**: Retain.

The Council on Socioeconomics recommends amending of the following policies:

65.009 **CMS Evaluation and Management Services Documentation Guidelines**: The Texas Medical Association supports the following essential principles regarding the Center for Medicare & Medicaid Service’s (CMS’s) E & M documentation guidelines: (1) AMA Policy (H-330.920 and 921) should be strongly reaffirmed. That policy includes opposition to inappropriate “quantitative formulas” or assignment of “numeric values” to determine medical record keeping; unfair fraud and abuse penalties for disagreements in E & M code assignments; and repayment of “alleged Medicare overpayments” without fair due process; (2) CMS should not focus on counting methodologies or numerical formulas as the primary reason for medical record documentation. Documentation should serve the interests of good patient care and the integrity of the patient-physician relationship before any auditing or program integrity objectives are considered; (3) Focused medical review should be the sole focus of CMS audit and outlier review programs. Random audits, conducted in addition to medical reviews indicated by analysis of Medicare claims data, should not be the focus of CMS’s audit function. Such reviews are unnecessarily intrusive in physicians’ practices and are an inefficient use of taxpayer dollars; (4) Medical decision-making should be
emphasized much more than is presently the case in either the 1995 or 1997 “revised”
guidelines; and (5) any proposed guideline that serves to criminalize the patient-physician
encounter should be vigorously and thoroughly opposed (Amended CSE Rep. 13-I-98;

110.007 Cost Containment: Members of the Texas Medical Association are encouraged to voluntarily
evaluate their practice patterns to further reduce and improve utilization of expensive hospital
and ambulatory services and to control costs. Insurance companies and fiscal intermediaries
are encouraged to support cost containment and cost-effective care by recommending use of
the least expensive setting in which a procedure can be performed safely and effectively.
Third-party payers should provide payment that should cover not only for professional services,
but for also all other practice expenses costs incurred in physicians’ offices (such as surgical
trays, sterile draping, and necessary supplies). Duplicate laboratory procedures and tests
should be eliminated (Council on Socioeconomics, p 177, I-94; amended CSE Rep. 1-A-10).

145.012 Health Insurance Individual Ownership: The Texas Medical Association supports
operational strategies that provide control of health care purchasing and financing to
individual patients, efforts that focus on strategies that offer equal tax deductibility to persons
who purchase individual policies, the use of health savings accounts with tax-deductible
contributions, and consumer choice provisions as modeled by the Federal Employees Health
Benefits Program and believes that these efforts include a study of the issue of individually
chosen, individually purchased basic health insurance with a system of premium support for
the uninsured and lower income wage earners (Amended Res. 413-A-99; amended CSE Rep.
1-A-10).

190.019 Medicaid and Medicaid Managed Care: The Texas Medical Association (1) advocates for
Medicaid managed care reform including administrative simplification, protection of the
Primary Care Case Management model, and continuation of the moratorium on new Medicaid
managed care service areas until such time that current operational, administrative, and
payment problems can be resolved; and (2) continues to explore development of alternative
care delivery models for Medicaid managed care that incorporate the following principles: (a)
patient access to a medical home; (b) access to prescription drugs; (c) evidence-based health
and disease management for high-risk, chronically ill, patients and patients with disabilities
disabled patients; (d) a flexible delivery system design to accommodate Texas’ diverse care
delivery systems and geography; (e) physician-driven, clinically appropriate quality and
utilization management systems; (f) simplified administration and claims payment processes;
and (g) competitive payment that reflects the rapidly increasing practice costs of physicians
who care for this patient population (Amended CSE Rep. 3-I-00; amended CSE Rep. 1-A-10).

235.030 Increase in Statewide Reimbursement Payment for After-Hours Care: The Texas Medical
Association continues to propose that support payment revisions to the Texas HHSC Medicaid
fee schedule to allow Medicaid fee-for-service payments for CPT codes 99050 and 99051,
pay physicians for after-hours, non-emergency care codes, when physicians provide after-
hours care within their offices 99050 and 99051 (Res. 403-A-10).

Recommendation 2: Retain as amended.
At TexMed 2019, the House of Delegates adopted Resolution 414-A-19, Studying Financial Barriers of Rural Hospitals, from the Medical Student Section, calling on the Texas Medical Association to research the root causes of rural hospital closures in Texas. Resolution 414 identified financial barriers as a main reason for rural hospital closures, but asked TMA to identify these causes more specifically in addition to studying the impact hospital closures have on rural communities and economies. Testimony emphasized that a rural hospital’s closure impedes rural patients’ ability to obtain timely access to care; decreases the community’s ability to recruit and retain physicians, nurses, and other health professionals as well as other employers; and diminishes the ability for rural communities to sustain a tax base sufficient enough to support other community and social services.

Although TMA and the American Medical Association already support and advocate for initiatives to ensure the financial integrity of rural hospitals, testimony from the Medical Student Section expressed concerns regarding the record number of hospital closures in Texas and requested more detailed research and support from TMA to mitigate this problem. The students questioned why Texas is the state with the highest number of rural hospital closures since 2010, given that facilities are purportedly reimbursed “allowable costs.” Moreover, the testimony also pondered if rural hospitals’ inability to negotiate reasonable payment rates with health insurance plans partly explained the financial challenges of so many rural hospitals. Testimony specifically asked for TMA to further research the Texas Health and Human Services Commission definition of “allowable cost” and “rural hospitals,” and the minimum net revenue needed to keep rural hospitals’ doors open.

National Policy Landscape
In the United States, more than 119 rural hospitals have closed since 2010. Texas leads the nation with 29 closures in this period. Although state and national policy leaders, lawmakers, and researchers have focused more attention on the issue in recent years, it is not new. According to the U.S. Department of Health and Human Services’ Office of Inspector General (OIG), the pattern began after the Prospective Payment System (PPS) was implemented in 1983. OIG conducted a study on closures annually from the late 1980s through the 1990s after this factor was identified. “As the rate of hospital closures increased throughout the 1990s, studies consistently found that smaller hospitals were more likely to close, putting rural hospitals at greater risk for closure.” To try to protect the smallest facilities, Congress established the Critical Access Hospital (CAH) program in 1997, ensuring hospitals meeting rural hospital criteria are paid on a reasonable cost basis for inpatient and outpatient services. These criteria include having 25 or fewer inpatient beds, providing 24/7 emergency services, meeting average length-of-stay requirements for acute care, and existing more than 25 miles from another hospital. Then, in the 2000s the rate of closure slowed, and interest waned until recently. The Affordable Care Act’s (ACA’s) replacement of disproportionate-share hospital (DSH) payments with Medicaid expansion coincided with an increase in rural hospital closure. However, the longevity of the issue is evidence that one piece of recent legislation cannot be the only problem.
A state’s decision whether to expand Medicaid to low-income, uninsured adults as authorized by the Affordable Care Act is highly correlated with rural hospital closure. In the context of the national rate of rural hospital closure, “the annual unadjusted hospital closure rate, measured as the number of closures per 100 hospitals, declined in both expansion and non-expansion states as the United States emerged from the 2008-09 Great Recession. Between 2010 and 2012, closure rates were nearly identical in the two groups of states.” However, beginning in July 2012, clear differences emerged between expansion and non-expansion states. Under the ACA, DSH payments were phased out in anticipation of hospitals having fewer uninsured patients. In 1981, DSH payments were implemented to offset the costs that hospitals incurred from a high payer mix of uninsured and Medicaid patients. Making matters worse, the 2% decrease in Medicare payments due to sequestration and the Budget Control Act of 2011 creates losses for public, rural hospitals that depended on federal dollars to make up a share of their revenue. Although some analysts attribute rural hospital closures to poor management, state and national policies can create difficult financial circumstances regardless of administrative choices.

National Financial and Market Statistics
A main question of this report is the financial circumstances that lead to closure. A study conducted in 2016 by the North Carolina Rural Health Research Program, Cecil G. Sheps Center for Health Services Research (a main source of information for this topic on a national scale), analyzed the financial performance and market statistics of rural hospitals that closed between 2010 and 2014 compared with those that remained open. Operating and total margin for hospitals that closed in this time frame was significantly lower (5% to 9%) in 2009 than for those that stayed open. “The median closed hospitals had a substantial negative operating and total margin, while the median open hospitals had a small positive operating and total margin.” Lower hospital liquidity is also associated with rural hospital closure, as closing CAHs and other rural hospitals (ORHs) had enough cash on hand to keep doors open for 14.67 and 8.33 days, respectively. Current ratio, or the number of times short-term liabilities can be paid with short-term assets, is also significantly lower for closed hospitals. Closed hospitals also had higher debt levels in 2009 than hospitals that stayed open during the 2010-14.

Hospitals can make more profit with procedures that keep the patient in the hospital longer, while outpatient dollars reap less benefit for the institution. Medical advances are increasing the number of outpatient procedures, thereby straining hospitals to find profits. This pattern is taking its toll on rural hospitals, as “outpatient to total revenue (the percentage of total revenues for outpatient services, including Rural Health Clinics, free-standing clinics, and home health clinics) was significantly lower in closed CAHs than in open CAHs.”

The daily census in ORHs that closed was also significantly lower, meaning more beds went empty and money was wasted on keeping lights on in larger facilities than necessary for daily use. The acute average daily census in these facilities was 8.5 patients. The number of full-time employees was also significantly lower in ORHs that closed than in open ones, as were workers’ salaries. Also, Medicare inpatient payer mix, or the percent of patients using Medicare, was significantly higher in ORHs that closed. Although the North Carolina Rural Health Research Program study focused on financial factors, it also acknowledges that “hospital factors associated with rural hospital closures include poor financial health, aging facilities, low occupancy rates, difficulty recruiting and retaining health care professionals, fewer medical services, and a small proportion of outpatient revenue.”

In addition to the financial data linked to closure, the committee studied the market that closing rural hospitals serve. The Medicare inpatient mix explains the populations that rural hospitals serve and the public policies regarding payment that affect these hospitals most. “Odds of unprofitability increase with proportion of residents over age 65, proportion of households in poverty, and decreased population density. An increase in total population of 10,000 reduces odds by 4%.” People living in rural areas are generally more expensive as patients because they experience higher rates of obesity, tobacco use, and
chronic disease, report fair to poor health, and/or have a greater number of potential years of life lost. Communities served by rural hospitals are more likely to be unemployed and uninsured, meaning a higher rate of poverty and a higher population of patients entering hospitals using Medicaid or having no insurance. This means rural hospitals proportionally accrue more debt caring for patients without insurance and by caring for patients with Medicare and only making 98 cents on the dollar due to Medicare payment reduction from sequestration efforts. The North Carolina Rural Health Research Program, discussed above, cites higher poverty rates in the South as a possible reason why this region experiences more hospital closures than other regions, at 64% of hospitals.

**Closure’s Impact on Patients**

Hospitals play a key role in rural economies as they can employ hundreds of residents and bring in significant revenue. Studies show that “if the 673 financially vulnerable hospitals [in the U.S.] closed, rural patients would need to seek alternatives for 11.7 million hospitals visits, 99,000 health care workers would need to find new jobs, and $277 billion in GDP would be lost.” High-paying jobs disappear, and it becomes more difficult for other local industries to recruit workers to a location without a hospital.

Emergency services would be significantly harder for rural patients to access as well. The time it would take to travel to the closest hospital can be detrimental to patients given the critical need for life-saving treatment for a “heart attack, stroke, anaphylactic allergic reaction, or complicated birth.” This may be why “60% of trauma deaths occur in rural America, even though only 20% of Americans live in rural areas.” The high, out-of-network costs of emergency helicopters also make the number of miles between a patient and the nearest emergency care essential to ensuring ambulances can bring a patient to care quickly.

Distance also hinders patients with chronic illnesses, like cancer, who must travel to hospitals for treatment on a regular, sometimes weekly basis. The cost of gasoline and car expenses to drive vast distances to the hospital and back in some cases makes care more inaccessible to rural patients.

Finally, the decreased profitability of rural hospitals due to the circumstances discussed makes it harder for these facilities to keep up technologically. Committee members agree that their patients often travel to larger, urban hospitals for care in order to access facilities that patients perceive as technologically savvy and of higher quality. Some patients would rather make a full-day trip across state lines to access more sophisticated treatments and equipment. These travel patterns are also caused by the physician shortage experienced in rural areas, as 125 of the 150 primary care health professional shortage areas (HPSAs) in Texas are rural or partially rural. Consequently, the Texas Organization of Rural & Community Hospitals acknowledges the low average daily census in Texas’s rural hospitals is a contributor to closure risk. Inaccessibility to care is a main reason why rural patients, especially in the South, lead in mortality rates for nearly all top-10 causes of death. According to the National Bureau of Economic Research, rural hospital closures contribute to mortality rates in surrounding areas rising nearly 6%.

**Addressing Physician Workforce Shortages**

Training rural physicians and expanding the workforce is critical to improving access to quality primary care and specialty care for rural patients. Infrastructure and health care cost affordability are also greatly influential, and a rural hospital cannot function without quality physicians, nurses, and other clinical staff. Texas needs an estimated 500 more primary care positions appropriately located in primary care HPSAs to remove all designations from the state. These physicians would need to be added to specific areas to meet the national shortage threshold for population-to-primary care physician ratio. The Texas Department of Health and Human Services estimates Texas could see a shortage of 3,375 primary care physicians by 2030, a 67% increase.
The committee determined that expanding efforts to recruit physicians to underserved areas should be further explored. TMA supports financial incentives for physicians who choose to practice in underserved areas, and medical schools’ development of programs increasing student exposure to primary care specialties, with state funding for such projects (Policy 185.001, Physician Workforce and Distribution).

Rural training tracks (RTT) are specifically designed to prepare physicians for the unique challenges of practicing in rural and isolated areas. These programs are a blend of the best of urban and rural training experiences and are structured to meet accreditation standards. Such programs in other states have demonstrated a high success rate, with 76% of participants in rural practice. Texas Tech University Health Sciences Center School of Medicine at the Permian Basin currently offers several family medicine rural training tracks. The University of Texas Health Science Center at Tyler also offers family medicine rural training tracks in East Texas.

Multiple state programs in Texas are designed to improve geographic distribution of physicians and enhance primary care access in underserved areas, but they are underfunded. Through House Bill 1065, a TMA bill, Texas established the Rural Resident Physician Grant Program in 2019 to encourage the creation of RTTs. A minimum of $1 million is necessary to start the program. In addition, the Texas Legislature reduced funding to the State Physician Educational Loan Repayment Program by a quarter in the 2018-19 budget. This funding cut prevents an estimated 94 physicians from receiving loan repayment funding each year. State funding for the Family Medicine Residency Program was cut 40% in the 2016-17 budget. In the 2019 legislative session, the Texas Higher Education Coordinating Board requested a partial restoration of $2 million, which TMA supported. The Texas Academy of Family Physicians sought $10 million in additional funding. No additional state funding was provided.

