

**AGENDA**  
**REFERENCE COMMITTEE ON SOCIOECONOMICS**

Friday, May 17, 2019

Tower Lobby, Sapphire Room - Hilton Anatole

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

*\*Resolution 406 was moved to the Reference Committee on Financial and Organizational Affairs and renamed Resolution 112*

## REPORT OF COMMITTEE ON RURAL HEALTH

C-RH Report 1-A-19

Subject: Expand Availability of Broadband Internet Access to Rural Texas

Presented by: Sandra D. Dickerson, MD, Chair

Referred to: Reference Committee on Socioeconomics

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1 At its fall 2018 meeting, the committee discussed the issues surrounding unreliable broadband internet access  
2 in rural areas. Reliable broadband internet access is essential to a modern health care delivery system that  
3 increasingly uses electronic means to communicate shared health information and to improve availability of  
4 services, such as by incorporating telemedicine and telehealth initiatives into practices or sharing information  
5 via health information exchanges or interoperable electronic health records.  
6

7 Texas has expansive rural areas accounting for 85 percent of the state's land, with 4 million residents living in  
8 rural areas. One out of every four rural Texans (1.25 million) lacks access to broadband infrastructure.  
9 Estimates show that more than \$5.1 billion in potential economic benefit is left unrealized among  
10 disconnected households. Broadband can offer residents access to health care, jobs, education, government  
11 services, and other modern amenities.  
12

13 For physicians practicing in rural Texas, lack of reliable broadband services forces physicians to use outdated  
14 and slower communications systems, including faxes, to communicate with other physicians, hospitals,  
15 pharmacies and patients. It also means rural patients will be deprived of the benefits new telemedicine and  
16 telehealth services can bring, including increased access to care.  
17

18 The committee supports TMA strongly pursuing legislative initiatives to support the expeditious expansion of  
19 broadband to rural communities.  
20

21 **Recommendation:** That the Texas Medical Association advocate for the expeditious expansion of broadband  
22 connectivity to all rural areas of Texas.  
23

### 24 Sources:

- 25 1. Federal Communications Commission. (2018). 2018 Broadband Deployment Report. Retrieved from  
26 [https://www.fcc.gov/reports-research/reports/broadband-progress-reports/2018-broadband-deployment-](https://www.fcc.gov/reports-research/reports/broadband-progress-reports/2018-broadband-deployment-report)  
27 [report](https://www.fcc.gov/reports-research/reports/broadband-progress-reports/2018-broadband-deployment-report).
- 28 2. Connected Nation. (2018). Rural Broadband: A Texas Tour, 2018 Listening Tour and Focus Groups.  
29 Retrieved from [https://www.edtx.org/getattachment/Get-Involved/Texas-Rural-Funders-](https://www.edtx.org/getattachment/Get-Involved/Texas-Rural-Funders-Collaborative/The-Future-of-Rural-Texas-2018_5-Rural-Broadband.pdf?lang=en-US)  
30 [Collaborative/The-Future-of-Rural-Texas-2018\\_5-Rural-Broadband.pdf?lang=en-US](https://www.edtx.org/getattachment/Get-Involved/Texas-Rural-Funders-Collaborative/The-Future-of-Rural-Texas-2018_5-Rural-Broadband.pdf?lang=en-US).

REPORT OF THE COMMITTEE ON RURAL HEALTH

CM-RH Report 3-A-19

Subject: Sunset Policy Review

Presented by: Sandra D. Dickerson, MD, Chair

Referred to: Reference Committee on Socioeconomics

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

3  
4 The committee recommends retaining Policy 100.016.

5  
6 **100.016 Texas Department of State Health Services Emergency Medical Services Local Projects**  
7 **Grant Program:** The Texas Medical Association supports the DSHS EMS Local Projects  
8 Grant program which provides emergency medical services education, training and  
9 equipment to rural and frontier areas of Texas (CM-EMS Rep. 2-A-99; reaffirmed CPH Rep.  
10 2-A-09).

11  
12 **Recommendation:** Retain.

## REPORT OF COUNCIL ON SOCIOECONOMICS

CSE Report 1-A-19

Subject: Health Plan Claim Auditing Programs

Presented by: John Flores, MD, Chair

Referred to: Reference Committee on Socioeconomics

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1 In recent years, there has been an observable increase in health plans using third-party software to analyze and  
2 audit claims for payment based solely on the diagnosis code(s), Current Procedural Terminology (CPT)  
3 code(s) and modifier(s) on the claim. The patient's previous claims history with the health plan is sometimes  
4 used as part of the software "equation" to determine if the claim should be paid. The physician's billing  
5 patterns compared with his or her peers is another possible part of the software equation.  
6

7 Software programs currently in use by some health plans include Coding Advisor from Change Healthcare that  
8 UnitedHealthcare (UHC) plans on piloting in Texas and ConVeregence Point from Verscend Technologies by  
9 Blue Cross and Blue Shield of Texas (BCBSTX). Coding Advisor looks at a physician's past use of high-level  
10 evaluation and management (E&M) codes and compares their use with that of physicians of the same  
11 specialty. ConVeregence Point flags claims that contain one or more modifiers appended to a CPT code(s).  
12 The E/M codes under review are typically level 4 and 5 codes. The modifiers under review include -25  
13 (unrelated evaluation and management service by the same physician or other qualified health care  
14 professional on the same day of the procedure or other service) and -59 (distinct procedural service).  
15

16 No nationally recognized guidelines on billing, coding, and payment support the use of these software  
17 programs as the sole determinant of claim payment or denial. A review of the patient's medical record is  
18 necessary to determine if it clearly documents the necessity of the modifier or supports the billing of a high-  
19 level E&M code.  
20

21 These software programs are applied at different times during the claim submission process. The UHC product  
22 stops the claim on the front end and sends it back to the practice. This means the claim never made it past  
23 submission to the clearinghouse. The practice has the option to change information on the claim and resubmit  
24 it or reject the suggested change and resubmit the claim. The BCBSTX product is applied at the back end. The  
25 claim is processed like other claims except that the system may deny payment on the line item(s) containing  
26 the modifiers in question. The portion of the claim not associated with the modifier proceeds as usual leading  
27 to the practice possibly receiving a partial payment of the claim. Any portion of the claim that is denied must  
28 be appealed following BCBSTX appeals procedures including submission of the medical record that supports  
29 the modifier(s) on the claim. After reviewing the medical record, BCBSTX will either send the claim back for  
30 payment or continue to deny the claim.  
31

32 The Texas Department of Insurance (TDI) is aware of these programs. TMA staff continue to have discussions  
33 with TDI about its role in monitoring the software use during claims auditing.  
34

35 Current TMA policy addresses general downcoding of claims and the E/M documentation guidelines. Current  
36 AMA policy addresses the appropriate use of modifiers.  
37

38 **Recommendation 1:** Amend TMA Policy 65.008 as follows:  
39

40 **65.008      Downcoding and Bundling of Claims:** The Texas Medical Association opposes:  
41

42 (1) The practices of insurance companies and their agents unilaterally downcoding evaluation and  
43 management services and bundling Current Procedural Terminology (CPT) codes that were  
44 correctly reported with a modifier; by insurance companies and their agents.

1           (2) the use of software or other methodologies to determine payment and/or denial of a claim based  
2           solely on the CPT codes, ICD-10 codes, and modifiers submitted on a claim;

3  
4           (3) the use of billing, coding, and payment methods that do not adhere to CPT guidelines, rules, and  
5           conventions; and

6  
7           (4) the patient's past medical claim history being used as a tool to deny or pay a claim. A patient's  
8           medical claim history is not an accurate or complete reflection of the patient's overall health and  
9           should not be used as a substitute for a medical record.

10  
11           TMA and will take all necessary and appropriate steps to stop these unreasonable business practices  
12           (Amended Res. 404-I-98; reaffirmed CSE Rep. 1-A-08; reaffirmed CSE Rep. 1-A-18).

13  
14           **Recommendation 2:** That the Texas Delegation take a resolution to the AMA House of Delegates at its 2019  
15           Annual Meeting asking for adoption of this policy and advocacy.

REPORT OF COUNCIL ON SOCIOECONOMICS

CSE Report 2-A-19

Subject: Sunset Policy Review

Presented by: John G. Flores MD, Chair

Referred to: Reference Committee on Socioeconomics

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

3  
4 The Council on Socioeconomics recommends retention of the following policies:

5  
6 **40.005 AMA Private Sector Advocacy:** The Texas Medical Association supports the actions of the  
7 AMA Division of Private Sector Advocacy in its coordination of advocacy activities and, with  
8 county medical society and specialty society partners, pledges to support the efforts of the  
9 division.

10  
11 **55.055 Increase Enrollment of Children in Health Insurance Plans:** The Texas Medical Association,  
12 as a high priority in conjunction with the Texas Medical Association Alliance and other groups,  
13 will work to increase the number of children enrolled in available health insurance programs with  
14 the goal of ensuring that all Texas children are provided a medical home for comprehensive basic  
15 medical care in the very near future. Reimbursement for services in the medical home should be  
16 adequate to keep the medical home a viable institution for Texas children (Res. 415-A-09).

17  
18 **130.019 Emergency Medical Treatment and Active Labor Act:** The Texas Medical Association  
19 supports requirements for health care payment plans to provide fair payment for services rendered  
20 under the Emergency Medical Treatment and Active Labor Act mandate and opposes efforts to  
21 limit or restrict balance billing of patients for out-of-network physician services (Amended Res.  
22 402-A-09).

23  
24 **145.025 Out-of-Network Payments:** The Texas Medical Association supports legislation for clear and  
25 transparent health insurance company language so that prudent lay persons would know their  
26 financial responsibility when receiving care out of network (Res. 401-A-09).

27  
28 **145.026 Expanding Coverage to Children:** The Texas Medical Association endorses multiple options for  
29 expanding coverage to children, such as government contributions to commercial premiums or  
30 payment to out-of-pocket, high-deductible insurance plans (Res. 411-A-09).

31  
32 **145.027 Transparency of Preventive Care Services:** The Texas Medical Association will seek legislation  
33 requiring insurance companies to adopt standardized, readily accessible, and understandable  
34 terminology spelling out coverage for preventive care services, including adequate payment for  
35 recommended vaccine products and services (Amended Res. 413-A-09).

36  
37 **160.017 Utilization Review:** The Texas Medical Association will pursue legislation to ensure that adverse  
38 utilization review determinations be made only by physicians who are fully licensed by the Texas  
39 Medical Board and monitor proposed legislation to maintain the Texas Medical Board's current  
40 authority to enforce the Medical Practice Act in regard to utilization review decisions (CL/CSE  
41 Rep. 2-A-09).

42  
43 **190.029 Health Care Coverage Legislative Initiatives:** The Texas Medical Association continues to  
44 strongly support legislation to establish a buy-in option under the Children's Health Insurance  
45 Program (CHIP) for families with uninsured children who do not currently qualify for CHIP. Any

1 CHIP buy-in program must include policies to deter families or employers from dropping private  
2 coverage in favor of public coverage, including graduated premium payments based on family  
3 income, a limited open-enrollment period, and a waiting period.  
4

5 TMA support for any CHIP buy-in legislation will be contingent on continued, aggressive, and  
6 simultaneous efforts to (1) increase Medicaid and CHIP payment rates to Medicare parity or  
7 better; (2) enact 12-months' continuous coverage for children in Medicaid; (3) ensure sufficient  
8 funding for the state's eligibility system so that applications for Medicaid or CHIP are timely  
9 adjudicated; and (4) expand availability of affordable private health insurance for small businesses  
10 and their employees (CL/CSE/SC-MCU Rep. 3-A-09).  
11

12 **235.029 Franchise Tax Issues:** The Texas Medical Association opposes all negative impacts of the  
13 franchise tax on a physician's practice, and supports the features that favor patients and physicians  
14 (CSE Rep. 3-A-09).  
15

16 **325.008 Insurance Discrimination Against Victims of Family Violence:** The Texas Medical Association  
17 supports insurance coverage of victims of family violence and abuse and recommends pursuit of  
18 legislation to prevent the discriminatory denial of coverage or reduction of reimbursement  
19 (Council on Public Health, p 81, I-95; amended CPH Rep. 2-A-09).  
20

21 **335.014 Workers' Compensation Delivery System:** Texas Medical Association supports the following in  
22 pursuit of a fair, efficient, and accountable workers' compensation delivery system in Texas:  
23 (1) Continue dialogue with legislative and executive branch policymakers to maintain the out-of-  
24 network medical fee reimbursement formula based on an annual MEI adjustment that may result  
25 in fair and reasonable physician payments;  
26 (2) Continue to educate policymakers and regulators on the need for employer accountability  
27 when dealing with injured workers and encouraging return to work initiatives;  
28 (3) Consider all appropriate strategies to help correct injustices within the system for doctors,  
29 specifically reducing inappropriate carrier gaming and reducing administrative hassles and  
30 burdens;  
31 (4) Diligently work with Texas Department of Insurance in the regulatory arena to improve  
32 physician input and physician stakeholder involvement to produce much needed reforms to the  
33 workers' compensation system (CSE Rep. 1-A-09).  
34

35 **Recommendation 1:** Retain.

36  
37 The Council on Socioeconomics recommends amending these policies as follows:  
38

39 **120.010 Principles for Evaluating Health System Reform:** The Texas Medical Association will use the  
40 following principles as evaluation criteria in examining all national health system reform  
41 proposals. These principles are not ranked in order of importance; all are viewed as high priorities.  
42

43 Promote portable and continuous health care coverage for all Americans using an affordable mix  
44 of public and private payer systems.  
45

46 Promote patient safety as a top priority for reform, recognizing an effective mix of initiatives that  
47 combine evidence-based accountability standards, committed financial resources, and rewards for  
48 performance that incentivize and ensure patient safety.

1 Adopt physician-developed, evidence-based tools for use in scientifically valid quality/patient  
2 safety initiatives that incentivize the physician-led health care delivery team, and include  
3 comparative effectiveness research used only to help those in patient-physician relationships  
4 choose the best care for patients.

5  
6 Preserve patient and physician choice and the integrity of the patient-physician relationship.  
7 Incorporate physician-developed, evidence-based measures and preventive health and wellness  
8 initiatives into any new or expanded health benefits package as a means to promote healthier  
9 citizens.

10  
11 Recognize and support the role of safety-net and public health systems in delivering essential  
12 health care services within our communities, to include essential prevention and health promotion  
13 public health services.

14  
15 Support the development of a well-funded, nationwide emergency and trauma care system that  
16 provides appropriate emergency and trauma care for all Americans.

17  
18 Support public policy that fosters ethical and effective end-of-life care decisions, to include  
19 requiring all Medicare patients to have an advance directive that a Medicare enrollee can discuss  
20 as part of a covered Medicare visit with a physician.

21  
22 Provide sustainable financing mechanisms that ensure the aforementioned affordable mix of  
23 services, and create personal responsibility among all stakeholders for financing and appropriate  
24 utilization of the system.

25  
26 Invest needed resources to expand the physician-led workforce to meet the health care needs of a  
27 growing and increasingly diverse and aging population.

28  
29 Provide financial and technological support to implement physician-led, patient-centered medical  
30 homes for all Americans, including increased funding and compensation for services provided by  
31 primary care physicians and the services provided by non-primary care, specialist physicians as  
32 part of the patient-centered medical home continuum.

33  
34 Through public policy enactments, require accountability and transparency among health insurers  
35 to disclose how their premium dollars are spent, eliminate preexisting condition exclusions,  
36 simplify administrative processes, and observe fair and competitive market practices.

37  
38 Reform the national tort system to prevent non-meritorious lawsuits, keeping Texas reforms in  
39 place as enacted by the Texas Legislature and constitutionally affirmed by Texas voters.

40  
41 ~~Abolish the Medicare Sustainable Growth Rate annual update system and~~ initiate a true cost of  
42 practice methodology that provides for annual updates in the Medicare Fee Schedule as  
43 determined by a credible, practice expense-based, medical economic index.

44  
45 Provide incentives that support the universal adoption of interoperable health information  
46 technology that supports physician workflow, increases practice efficiency, is safe for patients,  
47 and enhances quality of care. ~~implementation of an interoperable National Electronic Medical~~  
48 ~~Records System, financed and implemented through federal funding.~~

1            Require payers to have a standard, transparent contract with ~~providers~~ physicians that cannot be  
2            sold or leased for any other payer purposes without the express, written consent of the contracted  
3            physician.

4  
5            Support efforts to make health care financing and delivery ~~decision making~~ decisionmaking more  
6            of a professionally advised function, with appropriate standard setting, payment policy, and  
7            delivery system decisions fashioned by physician-led deliberative bodies as authorized  
8            legislatively (SC-HSR Rep. 1-A-09)

9  
10        **180.033    Payment for After-Hours Non-Emergent Care:** The Texas Medical Association proposes that  
11        the Texas Health and Human Services Commission standardize its contracts with ~~Texas health~~  
12        ~~care payment plan~~ Medicaid managed care organizations to allow and instruct each organization to  
13        cover and offer payment for after-hours ~~non-emergency nonemergency~~ care provided by  
14        physicians at a fair payment rate (Amended Res. 408-A-09).

15  
16        **Recommendation 2:** Retain as amended.

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 401  
A-19

Subject: Participation in Government Programs When Receiving Payment for Uncompensated Care

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Socioeconomics

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1 Whereas, Texas hospitals receive more than \$1 billion in funds each year for uncompensated care, and  
2 there is a shortfall under the Texas Medicaid program; and  
3

4 Whereas, Physicians who participate in Texas Medicaid receive payment at such a low rate for their  
5 services that there is a serious limitation on the number of Texas physicians caring for the Medicaid  
6 population both in primary care and subspecialty care; and  
7

8 Whereas, Uncompensated care costs continue to increase in Texas, with uncompensated care costs in  
9 2016 exceeding \$6.85 billion; and  
10

11 Whereas, 4.5 million Texans are uninsured, the highest number in the nation for any individual state; and  
12

13 Whereas, Texas counties are required to care for the uninsured if they are at or below 21 percent of the  
14 federal poverty level; and  
15

16 Whereas, The majority of Medicaid payments go to the hospitals in Texas, not to the physicians who  
17 provide the care; therefore be it  
18

19 RESOLVED, That all Texas health care facilities receiving federal or state funds for uncompensated care  
20 must also accept Medicare, Medicaid, TRICARE, CHIP, and federally subsidized health insurance via the  
21 Affordable Care Act from patients covered by these forms of insurance; and be it further  
22

23 RESOLVED, That some of the funds for uncompensated care now going to the hospitals in Texas be  
24 transferred to another part of the Texas Medicaid program and used to increase the payment rate for  
25 physicians who provide Medicaid services.  
26

27 **Related TMA Policy:**

28 **235.023 Reimbursement for Uncompensated Services to the Uninsured or Underinsured:**

29 Reimbursement for Uncompensated Services to the Uninsured or Underinsured: The Texas Medical  
30 Association supports legislative relief, such as tax code modifications, financial compensation, and  
31 liability relief, for physicians who provide uncompensated services to uninsured or underinsured  
32 patients in compliance with governmental mandates (Res. 210-I-01; reaffirmed CSE Rep. 8-A-11).  
33

34 **Related AMA Policy:**

35 **H-160.923 Offsetting the Costs of Providing Uncompensated Care:**

36 Our AMA: (1) supports the transitional redistribution of disproportionate share hospital (DSH) payments  
37 for use in subsidizing private health insurance coverage for the uninsured;(2) supports the use of  
38 innovative federal- or state-based projects that are not budget neutral for the purpose of supporting  
39 physicians that treat large numbers of uninsured patients, as well as EMTALA-directed care; and (3)  
40 encourages public and private sector researchers to utilize data collection methodologies that accurately

1 reflect the amount of uncompensated care (including both bad debt and charity care) provided by  
2 physicians.

