AGENDA
REFERENCE COMMITTEE ON SOCIOECONOMICS
Saturday, May 8, 2021

3. Patient-Physician Advocacy Committee Report 3 – Legislative Changes Regarding Vacating Orders
4. Board of Trustees Report 18 – Compensation to Physicians for Activities Other Than Direct Patient Care (Tabled BOT Report 13 2020)
5. Committee on Medical Home and Primary Care Report 1 – Sunset Policy Review
6. Committee on Rural Health Report 1 – Sunset Policy Review
7. Resolution 401 – Caps on Insulin Copayments with Insurance (Tabled Res 413 2020)
9. Resolution 403 – Insurance Promotion of Preventive Care Services via Incentive-Based Program (Tabled Res 417 2020)
11. Resolution 405 – Ensuring Medical Practice Viability Through Reallocation of Insurance Savings During the COVID-19 Pandemic
14. Resolution 408 – Need for and Funding of Level I and Level II Trauma Centers (Tabled Res 402 2020)
15. Resolution 409 – Taxes on Medical Billing Services (Tabled Res 403 2020)
17. Resolution 411 – Physicians to Retain Payment During Credentialing (Tabled Res 405 2020)
18. Resolution 412 – Maintaining the Integrity of Physicians Orders in an Electronic Environment
19. **Resolution 413** – Compensation to Physicians for Activities Other Than Direct Patient Care (Tabled Res 407 2020)

20. **Resolution 414** – Contracted Health Plans Must Apply the Same Level of Benefits Concerning Patient Responsibility (Tabled Res 408 2020)

21. **Resolution 415** – Paper Medical Record Chart Preparedness for Electronic Health Record Interruptions

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

23. **Resolution 417** – Verbal Physicians Orders

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

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

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

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

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

29. **Resolution 423** – Insurance Coverage for Fertility Preservation Procedures for Cancer Patients Undergoing Gonadotoxic Therapy

30. **Resolution 424** – Encourage the Establishment of an Express Lane Eligibility (ELE) Program in Texas


32. **Resolution 426** – Support for Rural Labor and Delivery Departments

33. **Resolution 427** – Limiting Out-of-Network Ground Ambulance Costs

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

35. **Resolution 429** – Adoption of Principles of Physician Value-Based Decisionmaking in Medical Practice and Professionalism (Tabled Resolution 424 2020)

36. **Resolution 430** – Paid Parental Leave (Tabled Resolution 418 2020)
Subject: Sunset Policy Review

Presented by: Rodney Young, MD, Chair

Referred to: Reference Committee on Socioeconomics

House of Delegates policies in the association’s Policy Compendium are reviewed periodically for relevance and appropriateness. Following are policies reviewed by the council with recommendations for retention, amendment, and deletion.

The Council on Socioeconomics recommends retention of the following policies:

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

115.014 Out-of-Network Referral Requirements: The Texas Medical Association opposes health insurance company policies or procedures that discourage or interfere with medically necessary referrals for medical care out of network by imposing requirements for physicians to obtain patient signatures, sign documents disclosing ownership interests, make telephone calls, or obtain notification numbers (CSE Rep. 4-A-11).

115.016 “A Modest Proposal” to Save our Health Care System: The Texas Medical Association through its membership and leadership position in medicine, strives to change the cost curve by stopping the enlarging bureaucracies and the unfunded mandates, and by asking the federal government to consider the imposed cost on physicians when making clinical recommendations and changes to providing health care (Res. 404-A-11).

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

145.015 Mandatory Referral and Precertification of Chronic Renal Failure Treatment: The Texas Medical Association seeks agreement of Texas HMO and insurance providers to accept and require only CMS form 2728 as the precertification and referral for dialysis or any subsequent change in renal replacement therapy as per federal guidelines (CSE Rep. 2-A-01; amended CSE Rep. 8-A-11).

190.002 Medicaid Medications: The Texas Medical Association encourages Texas Medicaid to revise its medications policy so that beneficiaries of the program may receive all necessary medications (YPS, p 156, I-90; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

190.003 Medicaid Payments to Increase Participation: The Texas Medical Association supports increasing Medicaid payments to physicians to Medicare parity or better to ensure greater participation by physicians in the program (Committee on Maternal and Child Health, p 113, I-90; reaffirmed CSE Rep. 5-I-01; amended CSE Rep. 8-A-11).
195.009 Medicare Hospital Incentive Payments: Federal law prohibits incentive payments by a hospital which are designed to induce physicians to admit Medicare patients to the hospital. The Texas Medical Association agrees that physicians may not lawfully or ethically accept such payments (Council on Health Facilities, p 72, A-91; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).


235.033 Coordination of Benefits: The Texas Medical Association will work with payers to (1) encourage expedited payment policies and streamline the coordination of benefit process by requiring that employers provide employee attestations directly to the health plans in a timely manner and also provide an option for insured members to provide this information directly to the health plan via a form or other electronic means and that all claims be immediately processed and paid by a health plan regardless of the lack of coordination benefit attestation information on file from the employer and/or insured members; and (2) streamline the proof of full-time student status by requiring that employers provide proof of full-time student status directly to the health plans in a timely manner and also provide an option for insured members to provide this information directly to the health plan via electronic means. Further, TMA should work with payers to encourage that all claims be immediately processed and paid by the health plan regardless of the lack of proof of full-time student status information on file from the employer and/or insured member (CSE Rep. 2-A-11).

240.001 Geographic Practice Cost Indices (GPCIs): The Texas Medical Association supports the collection and evaluation of the most current valid and reliable data and its use in calculating accurate geographic practice cost indices and in determining geographic payment areas. Variation between geographic payment areas should be minimized and equitable access to medical care services should not be diminished by geographic practice cost indices that are unreasonably low in rural areas (Supplemental CSE p 162, A-90; reaffirmed CSE Rep. 5-I-01; amended CSE Rep. 8-A-11).

Recommendation 1: Retain.

The Council on Socioeconomics recommends amending of the following policies:

100.003 Patient Transfers: The Texas Medical Association believes that to ensure continuity of care, physician-to-physician communication should occur prior to actual transfer of patients from one hospital facility to another. It should be clear that the receiving institution has available the anticipated services and space, and that the receiving physician and institution will accept the patient.

The physician requesting transfer should make direct contact with the receiving physician; this task should not be delegated to nurses, other hospital personnel or the family of the patient. The physician-to-physician communication should include planning for and implementation of pretransfer and intratransfer medical care of the transferee.

All transfers should be to facilities appropriate to the needs of the patient, and socioeconomic considerations should be secondary.
If the patient or those responsible for the patient requests transfer which seems medically inappropriate, the medical risks involved must be carefully explained to the patient or those responsible for the patient. The physician should provide the explanation, and if the patient or family insists on transfer, the decision should be documented in writing and signed by the patient or those responsible, as well as by the physician.

All necessary and pertinent medical information and instructions to transfer personnel and other records should accompany the patient.

Proper medical care should be provided before and during transfer, including monitoring and charting the status of the patient.

Nonemergency (elective) patient transfers are beyond the scope of this guideline, and such transfers should follow traditional referral patterns and practices (PPA Committee, p 133-134, A-91; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

115.001 **Indigent Care**: The Texas Medical Association approved the final report of its Task Force on Indigent Health Care which recommended the following:

1. TMA should work to improve the availability and affordability of comprehensive private health insurance and adopt measures to make health insurance more available and affordable;
2. TMA should work to preserve existing indigent health programs in the short term and work on improving streamlining and simplifying Medicaid eligibility for Medicaid and the Children’s Health Insurance Program in the long run;
3. TMA should continue to advocate that the state pursue all available federal funding to extend comprehensive health care coverage to low-income Texans;
4. TMA should continue to pursue improved reimbursement Medicaid physician payment, and every effort should be made to reduce the administrative complexities of the Medicaid program, including and TMA efforts in this area, such as continuation of monthly regular liaison meetings with the leadership of the state Medicaid agency and Medicaid managed care organizations carrier and Medicaid director, should continue;
5. TMA should support adequate funding for public mental behavioral health services and recommend that the Texas Medicaid program provide full benefits for treatment of mental illnesses as allowed by federal guidelines;
6. TMA should continue to support legislation and regulation which promote and encourage opportunities for physicians to practice in medically underserved areas of the state; and
7. Physicians should be reminded of their responsibility to provide care to all Texans. Further, physicians should be encouraged to pass these values on to new physicians during their education and training (Amended CSE, p 138-144, I-90; amended CSE Rep. 5-I-01; amended CSE Rep. 8-A-11).