Discussion

Patients’ access to quality health care is of top concern to physicians. Ensuring rural hospitals stay open is integral to this issue, especially in the case of emergency, maternal, and chronic care. Part of the reason rural hospitals are struggling is a payment system causing them to take on bad debt to treat uninsured or underinsured patients instead of paying physicians for the care they provide to patients in the United States.

Texas is especially hard hit by the policies discussed above because it is a large, southern state, with numerous rural communities, and to date has chosen not to expand Medicaid. This means a large population of uninsured and underinsured patients increasing debt in rural hospitals. However, given that Medicaid expansion remains politically unpalatable for the state’s legislative leadership, it is important to discuss the numerous other national and state policy recommendations and community-driven initiatives that can help alleviate this issue.

Telehealth and broadband expansion are legislative priorities for Texas physicians hoping to bring health care access to patients in communities far from hospitals without asking them to sacrifice a day of work or the cost of driving significant distances to see a doctor. This is a major priority for the state, as eight bills passed in the 2019 legislative session regarding telemedicine, including measures to expand telemedicine coverage, allow telehealth to count towards hospitals’ neonatal and maternal level of care designations, and repeal outdated regulations. Telehealth training and capabilities for physicians are important in order to implement these initiatives on a local level. It is vital to note that these services can supplement, but do not replace, person-to-person health care. Many health systems mandate that a patient see a physician in person first to establish a relationship before moving to telemedicine communications. This solution, and the way health care systems and states around the country are using telemedicine, should be further explored. Ensuring the doctor-patient relationship is maintained and doctors are paid fairly for these services is essential.
Physician advocacy to promote fair payment for Medicaid services and Medicaid expansion can help prevent further rural hospital closures in Texas. The involvement of doctors in the implementation of programs that can alleviate the pressure hospital closure puts on communities can help keep care accessible and lessen the blow these changes have on rural economies.

Conclusion
There are two schools of thought when approaching the rural hospital closure crisis. The first is to find ways to save the local hospital, while another is to implement a sustainable alternative. This report takes the position that these approaches are not mutually exclusive. Recommendations discussed are intended to put hospitals in a better financial position, examine common hospital alternatives, and explore ways to reform the definition of a hospital to serve rural communities in a cost-effective manner.

Due to the demographic composition of many southern rural communities, with increasing levels of unemployment and poverty, the committee’s research showed that the percent of uninsured patients is higher in rural hospitals. As is well known, when patients come to the hospital for emergency care, federal law obligates the hospital to treat them regardless of their ability to pay, often resulting in bad debt for the hospital. Expanding Medicaid to increase health care coverage for those too poor to pay and who do not qualify for Texas Medicaid could decrease the debt taken on by rural hospitals and prevent closure. Multiple studies reviewed in this report showed that rural hospital closure in expansion states is significantly less frequent than in nonexpansion states. A 2016 study from the *Journal on Rural Health* states, “We posit that the primary mechanism that underlies the relationship between hospital closures and Medicaid expansions is the substitution of utilization by patients with Medicaid coverage for utilization by uninsured patients. The financial benefit from this shift in utilization improved hospitals’ financial margins and enabled them to remain in business. We also found that the financial benefits of the ACA’s Medicaid expansion, and corresponding decreased risk of closure, were greater for hospitals in areas with higher uninsurance rates. This result was more pronounced for hospitals in rural areas. The finding that the relationship was stronger at hospitals in areas with higher uninsurance rates strongly supports the link between hospitals’ financial viability and increased rates of health insurance coverage because of the ACA’s Medicaid expansion.”

To date, 37 states, including Republican-led ones such as Arkansas, Indiana, Ohio, and Utah, have implemented such coverage. Under the ACA, states have considerable flexibility to implement expansion in a manner best suited for their populations and needs. Existing TMA policy supports pursuing a strategy to draw down all available federal funds to increase health care coverage to low-income Texans using private-sector solutions (Policy 190.032, Medicaid Coverage and Reform). The Texas Legislature introduced multiple bills in the 2019 session to reduce the state’s rate of uninsured – the highest in the country. The Episcopal Health Foundation’s 2019 Health Policy Poll found that two-thirds of Texans support Medicaid expansion. None of the bills gained traction last legislative session.

The 2016 *Journal of Rural Health* study also recorded common options for health care facilities in rural communities where hospitals close. About half of the closed hospitals no longer provided any type of care, while the other half converted into emergency or urgent care, outpatient or primary care, and skilled nursing and rehabilitation services. The study notes, “These models may mitigate the negative impact of hospital closure on rural communities by improving access to health services, providing employment, and reconceiving the rural health paradigm.”

There is also a middle ground to be explored between keeping conventional rural hospitals open in areas where they struggle financially and moving away from a hospital completely. Multiple federal bills and the Texas Organization of Rural and Community Hospital’s legislative priorities support a step-down hospital model. Step-down hospitals could make hospitals less expensive by decreasing size and capacity or providing only emergency services, while keeping some health care access in places where hospitals...
would otherwise close. Creating the step-down hospital model by reforming the federal and state
definitions of a hospital are essential to retaining Medicaid payments in these facilities.
The federal government would have to take the first step to establish step-down hospitals, then Texas
should enact mirror legislation to affirm recognition from the Centers for Medicare & Medicaid Services.
In 2018 there were three bills in Congress that would establish step-down hospital variations:

- HR 578 (Rural Emergency Medical Center Act of 2018 – Jenkins/Kind): CAHs and rural hospitals of
  50 beds or less could convert to a 24-hour emergency department and outpatient clinic. Patients could
  be held for up to 24 hours, and the hospital would not participate in traditional inpatient care. After 24
  hours, the patient would be discharged or transferred to a full-scale hospital.
- S. 1130 (Rural Emergency Acute Care Hospital [REACH] Act – Grassley/Klobuchar): Small rural
  hospitals with 50 or fewer beds could convert to emergency hospitals, with necessary emergency and
  observation services, while receiving Medicare payment rates of 110% of reasonable costs.
- HR 2957 (Save Rural Hospitals Act – Graves/Loebsack): Establishes a step-down hospital option
  with emergency, outpatient services, and one-night inpatient stay. These facilities would be paid
  105% of eligible costs on Medicare patients.38

In addition, the Texas Organization of Rural and Community Hospitals, a consultant to this committee,
explicitly states one of its legislative priorities is that “congress must create a step-down rural hospital to
address the closure crisis and gives rural communities an option for sustainable care that are about to lose
their hospital. Without this option, rural communities with a closed hospital will continue to find
themselves with little or no emergency or other care.” These are just a few of the many examples of step-
down hospital alternatives to keep some health care options in rural communities, both for the people who
live there and those traveling through who may need emergency care.

In addition, the state legislature took initiative to address the technology and infrastructure challenges
faced by rural hospitals numerous times and should consider doing so again. House Bill 7 of the 2001
Texas Legislature created the Rural Health Facility Capital Improvement Program. A total of $2 million
in grant funds was available for projects costing up to $50,000 in counties with populations less than
150,000 people for “improvements to existing facilities, construction of new facilities, and the purchase
capital equipment, including information systems hardware and software”39 Replenishing this funding
to provide more grants to rural hospitals could help retain facilities and improve quality of care.
The National Rural Health Association also lists several policy options to bring rural hospitals financial
relief. These include the elimination of Medicare sequestration for rural hospitals and of the CAH 96-hour
condition of payment regulation, which causes CAHs to lose payment if a patient is not discharged or
transferred within 96 hours.

Overall, expanding options to keep rural hospitals financially healthy and reducing the amount of bad
debt they take on is a primary step towards reducing rural hospital closure. Medicine should also continue
to research and advocate for reformed health care options in rural communities, so patients are not left in
the dust in the case of closure.

**Recommendation 1:** That the Texas Medical Association reaffirm support for existing TMA policy
190.032 Medicaid Coverage and Reform and redouble its efforts to reduce Texas’ rate of uninsured
during the 2021 legislative session.

**Recommendation 2:** That TMA highly prioritize replenishing funding for the State Physician Education
Loan Repayment Program, as 2018-19 budget cuts to this program prevent an estimated 94 physicians
from receiving loan repayment funding each year and prevent many underserved communities from
benefiting from increased access to physician services.

Recommendation 3: That TMA make a high priority adding $1 million to the state budget for 2022-23 to
start the Rural Resident Physician Grant Program, HB 1065.

Recommendation 4: That TMA support step-down hospital formation by expanding the bed capacity and
service requirements used to qualify a hospital for Medicaid and Medicare payments.

Recommendation 5: That TMA support elimination of the Medicare physician payment reductions
because of sequestration.

Recommendation 6: That TMA support elimination of the Medicare critical access hospital 96-hour
condition of payment regulation.

Recommendation 7: That TMA support expansion of Medicare critical access hospital (CAH)
designation requirements, increase funding for CAHs, and/or study why CAH designation doesn’t always
save rural hospitals.

Recommendation 8: That TMA support increasing funding for Prospective Payment System rural
hospitals under Medicare.

Related TMA Policy:
100.016 Texas Department of State Health Services Emergency Medical Services Local Projects Grant
Program
190.032 Medicaid Coverage and Reform
190.015 Medicaid and Rural Physicians
235.031 Equal Payment for Rural Health Clinics Regardless of Type of Ownership
275.003 Rural Health Clinic Regulations
275.006 Broadband Internet Access to Rural Texas
290.010 Improving Access to Care in Rural and Medically Underserved Areas
185.006 Physician Workforce and Distribution
185.019 Rural Physician Workforce Policy

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29 Texas Organization of Rural & Community Hospitals (TORCH), Rural Hospital Environmental IMPACT Study, Episcopal Health Foundation, March 2017.
30 Rural Health Disparities, RHI hub, Rural Health Information Hub, April 22, 2019.
32 Department of State Health Services, Texas Projections of Supply and Demand for Primary Care Physicians and Psychiatrists, 2017 – 2030, Texas Health and Human Services.
34 Kaufman, et al., The Rising Rate of Rural Hospital Closures.
35 Status of State Medicaid Expansion Decisions: Interactive Map, Kaiser Family Foundation.
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37 Kaufman, et al., The Rising Rate of Rural Hospital Closures.
38 Step-Down Rural Hospital Concept, www.legis.state.tx.us/tlodocs/85R/handouts/C41020180628130001/1324ef59-7d14-46f9-aa77-f2a115b328f2.PDF.
Resolution 411-A-19, introduced by the Medical Student Section, was referred to the Committee on Health Information Technology and the Office of the General Counsel. The resolution addresses the transfer and ownership of data when physicians change electronic health records.

The resolution recommends that (1) the Texas Medical Association work with the American Medical Association and other state medical societies to develop model contract and business associate agreement (BAA) language that ensures electronic health record (EHR) vendors are required to deliver the patient’s complete medical record in a discrete, industry-recognized, nonproprietary format that can be imported into the new EHR at no cost to the physicians; and (2) our TMA seek legislative and/or regulatory relief to require that physicians have access to their former EHR data while transitioning EHRs to ensure continuity of patient care, limit gaps in information exchange, and ensure physician ownership of data.

Status
Testimony during the reference committee indicated support of this resolution. Physicians have few options to transfer data from proprietary EHR vendors when trying to switch systems. Physicians who adopted EHRs, many with federal incentives, expected the benefits of EHR use to include the promotion of safer care, higher quality care, practice efficiency, and medical record accessibility. It has been more than a decade since the passage of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, and many EHRs still fall short. Physicians, with limited knowledge and experience of EHRs, made purchases in good faith, with the understanding that certified EHRs had the government’s “stamp of approval” and should meet the four previously listed benefits. Physicians adapted their practices and used EHRs as effectively as possible, yet, for many, switching to another product was inevitable. This could be for reasons including, but not limited to, poor service, limited usability, vendors going out of business, vendors being acquired, or the product being discontinued. In these circumstances, physicians were left with limited options for transitioning patient data from one EHR to the next.

The HIT Committee has heard testimony of members who have been cut off from their EHR data or forced to sign contracts without the ability to review or negotiate them in order to continue to receive access to their patient data.

There are multiple reasons to require data availability, including patient safety, medical record retention requirements, HIPAA regulations, and data blocking regulations. Each of these is explored below.

1. **Patient Safety**
When important information, such as allergies, key studies, and other information, is not available electronically in the new record, the clinical decision support systems of the new EHR cannot function as designed. Transferring information by putting it in a document (e.g., a .pdf) defeats the purposes of EHRs. Of course, one can argue that the physician can reinterview the patient during the first visit with the new EHR, but important information can be missed. One could also argue that the physician could employ a
scribe to review the old EHR for important information and reenter it, but again, this is fraught with risk of omission and error. Both choices are also expensive. It is also well known that when data are not available in the workflow of the physician, they often are overlooked.

Based on the above, electronic transfer of at least selected important information (e.g., problems, medications, allergies, immunizations, demographics, growth parameters, visit history, key notes, and key imaging/lab/procedure reports) in a manner that can be used by the new EHR for computer-aided decisionmaking is vitally important to fulfilling the promise of EHRs improving patient safety.

2. Legal Medical Record Requirements

Although each state has specific medical record requirements, EHR vendors generally have not sufficiently addressed them, leaving physicians to figure out how to meet them. When physicians don’t change their EHR, it’s relatively easy; the system retains all the old records, and many systems have tools for producing a legal medical record. But for physicians who change EHR, few, if any, systems provide mechanisms for making records available when the physician no longer is using the old EHR.

In Texas, the Texas Medical Board (TMB) rules require physicians to maintain adequate medical records of a patient for a minimum of seven years from the anniversary date of last treatment by the physician. If a patient was younger than 18 years of age when last treated by the physician, the physician is required to maintain the patient’s medical records until the patient reaches age 21 or for seven years from the date of last treatment, whichever is longer. Physicians must retain medical records for longer lengths of time than imposed by the TMB regulations when mandated by federal or by other state statute or regulation. A physician also may not destroy medical records that relate to any civil, criminal, or administrative proceeding if the physician knows the proceeding has not been finally resolved.

The specific TMB requirements related to the contents, release, and maintenance of a medical record, found in 22 Texas Administrative Code§§165.1-165.6, are extensive. Some of these are listed below:

*Contents of Medical Record*

Each licensed physician of the board shall maintain an adequate medical record for each patient that is complete, contemporaneous and legible. An “adequate medical record” should meet the following standards:

1. The documentation of each patient encounter should include:
   - (A) reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
   - (B) an assessment, clinical impression, or diagnosis;
   - (C) plan for care (including discharge plan if appropriate); and
   - (D) the date and legible identity of the observer.