3  
4 **H-160.971 Uncompensated Care:**

5 Our AMA supports (1) communicating to the public the problem of uncompensated care and the ever  
6 increasing regulations involving such care as well as the detrimental effect that uncompensated care has  
7 on the availability of necessary health care services to many citizens; and (2) publicizing the programs  
8 currently instituted to address uncompensated care and pursuing additional solutions for dealing with the  
9 problem of uncompensated care.

10  
11 **H-290.965 Affordable Care Act Medicaid Expansion:**

- 12 1. Our AMA encourages state medical associations to participate in the development of their state's  
13 Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.  
14  
15 2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for  
16 services provided by managed care organizations and state waiver programs, as well as by state Medicaid  
17 fee-for-service models.  
18  
19 3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services  
20 (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to  
21 care for Medicaid beneficiaries.  
22  
23 4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to  
24 specialty care for all Medicaid beneficiaries, including children and adolescents.  
25  
26 5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to  
27 assess the impact of Medicaid expansion programs on quality of care.  
28  
29 6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion  
30 programs.  
31  
32 7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid  
33 expansion states experiencing budget savings to encourage physician participation and increase patient  
34 access to care.  
35  
36 8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting  
37 and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation  
38 so that Medicaid patients can have equal access to necessary services.  
39  
40 9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge  
41 payment rates directly to CMS.  
42  
43 10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid  
44 expansions that are implemented beyond 2016.  
45  
46 11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent  
47 beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.  
48  
49 12. Our AMA supports improved communication among states to share successes and challenges of their  
50 respective Medicaid expansion approaches.  
51  
52 13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to  
53 reduce avoidable ED visits.

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 402  
A-19

Subject: Prescription Monitoring Program Integration Into Electronic Medical Records

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Socioeconomics

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1 Whereas, Prescription monitoring programs (PMPs) should be a resource for physicians in the safe  
2 treatment of patients; and  
3

4 Whereas, Physicians have been incentivized to install electronic medical records as a resource to try to  
5 improve patient care; and  
6

7 Whereas, New laws attempting to decrease the opioid epidemic will require physicians to query these  
8 databases prior to prescribing controlled substances; and  
9

10 Whereas, Monitoring on the PMP side will allow law enforcement to automatically target physicians for  
11 compliance; and  
12

13 Whereas, Electronic medical records can be integrated with PMPs, allowing physicians to have patient-  
14 specific information delivered within the physician's workflow; and  
15

16 Whereas, Physicians should not have to pay extra for PMP integration into electronic medical records;  
17 and  
18

19 Whereas, PMPs should be in the business of assisting physicians in the care of patients rather than an  
20 entrapment type of enforcement; therefore be it  
21

22 RESOLVED, That the Texas Medical Association advocate for prescription monitoring program  
23 integration into electronic medical records, at no cost to the physician, providing patient-specific  
24 information whenever a physician attempts to prescribe a controlled substance.  
25

26 **Related TMA Policy:**

27 **95.008 National All Schedules Prescription Electronic Reporting System:** National All Schedules  
28 Prescription Electronic Reporting System: The Texas Medical Association supports legislative and  
29 regulatory efforts to sunset the official prescription program and implement a real-time electronic  
30 prescription monitoring system based on the National All Schedules Prescription Electronic  
31 Reporting System with appropriate access by physicians, and clinical staff with delegated permission  
32 from physicians, pharmacists and practitioners with Drug Enforcement Administration permits  
33 (CSA, p 139, I-93; reaffirmed CSA Rep. 2-A-03; amended CSPH Rep. 1-A-13).  
34

35 **Related AMA Policy:**

36 **H-95.947 Prescription Drug Monitoring to Prevent Abuse of Controlled Substances:**

37 Our AMA:

- 1 (1) supports the refinement of state-based prescription drug monitoring programs and development and
- 2 implementation of appropriate technology to allow for Health Insurance Portability and Accountability
- 3 Act (HIPAA)-compliant sharing of information on prescriptions for controlled substances among states;
- 4 (2) policy is that the sharing of information on prescriptions for controlled substance with out-of-state
- 5 entities should be subject to same criteria and penalties for unauthorized use as in-state entities;
- 6 (3) actively supports the funding of the National All Schedules Prescription Electronic Reporting Act of
- 7 2005 which would allow federally funded, interoperative, state based prescription drug monitoring
- 8 programs as a tool for addressing patient misuse and diversion of controlled substances;
- 9 (4) encourages and supports the prompt development of, with appropriate privacy safeguards, treating
- 10 physician's real time access to their patient's controlled substances prescriptions;
- 11 (5) advocates that any information obtained through these programs be used first for education of the
- 12 specific physicians involved prior to any civil action against these physicians;
- 13 (6) will conduct a literature review of available data showing the outcomes of prescription drug
- 14 monitoring programs (PDMP) on opioid-related mortality and other harms; improved pain care; and other
- 15 measures to be determined in consultation with the AMA Task Force to Reduce Opioid Abuse;
- 16 (7) will advocate that U.S. Department of Veterans Affairs pharmacies report prescription information
- 17 required by the state into the state PDMP;
- 18 (8) will advocate for physicians and other health care professionals employed by the VA to be eligible to
- 19 register for and use the state PDMP in which they are practicing even if the physician or other health care
- 20 professional is not licensed in the state; and
- 21 (9) will seek clarification from SAMHSA on whether opioid treatment programs and other substance use
- 22 disorder treatment programs may share dispensing information with state-based PDMPs.

23  
24 **H-95.929 Support for Prescription Drug Monitoring Programs:**

25 Our AMA will: (1) continue to encourage Congress to assure that the National All Schedules Prescription  
26 Electronic Reporting Act (NASPER) and/or similar programs be fully funded to allow state prescription  
27 drug monitoring programs (PDMPs) to remain viable and active; and (2) work to assure that interstate  
28 operability of PDMPs in a manner that allows data to be easily accessed by physicians and does not place  
29 an onerous burden on their practices.

30  
31 **D-95.980 Opioid Treatment and Prescription Drug Monitoring Programs:**

32 Our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report  
33 to prescription monitoring programs.

34  
35 **H-95.990 Drug Abuse Related to Prescribing Practices:**

36 1. Our AMA recommends the following series of actions for implementation by state medical societies  
37 concerning drug abuse related to prescribing practices:

38  
39 A. Institution of comprehensive statewide programs to curtail prescription drug abuse and to promote  
40 appropriate prescribing practices, a program that reflects drug abuse problems currently within the state,  
41 and takes into account the fact that practices, laws and regulations differ from state to state. The program  
42 should incorporate these elements: (1) Determination of the nature and extent of the prescription drug  
43 abuse problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and  
44 other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries,  
45 thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such  
46 bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be  
47 improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for  
48 all physicians and for medical students.

- 1 B. Placement of the prescription drug abuse programs within the context of other drug abuse control  
2 efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that  
3 even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor  
4 appreciably affect the root causes of drug abuse. State medical societies should, in this regard, emphasize  
5 in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs,  
6 and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing  
7 physicians on the treatment of drug abuse and drug dependence in its various forms.  
8
- 9 2. Our AMA:  
10
  - 11 A. promotes physician training and competence on the proper use of controlled substances;  
12
  - 13 B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients;  
14
  - 15 C. will provide references and resources for physicians so they identify and promote treatment for  
16 unhealthy behaviors before they become life-threatening; and  
17
  - 18 D. encourages physicians to query a state's controlled substances databases for information on their  
19 patients on controlled substances.  
20
- 21 3. Our AMA opposes any federal legislation that would require physicians to check a prescription drug  
22 monitoring program (PDMP) prior to prescribing controlled substances.

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 403  
A-19

Subject: Prior Authorization Approval

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Socioeconomics

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1 Whereas, The prior authorization process is becoming one of the major sources of frustration for  
2 physicians who want to devote their time to providing medical care to their patients rather than  
3 completing onerous administrative tasks; and  
4

5 Whereas, The prior authorization process can be required for a variety of reasons, such as referrals to  
6 another health care professional, laboratory tests, radiology tests, medical or surgical procedures, and  
7 medications; and  
8

9 Whereas, At times, the physician has no idea what criteria must be met to justify the referral, test, surgery,  
10 procedure, or medication; and  
11

12 Whereas, The process for authorizations can be very time-consuming and require additional staff, thus  
13 increasing the cost of health care, already above 18 percent of the U.S. GDP, nearly 50 percent more than  
14 most other industrial countries; and  
15

16 Whereas, Many prior authorizations are not needed due to the fact that the referral, test, surgery,  
17 procedure, or medication is considered to be standard medical care; and  
18

19 Whereas, The physician often has no idea of the criteria that must be met to get approval from the  
20 insurance carrier; and  
21

22 Whereas, There are circumstances in which it is understandable that the insurance carrier requests certain  
23 information to ensure that expensive tests, therapies, or procedures are truly indicated, but this should be  
24 the exception, not the rule; therefore be it  
25

26 RESOLVED, That the criteria for prior approval for patient referrals, tests, surgeries, procedures, and  
27 medications be available to all physicians at the time of the request for such action; and be it further  
28

29 RESOLVED, That the types of patient referrals, tests, surgeries, procedures, and medications that  
30 typically require prior authorization be kept to a minimum, and such criteria be available to the physician  
31 and staff in a transparent manner; and be it further  
32

33 RESOLVED, That prior approval for patient referrals, tests, surgeries, procedures, and medications be  
34 handled in a rapid enough manner that patient care is not delayed.  
35

36 **Related TMA Policy:**

37 **235.038 Standardized Electronic Prior Authorization Transactions:** The Texas Medical Association  
38 supports policy and legislation that third-party payers, benefit managers, and any other party conducting  
39 utilization management be required to accept and respond to (1) standard electronic prior authorization

1 (ePA) transactions for pharmacy benefits that use a nationally recognized format, such as the National  
2 Council for Prescription Drug Programs (NCPDP) SCRIPT Standard; and (2) standard electronic  
3 transactions for review and response to prior authorization requests for medical service benefits that use a  
4 nationally recognized format, such as the ASC X12N 278 Health Care Service Review Request. (CSE  
5 Report 3-A-18)  
6

7 **235.034 Authorizations Initiated by Third-Party Payers:**

8 The Texas Medical Association supports policy and legislation that (1) third-party payers, benefit  
9 managers, and utilization review entities may not implement prior authorization mechanisms unless these  
10 payers compensate physician practices for work required independent of any payment for patient care;  
11 specifically, medical practices must be compensated for the burden of added staff and resources required  
12 to navigate payer-initiated prior authorizations for medications, studies, or procedures; (2) third-party  
13 payers, benefit managers, and utilization review entities should disclose all prior authorization  
14 requirements and restrictions on their websites in both the subscriber section and the physician section  
15 with neither location requiring a log-in or password; (3) third-party payers, benefit managers and  
16 utilization review entities should confirm patient eligibility, payment determinations, medical policies and  
17 subscriber specific exclusions as part of the prior authorization process; and (4) third-party payers, benefit  
18 managers, and utilization review entities should make detailed statistics regarding prior authorization  
19 approval and denial rates available on their website (Res. 401-A-11) (CSE Rep. 3-A-18).  
20

21 **Related AMA Policy:**

22 **H-320.939 Prior Authorization and Utilization Management Reform:**

- 23 1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including  
24 promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles,  
25 AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior  
26 Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient  
27 access to care.  
28 2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding  
29 and advocate for such decisions to be based on the direct review of a physician of the same medical  
30 specialty/subspecialty as the prescribing/ordering physician.  
31 3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and  
32 utilization management processes on patient access to necessary care and patient clinical outcomes,  
33 including the extent to which these processes contribute to patient harm.

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 404  
A-19

Subject: Medicare Part B Coverage of Vaccines

Introduced by: El Paso County Medical Society

Referred to: Reference Committee on Socioeconomics

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1 Whereas, Medicare Part B has a fee schedule for influenza vaccine, hepatitis B vaccine, tetanus-  
2 diphtheria-pertussis vaccine, pneumonia vaccine, and tetanus-diphtheria vaccine, and for administration  
3 of these vaccines; and  
4

5 Whereas, Medicare Part B does not have a fee schedule for herpes zoster vaccine, hepatitis A vaccine, or  
6 meningitis vaccine, or for the administration of these vaccines; and  
7

8 Whereas, The Centers for Disease Control and Prevention (CDC) Recommended Adult Immunization  
9 Schedule for the United States 2019 recommends either one dose of the live zoster virus be administered  
10 in the Medicare age group or two doses of the recombinant zoster (preferred) in those aged 50 and older;  
11 and  
12

13 Whereas, The CDC Recommended Adult Immunization Schedule by Medical Condition and Other  
14 Indications for the United States 2019 version recommends the hepatitis A vaccine for patients with  
15 chronic liver disease; and  
16

17 Whereas, The CDC Recommended Adult Immunization Schedule by Medical Condition and Other  
18 Indications for the United States 2019 version recommends the meningitis vaccine in patients with  
19 asplenia, complement deficiencies, and HIV infection; and  
20

21 Whereas, The CDC Recommended Immunizations for Travel recommends the hepatitis A and B vaccines  
22 prior to travel to countries with high or intermediate endemic status for these illnesses; therefore be it  
23

24 RESOLVED, That the Texas Medical Association advocate for Centers for Medicare & Medicaid  
25 Services to include the zoster virus vaccine, hepatitis A vaccine, and meningitis vaccine, and  
26 administration of these vaccines in its fee schedule.  
27

28 **Related TMA Policy:**

29 **135.009 Immunization in Adults:** The Texas Medical Association supports physician and public  
30 awareness on the importance of adult immunizations and endorses the adult schedule recommended by  
31 the Centers for Disease Control and Prevention Advisory Committee on Infectious Diseases.  
32

33 **Related AMA Policy:**

34 **H-440.875 Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines:** 1. It is AMA policy that  
35 all persons, regardless of economic and insurance status, receive all Advisory Committee on  
36 Immunization Practices (ACIP)-recommended vaccines as soon as possible following publication of these  
37 recommendations in the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality  
38 Weekly Report (MMWR).

- 1 2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to  
2 improve liability protection for vaccine manufacturers and health care professionals who provide  
3 immunization services and to examine and improve compensation mechanisms for patients who were  
4 legitimately injured by a vaccine.  
5
- 6 3. Our AMA will continue to work with the federal government, Congress, and other appropriate  
7 stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of  
8 existing and newly approved vaccines (including providing adequate resources for post-approval  
9 surveillance) so as to maintain and improve public confidence in the safety of vaccines.  
10
- 11 4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine  
12 distributors, the federal government, medical specialty societies, and third party payers, to guarantee a  
13 robust vaccine delivery infrastructure (including but not limited to, the research and development of new  
14 vaccines, the ability to track the real-time supply status of ACIP-recommended vaccines, and the timely  
15 distribution of ACIP-recommended vaccines to providers).  
16
- 17 5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure  
18 that state Medicaid agencies and private insurance plans pay health care professionals at least the  
19 approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer  
20 ACIP-recommended vaccines.  
21
- 22 6. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to address barriers  
23 associated with Medicare recipients receiving live zoster vaccine and the routine boosters Td and Tdap in  
24 physicians' offices.  
25
- 26 7. Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly  
27 include newly ACIP-recommended vaccines in their list of covered benefits, and to pay health care  
28 professionals fairly for the purchase and administration of ACIP-recommended vaccines.  
29
- 30 8. Our AMA will urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under  
31 Medicare Part B as a national public health measure to help prevent the spread of Pertussis.  
32
- 33 9. Until compliance of AMA Policy H-440.875(6) is actualized to the AMA's satisfaction regarding the  
34 tetanus vaccine, our AMA will aggressively petition CMS to include tetanus and Tdap at both the  
35 "Welcome to Medicare" and Annual Medicare Wellness visits, and other clinically appropriate  
36 encounters, as additional "triggering event codes" (using the AT or another modifier) that allow for  
37 coverage and payment of vaccines to Medicare recipients.  
38
- 39 10. Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations  
40 administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task  
41 Force (USPSTF), or based on prevailing preventive clinical health guidelines.

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 405  
A-19

Subject: Lower Drug Costs

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Socioeconomics

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1 Whereas, Medical care, especially drug prices, have accelerated significantly faster than the rate of  
2 inflation; and

3  
4 Whereas, The original Medicare bill had a restriction negotiating prices with physicians, and it only took  
5 three years until Medicare not only negotiated prices, but set prices for physician services; and

6  
7 Whereas, Drug companies and hospitals point out that there is a restriction on negotiation of prices in  
8 present Medicare law, and that it is somehow unchangeable; and

9  
10 Whereas, Price increases by drug manufacturers cannot be construed as capitalism; and

11  
12 Whereas, Pricing structures include intangible sources such as reduction of lawsuits and noneconomic  
13 conditions; and

14  
15 Whereas, Patients in the United States must pay prices that are multiple times the cost of drugs in other  
16 countries; and

17  
18 Whereas, Attempts are being made to completely upend all medical systems with a single-payer system,  
19 under the promise of reducing cost, and any cost reductions will certainly include negotiation of drug  
20 prices; therefore be it

21  
22 RESOLVED, That the Texas Medical Association advocate reducing the higher cost of medications by  
23 supporting negotiation of drug prices for Medicare and Medicaid.

24  
25 **Related TMA Policy:**

26 **195.037 Prescription Drug Negotiation in the Medicare Program:** The Texas Medical Association  
27 supports congressional authorization of Medicare to negotiate the prices of drugs paid for by Medicare  
28 Part D plans, as it does for other goods and services (CSE Rep. 3-A-17).