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

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

ACO Governance.

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

Physicians Retain Independent Medical Judgment Within an ACO. Medical decisions should be made by physicians. ACOs must be operationally structured and governed by an appropriate number of physicians (rather than lay entities) and place patients’ interests first. Physicians are the medical professionals best qualified by training, education, and experience to provide diagnosis and treatment of patients. Clinical decisions must be made by the physician or physician-controlled entity in an environment where they are free to exercise independent medical judgment free from commercial influence.

(1) Policies and Procedures. ACOs must not have any policies and or procedures that serve to impede a physician’s primary ethical obligation to the well-being and safety of his or her patients. Any time period for an appeal of an alleged breach of conduct must be heard in a clinically appropriate time frame.

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

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

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

Hospital-participating ACOs. Where a hospital is part of an ACO:

1. The governing board of the ACO, whose majority shall represent physicians participating in the ACO, which is comprised of physicians, should be separate and independent from the hospital governing board; and
2. The physician privileges and credentialing at the hospitals should not be conditioned on the physician’s exclusive participation in the hospital’s ACO or value-based care contracts, nor should the physician’s privileges at the hospital automatically cease upon the termination of the physician’s agreement with the ACO.

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

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

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

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

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

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

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

Economic and Quality Measures. Rather than payers selecting measures, practicing physicians currently in clinical practice must be actively involved in the development of economic and quality measures used by ACOs for performance measurement in value-based care contracts. Such measures and methodologies must be transparent, valid, and agreed to by the ACO’s governing board or the contracted physician group approved by the physician governing board. The economic and quality performance standards must meet the TMA principles for reporting, including the use of nationally accepted, physician specialty-validated clinical measures; the inclusion of a sufficient number of patients to produce statistically valid quality information; appropriate attribution methodology; risk adjustment; reflection of geographic costs; and the right for physicians to appeal inaccurate quality/efficiency reports and have them corrected. There also must be timely notification and feedback provided to physicians regarding the economic and quality measures and results. Physicians should be provided all economic and quality measures prior to the evaluation period. ACOs should periodically conduct assessments of patients’ satisfaction with the timeliness and availability of care.

Flexibility in Patient Referral and Antitrust Laws. The federal and state antikickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible (with bright-line exemptions) to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs or in legal jeopardy. This is particularly important for physicians in small- and medium-size practices who may want to remain independent but otherwise integrate and collaborate with other physicians (i.e., so-called virtual integration) for purposes of participating in the ACO. The Patient Protection and Affordable Care Act explicitly authorizes the secretary to waive requirements under the Civil Monetary Penalties statute, the Antikickback statute, and the Ethics in Patient Referrals (Stark) law for Medicare ACOs. The secretary should establish a full range of waivers and safe harbors that will enable independent physicians to use existing or new organizational structures to participate as Medicare ACOs. In addition, the secretary should work with the Federal Trade Commission to provide explicit exceptions to the antitrust laws for ACO participants in Medicare, Medicaid, other state-based programs, and commercial markets. Physicians cannot completely transform their practices only for the Medicare patients, and antitrust enforcement could prevent them from creating clinical integration structures involving their privately insured patients. These waivers and safe harbors should be allowed where appropriate to exist beyond the end of the initial agreement between the ACO and Centers for Medicare & Medicaid Services (CMS) so that any new organizational structures that are created to participate in the program do not suddenly become illegal simply because the shared savings program does not continue.
CMS Provision of ACO Resources. Additional resources should be provided up front to encourage ACO development. CMS’s Center for Medicare and Medicaid Innovation (CMI, the Innovation Center) should provide grants to physicians in order to finance up-front costs of creating an ACO. ACO incentives must be aligned with the physician or physician group’s risks (e.g., start-up costs, systems investments, culture changes, and financial uncertainty). Developing this capacity for physicians practicing in rural communities and solo-small group practices requires time and resources, and the outcome is unknown. Providing additional resources for the up-front costs will encourage the development of ACOs since the “shared savings” model only provides for , particularly given that potential savings at the back-end, which may discourage the creation of ACOs by (particularly among independent physicians and practicing in rural underserved communities).

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

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

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

(3) Prior to assignment to an ACO, benchmark a should be ACOs should conduct patient risk assessments adjusted to identify for the any socioeconomic and/or health status factors that may contribute to a patient’s poorer health outcomes, of the patients that are assigned to each ACO, such as income/poverty level, previous insurance status prior to Medicare enrollment, race and ethnicity, and health status chronic health conditions. Data from the assessment should be used to develop tailored patient care coordination plans and to arrange referrals to appropriate social services to address non-medical factors that may impact patient health. Studies show that patients with these factors have experienced barriers to care and are more costly and difficult to treat. once they reach Medicare eligibility.

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

(5) The ACO benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient socioeconomic and health status factors.
(6) There shall be a determination that access to care is not compromised in fragile medical environments (e.g., inner city and rural settings).

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

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

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

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

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

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

Medicaid ACOs and Value-Based Payment Arrangements.

If Medicaid tests the ACO concept, the Texas Medicaid state should seek ongoing input from practicing physicians and providers on the pilot’s design regarding the state’s value-based payment and quality roadmap, including the pilot’s quality and financial benchmarks, the mechanisms for collecting and reporting data, and how data will be shared with ACO physician participants, patients, and the public. Any ACO pilot tested in the Medicaid system must be of sufficient length to ensure valid and reliable evaluation of the pilot’s impact on health outcomes and spending, including ensuring any required performance measures for Medicaid managed care organizations and network physicians be relevant, practical, and meaningful.

Texas Medicaid should collaborate with practicing physicians, providers, and Medicaid managed care organizations to develop a menu of standardized value-based payment options that promote innovation, while also minimizing complexity stemming from the proliferation of similar but divergent models.

There shall be a determination that access to care is not compromised in fragile medical environments (e.g., inner city, rural settings).
State ACO Pilot Initiatives [e.g., Employee Retirement System (ERS)/Teachers Retirement System (TRS)] Spending Benchmarks. Any ACO spending benchmarks established under a direct contract state with a state-funded insurance program and an ACO pilot initiative should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.

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

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

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

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

If ERS tests a direct contract option with a statewide or regional the ACO concept, the state it should seek input from practicing physicians and providers on the pilot’s design, including the pilot’s quality and financial benchmarks, the mechanisms for collecting and reporting data, and how data will be shared with ACO physician participants, patients, and the public. Any ACO pilot tested in the ERS system must be of sufficient length to ensure valid and reliable evaluation of the pilot’s impact on health outcomes and spending.

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

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

ACOs should have the flexibility to use a variety of payment methods alone or simultaneously, including fee-for-service, care management fees, shared savings, partial capitation, or global capitation.
ACOs must have the flexibility to develop a mix of financial and other incentives designed to foster safe, high quality and cost-effective patient care. However, to ensure that incentives are fair and reasonable, and not intended to promote the inappropriate denial of medically necessary care or unfair restraint of trade, the ACO’s local physician governing board shall develop and oversee the incentive structure. Further, the ACO shall publicly disclose the types of incentives to avoid appearance of impropriety.

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

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

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

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

180.002 Managed Care Incentive Withholds: The Texas Medical Association voted to monitor insurer HMO and PPO compliance with Section 1301.068, Texas Insurance Code regarding prohibition of “incentive withholds” and their associated accounting practices. In addition, if carrier practices are determined to be in violation of state laws, TMA agreed to pursue appropriate legal, administrative, or other action to rectify any unlawful practices (Amended Res. 28W, p 169, A-91; reaffirmed CSE Rep. 5-I-01; amended CSE Rep. 8-A-11).

190.020 Sterilization Services: Medicaid policy law and regulations concerning informed consent for sterilizations should be amended to remove the time and age restrictions on informed consent. To eliminate barriers that prevent any legally competent pregnant women to choosing sterilization services while also continuing to ensure women remain in control of their reproductive decision-making (Amended Res. 405-A-01; reaffirmed CSE Rep. 8-A-11).

190.030 Simplified and Streamlined Physician Medicaid Enrollment and Credentialing in Medicaid HMOs: The Texas Medical Association continues to support efforts to establish a single, streamlined, and integrated its efforts to streamline Medicaid HMO paperwork, process for physicians to enroll in Medicaid and to initiate Medicaid HMO credentialing.