2. Past and present diagnoses should be accessible to the treating and/or consulting physician.

3. The rationale for and results of diagnostic and other ancillary services should be included in the medical record.

4. The patient’s progress, including response to treatment, change in diagnosis, and patient’s noncompliance should be documented.

5. Relevant risk factors should be identified.

6. The written plan for care should include when appropriate:
   - (A) treatments and medications (prescriptions and samples) specifying amount, frequency, number of refills, and dosage;
   - (B) any referrals and consultations;
   - (C) patient/family education; and,
   - (D) specific instructions for follow up.
(7) Include any written consents for treatment or surgery requested from the patient/family by the physician.

(8) Include a summary or documentation memorializing communications transmitted or received by the physician about which a medical decision is made regarding the patient.

(9) Billing codes, including CPT and ICD-9-CM codes, reported on health insurance claim forms or billing statements should be supported by the documentation in the medical record.

(10) All non-biographical populated fields, contained in a patient’s electronic medical record, must contain accurate data and information pertaining to the patient based on actual findings, assessments, evaluations, diagnostics or assessments as documented by the physician.

(11) Any amendment, supplementation, change, or correction in a medical record not made contemporaneously with the act or observation shall be noted by indicating the time and date of the amendment, supplementation, change, or correction, and clearly indicating that there has been an amendment, supplementation, change, or correction.

(12) Salient records received from another physician or health care provider involved in the care or treatment of the patient shall be maintained as part of the patient's medical records.

**Maintenance of Medical Records**

(1) A licensed physician shall maintain adequate medical records of a patient for a minimum of seven years from the anniversary date of the date of last treatment by the physician.

(2) If a patient was younger than 18 years of age when last treated by the physician, the medical records of the patient shall be maintained by the physician until the patient reaches age 21 or for seven years from the date of last treatment, whichever is longer.

(3) A licensed physician is required to retain records from a forensic medical examination in accordance with Section 153.003 of the Medical Practice Act.

(4) A physician may destroy medical records that relate to any civil, criminal or administrative proceeding only if the physician knows the proceeding has been finally resolved.

(5) Physicians shall retain medical records for such longer length of time than that imposed herein when mandated by other federal or state statute or regulation.

(6) Physicians may transfer ownership of records to another licensed physician or group of physicians only if the physician provides notice consistent with §165.5 of this title (relating to Transfer and Disposal of Medical Records) and the physician who assumes ownership of the records maintains the records consistent with this chapter.

(7) Medical records may be owned by a physician’s employer, to include group practices, professional association, and non-profit health organizations, provided records are maintained by these entities consistent with this chapter.

(8) Destruction of medical records shall be done in a manner that ensure continued confidentiality.

EHRs used by Texas physicians should meet all the above content and maintenance requirements if the physician uses the EHR as his or her medical record system.

### 3. HIPAA Regulations

In September 2016, the Department of Health and Human Services Office of Civil Rights (OCR) made it clear that physician-covered entities must be able to access the protected health information (PHI) of their patients when that PHI is maintained on their behalf by a business associate. This was addressed in an FAQ regarding the issue of a business associate blocking or terminating access by a covered entity to the PHI maintained for or on behalf of the covered entity.

**Question:** “May a business associate of a HIPAA covered entity block or terminate access by the covered entity to the protected health information (PHI) maintained by the business associate for or on behalf of the covered entity?”
Answer: “No.”

“First, a business associate may not use PHI in a manner or to accomplish a purpose or result that would violate the HIPAA Privacy Rule. See 45 CFR § 164.502(a)(3).

Generally, if a business associate blocks access to the PHI it maintains on behalf of a covered entity, including terminating access privileges of the covered entity, the business associate has engaged in an act that is an impermissible use under the Privacy Rule. For example, a business associate blocking access by a covered entity to PHI (such as where an Electronic Health Record (EHR) developer activates a “kill switch” embedded in its software that renders the data inaccessible to its provider client) to resolve a payment dispute with the covered entity is an impermissible use of PHI. Similarly, in the event of termination of the agreement by either party, a business associate must return PHI as provided for by the business associate agreement. If a business associate fails to do so, it has impermissibly used PHI.

“Second, a business associate is required by the HIPAA Security Rule to ensure the confidentiality, integrity, and availability of all electronic PHI (ePHI) that it creates, receives, maintains, or transmits on behalf of a covered entity. See 45 CFR § 164.306(a)(1). Maintaining the availability of the ePHI means ensuring the PHI is accessible and usable upon demand by the covered entity, whether the PHI is maintained in an EHR, cloud, data backup system, database, or other system. 45 CFR § 164.304. This also includes, in cases where the business associate agreement specifies that PHI is to be returned at termination of the agreement, returning the PHI to the covered entity in a format that is reasonable in light of the agreement to preserve its accessibility and usability. A business associate that terminates access privileges of a covered entity, or otherwise denies a covered entity’s access to the ePHI it holds on behalf of the covered entity, is violating the Security Rule.

“Third, a business associate is required by the HIPAA Privacy Rule and its business associate agreement to make PHI available to a covered entity as necessary to satisfy the covered entity’s obligations to provide access to individuals under 45 CFR § 164.524. See 45 CFR §§ 164.502(a)(4)(ii), 164.504(c)(2)(ii)(E). Therefore, a business associate may not deny a covered entity access to the PHI the business associate maintains on behalf of the covered entity if the covered entity needs the PHI to satisfy its obligations under 45 CFR § 164.524.

“OCR recognizes, however, that there may be certain arrangements that authorize the business associate to destroy or dispose of PHI, or perform data aggregation or otherwise combine data from multiple sources, and where, because of the nature of the services to be performed by the business associate with the PHI as specified in the contractual arrangements between the parties, the covered entity and business associate agree that the business associate will not provide the covered entity access to the PHI. For example, a covered entity may engage a business associate to perform data aggregation of information from multiple sources that renders the disaggregated original source data unreturnable to the covered entity. OCR does not consider these contractual arrangements to constitute the types of impermissible data blocking or access termination described above.

“Finally, OCR notes that a covered entity is responsible for ensuring the availability of its own PHI. To the extent that a covered entity has agreed to terms in a business associate
agreement that prevent the covered entity from ensuring the availability of its own PHI, whether in paper or electronic form, the covered entity is not in compliance with 45 CFR §§ 164.308(b)(3), 164.502(e)(2), and 164.504(e)(1).”

In the scenario described in this OCR FAQ, the EHR vendor would be the business associate of the physician-covered entity.

4. Data Blocking (21st Century Cures Act)

In the 21st Century Cures Act, Congress adopted language designed to promote EHR interoperability. As part of that language, Congress authorized civil penalties for certain information blocking activities. Congress included a definition of “information blocking” in Sec. 4004. Information Blocking and required the secretary “through rulemaking, … [to] identify reasonable and necessary activities that do not constitute information blocking.”

On March 4, 2019, addressing the 21st Century Cures Act, the Office of the National Coordinator (ONC) posted to the Federal Register proposed rules related to interoperability and information blocking. In the proposed rule, ONC gave examples of restricted access to information that included physicians switching EHRs.

The final rule is not yet posted, but TMA did comment indicating agreement that a new export criterion is needed so physicians can receive complete data exports when transitioning EHRs. TMA went on to implore ONC not to allow vendors to use transitioning as an opportunity to create another revenue stream. Physicians already pay hefty fees to purchase or lease the software, in addition to annual licensing fees. TMA further recommended that ONC should hold vendors responsible for standardized export practices that do not punish the EHR purchasers and users. The final rules will be analyzed once posted, and TMA will educate physicians as to any regulatory relief for data transition.

Considerations in Transition of EHR Data

Because EHR databases are not standardized, it usually is difficult to move data when physicians transition from one EHR vendor to another. Physicians trying to meet the patient safety goals and the legal medical record requirements above have few options without spending enormous amounts of money.

Current options, while not optimal, include these:

1. If the vendor permits this, maintain an active read-only license with the old EHR, allowing read-only access to view old patient records.
2. Save each patient’s full record to an electronic file (e.g., .pdf) and (optimally) save the file as an attachment to each patient’s record in the new EHR. Depending on the number of patients, this can take a dedicated staff person days, if not weeks, to complete. A best practice is to archive inactive patients, and only move the records of active patients to the new EHR. A practice also can print everything and make the paper records accessible to clinicians after the go-live for the new EHR.
3. Depending on the vendor database, archive and maintain the read-only version of the old EHR without paying for a read-only license. This also can be done with some third-party vendors, who provide electronic read-only access to the old EHR information that is stored using the third-party vendor’s software and database.
4. Migrate data from the old EHR to the new one. While this sounds simple, it is not, and it rarely works well. Most vendor databases do not map their data with metadata or “tags.” As a result, when migrating data, vendors attempt to map as much as possible of the old data so that when the data are extracted from the old EHR, they are correctly imported into the new EHR. This often is done on a
most basic level using a Continuity of Care Document (CCD), where predefined, standardized extensible markup language (XML) tags exist. Unfortunately, the accuracy and completeness of CDs are variable. It is worth having a conversation with both vendors to understand their experience and success with exporting and importing patient data. Even when it works well, it is unlikely the full record will transfer easily, as attachments, free text notes, and custom fields rarely get placed correctly within the new EHR and may require manual manipulation. Sometimes even small incompatibilities such as date formats cause problems (e.g., 02/18/1952 versus Feb-18-52). Also, this option is usually the most expensive approach.

5. Hire a conversion team that will enter key data (e.g., problems, allergies, medications, immunizations, and more) from the old system into the new system for patients who on the schedule for the next day. This solution is costly and incomplete, but it targets only those patients for whom the data are needed.

Some combinations of all the options are often used. For most, the experience is costly and difficult. The process also can be potentially harmful to patient safety. To better understand all the risks and challenges of the options above, it is advisable to discuss the situation with a privately retained attorney.

TMA Advocacy

TMA has long advocated for the ability to transition data from one EHR to another and maintain the full electronic patient records. TMA has urged federal agencies to require the universal (i.e., all EHR data) use of XML or a similar standard (e.g., FHIR – Fast Healthcare Interoperability Resources) as a way of exchanging health data, as is used in accounting and other industries. Universal common encoding of all data elements would allow physicians to change their EHR quickly with very little cost. Data consumed by a receiving EHR could be placed correctly within the new system to give them meaning and make them immediately useful. It is important that physicians have the ability to export and import tagged patient data from one EHR to another, especially when changing vendors. Unless EHR vendors are required to tag all data fields, allowing complete mapping between disparate systems, this problem will continue to exist.

TMA Resources

To help Texas physicians navigate the potential problems related to data migration and contracting, TMA has developed numerous resources that are available on the TMA website. They include:

- **EHR to EHR Conversions – When, Why and How** is a free (for members) webinar that provides expert insight on strategies and best practices for EHR system conversions, distinguishing risks within vendor contracts and ways to avoid those risks, and how to properly notify the current EHR vendor and promote a smooth transition.

- **Switching EHR Systems** is a free (for members) publication designed to help physicians think through all aspects of the EHR transition process and minimize disruption and risk as much as possible.

- **“EHR Buyer Beware: Issues to Consider When Contracting with EHR Vendors”** is a white paper that discusses eight important EHR contract terms a medical practice should consider before signing an EHR contract.

- **Guide to Licensing and Service Agreements** is a free guide that includes an assessment of things to consider before signing a technology-related product contract.

- **“Before You Sign: 10 Tips for Tech Contracts”** is a *Texas Medicine Today* article that lists 10 items to consider before signing a technology contract.

- **“Get the Know-How You Need When Upgrading Your EHR”** is a *Texas Medicine Today* article that lists resources and services that members can use when changing EHRs.

- **“EHR Vendors Behaving Badly: What Can You Do?”** is a *Texas Medicine Today* article that lists some things to consider and how to report EHR vendors if the physician can’t access data or transfer patient records to a new EHR.
• “Glitch in the Switch: Changing EHR Vendors Can Present Major Problems” is an article from *Texas Medicine* magazine that shows the difficulties of migrating patient records from one EHR system to another and how to minimize risk.

• “Switching EHRs? Transferring Data Can Be a Hurdle” is an e-tip article available on the TMA website that lists some resources and tips related to data transition.

• The Coker Group is a TMA group discount program vendor that offers TMA members free technology contract reviews. It looks for terms and conditions that may be unfavorable to TMA members. After reviewing the contract, Coker Group consultants will discuss it with the physician, including suggestions on how to address any unfavorable terms. TMA members who want help negotiating the contract are eligible for a 5% discount on Coker’s fees, which will be capped.

Additionally, TMA has a general model business associate agreement that physicians can use in consultation with their privately retained attorneys and modify specific to their practice.

**External Resources**
The Office of the National Coordinator has a good resource on the subject of switching EMRs on its website at [www.healthit.gov](http://www.healthit.gov).

**Recommendation:** That the Texas Delegation to the American Medical Association take a resolution to AMA formally requesting AMA assistance with model contract language and regulatory relief through electronic health record (EHR) vendor certification that ensures EHR vendors are contractually required to deliver the patient’s complete medical record in a discrete, industry-standardized, nonproprietary format that can be imported into the new EHR at no cost to the physicians by:

A. The development of an exportable AMA-endorsed standard-format database that all EHRs must be able to create electronically for all patients that would be suitable for importing the old EHR data into a new EHR. This must operate at no cost and with minimal effort by physicians and their practices. A Continuity of Care Document (CCD) format, Fast Healthcare Interoperability Resources (FHIR) (as this standard increases in use), or other methodology could be used for discrete data and a document repository for all other information.

B. Regulatory relief that requires EHR vendors to be contractually required to have such a medical-record transfer capability within 18 months of a final rule.

C. Regulatory relief that requires vendors to be contractually required to provide physicians and patients read-only access to and data extraction from (through .pdf, CCD, and FHIR) the old EHR system for the length of time required to meet state legal medical record retention requirements after contract termination or vendor bankruptcy. This should provide time to make electronic transfers and develop alternative methods of accessing information that is not transferred electronically under (A), above. Vendors should be able to transfer fulfillment of this requirement to a third party that can provide the same service. This must operate at no cost and with minimal effort by physicians and their practices.
The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The Committee on Health Information Technology recommends amending the following policy:

**155.009 Laboratory and Radiology Reports Database:** The Texas Medical Association supports immediate implementation of an effective method for helping physicians who did not order the patients’ lab, radiology, and other tests to access those results whether directly or through a health information exchange (Res. 409-A-10).

