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Report of Committee on Medical Home and Primary Care
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1. Informational Update

Report of Medical Student Section
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Report of Resident and Fellow Section
1. Resident and Fellow Section Update
Report of Young Physician Section
  1. Young Physician Section Update

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  1. Texas Medical Association Insurance Trust 2018 Annual Report

Report of Texas Medical Association Foundation
  1. TMA Foundation 2018 Annual Report

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

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

Report of Committee on Rural Health
  2. Rural Health Activities Update
In 2004, TMA purchased and began using Reply System’s Interactive Voter Response System (IVRS) that greatly improved the speed and accuracy of the TMA House of Delegates (HOD) voting and elections process. During the 2018 Annual Session, TMA’s IVRS failed to capture all delegate responses during the election process. The TMA IVRS was designed to receive votes from handheld devices on specific radio frequencies. Unfortunately, one of the frequencies used was impacted by a signal from another unknown communications device at the facility that did not occur during testing. Since the older technology required assigning a voting radio frequency to each handheld voting device in advance of the meeting, it was impossible to retrieve the devices and change the frequency in a timely manner. Voting proceeded by paper ballots at the direction of the TMA speaker and vice speaker. Prior to 2018, TMA’s IVRS had been used successfully for HOD voting since 2004.

In an effort to research current approaches used by other associations, TMA reached out to the American Medical Association (AMA), Florida Medical Association (FMA), and American College of Emergency Physicians (ACEP). Each used a unique form of house voting and were evaluated for use by TMA. Self-hosted and vendor-hosted solutions, looking for the best combination of cost and functionality, were also researched.

Beyond the specific systems and methods used by the AMA, FMA, and ACEP, TMA looked at leading solution providers of handheld electronic voting systems and third-party onsite voting consultants. Systems using Wi-Fi based technology, or browser-based solutions, were not evaluated due to inconsistencies in internet service at hotel and convention center locations historically used by TMA for TexMed meetings. In addition, it was determined that solutions that utilized individually owned personal devices, mobile phone, tablets, and laptops, were not feasible due to the large variety of potential devices, potential for poor mobile device internet service, and the number of staff available to support those devices onsite.

Three leading vendors of voting and election systems were fully researched. Each solution uses similar handheld voting devices using radio frequency (RF) technology for transmitting votes. The difference with these systems from the legacy TMA system is that RF frequencies are not set on each device. Each handheld voting unit uses a range of frequencies to find the voting base receiver, eliminating the problem caused during the 2018 Annual Session.

Vendors in the search included Meridia, Padgett, and Reply Systems. The first two vendors provided proposals for a purchased solution that would be operated by TMA. Reply Systems did not respond with a proposal. Each system utilizes wireless handheld voting devices and multiple voting receivers to accomplish both elections and Yes/No voting. Each software system seamlessly integrates with PowerPoint and can be incorporated into the TMA HOD order of business. Both system proposals were based upon 500 voting units and multiple receivers. Both software systems supplied with the devices were evaluated for the effectiveness of supporting current TMA house elections and voting procedures.

To fully evaluate alternatives using wireless handheld voting devices, the option of outsourcing elections to a third party for both equipment and onsite voting execution also were investigated. The leading
solution provider in this space is LumiGlobal. The primary two advantages of outsourcing are that the
electronic voting devices are maintained and supplied by LumiGlobal, resulting in the most recent voting device
technology used each year, and their onsite support staff handle association voting and elections for a
number of organizations throughout the year and are capable of handling any set of unique procedures or
policies.

Primarily due to the annual cost associated with the LumiGlobal solution, it was determined that a
purchased solution was preferred to an outsourced approach. TMA could theoretically update the
technology of a purchased solution every third year and still result in a lower cost of operation than the
outsourced approach.

In December 2018, the TMA Board of Trustees approved the purchase of a Handheld Wireless
Voting/Election System for TMA. This new system will be utilized at the 2019 Annual Session.
REPORT OF BOARD OF TRUSTEES

BOT Report 1-A-19

Subject: TMA Leadership College

Presented by: Diana L. Fite, MD, Chair

Funded by a grant from The Physicians Foundation, the Texas Medical Association Leadership College (TMALC) was launched in 2010 as part of TMA’s effort to ensure strong and sustainable physician leadership within organized medicine.

This successful program, now in its ninth year, boasts 160 alumni. Additionally, 130 graduates are currently serving in TMA leadership via councils, committees, and sections with others representing their county and specialty societies. These physicians serve as thought leaders who can close the divide among clinicians and health care policymakers, and serve as trusted leaders in their communities.

Participants must be active TMA physician members under the age of 40 or in the first eight years of practice. There is no tuition charge for scholars, but scholars are responsible for their own travel expenses.

Now Accepting Applications for 2020
Applications for the 2019-20 program are due by June 7, 2019. Visit www.texmed.org/Leadership for more information and to download the application. For questions, contact Melanie Harrison at melanie.harrison@texmed.org, or call (800) 880-1300, ext. 1443.

Congratulations the Class of 2019!
Twenty-four scholars will graduate during a luncheon ceremony held at TexMed 2019 on Saturday, May 18.

Class of 2019 Curriculum

Live Session Topics:
- Acts of Leadership
- Emotional Intelligence
- Personal Leadership
- Team Interaction and Development
- Conflict Management
- Personal Branding
- Using Social Media as a Thought Leader
- Legislative Process
- Advocacy in Action
- Media Training
- Intergenerational Communication
- Online Reputation Management
- Forging Productive Professional Relationships
- Communication Styles

Self-Study: Scholar Project
Scholars select from a comprehensive menu of project suggestions or create a project of their own that complements lessons/topics discussed.

<table>
<thead>
<tr>
<th>Scholar</th>
<th>Specialty</th>
<th>Sponsored By</th>
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<tbody>
<tr>
<td>Eman Attaya, MD</td>
<td>R</td>
<td>Lubbock County Medical Society</td>
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<tr>
<td>Emily Briggs, MD</td>
<td>FM</td>
<td>Texas Academy of Family Physicians</td>
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<tr>
<td>Brett Cooper, MD</td>
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<td>Renee Flores, MD</td>
<td>IMG</td>
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<td>Nishant Jalandhara, MD</td>
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<td>Zachary Jones, MD</td>
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<td>Christie Lincoln, MD</td>
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<td>Felicity Mack, MD</td>
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<td>Brian Masel, MD</td>
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<td>Tina Philip, DO</td>
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<td>Jacob Stetler, DO</td>
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<td>Acsa Zavala, MD</td>
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REPORT OF BOARD OF TRUSTEES

BOT Report 2-A-19

Subject: Disclosure of Affiliations

Presented by: Diana L. Fite, MD, Chair

In May 2006, the House of Delegates adopted Board of Trustees Report 18-A-06 as amended to read as follows:

that (1) any candidate for at-large trustee or any office that includes an ex officio seat on the Board of Trustees (president, president-elect, secretary/treasurer, and speaker and vice speaker of the House of Delegates) provide full disclosure of affiliations on a form developed by the speaker of the House of Delegates for that purpose; (2) all members of the Board of Trustees (at-large trustees and officers) provide full disclosure of affiliations each year at the time of the Winter Conference, and that full disclosure be reported to the House of Delegates in the Handbook for Delegates, on the TMA website, and by any other method deemed appropriate by the Board of Trustees; and (3) when a health insurance company or HMO requests recommendations for appointment to a physician advisory committee or any other component, the TMA president shall recommend for appointment individuals who best represent TMA’s position, and the names of those individuals recommended by TMA and subsequently appointed by the health insurance company or HMO will be reported to the House of Delegates for information at its next meeting.

At its January 2011 meeting, the Board of Trustees amended the disclosure form to require those who answer “yes” to the following questions must indicate the type of material financial interest using the letters, A, B, C, or D from the list below:

Do you or an immediate family member hold or plan to hold a material financial interest in any business which furnishes goods or services, or is seeking to furnish goods or services, to TMA or to any member of the TMA Board of Trustees, TMA Executive Vice President, or TMA Chief Operating Officer?

Do you or any immediate family member hold or plan to hold a material financial interest in any health care business, health insurance company, or health care facility, including a private medical practice?

The types of material financial interest to disclose are:

A. a financial ownership interest of 35 percent or more, or
B. a financial ownership interest which contributes materially (5 percent or more) to your income, or
C. a position as proprietor, director, managing partner, or key employee, or
D. any ordinary income, honorarium, or gift (other than dividends from stock) compensation exceeding $1,000 per year in excess of actual expenses.

Attached is a list of affiliations disclosed by all members of the Board of Trustees.
BY ORGANIZATION:

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   Douglas W. Curran, MD

American Academy of Ophthalmology
   Keith A. Bourgeois, MD

American Academy of Pediatrics
   Gary W. Floyd, MD

American Board of Anesthesiology
   G. Ray Callas, MD

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   Richard W. Snyder, MD

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   Diane L. Fite, MD
   Arlo F. Weltge, MD

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   Jayesh B. Shah, MD

American College of Physicians
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American Society of Anesthesiologists
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Anesthesia Associates
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   Michelle A. Berger, MD (D)

Bailey Square Surgery Center
   Michelle A. Berger, MD
   David C. Fleeger, MD

Beaumont Chamber of Commerce
   G. Ray Callas, MD

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   Sue S. Bornstein, MD (D)
   G. Ray Callas, MD (D)
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Gary W. Floyd, MD (D)
Richard W. Snyder, MD (D)
E. Linda Villarreal, MD (D)

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Richard W. Snyder, MD

Caring for Women, PA
Joseph S. Valenti, MD

Central Texas Colon & Rectal Surgeons
David C. Fleeger, MD

Doctors Hospital at Renaissance
Carlos J. Cardenas, MD (B, C, and D)

Emerus Community Hospital
Diana L. Fite, MD

Frost Bank McAllen Advisory Board
Carlos J. Cardenas, MD

HeartPlace, PA
Richard W. Snyder, MD

Houston Community College
Diana L. Fite, MD
Arlo F. Weltge, MD

Kare Infusion Center
G. Ray Callas, MD (C and D)

Keith A. Bourgeois, MD, PA
Keith A. Bourgeois, MD (A, B, C, and D)

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Douglas W. Curran, MD

Lone Star Alliance
Joseph S. Valenti, MD

Mallinckrodt Pharmaceuticals
G. Ray Callas, MD (D)

Memorial Medical Clinic
E. Linda Villarreal, MD

Mission Trail Baptist Hospital/Tenet
Jayesh B. Shah, MD

North Central Texas Medical Foundation
Susan M. Strate, MD
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Texas Department of Licensure and Regulations
   G. Ray Callas, MD

Texas Health Services Authority
   David C. Fleeger, MD

Texas Institute of Health Care Quality and Efficiency
   Susan M. Strate, MD

Texas Medical Association PracticeEdge, LLC
   Gary W. Floyd, MD

Texas Medical Association Specialty Services, LLC
   Richard W. Snyder, MD

Texas Medical Foundation Health Quality Institute
   Gary W. Floyd, MD

Texas Medical Home Initiative
   Sue S. Bornstein, MD

Texas Medical Liability Trust
   Keith A. Bourgeois, MD (D)
   G. Ray Callas, MD (D)
   Joseph S. Valenti

Texas Pediatric Society
   Gary W. Floyd, MD

Texas Society of Anesthesiologists
   G. Ray Callas, MD (C and D)

Texas Society of Pathologists
   Susan M. Strate, MD

Texoma Independent Physicians
   Susan M. Strate, MD

TIMEO2 Healing Concepts, LLP
   Jayesh B. Shah, MD

University of Texas Medical School at Houston
   Arlo F. Weltge, MD

VaxCare
   Douglas W. Curran, MD (D)

Workforce Solutions Board of Directors
   Carlos J. Cardenas, MD

Wound Care Alliance
   Jayesh B. Shah, MD
BY MEMBER:

Michelle A. Berger, MD
- Austin Ear Nose and Throat Clinic (D)
- Bailey Square Surgery Center
- Northwest Surgery Center

Sue S. Bornstein, MD
- American College of Physicians
- Blue Cross/Blue Shield (D)
- PathAdvantage Associated
- Texas Medical Home Initiative

Keith A. Bourgeois, MD
- American Academy of Ophthalmology
- Keith A. Bourgeois, MD, PA (A, B, C, and D)
- St. Joseph Medical Center (D)
- Texas Medical Liability Trust (D)

G. Ray Callas, MD
- AllCare Physicians Group Board of Directors (D)
- American Board of Anesthesiology
- American Society of Anesthesiologists
- Anesthesia Associates (D)
- Beaumont Chamber of Commerce
- Blue Cross Blue Shield (D)
- Kare Infusion Center (C and D)
- Mallinckrodt Pharmaceuticals (D)
- Texas Department of Licensure and Regulations
- Texas Medical Liability Trust (D)
- Texas Society of Anesthesiologists (C and D)

Carlos J. Cardenas, MD
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- Frost Bank McAllen, Advisory Board
- Renaissance Gastroenterology Institute (B and C)
- Renaissance Medical Foundation (B and C)
- Renaissance Outpatient Rehabilitation Institute DBA Kids Korner (B and C)
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- Workforce Solutions Board of Directors

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- Lakeland Medical Associates
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- VaxCare (D)

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Texoma Independent Physicians
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Physicians Foundation
Texas Medical Liability Trust

E. Linda Villarreal, MD
Blue Cross Blue Shield (D)
Memorial Medical Clinic

Arlo F. Weltge, MD
American College of Emergency Physicians
American Medical Response
Houston Community College
University of Texas Medical School at Houston
Texas Medical Association Insurance Trust (TMAIT) Board of Trustees
The TMA Board of Trustees has responsibility to appoint four members of the TMAIT Board of Trustees. In accordance with TMAIT’s Amended Agreement and Declaration of Trust, the fifth appointed position is held by the executive vice president of TMA without any term limitation. The board also fills the position reserved for a member of the Young Physician Section. In addition, the board offers nominations for the remaining three positions, which are elected by policyholders through the proxy mechanism.

In May 2018, the Board of Trustees recommended Richard J. Noel, MD, to serve a second three-year term; Kevin P. Magee, MD, to serve a three-year term; Charles E. Cowles Jr., MD, to serve a three-year term; Jack L. Cortese, MD, to serve a final three-year term; and Russell J. Juno III, MD, to serve a final three-year term. Dr. Noel and Dr. Magee were appointed by the TMA Board of Trustees; Dr. Cowles, Dr. Cortese, and Dr. Juno were elected at the TMAIT annual meeting in September.

TMF Health Quality Institute (TMFHQI) Board of Trustees
The TMF Health Quality Institute Board of Trustees is composed of nine physicians who are doctors of medicine, three doctors of osteopathy, two Medicare beneficiary representatives, and four nonphysicians, for a total of 18 elected members. The immediate past president serves ex officio with vote.

Nominations for places on the TMFHQI board to be filled by MDs are solicited from TMA. In addition, a general notice is sent to TMFHQI members, who may offer nominations. TMFHQI’s nominating committee then meets to choose one or more nominees for each place to be filled. The report of the nominating committee is sent to the entire TMFHQI membership along with a proxy card. The election, by those attending and by proxy, is held during the institute’s annual meeting in July.

In 2019, no physician terms are expiring.

The TMA Board of Trustees maintains active liaison with the Board of Trustees of TMFHQI through its TMA/TMF Liaison Committee.

Texas Medical Liability Trust (TMLT) Board of Governors
The Texas Medical Liability Trust Board of Governors makes nominations to the TMLT board and the TMA president submits them to the TMA House of Delegates. Policyholder nominations also are reported to the house for information. Beginning with elections in 2007, places on the TMLT board are slotted.

In 2019, no physician terms were expiring.
At each of its meetings, the Board of Trustees reviews an audit trail of pending lawsuits involving the association. The following is an updated report, prepared in January, by the Office of the General Counsel.

A. LITIGATION AS PLAINTIFF

1. TMA v. Texas Board of Chiropractic Examiners

   (Regarding scope of practice, specifically pertaining to vestibular-ocular-nystagmus (VON) testing)

   On Jan. 6, 2010, the Texas Board of Chiropractic Examiners (TBCE) proposed an amendment to §75.17(c)(3), concerning Scope of Practice, to add a new subparagraph (C) to describe training required for doctors of chiropractic to perform VON testing.

   The Texas Chiropractic Act defines the practice of chiropractic as using “objective or subjective means to analyze, examine, or evaluate the biomechanical condition of the spine and musculoskeletal system of the human body,” or performing “nonsurgical, nonincisive procedures, including adjustment and manipulation, to improve the subluxation complex or the biomechanics of the musculoskeletal system.” The performance of VON testing does not, in any way, fall within the scope of practice as defined in section 201.002(b) of the Texas Occupations Code, and therefore exceeds the rulemaking authority of the board.

   Vestibular-ocular-reflex (VOR) testing is a diagnostic test, used solely to diagnose a problem of the brain or inner ear, and treatment often involves the use of medications that can only be prescribed by a physician. Symptoms that would prompt VOR testing are dizziness, imbalance, and vertigo, which are very common conditions that cause patients to seek medical attention. It is imperative that a correct diagnosis be made rapidly because these symptoms can be caused by something as benign as a viral infection of the inner ear, or something as ominous as a brain tumor or an impending brainstem stroke.

   Ears and eyes are not part of the spine and musculoskeletal system of the human body. Furthermore, disorders affecting the biomechanical condition of the spine and musculoskeletal system of the human body do not cause vestibular system pathology. Vestibular-ocular-nystagmus testing does not fall within the statutory scope of practice of chiropractic. The board’s adopted rule exceeds the practice of chiropractic as defined by law, and impermissibly attempts to permit chiropractors to practice medicine without a license issued by the Texas Medical Board.

   TMA submitted comments, containing its strong objections, to the proposed rule. TBCE withdrew those proposed rules, based on the comments it had received. In its place, the board proposed a revised amendment to §75.17(c)(3)(C), with an increased requirement that, in order to administer this test, a licensee must have received a diploma in chiropractic neurology and successfully completed an additional 150-hour post-graduate specialty course in vestibular rehabilitation. In the preamble to the proposed rule, TBCE wrote the following interesting
statement, pertaining to diagnosis: “A vestibular and oculomotor functional assessment can
provide a neurologically trained doctor of chiropractic with a baseline for treatment of a patient as
well as the information necessary for a differential diagnosis and development of a plan for
treatment.”

TMA again submitted its strong objections in a comment letter on July 19, 2010. TBCE held a
rule hearing pertaining to the rule on Aug. 6, 2010. At that rule hearing, Sara Austin MD,
neurologist, testified on behalf of TMA. TBCE voted to adopt the rule, without any debate
whatsoever. The final rule has been formally adopted.

Incidentally, at that TBCE hearing, the TBCE president stated that any discussion pertaining to
scope of practice should be sent to one member through email, and not to all the board members,
in order to avoid the “open meetings” rule. In light of that statement, on Aug. 25, 2010, TMA sent
TBCE a Public Records Request under the authority of the Government Code, Section 552.021,
for copies of all policy statements or interpretations of the law or rules that have been adopted,
published, or issued by the Texas Board of Chiropractic Examiners, or emails or other writings
relating to scope of practice for chiropractors. TBCE produced some documents and withheld
others, seeking an attorney general opinion pertaining to the documents withheld. TMA prepared
a response letter to the attorney general, and the attorney general has ruled in TMA’s favor.
TBCE has since produced the documents it sought to withhold, which contain some information
that is quite contrary to TBCE’s position and very favorable to TMA’s position.

TMA’s main concern is with the vestibular testing rule adopted by TBCE, as VON testing should
not be performed by chiropractors, regardless of any additional chiropractic education or training
they may obtain pertaining to the test. TMA believes the proposed rule 75.17(c)(3) exceeds the
rulemaking authority of the board and is unconstitutional pursuant to Article XVI, section 31 of
the Texas Constitution.

The TMA Board of Trustees authorized TMA to proceed with a lawsuit. David Bragg was
retained to file the suit. The lawsuit was filed on Jan. 31, 2011.