29  
30 **95.041 Ensuring Patient Access to Affordable Prescription Medications:** The Texas Medical  
31 Association will: (1) support programs whose purpose is to contain the rising costs of prescription drugs  
32 provided that the following criteria are satisfied: (a) physicians must have significant input into the  
33 development and maintenance of such programs; (b) such programs must encourage optimum prescribing  
34 practices and quality of care; (c) all patients must have access to medically indicated prescription drugs  
35 necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate  
36 drug(s) and method of delivery for the individual patient; and (e) such programs should promote an  
37 environment that will give pharmaceutical manufacturers the incentive for research and development of  
38 new and innovative prescription drugs; (2) study the issue of drug pricing, including whether large price  
39 increases impact patient access to critical medications; (3) support the application of greater oversight to

1 the establishment of closed distribution systems for prescription drugs; (4) support the mandatory  
2 provision of samples of approved out-of-patent drugs upon request to generic manufacturers seeking to  
3 perform bioequivalence assays; (5) work with interested parties to support legislation or regulatory  
4 changes that streamline and expedite the FDA approval process for generic drugs; and (6) support  
5 measures that increase price transparency for generic and brand-name prescription drugs. (Substitute Res.  
6 405-A-16 and Res. 409-A-16).

7  
8 **Related AMA Policy:**

9 **H-110.997 Cost of Prescription Drugs: Our AMA:**

10 (1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the  
11 following criteria are satisfied: (a) physicians must have significant input into the development and  
12 maintenance of such programs; (b) such programs must encourage optimum prescribing practices and  
13 quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses;  
14 (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for  
15 the individual patient; and (e) such programs should promote an environment that will give  
16 pharmaceutical manufacturers the incentive for research and development of new and innovative  
17 prescription drugs;

18  
19 (2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in  
20 prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost  
21 considerations in making these choices;

22  
23 (3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs  
24 and will assist physicians in this regard by regularly publishing a summary list of the patient expiration  
25 dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;

26  
27 (4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and  
28 necessary medical therapies;

29  
30 (5) will monitor the ongoing study by Tufts University of the cost of drug development and its  
31 relationship to drug pricing as well as other major research efforts in this area and keep the AMA House  
32 of Delegates informed about the findings of these studies;

33  
34 (6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA  
35 A-rated generic); and

36  
37 (7) encourages all physicians to become familiar with the price in their community of the medications  
38 they prescribe and to consider this along with the therapeutic benefits of the medications they select for  
39 their patients.

40  
41 **H-125.990 Medicaid Payment for Over-The-Counter Drugs When They are the Drug of Choice:**

42 The AMA supports over-the-counter drug benefits under Medicaid that provide physician-prescribed  
43 medications to enrollees. Cost-conscious OTC drug programs should satisfy the criteria contained in  
44 Policy 110.997 for AMA support of programs designed to contain the rising costs of prescription drugs  
45 and follow AMA Policy 125.991 on development and implementation of drug formularies.

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 407  
A-19

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

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

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1 Whereas, Traditionally, physicians get paid for direct patient care, such as evaluation and management  
2 and procedures; and  
3

4 Whereas, Insurance and managed care companies (“payers”) demand and require physicians and their  
5 staff to perform services outside of direct patient care (“non-care services”) without any payment.  
6 Examples of such “non-care services” include authorization and preauthorization for coverage and  
7 payment for prescriptions, laboratory tests, radiology tests, procedures, surgeries, hospitalizations, and  
8 physician visits. Other examples of “non-care services” include the gathering, compilation, and  
9 submission of medical records and data that benefit payers as they delay and deny care, meet  
10 requirements for outside commercial and governmental auditors, and enhance their ability to compile and  
11 utilize actuarial data for their pricing and profitability. “Non-care services” (1) have greatly increased  
12 expenses for physicians; (2) have endangered the ability of physician practices to survive economically;  
13 and (3) have caused the demise of independent physician practices; and  
14

15 Whereas, The purpose of such “non-care services” is to delay and deny care, thus allowing payers to save,  
16 keep, and invest money that otherwise would pay for patient care, thus increasing their profits; and  
17

18 Whereas, The overwhelming majority of authorization and preauthorization requests eventually are  
19 authorized by payers; and  
20

21 Whereas, Such “non-care services” harm patients by delaying diagnosis and treatment, thus causing pain,  
22 suffering, morbidity, and mortality. The time spent by physicians and their staff in performing “non-care  
23 services” decreases their availability to provide direct patient care for other patients, thus exacerbating  
24 physician shortages; and  
25

26 Whereas, Other professionals, such as attorneys, accountants, and their staff bill and get paid for all  
27 services they provide to their clients. The payers’ demands and requirements for physicians and their staff  
28 to provide “non-care services” without compensation is theft, extortion, and indentured servitude; and  
29

30 Whereas, Despite existing Texas Medical Association policy, such “non-care services” and their direct  
31 and indirect costs have continued to increase and are endangering the viability of the private practice of  
32 medicine. As payers continue to disregard existing TMA policy, physicians are currently not compensated  
33 for such “non-care services” that benefit only payers, to the detriment of patients and physicians. The dire  
34 need for relief from payers’ demands and requirements for physicians to provide “non-care services”  
35 necessitates the reiteration and strengthening of existing TMA policy; therefore be it  
36

37 RESOLVED, That insurance companies and managed care companies, including companies managing  
38 governmental insurance plans (“payers”), compensate physicians for the time that physicians and their  
39 staff spend on “non-care services,” including, but not limited to, authorization and preauthorization for  
40 coverage and payment for prescriptions, laboratory tests, radiology tests, procedures, surgeries,  
41 hospitalizations, and physician visits; as well as the gathering, compilation, and submission of medical

1 records and data. Such compensation shall be promptly paid in full by payers to physicians at a level  
2 commensurate with the education, training, and expertise of the physician. Payment should be at a rate  
3 comparable to the most highly trained professionals. The physician shall bill the payers for time spent by  
4 the physician and his or her staff in performing “non-care services.” Billable time for “non-care services”  
5 includes, but is not limited to, time spent filling out forms, reviewing the patient’s medical record,  
6 gathering patient-related data, making telephone calls (including time spent negotiating “phone trees” and  
7 hold time), documenting in the patient’s medical record, communicating with the patient, including  
8 telemedicine in all its forms, altering treatment plans (such as changing medications to comply with  
9 formularies), printing, copying, and faxing. Upon receiving such a bill, the payers shall pay the physician  
10 promptly, with significant interest penalties assessed for delay in payment. Since “non-care services”  
11 benefit the insurance companies, compensation owed to physicians for “non-care services” should not be  
12 billable to patients.

#### 13 14 **Related TMA Policy:**

15 **115.016 “A Modest Proposal” to Save our Health Care System:** The Texas Medical Association  
16 through its membership and leadership position in medicine, strives to change the cost curve by stopping  
17 the enlarging bureaucracies and the unfunded mandates, and by asking the federal government to consider  
18 the imposed cost on physicians when making clinical recommendations and changes to providing health  
19 care (Res. 404-A-11).

20  
21 **120.003 Health System Reform Managed Care:** To provide a basic framework for association policies  
22 and activities in health system reform, the Texas Medical Association: (1) supports the concept of  
23 universal access to appropriate health care; (2) supports freedom of patients to select their own  
24 physicians; (3) supports meaningful professional liability reform for physicians as a key element of health  
25 system reform; (4) supports genuine relief from red-tape hassles and excessive administrative costs of  
26 health care; (5) supports freedom from unreasonable restrictions, including antitrust prohibitions, that  
27 prevent physicians from conducting peer review of quality and fees; (6) continues to support a health care  
28 system that includes a multiplicity of funding sources and payment mechanisms; (7) supports the right of  
29 a physician organization to negotiate at the federal or state level for payment of physician services,  
30 quality and utilization review, professional liability reform, and to reduce the hassle and cost of  
31 regulation; (8) continues to support sufficient autonomy for physicians to be advocates for patients and to  
32 make decisions in the best interests of their patients; (9) supports efforts to control costs in an efficient  
33 and effective manner that considers the needs of patients and allows the exercise of good medical  
34 judgment; (10) supports the funding of research and medical education in any health system reform  
35 proposal and believes that all corporate payers of health care share in the costs of graduate medical  
36 education; (11) supports quality assurance through practice parameters and outcomes research; (12)  
37 supports patient responsibility for first dollar coverage to allow patients to make individual decisions  
38 regarding their own health care spending with consideration given to patients’ ability to pay.  
39 In addition, TMA offers the following principles for managed care for adoption as AMA policy: (1)  
40 physician participation in any managed care organization he or she chooses, (2) patient freedom to select  
41 his or her own physician, (3) physician autonomy and freedom to be patient advocates (Second  
42 Supplemental BOT, p 36P-36S, A-93; amended CSE Rep. 6-A-03; reaffirmed CSE Rep. 1-A-13)

43  
44 **180.026 Health Insurance Plans:** The Texas Medical Association approves continued aggressive  
45 advocacy for members in dealing with health insurance plan issues and will expand where appropriate its  
46 cooperative, collaborative initiatives with health insurers to address issues and problems of mutual  
47 concern (BOT Rep. 22-A-99; amended CSE Rep. 1-A-10).

48  
49 **180.031 Pharmacy Benefit Managers:** The Texas Medical Association will (1) gather evidence of the  
50 administrative burden placed on physicians and patients by the policies and operating practices of  
51 Pharmacy Benefit Managers (PBMs) in order to document the impact on medical practices and determine  
52 whether the business practices of PBMs comply with state laws and regulations; (2) explore the

1 possibility of legislative action should no state laws or regulations apply to the preauthorization process  
2 required by PBMs; and (3) promote cooperation by Texas pharmacists to provide physicians with up-to-  
3 date information about prescriptive drugs covered by pharmacy benefit managers and appropriate  
4 alternative medications in pharmacy benefit managers' formularies (Amended Res. 401-A-06; reaffirmed  
5 CSE Rep. 6-A-16).

6  
7 **235.027 Payment for Physician Work Product:** A physician's time is not "free;" a physician's work  
8 product and time is justly compensable in accordance with standard business practices of learned  
9 professionals (Res. 409-A-07; reaffirmed CSE Rep. 7-A-17).

10  
11 **235.034 Authorizations Initiated by Third-Party Payers, Benefit Managers, and Utilization Review**  
12 **Entities:** The Texas Medical Association supports policy and legislation that (1) third-party payers,  
13 benefit managers, and utilization review entities may not implement prior authorization mechanisms  
14 unless these payers compensate physician practices for work required independent of any payment for  
15 patient care; specifically, medical practices must be compensated for the burden of added staff and  
16 resources required to navigate payer-initiated prior authorizations for medications, studies, or procedures;  
17 (2) third-party payers, benefit managers, and utilization review entities should disclose all prior  
18 authorization requirements and restrictions on their websites in both the subscriber section and the  
19 physician section with neither location requiring a log-in or password; (3) third-party payers, benefit  
20 managers and utilization review entities should confirm patient eligibility, payment determinations,  
21 medical policies and subscriber specific exclusions as part of the prior authorization process; and (4)  
22 third-party payers, benefit managers, and utilization review entities should make detailed statistics  
23 regarding prior authorization approval and denial rates available on their website (Res. 401-A-11) (CSE  
24 Rep. 3-A-18).

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 408  
A-19

Subject: Managing Patient-Physician Relations Within Medicare Advantage Plans

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

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1 Whereas, Medicare Advantage plans are usually Health Maintenance Organization (HMO) plans, and,  
2 therefore, patients must be assigned to a primary care physician's (PCP) patient panel; and  
3

4 Whereas, Most patients will choose a physician they wish to serve as their PCP. However, those patients  
5 who do not choose for themselves will be assigned by the plan to a PCP's patient panel, usually based on  
6 geographic area or zip code; and  
7

8 Whereas, PCPs are responsible for these assigned patients for completing Healthcare Effectiveness Data  
9 and Information Set (HEDIS) measures, such as an annual preventive visit, breast cancer screening,  
10 colorectal screening, diabetic eye examination, body mass index, hospital discharge follow up, medication  
11 adherence, etc.; and  
12

13 Whereas, PCPs are given bonuses/incentives or are penalized based on their HEDIS star rating score. Star  
14 rating scores range from one to five, with five stars being the best rating score; and  
15

16 Whereas, PCPs must endure time consuming and costly measures to remove from their patient panel  
17 those patients who will not establish a patient-physician relationship. In many instances, a relationship is  
18 not established because the PCP has not been provided the patient's correct contact information (address,  
19 telephone number) or because the patient refuses to make or show for an appointment. These time  
20 consuming and costly measures may even include the requirement to send certified letters to the patient;  
21 therefore be it  
22

23 RESOLVED, That the Texas Medical Association adopt a policy that Medicare Advantage plans allow a  
24 primary care physician (PCP) to remove patients from his or her patient panel if the PCP has proven that  
25 he or she has been unable to establish a patient-physician relationship, despite repeated attempts; and be it  
26 further  
27

28 RESOLVED, That the physician's Healthcare Effectiveness Data and Information Set (HEDIS) and other  
29 quality scores and ratings not be affected by those patients with whom the physician has been unable to  
30 establish a relationship; and be it further  
31

32 RESOLVED, That the Texas Delegation to the American Medical Association take this resolution to the  
33 AMA House of Delegates.  
34

35 **Related TMA Policy:**

36 **265.017 Pay-for-Performance Principles and Guidelines.** Physician pay-for-performance (PFP)  
37 programs that are designed primarily to improve the effectiveness and safety of patient care may serve as  
38 a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link  
39 evidence-based performance measures to financial incentives. Such PFP programs are in alignment with  
40 the American Medical Association Guidelines for Pay-for-Performance Programs and the following five  
41 American Medical Association Principles for Pay-for-Performance Programs:

- 1       1. **Ensure quality of care.** Fair and ethical PFP programs are committed to improved patient care as  
2       their most important mission. Evidence-based quality-of-care measures, created by physicians  
3       across appropriate specialties, are the measures used in the programs. Variations in an individual  
4       patient care regimen are permitted based on a physician's sound clinical judgment and should not  
5       adversely affect PFP program rewards.
- 6       2. **Foster the patient-physician relationship.** Fair and ethical PFP programs support the patient-  
7       physician relationship and overcome obstacles to physicians treating patients, regardless of  
8       patients' health conditions, ethnicity, economic circumstances, demographics, or treatment  
9       compliance patterns.
- 10      3. **Offer voluntary physician participation.** Fair and ethical PFP programs offer voluntary  
11      physician participation, and do not undermine the economic viability of nonparticipating  
12      physician practices. These programs support participation by physicians in all practice settings by  
13      minimizing potential financial and technological barriers including costs of start-up.
- 14      4. **Use accurate data and fair reporting.** Fair and ethical PFP programs use accurate data and  
15      scientifically valid analytical methods. Physicians are allowed to review, comment, and appeal  
16      results prior to the use of the results for programmatic reasons and any type of reporting.
- 17      5. **Provide fair and equitable program incentives.** Fair and ethical PFP programs provide new  
18      funds for positive incentives to physicians for their participation, progressive quality  
19      improvement, or attainment of goals within the program. The eligibility criteria for the incentives  
20      are fully explained to participating physicians. These programs support the goal of quality  
21      improvement across all participating physicians.

## 22 **Guidelines for Pay-for-Performance Programs**

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

### 28 **Quality of Care**

- 29       • The primary goal of any PFP program must be to promote quality patient care that is safe and  
30       effective across the health care delivery system, rather than to achieve monetary savings.
- 31       • Evidence-based quality-of-care measures must be the primary measures used in any program.
  - 32           1. All performance measures used in the program must be defined prospectively and  
33           developed collaboratively across physician specialties.
  - 34           2. Practicing physicians with expertise in the area of care in question must be integrally  
35           involved in the design, implementation, and evaluation of any program.
  - 36           3. All performance measures must be developed and maintained by appropriate professional  
37           organizations that periodically review and update these measures with evidence-based  
38           information in a process open to the medical profession.
  - 39           4. Performance measures should be scored against both absolute values and relative  
40           improvement in those values.
  - 41           5. Performance measures must be subject to the best available risk adjustment for patient  
42           demographics, severity of illness, and comorbidities.
  - 43           6. Performance measures must be kept current and reflect changes in clinical practice.  
44           Except for evidence-based updates, program measures must be stable for two years.
  - 45           7. Performance measures must be selected for clinical areas that have significant promise  
46           for improvement.
- 47       • Physician adherence to PFP program requirements must conform with improved patient care,  
48       quality, and safety.
- 49       • Programs should allow for variance from specific performance measures that are in conflict with  
50       sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- 51       • PFP programs must be able to demonstrate improved quality patient care that is safer and more  
52       effective as the result of program implementation.

- 1 • PFP programs help to ensure quality by encouraging collaborative efforts across all members of
- 2 the health care team.
- 3 • Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a
- 4 sufficient duration to obtain valid data in a variety of practice settings and across all affected
- 5 medical specialties. Pilot testing also should analyze for patient deselection. If implemented, the
- 6 program must be phased in over an appropriate period of time to enable participation by any
- 7 willing physician in affected specialties.
- 8 • Plans that sponsor PFP programs must explain these programs prospectively to the patients and
- 9 communities covered by them.

#### 10 **Patient-Physician Relationship**

- 11 • Programs must be designed to support the patient-physician relationship and recognize that
- 12 physicians are ethically required to use sound medical judgment, holding the best interests of the
- 13 patient as paramount.
- 14 • Programs must not cause conditions that limit access to improved care.
- 15 1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and
- 16 socioeconomic groups, as well as those with specific medical conditions, or the
- 17 physicians who serve these patients.
- 18 2. Programs must neither directly nor indirectly disadvantage patients and their physicians,
- 19 based on the setting where care is delivered or the location of populations served (such as
- 20 inner city or rural areas).
- 21 • Programs must neither directly nor indirectly encourage patient deselection.
- 22 • Programs must recognize outcome limitations caused by patient nonadherence, and sponsors of
- 23 PFP programs should attempt to minimize noncompliance through plan design.

#### 24 **Physician Participation**

- 25 • Physician participation in any PFP program must be completely voluntary.
- 26 • Sponsors of PFP programs must notify physicians of PFP program implementation and offer
- 27 physicians the opportunity to opt in or out of the PFP program without affecting the existing or
- 28 offered contract provisions from the sponsoring health plan or employer.
- 29 • Programs must be designed so that physician nonparticipation does not threaten the economic
- 30 viability of physician practices.
- 31 • Programs should be available to any physicians and specialties wishing to participate and must
- 32 not favor one specialty over another. Programs must be designed to encourage broad physician
- 33 participation across all modes of practice.
- 34 • Programs must not favor physician practices by size (large, small, or solo) or by capabilities in
- 35 information technology (IT).
- 36 1. Programs should provide physicians tools to facilitate participation.
- 37 2. Programs should be designed to minimize financial and technological barriers to
- 38 physician participation.
- 39 • Although some IT systems and software may facilitate improved patient management, programs
- 40 must avoid implementation plans that require physician practices to purchase health-plan specific
- 41 IT capabilities.
- 42 • Physician participation in a particular PFP program must not be linked to participation in other
- 43 health plan or government programs.
- 44 • Programs must educate physicians about the potential risks and rewards inherent in program
- 45 participation, and immediately notify participating physicians of newly identified risks and
- 46 rewards.
- 47 • Physician participants must be notified in writing about any changes in program requirements and
- 48 evaluation methods. Such changes must occur at most on an annual basis.