**Recommendation:** Retain as amended.
Subject: Compensation to Physicians for Activities Other Than Direct Patient Care

Presented by: E. Linda Villareal, MD, Chair

Referred to: Reference Committee on Socioeconomics

At TexMed 2019, the House of Delegates amended Resolution 401-A-19 Compensation to Physicians for Activities Other Than Direct Patient Care, submitted by Harris County Medical Society, and adopted it as follows:

RESOLVED, That the Texas Medical Association form a task force including members of the Council on Legislation, Council on Socioeconomics, Council on Health Care Quality and interested county medical societies to strategically prepare solutions for advocacy that address and mitigate the burden of prior authorization and that the task force bring a report back to the House of Delegates in 2020.

Resolution 401-A-19, as adopted, was referred to the Board of Trustees. Accordingly, the Board of Trustees voted at its 2019 Winter Conference meeting to create a task force to address the charge of the resolution. As a result, the TMA Prior Authorization Task Force was formed.

Debra Patt, MD, chair of the TMA Council on Legislation, was selected to chair the Prior Authorization Task Force. Under her leadership, TMA efforts to advocate for reforms of prior authorization processes and requirements were streamlined and unified by combining the task force’s membership with the Council on Legislation’s existing Workgroup on Prior Authorizations.

Dr. Patt called the task force’s first meeting in February 2020. During that meeting, the task force engaged in a robust discussion regarding the need for a wide variety of prior authorization reforms. More specifically, the taskforce discussed:

• TMA legislative efforts related to prior authorization during the 2019 session of the Texas Legislature;
• Interim legislative committees, including the Select Committee on Prior Authorization Reform and the Committee on Health Care Cost and Efficiency;
• Current regulatory efforts related to prior authorizations; and
• Strategies and support needed for success with prior authorization reforms.

The task force has been evaluating (and will continue to evaluate) physician survey data collected by TMA and other sources regarding the burden of prior authorization requirements and the impact these requirements have on patients. Furthermore, the task force is asking for physician testimonials to demonstrate the need for significant prior authorization reform. These testimonials will be helpful in preparing for interim hearing testimony. The task force also is working towards securing physician volunteers to provide oral testimony, when needed.

The task force has created a list of potential legislative and regulatory priorities for prior authorization reform. That working list may be modified and expanded as the task force continues its work. The task force has scheduled its next meeting for late March.
TMA and the task force are also working closely with the American Medical Association and other states in evaluating legislative initiatives.

**Recommendation:** That the Texas Medical Association advocate for significant legislative and/or regulatory reforms to lessen (1) the negative impact of state-regulated health plan prior authorization requirements on patients and (2) the burden of state-regulated health plan prior authorization requirements on physician practices.
Subject: Opposition to New Federal Public Charge Definition

Presented by: John Flores, MD, Chair

Referred to: Reference Committee on Socioeconomics

Background

In August 2019, the U.S. Department of Homeland Security adopted new rules revising the definition of “public charge” – the standard used by federal immigration officials to determine if a person seeking legal permanent residency (commonly known as a green card) is a risk for becoming reliant on public assistance. Per the new rules, immigration officers may consider whether a person lawfully immigrating to the U.S. is at risk of using Medicaid, Supplemental Nutrition Assistance Services (SNAP), housing, and other social services in the future. Heretofore, immigration officials only considered use of public cash assistance or government-sponsored long-term care institutionalization in making a public charge determination. Health care services were not, recognizing that health care coverage is an essential aspect of improving the health and well-being of individuals and the broader public.

Indeed, in 1999, the federal government issued guidance clarifying that immigration officials do not consider enrollment in Medicaid (except for long-term care services) or the Children’s Health Insurance Program (CHIP) in public charge determinations in order to quell fear among immigrants that if they or their children, the vast majority of whom are U.S.-born citizens, are so enrolled, it would count against them. At that time, immigration officials noted that enrollment in Medicaid or CHIP by lawfully present immigrants would benefit not only them and their families but also the communities in which they lived.

From the outset, TMA opposed the rules. While the association has historically not taken a position on federal immigration issues, the rules will undoubtedly have significant implications for the health of Texans and physician practices. As noted in TMA’s comment letter, “when proposed changes to federal immigration policy intersect with the state’s health care delivery system, it is incumbent on TMA to provide input on how the changes will affect our members’ ability to care for their patients.”

Implications to the Health of Texans and State’s Health Care Delivery System

Federal law already restricts the use of Medicaid, CHIP, and other publicly financed health care services by legal immigrants. Temporary visa holders are ineligible for enrollment in these programs. And for five years following immigration to the United States, green card holders cannot enroll in Medicaid or CHIP. But there are important exceptions to the five-year waiting period for pregnant women and children. States have the option to allow these populations to enroll in Medicaid or CHIP prior to the expiration of the five-year bar because doing so will ensure children and pregnant women receive the preventive, primary, and specialty care services they need to thrive. By receiving coverage, pregnant immigrants are more likely to obtain early prenatal care, a key factor in addressing Texas’ concerningly high rate of maternal mortality and morbidity. Additionally, a healthy pregnancy is vital to giving the unborn child — a future U.S. citizen — a head start on healthy development. If nothing else, such coverage is also just good business because healthy pregnancies and healthy babies result in lower future federal and state Medicaid costs.

According to the federal government, fewer than 400,000 legal immigrants nationwide will be directly impacted. However, the indirect impact of rules already has been widely felt. Nationwide, 13.5 million
Medicaid/CHIP enrollees, including 7.6 million children, live in a household with a noncitizen or are noncitizens themselves. Some 100,000 Texans receive a green card annually, though at any given time, many more legal immigrants are in the process of obtaining their green card. Misunderstanding and confusion about the rules has resulted in a “chilling effect” on Medicaid and CHIP enrollment, with immigrant parents skipping preventive care for their children, including immunizations, and forgoing Medicaid or CHIP coverage renewal for their children or themselves. Since adoption of the rules, Texas physicians, hospitals, community clinics, food banks and other social service agencies across the state have reported sharp decreases in use of health care and SNAP services by immigrant families and their children. Similarly, anecdotal information from physicians indicates fewer use of prenatal care services, including CHIP Perinatal, by immigrant pregnant women.

Unfortunately, as fewer immigrants enroll in Medicaid or CHIP, many of these patients resort to costly, taxpayer-supported emergency departments instead, increasing uncompensated care costs for the physicians and hospitals that are required to provide this care and ultimately contributing to higher costs and property taxes for Texans. Along the border, physicians report large increases in the number of immigrant families seeking care in emergency departments for conditions treatable in a primary care setting. Obstetricians and family physicians report an increase in immigrant women coming to their hospitals in labor with no prior prenatal care.

The anecdotal evidence corresponds to research conducted by the Urban Institute prior to the rules’ adoption. According to a survey it conducted, “one in seven adults in immigrant families reported avoiding public benefit programs for fear of risking future green card status.” Furthermore, from late 2017 until today, enrollment in Texas Medicaid among children dropped by more than 225,000. While multiple factors contributed to the decline, the public charge rules are one.

Furthermore, the rule also will invariably harm the state’s public health by contributing to the spread of communicable diseases. Though the rule explicitly excludes public preventive health services from the public charge definition, vaccine coverage among immigrants and their family members most certainly will decline as a result of people dropping Medicaid or CHIP coverage because they likely will forgo use of public vaccine clinics out of fear or misunderstanding about the rule.

Moreover, when the federal government published the proposed rule, the agency itself acknowledged the many negative consequences the rule will have on people and communities, including an increase in emergency department use, an increase in the prevalence of communicable diseases, an increase in uncompensated care, and worse health outcomes among immigrants and their families.

Already, the rules have worsened the state’s sky-high rate of uninsured – the highest in the country – and will immeasurably harm the health and well-being of Texas and Texans by:

- Undercutting efforts to improve maternal and infant health by deterring use of prenatal care among immigrant mothers in our country;
- Harming the health of children by deterring immigrant parents from enrolling their children in Medicaid or CHIP, which provides children important preventive, primary, and specialty care;
- Weakening efforts to address Texas’ opioid and substance use disorder crises by deterring pregnant and postpartum immigrant women from obtaining treatment; and
- Increasing uncompensated care by physicians, health care providers, and hospitals, a potentially devastating blow to rural communities where physician practices and hospitals already operate on razor-thin margins.
Status of Federal Rules

Quickly following adoption of the rules, multiple state attorneys general and advocacy organizations filed lawsuits seeking to halt enforcement, arguing the rules would negatively impact public health and increase indigent health care costs for state and local governments. Last October, federal courts in California, New York, and Washington issued injunctions preventing nationwide implementation of the rules, but the U.S. 4th Circuit Court of Appeals in a 2-1 ruling lifted the injunction in December. However, on Jan. 8, 2020, the U.S. Court of Appeals for the 2nd Circuit unanimously upheld the injunction. The week following that decision, the U.S. solicitor general filed an emergency application asking the U.S. Supreme Court to stay the injunctions and allow implementation of the new rule. As of this writing, the Supreme Court has not responded to the request. On January 27, the Supreme Court lifted the injunction. Enforcement of the rules began Feb. 24, 2020.

Recommendation 1: That the Texas Medical Association adopt new policy opposing revisions to the federal definition of public charge that prevent legal immigrants or their children from using local, state or national health, nutrition, and housing services, including Medicaid or the Children’s Health Insurance Program.

Recommendation 2: That the Texas Medical Association continue to advocate that the new federal rules be rescinded to protect the health of all Texans.

Recommendation 3: That the Texas Medical Association develop resources to help physicians accurately and concisely convey to their patients what the federal rules relating to public charge do and do not say.
The Texas Medical Board (TMB) is authorized to temporarily suspend or restrict a physician’s license if a panel of board members determines the physician’s practice constitutes a continuing threat to the public welfare. No minimum requirement of evidence must be satisfied for the temporary suspension or restriction.

Following a temporary suspension or restriction, TMB undergoes a full investigation and attempts informal settlement. In some cases, the physician refutes the allegations forming the basis of the suspension or restriction and does not wish to settle, preferring instead to have the alleged violations decided before the State Office of Administrative Hearings (SOAH).

In the end, SOAH issues findings of fact and conclusions of law on the case, determining either that the physician violated applicable law or regulation, or that there was no violation. TMB determines any penalty based on SOAH’s findings.

One particular recent case indicated a significant flaw with this process: Even if, following a temporary suspension or restriction, SOAH determines there was no violation of law or regulation, TMB does not void the initial suspension or restriction, and it stays as a permanent mark on the physician’s record.

When TMB imposes a temporary suspension or restriction, it is required by law to notify several different entities, including hospitals, professional societies, and government payers and other entities (Texas Occupations Code, Section 164.060). Additionally, this board action shows up on the National Practitioner Data Bank (NPDB) – a national database containing negative actions against a physician – and in TMB’s profile for the physician on its website.

Yet, when SOAH determines there has been no violation, and TMB affirms SOAH’s findings of fact and conclusions of law that there was no violation by dismissing all allegations against the physician, TMB merely revises, rather than voids and vacates, the earlier temporary suspension in its report to the NPDB. The NPDB maintains reference to the report of the earlier unproven and superseded temporary suspension or restriction.

Though TMB has an obligation to alert relevant parties when it imposes a temporary suspension or restriction, TMB believes it has no equivalent duty to inform those parties other than the NPDB that the temporary suspension or restriction was “superseded” (voided). TMB maintains that the temporary suspension or restriction should stay on the physicians’ profile even though, ultimately, the allegations were unproven. Both the charges and the earlier (later unproven) allegations remain on the TMB website and are referenced in the revised TMB report to the NPDB.

The Patient-Physician Advocacy Committee contends this is an unfair and unjust result. To address these issues, the Patient-Physician Advocacy makes the following recommendations:
Recommendation: That the Texas Medical Association seek legislation that would provide that: (1) should an administrative law judge find that the Texas Medical Board (TMB) failed to meet its burden of proof on charges that served as the basis for a temporary suspension or restriction of a physician’s license, TMB shall overturn and vacate the temporary suspension or restriction as soon as practicable and dismiss the case; (2) the effect of an overturned and vacated temporary suspension or restriction, unless specifically appealed by TMB to district court, shall be that the suspension or restriction never happened and never should have happened; and (3) any mention of charges against a physician related to the temporary suspension or restriction shall be removed from the physician’s TMB profile, any related report to the National Practitioner Data Bank voided, and the case dismissed, unless and until a court of law reverses the administrative law judge’s findings of facts and conclusion of law.
Subject: Insurance Coverage Transparency

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Socioeconomics

Whereas, Medical offices and facilities want to provide accurate estimates to patients of their cost-sharing liability prior to office visits, procedures, and tests; and

Whereas, They are often unable to do so because each commercial health insurance plan has its own set of rules regarding whether the patient is responsible for meeting the deductible or paying a copay or coinsurance for a particular type of visit, procedure, or test; and

Whereas, Medical offices and facilities typically call the commercial insurance carrier directly or go online to verify coverage but are frequently given inaccurate information regarding the patient’s cost-sharing liability; and

Whereas, This inaccurate information can harm the patient-physician relationship if the insurance carrier underestimates the patient’s liability; and

Whereas, This inaccurate information can delay needed medical care if the insurance carrier overestimates the patient’s liability, thereby making the patient reluctant to proceed with recommended tests or procedures; and

Whereas, Commercial insurance carriers have the technology to input the diagnosis codes and Current Procedural Terminology codes and know immediately the patient’s liability but rarely provide this information; therefore be it

RESOLVED, That the Texas Medical Association advocate for legislation requiring commercial insurance carriers to provide accurate information regarding the patient’s cost-sharing liability and the insurance plan’s liability when a medical office or facility provides the diagnosis codes and Current Procedural Terminology codes via phone or the internet; and be it further

RESOLVED, That TMA advocate for legislation requiring commercial insurance carriers to provide updated information at the time of insurance eligibility verification regarding factors that may result in the claim being denied (e.g. the insurance carrier is waiting for the primary policyholder to verify that he or she does not have other health insurance coverage); and be it further

RESOLVED, That TMA advocate for legislation requiring commercial insurance carriers to respond to telephone inquiries regarding the patient’s cost-sharing liability by providing accurate information both verbally and via a fax confirmation; and be it further

RESOLVED, That TMA advocate for legislation penalizing commercial insurance carriers (via fines and the publication of statistics showing the number of complaints regarding noncompliance by each
insurance carrier) for instances where the above information is inaccurate or not provided in a timely manner; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association carry a similar resolution to the AMA House of Delegates.