195.002 Medicare HMO Disclosure of Limitations on Choice of Physicians: The Texas Medical Association favors a requirement for full disclosure in a timely, simple and clear fashion to all
Medicare recipients as to who will be delivering their medical care in any Medicare HMO (Res. 27AA, p 204, A-90; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

**195.004 Disproportionate Share Fund:** The Texas Medical Association voted to request the American Medical Association to pursue regulatory and statutory means of establishing a disproportionate share fund for physicians in order to assure access to and quality of care (Res. 28CC, p 175, A-91; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

**195.006 Medicare Program Cutbacks:** The Texas Medical Association believes that U.S. representatives and senators from Texas should be educated on the need to formulate an overall plan with input from organized medicine so that any cuts to Medicare will have minimum impact on the quality of health care delivery. TMA also believes the American Medical Association should adopt a similar measure so that any changes in reimbursement payment will not affect the quality of health care delivery and will be a cooperative agreement between governmental agencies and organized medicine. TMA also urges AMA to oppose any further cuts in Medicare expenditures in the coming years as detrimental to beneficiaries' access to quality medical care. Finally, TMA agreed to seek AMA concurrence in support of the continued payment by the Medicare program for all appropriate services to support quality care (Res. 28K, p 157, and Res. 28Y, p 171, A-91; reaffirmed CSE Rep. 5-I-01; amended CSE Rep. 8-A-11).

**235.001 Fee for Service:** While also supporting voluntary participation in value-based payment arrangements, the Texas Medical Association reaffirms its support of the indemnity approach to fee-for-service physician payment (Supplemental CSE, p 161, A-90; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

**235.002 Individual Responsibility for Health Care and Funding:** The Texas Medical Association reaffirms the importance of individual responsibility for health care and health care funding where possible and societal responsibility where funding is unavailable. In addition, TMA encourages liaison with a variety of stakeholders and dialogue with other sectors of society, including members of the health professions, allied health, personnel, researchers, pharmacists, pharmaceutical manufacturers, health insurers, business and industry, liability insurers, and patients, to effect to secure private sector sources of funding for promised health care in addition to direct federal, state, and local government assistance (YPS, p 155, I-90; reaffirmed CSE Rep. 5-I-01; amended CSE Rep. 8-A-11).

**235.003 Reimbursement Payment Based on Years in Practice:** The Texas Medical Association strongly opposes discrimination in reimbursement payment practices based on age, gender, or years in practice (YPS, p 155, I-90; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

**235.004 Third-Party Payer Physician Payment Reductions:** In addressing the arbitrary increase in reductions to payments made to physicians by HMOs and PPOs through manipulation of CPT codes and modifiers, the Texas Medical Association will continue to voted to expand its current activities in investigation of these reductions by HMOs, PPOs and other third-party payors (Res. 27H, p 170, I-90; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).
235.006 **Bundled Payment Proposals**: The Texas Medical Association opposes mandatory payment models all proposals where payment for an entire episode of care, including physician services, are bundled together and paid to a single provider, who then reimburses other providers (Amended Council on Health Facilities, p 72, A-91; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

235.008 **Surgical Assistants**: The Texas Medical Association will continue to monitor voted to examine the arbitrary limitation placed on the use of surgical assistants in its investigation of insurance practices. Should abusive practices be identified, TMA will work with appropriate use its influence with third party carriers and appropriate payors and governmental agencies to correct such inequities (Res. 28V, p 168, A-91; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

235.023 **Reimbursement Payment for Uncompensated Services to the Uninsured or Underinsured**: The Texas Medical Association supports legislative relief, such as tax code modifications, financial compensation, and liability relief, for physicians who provide uncompensated services to uninsured or underinsured patients in compliance with governmental mandates (Res. 210-I-01; reaffirmed CSE Rep. 8-A-11).

240.004 **Medicare Reimbursement Payment for Emergencies**: The Texas Medical Association supports reversal of Medicare's policy of reimbursing for emergency visits only if patients are seen in an emergency room setting (Res. 27C, p 165, I-90; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

280.002 **Insurance Coverage for New Medical Procedures**: The Texas Medical Association will continue voted to initiate discussions with private insurers to assure that the approval of coverage for new safe and cost-effective medical procedures is prompt conducted. (Res. 27I, p 171, I-90; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

**Recommendation 2**: Retain as amended.

The Council on Socioeconomics recommends deleting the following policies:

95.036 **Tax-Deferred Health Benefits Mandate on Over-the-Counter Medication**: The Texas Medical Association will work with the AMA to propose legislation to reverse the Patient Protection and Affordable Care Act mandate that patients who participate in certain tax-deferred health benefits (flexible spending accounts, health savings accounts, health reimbursement accounts, and so forth) must get a prescription for over-the-counter medications to be eligible for reimbursement (Res. 405-A-11).

190.004 **Medicaid Allowance for Preterm Labor**: The Texas Medical Association supports Medicaid patients being allowed hospitalization for preterm labor and any other significant antepartum complications that could result in preterm delivery and subsequent neonatal morbidity and mortality (Committee on Maternal and Child Health, p 114, A-91; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

235.007 **Reimbursement of Preventive Health Care**: The Texas Medical Association emphasizes reimbursement of preventive health care in the Medicaid program and urges officials to reduce paper documentation. TMA also emphasizes education of practitioners to improve utilization.
review, rather than the punitive approach presently in operation (Committee on Access to Health Care, p 86, A-91; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

95.001 Prescription Triplicate Forms: The Texas Medical Association opposes state and federal legislation calling for use of triplicate prescription forms for Schedule II through Schedule V drugs (Substitute Res. 27P, p 178, I-90; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

Recommendation 3: Delete.
Subject: Opposition to New Federal Public Charge Definition

Presented by: Rodney Young, MD, Chair, Council on Socioeconomics

Referred to: Reference Committee on Socioeconomics

Background
In August 2019, the U.S. Department of Homeland Security adopted 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 Program (SNAP) services, public 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. Previously the rules did not take into account health care services, recognizing health care coverage as 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 to quell fear among immigrants that if they or their children, the vast majority of whom are U.S.-born citizens, were 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 where they lived.

At the direction of both the Council on Socioeconomics and the Council on Legislation, the Select Committee on Medicaid, CHIP, and Uninsured reviewed the rules and their potential implications for health care coverage. The committee unanimously recommended that TMA strongly oppose the rules, which TMA did. While the association has historically not taken a position on federal immigration issues, the rules undoubtedly will 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 for the Health of Texans and the 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 U.S., 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 them 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. Pregnant immigrants who are provided coverage are more likely to obtain early prenatal care, a key factor in addressing Texas’ alarmingly 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 affected. However, the indirect impact of the 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 cards. Misunderstanding and confusion about the rules have 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 less 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 with research the Urban Institute conducted 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 rules also will invariably harm the state’s public health by contributing to the spread of communicable diseases. Though the rules explicitly exclude 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 rules, the agency itself acknowledged the many negative consequences the rules will have on people and communities, including increases in emergency department use, prevalence of communicable diseases, and 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. They 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

After multiple lawsuits by state attorneys general and advocacy organizations and several injunctions, the U.S. Supreme Court ultimately allowed the rules to proceed. They took effect Feb. 24, 2020.

Nearly a year later, on Feb. 2, 2021, the Biden Administration issued an executive order instructing the secretary of state, attorney general, secretary of homeland security, and heads of other relevant agencies to review all agency actions related to the implementation of the public charge rules. It is widely expected the rules will be rescinded. Nevertheless, given the rules’ harm and the potential for a future administration to reinstate same or similar rules, the council believes TMA should make its opposition to them official TMA policy.

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

Presented by: Shannon Hancher-Hodges, MD, Chair

Referred to: Reference Committee on Socioeconomics

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, the 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. The 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, the SOAH judge determines there was no violation of law or regulation, and the TMB adopts the judge’s findings, the TMB does not void the initial suspension or restriction, and it stays as a permanent mark on the physician’s record.