The case was assigned to the 353rd Judicial District Court of Travis County, Texas. The Judge
was Rhonda Hurley. Both parties designated their testifying expert. All depositions of expert
witnesses were taken. TBCE experts that were deposed include Frederick Carrick (“chiropractic
neurologist”) and Dr. Brandon Brock (‘chiropractic neurologist”). TMA presented Bridgett
Wallace and Dr. Richard Kemper for deposition, and both did an excellent job testifying.

The parties filed cross motions for summary judgment and the court held a hearing on the
motions on Dec. 5, 2011. The court’s order essentially granted TMA all relief it sought in the
lawsuit and on March 15, 2012, TBCE filed its Notice of Appeal, and filed its Appellant’s Brief
denied oral arguments and set the case for submission on briefs on Oct. 2, 2012.

On Nov. 21, 2012, the Court of Appeals issued its opinion reversing the trial court’s ruling, which
had granted TMA’s Motion for Summary Judgment. The appellate court also remanded the case
back to the trial court to determine what VON testing is. According to the appellate court,
questions of fact exist regarding whether VON testing is solely a medical test, and whether the
test can be used for chiropractic purposes. In summary, the appellate court reversed on a
technicality — a Motion for Summary Judgment is a purely legal (not factual) finding, and
because the appellate court feels there are factual issues to decide (what is VON), it determined
that the Motion for Summary Judgment ruling was improper.
On remand, TMA filed its First Amended Original Petition on Sept. 13, 2013. In its amended petition, TMA added the following arguments for the court’s determination: the rules improperly define “musculoskeletal system” to include nerves, and also define that term with a functional context (“that move the body and maintain its form”), which implies that anything that affects movement of the body or maintenance of its form would be included in the musculoskeletal system; the rules improperly authorize certain chiropractors to perform “technologically instrumented vestibular-ocular-nystagmus” testing, which is unrelated to the biomechanical condition of the musculoskeletal system or the spine; and the rule improperly defines “subluxation complex” as a “neuromusculoskeletal condition,” which exceeds the scope of authority conferred on chiropractors by the Chiropractic Act. TMA also amended discovery responses to TBCE’s request for disclosure to reflect the new issues contested in the First Amended Original Petition.

TBCE filed a Brief in Support of a Plea to the Jurisdiction on Feb. 28, 2014, with respect to the issue of whether or not it is within the scope of practice for chiropractors to make a medical diagnosis. After hearing arguments, the Court denied the Plea and interlocutory appeal immediately followed on April 3, 2014. On Dec. 8, 2014, the Third Court of Appeals court affirmed denial of the Plea, and on Feb. 23, 2015, the Third Court of Appeals overruled TBCE’s Motion for Panel Rehearing and/or En Banc Rehearing. After petitioning for review with the Supreme Court of Texas, the petition was denied.

On June 16, 2016, TBCE filed a Motion for Partial Summary Judgment relating to the diagnosis issue, which the court denied. Accordingly, the case proceeded to trial from Aug. 2-3, 2016. TMA argued that, as VON testing reveals nothing about the biomechanical condition of the spine or musculoskeletal system; it is not included in the definition of chiropractic. Since the Legislature included only the musculoskeletal system and spine in the definition of chiropractic, TMA argued, the VONT rule exceeds the scope of chiropractic. The TBCE claimed that problems with the vestibular system can affect the musculoskeletal system and therefore are within the purview of chiropractic. As directed by Judge Hurley, written closing arguments were filed by all parties on Aug. 13, 2016.

On Oct. 19, 2016, Judge Hurley issued a Final Judgment declaring:

• The authorization for chiropractors to perform “Technological Instrumented Vestibular-Ocular-Nystagmus” exceeds the scope of chiropractic and is therefore void;
• The definition of “musculoskeletal system” to include “nerves” exceeds the scope of chiropractic and is therefore void;
• The definition of “subluxation complex” as a “neuromusculoskeletal condition” exceeds the scope of chiropractic and is therefore void; and
• The use of the term “diagnosis” as used by TBCE in its Scope of Practice Rule exceeds the scope of chiropractic and is therefore void.

On Oct. 25, 2016, TBCE asked the court to file findings and fact and conclusions of law. These were drafted by TMA’s outside counsel, David Bragg, and signed by Judge Hurley. TBCE requested additional findings of fact and conclusions of law. On Dec. 6, 2016, TMA filed its response to TBCE’s request for additional findings of fact and conclusions of law and made its own request for the same. On Dec. 7, 2016, Judge Hurley signed supplemental findings of fact and conclusions of law.

In Jan. 2017, TBCE filed an appeal with the Third Court of Appeals. In its appeal, TBCE argued three main points:
1. That nerves are associated with subluxation complexes and are an integral part of chiropractic treatment and correction of biomechanical problems affect nerves, which means that the rule’s references to “nerves” or “neuro” are consistent with the statutory scope of chiropractic.

2. TMA did not prove that the VONT provision is invalid because TMA did not demonstrate that VONT was intended to be used exclusively to diagnose disease of the brain, ear, or eye, whereas TBCE contends they offered uncontradicted evidence that VONT is useful in chiropractic evidence. And,

3. The term” diagnosis” in the challenged rule was within the statutory scope of chiropractic practice and that the issue has already been decided and may not be relitigated.

TMA filed its brief in response to TBCE’s brief on Sept. 11, 2017. The case was heard before the appellate court on Feb. 28, 2018.

On Nov. 21, 2018, the Third Court of Appeals issued a Memorandum Opinion (Justice C. Bourland) affirming the trial court’s judgment in part and reversing in part:

1. The Third Court overruled TBCE’s first point on appeal. The fact that nerves are affected by disorders in or treatment of the musculoskeletal system does not mean that the nervous system or the nerves themselves fall within the scope of chiropractic. Statutorily limited to evaluation of the “biomechanical condition of the spine and musculoskeletal system” citing 201.002(b).

2. The Third Court noted that although VONT may be a useful tool to chiropractors, the evidence establishes that VONT helps in the diagnosis of vestibular issues, and that such disorders do not fall within the ambit of chiropractic.

3. Finally, the Third Court noted that effective Sept. 1, 2017, Section 201.002 of the Occupations Code was amended to provide that a person practices chiropractic if she, among other things, “uses objective or subjective means to diagnose, analyze, examine, or evaluate the biomechanical condition of the spine and musculoskeletal system of the human body.” Thus, because the term “diagnose” is expressly included in the Occupations Code itself, it is valid to include it although limited to the biomechanical condition of the spine and musculoskeletal system.

On Dec. 31, 2018, TCBE filed a Motion for En Banc Reconsideration on Points 1 and 2 contending that the Third Court did not apply the proper de novo review in the statutory interpretation case and instead applied a sufficient evidence analysis. TCBE further argues that VONT is within the scope of chiropractic treatment as it helps chiropractors rule out other nonvestibular signs of dizziness and refer to other providers. Finally, TCBE challenges TMA’s standing to file suit in this particular cause under the Administrative Procedures Act. On or about Dec. 28, 2018, TCBE filed a Petition for Review to the Supreme Court of Texas. On Jan. 10, 2019, the Court denied TCBE’s Motion for En Banc Reconsideration.

B. LITIGATION AS DEFENDANT

No pending litigation at this time.

C. AMICUS CURIAE BRIEFS

1. Benge v. Williams

(Regarding whether a primary surgeon must tell a patient not only that a resident will be assisting in a surgery, but also exactly what that resident's education, training, and experience is in the surgery in question and exactly what parts of the surgery the resident is going to perform.)
In this case, Jim P. Benge, MD, and Kelsey-Seybold were sued when a patient, Lauren Williams, suffered a perforated bowel after a laparoscopically assisted vaginal hysterectomy. Ms. Williams did not sue the resident involved or the residency program.

Dr. Benge met with Ms. Williams a week before the surgery to obtain her informed consent. He had her sign a form consenting to the surgery and informing her of the risks, which specifically included the possibility of damage to the bowel (the injury that led to the filing of this lawsuit). The consent form also stated that Dr. Benge could use “such associates, technical assistants or other healthcare providers as he may deem necessary” for the surgery. Such language would have similarly allowed the use of a scrub tech or nurse. The form also stated that Dr. Benge could “require other physicians, including residents, to perform important tasks based upon their skill-set, in the case of residents, under the supervision of the responsible physician.” The form went on to state that “[r]esidents are doctors who have finished medical school but are getting more training.”

A third-year Methodist Hospital OB-GYN resident, Lauren Giacobbe, assisted the Kelsey-Seybold physician with the surgery. While the resident had extensive experience in laparoscopic surgery and hysterectomies, this was her first laparoscopically assisted vaginal hysterectomy. Both Dr. Benge and Dr. Giacobbe performed parts of the procedure. Though neither Dr. Benge nor Dr. Giacobbe saw damage occur, Ms. William’s bowel was perforated during, or as a result of, the surgery. Ms. Williams then developed sepsis, underwent a tracheotomy, was put on a mechanical ventilator, and remained in a chemically induced coma for 3 weeks. Once discharged, she required home health assistance for an extended recovery period and was unable to work. Finally, Ms. Williams had several subsequent surgeries to replace colostomy.

The plaintiff's lawyer based his claim primarily on the fact that while the plaintiff consented to having residents involved in her treatment, she was not specifically told that this was the first time that Dr. Giacobbe had assisted on this specific procedure. The plaintiff's lawyer claimed that the plaintiff would have never consented to a resident with that experience level assisting with the surgery. At trial, Dr. Benge requested that the jury be “instructed that in deciding whether [Dr. Benge] was negligent, you cannot consider what [Dr. Benge] told, or did not tell, [Williams] about [Dr. Giacobbe’s] being involved with the surgery. The trial court overruled Dr. Benge’s objection and refused to give the jury the requested instruction.

The jury awarded the plaintiff $1.9 million.

TMA joined with the Texas Alliance for Patient Access and the Texas Osteopathic Medical Association in filing an amicus brief on Sept. 13, 2013, in this case in support of Dr. Benge’s position, arguing that:

1. The Texas Legislature set up a statutory scheme contained in Chapter 74 regarding informed consent claims.
2. The legislature decided as a policy matter that most surgical procedures would have a particular and exclusive list of risks as delineated by the Texas Medical Disclosure Panel and that no other disclosures would be required in order to enjoy the benefits of the presumed informed consent.
3. The experience levels of surgeons and residents are not on List “A” for laparoscopically assisted vaginal hysterectomy procedures, so Dr. Benge was under no duty to disclose that information.
4. If this jury’s verdict is upheld, it would have a significant impact on resident education as it would be impractical, if not impossible, to tell each patient in advance about which residents
would be involved; what their education, training, and experience was with regard to that type of surgery; and exactly what they would be doing during the surgery.

(5) This could be a slippery slope: The next cause of action could be against primary surgeons for failing to tell patients about the limits of their own experience and training in a particular type of surgery.

The Court of Appeals for the First District of Texas in Houston issued its opinion on Nov. 18, 2014. The court found that there was no common law duty to disclose the relative experience of the surgeon assisting. The court found that the resident-disclosure theory did not concern a risk for hazard inherent to her hysterectomy surgery and that no such duty existed. The court found that the assertion of medical negligence that characterizes the failure to disclose this information as a breach of duty was an invalid theory and should not have been submitted. As the court could not determine whether the jury found in favor of the plaintiff on this theory as opposed to some other valid theory, the court concluded that it was required to order a new trial.

On Jan. 30, 2015, Ms. Williams filed a motion for rehearing and En Banc consideration with the Court of Appeals. On Feb. 26, 2015, the First Court of Appeals requested a response to the motion for rehearing. A response was filed on April 1, 2015.

On Sept. 22, 2015, the Houston First Court of Appeals denied the motion for rehearing en banc filed by the plaintiff in the case. The vote was 5-4 against en banc rehearing, and the panel voted to stay with the panel’s original decision to send the case back down to the trial court for a new trial.

On motion for rehearing en banc, Justices Radack, Jennings, Bland, Massengale, and Brown voted not to have an en banc rehearing, and Justices Bland, Keyes, Higley, and Lloyd voted in favor of an en banc rehearing. Justice Brown wrote a supplemental opinion in response to the motion for rehearing en banc. Justices Jennings, Keyes, and Lloyd all wrote dissenting opinions for the denial of the rehearing en banc.


On March 3, 2017, TMA joined with the Texas Alliance for Patient Access and the Texas Osteopathic Medical Association in filing an amicus brief with the Supreme Court of Texas.

On March 10, 2017, the Supreme Court of Texas granted both Petitions for Review. Oral arguments were made on Jan. 11, 2018. On May 25, 2018, the Texas Supreme Court (Chief Justice N. Hecht) handed down its decision, adopting the position supported by TMA. Plaintiff’s argument that informed consent should have been acquired regarding who was assisting in the surgery was not a proper claim under Texas law. The Court concluded that Ms. Williams’ characterization of the evidence of Dr. Benge’s nondisclosure was not a claim of lack of informed consent for which he could be liable. Indeed, Ms. Williams specifically disclaimed such basis for liability at trial.
Moreover, the Court further found no distinction between a claim of nondisclosure and lack of informed consent. Because the jury could have found that Dr. Benge was negligent in failing to disclose Dr. Giacobbe’s involvement in the surgery and her lack of experience, the jury should have been instructed not to consider the lack of disclosure in determining negligence when that claim was not asserted. As a result of the court’s holding, the case was remanded back to the trial court for a new trial.

2. *Gomez v. Memorial Hermann*

(Regarding whether the Supreme Court of Texas should grant the petition for writ of mandamus in this case.)

This case was brought by Miguel Gomez MD, a heart surgeon, against Memorial Hermann Hospital System (MH); Michael Macris, MD; and Keith Alexander (CEO of MH) in their official capacities. Dr. Gomez alleges tortious conduct on the part of MH and that anticompetitive actions were taken by the defendants.

Dr. Gomez seeks documents that purport to measure his quality and efficiency as compared to other doctors in the MH system. Allegedly, these were improperly compiled by another cardiovascular surgeon (Dr. Macris) and spread using MH’s wholly owned nonprofit health corporation (MHMD) to other physicians who likely would refer patients to Dr. Gomez and the rumor mill at MH. This allegedly was done after MH learned that Dr. Gomez had applied for privileges at a competing facility that was being constructed a few miles from MH’s Memorial City facility. After Dr. Gomez refused to accept a proposed monitoring of his practice without the benefit of peer review by the hospital medical staff’s peer review committee, attempts to restrict the privileges of Dr. Gomez through the MH Memorial City’s medical staff peer review committee failed. Subsequently, the defendants started an alleged rumor mill in an attempt to affect Dr. Gomez’s referrals adversely, thereby affecting patient choice. Some evidence of this, including the testimony of former MH executives now employed with another health care system, is in the case record.

The TMA Patient Physician Advocacy Committee (PPAC) reviewed numerous briefs and other documents authored by both sides of the case and spent several hours with presenters from each side of the issue at its meeting held May 1, 2014, in conjunction with TexMed 2014. Since that time, the Supreme Court of Texas has asked for briefing from Dr. Gomez on the issue of whether or not the court should accept the case.

Defendants, MH, Dr. Macris, and Mr. Alexander are seeking a writ of mandamus from the Supreme Court of Texas, which would order the trial court to withdraw its order mandating the discovery of certain medical peer review records. The defendants seeking the writ have already filed briefs with the court, arguing that the court should take the case, grant oral argument, and reverse the trial court’s determination that certain documents relevant to the allegation of anticompetitive conduct are discoverable and must be disclosed to the plaintiff. The trial court’s order came after the trial court judge reviewed the documents in camera and made a judgment on each document’s relevance to the allegation of anticompetitive conduct.

Some of the stipulated medical peer review documents were determined to be related to the alleged anticompetitive conduct by the defendants. Under the anticompetitive exception to peer review protection provided by the Texas Occupations Code, discovery of documents is permitted if the peer review records and proceedings requested are relevant to an anticompetitive action or to a federal civil rights proceeding.
The trial court determined that the Texas Occupation Code’s peer review provisions applied, rather than the medical committee protections found in the Texas Health and Safety Code. This determination was based upon the reasoning that the more specific statute controlled. (TMA drafted the original peer review bill and supported the resulting medical peer review language, which was passed in 1987 to adopt the protections in the federal Health Care Quality Improvement Act of 1986 and to shore up the Texas peer review protections that had been eroded by the Texas appellate courts.) The Texas Hospital Association also supported the bill. The 1987 Texas law protections prohibiting discovery of peer review minutes and proceedings had two exceptions: an anticompetitive action and a civil rights proceeding. These provisions remain unchanged today.

At the meeting of the PPAC, both sides requested that TMA file a brief in support of their respective positions. The defendants argued that the anticompetitive action exception did not fit this case because it did not reach the threshold of an antitrust action, as only one physician was allegedly discriminated against. The market for patients to choose a heart surgeon allegedly was not affected. Also, the defendants argued that the Texas Health and Safety Code medical committee provision keeping medical committee records and proceedings confidential should apply. There is neither an anticompetitive nor a civil rights exception included in that medical committee provision.

On June 19, 2014, TMA filed an amicus curiae brief in the case. TMA’s brief argued that plain language of the statute provides an exception to the confidentiality and privilege associated with peer review when a judge makes a preliminary finding that a proceeding or record of a medical peer review committee is relevant to an anticompetitive, not antitrust, action.

TMA’s brief also argued that the legislative history of, and public policy behind, this exception indicates that the facts alleged in this case are precisely those meant to be addressed by this statute. The record reflects that the trial judge in this case made the required preliminary finding and ordered production of some of the proceedings and records of the medical peer review committees involved, as required by the statute. The record also indicates that the judge was presented evidence outside of the contested peer review records and proceedings, which provided an extra check to the potential overuse of the exception. Therefore, there is no need to exercise court’s jurisdiction in this case and grant the petition.

On June 27, 2014, the court requested briefing on the merits. MH’s brief was filed on Aug. 27, 2014. Dr. Gomez’s brief was filed on Oct. 27, 2014. MH’s reply brief was filed on Nov. 26, 2014

Oral arguments were made on Feb. 25, 2015. TMA was in attendance. Dr. Gomez filed a post submission brief on March 10, 2015. MH filed a response to that brief on March 20, 2015.

On May 26, 2015, the court issued an opinion. The court adopted the logic TMA put forward in its amicus brief and held that the anticompetitive action exception is broader than an antitrust claim such that an individual physician can pursue a claim against a hospital.

Interestingly, the court went on to discuss how confidentiality would work if a committee was both a “medical committee” and a “medical peer review committee”: “records and proceedings of a dual medical committee and medical peer review committee do not enjoy any greater confidentiality under section 161.032(a) than they do under section 160.007(b).” Therefore, doctors in future lawsuits of this nature will have the benefit of the broader anticompetitive action claim no matter which peer review confidentiality section the hospital claims applies.
A jury trial in the case was held from March 17, 2017 through March 27, 2017. The jury deliberated for 2 days and delivered its verdict on March 29, 2017. The jury found that MH defamed Dr. Gomez and awarded Dr. Gomez $6.4 million, including $1 million in punitive damages. In May 2017, the state district court judge, who presided over the trial, affirmed the jury verdict by entering an order in Dr. Gomez’s favor that awarded over $6 million in damages. A notice of appeal was filed on Aug. 10, 2017. A post-judgment mediation was unsuccessful.

TMA submitted its amicus brief to the First Court of Appeals on Oct. 23, 2018. In the brief, TMA noted practical concerns on healthcare facilities abusing qualified privilege to engage in anti-competitive and retaliatory behavior against physicians. TMA further pointed out to the appellate court that MH’s defamatory statements are not privileged or subject to any qualified privilege. Finally, the brief reiterated the point that the jury found evidence of actual malice, which defeats any privilege defense. The parties presented oral argument on Oct. 30, 2018.

(Regarding the performance of acupuncture by chiropractors.)

This case was brought in a Travis County district court by the Texas Association of Acupuncture and Oriental Medicine (TAAOM) against the Texas Board of Chiropractic Examiners and its executive director (in her official capacity). The plaintiff challenged the validity of rules adopted by TBCE authorizing chiropractors to perform acupuncture. The trial court granted the defendants’ motion for summary judgment and denied a request for summary judgment made by the plaintiff acupuncture and oriental medicine association. The plaintiff appealed the denial to the Third Court of Appeals in Austin. TMA on Dec. 1, 2015, submitted an amicus brief to the appellate court, wherein TMA argued that TBCE went too far in allowing chiropractors to perform acupuncture. TMA asked for a reversal of the trial court’s judgment, as doing so would invalidate the relevant rules of the chiropractic board.