Related TMA Policy:
145.031 Requirement for Medical Insurance Companies to Provide Online Real-Time Insurance Claim Adjudication
180.027 Prompt Payment of Claims
145.020 Insurer Liability for Unpaid Claims

Related AMA Policy:
H-185.981 Third Party Responsibility for Payment
H-185.938 Health Insurance Exchange and 90-Day Grace Period
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES
Resolution 402
2020

Subject: Need for and Funding of Level I and Level II Trauma Centers

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, A shortage of Level I and Level II trauma centers exists in many communities in Texas; and

Whereas, The recent closing of Memorial Hermann Southwest Level II Trauma Center in Houston has created additional demand at the two Level I trauma centers in the area; and

Whereas, The Texas Legislature has not adequately funded trauma centers through the Drivers Responsibility Program funds and other funding; and

Whereas, A recently enacted law eliminated the Drivers Responsibility Program and reduced current funding to hospital trauma centers by 2%; therefore be it

RESOLVED, That the Texas Medical Association work with state officials to determine the number of Level I and Level II trauma centers necessary to support communities of various sizes throughout Texas and to provide necessary funding to make Level I and Level II trauma centers viable with adequate funding for all other service lines.

Related TMA Policy:
100.011 Trauma Care Funding
100.013 Trauma Funding
100.018 Emergency Medical Resources
100.025 Access to Emergency Care in Texas
120.010 Principles for Evaluating Health System Reform
TABLE

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 403
2020

Subject: Taxes on Medical Billing Services

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, In 2019, the Texas comptroller’s office announced that medical billing services by an outside company would be subject to sales and use taxes; and

Whereas, The comptroller’s opinion to tax medical billing services is based on an attorney general’s opinion that preparing an insurance claim is an “inherent part of the insurance claim process”; and

Whereas, In 2002, the comptroller had reasonably determined that merely completing a form for the insured did not rise to the level of claim processing, and thus, medical billing services performed before the claim was submitted were not taxable; and

Whereas, Physicians likely will be unable to pass along any of this tax, which could amount to 8.25%, to patients because payment rates would already have been set by insurance companies or the federal government; and

Whereas, Such a policy will further diminish the value of insurance payments, including those of Medicare and Medicaid, which already struggle to lure physician participation; and

Whereas, This policy potentially creates an even greater uneven playing field for the health care arena between nonprofit and for-profit entities; therefore be it

RESOLVED, That the Texas Medical Association oppose the imposition of service and use taxes on processes that are not actually part of delivering a medical service; and be it further

RESOLVED, That TMA work with the Texas Comptroller of Public Accounts and state legislators to resolve and clarify that medical billing, including outsourced billing services, is not the adjudication or practice of insurance, and thus should not be subject to insurance-related sales taxes.

Related TMA Policy:
235.028 Texas Revised Franchise Tax
235.029 Franchise Tax Issues
RESOLUTION 404
2020

Subject: Individual Physicians Be Paid While Awaiting Credentialing Approval

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, in addition to signing a contract, physicians must be credentialled by a health plan to get paid for the services they provide; and

Whereas, waiting several months to a year for their credentials to be approved can have drastic consequences on physicians' livelihoods and the viability of their practices; and

Whereas, while physicians are out of network, patients are likely to be balance billed or receive a surprise bill; and

Whereas, health plan network adequacy is frequently insufficient; and

Whereas, due to the magnitude of this issue, the 2007 Texas Legislature passed legislation (Texas Insurance Code, Title 8, Subtitle F, Chapter 1452, Secs. 1452.101-1452.108) allowing for physicians in group practices to be paid the contracted rate while waiting for their credentials to be approved; and

Whereas, that legislation did not address the issue for individual physicians, who have the same concerns as their group practice colleagues; therefore be it

RESOLVED, that the Texas Medical Association adopt as policy that individual physicians should be paid the contracted rate while awaiting approval of their credentials by a health plan; and be it further

RESOLVED, that TMA advocate for legislation that individual physicians be paid by health plans for their services while they are awaiting formal approval of their credentials.

Related TMA Policy:

80.003 Universal Credentialing Form
190.014 Medicaid Managed Care Guiding Principles

Information:
From the Texas Insurance Code, Title 8. Health Insurance and Other Health Coverages, Subtitle F. Physicians and Health Care Providers, Chapter 1452. Physician and Provider Credentials:
Sec. 1452.101. DEFINITIONS. In this subchapter:
(1) “Applicant physician” means a physician applying for expedited credentialing under this subchapter.
(2) “Enrollee” means an individual who is eligible to receive health care services under a managed care plan.
(3) “Health care provider” means:
(A) an individual who is licensed, certified, or otherwise authorized to provide health care services in this state; or
(B) a hospital, emergency clinic, outpatient clinic, or other facility providing health care services.
“Managed care plan” means a health benefit plan under which health care services are provided to enrollees through contracts with health care providers and that requires enrollees to use participating providers or that provides a different level of coverage for enrollees who use participating providers. The term includes a health benefit plan issued by:
(A) a health maintenance organization;
(B) a preferred provider benefit plan issuer; or
(C) any other entity that issues a health benefit plan, including an insurance company.

“Medical group” means:
(A) a single legal entity owned by two or more physicians;
(B) a professional association composed of licensed physicians;
(C) any other business entity composed of licensed physicians as permitted under Subchapter B, Chapter 162, Occupations Code; or
(D) two or more physicians on the medical staff of, or teaching at, a medical school or medical and dental unit, as defined or described by Section 61.003, 61.501, or 74.601, Education Code.

“Participating provider” means a health care provider who has contracted with a health benefit plan issuer to provide services to enrollees.

Sec. 1452.102. APPLICABILITY. This subchapter applies only to a physician who joins an established medical group that has a current contract in force with a managed care plan.

Sec. 1452.103. ELIGIBILITY REQUIREMENTS. To qualify for expedited credentialing under this subchapter and payment under Section 1452.104, an applicant physician must:
(1) be licensed in this state by, and in good standing with, the Texas Medical Board;
(2) submit all documentation and other information required by the issuer of the managed care plan as necessary to enable the issuer to begin the credentialing process required by the issuer to include a physician in the issuer’s health benefit plan network; and
(3) agree to comply with the terms of the managed care plan’s participating provider contract currently in force with the applicant physician’s established medical group.

Sec. 1452.104. PAYMENT OF APPLICANT PHYSICIAN DURING CREDENTIALING PROCESS. On submission by the applicant physician of the information required by the managed care plan issuer under Section 1452.103(2), and for payment purposes only, the issuer shall treat the applicant physician as if the physician were a participating provider in the health benefit plan network when the applicant physician provides services to the managed care plan’s enrollees, including:
(1) authorizing the applicant physician to collect copayments from the enrollees; and
(2) making payments to the applicant physician.

Sec. 1452.104. PAYMENT OF APPLICANT PHYSICIAN DURING CREDENTIALING PROCESS. On submission by the applicant physician of the information required by the managed care plan issuer under Section 1452.103(2), and for payment purposes only, the issuer shall treat the applicant physician as if the physician were a participating provider in the health benefit plan network when the applicant physician provides services to the managed care plan's enrollees, including:
(1) authorizing the applicant physician to collect copayments from the enrollees; and
(2) making payments to the applicant physician.
Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.
Subject: Physicians to Retain Payment During Credentialing

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, In addition to signing a contract, physicians must be credentialled by a health plan to get paid for the services they provide; and

Whereas, Waiting several months to a year for a physician’s credentials to be approved can have dire consequences on the physician’s livelihood and the viability of the practice; and

Whereas, While the physician is out of network, patients are likely to be balance billed or receive a surprise bill; and

Whereas, Health plan network adequacy is frequently insufficient; and

Whereas, Physicians are providing a service and should be compensated for that service; and

Whereas, Due to the magnitude of this issue, the 2017 Texas Legislature passed legislation (Texas Insurance Code, Title 8, Subtitle F, Chapter 1452, Secs. 1452.101-1452.108) allowing for physicians in group practices to be paid the contracted rate while waiting for their credentials to be approved; and

Whereas, This law states:

If, on completion of the credentialing process, the managed care plan issuer determines that the applicant physician does not meet the issuer’s credentialing requirements:

(1) the managed care plan issuer may recover from the applicant physician or the physician’s medical group an amount equal to the difference between payments for in-network benefits and out-of-network benefits; and

(2) the applicant physician or the physician’s medical group may retain any copayments collected or in the process of being collected as of the date of the issuer’s determination;

(Sec. 1452.106 Effect of Failure to Meet Credentialing Requirements); and

Whereas, No out-of-network benefit exists for HMO plans; thus physicians would be providing a service with only a copayment for compensation; therefore be it

RESOLVED, That the Texas Medical Association adopt as policy that physicians should not be required to refund the contracted rate should credentialing be denied by a health plan; and be it further

RESOLVED, That TMA advocate to amend, by changing “may recover” to “may not cover,” Texas Insurance Code, Title 8, Health Insurance and Other Health Coverages, Subtitle F. Physicians and Health Care Providers, Chapter 1452 Physician and Provider Credentials, Sect. 1452.106 Effect of Failure to Meet Credentialing Requirements, to state that “the managed care plan issuer may not recover from the
applicant physician or the physician’s medical group an amount equal to the difference between payments for in-network benefits and out-of-network benefits.”

Information:
From the Texas Insurance Code, Title 8. Health Insurance and Other Health Coverages, Subtitle F. Physicians and Health Care Providers, Chapter 1452. Physician and Provider Credentials:
Sec. 1452.106. EFFECT OF FAILURE TO MEET CREDENTIALING REQUIREMENTS. If, on completion of the credentialing process, the managed care plan issuer determines that the applicant physician does not meet the issuer's credentialing requirements:
(1) the managed care plan issuer may recover from the applicant physician or the physician's medical group an amount equal to the difference between payments for in-network benefits and out-of-network benefits; and
(2) the applicant physician or the physician's medical group may retain any copayments collected or in the process of being collected as of the date of the issuer's determination.
Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.
Whereas, Physicians now have a variety of contractual arrangements to consider when deciding where to practice; and

Whereas, More physicians are choosing to become employed, by either a hospital, an academic institution, or a large or small physician practice; and

Whereas, Physicians who wish to be employed need the proper tools to help them negotiate a fair salary when seeking employment; and

Whereas, The Texas Medical Association has available a book to assist employed physicians with contract terms; and

Whereas, Individual physician placement firms have salary data on the limited number of their placements; however, an overall survey of all physicians conducted by a respected physician association would provide much more robust, statistically valid results; and

Whereas, As in negotiations with health plans, a physician’s medical association should provide a tool that helps physicians stand up for themselves in employment negotiations; therefore be it

RESOLVED, That the Texas Medical Association work with an established and credible human resources or placement firm to develop, implement, and publish a physicians’ salary survey available to TMA members only that takes into account a variety of factors that affect salary including, but not limited to, specialty, demographics, practice type and size, geographic location, and different types of contractual payment arrangements.

Related TMA Policy:

None found
TABLE

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 407
2020

Subject: Compensation to Physicians for Activities Other Than Direct Patient Care

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, Traditionally, physicians get paid for direct patient care, such as evaluation and management and procedures; and

Whereas, Insurance and managed care companies (payers) demand and require physicians and their staff to perform services outside of direct patient care (noncare services) without any payment. Examples of such noncare services are obtaining authorization and preauthorization for coverage and payment for prescriptions, laboratory tests, radiology tests, procedures, surgeries, hospitalizations, and physician visits; and gathering, compiling, and submitting medical records and data that benefit payers as they delay and deny care, meet requirements for outside commercial and governmental auditors, and enhance their ability to compile and use actuarial data for their pricing and profitability. Noncare services (1) have greatly increased expenses for physicians, (2) have endangered the ability of physician practices to survive economically, and (3) have caused the demise of independent physician practices; and

Whereas, The purpose of such noncare services is to delay and deny care, thus allowing payers to save, keep, and invest money that otherwise would pay for patient care, thus increasing their profits; and

Whereas, The overwhelming majority of authorization and preauthorization requests eventually are authorized by payers; and

Whereas, Such noncare services harm patients by delaying diagnosis and treatment, thus causing pain, suffering, morbidity, and mortality. The time spent by physicians and their staff in performing noncare services decreases their availability to provide direct patient care for other patients, thus exacerbating physician shortages; and

Whereas, Other professionals, such as attorneys, accountants, and their staff bill and get paid for all services they provide to their clients. The payers’ demands and requirements for physicians and their staff to provide noncare services without compensation is theft, extortion, and indentured servitude; and

Whereas, Despite existing Texas Medical Association policy, such noncare services and their direct and indirect costs have continued to increase and are endangering the viability of the private practice of medicine. As payers continue to disregard existing TMA policy, physicians currently are not compensated for such noncare services that benefit only payers, to the detriment of patients and physicians. The dire need for relief from payers’ demands and requirements for physicians to provide noncare services necessitates the reiteration and strengthening of existing TMA policy; therefore it be

RESOLVED, That the Texas Medical Association adopt policy that payers – insurance companies and managed care companies, including companies managing governmental insurance plans – must compensate physicians for the time physicians and their staff spend on services outside of direct patient care (noncare services) such as authorization and preauthorization for coverage and payment for prescriptions, laboratory tests, radiology tests, procedures, surgeries, hospitalizations, and physician
visits, as well gathering, compiling, and submitting medical records and data. Such compensation shall be
promptly paid in full by payers to physicians at a level commensurate with the education, training, and
expertise of the physician and at a rate comparable to that of the most highly trained professionals. The
physician shall bill the payers for time spent by the physician and his or her staff in performing noncare
services including, but is not limited to, time spent filling out forms, reviewing the patient’s medical
record, gathering patient-related data, making telephone calls (including time spent negotiating “phone
trees” and hold time), documenting in the patient’s medical record, communicating with the patient,
altering treatment plans (such as changing medications to comply with formularies), printing, copying,
and faxing. Upon receiving such a bill, the payers shall pay the physician promptly, with significant
interest penalties assessed for delay in payment. Because noncare services benefit the payers,
compensation owed to physicians for these services should not be billable to patients.

Related TMA Policy:

- 115.016 “A Modest Proposal” to Save our Health Care System
- 120.003 Health System Reform Managed Care
- 155.012 Laboratory Benefit Managers
- 180.031 Pharmacy Benefit Managers
- 235.027 Payment for Physician Work Product
- 235.034 Authorizations Initiated by Third-Party Payers, Benefit Managers, and Utilization Review Entities
- 235.038 Standardized Electronic Prior Authorization Transactions
- 235.040 Prior Authorization Approval
Subject: Contracted Health Plans Must Apply the Same Level of Benefits Concerning Patient Responsibility

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, The purpose of contracts between physicians and health plans is to arrange for physicians to provide medical services to health plan policy holders; and

Whereas, Health plans encourage patients to find a medical home through these contracts, which helps keep down medical costs; and

Whereas, Many physicians have adopted telemedicine as another way to care for patients and reduce costs; and

Whereas, Health plans have been reluctant to adopt telemedicine as a covered benefit, thus refusing to pay physicians who use telemedicine; and

Whereas, Health plans recently have begun to offer telemedicine as a covered benefit, waiving any patient responsibility if the patient uses the plan’s preferred vendor (such as Teledoc), but charging a copay or coinsurance for a telemedicine encounter with a contracted physician, thereby offering a separate set of benefits for the same service based on who renders the service; therefore be it

RESOLVED, That the Texas Medical Association create policy that health plans in a binding contract with a physician must apply the same level of benefits concerning patient responsibility (copay, coinsurance) regardless of the contracted physician or provider rendering the service; and be it further

RESOLVED, That TMA take this issue to the state legislature for potential statutory action; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association carry a similar resolution to the AMA House of Delegates for policy development and legislative action.