When the 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 the SOAH judge determines there has been no violation, and the TMB affirms SOAH’s findings of fact and conclusions of law that there was no violation by dismissing all allegations against the physician, the 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 the TMB has an obligation to alert relevant parties when it imposes a temporary suspension or restriction, the TMB believes it has no equivalent duty to inform those parties other than the NPDB that the temporary suspension or restriction was “superseded” (voided). The 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 the 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, the TMB shall overturn and vacate the temporary suspension or restriction as soon as practicable and dismiss the case; (2) the effect of an overturned and vacated temporary suspension or restriction, unless specifically appealed by the TMB to district court, shall be that the suspension or restriction never happened and never should have happened; and (3) any mention of charges against a physician related to the temporary suspension or restriction shall be removed from the physician’s TMB profile, all parties shall be notified that the temporary restriction or suspension is void, any related report to the National Practitioner Data Bank shall be voided, and the case dismissed, unless and until the TMB appeals the case to district court and that court reverses the administrative law judge’s findings of facts and conclusion of law.
Subject: Compensation to Physicians for Activities Other Than Direct Patient Care (Tabled BOT Report 13 2020)

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 task force 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.
REPORT OF COMMITTEE ON MEDICAL HOME AND PRIMARY CARE

Subject: Sunset Policy Review

Presented by: Jeffrey Bullard, MD, Chair

Referred to: Reference Committee on Socioeconomics

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

The Committee on Medical Home and Primary Care recommends retention of the following policies:

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

Subject: Sunset Policy Review

Presented by: Lucia L. Williams, MD, Chair

Referred to: Reference Committee on Socioeconomics

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

The Committee on Rural Health recommends retention of the following policies:

**55.003 School Career Programs in Rural Areas:** The Texas Medical Association voted to ask members in rural areas to volunteer to speak at high school career programs to provide information and encourage student interest in health careers, and to encourage county medical societies in rural areas to sponsor medical students who are willing to speak to high school students in rural areas and reimburse them for travel expenses (Committee on Rural Health, p 149, I-90; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).
Subject: Caps on Insulin Copayments With Insurance (Tabled Res 413 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

WHEREAS, Diabetes affects approximately 11.2% of the population in Texas and is the seventh leading cause of death nationally and in Texas; and

WHEREAS, The direct medical cost for diagnosed diabetes in Texas was estimated at $18.9 billion in 2017, with an additional $6.7 billion spent on indirect costs from lost productivity due to diabetes; and

WHEREAS, The annual average medical cost per diabetic patient is $13,240 with approximately 44% of expenditures stemming from prescription medications, including insulin; and

WHEREAS, the Texas Medical Association advocates reducing the higher cost of medications by supporting the negotiation of drug prices for Medicare and Medicaid; and

WHEREAS, From 2012 to 2016, the average point-of-sale price of insulin nearly doubled from 13 cents per unit to 25 cents per unit, translating to a daily cost increase from $7.80 to $15 for a type 1 diabetic patient using an average amount of insulin (60 units per day); and

WHEREAS, One in four patients reported cost-related insulin underuse, including taking smaller doses and skipping doses, which was independent of the patient’s prescription drug coverage plan; and

WHEREAS, Patients who report cost-related underuse were more likely to have poor glycemic control, increasing their risk for complications such as hypertension, chronic kidney disease, neuropathy, lower limb amputations, retinopathy, stroke, coronary heart disease, depression, and cancer; and

WHEREAS, TMA has an existing policy that all patients must have access to medically indicated prescription drugs necessary to treat their illnesses; and

WHEREAS, TMA currently does not have an explicit policy regarding insulin pricing for patients; and

WHEREAS, The Texas Diabetes Council supports insulin caps in its State Plan for Diabetes; and

WHEREAS, The American Medical Association has policy consistent with the principle of increasing access to prescription medications including insulin for patients; and

WHEREAS, Some private insurance programs have shown the capability to offer a capped copayment on insulin for their customers; therefore be it

RESOLVED, That TMA 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:
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 during 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 screening provides a significant opportunity to identify factors that can affect maternal health, such as breastfeeding practices, family planning, and depression; and

Whereas, Untreated postpartum depression interferes with the mother’s ability to care for her newborn 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 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 mothers receive at least three visits from time of delivery to six weeks postpartum, where each visit includes psychosocial support to help 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 in 25 state Medicaid programs; and

Whereas, 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 in 2018; 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 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:
Extending Medicaid Coverage for One Year Postpartum D-290.974
Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 403
2021

Subject: Insurance Promotion of Preventive Care Services via Incentive-Based Programs
(Tabled Res 417 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, Approximately 45% of 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 high-priority, clinical preventive services; and

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

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

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

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

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

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

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

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

References:
1. Raghupathi W, Raghupathi V. An Empirical Study of Chronic Diseases in the United States: A
2. McCarthy M. Up to 40% of premature deaths in the US are preventable, says CDC. *BMJ* 2014;
   348:g3122.
4. Bradley CJ, Neumark D. Small Cash Incentives Can Encourage Primary Care Visits By Low-Income
5. Higgins A, Fahey K, Veselovskiy G. *Prevention and Wellness Programs of Commercial Health
   April 2017.
Subject: Training Requirements Imposed by Insurance Companies Preventing Patients’ Access to Quality Medical Care (Tabled Res 420 2020)

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Socioeconomics

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

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

Related TMA Policy:
None.

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

Resolution 405
2021

Subject: Ensuring Medical Practice Viability Through Reallocation of Insurance Savings During the COVID-19 Pandemic

Introduced by: Hidalgo-Starr County Medical Society and Lone Star Caucus

Referred to: Reference Committee on Socioeconomics

Whereas, The impact of COVID-19 has been evident in primary care physician and specialist offices throughout the state; and

Whereas, Government shutdowns and mandates have decreased the patient volume seen in physicians’ offices as well as the volume of elective procedures (including inpatient and outpatient surgeries); and

Whereas, In areas with a large proportion of Medicaid patients, the volume of patients needed to maintain practice viability could be as much as three times more than that in other areas; and

Whereas, Daily patient volume has remained low throughout the pandemic; and

Whereas, Currently uncompensated physician workload in this pandemic has increased because patient panel responsibility has remained unchanged; and

Whereas, Federal, state, and commercial payers function primarily as fee-for-service; and

Whereas, Uniformly decreased patient visits (services) across the state leads to increased savings (revenue) for federal, state, and commercial payers; therefore be it

RESOLVED, That the Texas Medical Association advocate for full transparency regarding Medicaid expenditures relative to allocated funds, as well as expenditures relative to gross income for all commercial payers during the pandemic; and be it further

RESOLVED, That TMA urge adoption of legislation that would mandate a review of the difference between the current physician financial deficit created by the COVID-19 pandemic and subsequent profits the insurance companies have reaped due to the government shutdowns and mandates; and be it further

RESOLVED, That a fair and equitable formula be implemented to divide and allocate the savings directly resulting from decreased patient encounters among patients/employers who paid their premiums, physicians who have been impacted directly by government mandates and shutdowns, and the insurance companies; and be it further

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

Related TMA Policy:
- 145.007 Competitive Insurance Models
- 145.028 Unequal Insurance Contract Reimbursement for Solo Practitioners
120.003 Health System Reform Managed Care
180.026 Health Insurance Plans
235.001 Fee for Service

Related AMA Policy:
H-180.975 Insurance Industry Antitrust Exemption
D-130.966 Domestic Disaster Relief Funding
Whereas, Medicaid and Medicare utilize CPT codes to reimburse physicians for office visits; and
Whereas, Medicaid and Medicare reimbursement rates differ substantially for the same service (see Table 1), even though services provided and medical visit times are identical; and
Whereas, Medicaid reimbursement rates have not varied significantly during the past 27 years, even though the cost of maintaining a medical practice, especially primary care, has skyrocketed; and
Whereas, Medicaid-Medicare disparities have become even more magnified during the COVID-19 pandemic; and
Whereas, Because of the low reimbursement rate, physicians who treat primarily Medicaid patients need high patient volume to cover fixed overhead costs; and
Whereas, Patient volume is down because of COVID-19 and may not return to pre-COVID levels anytime soon; without a significant increase in reimbursement rates, many physicians may be forced to close their practices or relocate; and
Whereas, Any drop in physicians accepting Medicaid patients would further devastate this group of patients, who already have difficulty accessing in-network physicians; therefore be it
RESOLVED, That the Texas Medical Association advocate to increase Texas Medicaid reimbursement rates to physicians at least equal to Medicare rates, as the COVID-19 pandemic has made operating a physician practice financially impossible for many practices with a large Medicaid population.