In the amicus brief, TMA argued that the chiropractic board’s rules on acupuncture exceed what state law allows under the Chiropractic Act. TMA also pointed out the Chiropractic Act doesn’t authorize any procedures on the nervous system nor does it authorize chiropractors to perform acupuncture. TMA’s brief said that the Chiropractic Act “addresses biomechanical conditions of the musculoskeletal system, not acupuncture.”

The appeal hearing took place on Dec. 2, 2015. At the hearing, the chiropractic board’s counsel contended that because the Chiropractic Act prohibits only the performance of incisive procedures, chiropractors should be able to perform acupuncture within the scope of their practice act. There was some discussion of whether biomechanics encompassed the use of acupuncture, with one justice saying, “Acupuncture is about nerves; that’s different from biomechanics.”

The Third Court of Appeals delivered its opinion on Aug 18, 2016. The court held that the lower court erred in granting summary judgment in favor of the TBCE on the validity of the TBCE’s rules regarding requirements for practicing acupuncture by chiropractors. The appellate court also opined that the trial court did not err in granting summary judgment in favor of the TBCE on the definition of “incision,” or in the use of needles in nonsurgical/nonincisive procedures, and remanded the case to the trial court. Finally, the appellate court requested that the Legislature solve the long-standing dilemma of how the scope of chiropractic correlates with the scope of practice in other health professionals’ licensing statutes.

On Feb. 17, 2017, the motion for rehearing was granted, in part, the previous opinion was withdrawn, and a new opinion was issued. The new opinion reverses the portion of the trial court’s judgment dismissing TAAOM’s challenge to TBCE’s rule expressly authorizing acupuncture and remands the case for further proceedings.

According to a Dec. 14, 2017 “Parties’ Status Update” of the case on remand, the Board voted “to continue negotiations with the Association as precedent to rule-making but, rather than proceeding under Chapter 2008 of the Texas Government Code, to conduct informal conferences or use other appropriate methods as preparation for rulemaking concerning the subject matter of this lawsuit. . . . Progress has been made but the Board is still in the process of gathering stakeholder input. It is projected that the entire rulemaking process—including stakeholder meetings—could take a year or longer. As such, this case should remain abated so that the parties can complete the rulemaking process that could lead to the termination of this litigation.” As of March 2018, stakeholder workgroup meetings are continuing.

In July 2018, the TBCE proposed amended rules in the Texas Register. While the status of the parties in litigation remains unchanged, TAAOM has indicated that the proposed rules do not reflect any agreement of the parties. TMA provided comments on these proposed rules (see item D.1 below). The parties are also exploring agreed legislation this session to resolve the litigation.

4. **D.A. and M.A., Individually and as Next Friends of A.A., a Minor v. Texas Health Presbyterian Hospital of Denton, Marc Wilson, MD and Alliance OB/GYN Specialists, PLLC d/b/a OB/GYN Specialists, PLLC**

(Regarding whether Texas Civil Practice and Remedies Code §74.153 applies to emergency medical care provided in an obstetrical unit without the patient first having been evaluated in a hospital emergency department.)

This is a health care liability claim arising out of the delivery of M.A. and D.A.’s son, A.A. (Plaintiffs), and the care provided by Marc A. Wilson, MD, Texas Health Presbyterian Hospital Denton, and Alliance OB/GYN Specialists, PLLC (Defendants). The delivery was complicated by a shoulder dystocia. Plaintiffs allege that Dr. Wilson was negligent in failing to stop all maternal pushing efforts once the shoulder dystocia was recognized, in failing to place Mrs. Akers in a correct McRoberts position, and in placing excessive lateral traction on the head and neck of the baby. Plaintiffs also allege that the care constituted “willful and wanton” negligence and gross negligence.

Dr. Wilson and the PLLC (alleged to be vicariously liable for Dr. Wilson’s conduct) argue that the standard applicable to Plaintiffs’ claims is the “willful and wanton” negligence standard contained in §74.153 of the Texas Civil Practice and Remedies Code.

§74.153 (emphasis added) reads:

In a suit involving a health care liability claim against a physician or health care provider for injury to or death of a patient arising out of the provision of emergency medical care in a hospital emergency department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department, the claimant bringing the suit may prove that the treatment or lack of treatment by the physician or health care provider departed from accepted standards of medical care or health care only if the claimant shows by a preponderance of the evidence that the physician or health care provider, with willful and wanton negligence, deviated from the
Dr. Wilson and the PLLC filed a motion for summary judgment addressing the application of §74.153 to Plaintiffs’ burden. Plaintiffs disputed that §74.153 applies because they claim the statute is only triggered if the claim arises out of emergency medical care provided in an obstetrical unit following the evaluation or treatment of the patient in a hospital emergency department and that M.A. did not present or receive any care in the emergency department prior to the delivery in the obstetrical unit of the hospital.

Defendants argue that Plaintiffs erroneously interpreted the plain language of §74.153. Defendants’ claim the plain language should be interpreted such that evaluation or treatment of the patient in hospital emergency department is not a prerequisite to application of the statute to a claim arising out of emergency medical care in an obstetrical unit. Defendants claim that prerequisite only applies if the claim arises out of emergency medical care in a surgical suite.

The trial court agreed with Defendants and concluded that §74.153 applies even though M.A. was not evaluated or treated in the emergency department prior to the emergency medical care which is the subject of this claim. The trial court granted the Defendants’ motion, and signed an order permitting a permissive interlocutory appeal to answer the following question:

Does the emergency medicine statute, section 74.153 of the Texas Civil Practice and Remedies Code, apply to a suit involving a health care liability claim against a physician or health care provider for injury to or death of a patient arising out of the provision of emergency medical care in an obstetrical unit without the patient first having been evaluated in a hospital emergency department?

On June 2, 2016, the Second Court of Appeals in Ft. Worth agreed to consider the question.

On Aug. 30, 2016, TAPA, TMA, THA and others filed an amicus curiae brief in the case in of support Defendants’ position that §74.153 applies to claims arising out of the provision of emergency medical care provided in an obstetrical unit without the patient first having been evaluated or treated in a hospital emergency department.

The case was submitted without oral argument on Oct. 11, 2016.

On Feb. 16, 2017, the Second Court of Appeals issued its Opinion, stating that “(w)e hold that section 74.153, which provides a willful and wanton standard for liability, does not apply to emergency medical care provided in an obstetrical unit when the patient was not evaluated or treated in a hospital emergency department immediately prior to receiving the emergency medical care.”

On May 2, 2017, a Petition for Review was filed by the defendants. On May 9, 2017, the Supreme Court of Texas requested a response to the Petition for Review. On July 10, 2017, a Response to the Petition for Review was filed. A Reply to the Response to the Petition for Review was filed on Aug. 24, 2017. On Sept. 22, 2017 the Court requested briefs on the merits from all parties. A Brief on the Merits was filed Nov. 22, 2017. A Response Brief was due Jan. 11, 2018 and a Reply Brief was due Jan. 26, 2018. Respondents (Plaintiffs in the lower court) filed their Brief on the Merits on Jan. 11, 2018. Petitioners (Defendants in the lower court) filed their Reply Brief on the Merits on Jan. 26, 2018.
On Oct. 2, 2018, TMA, TAPA, and the other signatories filed an amicus brief before the Texas Supreme Court. The Court heard oral argument on Oct. 9, 2018, and on Dec. 21, 2018, the Court issued a Memorandum Opinion (J. Boyd). In the brief, TMA noted that the phrase “immediately following” only modifies “surgical suite.” That would mean the higher standard of proof applies to health care practitioners who treat patients in any of three places: the ED, the obstetrical unit, or a surgical suite if the patient was previously evaluated or treated in the ED.

The Supreme Court, after careful analysis and construction of the statute, agreed with the argument of Dr. Wilson and TMA in a Dec. 21, 2018 decision. It said the higher “willful and wanton” standard applies when a case “arise[s] out of the provision of emergency medical care in a hospital obstetrical unit, regardless of whether that care is provided immediately following an evaluation or treatment in the hospital’s emergency department.” The Court called that interpretation “the only reasonable construction of the statute’s language” and affirmed dismissal of the case.

5. *Noel Dean v. Darshan Phatak, MD*

(Regarding whether a physician who met the standard of care, but later changed his autopsy finding, can be held liable for the earlier finding.)

This is a civil rights case against a physician practicing as a medical examiner in Harris County. Darshan Phatak, MD is employed as an assistant medical examiner with the Harris County Institute of Forensic Sciences, which contracts to provide autopsy services in Harris County, and performed the autopsy of a certain deceased woman and determined the cause of death to be “homicide” by gunshot wound. Following this determination, the deceased’s husband was arrested and tried for murder. The accused’s murder trial ended in a hung jury. After the trial, the chief deputy medical examiner, in reevaluating the evidence, performed another additional test in relation to the decedent and the gun wound—a gun-to-wound examination—and as a result, the medical examiner’s office changed the cause of death determination in the autopsy report from “homicide” to “undetermined.” Because of this change, the prosecutor dropped the charges, and the accused filed a civil rights suit in federal court against, among others, Dr. Phatak in his individual capacity.

The basis for the lawsuit is that, pursuant to the Fourth, Sixth, and Fourteenth Amendments to the U.S. Constitution, the accused had a right to be free from an intentionally falsified autopsy report, and the accused is asserting just that: that Dr. Phatak intentionally falsified the autopsy report. This assertion is based on the alleged fact that Dr. Phatak allowed a detective to influence the autopsy determination; that he failed to fully consider that the deceased had suicidal thoughts; and that he failed to perform a gun-to-wound comparison. Dr. Phatak has maintained that he did not conspire with detectives to falsify the report and has also maintained that nothing in his examination was extraordinary or unusual—he claims he followed protocol.

The federal district court has refused to recognize the defense of qualified immunity to which Dr. Phatak, a governmental employee, should be entitled. In an order on a motion for summary judgment, the court found that, viewed in the light most favorable to the plaintiff, a reasonable juror could conclude that a “reasonable medical examiner would have understood that intentional fabrication of evidence violated a defendant’s right to be free of a wrongful prosecution that cause his pretrial arrest and other deprivations of liberty.” The trouble is that the court’s articulation of the clearly established right—to be free from intentional fabrication of evidence— is far too broad and thus interferes with Dr. Phatak’s right to exercise his medical judgment. It is undisputed that Dr. Phatak followed the protocols of the medical examiner office. The fact that Dr. Phatak relied on reasonable medical judgment and medical standards offered no protection according to the court. Essentially, the court imposed a higher “standard of care” with its holding.
TMA gathered the support of the American Medical Association, the National Association of Medical Examiners, the College of American Pathologists, and the Texas Society of Pathologists and together filed a joint amicus brief to the U.S. Fifth Circuit Court of Appeals. The brief discussed the importance of medical examiners and that, because of their important function, they should not be held to a higher standard of care than what is ordinarily required of physicians.

On Dec. 6, 2017, the Fifth Circuit held oral arguments. On Dec. 20, 2018, the Fifth Circuit issued a decision vacating the district court’s denial of qualified immunity based on a procedural technicality.

Specifically, the Fifth Circuit determined that the district court’s order and analysis cites allegations in the pleadings (written statements) but did not reference actual “evidence” in the record. Without identification of summary judgment evidence, the Fifth Circuit determined it could not make a reasoned decision to affirm or deny qualified immunity. Accordingly, the Fifth Circuit remanded the case to the district court to reconsider the motion and instructed the district court to specifically reference summary judgment evidence in its order. After the district court issues a new order, the case is likely to be appealed back to the Fifth Circuit again.

(Regarding whether a physician employed by a Texas governmental entity but having staff privileges and performing employee duties at another facility is still entitled to immunity for actions that occurred at the other facility.)

In this case, the Perkins family is suing physicians and the Children’s Medical Center of Dallas (CMCD) as representatives of their deceased 16-year old son who had sought care at CMCD for a brain tumor associated with primary CNS lymphoma. The plaintiffs allege that though the surgery was successful, the follow-up treatment failed to meet the standard of care on the basis that physicians employed experimental protocols designed to treat patients with severe systemic disease, which they claim their son did not have. The plaintiffs allege that other physicians failed to recognize and remove their son from this improper protocol. Finally, they allege that another physician failed to keep their son on medication for his lungs for the proper amount of time and failed to scan the son’s chest prior to discharge.

The issue, though, is that the defendant-physicians were employees of UT Southwestern at Dallas (“UTSW”)—a governmental entity—and as such, would ordinarily be afforded governmental immunity under the Texas Tort Claims Act. As a result of the 2003 tort reforms pushed through by TMA, the Act entitles a Texas governmental entity physician employee to be dismissed from a lawsuit if the employer could have been sued in the employee’s place.

The plaintiffs allege that the physicians were only ostensibly UTSW employees, but when they were treating patients at CMCD, they were acting within the course and scope of their CMCD staff privileges, not their employment at UTSW.

The physician defendants motioned the court to be dismissed under the Texas Tort Claims Act, and then asked for summary judgment on the same grounds. The court dismissed the physicians’ motions, and the physicians appealed. The appellate court ruled in the physicians’ favor, holding that they were indeed employees of UTSW and thus entitled to immunity. The plaintiffs have appealed to the Supreme Court.

On Feb. 14, 2018, TMA and TAPA filed an amicus brief in the case.
The Texas Supreme Court refused to grant the petition for review on April 6, 2018, leaving the favorable court of appeals decision in place.

7. **Gunn v McCoy**
   (Regarding medical causation and expert testimony.)

TMA, AMA and TAPA submitted an amicus curiae brief in Gunn v. McCoy with the Texas Supreme Court on Feb. 5, 2018. The case deals with a husband’s lawsuit against physicians, physician groups (Obstetrical and Gynecological Associates, P.A. and Obstetrical and Gynecological Associates, PLLC, together OGA), and a hospital relating to the defendants’ management and treatment of his wife’s disseminated intravascular coagulation (DIC).

When she was 37 weeks pregnant, Shannon McCoy, who had been under the prenatal care of Debra Gunn, MD, an obstetrician and gynecologist, presented at the hospital with severe abdominal pain and lack of fetal movement. Under the supervision of the on-call obstetrician and later Dr. Gunn, Shannon received blood products, including fresh frozen plasma (“FFP”). She delivered a stillborn baby, received additional blood products, not including FFP, and was transferred to the ICU. Shannon continued to lose blood. In the ICU, Shannon developed tachycardia, and her uterus stopped contracting. Shannon underwent a hysterectomy. Just before the surgery, her heart stopped pumping blood and she went into cardiac arrest. CPR was performed. Shannon suffered brain damage and seizures, was transferred to a neurological ICU, and underwent months of therapy. Since Sept. 14, 2004, Shannon has required around-the-clock care as a quadriplegic. Subsequent to the trial, Shannon McCoy passed away.

Plaintiff Andre McCoy’s theory of the causation of the brain injury is that Dr. Gunn failed to adequately treat the DIC by failing to order additional FFP to replace Shannon’s clotting factors and slow her bleeding, and by failing to infuse enough units of blood.

Dr. Gunn and OGA claim that the plaintiff’s expert and the appellate court did not adequately consider the amount of blood and blood products that they did provide the patient, and that the medical record clearly supports that. They alternatively theorize that DIC caused small blood clots in Shannon’s vascular system and that some of those small clots lodged in blood vessels in Shannon’s brain, causing the injury. This theory was supported by testimony by two expert witnesses, a hematologist and a neurologist.

Andre McCoy, Shannon’s husband, sued Dr. Gunn, other physicians, OGA, and the hospital associated with his wife’s care alleging that their negligence in mismanaging his wife’s DIC caused the brain injury. All physicians aside from Dr. Gunn either settled or were dropped out of the lawsuit.

The jury returned an 11-to-1 verdict in favor of McCoy as to Dr. Gunn’s negligence and awarded damages of over $10 million, including approximately $700,000 in past medical expenses and over $7 million in future medical expenses.

On Feb. 5, 2018, TMA and TAPA filed a brief in support of Dr. Gunn and OGA. Oral argument in the case was heard on Feb. 8, 2018.

In June 2018, the Texas Supreme Court affirmed the appellate court’s decision, which affirmed the jury verdict against Dr. Gunn and the other defendants. The court held that the differing causation theories represented a battle of the experts that was properly resolved by the jury.
8. **In re City of Dickinson**

(Regarding preservation of the attorney-client privilege in the context of a designated party expert witness.)

On Sept. 6, 2018, TMA, jointly with the Texas Alliance for Patient Access, submitted an amicus brief in a case carrying implications for medical professional liability lawsuits. The city of Dickinson (the City) sued Texas Windstorm Insurance Association (Texas Windstorm) after a dispute regarding the amount Texas Windstorm owed the City under a policy for property damage caused by high winds during Hurricane Ike. In conjunction with some of its pleadings, Texas Windstorm included an affidavit of its corporate representative, who was also offering opinion evidence as a non-retained expert.

The City sought to compel production of communication between this expert and Texas Windstorm’s attorney relating to the preparation of that affidavit. The City based its argument on certain rules of civil procedure that entitle parties to all documents provided to, reviewed by, or prepared by or for an expert in anticipation of the expert’s testimony. After several hearings, the trial court eventually granted the City’s motion, ordering Texas Windstorm to produce items provided to, reviewed by, or prepared by or for the expert in anticipation of his testimony as an expert, including all e-mails and drafts he exchanged with Texas Windstorm’s counsel.

Texas Windstorm did not produce the documents, and instead filed a petition for writ of mandamus in the court of appeals, arguing that the documents should be protected by the attorney-client communication privilege. The court of appeals granted Texas Windstorm’s petition, holding that the trial court abused its discretion and that Texas Windstorm should not have been required to produce the email exchanges and drafts of the expert affidavit between Texas Windstorm’s counsel and the expert.

The City of Dickinson appealed to the Texas Supreme Court, alleging that the rules of civil procedure entitle parties to all documents provided to, reviewed by, or prepared by or for an expert in anticipation of the expert’s testimony, regardless of whether those documents are attorney-client communication.

The court requested briefing on the issue and set the case for oral argument on Sept. 12, 2018. The TAPPA and TMA brief supports the appellate court’s holding which preserves the protection of candid conversation between legal counsel and defendant experts. Accordingly, TMA argued that the Texas Supreme Court should not grant the petition for a writ of mandamus.

On Feb. 25, 2019, the Texas Supreme Court issued an opinion agreeing with TMA’s position. The Court agreed with the appellate decision (overruling the trial court) and affirmed the holding that a client’s decision to offer expert testimony does not waive the attorney-client privilege.


(Regarding the evidentiary standard for expert testimony in describing the standard of care)

On Oct. 22, 2018, TMA filed an amicus brief with the Texas Supreme Court in support of an appellate court ruling that reversed a trial court judgment of nearly $2 million against a Cypress neurosurgeon. In the underlying suit, Tracy Windrum sued Cypress neurosurgeon Victor Kareh, MD, after her husband, Lancer Windrum, died in May 2010 of complications of hydrocephalus from aqueductal stenosis, a block in the aqueduct of his brain through which cerebrospinal fluid flowed.
On Feb. 3, 2010, Lancer experienced slurred speech, disorientation, and other issues, which required an ambulance to take him to North Cypress Medical Center. Dr. Carrie Blades, the attending emergency room physician, ordered that Lance undergo a CT scan of his head. The CT scan report noted that the ventricles in Lance's brain were “dilated out of proportion,” indicating hydrocephalus. Dr. Blades ordered an MRI, which was reviewed by Dr. Christina Payan, a neuroradiologist – Dr. Payan noted that the MRI also indicated dilation and that the cerebral aqueduct was narrowed. Lance reported that he had contracted encephalitis when he was six years old and also reported three similar “episodes” over the past several months but that he went back to his “baseline” within a matter of hours.