#### 49 **Physician Data and Reporting**

- 50 • Patient privacy must be protected in all data collection, analysis, and reporting. Data collection
- 51 must be administratively simple and consistent with the Health Insurance Portability and
- 52 Accountability Act.

- 1 • The quality of data collection and analysis must be scientifically valid. Collecting and reporting  
2 of data must be reliable and easy for physicians and should not cause financial or other burdens  
3 on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of  
4 data in a nonpunitive manner.
  - 5 1. Programs should use accurate administrative data and data abstracted from medical  
6 records.
  - 7 2. Medical record data should be collected in a manner that is not burdensome and  
8 disruptive to physician practices.
  - 9 3. Program results must be based on data collected over a significant period of time and  
10 relate care delivered (numerator) to a statistically valid population of patients in the  
11 denominator.
- 12 • Physicians must be reimbursed for any added administrative costs incurred as a result of  
13 collecting and reporting data to the program.
- 14 • Physicians should be assessed in groups and/or across health care systems, rather than  
15 individually when feasible.
- 16 • Physicians must have the ability to review and comment on data and analysis used to construct  
17 any performance ratings prior to the use of such ratings to determine physician payment or for  
18 public reporting.
  - 19 1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust  
20 practice patterns over a reasonable period of time to more closely meet quality  
21 objectives.
  - 22 2. Prior to release of any physician ratings, programs must have a mechanism for physicians  
23 to see and appeal their ratings in writing. If requested by the physician, physician  
24 comments must be included adjacent to any ratings.
- 25 • If PFP programs identify physicians with exceptional performance in providing effective and safe  
26 patient care, the reasons for such performance should be shared with physician program  
27 participants and widely promulgated.
- 28 • The results of PFP programs must not be used against physicians in health plan credentialing,  
29 licensure, and certification. Individual physician quality performance information and data must  
30 remain confidential and not subject to discovery in legal or other proceedings.
- 31 • PFP programs must have defined security measures to prevent the unauthorized release of  
32 physician ratings.

### 33 **Program Rewards**

- 34 • Programs must be based on rewards and not on penalties.
- 35 • Program incentives must be sufficient in scope to cover any additional work and practice expense  
36 incurred by physicians as a result of program participation.
- 37 • Programs must offer financial support to physician practices that implement IT systems or  
38 software that interacts with aspects of the PFP program.
- 39 • Programs must finance bonus payments based on specified performance measures with  
40 supplemental funds.
- 41 • Programs must reward all physicians who actively participate in the program and who achieve  
42 prespecified absolute program goals or demonstrate prespecified relative improvement toward  
43 program goals.
- 44 • Programs must not reward physicians based on ranking compared with other physicians in the  
45 program.
- 46 • Programs must provide to all eligible physicians and practices a complete explanation of all  
47 program facets, to include the methods and performance measures used to determine incentive  
48 eligibility and incentive amounts, prior to program implementation.
- 49 • Programs must not penalize physicians financially based on factors outside of the physician's  
50 control.
- 51 • Programs utilizing bonus payments must be designed to protect patient access and must not  
52 financially disadvantage physicians who serve minority or uninsured patients.

- Programs must not penalize physicians financially when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.

TMA opposes private payer, congressional, or Centers for Medicare & Medicaid Services pay-for-performance initiatives if they do not meet the AMA's Principles and Guidelines for Pay for Performance (BOT Rep. 14-A-08; amended CSE Rep. 1-A-18).

#### **Related AMA Policy:**

**H-285.947 Retroactive Assignment of Patients by Managed Care Entities:** Our AMA opposes the practice of "retroactive or late assignment" of patients by managed care entities, noting that "retroactive or last assignment" includes: (a) the practice of failing to require enrollees in a capitated plan to select a responsible physician(s) at the time of enrollment; (b) the practice of failing to inform the responsible physician(s) of the enrollment of the patient and the assignment of responsibility until the patient has sought care; and (c) the practice of failing to pay the responsible physician the capitated rate until after the patient has sought care.

**H-450.947 Pay-for-Performance Principles and Guidelines:** 1. The following *Principles for Pay-for-Performance and Guidelines for Pay-for-Performance* are the official policy of our AMA.

### **PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS**

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

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

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

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

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

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

### **GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS**

Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation

1 of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles  
2 for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational  
3 boundaries that can be used in an assessment of specific PFP programs.

4  
5 Quality of Care

6  
7 - The primary goal of any PFP program must be to promote quality patient care that is safe and effective  
8 across the health care delivery system, rather than to achieve monetary savings.

9  
10 - Evidence-based quality of care measures must be the primary measures used in any program.

11 1. All performance measures used in the program must be prospectively defined and developed  
12 collaboratively across physician specialties.

13 2. Practicing physicians with expertise in the area of care in question must be integrally involved in the  
14 design, implementation, and evaluation of any program.

15 3. All performance measures must be developed and maintained by appropriate professional organizations  
16 that periodically review and update these measures with evidence-based information in a process open to  
17 the medical profession.

18 4. Performance measures should be scored against both absolute values and relative improvement in those  
19 values.

20 5. Performance measures must be subject to the best-available risk- adjustment for patient demographics,  
21 severity of illness, and co-morbidities.

22 6. Performance measures must be kept current and reflect changes in clinical practice. Except for  
23 evidence-based updates, program measures must be stable for two years.

24 7. Performance measures must be selected for clinical areas that have significant promise for  
25 improvement.

26  
27 - Physician adherence to PFP program requirements must conform with improved patient care quality and  
28 safety.

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30 - Programs should allow for variance from specific performance measures that are in conflict with sound  
31 clinical judgment and, in so doing, require minimal, but appropriate, documentation.

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34 as the result of program implementation.

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36 - PFP programs help to ensure quality by encouraging collaborative efforts across all members of the  
37 health care team.

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39 - Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient  
40 duration to obtain valid data in a variety of practice settings and across all affected medical specialties.  
41 Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in  
42 over an appropriate period of time to enable participation by any willing physician in affected specialties.

43  
44 - Plans that sponsor PFP programs must prospectively explain these programs to the patients and  
45 communities covered by them.

46  
47 Patient/Physician Relationship

48 - Programs must be designed to support the patient/physician relationship and recognize that physicians  
49 are ethically required to use sound medical judgment, holding the best interests of the patient as  
50 paramount.

- 1 - Programs must not create conditions that limit access to improved care.  
2 1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-  
3 economic groups, as well as those with specific medical conditions, or the physicians who serve these  
4 patients.  
5 2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the  
6 setting where care is delivered or the location of populations served (such as inner city or rural areas).

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11 programs should attempt to minimize non-adherence through plan design.

### 12 Physician Participation

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19 provisions from the sponsoring health plan or employer.

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22 of physician practices.

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24 - Programs should be available to any physicians and specialties who wish to participate and must not  
25 favor one specialty over another. Programs must be designed to encourage broad physician participation  
26 across all modes of practice.

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28 - Programs must not favor physician practices by size (large, small, or solo) or by capabilities in  
29 information technology (IT).

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32 participation.

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34 - Although some IT systems and software may facilitate improved patient management, programs must  
35 avoid implementation plans that require physician practices to purchase health-plan specific IT  
36 capabilities.

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38 - Physician participation in a particular PFP program must not be linked to participation in other health  
39 plan or government programs.

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42 participation, and immediately notify participating physicians of newly identified risks and rewards.

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44 - Physician participants must be notified in writing about any changes in program requirements and  
45 evaluation methods. Such changes must occur at most on an annual basis.

### 46 Physician Data and Reporting

47  
48 - Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be  
49 administratively simple and consistent with the Health Insurance Portability and Accountability Act  
50 (HIPAA).

- 1 - The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data
- 2 must be reliable and easy for physicians and should not create financial or other burdens on physicians
- 3 and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive
- 4 manner.
- 5 1. Programs should use accurate administrative data and data abstracted from medical records.
- 6 2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician
- 7 practices.
- 8 3. Program results must be based on data collected over a significant period of time and relate care
- 9 delivered (numerator) to a statistically valid population of patients in the denominator.
- 10
- 11 - Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and
- 12 reporting data to the program.
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- 14 - Physicians should be assessed in groups and/or across health care systems, rather than individually,
- 15 when feasible.
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- 17 - Physicians must have the ability to review and comment on data and analysis used to construct any
- 18 performance ratings prior to the use of such ratings to determine physician payment or for public
- 19 reporting.
- 20 1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice
- 21 patterns over a reasonable period of time to more closely meet quality objectives.
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- 23 appeal their ratings in writing. If requested by the physician, physician comments must be included
- 24 adjacent to any ratings.
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- 26 - If PFP programs identify physicians with exceptional performance in providing effective and safe
- 27 patient care, the reasons for such performance should be shared with physician program participants and
- 28 widely promulgated.
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- 30 - The results of PFP programs must not be used against physicians in health plan credentialing, licensure,
- 31 and certification. Individual physician quality performance information and data must remain confidential
- 32 and not subject to discovery in legal or other proceedings.
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- 34 - PFP programs must have defined security measures to prevent the unauthorized release of physician
- 35 ratings.
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- 37 Program Rewards
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- 39 - Programs must be based on rewards and not on penalties.
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- 42 incurred by physicians as a result of program participation.
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- 45 interact with aspects of the PFP program.
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- 47 - Programs must finance bonus payments based on specified performance measures with supplemental
- 48 funds.
- 49 - Programs must reward all physicians who actively participate in the program and who achieve pre-
- 50 specified absolute program goals or demonstrate pre-specified relative improvement toward program
- 51 goals.

- 1 - Programs must not reward physicians based on ranking compared with other physicians in the program.
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- 3 - Programs must provide to all eligible physicians and practices a complete explanation of all program
- 4 facets, to include the methods and performance measures used to determine incentive eligibility and
- 5 incentive amounts, prior to program implementation.
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- 7 - Programs must not financially penalize physicians based on factors outside of the physician's control.
- 8
- 9 - Programs utilizing bonus payments must be designed to protect patient access and must not financially
- 10 disadvantage physicians who serve minority or uninsured patients.
- 11
- 12 - Programs must not financially penalize physicians when they follow current, accepted clinical
- 13 guidelines that are different from measures adopted by payers, especially when measures have not been
- 14 updated to meet currently accepted guidelines.
- 15
- 16 2. Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-
- 17 for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-
- 18 Performance."

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 409  
A-19

Subject: Update Practice Expense Component of Relative Value Units

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

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1 Whereas, In 1992, Medicare established a standardized physician payment schedule based on a resource-  
2 based relative value scale (RBRVS), where payments for services are determined by the resource costs  
3 needed to provide them; and  
4

5 Whereas, The American Medical Association created the RVS Update Committee (RUC) to recommend  
6 payment schedules to the Centers for Medicare & Medicaid Services (CMS), and 90 percent of RUC  
7 recommendations are accepted by CMS; and  
8

9 Whereas, RBRVS costs are composed of three components: physician work, practice expense, and  
10 professional liability insurance; and  
11

12 Whereas, The AMA Practice Expense Advisory Committee, a subcommittee of the RUC, was charged to  
13 review direct practice expenses (clinical labor activities, medical supplies, and equipment) to calculate  
14 practice expense relative values and to make code-specific recommendations to the RUC; and  
15

16 Whereas, Physician practice expenses have not been comprehensively reviewed since 2004, nor updated  
17 since 2007, while actual practice costs have increased dramatically since the last reviews in 2004 and  
18 2007, including new practice costs related to electronic health records; quality documentation and  
19 reporting; population health registries; prior authorizations; pharmacy benefit manager reviews;  
20 prescription drug monitoring programs; interval increases in other federal, state, and local documentation  
21 requirements; additional staff required to comply with these new reporting requirements; as well as rent,  
22 equipment, supplies, salaries, and inflation; and  
23

24 Whereas, Physicians require the resources to practice 21st-century medicine and implement the value-  
25 based payment requirements established by the 2015 Medicare Access and CHIP Reauthorization Act;  
26 and  
27

28 Whereas, Current TMA policy supports AMA development of an RBRVS free of the distortions imposed  
29 by the federal government, reform of the Medicare payment system to provide adequate and equitable  
30 funding to all physicians providing services to patients who are Medicare beneficiaries, as well as  
31 requesting Congress to act to set Medicare fees at an adequate rate and enact requirements for future  
32 updates that are adequate to accommodate increasing practice costs; and  
33

34 Whereas, The 2018 Rand Practice Expense Analysis concluded, “the PPIS [Physician Practice  
35 Information Survey] survey inputs that are used for indirect cost allocation are outdated and likely to  
36 become increasingly inaccurate over time. ... We recommend establishing a new PE survey that can be  
37 repeated on an ongoing basis;” therefore be it  
38

39 RESOLVED, That the Texas Delegation to the American Medical Association submit a resolution to the  
40 AMA House of Delegates at the 2019 Annual Meeting requesting that the AMA pursue efforts to update

1 resource-based relative value unit practice expense methodology so that it accurately reflects current  
2 physician practice costs, with report back at the AMA House of Delegates 2019 Interim Meeting.

3  
4 **Related TMA Policy:**

5 **230.005 Fee Schedules Mandated by Federal Government:** Amounts listed in fee schedules for  
6 medical services mandated by the federal government (e.g., Medicare, Medicaid, and TRICARE fee  
7 schedules) are unrelated to “usual and customary,” “customary and reasonable,” “prevailing,” or any  
8 other characterization implying a market-based determination (Res. 413-A-08; amended CSE Rep. 1-A-  
9 18).

10  
11 **240.13 RBRVS -- AMA Development:** The Texas Medical Association strongly supports AMA  
12 development of an RBRVS free of the distortions imposed by the federal government on the RBRVS  
13 currently in use by Medicare. The AMA should continue to work through the Relative Value System  
14 Update Committee (RUC) to remove any distortions from the RBRVS currently in use by Medicare  
15 (Council on Socioeconomics, p 110, A-95; amended CSE Rep. 1-A-05; reaffirmed CSE Rep. 1-A-15).

16  
17 **240.016 Medicare Reimbursement Rates:** The Texas Medical Association will work to reform the  
18 Medicare payment system to provide adequate and equitable funding to all physicians providing services  
19 to patients who are Medicare beneficiaries (Substitute Res. 401-A-03 reaffirmed CSE Rep. 1-A-13).

20  
21 **240.018 Medicare Fees:** Inadequate fee updates since 2001 have caused Medicare physician payments to  
22 fall well below the average cost to provide services, so that physician practices are unable to survive at  
23 Medicare payment rates. Inadequate fees lead to a shift of care to costly hospital-based settings. Adequate  
24 fees and update factors are necessary to maintain beneficiary access to outpatient care and to accomplish  
25 improvements in medical care quality. Congress should act now to set Medicare fees at an adequate rate  
26 and enact requirements for future updates that are adequate to accommodate increasing practice costs  
27 (CSE Rep. 3-A-07; amended CSE Rep. 6-A-17).

28  
29 **235.026 Medical Care and Fair Compensation:** Medical care should not be an unfunded mandate from  
30 the government. If a governmental body provides access to health care, fair compensation to the physician  
31 must be provided (Amended Res.104-A-07; amended CSE Rep. 7-A-17).

32  
33 **235.027 Payment for Physician Work Product:** A physician's time is not "free;" a physician's work  
34 product and time is justly compensable in accordance with standard business practices of learned  
35 professionals (Res. 409-A-07; reaffirmed CSE Rep. 7-A-17).

36  
37 **Related AMA Policy:**

38 **D-400.986 The RUC: Recent Activities to Improve the Valuation of Primary Care Services:**  
39 Our AMA continues to advocate for the adoption of AMA/Specialty Society RVS Update Committee  
40 (RUC) recommendations, and separate payment for physician services that do not necessarily require  
41 face-to-face interaction with a patient.

42  
43 **D-400.988 PLI-RVU Component of RBRVS Medicare Fee Schedule:** Our AMA will: (1) continue its  
44 current activities to seek correction of the inadequate professional liability insurance component in the  
45 Resource-Based Relative Value Scale Formula; (2) continue its current activities to seek action from the  
46 Centers for Medicare & Medicaid Services to update the Professional Liability Insurance Relative Value  
47 Units (PLI-RVU) component of the RBRVS to correctly account for the current relative cost of  
48 professional liability insurance and its funding; and (3) support federal legislation to provide additional  
49 funds for this correction and update of the PLI-RVU component of the RBRVS, rather than simply  
50 making adjustments in a budget-neutral fashion.

1 **D-400.99 CPT Modifiers:** (1) Our AMA will continue to actively collect information, through existing  
2 processes, including the semi-annual study of non-Medicare use of the Medicare RBRVS conducted by  
3 the AMA Department of Physician Payment Policy and Systems and the recently unveiled AMA Private  
4 Sector Advocacy (PSA) Health Plan Complaint Form, and solicit input and assistance in this data  
5 collection from other interested members of the Federation on the acceptance of CPT modifiers by third  
6 party payers.

7  
8 (2) Pertinent information collected by our AMA through existing methods and collected through the  
9 AMA PSA Health Plan Complaint Form about acceptance of CPT modifiers by third party payers be  
10 shared with applicable state, county and national medical specialty societies in order to promote a greater  
11 understanding of third party payer payment policies related to CPT modifiers.

12  
13 (3) Our AMA use the available information to engage in discussions with payers.

14  
15 (4) Aggregate information collected through existing methods and collected through the AMA PSA  
16 Health Plan Complaint Form on acceptance for payment of CPT modifiers by third party payers be  
17 disseminated to state and federal regulators and legislators.

18  
19 **D-400.999 Non- Medicare Use of the RBRVS:** Our AMA will: (1) reaffirm Policy H-400.960 which  
20 advocates that annually updated and rigorously validated Resource Based Relative Value Scale (RBRVS)  
21 relative values could provide a basis for non-Medicare physician payment schedules, and that the AMA  
22 help to ensure that any potential non-Medicare use of an RBRVS reflects the most current and accurate  
23 data and implementation methods; (2) reaffirm Policy H-400.969 which supports the use of the  
24 AMA/Specialty Society process as the principal method of refining and maintaining the Medicare relative  
25 value scale; (3) continue to identify the extent to which third party payers and other public programs  
26 modify, adopt, and implement Medicare RBRVS payment policies; (4) strongly oppose and protests the  
27 Centers for Medicare & Medicaid Services' Medicare multiple surgery reduction policy which reduces  
28 payment for additional surgical procedures after the first procedure by more than 50%; and (5) encourage  
29 third party payers and other public programs to utilize the most current CPT codes updated by the first  
30 quarter of the calendar year, modifiers, and relative values to ensure an accurate implementation of  
31 the RBRVS.

32  
33 **H-400.955 Establishing Capitation Rates:**

34 1. Our AMA believes Geographic variations in capitation rates from public programs (e.g., Medicare or  
35 Medicaid) should reflect only demonstrable variations in practice costs and correctly validated variations  
36 in utilization that reflect legitimate and demonstrable differences in health care need. In particular, areas  
37 that have relatively low utilization rates due to cost containment efforts should not be penalized with  
38 unrealistically low reimbursement rates. In addition, these payments should be adjusted at the individual  
39 level with improved risk adjustors that include demographic factors, health status, and other useful and  
40 cost-effective predictors of health care use.