Related TMA Policy:
190.003 Medicaid Payments to Increase Participation
190.007 Medicaid Funding
190.035 Floor for Medicaid Payments

Related AMA Policy:
H-290.965 Affordable Care Act Medicaid Expansion
H-290.982 Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured
H-330.932 Cuts in Medicare and Medicaid Reimbursement
## References:

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<th>Table 1: 2020 Reimbursement Rates</th>
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</thead>
<tbody>
<tr>
<td><strong>CPT Code</strong></td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>99213 Office Visit – 15 min</td>
</tr>
<tr>
<td>99214 Office Visit – 25 min</td>
</tr>
<tr>
<td>85025 CBC</td>
</tr>
<tr>
<td>87807 RSV Test</td>
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<tr>
<td>87880 Strep Test</td>
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<tr>
<td>86308 Mono Test</td>
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<tr>
<td>87804 Flu Test</td>
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<tr>
<td>81002 Urinalysis</td>
</tr>
<tr>
<td>69210 Wax removal w/curette</td>
</tr>
<tr>
<td>69209 Ear Lavage</td>
</tr>
<tr>
<td>99354 Extended time (e.g., suture removal)</td>
</tr>
<tr>
<td>10060 I &amp; D</td>
</tr>
<tr>
<td>17110 Cryo (e.g., warts)</td>
</tr>
<tr>
<td>10120 Incision/Removal of foreign body</td>
</tr>
<tr>
<td>94640 Nebulizer treatment</td>
</tr>
</tbody>
</table>
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 407
2021

Subject: Ensuring That Telehealth Coverage Does Not Discourage Use of Local Physicians

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Socioeconomics

Whereas, Telehealth services play an important role in ensuring the health of Texans and can sometimes be preferable to an in-person visit, especially in the event of a pandemic; and

Whereas, Organized medicine has been advocating over the past year for telehealth coverage by all payers; and

Whereas, Commercial payers have a history of enacting policies that are beneficial to them financially in the short term at the expense of the long-term health of patients and their access to medical care; and

Whereas, There is the potential for some payers to respond to heightened interest in telehealth services by offering telehealth coverage but setting cost-sharing in such a way that patients are encouraged to obtain care from nonlocal physicians or midlevel providers instead of locally based ones; and

Whereas, Incentivizing individuals to schedule multiple telehealth visits for the same problem instead of seeing a local physician for an in-person visit and undergoing a more complete physical exam that could aid in diagnosis and treatment potentially puts patients in medical jeopardy; and

Whereas, Access to care in rural areas and small cities could become limited as a consequence of reducing patient volume to the point that local physicians are unable to cover fixed expenses and are therefore forced to relocate to larger cities; therefore be it

RESOLVED, That the Texas Medical Association recognize that a benefit of having local physicians and their team of local health care providers provide telemedicine services is that they have the ability to ask the patient to switch to an in-person visit if circumstances warrant this approach; and be it further

RESOLVED, That TMA advocate for legislation that requires insurance carriers not to establish cost-sharing policies that encourage patients to use nonlocal physicians and providers instead of local physicians; and be it further

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

Related TMA Policy:
290.006 Telemedicine Reimbursement

Related AMA Policy:
D-480.965 Reimbursement for Telehealth
D-480.970 Access and Equity in Telemedicine Payments
D-480.969 Insurance Coverage Parity for Telemedicine Service
1 D-480.968 Telemedicine Encounters by Third Party Vendors
Subject: Need for and Funding of Level I and Level II Trauma Centers (Tabled Res 402 2020)

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 the 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 Driver Responsibility Program and other funding; and

Whereas, The 86th Texas Legislature enacted a law to repeal the Driver Responsibility Program and reduced 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 needed to support communities throughout Texas and to provide funding to make Level I and Level II trauma centers viable for all other service lines.

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
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
Subject: Individual Physicians Be Paid While Awaiting Credentialing Approval
(Tabled Res 404 2021)

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.
(4) “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.

(5) “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.

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

Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.

Amended by:
Acts 2009, 81st Leg., R.S., Ch. 296 (H.B. 389), Sec. 1, eff. September 1, 2009.
Acts 2011, 82nd Leg., R.S., Ch. 414 (S.B. 822), Sec. 1, eff. September 1, 2011.

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.

Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.

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.

Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.

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.
1  Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 411
2021

Subject: Physicians to Retain Payment During Credentialing (Tabled Res 405 2020)

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, In addition to signing a contract, physicians must be credentialed 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 for 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 (House Bill 1594, encoded in 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 in Sec. 1452.106, Effect of Failure to Meet Credentialing Requirements, 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”; 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 cover” to “may not cover,” Texas Insurance Code, Title 8, Health Insurance and Other Health Coverages, Subtitle F. Physicians and Health Care Providers, Chapter 1452 Physician and Provider Credentials, Sect. 1452.106 Effect of Failure to Meet Credentialing Requirements, to state “the managed care plan issuer may not recover from the applicant physician or the physician’s medical group an amount equal to the difference between payments for in-network benefits and out-of-network benefits.”

Related TMA Policy:

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

Resolution 412
2021

Subject: Maintaining the Integrity of Physicians Orders in an Electronic Environment

Introduced by: Webb-Zapata-Jim Hogg County Medical Society and Lone Star Caucus

Referred to: Reference Committee on Socioeconomics

Whereas, Physicians place orders after careful medical decisionmaking; and

Whereas, Modification or discontinuation of physician orders by nonphysicians without physician approval may be considered as practicing medicine; and

Whereas, Electronic orders by physicians are sometimes modified or discontinued without knowledge or approval of physicians (e.g., time of discontinuation of Foley catheter) because of policies not approved by the medical staff and/or the physicians responsible for the initial orders; and

Whereas, The authors of electronic health record orders when changes are made by computer algorithms and under whose authority the changes are made can be unclear; therefore be it

RESOLVED, That the Texas Medical Association support legislation stating that altering physician orders without the approval of the order’s original author or the covering physician is practicing medicine and is prohibited except in an emergency (i.e., a patient safety situation).

Related TMA Policy:
30.013 Physician Standing Orders
30.039 Pharmacists Practicing Medicine
130.006 Hospital Medical Staff Bylaws

Related AMA Policy:
H-225.996 Computer-Based Hospital and Order System
D-235.994 Medical Staff Autonomy and Self-Governance
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 413
2021

Subject: Compensation to Physicians for Activities Other Than Direct Patient Care
(Tabled Res 407 2020)

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, Physicians traditionally 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 payment, including 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; and

Whereas, Noncare services have (1) greatly increased expenses for physicians; (2) endangered the ability of physician practices to survive economically; and (3) caused the demise of independent physician practices; and

Whereas, The purpose of such noncare services is to delay and deny care, allowing payers to increase their profits by saving and investing money that otherwise would pay for patient care; and

Whereas, Payers eventually authorize the majority of authorization and preauthorization requests; and

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

Whereas, Other professionals, such as attorneys and 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 endanger the viability of the private practice of medicine; and

Whereas, Payers continue to disregard existing TMA policy, physicians currently are not compensated for such noncare services to the benefit of payers, and to the detriment of patients and physicians; and the dire need for relief from payers’ demands and requirements for physicians to provide noncare services necessitates strengthening existing TMA policy; therefore it be
RESOLVED, That the Texas Medical Association adopt a Funding for Physician Noncare Services policy as follows:

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

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

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

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

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
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 414
2021

Subject: Contracted Health Plans Must Apply the Same Level of Benefits Concerning Patient Responsibility (Tabled Res 408 2020)

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 adopt as policy that health plans in a binding contract with a physician must apply the same level of benefits concerning patient responsibility (copay, coinsurance) regardless of the contracted physician or provider rendering the service; 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
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 415
2021

Subject: Paper Medical Record Chart Preparedness for Electronic Health Record Interruptions

Introduced by: Webb-Zapata-Jim Hogg County Medical Society and Lone Star Caucus

Referred to: Reference Committee on Socioeconomics

Whereas, An increasing number of ransomware and other cyber attacks have been made against health care facilities, including physician practices; and

Whereas, Often as a result of these attacks, electronic health record access is limited or nonexistent; and

Whereas, When patients’ electronic medical records are not available for review and use, paper records are used as a last resort; and

Whereas, Many clinicians have no training on the use of paper medical records or have used paper records only for a brief time in their career and may not remember how to use them in an emergency; and

Whereas, Many clinicians and employees are required to go through annual training in HIPAA and other topics but are not required to refresh their knowledge of using paper records; and

Whereas, This unfamiliarity with the paper record not only compromises patient safety, potentially even leading to death, but also creates medicolegal issues such as notes and orders that are not sequential or understandable; therefore be it

RESOLVED, That the Texas Medical Association encourage all users of electronic health records (EHRs) in all health care environments to have an easily accessible paper medical record option available at the time of EHR interruptions, such as those from cyber attacks; and be it further

RESOLVED, That TMA encourage all health care entities to conduct training at least annually on the use of these emergency paper medical records; and be it further

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

Related TMA Policy:
None.