Dr. Gill then referred Lancer to Dr. Victor Kareh, a neurosurgeon, to determine whether Lance had increased intracranial pressure which might require surgery to alleviate. The next morning on Feb. 4, 2010, Lancer did not have any symptoms he presented the previous evening. All of Lance’s cranial nerves exhibited normal functioning and Lance did not have any double vision or swelling of the optic nerve. Dr. Kareh informed Lance that if he had increased intracranial pressure, he might need to have a shunt placed. Dr. Kareh monitored the intracranial pressure over a 24-hour period, which indicated that there was no increased pressure at the time the monitor was placed. Lance’s intracranial pressure spiked to higher than normal levels on a few occasions but would quickly return to normal on each occasion and he did not experience any periods of sustained intracranial pressure. Dr. Kareh determined that although Lance had hydrocephalus, he did not have increased intracranial pressure and no shunt was placed. Lance eventually took a second MRI scan in April. Dr. Gill did not discuss the MRI results with Lance but Lance did undergo an EEG on April 29, 2010 at Dr. Gill’s direction, which came up with normal results. No one informed Dr. Kareh of Lance’s symptoms or the results of the April MRI scan. On May 2, 2010, Lancer passed away in his sleep after complaining of similar symptoms the day before (sluggishness, slurred speech, etc.). It was determined that Lancer died from complications of blockage of a cerebral aqueduct.

The family of Lancer Windrum (collectively the “Windrums”) filed suit against Dr. Gill, as well as North Cypress Medical Center, North Cypress Medical Center Operating Company, and Dr. Victor Kareh (a neurosurgeon). All defendants settled with Windrum except Dr. Kareh. The case was tried to a jury in Harris County over 10 days. At trial, the Windrums presented a medical expert, Rob G. Parrish, MD, a board-certified neurosurgeon and neurosurgery instructor at Methodist Hospital in Houston. Dr. Parrish opined that, when Dr. Kareh saw Lancer on Feb. 4, 2010, the applicable standard of care required Dr. Kareh to install a shunt, or a permanent drain, in Lance’s brain to prevent a fatal build-up of cerebrospinal fluid and intracranial pressure. Dr. Parrish also opined on causation issues related to Mr. Windrum’s death. Dr. Parrish also testified that “but for” Dr. Kareh’s negligence, Mr. Windrum would not have died 3 months after being evaluated. Ms. Windrum claimed that her husband’s fatal spike in intracranial pressure would not have happened if Dr. Kareh had installed a shunt or performed a ventriculostomy.

A Harris County district court found Dr. Kareh was negligent and ultimately awarded Ms. Windrum and her children $1.875 million (after applying statutory caps and settlement credits) The Houston Court of Appeals reversed and decided that Dr. Parrish “presented no evidence concerning the standard of care and Dr. Kareh’s breach of the standard of care” so his testimony was “conclusory and, therefore, legally and factually insufficient to support the jury’s verdict.” It also found that Dr. Kareh’s decision not to recommend placement of a shunt in February 2010 was “too remote from Lance’s death on May 2, 2010 to be proximate cause of Lance’s death.”

Dr. Kareh appealed the judgment to the First Court of Appeals in Houston. On appeal, Dr. Kareh raised several issues including a challenge against Dr. Parrish’s testimony on legal insufficiency grounds, contending his testimony was conclusory and thus constituted “no evidence” for the
required standard of care or causation. The Court of Appeals reversed the trial court’s judgment and rendered a take nothing verdict in favor of Dr. Kareh. On a motion for rehearing and request for en banc consideration, the court upheld the Court of Appeals unanimous decision and a majority of the court denied the en banc consideration. Three judges dissented to the denial of en banc consideration, including Justice Brown who contends there are two areas of possible misinterpretation of the majority opinion regarding the standard for an expert’s negligence opinion that is based on experience and/or supporting literature.

The Windrums then appealed to the Texas Supreme Court which has accepted the Petition for Review. The parties submitted full briefing and the Court held oral argument on Oct. 10, 2018. On Nov. 7, 2018, TMA filed its amicus brief in support of Dr. Windrum. On Jan. 25, 2019, the Texas Supreme Court issued its opinion reversing the appellate court decision and remanding the case to the appellate court. The Court concluded the evidence was legally sufficient to uphold the verdict but instructed the appellate court failed to apply the proper standard of review by assessing the “factual sufficiency” of the evidence.

Specifically, Supreme Court concluded that although Dr. Parrish’s testimony concerning the standard of care Dr. Kareh owed to Mr. Windrum and whether Dr. Kareh’s breach of that standard of care caused Mr. Windrum’s death “was hardly supported by medical literature,” it was not conclusory. The Court concluded that a jury could reasonably find Dr. Parrish’s opinion persuasive over other opinions, and that an appellate court cannot substitute its own judgment for the jury’s. Further, the Court concluded that any breach by Dr. Kareh of the standard of care would not be too remote for a reasonable jury to find proximate cause. However, as noted above, the Court remanded the case to the appellate court to conduct a “factual sufficiency” standard of review to the evidence, which is a heavy hurdle. The standard requires the appellate court to detail the evidence relevant to the issue in consideration and clearly state why the jury’s finding is factually insufficient or is so against the great weight and preponderance of the evidence as to be “manifestly unjust,” “shock the conscience,” or clearly demonstrates bias.

10. Ruben Aleman, MD v. Texas Medical Board
(Regarding the Texas Medical Board’s sanction authority)

On Feb. 26, 2019, TMA filed an amicus brief the Texas Supreme Court in support of Dr. Aleman and urging reversal of a trial court order affirming the Texas Medical Board’s (the “Board”) assessment of an administrative penalty in the amount of $3,000.00 for Dr. Aleman’s alleged violation of the Texas Medical Practice Act (“MPA”).

Specifically, the TMB alleged Dr. Aleman failed to comply with Texas Health and Safety Code section 193.005(h), which requires an attending physician for a deceased person completing medical certification on a death certificate to submit information and attest to its validity electronically using the Texas Electronic Death Registry (“TEDR”). On July 29, 2011, a mortician presented Dr. Aleman with a physical paper Certificate of Death for a deceased patient and requested Dr. Aleman to sign the medical certification portion of the certificate. Dr. Aleman signed the paper certificate with a pen. By signing the paper Certificate of Death with a pen, Dr. Aleman was unable to sign the Certificate of Death electronically using the TEDR. The Board initiated a formal complaint with the State Office of Administrative Hearings (“SOAH”) against Dr. Aleman for allegedly violating the MPA by purportedly failing to comply with Section 193.005(h) of the Health and Safety Code’s requirement that the death certificate be signed electronically.
In response, Dr. Aleman argued that:

1. failure to submit the electronic signature was not “unprofessional conduct” as intended under the MPA;

2. the alleged violation of Section 193.005(h) of the Health and Safety Code is not related to the practice of medicine for the purpose of the Board’s enforcement jurisdiction but just an unrelated administrative violation;

3. the sanctions the Board imposed were excessive and arbitrary, and were assessed in retaliation for Dr. Aleman not accepting an agreed order relating to the alleged violation; and

4. SOAH lacked jurisdiction over the formal complaint due to the Board’s failure to comply with a certain statutory notice requirement.

The trial court affirmed the Board’s order, except to the extent, that the Board’s order waived a statutory notice requirement (the trial court held the failure to meet the requirement was procedural and not jurisdictional). On May 18, 2016, Dr. Aleman appealed to the Texas Third Court of Appeals, and the court of appeals affirmed the trial court’s judgment. On May 15, 2017, Dr. Aleman filed a petition for review with the Texas Supreme Court. Oral arguments were heard on Jan. 22, 2019.

TMA filed the amicus brief on Feb. 26, 2019, focusing on whether the Board abused its disciplinary powers by imposing sanctions higher than the lower-end sanctions applicable to first-time violators and in excess of the standard sanctions mandated by the Board’s own rules. Specifically, the Board’s rules, 22 Tex. Admin. Code section 190.14, state:

The standard sanctions outlined in paragraph (9) of this section provide a range from “Low Sanction” to “High Sanction” based upon any aggravating or mitigating factors that are found to apply in a particular case. The board may impose more restrictive sanctions when there are multiple violations…or…any aggravating…factors…. The minimum sanctions…are applicable to first time violators…The following standard sanctions shall apply to violations of the Act.

The following shows the low and high-end sanctions for failure to electronically sign a death certificate:

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<tr>
<th>Sanctions</th>
<th>Low</th>
<th>High</th>
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<tbody>
<tr>
<td>Failure to Electronic sign a death certificate under Health and Safety Code Chapter 193</td>
<td>Remedial Plan: 4 hours of ethics/risk management; $500 administration fee</td>
<td>Agreed Order: 8 hours of risk management; 4-8 hours of medical ethics; $2,000 administrative penalty; take the JP exam</td>
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Instead of issuing a low-end sanction, which is “applicable” to first-time violators, the TMB issued the following sanctions: (1) a $3,000.00 administrative penalty; (2) take and pass the Medical Jurisprudence Exam; (3) complete sixteen hours of continuing education (with at least eight hours each in the areas of ethics and risk management); and (4) distribute copies of the Board’s final Order to health care entities where Dr. Aleman has privileges. Notably, this is higher than the maximum sanctions identified for this type of alleged violation—there were no aggravating factors identified in the Board’s Final Order or SOAH’s findings of fact and conclusions of law. During oral argument, TMB argued that the low-end sanction was only
applicable to informal settlement discussions; however, this is not what the plain language of section 190.14 states. The case is currently pending before the Supreme Court.

11. **Evelyn Kelly, Individually and on Behalf of the Estate of David Christopher Dunn, v. Houston Methodist Hospital**

(Regarding necessity and constitutionality of the Texas Advance Directives Act)

On Oct. 12, 2015, Aditya Uppalapati, M.D., admitted David Christopher Dunn to Houston Methodist with diagnoses of, among other things: end-stage liver disease; the presence of a malignant pancreatic neoplasm with suspected metastasis to the liver; complications of gastric outlet obstruction secondary to his pancreatic mass; hepatic encephalopathy; acute renal failure; sepsis; acute respiratory failure; multi-organ failure; and gastrointestinal bleed.

Shortly after Mr. Dunn’s admission, Dr. Uppalapati advised Dunn’s family that his condition was irreversible and progressively terminal. Mr. Dunn’s treating physicians concluded that he was suffering from the treatment necessary to sustain his life, and with no expectation for improvement, life-sustaining treatment was medically inappropriate for him. As a result, Mr. Dunn’s attending physicians, patient care team recommended to his divorced parents that aggressive treatment measures be withdrawn, and that only palliative or comfort care be provided. The parents disagreed on the recommendation and plan and since Mr. Dunn did not have an advance directive in place, was not married, and had no children, his parents became his surrogate decision makers.

On Oct. 28, 2015, the matter was referred to the Houston Methodist Biomedical Ethics Committee (ethics committee) for consultation, in accordance with the procedures specified by Texas Health and Safety Code §166.046. Over the next days, hospital representatives exhausted efforts to transfer Mr. Dunn to another facility. Testimony demonstrated that 66 separate facilities were contacted by Houston Methodist representatives requesting transfer. Potential transfer facilities were provided with the patient’s demographic information and recent clinical information so a transfer determination could be made. All 66 facilities declined the transfer.

On Nov. 20, 2015, attorneys purportedly acting on behalf of Mr. Dunn filed a suit in state court in Harris County District Court seeking injunctive relief (despite the fact that he had been determined mentally incapacitated since his admission to the hospital). It should be noted that former state Senator Joe Nixon, one of the primary sponsors of 2003’s HB 4 (relating to professional liability insurance reform), is representing the plaintiff. In the filing, counsel sought a Temporary Restraining Order preserving the status quo of the life-sustaining treatment being provided to Dunn while an alternative facility could be located. Additionally, the filing sought a declaration that Houston Methodist’s implementation of §166.046 (the statute regarding procedure if not effectuating a directive or treatment decision) violated the due process rights afforded to Mr. Dunn by the both the Texas and United States Constitutions. On the same day and without the necessity of a hearing, Houston Methodist voluntarily agreed to an Agreed Temporary Restraining Order preserving the status quo by continuing life-sustaining treatment to Mr. Dunn, and extending the statutory 10 day period by an additional 14 days in order to continue efforts to locate a transfer facility.

The Temporary Injunction hearing was scheduled for Dec. 3, 2015. Prior to the Temporary Injunction hearing, Houston Methodist formally appeared in the matter. In its pleading, Houston Methodist requested an abatement of the matter, which necessarily acted as a prolonged extension of Houston Methodist’s agreed provision of life-sustaining treatment, while guardianship issues of an incapacitated Mr. Dunn, the current plaintiff, could be resolved through the probate court system. The Court agreed with the assessment of Mr. Dunn’s incapacity and executed an Order of
Abatement, the form of which was agreed to by counsel for all parties. Notably, in the Order of Abatement, Houston Methodist voluntarily agreed to preserve the status quo by continuing all life-sustaining treatment.

On Dec. 23, 2015, Mr. Dunn succumbed to his terminal illnesses and passed away. It is undisputed that from the day of his admission until the time of his death Houston Methodist provided continuous life-sustaining treatment to Mr. Dunn. In fact, following his death, Mr. Dunn’s mother wrote, “we would like to express our deepest gratitude to the nurses who have cared for Chris and for Methodist Hospital for continuing life sustaining treatment of Chris until his natural death.”

On Jan 8, 2016, the court lifted the stay and allowed substitution of the parties as Mr. Dunn had passed (allowing Ms. Kelly, Mr. Dunn’s mother, to substitute as the plaintiff). The suit continued and alleged that the statute failed to provide adequate constitutional protections for her son in the process that culminated in the determination by the hospital ethics committee that life-sustaining treatment was medically inappropriate. Specifically, the plaintiff alleges that §166.046 violates procedural due process by: (1) failing to provide the patient or the patient’s decision-maker an opportunity to be heard; (2) failing to provide a reasonable opportunity to prepare for a hearing; (3) failing to provide reasonable notice of the reasons why removal of life-sustaining treatment is to occur; and (4) failure to utilize an impartial tribunal to make the decision to withdraw life-sustaining treatment. The plaintiff also argues that §166.046 violates substantive due process in that it deprives an individual of rights protected under the U.S. Constitution. Among these rights, according to the plaintiff, is the right of the individual to make their own life-related medical decisions.

TMA filed an amicus brief in the trial court that provided background information regarding the Texas Advance Directives Act and explained why medical futility laws are necessary to maintain the integrity of the medical profession. The trial court ruled on summary judgment against plaintiff with a conclusion that it lacked jurisdiction over Mr. Dunn’s claims due to his death. On Nov. 7, 2017, Plaintiff appealed to the Court of Appeals in Houston [First District]. The Court has set oral argument for March 19, 2019.

On March 5, 2019, TMA joined in the filing of an amicus brief with the Texas Alliance for Patient Access (TAPA), Texas Alliance for Life (TAL), Texas Catholic Conference of Bishops (TCCB), Texas Baptist Christian Life Commission (CLC), Texans for Life Coalition (TLC), Coalition of Texans with Disabilities (CTD), The Texas Hospital Association (THA), Texas Osteopathic Medical Association (TOMA), and LeadingAge Texas (LAT). The brief, submitted by Wallace Jefferson (former Chief Justice of the Texas Supreme Court) reiterates the points in the trial court brief, among other things, that: (1) §166.046 is constitutional; (2) dispute resolution laws are necessary to maintain the integrity of the medical profession; (3) a private physician’s treatment decision does not constitute state action; (4) the medical-futility procedure only rarely contradicts a patient’s wish for further intervention; and (5) while §166.046 gives attending physicians a safe harbor, it does not mandate a specific course of action.

D. COMMENTS TO ADMINISTRATIVE AGENCIES

1. Texas Board of Chiropractic Examiners Proposed Rules Concerning the Practice of Acupuncture (1 Tex. Admin. Code § 78.14)

The Texas Board of Chiropractic Examiners proposed rules reaffirming its position that licensed chiropractors may use acupuncture in their chiropractic practices, notwithstanding ongoing litigation on the very issue (see item C.3 above). The proposed rules also make such changes as
no longer requiring a national standardized certification exam in acupuncture in order to perform acupuncture and allowing chiropractors authorized to practice acupuncture to refer to themselves as being “Board Certified in Acupuncture as an adjunctive modality by the Texas Board of Chiropractic Examiners.”

TMA comments in response to the proposed rules took a similar position as its amicus brief in the ongoing litigation. That is, TMA strongly opposed the rules on the basis that the legislature has not authorized chiropractors to use acupuncture. The legislature has prescribed the scope of chiropractic, and it neither includes acupuncture nor treatment of the nervous system or nerves.

The Chiropractic Board adopted the proposed rules to be effective Dec. 5, 2018. The Chiropractic Board disagreed with TMA’s position on all grounds.


The Texas Health and Human Services Commission proposed rules to “clarify the grounds on which HHSC may establish and adjust fees, rates, and charges for Medicaid services.” The propose rule changes actually would remove parts of the rule, TMA would argue, that provide clarity and transparency for the methods behind HHSC’s rate-setting processes.

TMA and other entities including the Texas Pediatric Society, Texas Academy of Family Physicians, American Congress of Obstetricians and Gynecologists - District XI (Texas), and the Texas Association of Obstetricians and Gynecologists, offered comments in response to the proposed rule changes. TMA and the other entities urged HHSC to maintain in rule the guidance that the rules then offered. For instance, TMA urged that the rules direct HHSC to make specific consideration for economic factors that affect physicians and other providers when setting or adjusting Medicaid rates. TMA further commented that HHSC offer a clearer and more comprehensive notice to the public when it proposes to establish or adjust rates.

HHSC adopted the proposed rules to be effective Dec. 26, 2018. HHSC chose to not make any changes to the rules as proposed.

3. Texas Health and Human Services Commission Proposed Rules Concerning Peer Services

The Health and Human Services Commission proposed rules in September 2018 regarding peer services. The rules were in order to implement House Bill 1486, which requires HHSC to include peer support services provided by certified peer specialists in the scope of services under the state Medicaid plan. HHSC had previously solicited comment on a draft version of these rules, in response to which TMA provided comment. See D.19.

TMA commented to encourage HHSC to include this benefit for Medicaid recipients who are at least 18, rather than imposing a 21-year-old limitation in the draft rules. TMA also commented to ensure that a peer specialist’s services were clearly defined in order to ensure patient safety. While peer specialists provide indispensable support for recipients, TMA noted, it is still important for both the peer specialist and the recipient to understand the limitations of those services and to know when the recipient should seek medical assistance from a physician or another professional with more advanced training. TMA finally commented to say that training curricula should include information on legal obligations regarding services provided under occupational licenses.
4. **Texas Health and Human Services Commission Proposed Rules Concerning Medicaid**

*Managed Care Organization access standards (1 Tex. Admin. Code §§ 343.2, 343.411, 353.423)*

The Health and Human Services Commission proposed rules in October 2018 regarding Medicaid Managed Care. These proposed rules touched on network adequacy, access and expedited credentialing standards for managed care organizations participating in the Medicaid program.

TMA joined the Texas Pediatric Society, Texas Academy of Family Physicians, and Texas Association of Obstetricians and Gynecologists in commenting in response to these rules. TMA’s comments encouraged HHSC to amend the proposed rules to establish clear and well-defined standards and to create in the rules a comprehensive body of standards by incorporating standards that have been articulated or developed in other documents. TMA further asserted that the rules as proposed failed to meet the agency’s own recommendations for and stakeholder expectations about clear, well-defined network adequacy standards because the rules only provided ambiguous references to standards or criteria for compliance.

As of March 2019, HHSC has not taken final action on the proposed rules.


In September 2018, the Texas Medical Disclosure Panel proposed amendments to two forms—the medical and surgical procedures form and the hysterectomy form. The proposed amendments were purportedly in order to make the document more reader-friendly and more readily understandable.

TMA responded with comments in strong opposition to the changes to the medical and surgical procedures form. TMA asserted that those proposed amendments “contain substantive modifications to the form: (1) without any explanation that justifies the need or intent of those modifications and (2) with insufficient consideration of the potential impact of those changes on healthcare liability costs.” TMA expressed concern that there would be serious potential unintended consequences were the proposed changes to be made effective.