41  
42 2. Our AMA will work to assure that any current or proposed Medicare or Medicaid (including waivers)  
43 capitated payments should be set at levels that would establish and maintain access to quality care.

44  
45 3. Our AMA seeks modifications as appropriate to the regulations and/or statues affecting Medicare  
46 HMOs and other Medicare managed care arrangements to incorporate the revised Patient Protection Act  
47 and to ensure equal access to Medicare managed care contracts for physician-sponsored managed care  
48 organizations.

49  
50 4. Our AMA supports development of a Medicare risk payment methodology that would set payment  
51 levels that are fair and equitable across geographic regions; in particular, such methodology should allow

1 for equitable payment rates in those localities with relatively low utilization rates due to cost containment  
2 efforts.

3  
4 **H-400.956 RBRVS Development:**

5 (1) That the AMA strongly advocate CMS adoption and implementation of all the RUC's  
6 recommendations for the five-year review;

7 (2) That the AMA closely monitor all phases in the development of resource-based practice expense  
8 relative values to ensure that studies are methodologically sound and produce valid data, that practicing  
9 physicians and organized medicine have meaningful opportunities to participate, and that any  
10 implementation plans are consistent with AMA policies;

11 (3) That the AMA work to ensure that the integrity of the physician work relative values is not  
12 compromised by annual budget neutrality or other adjustments that are unrelated to physician work;

13 (4) That the AMA encourage payers using the relative work values of the Medicare RBRVS to also  
14 incorporate the key assumptions underlying these values, such as the Medicare global periods; and

15 (5) That the AMA continue to pursue a favorable advisory opinion from the Federal Trade Commission  
16 regarding AMA provision of a valid RBRVS as developed by the RUC process to private payers and  
17 physicians.

18  
19 **H-400.957 Medicare Reimbursement of Office-Based Procedures:** Our AMA will: (1) encourage  
20 CMS to expand the extent and amount of reimbursement for procedures performed in the physician's  
21 office, to shift more procedures from the hospital to the office setting, which is more cost effective; (2)  
22 seek to have the RBRVS practice expense RVUs reflect the true cost of performing office procedures; and  
23 (3) work with CMS to develop consistent regulations to be followed by carriers that include  
24 reimbursement for the costs of disposable supplies and surgical tray fees incurred with office-based  
25 procedures and surgery.

26  
27 **H-400.959 Refining and Updating the Physician Work Component of the RBRVS:** The AMA: (1)  
28 supports the efforts of the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee's  
29 (RUC's) work with the American Academy of Pediatrics and other specialty societies to develop  
30 pediatric-specific CPT codes and physician work relative value units to incorporate children's services  
31 into the RBRVS; (2) supports the RUC's efforts to improve the validity of the RBRVS through  
32 development of methodologies for assessing the relative work of new technologies and for assisting CMS  
33 in a more comprehensive review and refinement of the work component of the RBRVS; and (3) continues  
34 to object to use of the relative values as a mechanism to preserve budget neutrality.

35  
36 **H-400.962 The AMA/Specialty Society RVS Update Process:** Our AMA will strengthen its efforts to  
37 secure CMS adoption of the AMA/Specialty Society RVS Update Committee's (RUC) recommendations.

38  
39 **H-400.969 RVS Updating: Status Report and Future Plans:** The AMA/Specialty Society RVS Update  
40 Committee (RUC) represents an important opportunity for the medical profession to maintain  
41 professional control of the clinical practice of medicine. The AMA urges each and every organization  
42 represented in its House of Delegates to become an advocate for the RUC process in its interactions with  
43 the federal government and with its physician members. The AMA (1) will continue to urge CMS to  
44 adopt the recommendations of the AMA/Specialty Society RVS Update Committee for physician work  
45 relative values for new and revised CPT codes; (2) supports strongly use of this AMA/Specialty Society  
46 process as the principal method of refining and maintaining the Medicare RVS; (3) encourages CMS to  
47 rely upon this process as it considers new methodologies for addressing the practice expense components  
48 of the Medicare RVS and other RBRVS issues; and (4) opposes changes in Relative Value Units that are  
49 in excess of those recommended by the AMA/Specialty Society Relative Value Scale Update Committee  
50 (RUC).

1 **H-400.972 Physician Payment Reform:** It is the policy of the AMA to (1) take all necessary legal,  
2 legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but  
3 not limited to, (a) reduction of allowances for new physicians; (b) the non-payment of EKG  
4 interpretations; (c) defects in the Geographic Practice Cost Indices and area designations; (d)  
5 inappropriate Resource-Based Relative Value Units; (e) the deteriorating economic condition of  
6 physicians' practices disproportionately affected by the Medicare payment system; (f) the need for  
7 restoration of the RBRVS conversion factor to levels consistent with the statutory requirement for budget  
8 neutrality; (g) the inadequacy of payment for services of assistant surgeons; and (h) the loss of surgical-  
9 tray benefit for many outpatient procedures ( Reaffirmed by Rules & Credentials Cmt., A-96);

10  
11 (2) seek an evaluation of (a) stress factors (i.e., intensity values) as they affect the calculation of the  
12 Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments; and (b)  
13 descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment  
14 levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the  
15 elderly and often infirm patients;

16  
17 (3) evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment  
18 Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a  
19 resource-based relative value system;

20  
21 (4) seek to assure that all modifiers, including global descriptors, are well publicized and include adequate  
22 descriptors;

23  
24 (5) seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically  
25 with preoperative office visits, concomitant office procedures, and/or future procedures;

26  
27 (6) seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992;

28  
29 (7) seek the elimination of regulations directing patients to points of service;

30  
31 (8) support further study of refinements in the practice cost component of the RBRVS to ensure better  
32 reflection of both absolute and relative costs associated with individual services, physician practices, and  
33 medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely  
34 to be associated with any policy change;

35  
36 (9) take steps to assure that relative value units in the Medicare payment schedule, such as nursing home  
37 visits, are adjusted to account for increased resources needed to deliver care and comply with federal and  
38 state regulatory programs that disproportionately affect these services and that the Medicare conversion  
39 factor be adjusted and updated to reflect these increased overall costs;

40  
41 (10) support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the  
42 Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy  
43 Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with  
44 CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect  
45 actual physician costs, including gross receipt taxes;

46  
47 (11) request that CMS refine relative values for particular services on the basis of valid and reliable data  
48 and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for  
49 assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC  
50 can provide credible recommendations;

1 (12) pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor  
2 updates of an index providing the best assurance of increases in the monetary conversion factor reflective  
3 of changes in physician practice costs, and to this end, to consider seriously the development of a  
4 "shadow" Medicare Economic Index;

5  
6 (13) continue to implement and refine the Payment Reform Education Project to provide member  
7 physicians with accurate and timely information on developments in Medicare physician payment reform;  
8 and  
9

10 (14) take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as  
11 needed to comply with ever-increasing federal and state regulatory requirements.  
12

13 **H-400.973 Limited Licensed Practitioners and RBRVS:** It is the policy of the AMA to advocate that  
14 Medicare expenditure data clearly differentiate between the services of fully licensed physicians and  
15 those of limited licensed practitioners and of other Part B services.  
16

17 **H-400.980 Behavioral Adjustments on Physician Payments:** It is the policy of the AMA to do  
18 whatever it deems necessary to make certain that the RBRVS fee schedule does not include behavioral  
19 adjustments.  
20

21 **H-400.988 Medicare Reimbursement, Geographical Differences:** The AMA reaffirms its policy that  
22 geographic variations under a Medicare payment schedule should reflect only valid and demonstrable  
23 differences in physician practice costs, especially liability premiums, with other non-geographic practice  
24 cost index (GPCI) -based adjustments as needed to remedy demonstrable access problems in specific  
25 geographic areas.  
26

27 **H-400.990 Refinement of Medicare Physician Payment System:** The AMA: (1) reaffirms its support  
28 for development and implementation of a Medicare indemnity payment schedule according to the policies  
29 established in Policy 400.991; (2) supports reasonable attempts to remedy geographic Medicare physician  
30 payment inequities that do not substantially interfere with the AMA's support for an RBRVS-based  
31 indemnity payment system; (3) supports continued efforts to ensure that implementation of an RBRVS-  
32 based Medicare payment schedule occurs upon the expansion, correction, and refinement of the  
33 Harvard RBRVS study and data as called for in Board Report AA (I-88), and upon AMA review and  
34 approval of the relevant proposed enabling legislation; and (4) continues to oppose any effort to link the  
35 acceptance of an RBRVS with any proposal that is counter to AMA policy, such as expenditure targets or  
36 mandatory assignment.  
37

38 **H-400.991 Guidelines for the Resource-Based Relative Value Scale:**

39 (1) The AMA reaffirms its current policy in support of adoption of a fair and equitable Medicare  
40 indemnity payment schedule under which physicians would determine their own fees and Medicare  
41 would establish its payments for physician services using: (a) an appropriate RVS based on the resource  
42 costs of providing physician services; (b) an appropriate monetary conversion factor; and (c) an  
43 appropriate set of conversion factor multipliers.  
44

45 (2) The AMA supports the position that the current Harvard RBRVS study and data, when sufficiently  
46 expanded, corrected and refined, would provide an acceptable basis for a Medicare indemnity payment  
47 system.  
48

49 (3) The AMA reaffirms its strong support for physicians' right to decide on a claim-by-claim basis  
50 whether or not to accept Medicare assignment and its opposition to elimination of balance billing  
51 (Reaffirmed: Sub. Res. 132, A-94).

1 (4) The AMA reaffirms its opposition to the continuation of the Medicare maximum allowable actual  
2 charge (MAAC) limits.

3 (5) The AMA promotes enhanced physician discussion of fees with patients as an explicit objective of a  
4 Medicare indemnity payment system.

5  
6 (6) The AMA supports expanding its activities in support of state and county medical society-initiated  
7 voluntary assignment programs for low-income Medicare beneficiaries.

8  
9 (7) The AMA reaffirms its current policy that payments under a Medicare indemnity payment system  
10 should reflect valid and demonstrable geographic differences in practice costs, including professional  
11 liability insurance premiums. In addition, as warranted and feasible, the costs of such premiums should be  
12 reflected in the payment system in a manner distinct from the treatment of other practice costs.

13  
14 (8) The AMA believes that payment localities should be determined based on principles of  
15 reasonableness, flexibility and common sense (e.g., localities could consist of a combination of regions,  
16 states, and metropolitan and nonmetropolitan areas within states) based on the availability of high quality  
17 data.

18  
19 (9) The AMA believes that, in addition to adjusting indemnity payments based on geographic practice  
20 cost differentials, a method of adjusting payments to effectively remedy demonstrable access problems in  
21 specific geographic areas should be developed and implemented.

22  
23 (10) Where specialty differentials exist, criteria for specialty designation should avoid sole dependence on  
24 rigid criteria, such as board certification or completion of residency training. Instead, a variety of general  
25 national criteria should be utilized, with carriers having sufficient flexibility to respond to local  
26 conditions. In addition to board certification or completion of a residency, such criteria could include, but  
27 not be limited to: (a) partial completion of a residency plus time in practice; (b) local peer recognition;  
28 and (c) carrier analysis of practice patterns. A provision should also be implemented to protect the  
29 patients of physicians who have practiced as specialists for a number of years.

30  
31 (11) The AMA strongly opposes any attempt to use the initial implementation or subsequent use of any  
32 new Medicare payment system to freeze or cut Medicare expenditures for physician services in order to  
33 produce federal budget savings.

34  
35 (12) The AMA believes that whatever process is selected to update the RVS and conversion factor, only  
36 the AMA has the resources, experience and umbrella structure necessary to represent the collective  
37 interests of medicine, and that it seek to do so with appropriate mechanisms for full participation from all  
38 of organized medicine, especially taking advantage of the unique contributions of national medical  
39 specialty societies.

40  
41 **Sources:**

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 410  
A-19

Subject: Laboratory Benefit Managers

Introduced by: Texas Society of Pathologists and Travis County Medical Society

Referred to: Reference Committee on Socioeconomics

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1 Whereas, Health insurance payers' use of laboratory benefit management has the potential to impinge  
2 upon the practice of medicine if not properly administered and structured; and  
3

4 Whereas, Laboratory benefit management programs used by health insurance payers should be based  
5 upon transparent, verifiable, and published medical and scientific evidence, and should not be influenced  
6 by improper financial conflicts of interests in the administration of such programs arising from the health  
7 insurance payer or program administrator; and  
8

9 Whereas, More than nine in 10 physicians (92 percent) say that prior authorization programs have a  
10 negative impact on patient clinical outcomes, according to a physician survey released in March 2018 by  
11 the American Medical Association; and  
12

13 Whereas, The Texas Medical Association currently has policy on pharmaceutical benefits management  
14 companies (180.031); however, no policy specifically addresses laboratory benefit management; and  
15

16 Whereas, The use of laboratory benefit management programs by health insurance payers should not  
17 adversely curtail physician medical judgment nor adversely impact patient diagnosis and treatment,  
18 especially for life-threatening medical conditions; and  
19

20 Whereas, Ordering physician referrals to in-network laboratories should not be dictated nor constrained  
21 by laboratory benefit management; and  
22

23 Whereas, No adverse claims impact should accrue to any laboratory or physician who performs a  
24 pathology or laboratory service pursuant to a lawful order for such services by a health care professional;  
25 therefore be it  
26

27 RESOLVED, That the Texas Medical Association support efforts to reduce laboratory benefit  
28 management policies that result in delays in patient care, reduced patient access, or increased patient costs  
29 without clinical justification; and be it further  
30

31 RESOLVED, That TMA support any policies regarding laboratory benefit management arrangements that  
32 preclude any potential conflict of interest in programs adopted by health insurance payers to provide  
33 laboratory benefit management, including prohibition on the use of any laboratory benefit management  
34 entity financially affiliated with a clinical laboratory.  
35

36 **Related TMA Policy:**

37 **180.031 Pharmacy Benefit Managers:** The Texas Medical Association will (1) gather evidence of  
38 the administrative burden placed on physicians and patients by the policies and operating practices of

1 Pharmacy Benefit Managers (PBMs) in order to document the impact on medical practices and  
2 determine whether the business practices of PBMs comply with state laws and regulations; (2)  
3 explore the possibility of legislative action should no state laws or regulations apply to the  
4 preauthorization process required by PBMs; and (3) promote cooperation by Texas pharmacists to  
5 provide physicians with up-to-date information about prescriptive drugs covered by pharmacy benefit  
6 managers and appropriate alternative medications in pharmacy benefit managers' formularies  
7 (Amended Res. 401-A-06; reaffirmed CSE Rep. 6-A-16).

8  
9 **Related AMA Policy:**

10 **H-260.962 Laboratory Benefit Managers:** Our AMA will: (1) support efforts to reduce laboratory  
11 benefit management policies that result in delays in patient care, reduced patient access, or increased  
12 patient costs without clinical justification; and (2) support... that any policies regarding laboratory benefit  
13 management arrangements preclude any potential conflict of interest in programs adopted by health  
14 insurance payors to provide laboratory benefit management, including prohibition on the use of any  
15 laboratory benefit management...

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 411  
A-19

Subject: Data Migration Responsibilities of Electronic Health Record Vendors in Client  
Contract Termination

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

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- 1 Whereas, 22.Tex.Admin Code §165.1 confers medical record ownership to a physician’s employer, including  
2 group practices, professional associations, and nonprofit health organizations, but does not delegate a  
3 physician’s ownership of data as it applies to electronic health record (EHR) vendors; and  
4
- 5 Whereas, the Texas Medical Association supports efforts to hold health information technology (HIT)  
6 vendors accountable for developing processes, systems, and customer support that are responsive to patient  
7 safety concerns and proactively work to prevent and resolve patient safety concerns, but does not specify an  
8 EHR vendor’s role upon contract termination; and  
9
- 10 Whereas, The Health Insurance Portability and Accountability Act of 1996 (HIPAA) specifies that business  
11 associates, including EHR vendors, must return or destroy patient health information upon termination of  
12 their agreement, but does not specify timeliness, transfer format, or the longevity of data access granted to a  
13 physician; and  
14
- 15 Whereas, Physician dissatisfaction with EHRs is at an all-time high, and many physicians are looking to  
16 change systems; and  
17
- 18 Whereas, EHR vendors are consolidating through acquisitions and mergers, and vendors are going out of  
19 business, resulting in physician practices and health care systems seeking to replace their EHRs; and  
20
- 21 Whereas, The transition between EHR systems already may lead to unintended negative patient safety  
22 consequences and pose important safety threats, particularly in early post-transition; and  
23
- 24 Whereas, Incomplete or barred physician access to patient records poses a threat to patient safety and  
25 continuity of care; and  
26
- 27 Whereas, EHR vendor contract terms may not specify EHR data rights and may limit a physician’s ability to  
28 migrate data easily and inexpensively to a new EHR system in the event of a future transition; and  
29
- 30 Whereas, Migrating data between different EHR systems is often incompatible, rendering an incomplete  
31 transfer of data between EHRs, compromising data integrity migration and patient safety; and  
32
- 33 Whereas, 83 percent of individuals went to a health care professional at least once in the past year, with 32  
34 percent reporting they experienced a gap in information exchange, had to redo a test or procedure because  
35 their prior data was unavailable, or had to provide medical history again because their chart could not be  
36 found; and

1 Whereas, Access to the old EHR is often revoked or granted for a limited time following termination, and an  
2 EHR company may not migrate patient data (progress notes, consults, radiology reports, laboratory results) in  
3 a timely manner or in a format that is useful to a physician or at all; therefore be it  
4

5 RESOLVED, That the Texas Medical Association support policy that electronic health record (EHR) vendors  
6 assist in completing a data transfer and that all data be given to the physician in an industry-recognized,  
7 nonproprietary format immediately upon termination of the contract or when the EHR vendor goes out of  
8 business; and be it further  
9

10 RESOLVED, That our TMA seek legislative and/or regulatory relief to require that physicians have access to  
11 their former EHR data while transitioning EHRs to ensure continuity of patient care, limit gaps in information  
12 exchange, and ensure physician ownership of data.  
13

14 **Related TMA Policy:**

15 **118.004 Health Information Technology – Health Information Exchange:**  
16

- 17 1. Patient safety, privacy, and quality of care are the guiding principles of all HIE efforts; cost reduction  
18 and efficiency are expected byproducts.
- 19 2. TMA is a professional organization for physicians and as such recognizes that some parts of patients’  
20 medical records should be considered the intellectual property of the physician. HIE efforts should  
21 recognize that the physician’s work product has value for which he or she, along with the patient, has  
22 intrinsic ownership, and therefore both should control its use. Patient records are the documentation  
23 of interactions between physicians and patients. Patient privacy protections that traditionally exist in  
24 the patient-physician relationship continue to apply where HIT is used. Physicians must uphold their  
25 responsibility to protect and secure all information related to the sacred patient-physician relationship.
- 26 3. Patients have the right to withhold information. Physicians may provide a notice to users that the  
27 record is incomplete when a patient withholds information.
- 28 4. Patient privacy and confidentiality shall be maintained in all HIE efforts by using secure systems and  
29 transmission methods.
- 30 5. Patients must have complete control over all uses of individually identified medical data. Except for  
31 emergencies, or otherwise as required by law, their medical data must not be disclosed or  
32 disseminated to third parties without patient consent.
- 33 6. Open standards for the interoperable electronic transmission of clinical data should be mutually  
34 acceptable to the medical community and compatible with national and regional standards.  
35

36 Foundational Principles for HIE Participation

- 37 7. Participation in HIE, beyond that required by law or in emergencies, should be determined at the local  
38 level. Regardless, participants should be able to withdraw upon reasonable notice.
- 39 8. HIE should strive to provide, at the point of care as part of the physician’s workflow, complete,  
40 timely, and relevant patient-focused information in a fully enabled electronic information  
41 environment designed to engage patients, transform care delivery, and improve population health.  
42 Patients and physicians will have confidence that personal health information is reliable; private;  
43 secure; and used with patient consent in appropriate, beneficial ways for patient and public good.
- 44 9. Any costs of supporting systems should be borne by all stakeholders, clearly defined, fair, simple to  
45 understand, and accountable, and should support the financial viability of the considered practice.
- 46 10. To ensure HIE activity remains focused on the patient interest, HIE governance should be  
47 representative of and responsive to the needs and concerns of stakeholders, with particular attention to  
48 the concerns of physicians and patients.
- 49 11. To protect the interest of patients, an HIE provider or entity must define whether and how it will share  
50 information for public health research, and surveillance and evaluation of health care quality. When

1 participants choose to allow these uses, patient information must be deidentified unless informed  
2 consent has been obtained and can be documented.