Related AMA Policy:
None.
Subject: Physician Societies to Create a Self-Funded, Balanced, and Nonpartisan Center for the Study of Health Care Reform (Tabled Res 421 2020)

Introduced by: Harris County Medical Society

Whereas, Evidence suggests growing support among legislators and the general public for expansive health care reform, and national legislation to create a universal Medicare or single-payer system could be proposed soon; and

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

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

Whereas, Some proposed reforms conflict with Texas Medical Association and American Medical Association policy, specifically that health care reform be evidence-based, responsible, sustainable, and incremental, and preserve patient and physician choice (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 to collect, study, and distribute information about potential effects of proposed health care reform; and

Whereas, The start-up investment by medical societies to create the proposed entity can be structured as a loan for future repayment; and the initial phase could include personnel and resources to create a website, solicit additional 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; and that this entity maintain and promote an online platform to provide for balanced critique about general and specific policy proposals, health care reports, and national health care systems for the benefit of the general public; and 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.

Fiscal Note: $1.5-$2.5 million/year

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:
H-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 Universal Health Coverage
D-165.935 Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 417
2021

Subject: Verbal Physicians Orders

Introduced by: Webb-Zapata-Jim Hogg County Medical Society and Lone Star Caucus

Referred to: Reference Committee on Socioeconomics

 Whereas, Hospital administrators at some health care facilities have implemented a ban on physician verbal orders to force usage of computerized order entry; and

 Whereas, This action can potentially disrupt critical clinician workflows and compromise patient safety; and

 Whereas, The art of understanding and implementing verbal orders requires continual practice and can be forgotten; and

 Whereas, During disasters (e.g., electricity outages) or computer inaccessibility (e.g., stuck in traffic), physicians may need to give urgent orders verbally to appropriately care for the patient; and

 Whereas, The Centers for Medicare & Medicaid Services recently unveiled rules aimed at easing clinician burden that state orders for x-rays may be transmitted by telephone rather than written and signed; therefore be it

 RESOLVED, That the Texas Medical Association advocate for legislation or Texas Medical Board rules that require medical staff approval for any limitations on the types of physician orders that are permissible; and be it further

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

 Related TMA Policy:

 None.

 Related AMA Policy:

 D-160.987 48-Hour Signature Rule
 D-225.988 Elimination of 48-Hour Signature Rule for Verbal Orders

 References:

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 418
2021

Subject: Electronic Prescribing of Controlled Substances (EPCS) Unfunded Mandate and Pharma Financial Settlements

Introduced by: Harris County Medical Society and the Texas Pain Society (co-sponsors)

Referred to: Reference Committee on Socioeconomics

Whereas, A national opioid crisis has been deemed to exist and mandates are a government-led cure for the crisis; and

Whereas, The federal and Texas governments have mandated electronic prescribing of controlled substances (EPCS) laws in response to the national opioid crisis, which has created direct unreimbursable cost to physicians from electronic health record (EHR) companies; and

Whereas, EHR companies are for-profit supportive industries, that already provide electronic prescription services for Schedule IV non controlled medications as part of their standard service fees; and

Whereas, Physicians have not had a pay raise in 22 years and have no way to pass on financial unfunded mandates; and

Whereas, The U.S. Department of Justice received an $8.3 billion Purdue Pharma opioid settlement, as well as other such settlements; therefore be it

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

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

RESOLVED, That the Texas Delegation to the AMA take a resolution to the AMA House of Delegates to initiate movement on the request; and be it further

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

Related TMA Policy:
235.026 Medical Care and Fair Compensation
115.016 A Modest Proposal to Save our Health Care System
115.018 Overwhelming Compliance Mandates and Payment Uncertainty
118.001 Health Information Technology
265.027 Costs to Update Health Information Technology Products to Address Issues of Sex and Gender

Related AMA Policy:
H-270.962 Unfunded Mandates.
D-120.956 Electronic Prescribing and Conflicting Federal Guidelines
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 419
2021

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

Introduced by: Dallas County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, Studies show that the availability of local psychiatric beds can decrease the use of involuntary admissions and reliance on the criminal justice system for inpatient psychiatric care; and

Whereas, In 2020, Texas ranked third highest among the states in prevalence of mental illness, yet 51st in access to mental health care, according to a report by Mental Health America; and

Whereas, The Parkland Health & Hospital System and Dallas County Health and Human Services 2019 Community Health Needs Assessment found that Dallas County does not have enough behavioral health capacity to support the high demand for services, and as many as 22% of adults aged 18 and over report physical limitation of more than 14 days from poor mental health; and

Whereas, Many parts of the state, including North Texas, have little to no access to a local state mental health facility (SMHF), e.g., the nearest SMHF for Dallas and Tarrant county patients is in Terrell; and

Whereas, Patients with complex behavioral health care needs account for disproportionate percentages of health care costs that could be reduced with improved care coordination between inpatient and outpatient status as well as wrap-around services; and

Whereas, Availability of psychiatric inpatient treatment centers specializing in youth and adolescents is even worse than adult bed availability, with only about half the state hospitals accepting patients under age 18; and

Whereas, As of July 2019, North Texas had only 580 licensed behavioral health beds, resulting in area hospital emergency departments serving as observation units until a psychiatric bed can be located, often hundreds of miles away; therefore be it

RESOLVED, That the Texas Medical Association advocate for increased funding and capacity for inpatient psychiatric beds throughout Texas with a priority emphasis in areas that lack local access to mental health facilities; and be it further

RESOLVED, That TMA Policy 215.019 Public Mental Health Care Funding be amended as follows:

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

;and be it further

RESOLVED, That TMA Policy 55.033 Children’s Mental and Behavioral Health be amended as follows:

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

Managing mental health disorders among children requires multiple strategies.

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

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

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

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

Advocacy. TMA should facilitate and advocate for:

a. Continuing mental health education programs for physicians and mental health care providers regarding child and adolescent mental health and substance abuse,

b. Medical schools and graduate medical education programs that recognize the role of primary care physicians and provide effective training and research in all aspects of child and adolescent mental health and substance abuse,

c. Continuing dialogue and networking with the public mental health community on these issues,

d. Minimizing youth exposure to advertisements for legal addicting substances,
e. Positive mental health messages that counteract tobacco and alcohol advertisements,

f. Strong children’s mental health networks throughout the state,

g. Emphasizing pediatric mental health education for all physicians who see children,

h. Adequate numbers and quality of mental health professionals and behavioral health facilities throughout the state,

i. Coordinating with the educational system for mentally healthy schools, and

j. Public and private payment systems that fully integrate mental health care services into primary patient care and provide appropriate payment for mental health services.