The TMDP responded in December 2018 by stating that it would take TMA’s comments under consideration and would republish an amended form for comment in early 2019. TMDP republished these forms in the Feb. 22, 2019 Texas Registrar. TMA is preparing comments.


In October 2018, the Texas Department of Insurance published proposed changes to rules relating to the notification requirement for HMO terminations. Specifically, the proposed change would strike the minimum 90-day notice requirement for HMO terminations, as well as other language that provides important regulatory guidance on the implementation of certain provisions of the Texas Insurance Code.

The Texas Medical Association, Texas Orthopaedic Association, Texas Pediatric Society, Texas Society of Anesthesiologists, Texas Association of Obstetricians and Gynecologists, Texas Society of Pathologists, Texas Ophthalmological Association, Texas Radiological Society, and
Texas Ambulatory Surgery Center Society responded with joint comments in strong opposition to the proposed changes. TMA’s comments encouraged TDI to maintain the minimum 90-day notice requirement for a variety of reasons, including that the rule is necessary to implement state statute and that it has been a longstanding part of TDI regulations.

As of March 2019, TDI has not taken formal action on the proposed rules.

7. **Texas Board of Nursing Proposed Rules on Conformity with the Advanced Practice Registered Nurse Consensus Model**

The Texas Board of Nursing proposed rules in October 2018 that would amend the Board’s rules relating to education and licensing requirements for advanced practice registered nurses. The Board stated that the amendments were intended to promote consistency with the Advanced Practice Registered Nurse Consensus Model and national nursing licensing standards.

In comments sent to the Board in response to the proposal, TMA strongly opposed the proposed rules on the basis that the proposed changes would mark a departure from state law. TMA expressed that the Board should be concerned with maintaining consistency with state law rather than the APRN Consensus Model, which advocates for APRNs to undertake roles and tasks that state law does not authorize. The Consensus Model and the Board’s proposed rules mention, for example, an APRN’s authority to diagnose, while state law expressly states that professional nursing does not include acts of medical diagnosis. TMA’s comments encouraged the Board to withdraw the proposed rules.

As of January 2019, the Board has not taken formal action on the proposed rules.

8. **Texas Board of Pharmacy Proposed Rules Relating to the Prescription Monitoring Program**

The Texas State Board of Pharmacy proposed rule amendments relating to the Prescription Monitoring Program (PMP). The proposed rules implemented changes to the PMP in accordance with legislation passed in 2017.

TMA opposed parts of the proposed rules that would allow the Pharmacy Board to regulate physicians and enforce its rules against physicians. TMA pointed out that the Pharmacy Board was authorized by the legislature to administer, but not enforce, key provisions of the law that require physicians to check the PMP in certain circumstances. TMA further offered support for rules that clarified that using electronic medical records integrated with the PMP satisfies the requirement to check the PMP.

In light of TMA’s comments, the Pharmacy Board in November 2018 revised the proposed rules to remove provisions authorizing the Board’s regulation of physicians.


In September 2018, the Texas Department of Licensing and Regulation proposed rule changes relating to the department’s regulation of lay midwives. Among other things, the proposed rules altered definitions relating to a midwife’s collaboration and consultation with other health care professionals and amended requirements relating to the transfer of care of a patient from a midwife to a physician or another professional.
TMA in conjunction with District XI of the American Congress of Obstetricians and Gynecologists and the Texas Association of Obstetricians and Gynecologists responded with comments in opposition to certain parts of the proposed rule amendments. TMA’s comments encouraged the rules be further amended to clarify the meaning of certain terms, to be internally consistent, and to require transfer or referral to Texas-licensed physicians (as opposed to a physician licensed in any state). TMA further encouraged TDLR to incorporate references to the Global Practice Standards for Midwifery, to require transfer to physicians under certain circumstances, and to require midwives to do more to record their care for patients and to transfer those records when a physician assumes responsibility for the patient.

As of March 2019, the Department has not taken formal action on the proposed rules.


The Texas Board of Nursing proposed rules in September 2018 to implement Senate Bill 1107 (2017), relating to telemedicine medical services. The proposed rules relate to the provision of telemedicine medical services and telehealth services by nurses.

TMA commented to encourage the Board to add needed clarity to the proposed rules. The proposed rules did not, for instance, specify that in order to issue a prescription in conjunction with a telemedicine medical service, an advanced practice registered nurse must first have prescriptive authority under a proper agreement with a physician. TMA encouraged the Board to add this clarification, as well as to add clarification that in order to provide telemedicine medical services, a nurse must be acting under physician delegation and supervision.

As of November 16, 2018, the Board adopted its final rules without making any changes substantive changes.

**11. Texas Department of Insurance-Division of Workers’ Compensation Proposed Rules Relating to Designated Doctors**

In May 2018, the Texas Department of Insurance-Division of Workers’ Compensation proposed rules relating to the Designated Doctor Program. The proposed rules sought to identify potential solutions for increasing physician participation in the Designated Doctor program so that injured employees with the most serious injuries will have access to physicians with the highest level of training.

TMA supported some parts of the proposed changes that addressed areas that cause some physician participations frustration with the program. TMA also expressed concern that some parts of the proposed rule changes could be misconstrued with respect to other non-physician health care providers who participate in the program. TMA finally encouraged DWC to make changes with respect to board certification requirements, stating that DWC should be mindful of recently enacted legislation that prohibits differentiating among physicians on the basis of maintenance of board certification.

In October 2018, the DWC adopted the proposed rules without making any substantive changes.
12. Texas Medical Board Proposed Rules Relating to Certified Medical Radiological Technicians and Noncertified Technicians (2 Tex. Admin. Code §§ 194.6, 194.10, 194.12, 194.13, 194.23)

In December 2018, the Texas Medical Board proposed rules relating to its regulation of certified medical radiological technicians and noncertified technicians. The proposed changes made more significant changes to the regulation of noncertified technicians (NCTs).

TMA commented in response to these proposed rules, and its comments focused on regulations relating to NCTs. TMA explained that a physician’s use of NCTs is an effective way to meet high clinical demands while managing costs of providing services to patients, and thus encouraged the TMB to simplify its regulation of and training requirements applicable to NCTs. This included eliminating the requirement in the proposed rules for NCTs to pass the jurisprudence exam, and ensuring that the application and approval procedures are easy, transparent, and efficient.

As of March 2019, the Board has not taken formal action on the proposed rules.

13. TMA Comments to the Texas Medical Board Regarding the Corporate Practice of Medicine and Unauthorized Practice of Medicine

In conjunction with the Texas Medical Board’s public comment period in association with its December 2018 full board meeting, TMA submitted written comments relating to violations related to the prohibition on the corporate practice of medicine and the unauthorized practice of medicine. Specifically, TMA wrote to encourage and facilitate discussion regarding the ability of a physician to submit complaints relating to a nonprofit health corporation’s (NPHC) violation of certain laws prohibiting interference with a physician’s professional judgment. TMA noted that there is a complaint form for licensees, but there appears to be no avenue for a complaint against an entity like an NPHC. TMA further encouraged the TMB to clarify on TMB’s website and complaint form that the Board has cease and desist authority to enforce unauthorized practice of medicine.

As of February 2019, the TMB has not responded to TMA’s comments.


In November 2018, the Health and Human Services Commission proposed rules changes relating to supplemental payments to eligible teaching hospitals owned and operated by non-state governmental entities. HHSC further solicited comment regarding expanding funding to hospitals owned by non-governmental entities.

TMA commented to express support of adequate funding for graduate medical education (GME) and expanding the state’s GME capacity. TMA expressed the need to increase the state’s physician workforce concomitant with population growth through the training of residents in the state and the need for an adequate number of GME positions to ensure the increasing number of Texas medical school graduates have a reasonable opportunity to remain in the state for training. TMA thus supported HHSC’s expanded supplemental payments and further expressed support for possible expansion of payment to non-governmental hospitals.

As of Jan. 25 2019, HHSC finalized its proposed rules and expanded funding to non-state government-owned and operated teaching hospitals. No update has been made regarding hospitals owned by non-governmental entities. TMA staff will monitor.

In November 2018, the Texas Department of Insurance-Division of Workers’ Compensation (DWC) proposed rule amendments in response to recently enacted legislation relating to special provisions for administrative penalties.

TMA commented that this rule change could impact physicians. TMA encouraged DWC to ensure that the rule changes were in line with the intent of the enacted legislation, including that compliance with a sanction should not be imposed until after an order becomes final and unappealable, and that the rule changes were internally consistent so the rule clearly stated obligations for compliance.

As of Jan. 11, 2019, DWC finalized these proposed rules. DWC incorporated TMA’s recommended changes.


The Health and Human Services Commission in December 2018 proposed rule changes that would serve to inform stakeholders and Laboratory Services Section (LSS) customers that future changes to the public fee schedule would be posted on the LSS website. In response to these proposed changes, TMA submitted comments in support of the intent to increase transparency of fee changes. TMA further recommended that the department provide automatic email notification of changes to the fee schedule through an email subscription management system. TMA recommended that automatic notices should be of final and adopted changes as well as the proposed changes. TMA asserted that these changes would more properly effectuate the department’s goals.

As of March 2019, the commission has not finalized these proposed rule changes.

17. **Joint Comments to Health and Human Services Commission Relating to Medicaid Reimbursement for Telemedicine Medical Services**

In January 2019, TMA along with the Texas Association of Health Plans, the Texas Hospital Association, the Texas Association of Community Health Plans, and the Texas Pediatric Society submitted joint comments to the Health and Human Services Commission to encourage the commission to update its billing policies relating to telemedicine.

The joint comments grew out of a series of summit meeting among the organizations to identify ways to improve the Medicaid program. TMA and the other organizations encouraged HHSC to bring its telemedicine reimbursement policies in line with state law by allowing reimbursement for all services that could be provided through telemedicine. TMA staff had been told by HHSC that it was reviewing each service one at a time to examine its compatibility with telemedicine. TMA encouraged HHSC instead to identify only those codes that could not be compatible with telemedicine in order to avoid stifling the increased access to services that telemedicine could afford.

As of February 2019, HHSC has not responded to TMA’s letter.

In January 2019, the Texas State Board of Pharmacy proposed rules that authorized pharmacists to provide “medication therapy management (MTM) services” in certain pharmacies. TMA commented to express strong opposition to the proposed rules because the rules were not clearly articulated and would result in pharmacists providing medication-related services outside the scope of their practice as defined by state law.

TMA pointed out that there was no statutory basis for a pharmacist’s provision of MTM services and so the extent to which a pharmacist could be authorized to do so under state law was not clear. It was not clear particularly because the proposed rules articulated a scope of MTM services that was very broad.

TMA pointed out that under Medicare, there were much more clearly defined boundaries for MTM services, and Medicare policies also heavily stressed the collaborative nature of MTM services between a physician and a pharmacist. TMA noted that the Board of Pharmacy’s rules should more heavily emphasize this collaborative relationship and ensure that a patient’s physician was involved in any MTM services provided.

TMA encouraged the Board of Pharmacy to wait for authorizing legislation before moving forward with proposed rules, but also provided possible amendments to the proposed rule to ensure that MTM services were provided within a pharmacist’s scope of practice and also were provided on a collaborative basis with a patient’s physician.

As of February 2019, the Board of Pharmacy has withdrawn these proposed rules.


In January 2019, the Texas Medical Board proposed rules relating to a physician’s delegation of authority. In the first set of changes, the TMB proposed rules that would impose a reporting requirement on a physician who delegates an act to an individual who is otherwise unregulated (i.e., who does not have an occupational certification or license issued by a state agency). TMA expressed strong opposition in response to these proposed rules on the basis that the proposed rules are not in compliance with statutory authority, leave many questions unanswered, lack an adequate framework, and may have unintentional consequences.

TMA explains in its comments that compliance with the rule proposal would be extremely difficult because it was unclear exactly what the TMB expected these physicians to do. The proposed rules state only that a physician delegating an act to these unregulated professionals have a responsibility to “report” the professionals. The rules do state that the reporting obligation would be relating to discipline or termination of the professional, but it is not clear whether this is the only thing that is to be reported, nor is it clear what type of discipline should be reported. TMA further explains that because the proposed rule would impose such a significant burden, that it would have the consequence of either discouraging disciplining these professionals, or discouraging the delegation in the first place. TMA encouraged the TMB to withdraw the proposed rules and hold a stakeholders meeting.

The proposed rules also related to delegation of radiological procedures to midlevel providers. Here again, the intent of the TMB’s proposed rules was not clear and TMA commented to
encourage the TMB to hold a stakeholders meeting to ensure that the proposed rules would not
disrupt collaborative team-based practice.

As of March 2019, the TMB has not finalized these proposed rules. Prior to the submission of
TMA’s comments, the TMB did notify TMA that it would be holding a stakeholders meeting on
the second set of rules relating to delegation of radiological procedures, but the timing for that
meeting has yet to be determined.

20. Texas Department of Insurance Proposed Rules Relating to Utilization Review

In January 2019, the Texas Department of Insurance proposed rules concerning notice of
determinations made in utilization review and written procedures for appeals of adverse
determinations by utilization review agents. Specifically, the rules would require expedited
appeals for denials of prescription drugs or intravenous infusions for which an enrollee is
receiving benefits under the health insurance policy, and adverse determinations of a step therapy
protocol exception request under Insurance Code §1369.0546.

TMA commented to express strong support for the changes, noting that the rule changes would
be in line with recently enacted legislation. TMA stated that the proposed amendment would aid
the regulated community and enrollees in understanding statutory requirements for expedited
appeals, thereby increasing the value of important consumer protections in law.

As of March 2019, TDI has not finalized the proposed rule changes.

21. Texas Health and Human Services Commission Draft Rules Concerning Medicaid
Telemedicine Requirements (1 Tex. Admin. Code §§ 354.1430 and 354.1432)

In April 2018, the Health and Human Services Commission released and solicited comments on
draft rules intended to implement Senate Bill 1107, regarding telemedicine. Like the Medicaid
benefits policy on telemedicine published one month prior, these draft rules made many changes
to reflect the intended expansion under SB 1107. Some parts of the draft rules, however, did not
accurately follow the provisions of the bill.

TMA, along with the Texas Association of Obstetricians and Gynecologists, the Texas Academy
of Family Physicians, and the Texas Pediatric Society, commented that the rules should adhere to
the bill’s provisions. TMA’s comments included again reiterating that Texas statute requires
HHSC to pay for telemedicine under Medicaid for services that otherwise satisfy applicable
requirements. The comments also stated that there should be greater clarity regarding patient site
restrictions and that notice to a patient’s primary care provider is conditional upon that patient’s
consent to do so.

As of March 2019, HHSC has not officially proposed these rules. TMA staff will continue to
monitor the progress of these rules.

22. Texas Office of Inspector General Solicitation for Feedback on the IG’s Determination of
Administrative Actions or Sanctions

In May 2018, the Texas Office of the Inspector General published a solicitation for feedback
regarding its current rules relating to the criteria the IG uses to determine administrative sanctions
or actions to impose provider violations, as found in 1 Tex. Admin. Code § 371.1603(f)-(h). TMA
provided comments for improvements that could be made to those considerations. Generally,
TMA’s comments focused on making the process more fair and ensuring that all relevant considerations would be made in imposing sanctions against a provider.

TMA’s comments included clarifying already listed considerations that were ambiguous, following statutory language, adding consideration of mitigating factors, and limiting consideration of aggravating factors in a way that ensures only relevant aggravating factors are considered.

TMA staff is monitoring any further development of what may be amendments to these rules.


In June 2018, the Health and Human Services Commission released and solicited comments on draft rule regarding peer services. The draft rules were in order to implement House Bill 1486, which requires HHSC to include peer support services provided by certified peer specialists in the scope of services under the state Medicaid plan.

TMA commented to encourage HHSC to include this benefit for Medicaid recipients who are at least 18, rather than imposing a 21-year-old limitation in the draft rules. TMA also commented to ensure that a peer specialist’s services were clearly defined in order to ensure patient safety. While peer specialists provide indispensable support for recipients, TMA noted, it is still important for both the peer specialist and the recipient to understand the limitations of those services and to know when the recipient should seek medical assistance from a physician or another professional with more advanced training.

HHSC has proposed and adopted rules concerning peer services. See D.27.


The Texas Board of Nursing proposed rules in June 2018 in response to Senate Bill 507, which amended the state’s out-of-network health benefit claims mediation process. The proposed rules would implement changes made by that legislation in order to apply to the board’s licensees.

TMA provided comment in order ensure that the rules properly and accurately followed the underlying legislation in order to avoid confusion among licensing boards whose licensees would be subject to the legislation. This included encouraging the board to make it clear that its rules did not apply to any licensee regulated by another state agency.

In August 2018, the board finalized its proposed rules. The board did accept some of TMA’s suggested changes in its final adopted rule.


The Texas Medical Board proposed rules in July 2018 to amend its rules on out-of-network claims mediation in response to Senate Bill 507 enacted in 2017. In large part, the proposed amended rules closely followed changes made by that legislation.

TMA provided comment to encourage the TMB to add clarity on a few points, including ensuring that the appropriate advisory boards were properly identified, that the applicability of certain
provisions of the rules was limited to only out-of-network facility based providers, and to ensure that required notice provisions applied only to claims eligible for mediation under Chapter 1467 of the Insurance Code.

TMB held a stakeholder meeting on Aug. 24, 2018 to discuss adoption of proposed rule amendments and rule review to 187.87-89. As of March 4, 2019, the proposed changes are still withdrawn.


In June 2018, the Health and Human Services Commission published rules authorizing nurse practitioners and physician assistants to make medical necessity determinations for hearing aids “under physician delegation.” TMA and the Texas Association of Otolaryngology commented to encourage HHSC to amend the proposed rules to clarify that these medical necessity determinations should be done under physician delegation and supervision. TMA stated that this amendment would clarify that these allied health professionals must be under a physician’s supervision when making medical necessity determinations and would thus be consistent with state law.

HHSC adopted these rules to be effective Nov. 20, 2018. HHSC declined making the amendment and stated that the amendments as proposed reinforce the physician’s ability to delegate tasks.

27. Texas Health and Human Services Commission Proposed Rules Concerning the Office of Ombudsman (1 Tex. Admin. Code Chapter 87)

In June 2018, the Health and Human Services Commission published rules relating to the HHSC’s Office of Ombudsman (OO). The rules would organize the OO into different divisions with different emphases. The roles would generally be to solicit and receive complaints from consumers relating to services provided by HHSC.

TMA provided comment for two general purposes: to ensure that, as authorized in underlying statute, physicians and other health care providers could play a role in the fulfillment of the mission of the OO, and to ensure that physicians could interact with the OO in a manner that is compliant with applicable privacy laws and regulations.

Underlying statute suggests that HHSC’s OO could solicit and receive feedback from any interested party who would raise a matter within the HHS system, but the proposed rules did not seem to include physicians in the OO’s function. TMA noted that physicians have a unique and important perspective on services provided within the HHS system, and that physicians should also be permitted to take advantage of the outlet that the OO would provide. TMA further suggested that HHSC make it clear providing information to the OO would not be a violation of privacy laws and regulations.

As of Jan. 11, 2019, HHSC finalized these proposed rules. HHSC accepted some of TMA’s proposed recommendations on privacy laws and regulations.


In June 2018, the Texas State Board of Pharmacy proposed rules intended to provide to pharmacists guidance for considerations to make when determining the legitimacy of a
prescription. This guidance was in the form of a list of “red flag factors” that a pharmacist was to observe and consider in order to reduce the incidence of drug abuse and diversion.

TMA along with the Texas Pain Society and the Texas Orthopaedic Association noted problems with these factors in comments submitted to the board. The comments recognized that while the red flag factors had a noble purpose, TMA was concerned that the proposed rules undermined the shared responsibility between physicians and pharmacists, and also that the rules were drafted so vaguely that they may cause pharmacists to erroneously reject legitimate prescriptions. The comments went through many of the listed red flag factors and pointed out how a factor either unjustifiably scrutinized the prescriber’s actions or the prescriber themselves, or how the factor was so vague that it risked including many legitimate prescriptions.