- 3 12. An HIE provider or entity must be designed and function to enable and enhance coordinated  
4 collaboration for improving health and patient safety. Participants should give consideration to special  
5 populations who are otherwise incapable of representing themselves (e.g., children; the aged; people  
6 who are disabled, uninsured, or homeless).
- 7 13. The patient's Social Security number should not be used as the de facto unique patient identifier.
- 8 14. Patient data should be transmitted over a secure network, with provisions for authentication and  
9 encryption in accordance with HIPAA and other appropriate guidelines. Standard email services do  
10 not meet these guidelines. HIE participants need to be aware of potential security risks, including  
11 unauthorized physical access and security of computer hardware, and guard against them with  
12 technologies such as automatic logout and password protection.
- 13 15. HIE operations will not modify original patient data in any way.
- 14 16. The HIE entity or provider must have a means to audit, track, and use reasonable efforts to ensure the  
15 integrity of all entities or individuals engaged in receiving and converting transaction data.
- 16 17. Dissemination of information identifiable with a specific patient is permissible only when the patient  
17 provides express permission to do so.
- 18 18. The HIE entity or provider should maintain and enforce strict conflict of interest policies that require  
19 members to disclose all possible conflicts of interest, to recuse themselves from deliberations on  
20 matters in which they have a conflict of interest, and to abstain from voting on such matters. The HIE  
21 must further maintain financial transparency in its operations, acknowledging all material sources and  
22 uses of funds.
- 23 19. State support for HIE is important. However, state government's primary role should be to foster  
24 coordination of HIE efforts, including providing access to funding or other financial incentives that  
25 promote the adoption of health information technologies. TMA opposes a governmental entity  
26 owning or primarily controlling an HIE entity or provider.
- 27 20. TMA physicians should cooperate with nongovernmental entities developing HIE solutions with  
28 minimal mandates, but only where it leads to physicians' stewardship of the data they produce, and  
29 patients' control over data that may identify them.
- 30 21. TMA supports national health information standards such as Nationwide Health Information  
31 Network, HL7, Continuity of Care Record (CCR)/Continuity of Care Document (CCD), and other  
32 standards adopted by the Centers for Medicare & Medicaid Services. In addition to the CCR/CCD  
33 contents, HIE participants' data also should include labs, radiology results (text), history and physical,  
34 discharge summaries, and progress and other notes.
- 35 22. TMA supports HIE participation of the U.S. Department of Veterans Affairs, U.S. Department of  
36 Defense, the uninsured, and other populations that may have medical records inadequately integrated  
37 into the health care system.
- 38 23. TMA supports a legislative safe harbor that limits a physician's liability exposure if patient data  
39 provided to an HIE by the physician are breached due to the actions or inactions of the HIE, another  
40 HIE participant, or any other person. Each participating individual or entity should be responsible  
41 only for their own actions or inactions as these relate to a possible breach of protected health  
42 information provided to an HIE.

#### 43 44 Data Warehouses — Principles for the Collection, Use, and Warehousing of EHRs and Claims Data

45 TMA supports policy that any payer, clearinghouse, vendor, or other entity that collects, warehouses, and uses  
46 EHRs and claims data adhere to the following principles. For purposes of this policy, the compilation of  
47 electronic records in a physician's office does not constitute a data warehouse.

- 48 1. EHRs and claims data transmitted for any purpose to a third party must contain the minimum  
49 necessary needed to accomplish the intended purpose. TMA supports the development of simple and  
50 efficient tools to facilitate extraction and submission of such data sets.

- 1           2. The physician and his or her patients must be informed of and provide permission for third-party
- 2           analyses undertaken with the physician's EHR and claims data, including the data being studied and
- 3           how the results will be used.
- 4           3. The physician must be compensated by the requesting entity for any additional work required to
- 5           collect data.
- 6           4. Criteria developed for the analysis of physician claims or medical record data must be open for
- 7           review and input.
- 8           5. Methods and criteria for analyzing the EHR and claims data must be provided to the physician or an
- 9           independent third party so that reanalysis of the data can be performed.
- 10          6. An appeals process must be in place for a physician to appeal, prior to public release, any adverse
- 11          decision derived from an analysis of his or her EHR and claims data.
- 12          7. Clinical data collected by a data exchange network and searchable by a record locator service must be
- 13          accessible only for payment and health care processes.
- 14          8. The warehouse vendor must take the necessary steps to ensure the confidentiality and integrity of
- 15          patient records and claims data.
- 16          9. Organizations that store, transmit, or use patient records or claims data must have internal policies
- 17          and procedures in place that adequately protect the integrity, security, and confidentiality of such
- 18          data.
- 19          10. EHR data must remain accessible to authorized users for purposes of treatment, public health, patient
- 20          safety, quality improvement, medical liability defense, and research.
- 21          11. Following the request from a physician to transfer his or her data to another data warehouse, the
- 22          current warehouse vendor must transfer the EHR and claims data and must delete or destroy the data
- 23          from its data warehouse once the transfer has been completed and confirmed, at the request of the
- 24          physician or patient. (Previously 265.029; CPMS; Rep. 2-A-18).
- 25

26 **118.002 Health Information Technology – Electronic Health Records and Personal Health Records:**

27 **Health Information Technology – Electronic Health Records and Personal Health Records:** The Texas  
28 Medical Association supports voluntary universal adoption of health information technology (HIT) that  
29 supports physician workflow, increases practice efficiency, is safe for patients, and enhances quality of care.  
30 TMA believes HIT vendors should adhere to these principles.

31  
32 Electronic Health Record Adoption

33  
34 The Texas Medical Association:

- 35           1. Supports legislation and other appropriate initiatives that provide positive incentives for physicians to
- 36           acquire and maintain health information technology.
- 37           2. Supports the ability of the physician and patients to change HIT programs or vendors with minimal
- 38           workflow and financial impact. Systems must have interoperability that allows movement of data
- 39           between databases without the need for data conversion to ensure compatibility among all HIT
- 40           systems.
- 41           3. Supports appropriate financial, operational, and technical assistance from an inpatient facility and
- 42           other entities for physicians who need help converting to and maintaining electronic health records
- 43           (EHRs) when it does not unreasonably constrain the physician's choice of which ambulatory EHR
- 44           systems to purchase.
- 45           4. Promotes voluntary rather than mandatory sharing of protected health information (PHI) consistent
- 46           with the patient's wishes, as well as applicable legal, ethical, and public good considerations.
- 47           5. Supports the use of clinical checklists contained in EHRs to increase patient safety and decrease
- 48           errors of omission. These checklists should allow for data entry by any member of the care team
- 49           under the physician's supervision, and be developed with appropriate quality guidelines as endorsed
- 50           by nationally recognized medical specialty societies and quality improvement organizations.

6. TMA, where possible, will provide its members with up-to-date, accurate information enabling them to select HIT that improves the quality of their patients' care, interoperates seamlessly with other automated clinical information sources, and enhances the efficiency and viability of their practices.

#### Personal Health Records

1. TMA supports the use of personal health records (PHRs) by individuals and families.
2. TMA supports the concept that patients should be able to use their PHR as a source of information regarding their medical status.
3. PHRs need standardized formats that contain at minimum core medical information necessary to treat the patient.
4. TMA supports legislative efforts directed at providing incentives to facilitate PHR use and maintenance.
5. Physicians should be able to access PHR-released information free of charge.
6. TMA supports interoperability of PHRs allowing access to patient health information in patient care settings.
7. TMA supports ensuring that the source of information in PHRs is clearly identifiable.

#### Access to Cost of Treatment Information

1. Physicians should have simple and efficient access to cost information associated with potential treatments ordered.
2. Physicians should have simple and efficient access to costs of treatments ordered that the patient will pay.

#### Patient Safety, Risk Management, and Liability

1. Physicians' current standards of practice should not be compromised by their use of EHRs. There is a degree of precision with EHRs that does not exist with the use of paper records. Physicians should not be held liable for innocent inconsistencies that occur within the EHR environment, for example a computer stamp versus a manual time entry by the physician.
2. TMA supports efforts to hold HIT vendors accountable for developing processes, systems, and customer support that are responsive to patient safety concerns and proactively work to prevent and resolve patient safety concerns.
3. TMA supports the development of a national "no fault" reporting system for errors and near-misses that occur through the use of EHRs to prevent unintended consequences.
4. TMA supports the development and application of performance standards that are cognizant of the burden of data collection, particularly in the aggregation of multiple quality measures.
5. TMA supports the study and evaluation of the potential impact that physician efforts directed towards compliance with unduly burdensome state and federal regulation may have on patient care. These new compliance burdens compete for the physician's attended and limited resources and may distract the physician from patient care (Previously **265.012**; Amended Res. 402-A-05; amended CPMS Rep. 3-A-07; substituted CPMS Rep. 2-A-10; amended CPMS Rep. 2-A-13; amended CPMS Rep. 1-A-14; amended CPMS Rep. 2-A-18).

#### **Related AMA Policy:**

- D-478.973 Principles for Hospital Sponsored Electronic Health Records:**
1. Our AMA will promote electronic health record (EHR) interoperability, data portability, and health IT data exchange testing as a priority of the Office of the National Coordinator for Health Information Technology (ONC).
  2. Our AMA will work with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production.

1 3. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) and ONC to identify  
2 barriers and potential solutions to data blocking to allow hospitals and physicians greater choice when  
3 purchasing, donating, subsidizing, or migrating to new EHRs.

4 4. Our AMA will advocate that sponsoring institutions providing EHRs to physician practices provide data  
5 access and portability to affected physicians if they withdraw support of EHR sponsorship.  
6

7 **D-478.996 Information Technology Standards and Costs:** 1. Our AMA will: (a) encourage the setting of  
8 standards for health care information technology whereby the different products will be interoperable and able  
9 to retrieve and share data for the identified important functions while allowing the software companies to  
10 develop competitive systems; (b) work with Congress and insurance companies to appropriately align  
11 incentives as part of the development of a National Health Information Infrastructure (NHII), so that the  
12 financial burden on physicians is not disproportionate when they implement these technologies in their  
13 offices; (c) review the following issues when participating in or commenting on initiatives to create a NHII:  
14 (i) cost to physicians at the office-based level; (ii) security of electronic records; and (iii) the standardization  
15 of electronic systems; (d) continue to advocate for and support initiatives that minimize the financial burden  
16 to physician practices of adopting and maintaining electronic medical records; and (e) continue its active  
17 involvement in efforts to define and promote standards that will facilitate the interoperability of health  
18 information technology systems.  
19

20 2. Our AMA advocates that physicians: (a) are offered flexibility related to the adoption and use of new  
21 certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR  
22 products that meet the specified certification standards; and (b) not be financially penalized for certified EHR  
23 technology not meeting current standards.  
24

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 412  
A-19

Subject: Medical Necessity Tax Exemption for Feminine Hygiene Products

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

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1 Whereas, The American Medical Association considers feminine hygiene products, such as sanitary napkins  
2 and tampons, to be medical necessities; and  
3

4 Whereas, The American Medical Association’s current Policy H-270.953 Tax Exemptions for Feminine  
5 Hygiene Products states “Our AMA supports legislation to remove all sales tax on feminine hygiene  
6 products”; and  
7

8 Whereas, The Texas Tax Code provides sales tax exemptions for over-the-counter drugs and medications,  
9 including cold remedies, antiperspirants, sunscreens, and wound care products, products that are considered to  
10 be medical necessities; and  
11

12 Whereas, 64 percent of women with limited resources have difficulty affording feminine hygiene products  
13 due to prioritization of other basic necessities, and many women make do without proper hygiene products by  
14 using toilet paper, tissues, or rags; and  
15

16 Whereas, Poor feminine hygiene management has been associated with reproductive tract infections, social  
17 restriction, and school absenteeism; and  
18

19 Whereas, The Texas Medical Association supports the removal of the state sales tax on diapers, as they are  
20 recognized as basic and essential health care necessities; therefore be it  
21

22 RESOLVED, That Texas Medical Association recognize feminine hygiene products as basic and essential  
23 health care necessities; and be it further  
24

25 RESOLVED, That TMA support the removal of the Texas sales tax on feminine hygiene products.  
26

27 **Related TMA Policy:**

28 **260.108 Addressing the Diaper Gap:** The Texas Medical Association encourages physicians to screen for  
29 social and economic risk factors in order to support care plans and to direct patients to appropriate local social  
30 support resources. TMA will provide information to members on community resources related to free and  
31 low-cost diapers and other basic material needs. TMA recognizes diapers, especially for adults, are a basic  
32 and essential health care necessity that helps to mitigate disease and illness and enables many to remain at  
33 home, and supports efforts to remove the state sales tax applied to diapers (CSPH Rep. 2-A-18). .  
34

35 **Related AMA Policy:**

36 **H-525.974 Considering Feminine Hygiene Products as Medical Necessities:** Our AMA will: (1) encourage  
37 the Internal Revenue Service to classify feminine hygiene products as medical necessities; and (2) work with  
38 federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene

1 products in state and local prisons and correctional institutions to ensure incarcerated women be provided free  
2 of charge, the appropriate type and quantity of feminine hygiene products including tampons for their needs.

3  
4 **H-270.953 Tax Exemptions for Feminine Hygiene Products:** Our AMA supports legislation to remove all  
5 sales tax on feminine hygiene products.

6  
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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 413  
A-19

Subject: The Benefits of Importation of International Pharmaceutical Medications

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

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- 1 Whereas, The cost of basic prescription drugs in the United States is among the highest in the world due to  
2 market exclusivity and a lack of payer negotiating power; and  
3
- 4 Whereas, These prescription drug prices impose a substantial financial burden on consumers and represent a  
5 significant cause of nonadherence, resulting in worsened health outcomes; and  
6
- 7 Whereas, Millions of Americans already obtain their prescription drugs from international markets through  
8 extralegal means; and  
9
- 10 Whereas, 72 percent of Americans believe prescription drug costs are unreasonable, and 74 percent believe  
11 they pay higher prices for prescription drugs than citizens of other countries; and  
12
- 13 Whereas, 72 percent of Americans favor allowing the legal importation of prescription drugs from Canada;  
14 and  
15
- 16 Whereas, There is bipartisan support for a prescription drug importation program as evidenced by the  
17 proposal of a federal bill by Sen. Amy Klobuchar (D-MN) and Sen. Chuck Grassley (R-IN) in 2019, proposed  
18 federal laws by Sen. Bernie Sanders (I-VT) in 2015 and 2017, and a proposed federal law by the late Sen.  
19 John McCain (R-AZ) in 2015; and  
20
- 21 Whereas, The Trump Administration is looking into expanding the scope of legal prescription drug  
22 importation; and  
23
- 24 Whereas, Utah lawmakers are currently proposing a law that would allow the wholesale purchase of  
25 prescription drugs from Canada for use in their state Medicaid program; and  
26
- 27 Whereas, The State of Vermont passed a law in 2018 developing a wholesale importation program for  
28 prescription drugs that complies with 21 U.S.C. § 384 [11] and Section 804 of the Federal Food, Drug, and  
29 Cosmetic Act; and  
30
- 31 Whereas, The State of Maine passed a law (later deemed noncompliant with federal law) allowing its  
32 residents to import prescription drugs from licensed pharmacies in several developed countries; and  
33
- 34 Whereas, The Texas Board of Pharmacy has attempted (but failed due to noncompliance with federal law) in  
35 the past to make a list of reputable Canadian pharmacies that can import prescription drugs into Texas; and  
36
- 37 Whereas, In spite of past legal challenges, continued action on the part of states may place pressure on the  
38 federal government to relax enforcement of federal laws or eventually even change its policy; and

1 Whereas, The framework for a national prescription drug importation program already has been developed in  
2 the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and is only pending approval  
3 by the Secretary of Health and Human Services before being enacted as official policy; and

4  
5 Whereas, The Food and Drug Administration (FDA) has, in the past, allowed for the legal importation of  
6 prescription drugs in emergency situations; and

7  
8 Whereas, The FDA already permits the legal importation of Canadian medications under defined  
9 circumstances, suggesting passage of this resolution does not constitute a radical change, but rather an  
10 expansion of existing policy; and

11  
12 Whereas, A significant share of prescription drugs are considerably more affordable in Canada; and

13  
14 Whereas, One study commissioned by the State of Vermont found that their recently enacted bill allowing for  
15 importation of prescription drugs from Canada could save payers anywhere from \$1 million to \$5 million per  
16 year on reduced prices; and

17  
18 Whereas, The State of Utah established that a similar program would save \$70 million in the private sector  
19 and another \$20 million in state-funded insurance programs; and

20  
21 Whereas, Many off-patent prescription drugs that are at risk of sudden price increases or shortages in the  
22 United States are available in international markets, thereby increasing the potential for price competition; and

23  
24 Whereas, Health Canada, Canada's FDA counterpart, follows rigorous safety standards quite similar to those  
25 in the United States; and

26  
27 Whereas, Continued efforts on the parts of individual states to establish prescription drug importation  
28 programs may place sufficient market pressure on pharmaceutical companies to make domestic medication  
29 prices more competitive with those in international markets; and

30  
31 Whereas, The Texas Medical Association supports programs whose purpose is to contain the rising costs of  
32 prescription drugs; and

33  
34 Whereas, TMA emphasizes health system reform with cost control reform measures that protect Medicare  
35 quality and freedom of access; therefore be it

36  
37 RESOLVED, That the Texas Medical Association study the positive and negative effects of potential  
38 programs for Texans to obtain safe, cost-effective prescription drugs from outside the United States; and be it  
39 further

40  
41 RESOLVED, That the Texas Delegation to the American Medical Association ask the AMA to study current  
42 state and federal laws and regulations regarding obtaining prescription drugs from outside the United States;  
43 and be it further

44  
45 RESOLVED, That the Texas Delegation to the AMA ask the AMA to study the implications of a prescription  
46 drug importation program that allows for patient purchase or wholesale purchase by the state Medicaid  
47 agency given that it (1) poses no additional risk to the public's health and safety, and (2) results in a  
48 significant reduction in the cost of covered products, as pursuant to Section 804 of the Federal Food, Drug,  
49 and Cosmetic Act.