Related TMA Policy:
290.010 Improving Access to Care in Rural and Medically Underserved Areas

Related AMA Policy:
Access to Psychiatric Beds and Impact on Emergency Medicine H-345.978
Medicaid Coverage of Adults in Psychiatric Hospitals H-345.976
National Child Traumatic Stress Network H-60.929

References:


4. Texas Department of State Health Services. State Hospitals.

5. Mental Health America. State of Mental Health in America Ranking States.


Resolution 420
2021

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

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 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
Subject: Augmented Intelligence (AI) in Health Care (Tabled Res 201 2020)

Introduced by: Bexar County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, From 2010 to 2018, there were 79,936 patent applications filed in the United States involving augmented intelligence (AI), of which nearly one-third were in health care; and

Whereas, AI will have a growing role in health care; and

Whereas, The statutory and regulatory framework around AI in Texas may evolve rapidly, providing physicians an opportunity for input; and

Whereas, Physicians will require education and guidance on AI-related matters such as liability and clinical validation; and

Whereas, Because the quadruple aim in health care includes provider satisfaction, physicians stand to inform the use of AI in patient care towards this goal; therefore be it

RESOLVED, That the Texas Medical Association Council on Socioeconomics, TMA Committee on Health Information Technology, and TMA Council on Medical Education collaboratively study the effects of augmented intelligence (AI) on health care in Texas; and be it further

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

Fiscal Note: $15,000

Related TMA Policy:
None

Related AMA Policy:
Augmented Intelligence in Health Care H-480.940
Augmented Intelligence in Medical Education H-295.857
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 422
2021

Subject: Adjustments to Hospice Dementia Enrollment Criteria (Tabled Res 427 2020)

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:

1. 20.006 Alzheimer’s Disease and Other Dementia: The Texas Medical Association
2. 85.018 Supportive Palliative Care
3. 125.003 Home Health and Hospice

Relevant AMA Policy:

4. Alzheimer’s Disease H-25.991
5. Payment for Dementia Treatment in Hospitals and Other Psychiatric Facilities D-345.985
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 423
2021

Subject: Insurance Coverage for Fertility Preservation Procedures for Cancer Patients Undergoing Gonadotoxic Therapy

Introduced by: Dallas County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, In 2006, the American Society of Clinical Oncology (ASCO) published a clinical practice guideline on fertility preservation for adults and children with cancer encouraging physicians to address fertility preservation with patients undergoing gonadotoxic therapy; and

Whereas, ASCO updated its guidelines in October 2012 after a systematic review of the new literature and determined that the recommendations remained the same, with the exception of adding oocyte cryopreservation as a standard practice (in the previous guideline, oocyte cryopreservation was still considered experimental); and

Whereas, In August 2018 the Ethics Committee of the American Society for Reproductive Medicine (ASRM) published an opinion that clinicians should inform patients receiving potentially gonadotoxic therapies about options for fertility preservation and future reproduction prior to the initiation of such treatment; and

Whereas, In December 2019, the ASRM Practice Committee published recommendations for fertility preservation in patients undergoing gonadotoxic therapy or gonadectomy, stating that patients facing treatments likely to impair reproductive function deserve prompt counseling regarding their options for fertility preservation and rapid referral to an appropriate program; and

Whereas, Based on the current body of published literature regarding ovarian tissue cryopreservation, this procedure should be considered an established medical procedure with limited effectiveness that should be offered to carefully selected patients; and

Whereas, Established methods of fertility preservation include embryo cryopreservation for men and women, sperm cryopreservation in men, and oocyte cryopreservation in women; and

Whereas, Improvements in treating cancer have enabled many younger persons with cancer to survive, and five-year survival rates with testicular cancer, hematologic malignancies, breast cancer, and other cancers that strike young people may be 90% or greater; however, treatment of these cancers is often detrimental to both male and female reproductive function; and

Whereas, Multiple organizations have published guidelines endorsing fertility preservation procedures prior to receiving gonadotoxic therapy including the American Society of Clinical Oncology, the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, the National Comprehensive Cancer Network, and Livestrong and the Cancer Legal Resource Center; and

Whereas, The American Medical Association encourages third-party payers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility; and
Whereas, AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician; therefore be it

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

**Relevant TMA Policy:**
None.

**Relevant AMA Policy:**
- Disclosure of Risk to Fertility with Gonadotoxic Treatment H-425.967
- Infertility and Fertility Preservation Insurance Coverage H-185.990
- Recognition of Infertility as a Disease H-420.952

**Reference:**
Subject: Encourage the Establishment of an Express Lane Eligibility (ELE) Program in Texas

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, The Children’s Health Insurance Program Reauthorization Act of 2009 introduced express lane eligibility (ELE) to enable the enrollment of eligible children in Medicaid and the Children’s Health Insurance Program (CHIP); and

Whereas, ELE permits states to use income, household size, or other eligibility information previously collected from an Express Lane Agency (ELA) to facilitate enrollment in health coverage; and

Whereas, ELAs include the Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, Head Start, National School Lunch Program, and Women, Infants, and Children; and

Whereas, A state also may use income tax data to identify children in families that qualify for CHIP without requiring the family to resubmit income information to verify eligibility; and

Whereas, ELE enables a state to create a Medicaid/CHIP renewal process that does not require action by the family, simplifying renewal processes and enabling continuous coverage for children, which has important implications for their care; and

Whereas, Even brief gaps in children’s coverage are associated with reduced access to care and increased rates of unmet needs and forgone care; and

Whereas, When family income changes, ELE can ease transitions between Medicaid and CHIP because both are ELA agencies; and

Whereas, CHIP and Medicaid use different income methodologies in a state; however, when one program terminates a child’s eligibility based on family income findings, ELE enables coverage in the qualified program without further income analysis; and

Whereas, According to 2019 U.S. Census data, the share of Texans without health insurance – 18.4% – was twice the national average of 9.2%; and

Whereas, The number of Texans without health insurance has risen during the COVID-19 pandemic, which has resulted in economic turmoil and massive job losses; and

Whereas, The Journal of the American Medicine Association (JAMA) highlighted Louisiana, which implemented ELE and automatically enrolled 20,000 people in Medicaid in 2019, costing the state less than an outreach campaign that enrolled only 329 children; and

Whereas, Texas Medical Association Policy 55.055 advocates to increase the number of children enrolled in available health insurance programs; therefore be it
RESOLVED, That our Texas Medical Association encourage the establishment of an express lane eligibility (ELE) program in Texas that permits the use of income, household size, or other eligibility information previously collected from an Express Lane Agency (ELA), as described by the Centers for Medicare & Medicaid Services, to facilitate enrollment in Medicaid and the Children’s Health Insurance Program (CHIP).

References:

Relevant TMA Policy:
55.055 Increase enrollment of children into health insurance plans
190.028 Medicaid and CHIP Applications

Relevant AMA Policy:
Expanding Enrollment for the State Children’s Health Insurance Program (SCHIP) H-290.971
Subject: Making COVID-19 Emergency Telehealth Policies Permanent

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, The Centers for Disease Control and Prevention (CDC) reports an exponential increase in the use of telemedicine by healthcare providers as a result of the COVID-19 pandemic; and

Whereas, Telemedicine provides a convenient, low-cost means for health care providers to connect with patients and has been used during the pandemic to promote social distancing, and limit hospital visits and supplies to the most urgent cases; and

Whereas, Even before the pandemic, telemedicine had been shown to increase patient access to care by reducing transportation and geographic barriers, and decreasing overall mortality and length of stay in hospitals; and

Whereas, Projected physician workforce shortages compound the need for Texas to provide rural patients with access to primary and specialty care, and Texas Medical Association Policy 185.019 supports the use of telemedicine as a method to improve outreach in underserved communities; and

Whereas, The CDC reports the increase in telemedicine usage could be a result of pandemic-related telehealth policy changes; and

Whereas, Texas Gov. Greg Abbott signed emergency order 28 TAC §35.1 in March 2020, which requires that “health benefit plans provide coverage for covered services or procedures delivered by telemedicine on the same basis and to the same extent that the plan provides coverage for the same service or procedure in an in-person setting;” and

Whereas, The U.S. Centers for Medicare & Medicaid Services (CMS) also broadened access to telehealth services in March 2020 under the 1135 waiver authority and the Coronavirus Preparedness and Response Supplemental Appropriations Act for the COVID-19 public health emergency (PHE) declaration; and

Whereas, The key changes to telemedicine under the COVID-19 PHE declaration include (1) payment parity, meaning telehealth visits are paid at the same rate as in-person visits; (2) payment for Medicare telehealth services in any healthcare facility or patients’ homes; (3) elimination of the requirement requiring a prior relationship between the physician and patient; and (4) allowance for providers to serve out-of-state patients; and

Whereas, The changes to telehealth under the COVID-19 PHE declaration are not permanent and must be renewed every 90 days; and

Whereas, The CMS is proposing making certain telehealth services permanent, such as home visits for the evaluation and management of a patient, and for patients with certain cognitive impairments; and
Whereas, TMA Policy 290.006 supports providing equitable reimbursement for clinical services delivered via telecommunications technology; and

Whereas, In January, TMA began advocating to make permanent the temporary regulatory changes, such as payment parity; therefore be it

RESOLVED, That the Texas Medical Association support policy for payment parity, as initiated by the COVID-19 PHE declaration and 28 TAC §35.1 enacted by Governor Abbott, for the same covered service provided to an enrolled patient by a contracted physician via telemedicine; and be it further

RESOLVED, That TMA support research on the use of telemedicine services in rural settings in response to 28 TAC §35.1 to determine its effect on increasing access to health care services across the state.