TMA, TPS, and TOA thus encouraged the Pharmacy Board to postpone adoption of the rules to allow for a stakeholder forum where prescribers and pharmacists could together articulate factors and indicators for which both populations could monitor.

In response to the submitted comments, Pharmacy Board staff proposed some amendments to the initially proposed version and solicited TMA feedback. In response, TMA and TPS submitted written comments which again pointed out flaws in even the revised factors. To be sure, the revisions made incremental improvements, but, according to TMA comments, the factors still placed too much blame on prescribers and would risk capturing legitimate prescriptions.

In August 2018, the Pharmacy Board made some other small changes in response to TMA’s second round of comments, and ultimately adopted the rules with revisions without holding a stakeholder meeting.
Subject: Investments

Presented by: Diana L. Fite, MD, Chair

**TMA and Separate Fund Investments**

Members of the TMA Board of Trustees serve as trustees or as the board of trustees for two library funds, two student loan funds, one student and resident loan fund, the Physicians Benevolent Fund, and the TMA Special Funds Foundation. The investment portfolios for TMA, and for the funds for which members of the TMA Board of Trustees serve as trustees or as the board of trustees, are invested by the Board of Trustees by way of designated investment managers. The board acts on recommendations of its Investments Committee, which meets three times a year. The committee and the board review quarterly reports from: TMA’s equity investment manager, Luther King Capital Management; TMA’s fixed income investment manager, Vaughan Nelson Investment Management, LP; and TMA’s international stock fund managers, Dodge & Cox. The board establishes investment performance objectives for the investment portfolios of TMA and seven separate funds, and sets policy for the mix of investment media (equities, fixed income, alternative mutual funds, and cash equivalents).

TMA’s investments monitor is The Quantitative Group at Graystone Consulting, and the board’s Investments Committee meets with W. Joseph Sammons, senior vice president, and Ronald Kern, executive director. The Quantitative Group is the investment monitor for TMA funds and all funds TMA manages. The committee and the board review quarterly composite reports prepared by The Quantitative Group.

The Dec. 31, 2018, net assets of the funds managed by these investment managers were reported as follows: TMA, $29,443,359; Texas Medical Association Library, $2,440,883; Annie Lee Thompson Library Trust Fund, $3,228,039; May Owen Irrevocable Trust, $2,926,728; Dr. S.E. Thompson Scholarship Fund, $5,667,946; Physicians Benevolent Fund, $4,047,574; and Texas Medical Association Special Funds Foundation, $2,436,824.

**Dec. 31, 2018, Investment Manager Performance Report**

Since Dec. 31, 1993, the composite annualized performance for all equity investments has been 8.04 percent versus the equity composite index annualized rate of return of 8.63 percent. The one-year rate of return was -8.74 percent versus the equity composite index return of -6.66 percent. Equity investment allocation by manager is approximately 54 percent at Luther King Capital Management, 40 percent in iShares blended mutual funds, 4 percent in Dodge & Cox International Stock Fund, and 2 percent in the Invesco Developing Markets mutual fund.

Fixed income investment manager Vaughan Nelson Investment Management achieved a 5.23 percent annualized return versus the Barclays Aggregate annualized return of 5.34 percent for the period of June 30, 1992, through Dec. 31, 2018. The one-year rate of return was 0.64 percent versus the index return of 0.01 percent. Fixed income investment allocation by manager is approximately 51 percent at Vaughan Nelson, 23 percent in the Metropolitan West Intermediate Bond Fund, 13 percent in the JP Morgan Strategic Income Bond Fund, and 13 percent in the FPA New Income Bond Fund.

Alternative mutual fund investments have experienced an annualized return of -4.05 percent versus the HFRI Fund of Funds Composite Index annualized return of 1.50 percent for the three-year period through Dec. 31, 2018. The one-year rate of return was -10.52 percent versus the benchmark return of -4.43 percent. Alternatives investment allocation by manager is 100 percent in the FPA Crescent Fund.
REPORT OF BOARD OF TRUSTEES

BOT Report 6-A-19

Subject: Audit of 2017 Financial Statements and 2018-19 Operating Budgets

Presented by: Diana L. Fite, MD, Chair

Audit of 2017 Financial Statements
The Audit of 2017 Financial Statements report was presented to the TMA Board of Trustees at its Sept. 28, 2018, meeting. Independent auditor Holtzman Partners, LLP, determined that the consolidated financial statements “present fairly, in all material respects, the consolidated financial position of Texas Medical Association and Texas Medical Association Board Administered Organizations … in accordance with accounting principles generally accepted in the United States of America.” Copies of the audit report are available in the association’s offices for review by any TMA member.

2018 Operating Budget
For 2018, operating income was $26,251,818 and operating expenses were $26,404,429. At year-end, total actual operating income for the year exceeded the budgeted operating income by $23,708 (0.09 percent). Total actual operating expenses were over budget by $176,319 (0.67 percent), resulting in an actual net operating deficit of $152,611. This actual net operating deficit was greater than the budgeted net operating deficit by $152,611. An unaudited report on 2018 operations is attached.

The Audit of 2018 Financial Statements report by Holtzman Partners, LLP, will be completed and presented to the Board of Trustees at its 2019 fall meeting. The board will present the audit reports to the House of Delegates in 2020.

2019 Operating Budget
In November 2018, the Board of Trustees approved a 2019 operating budget projecting an income of $26,611,060 and expenses of $26,611,060, with a 2019 capital expenditure budget of $477,000. The operating budget will be presented to the house by Board of Trustees Chair Diana Fite, MD. The board also approved direct financial support of related organizations in 2019 as follows: TEXPAC request for support totaling $373,080; TMA Alliance request for support totaling $259,670; TMA Foundation request for support totaling $115,000; and Association Management Services request for support totaling $1,197,950. Offsetting these expenses are: projected 2019 TMA special society administration fees totaling $1,172,250; corporate contributions of $50,000 to TEXPAC; and $15,000 in grant revenue received for TMA Foundation programming.

The 2019 expense budget of $26,611,060 represents an increase of $382,950 from the final 2018 expense budget. Supporting this expense budget is a projected income budget of $26,611,060. This represents an increase of $382,950 from the final 2018 income budget of $26,228,110. As a result, a break-even budget is projected for 2019.

The 2019 budgeting process included a review of all programmatic activities. TMA’s relevance and value to its members were used as benchmarks for evaluating programs and determining which areas to expand or reduce. As containing expenses for approved programs becomes increasingly difficult, programmatic growth must be restrained or new sources of income identified. The 2019 Operating Budget adopted by the board is as follows:
**Texas Medical Association**

*Statement of Income and Expense by Program*

*For the Year Ending December 31, 2018*

<table>
<thead>
<tr>
<th>Income</th>
<th>Total Income</th>
<th>Building Fund Income</th>
<th>Actual Income</th>
<th>Budgeted Income</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership Recruitment &amp; Retention</td>
<td>$16,431,575</td>
<td>$16,431,575</td>
<td>$16,550,000</td>
<td>($118,425)</td>
<td>0.72%</td>
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</tr>
<tr>
<td>Royalty Income</td>
<td>2,186,154</td>
<td>2,186,154</td>
<td>2,169,800</td>
<td>16,354</td>
<td>0.75%</td>
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<tr>
<td>Rental Income</td>
<td>1,594,171</td>
<td>1,594,171</td>
<td>1,556,050</td>
<td>38,121</td>
<td>2.45%</td>
<td></td>
</tr>
<tr>
<td>Organizational Support Activities</td>
<td>1,262,318</td>
<td>1,262,318</td>
<td>1,163,940</td>
<td>98,378</td>
<td>8.45%</td>
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</tr>
<tr>
<td>Related Organizations</td>
<td>1,210,475</td>
<td>1,210,475</td>
<td>1,237,250</td>
<td>(26,775)</td>
<td>(2.16%)</td>
<td></td>
</tr>
<tr>
<td>Communications</td>
<td>801,333</td>
<td>801,333</td>
<td>833,050</td>
<td>(31,717)</td>
<td>(3.81%)</td>
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</tr>
<tr>
<td>Marketing and Member Services</td>
<td>779,264</td>
<td>779,264</td>
<td>1,066,470</td>
<td>(287,206)</td>
<td>(26.93%)</td>
<td></td>
</tr>
<tr>
<td>Investment Income</td>
<td>669,577</td>
<td>551,064</td>
<td>321,000</td>
<td>230,064</td>
<td>71.67%</td>
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</tr>
<tr>
<td>Educational Programs</td>
<td>505,690</td>
<td>505,690</td>
<td>534,400</td>
<td>(28,710)</td>
<td>(5.37%)</td>
<td></td>
</tr>
<tr>
<td>TexMed and Conferences</td>
<td>447,299</td>
<td>447,299</td>
<td>421,000</td>
<td>26,299</td>
<td>6.25%</td>
<td></td>
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<tr>
<td>Medical Education</td>
<td>214,853</td>
<td>214,853</td>
<td>186,050</td>
<td>28,803</td>
<td>15.48%</td>
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<tr>
<td>Public Health - Quality - Science</td>
<td>117,953</td>
<td>117,953</td>
<td>79,500</td>
<td>38,453</td>
<td>48.37%</td>
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<tr>
<td>Advocacy and Public Policy</td>
<td>79,522</td>
<td>79,522</td>
<td>60,000</td>
<td>19,522</td>
<td>32.54%</td>
<td></td>
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<tr>
<td>Legal</td>
<td>27,681</td>
<td>27,681</td>
<td>30,600</td>
<td>(2,919)</td>
<td>(9.54%)</td>
<td></td>
</tr>
<tr>
<td>Boards, Councils, Committees</td>
<td>23,476</td>
<td>23,476</td>
<td>0</td>
<td>23,476</td>
<td>0.00%</td>
<td></td>
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<tr>
<td>Information Systems</td>
<td>19,000</td>
<td>19,000</td>
<td>19,000</td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td><strong>$26,370,331</strong></td>
<td><strong>$118,513</strong></td>
<td><strong>$26,251,818</strong></td>
<td><strong>$26,228,110</strong></td>
<td><strong>$23,708</strong></td>
<td><strong>0.09%</strong></td>
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<table>
<thead>
<tr>
<th>Expense</th>
<th>Total Expense</th>
<th>Building Fund Expense</th>
<th>Actual Expense</th>
<th>Budgeted Expense</th>
<th>Variance</th>
<th>% Variance</th>
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<tr>
<td>Communications</td>
<td>$2,986,163</td>
<td>$2,986,163</td>
<td>$2,955,320</td>
<td>($30,843)</td>
<td>(1.06%)</td>
<td></td>
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<tr>
<td>Organizational Support Activities</td>
<td>4,560,769</td>
<td>4,560,769</td>
<td>4,280,500</td>
<td>272,269</td>
<td>6.35%</td>
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</tr>
<tr>
<td>Building Operations</td>
<td>2,256,472</td>
<td>2,256,472</td>
<td>2,232,820</td>
<td>13,652</td>
<td>0.60%</td>
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</tr>
<tr>
<td>Related Organizations</td>
<td>2,031,792</td>
<td>2,031,792</td>
<td>1,963,050</td>
<td>68,742</td>
<td>3.50%</td>
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<tr>
<td>Legal</td>
<td>1,282,609</td>
<td>1,282,609</td>
<td>1,306,510</td>
<td>(22,901)</td>
<td>(1.75%)</td>
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<tr>
<td>Advocacy and Public Policy</td>
<td>2,215,856</td>
<td>2,215,856</td>
<td>2,331,100</td>
<td>(115,244)</td>
<td>(4.94%)</td>
<td></td>
</tr>
<tr>
<td>TexMed and Conferences</td>
<td>1,754,552</td>
<td>1,754,552</td>
<td>1,664,010</td>
<td>90,542</td>
<td>6.08%</td>
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<tr>
<td>Depreciation</td>
<td>1,162,114</td>
<td>1,162,114</td>
<td>1,116,900</td>
<td>45,214</td>
<td>4.05%</td>
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<tr>
<td>Health Policy - Regulation</td>
<td>1,070,176</td>
<td>1,070,176</td>
<td>1,066,760</td>
<td>3,416</td>
<td>0.32%</td>
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<tr>
<td>Information Systems</td>
<td>1,843,917</td>
<td>1,843,917</td>
<td>1,723,050</td>
<td>120,867</td>
<td>7.01%</td>
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</tr>
<tr>
<td>Membership Recruitment &amp; Retention</td>
<td>2,305,334</td>
<td>2,305,334</td>
<td>2,226,650</td>
<td>78,684</td>
<td>3.53%</td>
<td></td>
</tr>
<tr>
<td>Marketing and Member Services</td>
<td>854,494</td>
<td>854,494</td>
<td>945,720</td>
<td>(91,226)</td>
<td>(9.92%)</td>
<td></td>
</tr>
<tr>
<td>Public Health - Quality - Science</td>
<td>1,038,424</td>
<td>1,038,424</td>
<td>953,580</td>
<td>84,844</td>
<td>8.90%</td>
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<tr>
<td>Boards, Councils, Committees</td>
<td>449,880</td>
<td>449,880</td>
<td>483,390</td>
<td>(33,510)</td>
<td>(6.93%)</td>
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</tr>
<tr>
<td>Medical Education</td>
<td>462,434</td>
<td>462,434</td>
<td>475,650</td>
<td>(13,216)</td>
<td>(2.78%)</td>
<td></td>
</tr>
<tr>
<td>Educational Programs</td>
<td>248,473</td>
<td>248,473</td>
<td>503,500</td>
<td>(255,027)</td>
<td>(50.65%)</td>
<td></td>
</tr>
<tr>
<td><strong>Total Expense</strong></td>
<td><strong>$26,404,429</strong></td>
<td><strong>0</strong></td>
<td><strong>$26,404,429</strong></td>
<td><strong>$26,228,110</strong></td>
<td><strong>$176,319</strong></td>
<td><strong>0.67%</strong></td>
</tr>
</tbody>
</table>

**Net Income (Loss)**

- **Realized Investment Gain (Loss)**: ($34,098) $118,513 ($152,611) $0 ($152,611)
- **Unrealized Gain (Loss) on Investments**: (3,677,385) (628,123) (3,049,262)
- **Other Gain (Loss)**: (18,327) (18,327)

**Net Balance**: $2,131,657 ($285,452) ($1,846,205).
## Texas Medical Association

### 2019 Operating Budget

<table>
<thead>
<tr>
<th></th>
<th>2019 Budget</th>
<th>2018 Budget</th>
<th>Change</th>
<th>% of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Membership Recruitment and Retention</td>
<td>$16,800,000</td>
<td>$16,550,000</td>
<td>$250,000</td>
<td>1.5%</td>
</tr>
<tr>
<td>Marketing and Member Services</td>
<td>3,571,220</td>
<td>3,606,270</td>
<td>(35,050)</td>
<td>(1.0%)</td>
</tr>
<tr>
<td>Building Operations</td>
<td>1,642,960</td>
<td>1,556,050</td>
<td>86,910</td>
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<tr>
<td>Related Organization Support</td>
<td>1,237,250</td>
<td>1,237,250</td>
<td>0</td>
<td>0.0%</td>
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<tr>
<td>Organization and Support Activities</td>
<td>928,220</td>
<td>904,960</td>
<td>23,240</td>
<td>2.6%</td>
</tr>
<tr>
<td>Communications</td>
<td>832,050</td>
<td>833,050</td>
<td>(1,000)</td>
<td>(0.1%)</td>
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<tr>
<td>Educational Seminars and Publications</td>
<td>579,400</td>
<td>534,400</td>
<td>45,000</td>
<td>8.4%</td>
</tr>
<tr>
<td>Conferences</td>
<td>421,000</td>
<td>421,000</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Information Technology</td>
<td>228,960</td>
<td>228,960</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Medical Education</td>
<td>201,500</td>
<td>185,050</td>
<td>15,450</td>
<td>8.3%</td>
</tr>
<tr>
<td>Public Health - Quality - Science</td>
<td>79,500</td>
<td>79,500</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Advocacy and Public Policy</td>
<td>60,000</td>
<td>60,000</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Legal</td>
<td>29,000</td>
<td>30,600</td>
<td>(1,600)</td>
<td>(5.2%)</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>$26,611,060</td>
<td>$26,228,110</td>
<td>$382,950</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Expense</strong></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization and Support Activities</td>
<td>$3,279,290</td>
<td>$3,586,420</td>
<td>(307,130)</td>
<td>(8.6%)</td>
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<tr>
<td>Membership Recruitment and Retention</td>
<td>3,165,710</td>
<td>2,889,360</td>
<td>277,350</td>
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<td>2,985,670</td>
<td>30,620</td>
<td>1.0%</td>
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<tr>
<td>Advocacy and Public Policy</td>
<td>2,376,570</td>
<td>2,348,100</td>
<td>28,470</td>
<td>1.2%</td>
</tr>
<tr>
<td>Building Operations</td>
<td>2,278,940</td>
<td>2,232,820</td>
<td>46,120</td>
<td>2.1%</td>
</tr>
<tr>
<td>Related Organization Support</td>
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<td>1,973,680</td>
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<td>(1.4%)</td>
</tr>
<tr>
<td>Conferences</td>
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<td>1,663,070</td>
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<td>(10.2%)</td>
</tr>
<tr>
<td>Legal</td>
<td>1,467,830</td>
<td>1,310,550</td>
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<tr>
<td>Marketing and Member Services</td>
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<td>1,363,400</td>
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<td>(1.2%)</td>
</tr>
<tr>
<td>Information Technology</td>
<td>1,330,550</td>
<td>1,272,690</td>
<td>57,860</td>
<td>4.5%</td>
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<tr>
<td>Public Health - Quality - Science</td>
<td>1,134,390</td>
<td>953,580</td>
<td>180,810</td>
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</tr>
<tr>
<td>Health Policy - Regulation</td>
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<td>1,069,230</td>
<td>(13,950)</td>
<td>(1.3%)</td>
</tr>
<tr>
<td>Depreciation on Furniture and Equipment</td>
<td>628,900</td>
<td>584,800</td>
<td>44,100</td>
<td>7.5%</td>
</tr>
<tr>
<td>Depreciation on Building</td>
<td>567,100</td>
<td>532,100</td>
<td>35,000</td>
<td>6.6%</td>
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<td>Boards, Councils and Committees</td>
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<td>483,350</td>
<td>39,040</td>
<td>8.1%</td>
</tr>
<tr>
<td>Educational Seminars and Publications</td>
<td>508,150</td>
<td>503,500</td>
<td>4,650</td>
<td>0.9%</td>
</tr>
<tr>
<td>Medical Education</td>
<td>492,390</td>
<td>475,650</td>
<td>16,740</td>
<td>3.5%</td>
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<tr>
<td><strong>Total Expense</strong></td>
<td>$26,611,060</td>
<td>$26,228,110</td>
<td>$382,950</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

**Net Budget Surplus**

| Total Net Surplus | $ 0 | $ 0 | $ 382,950 | 100.0% |

**Notes:**

- The calculations are based on the budgeted amounts for 2019 and 2018.
- The change is calculated as the difference between the current year and the previous year.
- The % of Budget is calculated as a percentage of the total income or expense for each category.
Subject: 2018-19 Board Officers and Committees

Presented by: Diana L. Fite, MD, Chair

Texas Medical Association Bylaws provide that the board shall organize by electing a chair, a vice chair, and a secretary, and that the chair shall appoint committees as needed. In May 2018, the board elected Diana L. Fite, MD, as chair; E. Linda Villarreal, MD, as vice chair; and Gary W. Floyd, MD, as secretary. Keith A. Bourgeois, MD, and G. Ray Callas, MD, were elected to fill the at-large positions on the board’s executive committee. Ex officio members of the board’s executive committee are the chair and vice chair of the board and the president of the association, Douglas W. Curran, MD. The board also welcomed Lindsay K. Botsford, MD, as the young physician member for 2018-20, and William Estes as the medical student member for 2018-19.