1 **Related TMA Policy:**

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

18  
19 **190.023 Policy Principles for Medicaid and CHIP Legislative Initiatives:** Policy Principles for Medicaid  
20 and CHIP Legislative Initiatives: The Texas Medical Association supports the following policy principles to  
21 guide the evaluation of Medicaid and CHIP budget and legislative initiatives and association advocacy  
22 efforts:

23  
24 A. Ensure patient access to timely, medically necessary primary and specialty health care services. Physician  
25 participation in Medicaid is perilously low in many parts of the state. Statewide, fewer than 50 percent of  
26 Texas physicians participate in the program, with the number steadily dropping. While the most severe  
27 shortages are among subspecialists, particularly those who treat children, access to primary care physicians  
28 also is declining.

29  
30 Physicians are the backbone of a cost-effective system. Without them, the state's efforts to increase preventive  
31 care, improve treatment for the chronically ill, and reduce inappropriate emergency room utilization will  
32 falter. Competitive reimbursement is a critical component of building an adequate and stable primary and  
33 specialty physician network.

34  
35 **Legislative Strategies:**

36 Promote use of a "medical home" for all patients to coordinate and manage preventive, primary, specialty, and  
37 ancillary services and to assure more cost-effective use of resources.

38  
39 Advocate enactment of competitive Medicaid and CHIP reimbursement rates. Medicaid rates average 70  
40 percent of Medicare and 50 percent of commercial, failing to cover the costs of providing services. As  
41 practice overhead costs rise and payment from other payers stagnates or declines, physicians must make the  
42 difficult economic decision to leave Medicaid.

43  
44 B. Promote cost-effective, proactive, and appropriate use of medical services. Long-term health care cost  
45 savings are predicated not only on encouraging appropriate utilization of health care services but also on  
46 preventing the need for those services in the first place. Texas should proactively promote preventive health  
47 services within Medicaid as well as early identification and intervention for patients at risk for - or who  
48 already have developed - a chronic illness. Additionally, Texas must expand opportunities to educate patients  
49 about appropriate use of the health care delivery system, preventive care, and basic self-care.

1 Legislative Strategies:

2 Advocate use of health risk assessment for at-risk patients.

3  
4 Support legislative initiatives to educate patients of all ages, but particularly children, about healthy lifestyles,  
5 including exercise and nutrition.

6  
7 Advocate enactment of initiatives that educate parents about basic self-care techniques and prevention.

8  
9 Promote use of standardized and centralized "ask a nurse" programs as a means to reduce inappropriate  
10 emergency room utilization by Medicaid and CHIP patients.

11  
12 C. Simplify Medicaid regulatory requirements and streamline the delivery system. The complexity of the  
13 Medicaid program is a key factor in deterring physician participation. The proliferation of multiple Medicaid  
14 managed care plans and models, for example, split a straightforward delivery system into many components,  
15 each with distinct administrative, eligibility, and payment requirements. To make the program more attractive  
16 to physicians, Texas should consider options to streamline the Medicaid delivery and payment systems.  
17 Efforts also should be made to reduce unnecessary paperwork and their attendant costs.

18  
19 For patients, the program also is fraught with administrative burdens, including navigating the same complex  
20 delivery system physicians contend with. Simplifying the eligibility process is a key component of all the  
21 other principles because it encourages patients to seek cost-effective treatment and preventive care from their  
22 medical home.

23  
24 Legislative Strategies:

25 Maintain children's Medicaid simplification and extend those reforms, when feasible, to other populations.

26  
27 Pursue Internet-based or "smart card" technologies that integrate eligibility, claims submission, and health and  
28 human service programs under one platform.

29  
30 Promote use of community-based HMOs and physician-led accountable care organizations and other  
31 emerging innovative models within the Medicaid delivery system, including patient-centered medical homes.

32  
33 D. Promote and improve health care quality. The foundation of an efficient, effective delivery system is high  
34 quality care. Yet measuring quality is notoriously difficult. Texas should work collaboratively with physicians  
35 and health care providers to devise realistic, clinically driven ways to measure and improve quality across the  
36 spectrum of care.

37  
38 Legislative Strategies:

39 Advocate Medicaid HMO use of incentive payments for physicians who achieve predetermined, physician-  
40 driven performance standards, such as immunization rates, disease management participation, and well-child  
41 exams.

42  
43 Support "e-medicine" efforts that enhance patient care, physician-to-patient and physician-to-physician  
44 communications, and outreach. E-medicine must be appropriately compensated.

45 Reward prevention and wellness promotion as well as innovative treatment and delivery alternatives, such as  
46 physician and clinic support of health education, after-hours services, or participation in disease management.

47  
48 Explore opportunities to incorporate enriched health care education into school curricula (e.g., education that  
49 focuses on prevention, nutrition, fitness, and immunizations).

1 Develop protocols for appropriate transfer of patients from the nursing home to hospitals and from state  
2 schools to hospitals. Physicians indicate a common occurrence is transportation of a nursing home or state  
3 school patient to an emergency department for routine care that could be treated safely and effectively within  
4 the nursing home/school.

5  
6 E. Assure accountability among all elements of the Medicaid system. Each component of the Medicaid  
7 program - patients, physicians, providers, community, and government - has a shared responsibility toward  
8 making Medicaid successful. Medicaid policies should articulate, promote, and reward, when met, those  
9 responsibilities. For example, physicians have an obligation to practice high quality, evidenced-based  
10 medicine as well as to promote preventive care. Patients should help with treatment decision-making, comply  
11 with treatment protocols, and begin to assume a nominal share of the cost of care; communities should  
12 recognize their unique role in educating patients about the health care system and how to use it.

13  
14 Legislative Strategies:

15 Promote the purchase/underwriting of long-term care insurance to defray state costs of nursing home  
16 coverage.

17  
18 Advocate federal reform to allow implementation of fair, nominal, sliding-scale cost sharing (similar to the  
19 CHIP model) for Medicaid patients. Cost sharing must be easy for the state and health care providers to  
20 administer.

21  
22 Advocate simplification of the Medicaid Preferred Drug List, including an open, accessible process for  
23 classifying drugs as preferred or nonpreferred:

24  
25 Require use of generic drugs when available; all generics would be available without prior authorization  
26 unless there is a safety concern.

27  
28 For brand name drugs, continue use of the supplemental rebate process, but apply it only to drugs whose  
29 properties are available in more than one product (e.g., Lantus is the only long-acting insulin, but it requires  
30 prior authorization because the manufacturer refused to provide a rebate. Under this proposal, Lantus would  
31 remain available. If another brand or generic became available with the same properties, then HHSC could  
32 seek a supplemental rebate process so long as at least one drug with the needed properties remained available  
33 without prior authorization).

34  
35 Promote publication of the relative price of Medicaid and CHIP drugs so that physicians are aware of the  
36 costs of prescribed drugs.

37  
38 Promote physician "counter detailing" to encourage evidence-based prescribing of prescription drugs and  
39 long-term changes in physician prescribing behavior.

40  
41 Require the HHSC Pharmaceutical and Therapeutics (P&T) Committee to conduct clinical and safety  
42 discussions in public to assure that stakeholders understand rationale for classifying a drug as preferred or  
43 nonpreferred.

44 Establish a formal appeal mechanism when drugs are not approved based on quality.

45  
46 Require the P&T Committee to establish liaisons to specialty physician organizations to assure broader  
47 clinical input regarding drugs on the Preferred Drug List.

1 Require the Drug Utilization Review Board membership include a mix of physicians to represent the diverse  
2 Medicaid population, including pediatricians, obstetricians, primary care physicians and pediatric and adult  
3 psychiatrists.

4  
5 Require HHSC to clearly specify which preferred prescription drugs on the Preferred Drug List are subject to  
6 additional clinical edits. Such information should be easily searchable on the VDP website, Epocrates, and the  
7 Medicaid HMO pharmacy benefit manager websites.

8  
9 Require HHSC to provide timely notice of proposed clinical edits and to solicit input from appropriate  
10 physician specialties on the criteria. HHSC should provide the rationale for the proposed clinical edit, the  
11 potential cost-savings, if any, and the name of the entity that proposed the change.

12  
13 Require Medicaid HMOs to adhere to prompt payment provisions, except where the statute conflicts with  
14 federal law, and assure that any standardized contracting legislation applies to Medicaid and CHIP plans.

15  
16 Educate physicians and patients about how to report actual fraud and abuse within Medicaid and CHIP, while  
17 educating policymakers that clerical and billing errors are not tantamount to fraud.

18  
19 Require fraud and abuse reports prepared by the Medicaid Office of Inspector General, comptroller, and other  
20 oversight agencies to distinguish within their reporting statistics relating to inadvertent coding and billing  
21 errors and those relating to actual fraud. State payment recoveries stemming from billing errors are not the  
22 same as those resulting from fraud.

23  
24 F. Maximize use of all available funding streams. Texas should continue to identify options for accessing and  
25 maximizing federal Medicaid funds. Texas also should explore mechanisms to use county indigent health care  
26 dollars to attract additional Medicaid funds that could be used to subsidize coverage for uninsured patients.  
27 Local governments spend substantial tax dollars on health care for uninsured or underinsured patients.  
28 Matching these funds potentially could provide Texas additional dollars to fund innovative partnerships that  
29 reduce the number of uninsured patients.

30  
31 Legislative Strategy:

32 Support restoration of Medicaid and CHIP services reduced or eliminated during the 78th legislative session,  
33 including, but not limited to, full restoration of:

34  
35 Medicaid graduate medical education;

36  
37 Funding for public mental health services, particularly for children;

38  
39 Adult Medically Needy Program;

40  
41 Advocate enactment of federal waivers that allow Texas to draw down additional federal matching funds.

42  
43 G. Recognize the necessity of an adequate, diverse physician and allied health professional workforce. An  
44 adequate, diverse medical workforce is critical to the efficient functioning not only of Medicaid but also of all  
45 public and private health care systems in Texas. Medicaid is critical to the workforce debate for two reasons:  
46 (1) the program historically has offered significant funding to train future physicians by providing funding for  
47 graduate medical education, and (2) Medicaid patients account for the bulk of the workload in medical  
48 schools, residency programs, and community clinics where medical students and residents receive valuable,  
49 real-world training. Ignoring the growing indications of physician and allied health professional shortages will  
50 be at the peril of the entire Texas health care delivery system.

1 Legislative Strategy:

2 Actively promote restoration of funding for Medicaid graduate medical education and physician residency  
3 programs.

4  
5 H. Encourage innovative partnerships between the public and private sectors to address shared health goals.  
6 Government and the private sector each play an important role in the financing, regulation, organization, and  
7 innovation of health care. Too often, however, those spheres of influence remain separate, failing to recognize  
8 the relative strengths of each. Texas should explore ways to integrate public and private health insurance  
9 initiatives to address the mutual concerns of improving quality care and patient safety, reducing the number of  
10 uninsured, and promoting prevention and wellness.

11  
12 A good example of private-public partnerships is TMA-supported legislation passed last year that encourages  
13 blending Medicaid funds with employer subsidies to purchase affordable health insurance for uninsured  
14 workers. Texas should consider expanding these initiatives and exploring other innovative options.

15  
16 I. Recognize the diversity of the Medicaid population and devise strategies to address the unique health care  
17 needs and costs of each. Medicaid often is evaluated and discussed as one, monolithic system. In fact, it is  
18 many. Medicare serves primarily an adult, aged population; private health plans serve primarily healthy,  
19 working adults. Medicaid, however, insures a range of populations with vastly different needs (children,  
20 individuals with disabilities, the elderly) and in vastly different settings (acute vs. long-term care, community  
21 vs. institutions). Medicaid reforms require developing strategies appropriate for the diversity of the  
22 populations served and the cost drivers inherent to each.

23  
24 Legislative Strategy:

25 Collaborate with the governor, lieutenant governor, speaker and legislative leaders to identify potential  
26 changes to federal Medicaid and CHIP statutes that would benefit the state, patients, and physicians.

27  
28 J. Recognize the interdependence of Medicaid and the public health system. As one of the largest health care  
29 systems in Texas, Medicaid plays a critical role in supporting public health services. The two most notable  
30 examples are disease detection and prevention, services that ultimately benefit not just Medicaid patients but  
31 all Texans.

32  
33 Legislative Strategies:

34 Strengthen the public health infrastructure.

35  
36 Support public health programs aimed at preventive health care, including immunizations, maternal and child  
37 health, cancer screening and prevention, and disease detection and surveillance.

38  
39 Provide incentives for physicians to work closely with public health agencies to coordinate major initiatives  
40 (AHCM-MAC Rep. 1-1-04; amended SC-MCU Rep. 1-A-15).

41 **110.002 Cost Effectiveness:** The Texas Medical Association encourages physicians to become  
42 knowledgeable of the actual costs of services they order on behalf of patients in order to join their patients in  
43 decisions for the most cost effective expenditures of dollars for quality health care (Amended Res. 28CC, p  
44 179G, A-93; amended CSE Rep. 6-A-03; amended CSE Rep. 1-A-13).

45  
46 **120.002 Health System Reform Cost Control:** Health System Reform cost Control: The Texas Medical  
47 Association emphasizes health system reform with cost control reform measures that protect the freedom of  
48 access and the quality of medical care to patients and leaves government in the subordinate position and role

1 of taxation and funding (Res. 28Z, p 179D, A-93; reaffirmed CSE Rep. 6-A-03; reaffirmed CSE Rep. 1-A-  
2 13).

3  
4 **Related AMA Policy:**

5  
6 **D-110.993 Reducing Prescription Drug Prices:** Our AMA will (1) continue to meet with the  
7 Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the  
8 pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state  
9 medical associations and others that are interested in pharmaceutical bulk purchasing alliances,  
10 pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to  
11 contact the National Conference of State Legislatures, which maintains a comprehensive database on all such  
12 programs and legislation.

13  
14 **100.995 Support of American Drug Industry:** Our AMA continues to support the American pharmaceutical  
15 manufacturing industry in its efforts to develop and market pharmaceutical products meeting proper standards  
16 of safety and efficacy for the benefit of the American people.

17  
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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 414  
A-19

Subject: Studying Financial Barriers of Rural Hospitals

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

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1 Whereas, Rural hospital closure is defined as, “A facility located in a rural area that provided general, short-  
2 term, acute medical and surgical inpatient services” that closed during calendar years 1990-2000, according to  
3 the Department of Health and Human Services; and  
4

5 Whereas, Rural and critical access hospitals in Texas continue to close, even those that operate under positive  
6 revenue margins, and more are considered to be at high risk for closure in the coming years; and  
7

8 Whereas, Texas has recently accounted for the highest number of rural hospital closures nationwide, with 16  
9 closures since 2010; and  
10

11 Whereas, Compared with specialty, for-profit, teaching hospitals and trauma centers, rural hospital systems  
12 have significantly less power when negotiating with commercial insurance companies; and  
13

14 Whereas, The American Medical Association recognizes that rural hospitals are critical to ensuring patient  
15 access to care and physician employment sustainability in rural communities; and  
16

17 Whereas, The Texas Legislature has introduced policy that permits the Texas Health and Human Services  
18 Commission to reimburse rural hospitals directly or permit a managed care organization to reimburse rural  
19 hospitals so they can afford to treat their target population; and  
20

21 Whereas, The Texas Medical Association has passed policy with respect to rural physician independent  
22 practice but has not generated similar policy regarding county hospitals; and  
23

24 Whereas, Based on extensive searches in the literature, there have not yet been studies on rural hospital  
25 closures specifically in Texas; and  
26

27 Whereas, Without understanding financial barriers faced by rural hospitals, it is not possible to identify  
28 appropriate methods for legislators and/or the Texas Medical Association to address rural hospital closures in  
29 Texas, protect rural physician employment, and improve patient access to care; therefore be it  
30

31 RESOLVED, That the Texas Medical Association advocate for examining the financial factors contributing  
32 to rural hospital closures.  
33

34 **Related TMA Policy:**

35 **275.003 Rural Health Clinic Regulations:** The Texas Medical Association continues to monitor proposed  
36 changes to current rural health clinic regulations and to work with the Centers for Medicare and Medicaid  
37 Services to ensure that any modifications to the regulations do not unnecessarily burden rural health clinics or  
38 the patients they serve (Committee on Rural Health, p 118, A-95; amended CSE Rep. 1-A-05; reaffirmed  
39 CM-RH Rep. 2-A-16).

1 **185.019 Rural Physician Workforce Policy:** The Texas Medical Association recognizes the following 25  
2 recommendations for improving physician supply in rural Texas: (CM-PDHCA Rep. 1-A-11).

3  
4 Practice Incentive/Benefit and Other Recruitment Programs

- 5 1. Federal and state rural practice incentive/benefit programs should be sufficiently funded to be successful in  
6 recruiting and retaining physicians in rural, underserved communities.
- 7 2. Physicians, medical students, and residents should have easy access to information about rural practice  
8 incentive programs. Further, the programs should be widely publicized by state authorities, the Texas Medical  
9 Association, and the Texas Osteopathic Medical Association, and application forms readily accessible and  
10 user-friendly.
- 11 3. Area health education centers need to be adequately funded through federal and state funding sources to:  
12 (a) provide recruitment and retention services in rural areas; (b) assist in locating reasonable housing for  
13 student and resident preceptorships; and (c) provide practice support services to providers and communities,  
14 as referenced in other principles listed herein.
- 15 4. Incentives should be developed by state authorities to encourage physicians to add a secondary, part-time  
16 practice in rural, underserved communities located within a reasonable distance of their primary practice site.  
17 Physicians are encouraged to consider hiring and supervising mid-level practitioners, as appropriate, to  
18 augment their secondary practices.
- 19 5. Physicians are urged to adopt telemedicine services in their practices as outreach to patients in underserved  
20 communities, when applicable and purposeful in meeting health care needs.
- 21 6. Physicians should be informed of the potential impact of the employed-practice model on their scope of  
22 practice and should seek professional advice before signing hospital employment contracts, including  
23 resources provided by the Texas Medical Association and the Texas Osteopathic Medical Association.