Related TMA Policy:
145.028 Unequal Insurance Contract Reimbursement for Solo Practitioners
180.024 Conflict Between Physician Ethics and Health Plan Business Practices
180.026 Health Insurance Plans
180.032 Advocacy Efforts Regarding Health Care Payment Plans

Related AMA Policy:
D-285.972 Tiered, Narrow, or Restricted Physician Networks
H-450.941 Pay-For-Performance, Physician Economic Profiling, and Tiered and Narrow Networks
Whereas, The University Interscholastic League already has established the importance of athletic
preparticipation physical examinations by requiring them for school-based athletics; and
Whereas, Children and adolescents are developmentally different from the adult population and have very
different physical attributes depending on age and different nutritional, psychological, physical,
emotional, and developmental needs; and
Whereas, Because of their extensive training, physicians are best qualified to conduct athletic
preparticipation physical examinations; and
Whereas, The Texas Medical Association has established policy (55.056) supporting changes to the Texas
Education Code requiring that athletic preparticipation physicals for school-age children be conducted
only by licensed physicians or appropriately supervised physician assistants or advanced practice nurses
licensed in Texas; and
Whereas, Some school districts in Texas allow nonphysician practitioners to conduct athletic
preparticipation physicals; therefore be it
RESOLVED, That the Texas Medical Association advocate for legislative changes to the Texas
Education Code as described in TMA Policy 55.056 requiring that athletic preparticipation physical
examinations for school-age children be conducted only by licensed allopathic or osteopathic physicians,
or appropriately supervised physician assistants or advanced practice nurses licensed in Texas.

Related TMA Policy:
55.056 Physician Examinations for Young Athletes
55.046 Recommendations for Ensuring the Health of the Adolescent Athlete
30.004 Allied Health
30.012 Nursing and Nurses with Advanced Training
30.015 Nurses in Advanced Practice
30.016 Physician Assistants and Allied Health Personnel
30.025 Allied Health Care Professionals
30.029 Physician Extenders in Rural Health Clinics
30.035 Federal Prohibition of the Independent Practice of Medicine by Nurse Practitioners
30.036 Opposition to New State Licensing Category for Physicians Who Do Not Complete Residency
Training
55.006 School-Based Health Care Centers

Information:
From the Texas Education Code, Title 2. Public Education, Subtitle F. Curriculum, Programs and
Services, Chapter 33. Service Programs and Extracurricular Activities:
Sec. 33.096. CARDIAC ASSESSMENTS OF HIGH SCHOOL PARTICIPANTS IN EXTRACURRICULAR ATHLETIC ACTIVITIES. (a) A school district must provide a district student, who is required under University Interscholastic League rule or policy to receive a physical examination before being allowed to participate in an athletic activity sponsored or sanctioned by the University Interscholastic League, the following:

(1) information about sudden cardiac arrest and electrocardiogram testing; and

(2) notification of the option of the student to request the administration of an electrocardiogram, in addition to the physical examination.

(b) A student may request an electrocardiogram from any health care professional, including a health care professional provided through the student’s patient-centered medical home, as defined by Section 533.0029, Government Code, a health care professional provided through a school district program, or another health care professional chosen by the parent or person standing in parental relation to the student, provided that the health care professional is:

(1) appropriately licensed in this state; and

(2) authorized to administer and interpret electrocardiograms under the health care professional’s scope of practice, as established by the health care professional’s Texas licensing act.

(c) The University Interscholastic League shall adopt rules as necessary to administer this section.

(d) The rules adopted under Subsection (c) must include:

(1) criteria under which a school district may request an exemption from the requirements of Subsection (a);

(2) variances that allow for a delay of the implementation of the requirement to notify students of the option to request an electrocardiogram under this section;

(3) procedures to ensure students receiving the required annual physical examination are notified of the option to request an electrocardiogram; and

(4) provisions to ensure that the requirements under this section are minimum standards that provide a school district with the option to implement a program that exceeds the standards required by this section.

(e) This section does not create a cause of action or liability or a standard of care, obligation, or duty that provides a basis for a cause of action or liability against a health care professional described by Subsection (b), the University Interscholastic League, a school district, or a district officer or employee for:

(1) the injury or death of a student participating in or practicing for an athletic activity sponsored or sanctioned by the University Interscholastic League based on or in connection with the administration or interpretation of or reliance on an electrocardiogram; or

(2) the content or distribution of the information required under Subsection (a) or the failure to distribute the required information under this section.

Added by Acts 2019, 86th Leg., R.S., Ch. 1023 (H.B. 76), Sec. 1, eff. September 1, 2019.
Subject: Utilization Review, Medical Necessity Determination, Prior Authorization Decisions

Introduced by: Bexar County Medical Society

Whereas, Prior authorization requirements are increasing in number yearly, and this burden is driving administrative costs higher to an estimated $68,274 per physician per year, which equates to $31 billion annually, according to Health Affairs; and

Whereas, Prior authorizations delay care and are obstacles to patients receiving optimal care. A recent American Medical Association survey reported that 91% of physicians said prior authorization had a significant or somewhat negative impact on their patients’ clinical outcome, and 28% said prior authorization intrusion led to a serious adverse event for a patient under their care; and

Whereas, The Texas Medical Association Board of Councilors’ current opinions state that medical necessity determination “is the practice of medicine; it is not a benefit determination”; and

Whereas, The TMA Board of Councilors also opined that physicians who perform prospective and/or concurrent utilization review are “obligated to review the request for treatment with the same standard of care as would be required by the profession in the community in which the patient is being treated”; and

Whereas, Decisions made by insurance medical directors, physicians conducting utilization reviews, and physicians providing peer-to-peer reviews on behalf of insurance companies affect patient care and can lead to adverse outcomes; therefore be it

RESOLVED, That the Texas Medical Association urge physicians to bring their concerns regarding decisions made by physicians working for insurance companies to the attention of the Texas Medical Board and Texas Department of Insurance, as these decisions affect patient outcome, and that TMA create a clearinghouse of all complaints against insurance companies and insurance doctors and aggregate this data; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association take this resolution to the AMA House of Delegates, urge the AMA House of Delegates to adopt similar policy, and urge the AMA Council on Ethical and Judicial Affairs to devise ethical opinions similar to the TMA Board of Councilors’ opinions on medical necessity determination and utilization review.

Related TMA Policy:

235.034 Authorizations Initiated by Third-Party Payers
235.040 Prior Authorization Approval
235.038 Standardized Electronic Prior Authorization Transactions
160.017 Utilization Review
145.024 Medical Decision Makers Licensed in Texas
Related AMA Policy:
1. Utilization Review by Physicians H-320.973
2. Principles of Drug Utilization Review H-120.978
3. Medical Necessity and Utilization Review H-320.942
Subject: Prior Authorizations

Introduced by: Bexar County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, Prior authorizations are increasing in number and driving administrative costs higher – by an estimated $68,274 per physician per year, which equates to $31 billion annually, according to *Health Affairs*; and

Whereas, When a prior authorization is required, only 29% of patients end up with the originally prescribed product, and 40% abandon therapy altogether; and

Whereas, In one study of more than 4,000 type 2 diabetics patients, those denied their diabetic drugs had higher overall medical costs the following year; and

Whereas, Although the purpose of prior authorizations was to save money, they have not lowered insurance premiums; in fact, health care insurance premiums increased more than wages in 2019, with the average premium for family coverage having increased 22% over the past five years and 54% over the past 10 years; and

Whereas, prior authorizations have neither saved money for the patient nor improved patient outcomes, but rather have increased the financial burden on physicians while delaying or denying needed care for patients; therefore be it

RESOLVED, That the Texas Medical Association work to limit the use of prior authorizations to only treatments not supported by the medical literature.

Related TMA Policy:

235.034 Authorizations Initiated by Third-Party Payers
235.040 Prior Authorization Approval
235.038 Standardized Electronic Prior Authorization Transactions

Related AMA Policy:

Prior Authorization and Utilization Management Reform H-320.939
Prior Authorization Reform D-320.982
Promoting Accountability in Prior Authorization D-320.983
Preauthorization D-320.988
Opposition to Prescription Prior Approval D-125.992
The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987
Subject: Step-Edit Therapy Contributes to Denial of Care and Has Not Demonstrated Improved Patient Outcomes or Overall Cost Savings

Introduced by: Bexar County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, step-edit therapy – also known as a “fail first” policy – is used by insurance companies as a form of prior authorization that dictates a required first line of drug therapy for a patient, and defines first-line drugs as preferred and designated as Tier 1, while nonpreferred drugs are designated as Tier 2 or Tier 3, with copays for nonpreferred drugs in Tier 2 higher than in Tier 1 and highest in Tier 3; and

Whereas, Studies have shown patients underutilize therapeutic drugs when a copay is higher, with a nonadherence rate as high as 52% for antihypertensive drugs and with similar results of nonadherence for antidepressants, nonsteroidal anti-inflammatory drugs, and antidiabetic drugs; and

Whereas, Although the underutilized drugs have demonstrated a cost savings on drugs, studies have shown an increase in medical cost; however, overall costs savings have been shown to occur when medicines were affordable without a tier system; therefore be it

RESOLVED, That the Texas Medical Association (TMA) urge our legislators to review and make transparent the “fail-first” policy of step-edit therapy and study how it affects patient outcomes; and be it further

RESOLVED, That the TMA ask the American Medical Association to review the ethical implication of step-edit therapy and make further recommendations on its use.

Related TMA Policy:
235.034 Authorizations Initiated by Third-Party Payers
235.040 Prior Authorization Approval
235.038 Standardized Electronic Prior Authorization Transactions
95.012 Drugs Antisubstitution Laws and Generic Prescriptions
245.020 Physicians Retaining Autonomous Clinical Decision-Making Authority
95.043 Prescription Drug Value Based Contracting

Related AMA Policy:
Step Therapy D-320.981
Step Therapy H-320.937
Resolved, That the Texas Medical Association support limiting the copayments insured patients pay per month for prescribed insulin.
**Related TMA Policy:**
1. 195.039 Lower Drug Costs
2. 195.037 Prescription Drug Negotiation in the Medicare Program
3. 95.043 Prescription Drug Value Based Contracting
4. 95.041 Ensuring Patient Access to Affordable Prescription Medications

**Related AMA Policy:**
5. Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980
6. Insulin Affordability H-110.984
7. Pharmaceutical Costs H-110.987
8. Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988
9. Cost of Prescription Drugs H-110.997
10. Reducing Prescription Drug Prices D-110.993
11. Prescription Drug Prices and Medicare D-330.954

**References:**
Subject: Postpartum Maternal Healthcare Coverage Under Children’s Insurance

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, Perinatal depression is defined as a major or minor depressive disorder with a depressive episode occurring during pregnancy or within the first year after childbirth; and

Whereas, One in seven women suffer from perinatal depression within the first year of motherhood; and

Whereas, Estimated rates of depression among pregnant and postpartum women range from 10% to 25% depending on socioeconomic status and additional risk factors; and

Whereas, Postpartum screening is important to maximize the health of mothers with newborns as it provides a significant opportunity to identify possible factors that can affect maternal health, such as breastfeeding practices, family planning, and depression, among others; and

Whereas, Untreated postpartum depression interferes with the mother’s ability to care for her newborn child and can lead to problems with the child’s physical, cognitive, and behavioral development; and

Whereas, Regular monitoring and support during the first three months postpartum should be required to optimize maternal mental health care and reduce the risk of suicide, especially among mothers with a history of psychiatric disorders; and

Whereas, Barriers prevent peripartum women from accessing postpartum depression screening and care, such as financial and geographic barriers that limit access to health care, societal and familial stigma, and lack of postpartum depression education and awareness; and

Whereas, The World Health Organization recommends all mothers receive at minimum three postpartum visits from time of delivery to six weeks postpartum, where each visit includes psychosocial support to prevent postpartum depression; and

Whereas, The American Academy of Pediatrics recommends screening for maternal-perinatal depression during pediatric visits; and

Whereas, In 2016, the Centers for Medicare & Medicaid Services published best practices for state Medicaid programs to cover maternal depression screening as part of the pediatric well-child visit; and

Whereas, As of 2018, screening for perinatal depression during the pediatric well-child visit is a covered benefit under state Medicaid programs for 25 states; and

Whereas, In 2018, Texas added a one-time postpartum depression screening per eligible child as a covered benefit under Children’s Medicaid and the Children’s Health Insurance Program; and
Whereas, Insurance coverage greatly improves health outcomes for individuals and families because they have access to preventive and screening services; therefore be it

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

Related TMA Policy:
330.015 Physician-Led Initiatives to Address Maternal Mortality and Morbidity

Related AMA Policy:
Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953
Extending Medicaid Coverage for One Year Postpartum D-290.974

References:
TABLE

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 415
2020

Subject: Promotion of LGBTQ+ Friendly and Gender-Neutral Options on Medical Documentation and Intake Forms

Introduced by: Neil Gupta, MSS Delegate

Referred to: Reference Committee on Socioeconomics

Whereas, The visibility of lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ+) individuals is increasing with more social acknowledgment, social movements, and legal precedents; and

Whereas, The Center for American Progress (CAP) has documented that the discrimination faced by the LGBTQ+ population discourages members of the community from seeking health care; and

Whereas, A 2017 CAP survey indicated 8% of all LGBTQ+ people, 22% of transgender people, and 14% of LGBTQ+ people who had experienced discrimination based on their sexual orientation and gender identity in the past year avoided or postponed medical care because of disrespect or discrimination from medical staff; and

Whereas, The 2017 Texas Pride Impact Funds report indicates that roughly 740,000, or 3.6%, of Texas residents identify as LGBTQ+, and the 854 survey respondents universally ranked routine health care as their No. 1 priority need, followed by health care provider LGBTQ+ competency; and

Whereas, While almost 100% of Texas Pride Impact Funds survey respondents reported being out to close friends, more than 30% of respondents reported not being out or open to their health care providers, with many experiencing biased and discourteous encounters with medical professionals as patients when they were open about their gender identity and/or sexual orientation; and

Whereas, Physicians and researchers leading the charge in understanding the gaps in LGBTQ+ health needs have voiced an urgent need to collect and standardize demographic data of these populations in federally and privately funded surveys and electronic health records; and