Related TMA Policy:
185.019 Rural Physician Workforce Policy
290.002 Telemedicine Use to Improve Health Care
290.003 Telemedicine Use As Supportive Mechanism in Delivery of Care
290.005 Telemedicine
290.006 Telemedicine Reimbursement
290.007 Telemedicine and Confidentiality
290.008 Telemedicine Use in Protecting the Health and Welfare of Citizens
290.009 Guidelines for Electronic Communications with Patients

Related AMA Policy:
H-480.946 Coverage of and Payment for Telemedicine
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 426
2021

Subject: Support for Rural Labor and Delivery Departments

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, Texas has the eighth highest maternal mortality rate in the U.S., with 34.5 deaths per 100,000 births; and

Whereas, High maternal mortality rates often occur because hospitals are unprepared for childbirth or maternal emergencies during childbirth, indicating a need to invest additional resources into labor and delivery departments; and

Whereas, A 2019 study discovered maternal morbidity and mortality rates are 9% higher for rural residents compared with urban residents, when controlled for other variables such as sociodemographic factors and clinical conditions; and

Whereas, Inadequate Medicaid reimbursement has caused a disproportionate increase in the closure of rural labor and delivery departments because they account for significant income loss for rural hospitals; and

Whereas, Rural settings have a higher percentage of Medicaid-eligible patients, whose intrapartum care was reimbursed by the Disproportionate Share Hospital (DSH) provision until it was phased out under the Affordable Care Act’s Medicaid expansion plan; and

Whereas, Texas has not expanded Medicaid, putting even greater financial strain on rural hospitals because of funding gaps resulting from inadequate Medicaid reimbursement; and

Whereas, Smaller hospitals with a limited obstetric workforce experience increased financial strain because of the lack of federal funding and new state regulations for neonatal and maternal care for small hospitals that offer labor and delivery services; and

Whereas, Women in rural counties without labor and delivery departments face increased travel for standard intrapartum care, which contributes to an increased risk of maternal mortality and morbidity, as well as infant mortality; and

Whereas, Lack of access to labor and delivery departments leads to an increase in infant mortality, reduced birth weight, perinatal mortality, neonatal mortality, and an increase in Neonatal Intensive Care Unit (NICU) care; and

Whereas, Infants requiring NICU stays and infants born weighing 119 grams or less cost the state roughly 200 times more in medical expenditures than a healthy, full-term baby; and

Whereas, Texas has experienced the highest rate of rural hospital closures in the U.S., and the COVID-19 pandemic poses further challenges for struggling small, rural hospitals; and
Whereas, TMA Policy 290.010 supports improving access to care in rural and medically underserved areas by promoting Project ECHO and the Child Psychiatry Access Network, but fails to explicitly support access to and funding for labor and delivery departments and intrapartum care, leaving this population overlooked by the general public and policy-makers; and

Whereas, The consequences of the COVID-19 pandemic remain to be seen, and the disruption in health care and intentional choices in response to the pandemic are expected to indirectly result in an increase in maternal and child death; and

Whereas, The Texas Department of Agriculture (TDA) continues to allocate funds from the HHS (Health and Human Services) Provider Relief Fund to provide bridge funding for rural facilities to help ease financial implications of the COVID-19 pandemic; and

Whereas, HHS Provider Relief Fund allocations by TDA target COVID-19 relief and do not address existing burdens on already financially strained rural labor and delivery departments, partly because of the lack of awareness about challenges experienced by rural pregnant women; therefore be it

RESOLVED, That the Texas Medical Association support legislation and advocate for increased funding for rural labor and delivery departments under financial strain to allow for improved access to intrapartum care; and be it further

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

Related TMA Policy:
290.010 Improving Access to Care in Rural and Medically Underserved Areas
330.015 Physician-Led Initiatives to Address Maternal Mortality and Morbidity

Related AMA Policy:
H-465.990 Closing of Small Rural Hospitals
H-465.994 Improving Rural Health
H-465.997 Access to and Quality of Rural Health Care

References:


TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 427
2021

Subject: Limiting Out-of-Network Ground Ambulance Costs

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, 71% of ground ambulance transports for patients with large, national insurance plans resulted, in average, with a surprise medical bill of $450; and
Whereas, In Texas, more than 85% of ground ambulance services are billed as out of network; and
Whereas, Nationally, costs associated with ground ambulance usage account for most out-of-network bills; and
Whereas, As of 2021, the federal government does not limit ambulance charges for patients with private insurance; therefore, the cost of an ambulance ride can vary widely by location; and
Whereas, The global ambulance services market has grown significantly during the COVID-19 pandemic, particularly because of emergency transports for COVID-19 patients; and
Whereas, The global ambulance services market is expected to hit $34.8 billion in 2027 with a growth rate of 1.2%, compared to the pre-pandemic projected growth rate of 1.1% from 2019-26; and
Whereas, The Texas Constitution does not allow cities to negotiate lower rates, and most Texas cities follow local ordinances to set rates for their emergency medical services ambulance fees; and
Whereas, Congress passed the bipartisan No Surprises Act Dec. 27, 2020, as part of the omnibus spending bill that protects patients from surprise medical billing; and
Whereas, The No Surprises Act includes patient protections from surprise medical billing for air ambulances, but purposely excludes ground ambulances because of the complexity of local and state regulations, and lack of transparency of ambulance costs; and
Whereas, The No Surprises Act established a commission to study ground ambulance billing; and
Whereas, While the American Medical Association objected to the No Surprises Act for reasons unrelated to ambulances, the AMA states patients must not be penalized financially for receiving unexpected care from out-of-network providers; and
Whereas, Texas Senate Bill 1264 protects consumers who have state-regulated health plans from surprise medical bills in certain situations and bans balance billing for emergency care; and
Whereas, Texas Senate Bill 1264 excluded air and ground ambulances; and
Whereas, The Texas Department of Insurance has urged state lawmakers to “amend the state’s protections against medical balance bills when the consumer doesn’t have choice of providers to include ambulance services;” therefore be it

RESOLVED, That the Texas Medical Association support increased data collection and price transparency of ground ambulance providers and services; and be it further

RESOLVED, That TMA support policies and initiatives to reduce surprise, out-of-network billing related to ground ambulance services.

Related TMA Policy:
110.007 Cost Containment

Related AMA Policy:
D-130.962 Air Ambulance Regulations and Payments
H-240.978 Medicare’s Ambulance Service Regulations
H-285.904 Out-of-Network Care

References:


Subject: Insurance Coverage Transparency (Tabled Res 401 2020)

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Socioeconomics

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

Whereas, Medical offices and facilities often are unable to provide such estimates because each commercial health insurance plan has its own rules regarding patient responsibility for deductibles, copays, or coinsurance; and

Whereas, When medical offices and facilities call the insurance carrier or check online to verify coverage, they frequently receive 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 also can delay medical care if the insurance carrier overestimates the patient’s liability, making the patient reluctant to proceed with recommended tests or procedures; and

Whereas, Commercial insurance carriers have the technology to input the diagnosis and CPT codes to immediately determine the patient’s liability, they rarely provide this information to medical offices and facilities; therefore be it

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

RESOLVED, That TMA advocate for legislation that requires commercial insurance carriers, during insurance eligibility verification, to provide information regarding factors that may result in denial of the claim, e.g., the insurance carrier is waiting for the primary policyholder to verify whether he or she has other health insurance coverage; and be it further

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

RESOLVED, That TMA advocate for legislation that penalizes commercial insurance carriers, via fines and the publication of each carrier’s number of noncompliance complaints, when the above information is inaccurate or not provided in a timely manner; and 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-185.938 Health Insurance Exchange and 90-Day Grace Period**
- **H-185.981 Third Party Responsibility for Payment**
Subject: Adoption of Principles of Physician Value-Based Decisionmaking in Medical Practice and Professionalism (Tabled Resolution 424 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

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 Social, Technological, Economical, Environmental and Political (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 Physicians 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, the 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 of 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 decisionmaking:

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

And be it further

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:


Subject: Paid Parental Leave (Tabled Res 418 2020)

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.