Board committees for 2018-19 are:

- Investments (Dr. Floyd, chair; Michelle A. Berger, MD; Dr. Bourgeois; Dr. Callas; Dr. Curran; Dr. Fite; David C. Fleeger, MD; Richard W. Snyder, MD; Dr. Villarreal; and TMA Foundation liaison Craig Norman, RPh),
- Educational Scholarship and Loan (Sue S. Bornstein, MD, chair; Carlos J. Cardenas, MD; Dr. Fite; Jayesh B. Shah, MD; Joseph S. Valenti, MD; Arlo F. Weltge, MD; Justin M. Bishop, MD; Mr. Estes; Dr. S.E. Thompson Scholarship Fund Trustee Raymond S. Greenberg, MD; Medical Student Section (MSS) representative Jordan McKinney; MSS alternate representative Joseph Camarano; and TMA Alliance representatives Pam Abernathy and James P. Davis), and
- Finance (Dr. Berger, chair; Dr. Botsford; Dr. Fleeger; Dr. Floyd; Dr. Shah; and Dr. Valenti).

Drs. Fite, Villarreal, Bourgeois, Callas, Floyd, Cardenas, Weltge, and Fleeger, and Susan M. Strate, MD, represent the board on the TMA/Texas Osteopathic Medical Association/TMF Health Quality Institute Liaison Committee. Drs. Bornstein, Callas, Curran, Bourgeois, Cardenas, Fite, Fleeger, Shah, Strate, and Valenti represent the board on the TMA/Texas Medical Liability Trust Liaison Committee.

Nancy Foster, MD, chairs the board’s Committee on Physicians Benevolent Fund. Committee members are Sue Bailey; Vickie Blumhagen; Beverly Ozanne; Raymond C. Jess, MD; Muriel Mendell; Ann Morales; George Peterkin III, MD; and Shirley Sanders. Dr. Villarreal is the board’s liaison to the committee.

J. Marvin Smith III, MD, chairs the board’s History of Medicine Committee. Members are Joel S. Dunnington; Mark J. Kubala, MD; Mellick Sykes, MD; Mac Sykes, MD; Margaret Vugrin, MSLS, AHIP; and J. Patrick Walker, MD. J.J. Waller, MD, serves as the TMA Alliance representative; George Parker as the MSS representative; and Colleen O’Neill as the MSS alternate representative.

The TMA board also appoints the Texas Medicine Editorial Board. Owen E. Winsett, MD, chairs the board. Members are Chelsea I. Clinton, MD; Christopher J. Garrison, MD; John C. Jennings, MD; Roger S. Khetan, MD; Charlotte H. Smith, MD; Gary Ventolini, MD; and Alexis A. Wiesenthal, MD. Vastal Patel, MD, serves as the Resident and Fellow Section representative and Pranati Pillutla as the MSS representative.
REPORT OF BOARD OF TRUSTEES

BOT Report 8-A-19

Subject: Medical Student and Resident Physician Loan Funds

Presented by: Diana L. Fite, MD, Chair

TMA Board of Trustees members serve as trustees or as members of the boards of trustees for five student loan funds: Dr. S.E. Thompson Scholarship Fund, May Owen Irrevocable Trust, Texas Medical Association Alliance Student Loan Fund, and, through the TMA Special Funds Foundation, Durham Student Loan Fund and Medical Student Loan Fund. From July 1 through Dec. 31, 2018, 64 loans totaling $270,500 were disbursed from the five funds, and additional applications remain in process.

The Dr. S.E. Thompson Scholarship Fund and the Patricia Lee Palmer, MD, Memorial Resident Loan Fund offer loans to resident physicians. Four resident loans totaling $18,000 were disbursed from July 1 through Dec. 31, 2018.

In January 2019, the board approved allocations for the 2019-20 school year totaling $561,000, including $38,000 for residents. The loan allocations to the 13 medical schools are based on availability of funds and the history of each school’s utilization.
The TMA Minority Scholarship Program has given one hundred and one (101) $5,000; thirty-four (34) $10,000; and one (1) $2,500 scholarships to underrepresented minority medical students in Texas since it was established in 1998. Twelve Texas medical schools have received an award, and the rotation schedule will continue as funds are available. As of Jan. 25, 2019, the TMA Foundation has collected $6,000 in cash and pledges for the 2019 scholarships. All shortfalls will be covered by 2016 donations received from two private donors: Robert J. Bayardo, MD, and Patrick Leung, MD.

This year, the program will award thirteen (13) $10,000 scholarships to students matriculating at Texas Tech University Health Sciences Center School of Medicine, Texas A&M College of Medicine, Texas Tech University Health Sciences Center Paul L. Foster School of Medicine, UT Southwestern Medical School, UT Health San Antonio Long School of Medicine, The University of Texas Medical Branch School of Medicine, Baylor College of Medicine, McGovern Medical School at UTHealth, University of North Texas Health Science Center at Fort Worth Texas College of Osteopathic Medicine, The University of Texas at Austin Dell Medical School, The University of Texas Rio Grande Valley School of Medicine, The University of the Incarnate Word School of Osteopathic Medicine, and the new Texas Christian University School of Medicine. The TMA Office of Trust Fund Administration must have received candidate applications by Feb. 23, 2019. TMA will notify scholarship recipients in April and make the presentation ceremony at TexMed 2019 on May 17 in Dallas.

Although the U.S. Supreme Court ruling in 2003 allows race to be used in admissions and financial aid processes of academic institutions (subject to certain criteria), few have altered their financial aid policies to reestablish minority-specific programs. This leaves the TMA scholarship program as one of the few available in the state for underrepresented minority students seeking a career in medicine. Title VI restrictions generally do not apply to private scholarship programs when not administered by an academic institution.
At the 2018 Annual Session, the House of Delegates referred Resolution 105-A-18, Revision of Section 165.155(a) of the Texas Occupations Code, Solicitation of Patients (Bexar CMS), to the TMA Board of Trustees for decision. That resolution’s resolve clause states:

That the Texas Medical Association work to pass legislation that would rewrite Section 165.155 of the Texas Occupations Code, in particular, part (a) of the section, in order to eliminate the great potential for selective regulatory abuse, to eliminate any competitive burdens that are now placed on some groups of physicians, and to eliminate the present situation where physicians are unknowingly breaking the law.

As the house referred Resolution 105-A-18 to the board “for decision,” the board has full power of the house to act on that item, and may decide to adopt it, defeat it, amend it, refer it to still another body for study, or to dispose of it in any other way, and to implement whatever action is taken.

According to Parker v. Texas Medical Association, an “unreported” case, the purpose of Section 165.155 of the Texas Occupations Code is to prohibit physicians from paying for or rewarding referrals. This statutory provision states:

Sec. 165.155. SOLICITATION OF PATIENTS; PENALTY.

a) A physician commits an offense if the physician employs or agrees to employ, pays or promises to pay, or rewards or promises to reward any person, firm, association, partnership, or corporation for securing or soliciting a patient or patronage.

b) Each payment, reward, or fee or agreement to pay or accept a reward or fee constitutes a separate offense.

c) A physician commits an offense if the physician accepts or agrees to accept a payment or other thing of value for securing or soliciting patronage for another physician.

d) This section does not prohibit advertising except that which:

(1) is false, misleading, or deceptive; or

(2) advertises professional superiority or the performance of professional service in a superior manner and which is not readily subject to verification.

e) An offense under this section is a Class A misdemeanor.

It is important to note that the above-referenced statutory provision addresses both payments for referrals and fee splitting. Each of these topics has ethical implications and, accordingly, has been the subject of ethics opinions by both the TMA Board of Councilors and the AMA Council on Ethical and Judicial Affairs. (See ethics opinions below.)

Under the TMA Constitution and Bylaws, the Board of Councilors has jurisdiction over questions pertaining to medical ethics. Article VII of the TMA Constitution states that all questions of medical ethics shall be referred to this board, as provided in the bylaws. TMA Bylaw 3.721 specifies that “all questions pertaining to medical ethics shall be referred to the Board of Councilors without debate.”
Resolution 105 was debated by the TMA House of Delegates at TexMed 2018 because it was drafted with legislative directives; however, as its subject matter (1) is closely tied to medical ethics, and (2) implicates current TMA Board of Councilors ethics opinions and TMA Bylaws provisions regarding fee splitting, the Board of Trustees approved a recommendation to refer Resolution 105-A-18 to the Board of Councilors.

The jurisdiction of the Board of Councilors on this topic is reinforced by TMA Bylaw 15.30, which provides that “It shall be considered unprofessional and unethical to engage in the practice commonly known as ‘fee splitting’ in any of its forms as defined by the Board of Councilors” (emphasis added).

**TMA Board of Councilors’ Ethics Opinions:**

**FEE SPLITTING.** Payment by or to a physician for the referral of a patient is fee splitting and is improper. The payment for referrals violates the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral. All referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed.

**HEALTH FACILITY OWNERSHIP, INCENTIVE PAYMENTS AND CONFLICTS OF INTEREST.** It is not unethical, as a general rule, for a physician to own or have a financial interest in a for-profit hospital, nursing home, or other health facility, such as a free-standing surgical center or emergency clinic, even where the physician refers patients to such facility. The Board of Councilors recognizes that many health care facilities would not exist and that many medical services would not be available to patients except for the fact that responsible physicians invested in these facilities and services, thereby rendering a valuable public service. Such actions are consistent with the Principle of Medical Ethics that physicians recognize an ethical responsibility to participate in activities contributing to an improved community. However, when the holding of such business interests is influenced more by profit motive than appropriate patient care, such actions are unethical.

However, due to the potential for abuse of such arrangements, the Board of Councilors recommends that physicians be mindful of the following considerations:

Resolve conflicts of interest. The prime objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Under no circumstances may the physician place his own financial interest above the welfare of his patients. For example, it would be unethical or a physician to unnecessarily hospitalize a patient or prolong or reduce a patient's stay in the health facility for the physician's financial benefit. When a conflict develops between the physician's financial interests and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit.

Additionally, a physician should not be influenced in the prescribing of drugs, devices, or appliances by a direct or indirect financial interest in a pharmaceutical firm or other supplier. Whether the firm is a manufacturer, distributor, wholesaler, or repackager of the products involved is immaterial. Reputable firms rely on quality and efficacy to sell their products under competitive circumstances and do not appeal to physicians to have financial involvements with the firm in order to influence their prescribing. Thus, a physician may own or operate a pharmacy if there is no resulting exploitation of patients.

Furthermore, any remuneration or return on investment should be based on the physician's percentage of capital investment and not on utilization, or the volume or value of referrals of patients to a particular facility. It is not unethical for a physician to recover his or her investment in such a facility and earn a reasonable rate of return.
Do not engage in fee splitting. Payment by one physician to another solely for the referral of a patient is fee splitting and is improper both for the physician making the payment and the physician receiving the payment. Fee splitting violates the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral.

All referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed. The Board of Councilors reminds physicians that fee splitting is a violation of TMA Bylaws and may subject a member to disciplinary action.

Ensure that the facility renders the best possible service. The Board of Councilors believes that the physician's ethical duty to place the patient's interest above his own interest is served where the health care facility to which the physician refers patients has an effective quality assurance and utilization review program to assess the quality of care provided and guard against unnecessary utilization. Additionally, the Board of Councilors believes that the opportunity for abuse is lessened when the investing physician refers patients to a health care facility in which the physician will personally render medical care to the patient. While these are not absolute requirements, they are examples of indications that the referring physician participates in a facility which has the patient's best interests in mind.

Disclose ownership to patients. The physician has an affirmative ethical obligation to disclose his ownership of a health facility to his patient, prior to admission or utilization. Upon request, a physician should give the patient a list of alternative facilities, if such are available, and inform the patient that they have the option to use one of the alternative facilities.

Comply with applicable law. Federal and state law prohibits incentive payments designed to induce physicians to admit patients to a hospital or other health care facility. Physicians may not lawfully or ethically accept such payments. Physicians may not ethically accept any payment, directly or indirectly, overtly or covertly, in cash or in kind, from a health care facility for services delivered by the facility. Further, the Medical Practice Act, as interpreted by the Office of the Attorney General of Texas, may prohibit the direct division on a percentage basis of a physician's professional income with lay persons or to lay shareholders in a corporation or other business enterprise.

Duty to seek responsible change. Physicians recognize an ethical responsibility to seek changes in those requirements which are contrary to the best interests of the patient. The Board of Councilors believes that physicians have a right to seek changes in those laws which unduly restrict physician participation in health care facilities which primarily exist to serve the interest of the patient, do not result in exploitation of patients, do not involve fee splitting or other improper incentive payments, and do not present unresolvable conflicts of interest. It is in the best interest of the patient and community, not the physician, that such arrangements be allowed to continue.

CEJA Ethics Opinions:

11.3.4 Fee Splitting. Patients must be able to trust that their physicians will be honest with them and will make treatment recommendations, including referrals, based on medical need, the skill of other health care professionals or facilities to whom the patient is referred, and the quality of products or services provided. Payment by or to a physician or health care institution solely for referral of a patient is fee splitting and is unethical.
Physicians may not accept:

(a) Any payment of any kind, from any source for referring a patient other than distributions of a health care organization’s revenues as permitted by law.
(b) Any payment of any kind, from any source for prescribing a specific drug, product, or service.
(c) Payment for services relating to the care of a patient from any health care facility/organization to which the physician has referred the patient.
(d) Payment referring a patient to a research study.

Physicians in a capitated primary care practice may not refer patients based on whether the referring physician has negotiated a discount for specialty services.

AMA Principles of Medical Ethics: II

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

9.6.9 Physician Self-Referral: Business arrangements among physicians in the health care marketplace have the potential to benefit patients by enhancing quality of care and access to health care services. However, these arrangements can also be ethically challenging when they create opportunities for self-referral in which patients’ medical interests can be in tension with physicians’ financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as trust in the profession.

In general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationships—including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices—are expected to uphold their responsibilities to patients first. When physicians enter into arrangements that provide opportunities for self-referral they must:

(a) Ensure that referrals are based on objective, medically relevant criteria.
(b) Ensure that the arrangement:
   (i) is structured to enhance access to appropriate, high quality health care services or products; and
   (ii) within the constraints of applicable law:
      a. does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation;
      b. does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and
      c. adheres to fair business practices vis-à-vis the medical professional community—for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.
   (c) Take steps to mitigate conflicts of interest, including:
      (i) ensuring that financial benefit is not dependent on the physician-owner/investor’s volume of referrals for services or sales of products;
      (ii) establishing mechanisms for utilization review to monitor referral practices; and
      (iii) identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.
   (d) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral.
AMA Principles of Medical Ethics: II,III,VIII

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

9.6.3 Incentives to Patients for Referral: Endorsement by current patients can be a strong incentive to direct new patients to a medical practice and physicians often rely on word of mouth as a source of referrals. However, to be ethically appropriate, word-of-mouth referrals must be voluntary on the part of current patients and should reflect honestly on the practice. Physicians must not offer financial incentives or other valuable incentives to current patients in exchange for recruitment of other patients. Such incentives can distort the information patients provide and skew the expectations of prospective patients, thus compromising the trust that is the foundation of patient-physician relationships.
The TMA Education Center was launched in January 2012 to offer Texas physicians convenient and on-demand access to live and online CME. TMA’s course catalog is under constant review to keep it up to date with new and current topics; there are currently more than 100 courses available.

The TMA Education Center is one of the few CME platforms to offer a wide array of practice management CME with ethics credits. Courses are available in a variety of formats, including webcasts, live and on-demand webinars, electronic and hard-copy publications, CDs, and podcasts. Within the education center, courses are grouped into the following key subject areas:

- Billing and Coding,
- Communications,
- Ethics,
- HIPAA,
- Medicare and Medicaid,
- Nonphysician Practitioners,
- Patient Safety,
- Physician Health,
- Practice Operations,
- Public Health,
- Risk Management, and
- Technology.

The courses provide much-needed education, tools, and resources that can be accessed on handheld devices, tablets, and computers. Course content is relevant to physicians across all specialties, as well as practice staff with varying levels of experience and knowledge. A new marketing campaign will launch in 2019 to more directly market select courses to practice staff to supplement their efforts in keeping practices regulatory compliant, up to speed on hot topics, and to fulfill mandatory training requirements.

The association develops new courses based on need as determined by calls to the TMA Knowledge Center, information gathered in the field, and input from various TMA councils and committees. This year, more than 50 topics already have been identified for CME programming, of which approximately 80 percent will be newly developed courses.

Due to a generous $500,000 sponsorship from the Texas Medical Association Insurance Trust, approximately 75 percent of the TMA Education Center catalog became free for TMA members and their staff effective March 1, 2018. Because of this new member benefit, the percentage of TMA membership utilizing the platform in 2018 increased 31 percent. Course registrations increased 164 percent, with the number of unique users increasing 233 percent.
On Sept. 27, 2018, Louis J. Goodman, PhD, CAE, TMA executive vice president/chief executive officer, announced his intention to retire as the EVP/CEO of the Texas Medical Association after a 32-year career at the association. His retirement date will depend on the timing, process, appointment, and selection of a new EVP/CEO. To assist the board in this action, the board secured the national search firm of Tuft & Associates, Inc., to begin the search for a new TMA EVP/CEO.

In December 2018, the board approved a recommendation to rename the TMA building in honor of Dr. Goodman, the “Louis J. Goodman Texas Medical Association Building,” and to plan a celebration ceremony in honor of Dr. Goodman at the 2019 annual meeting.

At the March 2019 First Tuesdays event, held on March 5, the board hosted a building dedication ceremony to honor and recognize the dedication and commitment of his hallmark career and steadfast commitment to the integrity of the practice of medicine and patient care in Texas. New building markers were unveiled during the ceremony. The event was attended by more than 320 people and was live-streamed at texmed.org/Lou. Guest speakers included TMA Board of Trustees Chair Diana Fite, MD; U.S. Rep. Michael Burgess, MD (R-Texas); State Sen. Jane Nelson (R-Flower Mound); and TMA President Doug Curran, MD.

The board also is hosting a reception to honor Dr. Goodman at the 2019 annual meeting. A celebration will take place on Thursday, May 16, 2019, from 5 to 6:30 pm to allow all TexMed attendees to visit with Lou and congratulate him on his accomplishments as the EVP/CEO of the association.
REPORT OF BOARD OF TRUSTEES

BOT Report 13-A-19

Subject: Compensation to Physicians for Authorizations and Preauthorizations, Res. 405-A-18

Presented by: Diana L. Fite, MD, Chair

At the 2018 Annual Session, the House of Delegates referred Resolution 405-A-18, Compensation to Physicians for Authorizations and Preauthorizations, to the TMA Board of Trustees for decision. This resolution was introduced to the TMA House of Delegates by Ori Z. Hampel, MD, a physician from Pasadena.

As the house referred Resolution 405-A-18 to the board “for decision,” the board has full power of the house to act on that item, and may decide to adopt it, defeat it, amend it, refer it to still another body for study, or to dispose of it in any other way, and to implement whatever action is taken.

The resolution recommends:

That insurance and managed care companies (“payers”) compensate physicians for the time that physicians and their staff spend on authorization and preauthorization procedures. Such compensation shall be paid in full by payers to physicians without deductible, coinsurance, or copayment billable to patients; thus, patients will not bear the burden for such processes imposed by payers. The fee schedule shall be based on the compensation due physicians for patient evaluation and management according to the Current Procedural Terminology (CPT) coding system. For physicians contracted with payers, the payers shall compensate the physician at the contracted fee schedule. For out-of-network physicians, the payers shall compensate physicians at 60 percent of billed charges. The physician and/or physician staff shall track the time spent per patient per day performing tasks related to authorization and preauthorization, and round the time spent per task up to the nearest five-minute increment. The physician shall bill the payer in accordance with the CPT coding system based on the time spent. If necessary, multiple codes shall be used and payable to account for the time spent. Billable minutes for authorization and preauthorization include, but are not limited to, time spent filling out forms, making telephone calls (including time spent negotiating phone trees and hold time), documenting in the patient’s medical record, communicating with the patient, printing, copying, and faxing. Texas laws pertaining to payment timeliness by third-party payers shall apply to payers for such billing as well.