Whereas, Increased medical documentation of sexual identity and gender preferences can help researchers better understand the specific health needs of each distinct population group under the LGBTQ+ umbrella; and

Whereas, The National LGBT Health Education Center states that using LGBTQ+ friendly and gender-neutral options on forms will help ensure LGBTQ+ people are comfortable sharing information relevant to their care with physicians and staff, and by taking this step, health centers can ensure all their patients, including their LGBTQ+ patients, attain the highest possible level of health; and

Whereas, The National LGBT Health Education Center states a best practice as the following: document patient name, pronoun(s), a process for ensuring staff compliance of those names and pronouns, answers to questions about sexual orientation and gender identity in the demographics section of registration forms, current gender identity, and sex assigned at birth; and
Whereas, The National LGBT Health Education Center advocates for the avoidance of gender-specific
terms on forms, such as “husband/wife” or “mother/father,” and should reflect the reality of LGBT
families by asking about “relationships,” “partners,” and “parent(s);” and

Whereas, The American Medical Association has adopted policies H-315.967, Promoting Inclusive
Gender, Sex, and Sexual Orientation Options on Medical Documentation, and D-315.974, Promotion of
LGBTQ-Friendly and Gender-Neutral Intake Forms (including in electronic health records and other
health information technology); and

Whereas, Current TMA Policy 265.028 supports increasing educational opportunities for physicians on
LGBTQ+ issues to improve health outcomes and increase gender identity and sexual orientation reporting
of LGBTQ+ patients; and

Whereas, TMA has established a LBGTQ+ Health Workgroup to “raise awareness among physicians’
colleagues” so LGBTQ+ health needs are adequately met; and

Whereas, Current TMA policy supports the use of standardized, free-of-charge, personal health records
(PHRs) and supports the “interoperability of PHRs in allowing access to patient health information in
patient care settings”; therefore be it

RESOLVED, That the Texas Medical Association amend the wording of TMA Policy 265.028 to support
inclusion of a patient’s biological sex; current gender identity; sexual orientation; preferred gender
pronoun(s); preferred name; and clinically relevant, sex-specific anatomy in medical documentation and
related forms, including in electronic health records, in a culturally sensitive and voluntary manner; and
be it further

RESOLVED, That TMA amend the wording for TMA Policy 265.028 to advocate for the incorporation
of recommended best practices of LGBTQ+ friendly and gender-neutral medical documentation into
electronic health records and other health information technology products at no additional cost to
physicians; and be it further

RESOLVED, That TMA, with input from the TMA LGBTQ+ Health Workgroup and appropriate
medical and community-based organizations, promote among our membership these recommendations
pertaining to medical documentation and related forms, including in electronic health records.

Related TMA Policy:
265.028 Improving LGBTQ Health Care Access
118.004 Health Information Technology – Health Information Exchange
118.002 Health Information Technology – Electronic Health Records and Personal Health Records
265.027 Costs to Update Health Information Technology Products to Address Issues of Sex and Gender

Related AMA Policy:
D-315.974 Promotion of LGBTQ-Friendly and Gender-Neutral Intake Forms
H-315.967 Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation

Sources:


Whereas, In 2015, a citizen of New Mexico filed a medical malpractice suit against a Texas physician in the New Mexico District Court System for care rendered in Lubbock, Texas; and

Whereas, Texas law would have required that the lawsuit be dismissed under Texas Tort Claims Act §101.106(f) (sovereign immunity) because the physician was a Texas governmental employee and the plaintiff failed to timely substitute the governmental entity as the defendant; and

Whereas, Texas physicians threatened to stop seeing New Mexico patients as a result of this lawsuit; and

Whereas, Texas physicians ultimately provide care for more than 22% of hospitalized patients in southern and eastern New Mexico; and

Whereas, The American Medical Association Litigation Center, along with TMA and the New Mexico Medical Society (NMMS), filed an amicus brief supporting the enforcement of Texas law in solidarity with Texas physicians; and

Whereas, In 2017, the New Mexico Supreme Court dismissed the case in favor of the defendant (Texas physician) based upon the legal principle of comity; and

Whereas, Comity is defined as “the legal principle that political entities (such as states, nations, or courts from different jurisdictions) will mutually recognize each other’s legislative, executive, and judicial acts. The underlying notion is that different jurisdictions will reciprocate each other’s judgments out of deference, mutuality, and respect”; and

Whereas, In 2016, the New Mexico Legislature responded by passing New Mexico House Bill 270 clarifying that New Mexico courts would honor choice-of-law and exclusive-forum-selection clauses in contracts between New Mexico patients and out-of-state caregivers; and

Whereas, A legal forum is a defined as “a place where disputes are heard and decided, such as a tribunal or court”; and

Whereas, NMMS, in solidarity with Texas physicians, provided a “summary of HB 270 and sample forms for physicians to use in Texas (or other states) when accepting patients from New Mexico”; and

Whereas, House Bill 270 was repealed effective July 01, 2019, per its original language, which poses a recurrence of risk for physicians to be litigated under New Mexico tort law for care rendered in Texas; and
Whereas, In the case described above, the New Mexico Supreme Court ruling was in favor of the Texas defendant, but in absence of clarifying legislation, the original question of whether New Mexico will exert jurisdiction in out-of-state care litigation is once again relevant, creating uncertainty for our Texas physicians; therefore be it

RESOLVED, The Texas Medical Association recognize that the appropriate forum for medical liability suits against physicians is the state in which care is rendered; and be it further

RESOLVED, The Texas Delegation to the AMA take this resolution with the added language below to AMA:

That our AMA recognize that access to care for patients seen by out-of-state physicians may be diminished when there is uncertainty about the appropriate legal forum for medical liability claims.

Related TMA Policy:
Professional Liability 170.007

Related AMA Policy:
Health System and Litigation Reform D-435.974
Support of Campaigns Against Lawsuit Abuse H-435.974
Insurance Coverage Parity for Telemedicine Service D-480.969
Established Patient Relationships and Telemedicine D-480.964

References:
Resolution 417
2020

Subject: Insurance Promotion of Preventive Care Services via Incentive-Based Programs

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, Approximately 45% of all Americans suffer from at least one chronic disease; and

Whereas, 34% of heart disease deaths, 21% of cancer deaths, and 39% of chronic lower respiratory deaths from 2008 to 2011 were preventable; and

Whereas, In 2015, only 8% of U.S. adults aged 35 and older had received all the high-priority, appropriate clinical preventive services recommended for them; and

Whereas, Small cash incentives to patients have been shown to improve visits to primary care and as a result help with screening for preventable health conditions; and

Whereas, 79% of commercially available health insurance plans had offered positive incentives to members for receiving specific clinical preventive services; and

Whereas, 49% of commercial health insurance plans found incentives very useful for uptake of preventive health care services; and

Whereas, Texas created the Wellness Incentives and Navigation (WIN) project funded by the Medicare Incentives for Prevention of Chronic Disease (MIPCD) program from 2011 to 2015 to monetarily incentivize usage of health promotion programs to prevent diseases such as diabetes prevention, heart disease and hyperlipidemia; and

Whereas, 76% of the beneficiaries of the MIPCD program nationwide reported the program had encouraged lifestyle changes such as setting goals and working towards improving improve their health; therefore be it

RESOLVED, That the Texas Medical Association advocate for health insurance companies to adopt cash-based incentive programs like the Medicare Incentives for Prevention of Chronic Disease program to promote usage of preventive care services; and be it further

RESOLVED, That TMA support further research on health care initiatives that can increase usage of preventive care services by individuals.

Related TMA Policy:
145.027 Transparency of Preventive Care Services
260.029 Preventive Medicine
Related AMA Policy:
None.

References:
2. McCarthy M. Up to 40% of premature deaths in the US are preventable, says CDC. BMJ 2014; 348:g3122.
Subject: Paid Parental Leave

Introduced by: Women Physicians Section

Referred to: Reference Committee on Socioeconomics

Whereas, Beginning on Oct. 1, 2020, federal workers employed by the government for at least one year will be guaranteed 12 weeks of paid parental leave upon the birth or adoption of a child; and

Whereas, Six states and the District of Columbia have enacted paid parental leave policies set to take effect in 2020 or 2021; and

Whereas, Numerous studies have confirmed the benefits of paid parental leave on health outcomes for children and families, such as fewer low birthweight and preterm births, increased breastfeeding, fewer hospitalizations among infants, and improved maternal health; and

Whereas, Paid parental leave increases long-term employment and job continuity for mothers, and

Whereas, Research suggests more low-income and disadvantaged families used the time for parental leave more when this leave was paid than when it was not a paid leave policy; and

Whereas, Approximately 38% of employers currently offer paid parental leave for employees who are new parents; and

Whereas, Currently under the Family Medical Leave Act, all eligible parents are guaranteed up to 12 weeks of unpaid leave if they are employed by an organization with at least 50 employees; therefore be it

RESOLVED, That the Texas Medical Association promote awareness and education for physicians, legislators, and the public on the importance of adequate parental leave, especially paid leave, in ensuring good maternal and infant health outcomes and promoting the health and well-being of the family; and be it further

RESOLVED, That TMA support federal, state, local, and private parental leave policies that provide adequate time to give birth, recover, and breastfeed, and allow for parental bonding following the birth or adoption of a child; and be it further

RESOLVED, That TMA support policies that provide at least 12 weeks of paid parental leave following the birth or adoption of a child; and be it further

RESOLVED, That TMA support that paid parental leave policies incorporate funding mechanisms that do not put an undue burden on solo or small business owners; and be it further

RESOLVED, That TMA evaluate how internal policies for employees should be updated to provide paid parental leave following the birth or adoption of a child.
Whereas, Texas declined to expand Medicaid to cover individuals with incomes up to 138% of the federal poverty level following the passage of the Affordable Care Act (ACA); and

Whereas, Texas has 5 million uninsured residents, or 17.7% of the total population; and

Whereas, Texas has the highest rate of uninsured individuals of all 50 states and is above the national average of 8.5%; and

Whereas, If Texas opted to expand its program through the ACA, 1.5 million Texans would become eligible for Medicaid; and

Whereas, The American Medical Association endorsed state Medicaid expansion to 138% of the federal poverty level in its policy Medicaid Expansion D-290.979; and

Whereas, States that expanded Medicaid to 138% of the federal poverty level experienced significant drops in their rates of uninsured individuals, particularly among those in small towns and rural areas; and

Whereas, The value of lost earnings and poor health for uninsured Texans was estimated to be $57 billion in 2016; and

Whereas, The cost of lost earnings and poor health for uninsured Texans is estimated to rise to $174 billion by 2040 unless action is taken to reduce the number of uninsured Texans; and

Whereas, Medicaid expansion to 138% of the federal poverty level has been correlated to increased economic gains among newly covered individuals; and

Whereas, Rural community health centers in states that expanded Medicaid experienced consistent improvements in quality and volume of care; and

Whereas, States that opted to expand Medicaid experienced fewer closures of rural hospitals; and

Whereas, From 2010 to 2018, Texas experienced the highest number of rural hospital closures of all 50 states with 15 closures; and

Whereas, Texas hospitals and physicians spent $3.5 billion in 2016 on uncompensated care; and

Whereas, The cost of uncompensated care in Texas is expected to rise to $12.4 billion in 2040 unless action is taken to reduce the number of uninsured; and
Whereas, Maine expanded Medicaid in January 2019 after the state’s voters approved a ballot initiative in November 2017 to expand; and

Whereas, The states of Utah, Idaho, and Nebraska opted to expand Medicaid following approval of a ballot initiative by each states’ voters in November 2020; and

Whereas, Sixty-four percent of Texans support Medicaid expansion; therefore be it

RESOLVED, That the Texas Medical Association advocate for the inclusion of Medicaid expansion initiatives on a statewide ballot to allow eligible Texas voters to decide; and be it further

RESOLVED, That TMA encourage a reopened dialogue on the topic of Medicaid expansion as an avenue to reduce the high rate of uninsured individuals in Texas.

Related TMA Policy:
None.

Related AMA Policy:
Medicaid Expansion D-290.979

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 420
2020

Subject: Training Requirements Imposed by Insurance Companies Preventing Patients’ Access to Quality Medical Care

Introduced by: Lone Star Caucus

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

Whereas, Physicians undergo rigorous education in medical schools, extensive training in their residencies, and in some cases intensive training in subspecialties (fellowships) prior to entering clinical practice; and

Whereas, Physicians are licensed by state medical boards after initial review of their training and credentials; and

Whereas, Physicians face rigorous and stringent license renewal criteria in the form of continuing education credits annually or biannually; and

Whereas, In some cases, physicians are required to obtain periodic recertifications by their specialty boards; and

Whereas, A physician’s primary obligation is attending to a patient’s well-being by applying his or her medical knowledge and experience and not learning the various and sundry business practices of insurance companies; therefore be it

RESOLVED, That the Texas Medical Association urge insurance companies to cease and desist from requiring physicians to spend time – in addition to their extensive professional training – in training in each companies’ requirements for patient care; and be it further

RESOLVED, That the Texas Medical Association urge the Texas Medical Board to condemn such practice by insurance companies as beyond the companies’ purview of physician training responsibilities; and be it further

RESOLVED, That the Texas Medical Association urge the Texas insurance commissioner to investigate the appropriateness of insurance companies imposing on physicians the onerous and unnecessary burden of web-based or otherwise administered training; and be it further

RESOLVED, That the Texas Medical Association urge the Texas Legislature to take adequate measures to prevent insurance companies from interfering with the education of physicians by engaging in the wasteful exercise of requiring physicians to train in the companies’ preferences, objectives, and/or goals.

Related TMA Policy:
None.