24  
25 Promoting Rural Practice

- 26 7. Information on rural physician shortage areas should be readily available through coordinated websites of  
27 state agencies such as the Texas Department of State Health Services, the Texas Medical Board, area health  
28 education centers, and the Texas Department of Rural Affairs, to practicing physicians, medical students, and  
29 residents seeking rural practice opportunities, as well as to underserved communities. To assist physicians in  
30 selecting practice opportunities, comprehensive community profiles should be compiled to identify  
31 characteristics and statistics such as: population demographics (percentage child-bearing [for obstetrical  
32 needs], aged [for adult medicine-needs], etc.); insurance status; supply of physicians and other health  
33 professionals; degree of physician shortage; socioeconomic status; as well as educational and recreational  
34 opportunities.
- 35 8. Physicians who locate to rural areas, as well as medical students and residents interested in locating to rural  
36 areas, should be informed by state and/or local authorities of benefits and incentives available to strengthen  
37 the financial viability of their practice, including Medicare bonus payments, recruitment assistance, publicly  
38 funded locum tenens programs, etc. Further, they should be informed of the health care infrastructure in their  
39 area, including systems of care such as federally qualified health centers, indigent care clinics, rural health  
40 clinics, hospitals (including critical access hospitals), long-term care facilities, emergency medical services,  
41 and hospice. They also should be informed about the availability of other health providers and services such  
42 as nursing, pharmacies, therapists, and medical equipment.
- 43 9. Physicians should be informed by state authorities, including the Texas Medical Board, of the unique peer  
44 review services offered by the Knowledge, Skills, Training, Assessment, and Research (KSTAR) Program at  
45 Texas A&M University Health Science Center for rural hospitals and physicians.
- 46 10. County medical societies, hospitals, and other health facilities (when available) should facilitate  
47 communication between new physicians and physicians with established practices in the community to help  
48 new physicians be better prepared for entering practice in an underserved community.

1 11. Physicians who receive benefits through state loan repayment programs also should be informed by state  
2 authorities of specialized practice support services, including practice start-up, billing, locum tenens,  
3 professional development and CME, staff recruitment and training, telemedicine, and so on.

4 12. Physician practice reentry programs should be widely publicized and monitored to assess their ability to  
5 meet demands by state authorities, the Texas Medical Association, and the Texas Osteopathic Medical  
6 Association. Further, when licensed physicians allow their Texas medical license to lapse, they should be  
7 informed by the Texas Medical Board of the potential obstacles to relicensure should they decide to reenter  
8 practice following an extended absence from practice.

9 13. Outreach should be provided by state authorities, to physicians without a full-time medical practice to  
10 promote volunteer work or part-time practice at clinics in underserved communities.

11 14. Federal and state policies that impact rural medicine, e.g., payment policies, should be monitored by the  
12 Texas Department of Rural Affairs for their potential impact on the viability of rural practices. The Texas  
13 Medical Association and the Texas Osteopathic Medical Association should continue to advocate for  
14 reimbursement parity between Medicaid and Medicare beyond the two-year period authorized by the Patient  
15 Protection and Affordable Care Act. In addition, reimbursement policies that discount professional services to  
16 be delivered in rural communities discourage rural practice and should be addressed.

17 15. Physicians in practice and those in training programs should be informed by the Texas Medical Board,  
18 Texas Medical Association, Texas Osteopathic Medical Association, and other state authorities of special  
19 state medical licensing provisions applicable for practice in rural, underserved areas.

#### 20 Preparing Physicians for Rural Practice

21 16. Medical schools and residency programs should be incentivized by state authorities to develop and  
22 adequately support rural education and training tracks. Examples include bonuses for medical students or  
23 residents who participate in rural training tracks, and additional state formula funding for medical student and  
24 residents in rural training tracks.

25 17. Appropriate screening criteria should be used by medical schools for identifying student-applicants and  
26 residents most likely to be successful in rural practice.

27 18. To measure outcomes, assessments should be conducted to identify whether students and residents who  
28 participate in rural educational or training tracks are retained in the state for practice after completion of  
29 training.

30 19. Area health education centers should offer opportunities for community physicians who volunteer as  
31 preceptors to access information and knowledge of practices that contribute to a positive clinical learning  
32 experience. Further, educational institutions should provide adequate support and incentives to recruit and  
33 retain physician preceptors, including appropriate levels of recognition and benefits for their teaching efforts.  
34 This will become increasingly important as community physicians face continuing pressures to increase  
35 productivity.

36 20. Medicare GME policies should allow for residency program-specific support rather than institutional  
37 support for resident training to allow GME funding to follow the resident throughout their training.

38 21. Primary Care Residency Review Committees (RRCs) of the Accreditation Council for Graduate Medical  
39 Education, and Primary Care Residency Review Committees of the American Osteopathic Association,  
40 should consider allowing more flexibility for residents to travel away from their core programs to rural areas  
41 in order to achieve established training goals for minimum numbers of procedures or encounters.

42 22. The impact of changes in resident duty-hour restrictions should be monitored for the impact on rural  
43 training programs and health care delivery in comparison to institution-based residency programs.

#### 44 Rural Access to Care

45 23. The Texas Medical Association and Texas Osteopathic Medical Association should continue to advocate  
46 for a single standard of care for all Texans in all areas of the state.

47 24. Discussions are needed to develop solutions for providing after-hours care for patients of federally funded  
48 health clinics requiring urgent or emergent care to prevent undue burdens on community physicians.

1 25. Periodic research should be conducted by the Texas Health Professions Resource Center at the Texas  
2 Department of State Health Services to monitor significant changes in rural physician workforce trends,  
3 including physician demographics and practice characteristics. (CM-PDHCA Rep. 1-A-11).

4 110.007 Cost Containment: Members of the Texas Medical Association are encouraged to voluntarily  
5 evaluate their practice patterns to further reduce and improve utilization of expensive hospital and ambulatory  
6 services and to control costs. Insurance companies and fiscal intermediaries are encouraged to support cost  
7 containment and cost effective care by recommending use of the least expensive setting in which a procedure  
8 can be performed safely and effectively. Third party payers should provide payment not only for professional  
9 services, but for other costs incurred in physicians' offices (such as surgical trays, sterile draping, and  
10 necessary supplies). Duplicate laboratory procedures and tests should be eliminated (Council on  
11 Socioeconomics, p 177, I-94; amended CSE Rep. 1-A-10).

12  
13 **Related AMA Policy:**

14 **H-465.979 Economic Viability of Rural Sole Community Hospitals:** Our AMA: (1) recognizes that  
15 economically viable small rural hospitals are critical to preserving patient access to high-quality care and  
16 provider sustainability in rural communities; and (2) supports the efforts of organizations advocating directly  
17 on behalf of small rural hospitals provided that the efforts are consistent with AMA policy.

18 Policy Timeline: CMS Rep. 3, A-15

19  
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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 415  
A-19

Subject: Improving Buprenorphine Access for Opioid Substance Use Disorder Treatment

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

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1 Whereas, One in 10 Texans have a substance use disorder, and overdose deaths in Texas have nearly tripled  
2 from 1999 to 2014; and

3  
4 Whereas, The majority of Texans with substance use disorders never receive treatment due to access barriers  
5 including provider shortages, lack of insurance coverage, and lack of appointment availability in state-funded  
6 facilities; and

7  
8 Whereas, Four of the top 25 cities in the United States for opioid use disorders are rural cities in Texas  
9 (Texarkana, Amarillo, Odessa, Longview); and

10  
11 Whereas, Patients with opioid use disorders tend to prefer buprenorphine over methadone treatment because  
12 they feel that buprenorphine is more effective at suppressing opioid withdrawal symptoms, is less sedating  
13 and carries fewer side effects, has a lower risk of abuse, and has greater perceived therapeutic benefits; and

14  
15 Whereas, Patients more readily choose buprenorphine over methadone because they can access it through any  
16 licensed and waived medical health care professional rather than only certified opioid treatment programs,  
17 thereby reducing the stigma associated with seeking care for an opioid use disorder; and

18  
19 Whereas, Buprenorphine reimbursement rates for state-contracted medication-assisted treatment providers are  
20 often inadequate to cover the actual costs of purchasing and distributing buprenorphine; Texas physicians  
21 have anecdotally reported this same concern already described by physicians in other states; and

22  
23 Whereas, Medicaid and private insurance companies often require prior authorization for buprenorphine  
24 treatment in addition to a formal opioid use disorder diagnosis, resulting in administrative delays in treatment  
25 that increase the likelihood of relapse and overdose; and

26  
27 Whereas, The Texas Medical Association supports equitable access to evidence-based medication-assisted  
28 treatment for individuals with substance use disorders; and

29  
30 Whereas, The American Medical Association supports the expansion of buprenorphine access and the  
31 elimination of required physician waivers to prescribe buprenorphine for patients with opioid use disorder;  
32 and

33  
34 Whereas, Only 4 percent of physicians in the United States have the appropriate waiver required to prescribe  
35 buprenorphine, further restricting patients with opioid use disorder from accessing this treatment option;  
36 therefore be it

1 RESOLVED, That the Texas Medical Association support state efforts to increase the reimbursement rate of  
2 buprenorphine to better reflect its actual cost and medication-assisted treatment overhead costs to physicians;  
3 and be it further  
4

5 RESOLVED, That TMA support the elimination of preauthorization requirements for insured patients with  
6 opioid use disorders seeking buprenorphine treatment; and be it further  
7

8 RESOLVED, That TMA support the elimination of physician waiver requirements to prescribe  
9 buprenorphine to patients diagnosed with opioid use disorder.  
10

11 **Related TMA Policy:**

12 **95.045 Evidence-Based Management of Substance Use Disorders:** The Texas Medical Association  
13 believes that substance use disorders are complex diseases with biological, psychological, and sociological  
14 components, and that these disorders should be recognized and treated as are all other diseases. TMA believes  
15 that effectively addressing substance use disorders requires major initiatives for prevention, risk reduction,  
16 and treatment, inclusive of the following strategies for physician education and for improving public health  
17 programming to address these disorders in Texas.  
18

19 Physician education on:

20 The evidence-based prescription of addicting medications, especially benzodiazepines and opiates;  
21 The increased public- and private-sector access to nonpharmacological management of pain and anxiety;  
22 The goal of universal screening of adolescents and adults including pregnant and postpartum women for  
23 substance use disorders as part of their preventive and primary care; and  
24 Improving public- and private-sector access to evidence-based medication-assisted treatment for all substance  
25 use disorders for which such an intervention is clinically indicated.  
26

27 Public health programming to:

28 Improve public- and private-sector access to evidence-based treatment of substance use disorders, and  
29 aggressive, early linkage of patients in need;  
30 Support public health policymaker commitments to financing improved data collection on drug overdoses and  
31 fatalities and to a robust public health response to the data;  
32 Increase the availability of harm reduction measures for current users, including access to clean syringes,  
33 naloxone, and Housing-First recovery models; and  
34 Continue federal and local efforts to interrupt access to illegally obtained drugs (CSPH Rep. 7-A-18).  
35

36 **95.040 Addressing Prescription Drug Abuse and Overdose:** Following is Texas Medical Association  
37 policy on addressing prescription drug abuse and overdose:  
38

39 1. That TMA collaborate with state and local public health agencies to promote increased public education  
40 programming on the misuse of prescribed medications, support community programs such as ‘take back’  
41 programs, and targeted programs for special populations, particularly women of reproductive age and families  
42 with adolescents and teenagers.  
43

44 2. That TMA endorse the education of health care workers and opioid users about the use of naloxone (and  
45 other opioid antagonists) in preventing opioid overdose fatalities.  
46

47 3. That TMA implement a plan to promote physician awareness and participation in educational programs on  
48 pain relief.

1 4. That TMA support continued expansion of public funding for treatment and recovery support for persons at  
2 risk of substance use and misuse, with a priority given to programs for pregnant and postpartum women.

3  
4 5. That TMA support improved access to substance use treatment, especially through co-location of physical  
5 health, mental health, and substance use services and through wider availability of evidence-based  
6 medication-assisted treatments.

7  
8 That TMA advocate for legislation that (1) allows for appropriate storage and for a trained individual, acting  
9 under a standing order issued by a physician, to administer an opioid antagonist to prevent deaths from opioid  
10 overdose (2) allows first responders, such as police and fire fighters to have access to and administer an  
11 opioid antagonist in the event of an emergency overdose (3) reduces barriers for medical professionals to  
12 prescribe and dispense naloxone (or other opioid antagonists) to family members and friends of an identified  
13 patient, and for administrators to do so without fear of legal repercussions, as described as Third Party  
14 Prescription/Standing Order Distribution.

15  
16 That TMA support providing legal protection from drug possession charges for persons seeking medical  
17 attention after overdose, as described in model 911 Good Samaritan fatal overdose prevention laws (CSPH  
18 and TF-BH Joint Rep. 1-A-15).

19  
20 **Related AMA Policy:**

21 **D-95.972 Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder:**

- 22 1. Our AMA's Opioid Task Force will publicize existing resources that provide advice on overcoming  
23 barriers and implementing solutions for prescribing buprenorphine for treatment of Opioid Use Disorder.  
24 2. Our AMA supports eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the  
25 treatment of opioid use disorder.

26  
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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 416  
A-19

Subject: Revising the Texas Department of Insurance Division of Workers' Compensation Designated Doctor Training and Education Process

Presented by: Bexar County Medical Society

Referred to: Reference Committee on Socioeconomics

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1 Whereas, The American Medical Association's *Guides to the Evaluation of Permanent Impairment, 4<sup>th</sup>*  
2 *edition*, has for more than 10 years been the book legally mandated by the legislature to use by  
3 Designated Doctors to calculate the impairment of an injured worker in Texas; and  
4

5 Whereas, In order to become a Designated Doctor, the Texas Department of Insurance Division of  
6 Workers' Compensation (TDI-DWC) has mandated that a physician must take several days away from his  
7 practice, pay to attend a TDI-DWC Designated Doctor educational course, and then pass an examination  
8 with questions dealing specifically on the proper use of the AMA *Guides to the Evaluation of Permanent*  
9 *Impairment, 4<sup>th</sup> edition*; and  
10

11 Whereas, The TDI-DWC also has mandated that in order to continue to participate in the Designated  
12 Doctor program, a Texas physician must repeat this process of paying to sit through a course and take the  
13 exam every two years, even though the book, *Guides to the Evaluation of Permanent Impairment, 4<sup>th</sup>*  
14 *edition*, remains the same; therefore be it  
15

16 RESOLVED, That the Texas Medical Association work with the Texas Department of Insurance Division  
17 of Worker's Compensation (TDI-DWC) through the regulatory process to ensure that the TDI-DWC  
18 examination being given has questions that are accurate and have been validated; and be it further  
19

20 RESOLVED, That TMA work with the TDI-DWC to eliminate the requirement for physicians to repeat  
21 the course and exam process every two years; and be it further  
22

23 RESOLVED, That TMA work with the TDI-DWC to develop less costly methods of obtaining and  
24 maintaining the appropriate level of education required to ensure that the Designated Doctors are using  
25 the *Guides to the Evaluation of Permanent Impairment, 4<sup>th</sup> edition* accurately and that injured workers are  
26 being evaluated fairly.  
27

28 **Related TMA Policy:**

29 **335.005 Workers' Compensation Impairment Ratings:** The Texas Medical Association voted to work  
30 through the regulatory process to prevent the Texas Division of Workers' Compensation from limiting the  
31 ability of licensed physicians who have otherwise met necessary requirements from performing  
32 impairment ratings and becoming designated doctors in the State of Texas (Amended Res. 28J, p 129, I-  
33 95; reaffirmed CSE Rep. 1-A-05; amended CSE Rep. 1-A-15).  
34

35 **335.014 Workers' Compensation Delivery System:** Texas Medical Association supports the following  
36 in pursuit of a fair, efficient, and accountable workers' compensation delivery system in Texas:

37 (1) Continue dialogue with legislative and executive branch policymakers to maintain the out-of-network  
38 medical fee reimbursement formula based on an annual MEI adjustment that may result in fair and  
39 reasonable physician payments;

40  
41 (2) Continue to educate policymakers and regulators on the need for employer accountability when  
42 dealing with injured workers and encouraging return to work initiatives;

43  
44 (3) Consider all appropriate strategies to help correct injustices within the system for doctors, specifically  
45 reducing inappropriate carrier gaming and reducing administrative hassles and burdens;

46  
47 (4) Diligently work with Texas Department of Insurance in the regulatory arena to improve physician  
48 input and physician stakeholder involvement to produce much needed reforms to the workers'  
49 compensation system (CSE Rep. 1-A-09).

50

51 **Related AMA Policy:**

52 **H-365.981 Workers' Compensation:** Our AMA:

53 (1) will promote the development of practice parameters, when appropriate, for use in the treatment of  
54 injured workers and encourages those experienced in the care of injured workers to participate in such  
55 development.

56 (2) will investigate support for appropriate utilization review guidelines for referrals, appropriate  
57 procedures and tests, and ancillary services as a method of containing costs and curbing overutilization  
58 and fraud in the workers' compensation system. Any such utilization review should be based on open and  
59 consistent review criteria that are acceptable to and have been developed in concert with the medical  
60 profession. Physicians with background appropriate to the care under review should have the ultimate  
61 responsibility for determining quality and necessity of care.

62 (3) encourages the use of the Guides to the Evaluation of Permanent Impairment. The correct use of the  
63 Guides can facilitate prompt dispute resolution by providing a single, scientifically developed, uniform,  
64 and objective means of evaluating medical impairment.

65 (4) encourages physicians to participate in the development of workplace health and safety programs.  
66 Physician input into healthy lifestyle programs (the risks associated with alcohol and drug use, nutrition  
67 information, the benefits of exercise, for example) could be particularly helpful and appropriate.

68 (5) encourages the use of uniform claim forms (CMS 1500, UB04), electronic billing (with appropriate  
69 mechanisms to protect the confidentiality of patient information), and familiar diagnostic coding  
70 guidelines (ICD-9-CM, CPT; ICD-10-CM, CPT), when appropriate, to facilitate prompt reporting and  
71 payment of workers' compensation claims.

72 (6) will evaluate the concept of Independent Medical Examinations (IME) and make recommendations  
73 concerning IME's (i) effectiveness; (ii) process for identifying and credentialing independent medical  
74 examiners; and (iii) requirements for continuing medical education for examiners.

75 (7) encourages state medical societies to support strong legislative efforts to prevent fraud in workers'  
76 compensation.

77 (8) will continue to monitor and evaluate state and federal health system reform proposals which propose  
78 some form of 24-hour coverage.

79 (9) will continue to evaluate these and other medical care aspects of workers' compensation and make  
80 timely recommendations as appropriate.

81 (10) will continue activities to develop a unified body of policy addressing the medical care issues  
82 associated with workers' compensation, disseminate information developed to date to the Federation and  
83 provide updates to the Federation as additional relevant information on workers' compensation becomes  
84 available.