Related AMA Policy:
None.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 421
2020

Subject: Physician Societies to Create a Self-Funded, Balanced, and Nonpartisan Center for the Study of Health Care Reform

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, Evidence suggests growing support among national politicians and the general public for expansive health care reform, and it is feasible that national legislation creating a universal Medicare or single-payer system will be proposed soon; and

Whereas, In the absence of clear and accessible evidence derived from the scientific method and rational skepticism, such reform is driven by anecdotes, assumptions, emotion, and politics; and

Whereas, Health care reform legislation is often massive, opaque, and unproven, and without the benefit of pilot studies or existing models, the downstream consequences of such legislation are unpredictable and riddled with unintended consequences; and

Whereas, Despite the support for significant change to our health care system, the implications for patient choice, physician autonomy, and the “rationing of care” are often poorly understood; and

Whereas, Some of the proposed reforms directly conflict with Texas Medical Association and American Medical Association policy – that health care reform should be evidence-based, responsible, sustainable, and incremental, and preserve patient and physician choice, as described in TMA policy 120.010; and

Whereas, To promote greater public awareness and elevate the current partisan political discourse, a physician-led, balanced, and nonpartisan entity would provide a more effective and trusted platform for the collection, study, and distribution of information regarding the potential effects of proposed health care reform; and

Whereas, The startup investment provided by medical societies for the creation of the proposed entity can be structured in the form of a loan to be repaid at a future date. The initial phase of development could include the minimum personnel and resources necessary to create a website, solicit additional sources of funding from individuals and organizations, and recruit essential staff; therefore be it

RESOLVED, That the Texas Medical Association, in collaboration with other medical societies, create and support a permanent, physician-led, independently funded “center” for the balanced, nonpartisan study of health care reform. This entity will maintain and advertise for an online platform to provide a balanced critique upon the strengths and limitations of general and specific policy proposals, health care reports, and national health care systems for the benefit of the general public; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association carry a similar resolution to the AMA House of Delegates, calling upon AMA to support the aforementioned permanent, physician-led, independently funded center for balanced, nonpartisan study of health care reform.
Related TMA Policy:

60.004 Freedom of Choice
110.003 Private Individualized Medical Care
110.009 Health Care Coverage
120.001 Health Care Reform
120.002 Health System Reform Cost Control
120.003 Health System Reform Managed Care
120.010 Principles for Evaluating Health System Reform
145.005 Single Payer Systems
145.007 Competitive Insurance Models
145.009 Individual Responsibility for Health Care
145.012 Health Insurance Individual Ownership
145.013 Private Healthcare System, Impact of Uninsured
190.032 Medicaid Coverage and Reform

Related AMA Policy:

165.838 Health System Reform Legislation
H-165.844 Educating the American People About Health System Reform
H-165.888 Evaluating Health System Reform Proposals
H-165.904 Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care
D-165.935 Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 422
2020

Subject: Develop Guidelines for Proper Oversight and Collaboration of Midlevel Practitioner by Physicians

Introduced by: Bexar County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, Patients deserve care led by physicians, as four out of five patients prefer having physicians lead their health care team; and

Whereas, Many states like Texas require physician supervision of midlevel practitioners, and TMA has published a resource guide on midlevel supervision; and

Whereas, Physician supervision of midlevel practitioners is enforced by the Texas Medical Board; therefore be it

RESOLVED, That the Texas Medical Association (TMA) educate physicians and disseminate to them information on basic tenets of proper physician oversight and supervision of midlevel practitioners and encourage physicians to bring to the attention of the Texas Medical Board physicians who are not providing supervision as required per the delegation of duties; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association take this resolution to the AMA House of Delegates, urging it to develop national guidelines for proper oversight and collaboration of midlevel practitioners by a physician.

Related TMA Policy:
100.032 Appropriate Physician Oversight of Emergency Medical Service Medical Practices
30.035 Federal Prohibition of the Independent Practice of Medicine by Nurse Practitioners
30.025 Allied Health Care Professionals
30.029 Physician Extenders in Rural Health Clinics
Subject: A Push for Mobile-First Design Principles Within Medical IOT (Internet of Things) Interfaces

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, Eighty-one percent of Americans own a smartphone, and at least 96% own a cellphone; and
Whereas, Sixty-seven percent of web traffic is mobile device-oriented and continues to rise; and
Whereas, Lower-income adults are more likely than those in higher-earning households to be smartphone-only internet users; and
Whereas, One-quarter of Hispanic and black Americans are smartphone-only internet users compared with about one in 10 white Americans; and
Whereas, Studies of rural America report greater ownership of smartphones compared with broadband access; and
Whereas, Broadband access is a primary concern for the Texas Medical Association, as shown by Policy 275.06, in part due to informational accessibility concerns as shown by Policy 118.002; and
Whereas, American Medical Association Policy H-478.981 promotes mobile engagement in health information technology; and
Whereas, Broadband coverage for desktop computers has improved only slightly, while smartphone web traffic has risen dramatically to 58% in 2018, with a predicted 72% of web users being mobile-only by 2025, according to industry research; and
Whereas, Smartphone users are five times more likely to abandon a task if the site isn’t optimized for mobile use; and
Whereas, “Ninety-six percent of organizations using smartphones, tablets and other mobile devices see an increase in patient experience scores. Of those, 32 percent say their scores have risen drastically.” (Jamf 2018 survey); and
Whereas, In a hospital setting, stationary terminals do not provide the mobility health care requires; and
Whereas, Physicians worldwide show an increased usage of mobile devices in their daily practice and patient interactions; and
Whereas, Feasibility reports predict that transitioning from web to mobile is not expected to significantly increase cost and that mobile-oriented care can overcome rural disparities; therefore be it
RESOLVED, That the Texas Medical Association recognize and encourage mobile-first designs within our health care systems IOT (internet of things) vendors; and be it further

RESOLVED, That our TMA encourage a mobile-first design goal among hospital administrations within their own local scope of health care systems; and be it further

RESOLVED, That our TMA be aware of rising trends in patient informational technology and adjust future legislation accordingly with respect to previously written TMA policy and future technological trends.

Relevant TMA Policy:

- 275.006 Broadband Internet Access to Rural Texas
- 118.002 Health Information Technology – Electronic Health Records and Personal Health Records

Relevant AMA policy:

- Health Information Technology Principles H-478.981

References:

TABLE

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 424
2020

Subject: Adoption of Principles of Physician Value-Based Decisionmaking in Medical Practice and Professionalism

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, Value-based medicine is the practice of medicine that emphasizes the patient’s improvement in quality of life, outcomes, safety, and service, divided by the total cost of patient care over time to minimize unnecessary interventions; and

Whereas, The National Academy of Medicine developed a STEEP framework that describes value-based medicine as safe, timely, effective, efficient, equitable, and patient-centered; and

Whereas, The Institute for Healthcare Improvement developed the widely used Triple Aim framework to measure value in the health care system: (1) improve the quality, satisfaction, and patient experience of care; (2) improve the health of populations; and (3) reduce the per-capita cost of health care; and

Whereas, Improvements in technology, advances in research on cost-effective clinical decisionmaking cascades of care, and initiatives like Choosing Wisely are equipping physicians with tools to make better value-based decisions by providing ready access to current data and value frameworks; and

Whereas, In 2002, in the Annals of Internal Medicine, the Charter on Medical Professionalism was published through collaboration of the ABIM Foundation, ACP Foundation, and European Federation of Internal Medicine consisting of three principles and 10 commitments recognized by many physicians as the bedrock of their professional relationships with their patients and the public; and

Whereas, The charter explicitly states the importance of “minimiz[ing] overuse of health care resources, and optimiz[ing] the outcomes of care,” “scrupulous avoidance of superfluous tests and procedures,” and “cost-effective management of limited clinical resources,” all of which align with the principles of value-based decisionmaking in medical practice; and

Whereas, Medical professionals have further championed the need to adopt value-based medicine principles as the core of physician professionalism; and

Whereas, Multiple professional societies have adopted value-based medicine principles such as the American Medical Association’s STEPS Forward practice improvement strategies and the American College of Physician’s High Value Care initiative; and

Whereas, The evidence-based medicine policy previously adopted by the Texas Medical Association (265.018), although addressing an important component of value-based medicine, cannot fully account for the principles of value-based medicine and decisionmaking, such as emphasizing patients’ values in clinical decisionmaking and prioritizing quality-of-life improvements; and
Whereas, TMA Board of Councilors recognizes physician professionalism as described in the Principles of Medical Ethics of the American Medical Association; and

Whereas, Current TMA policy recognizes the need to advocate for inclusion and integration of topics of health care value in undergraduate and graduate medical education (200.054) and the adoption the Choosing Wisely campaign (265.023); therefore be it

RESOLVED, That the Texas Medical Association adopt the American Medical Association policy Value-Based Decision-Making in the Health Care System H-450.938:

Principles to guide physician value-based decision-making

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

RESOLVED, That TMA adopt policy encouraging physicians to practice value-based decisionmaking, to the best of their ability, as a core tenet of physician professionalism.

Relevant TMA Policy:
- 265.023 Choosing Wisely® Campaign
- 200.054 High-Value Care in Undergraduate and Graduate Medical Education
- 110.002 Cost Effectiveness
- 110.007 Cost Containment
- 265.018 Evidence-Based Medicine and Practice

Relevant AMA Policy:
- Value-Based Decision-Making in the Health Care System H-450.938
- Strategies to Address Rising Health Care Costs H-155.960
- Professionalism in Health Care Systems 11.2.1

References:
Resolution 424
2020 Page 3


TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 425
2020

Subject: Plastic Surgery Board-Certification

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, The Texas Medical Association endorses physicians having a social contract to maintain professional competency and ensure patient safety and quality care is provided; and

Whereas, The Texas Medical Board does not allow the performance of surgical cosmetic procedures by an individual or the delegation of such to an individual who is not an appropriately licensed surgeon practicing within the scope of practice provided by such a license; and

Whereas, The American Board of Plastic Surgery is the only board accredited by the American Board of Medical Specialties that certifies physicians to practice cosmetic surgery; and

Whereas, Multiple self-designated medical boards claim to certify physicians who have not completed a plastic surgery residency in cosmetic surgical procedures accredited by the Accreditation Council for Graduate Medical Education, allowing these physicians to advertise themselves as “board certified” with as little as one year of training in cosmetic surgery and provide patients with a false sense of trust in their surgical competence; and

Whereas, The Medical Practice Act states that an individual commits a prohibited practice if that person advertises himself or herself in a way that could be considered false, misleading, or deceptive; and

Whereas, The American Medical Association Truth in Advertising Campaign encourages state medical societies to advocate for physicians and health care practitioners to clearly and honestly state their level of training, education, and licensing to patients; and

Whereas, TMA adopts the standard that patient safety and quality are paramount, and thus patients should be assured that individuals who perform surgical procedures are appropriately trained physicians; and

Whereas, A 2017 study from Plastic and Reconstructive Surgery indicated that 70.8% of cosmetic surgery patients (n=5,239) are unaware of the differences in training requirements between ABPS diplomates and diplomates from self-designated boards; and

Whereas, A 2018 study from Aesthetic Surgery Journal indicated that only 17.8% of the top 163 plastic surgery posts on Instagram were from plastic surgeons certified by ABPS and that 67.1% of these posts were self-promotional as opposed to educational; and

Whereas, The American Society of Plastic Surgeons’ Do Your Homework campaign endeavors to help educate the public on how to correctly identify an ABPS board-certified plastic surgeon, but misperceptions among the patient populace still remain regarding who can safely perform plastic surgery; therefore be it
RESOLVED, That the Texas Medical Association support efforts to inform patients of the difference in training requirements between American Board of Plastic Surgery (ABPS) board-certified plastic surgeons and individuals board certified through self-designated medical boards; and be it further RESOLVED, That TMA reaffirm its commitment to advocate for appropriate scope of practice by discouraging non-ABPS-certified individuals from advertising themselves as board-certified plastic surgeons and performing plastic surgery procedures.

Related TMA Policy:
- 175.023 Initial Guiding Principles on Maintenance of Certification
- 280.032 Definition of Surgery

Related AMA Policy:
- Truth in Advertising H-405.964

References:
Subject: Results and Regulation of Freestanding Birthing Centers and at Home Birthing Services

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, Texas maternal mortality rates are higher than the U.S. average; and

Whereas, Many mothers are opting to deliver their babies at birthing centers and at home; and

Whereas, Adequate regulation of individuals assisting with the deliveries appears not to exist; and

Whereas, Clarity is needed to determine if the delivery of a baby is the practice of medicine; and

Whereas, Studies show worse outcomes for mother and child when complications arise during deliveries at home or in freestanding birthing centers; and

Whereas, Reducing maternal mortality is already Texas Medical Association policy; therefore be it

RESOLVED, That the Texas Medical Association work with state agencies to study the results, regulation, and quality review mechanisms of freestanding birthing centers and at-home birthing services; and be it further

RESOLVED, That TMA determine if additional regulations and public education are needed.

Related TMA Policy:

30.005 Midwifery
330.011 Home Deliveries
330.012 Obstetrical Delivery in the Home or Outpatient Facility
330.013 Maternal Mortality Review
330.015 Physician-Led Initiatives to Address Maternal Mortality and Morbidity
Subject: Adjustments to Hospice Dementia Enrollment Criteria

Introduced by: Dallas County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, The enrollment criteria for hospice established in the early 1980s were based on a six-month life expectancy if the “underlying disease were to run its natural course.” At the time of the development of six-month criteria, most hospice patients were cancer patients; and

Whereas, It has since been appreciated that the six-month expectancy is more accurate in the cancer setting than for other medical conditions, namely dementia; and

Whereas, The admission criteria for hospice enrollment for dementia patients rely on the Functional Assessment Staging Test (FAST) scoring mechanism, which measures activities of daily living and rates appetite, nourishment, and mobility, based on the presumption of a linear progression (ordinal) of decline; and

Whereas, FAST Stage 7c is used as the cut-off point for acceptable, primary dementia criteria for hospice enrollment and provides accurate prognostication for dementia patients who follow ordinal degradation through FAST stages of decline; and

Whereas, A full 41% of dementia patients are either unable to be scored accurately using FAST or do not follow ordinal patterns of degradation, and of these patients who did not follow ordinal degradation or were unable to be accurately scored via FAST, 42% died within six months; and

Whereas, For patients who follow nonordinal decline, there is a three-fold difference in survival between those who did and did not receive medications for acute illness: 14.9 months for receivers and 5.2 months for nonreceivers; and

Whereas, This effect of treatment suggests that nonordinal patients with impaired mobility and better-preserved language might be suitable for hospice if their palliative care plans were conservative but not suitable if more life-prolonging care was anticipated; therefore be it

RESOLVED, That the Texas Medical Association collaborate with the American Medical Association in advocating for the Centers for Medicare & Medicaid Services (CMS) to adjust the secondary hospice enrollment criteria for dementia. Specifically, CMS should incorporate dementia patients who are Functional Assessment Staging Test Stage 6e, who, or their families on their behalf, have chosen not to receive medications or interventions for acute illnesses; and be it further

RESOLVED, That TMA collaborate with AMA in advocating for CMS to expand the coverage and availability of other, novel provisions of care for dementia patients, such as expanding the Medicare Care Choices model that allows palliative services to be provided in the home setting, as a bridge to hospice care.
Relevant TMA Policy:

20.006 Alzheimer’s Disease and Other Dementia: The Texas Medical Association
85.018 Supportive Palliative Care
125.003 Home Health and Hospice

Relevant AMA Policy:

Alzheimer’s Disease H-25.991
Payment for Dementia Treatment in Hospitals and Other Psychiatric Facilities D-345.985
Physicians and Family Caregivers: Shared Responsibility H-210.980