Also at the 2018 Annual Session, the Council on Socioeconomics presented reports on two prior authorization resolutions that were referred to it in 2017. Those reports were approved by the House of Delegates and form the basis for the Board of Trustees’ decision not to proceed with Resolution 405-A-18.

Resolution 406-A-17, Transparency and Payments for Prior Authorizations, required the Council on Socioeconomics to review:

- Amending TMA Policy 235.034, Authorizations Initiated by Third-Party Payers;
- Allowing physicians to charge subscribers if payers and third parties do not compensate physicians for the prior authorization burdens, as these burdens are not a covered service;
• Allowing prior authorizations for only new medications and not for medications that patients have been receiving previously and continuously;
• Pursuing new Texas laws that incorporate the American Medical Association’s Ensuring Transparency in Prior Authorizations Act model bill, including provisions that prior authorization requirements and restrictions be readily accessible on payers’ websites for physicians and subscribers, and that statistics regarding prior authorization approvals and denials be available on payers’ websites;
• Supporting legislation that mandates payers accept and respond to standard electronic prior authorization (ePA) transactions, such as the National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard ePA transactions; and
• Asking the Texas Delegation to the AMA to take this resolution to the AMA for a national unified movement.

Resolution 408-A-17, Compensation of Physicians for Authorizations and Preauthorizations, requested:

That insurance and managed care companies (“payers”) compensate physicians for the time that physicians and their staff spend on authorization and preauthorization procedures. Such compensation shall be paid in full by payers to physicians without deductible, coinsurance, or copayment billable to patients. The fee schedule shall be based on the compensation due physicians for direct patient care according to the Current Procedural Terminology (CPT) coding system. For physicians contracted with payers, the payers shall compensate the physician at the contracted fee schedule. For out-of-network physicians, the payers shall compensate physicians at 60 percent of billed charges. The physician and/or physician staff shall track the time spent per patient per day performing tasks related to authorization and preauthorization. The physician shall bill the payer in accordance with a specific conversion table of time spent to CPT code. Billable minutes for authorization and preauthorization include, but are not limited to, time spent filling out forms, making telephone calls (including time spent negotiating phone trees and hold time), documenting in the patient’s medical record, communicating with the patient, printing, copying, and faxing. Texas laws pertaining to payment timeliness shall apply to payers for such billing as well.

The Council on Socioeconomics expressed concern that shifting costs associated with prior authorizations to patients, as suggested in Resolution 406-A-17, could disrupt the patient-physician relationship and potentially cause patients to forgo necessary care. The council noted that last year, the 85th Texas Legislature passed and the governor signed into law SB 680, which provides a more standardized process for physician exception requests for step therapy drug protocols. Additionally, TMA endorsed 21 principles for reforming prior authorization and utilization reviews developed by a coalition of national and state medical organizations at the beginning of 2018. The principles cover the broad categories of clinical validity, continuity of care, transparency and fairness, timely access and administrative efficiency, and alternatives and exemptions.

The TMA House of Delegates adopted CSE Report 3-A-18, Transparency and Payments for Prior Authorizations, in lieu of Resolution 406-A-17, and existing TMA policy was amended as follows:

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

CSE Report 3-A-18 also established TMA policy on standardized electronic prior authorizations:

**235.038 Standardized Electronic Prior Authorization Transactions:** The Texas Medical Association supports policy and legislation that third-party payers, benefit managers, and any other party conducting utilization management be required to accept and respond to (1) standard electronic prior authorization (ePA) transactions for pharmacy benefits that use a nationally recognized format, such as the National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard; and (2) standard electronic transactions for review and response to prior authorization requests for medical service benefits that use a nationally recognized format, such as the ASC X12N 278 Health Care Service Review Request (CSE Report 3-A-18).

In its report, the council identified concerns that implementing Resolution 408-A-17 would require revisions to both state and federal statutes governing:

- How health insurance coverage policies are designed;
- How administrative services physicians provide are applied to deductibles, coinsurance, and copayments;
- How health plans calculate and pay prompt payment penalties to contracted physicians;
- How out-of-network physicians are compensated for the services they provide; and
- How out-of-network physicians are not required to accept assignment on insurance claims.

The council expressed concern that efforts to modify Texas’ prompt payment law could result in the loss of other provisions in the law currently favorable to physicians and that any modifications to the CPT codes would require review by the American Medical Association.

CSE Report 3-A-18 was approved by the House of Delegates and forms the basis for the board’s decision that TMA not proceed with Resolution 405-A-18. The board approved not adopting Resolution 405-A-18 and reaffirming current TMA Policy 235.034 and Policy 235.038.
REPORT OF EXECUTIVE VICE PRESIDENT

EVP Report 1-A-19

Subject: 2018-19 Update

Presented by: Louis J. Goodman, PhD

**State of the Association**

Your association had another successful year in 2018, closing with a total of 52,387 members, a net gain of 855, and a membership retention rate of 93 percent. The following is a list of major TMA accomplishments for 2018 and goals for 2019.

**Practice Viability**

- Assisted physicians in recovering more than $1.6 million from third party payors through the Hassle Factor Log.
- Secured $500,000 grant from TMA Insurance Trust (TMAIT) to fund free continuing medical education (CME) for TMA members. Gained high visibility for both TMA and TMAIT, and tripled member usage of the TMA Education Center over the course of just eight months.
- Filed amicus curiae briefs in cases with favorable holdings for physicians: (1) Regarding whether a primary surgeon must tell a patient that a resident will be assisting in a surgery, and what that resident's education, training, and experience is in the surgery, and what parts of the surgery the resident is going to perform. (2) Regarding whether a physician employed by a Texas governmental entity but having staff privileges and performing employee duties at another facility is entitled to immunity for actions that occurred at the other facility.
- Submitted extensive response to the Centers for Medicare & Medicaid Services' proposed 2019 Medicare Payment Schedule and Quality Payment Program rules.
- Advocated for American Board of Medical Specialties to provide greater clarity across member boards for consequences of administrative actions and due process for physicians.
- Advocated against maintenance of certification (MOC) requirements in administrative rules and in physician ratings.
- Increased the number of practice management consulting projects by 16 percent.

**Healthy Environment**

- Enjoyed positive 2018 election cycle.
- Produced all-new *Healthy Vision 2025* to promote TMA's advocacy agenda to legislators, news media, and opinion leaders.
- Educated legislators and doctors on issues important to medicine in the 2019 session.
- Texas reached the 1.1:1 goal for the ratio of first-year residency positions per Texas medical school graduate.
- Due to TMA's advocacy efforts that have strengthened the practice environment, Texas set another new record for the number of medical license applications.
- Convened the first summit among all key players to identify opportunities to improve Medicaid managed care. Recommendations from the summit will be presented to the Texas Health and Human Services Commission and serve as the basis for Medicaid managed care reform legislation.
- Produced numerous advocacy documents for the 2019 Texas Public Health Coalition, representing more than 30 statewide health stakeholders.
Trusted Leader

- Cohosted TMA's Presidential Maternal Health Congress. Recommendations from this report resulted in new TMA policy, CME opportunities, close collaboration with the Texas Department of State Health Services, and The University of Texas System, and set a framework for TMA legislative advocacy in 2019.
- TMA Foundation (TMAF) funded all requests from TMA science, population health, and quality initiatives, including Walk With a Doc, Be Wise – ImmunizeSM, Distinguished Speaker Series in Population Health, and Hard Hats for Little Heads.

One Voice

- Membership reached 52,387 (+855 members), with retention of 93 percent.
- Collected $16.48 million in dues of a goal of $16.55 million, or 99.6 percent.
- TMA and TMA Trust funds received an unqualified or "clean" audit opinion for 2017 audits.
- Attained 98 percent of TexMed revenue goal; 142 percent of leadership conferences revenue goal; 118 percent of sponsorship goal. Maintained strong advertising sales in spite of slow print ad market.
- Launched redesigned and revamped Texas Medicine magazine and hugely successful Texas Medicine Today personalized, digital news delivery system.
- Brought Grayson County Medical Society back to life over a six-month period.
- Solved financial issues in four different county medical societies. Forty-eight different county medical societies and AMS organizations are tracked in QuickBooks online.
- Strengthened use of all TMA social media accounts.
- Enhanced digital and social media marketing, reaching current and potential members with nearly 1.15 million digital impressions through Facebook, Google Ads, and other channels.
- TMA Knowledge Center received, processed, and answered 12,150 inbound calls and emails.
- Power BI financial dashboards are currently in the final stages of development to enable the presentation of high level dashboards for CEO, COO, and VP level TMA staff.
- Tennessee and Alabama have joined the states currently being hosted as TMA technology clients in 2018 for a total of 11.

2019 Goals

- Meet or exceed 2019 dues budget of $16,800,000 and membership goal of 53,160.
- Meet 2019 operating income and expense budget.
- Successful Executive Vice President search.
- Achieve successful legislative session, including:
  - Reduce burdensome red tape and establishing competitive physician payments to improve physician participation in Medicaid.
  - Renew Medical Practice Act to continue agency and seek reforms to assure just, fair, and prompt Texas Medical Board action in licensing and enforcement.
  - Improve prior authorization process, health plan network adequacy, and provider directory accuracy.
  - Pass TMA package of legislation to improve maternal and child health.
  - Reduce administrative hassles of physician drug monitoring program compliance.
  - Maintain the 1.1:1 ratio of residency positions per medical school graduate.
  - Improve access to care in underserved areas through physician loan repayment and rural training tracks for resident physicians.
  - Achieve Texas Public Health Coalition goals regarding tobacco, immunization, public health infrastructure, and chronic disease.
  - Protect 2003 liability reforms.
- Receive unqualified or "clean" audit opinion for 2018 TMA and TMA Trust Fund audit.
- Improve engagement scores for young physicians and women in medicine by 20 percent. Improve engagement scores overall by 15 percent.
• Use newly upgraded TMA Grassroots Action Center to increase effectiveness of member involvement in the legislative process – including First Tuesdays at the Capitol activities.
• Use year one *Texas Medicine Today* data to enhance customization of daily e-newsletter and increase member engagement.
• Work with task force to revitalize inactive county societies and implement virtual county society meetings.
• Earn marketing and member services revenue of $3.6 million; Education Center revenue of $579,400; advertising income of almost $600,000; and TexMed and conference revenue of $420,000.
• Increase visibility of consulting services using content marketing.
• Increase usage of TMA Education Center as a member benefit, adding new products and packaging products by topic.
• Endorse one or more affinity credit card to replace current royalty relationship.
• Develop additional revenue of $100,000 in net new marketing contracts, including service to TMA member practices in small and medium sized markets.
• Launch revenue-producing, self-publishing business directory.
• Expand CME MOC offerings.
• Increase employee engagement.
• Audit and update TMA's Policies and Procedures manual.
• Reduce the increasing administrative hassles in Medicare Advantage plans.
• Continue efforts to help physicians transition to value-based payment models within Medicaid managed care as a means of improving patient care and physician satisfaction.
• Significantly increase news media (both traditional and new media) coverage of TMA, TMA's key policy issues, and Texas physicians.
• Increase TMAF fundraising goals and develop stronger evaluations of existing grants.
• Develop a formal education program for physicians, nurses, and hospitals on best practices to reduce maternal morbidity and mortality. This will include physician education to recognize substance use disorders and find treatment options.
• Increase the number of state medical societies currently being hosted as TMA technology clients.
• Fully implement Power BI financial and membership dashboard enhancement and deploy to TMA executive staff.

**TMA Fall and Winter Conferences**

In total, 485 physicians and medical students attended 2018 TMA Fall Conference; the theme of the conference was Taking Back Medicine. At the general session, Jason Terk, MD, moderated a panel discussion on Opioids: A Legislative Perspective, with State Rep. Four Price and U.S. Rep. Michael Burgess, MD; Brian Sayers, MD, chair of the Travis CMS Physician Health and Rehabilitation Committee, presented True North: Rethinking Physician Wellness; and Kyu Rhee, MD, Chief Operating Officer for IBM, presented on Predicting and Inventing a New Era of Health with Augmented Intelligence (AI).

The Dawn Duster session featured a panel discussion titled Venture Capitalists and the Impact on the Health Care Marketplace moderated by TMA PracticeEdge COO Dave Spalding, with Kevin Wood, JD, of Strasburger & Price, and Jay Zdunek, DO, MBA, chief medical officer of Austin Regional Clinic.

There were 568 physicians and medical students in attendance at 2019 TMA Winter Conference. The program began with TMAF Awards and Donor Recognition and an update on the AMA presented by AMA President Barbara L. McAneny, MD. Steve Murdock, PhD, presented Change is Coming: Texas Demographics. Sen. Lois Kolkhorst gave an overview on the Legislative Health Care Agenda. TMA President Douglas Curran, MD, led a panel discussion on Access Expansion with Sue Bornstein, MD, TMA Board of Trustees member, Stephanie Muth, Texas state Medicaid director; and Ryan Van Ramshorst, MD, chair of the TMA Select Committee on Medicaid, CHIP, and the Uninsured. John Carlo,
MD, concluded the General Session by leading a second panel discussion on Keeping Texas Strong: TMA Strategies for Maternal Health and Immunizations with Emily Briggs, MD, chair of the TMA Reproductive, Women’s, and Perinatal Health Committee; and C. Mary Healy, MD, director of vaccinology and maternal immunization, Center for Vaccine Awareness and Research, Texas Children’s Hospital.

The Dawn Duster featured Kimberly Monday, MD, neurologist from Houston, moderating a discussion on DNR and Advance Directives with Missy Atwood, JD, partner at Germer Beaman & Brown, PLLC, and Jason Morrow, MD, PhD, medical director of inpatient palliative medicine at University Health System.

Human Resources

The association has 145 regular full-time and six part-time equivalent positions, 11.25 of which are funded by outside sources. TMA Insurance Trust has 20 full-time equivalent positions.

The following significant staff changes occurred in 2018:

- Alan Atwood was promoted to associate vice president, TIS and association management services;
- Loretto Koepsel, TMA Alliance, retired after 30 years of service;
- Pam Hale, House of Delegates, retired after 30 years of service; and
- Pam Udall was rehired to executive director, TMA Alliance.

Consistent with House of Delegates policy on health insurance, TMA continues to offer health and dental insurance to employees and their dependents. Each of the options renewed for the 2019 plan year with no cost increase for TMA or staff.

TMA also offers a health savings account and a flexible spending account, which allows eligible employees to set aside a certain amount of their paycheck into a reimbursement account before paying income taxes. Reimbursement of medical expenses not covered by insurance includes deductibles, copays, prescription drugs, dental services, and the like.

Staff are honored for service to the association every five years with a luncheon and presentation of a service award. This year, we are celebrating the following staff anniversaries:

Five Years
- Morgan Cotham, TMA Membership and Business Development
- Liz Sansom, TMA Conference Management
- Keri Swanson, TMA Conference Management
- Lindsey Toms, TMA Conference Management

10 Years
- David Wilhelm, TMA Advocacy

15 Years
- Darren Whitehurst, TMA Advocacy

20 Years
- Cheryl Krhovják, TMA Membership and Business Development
- Alan Atwood, TMA Technology and Information Systems
- Kristina Haley, TMA Conference and Association Management
- Gay Anderson, TMA Communications
- Patricia Overton, TMA Communications
- Shannon Vogel, TMA Membership and Business Development
25 Years
- Ann Arnett, TMA General Counsel
- Bridget McPhillips, TMA Membership and Business Development
- Claire Duncan, TMA Communications
- Clyde Barre, TMA Administrative Services
- Lisa Hensley, TMA Administrative Services
- Janet Jones, TMA Finance

30 Years
- Karen Batory, TMA Population Health and Medical Education

40 Years
- Rocky Wilcox, TMA General Counsel

The Physicians Foundation
In 2018, the Physicians Foundation continued to focus on enhancing physician leadership skills while raising awareness about physician wellness. This support was needed more than ever as physicians were particularly strained this year. Many trends in health care persisted – especially as tax and health reform remained in the forefront, and the opioid epidemic continued growing.

The Physicians Foundation continued to produce research to better understand and address the new and unmet needs in the evolving health care industry. In 2018, the foundation’s sixth biennial Physician Survey gathered responses from nearly 9,000 U.S. physicians to examine the impact of poverty on health care outcomes, practice patterns, career plans, how physicians are responding to the opioid crisis and perspectives of today’s physicians. This survey revealed a growing number of physicians dealing with symptoms of burnout (78 percent), with 80 percent of physicians reporting that they have no time to see new patients or take on more duties, making the foundation’s commitment to raising awareness about physician wellness ever more important.

The Physicians Foundation invested over $3.1 million in 2018 to support grants that empower the nation’s physicians in their delivery of care. In the devastating aftermath of hurricanes Michael and Florence, the Physicians Foundation stepped into action to provide disaster relief funding amounting to over $1 million. The funding aided thousands of affected physicians in North Carolina, South Carolina, and Florida, in rebuilding practices and continuing to care for patients.

As America continues to consider changes in health care policy, the perspectives of practicing physicians and their patients are ever more important, and must be addressed. The Physicians Foundation will continue to be a leading voice for practicing physicians to help them navigate the changing health care system, to strengthen the patient-physician relationship, and to support physicians in sustaining their medical practices through decreasing autonomy and increasing administrative burdens. The year ahead will be vital. In 2019, the foundation will field and report its third biennial patient survey, use its new collaboration with The Health Initiative to elevate physicians’ and medical societies’ voices around the impact of poverty on health, and continue to support the timely research of Lawrence Casalino, MD, PhD, through the Physicians Foundation Center for the Study of Physician Practice and Leadership in collaboration with Weill Cornell Medical College, among other core initiatives. All of these efforts, and more, will continue supporting physicians as they navigate the changing health care landscape.

Coalition of State Medical Societies
Founded by TMA in 2012, the coalition now comprises 10 state medical associations with more than 180,000 physician and medical student members. The Coalition of State Medical Societies wrote a formal comment letter to the Centers for Medicare & Medicaid Services in opposition to its plan to collapse Medicare’s evaluation and management (E/M) payment and coding levels. The coalition also arranged for member society leaders and staff to visit Capitol Hill to lobby senators, representatives, and key
congressional staff on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), regulatory relief, balance billing, the Affordable Care Act, graduate medical education, and physician-owned hospitals. The coalition works with a contract lobby firm to monitor important health care issues in Congress and the administration, and to coordinate responses as necessary.

**TMA PracticeEdge**

Now in its fourth year, TMA PracticeEdge entered 2019 in a strong position with a portfolio of 15 accountable care organization (ACO) clients providing care for more than 230,000 patients in value-based contracts. And while shared savings and quality incentives for the 2018 performance year have not yet been reconciled, the TMA PracticeEdge family of ACOs has generated approximately $9 million in earned incentives for member physicians from 2016 to 2018. That result could be doubled in 2019 as the maturing networks move into risk-based contracts in Medicare, Medicare Advantage, and commercial contracts.

**TMA Specialty Services**

TMA Specialty Services (TMASS) began operations in the first half of 2018 with the successful launch of a proprietary data warehouse to support independent specialists as leaders in value-based care. The company integrates clinical and claims data from more than 15 unique sources including electronic health records, payers, hospitals, health information exchanges, and a patient-reported outcomes application. A total of 500 physicians from eight specialties contract to utilize the TMASS analytics toolset to advance quality outcomes and value-based care opportunities. Discussions continue with multiple payers to develop scalable episodic payment models for specialists based upon shared savings concepts commonly utilized in the ACO market.
REPORT OF COMMITTEE ON MEMBERSHIP

CM-M Report 1-A-19

Subject: Membership Development

Presented by: Tina J. Philip, DO, Chair

TMA Membership
TMA ended 2018 with 52,634 members, a net gain of 1,102 members and a year-over-year membership increase of 2.1 percent. Compared with this same time last year, membership in the active dues-paying categories (including active and first year in practice) increased by 31 members or .1 percent. Residents increased by 306 members or 4.6 percent. Students also increased by 584 members or 9.6 percent.

Additionally, TMA collected $16.48 million in dues on a dues revenue budget goal of $16.55 million, or 99.6 percent. TMA’s retention rate was 93 percent.

TMA 2019 Membership Goals
• Increase membership in the association to 53,792, an increase of 1,158 or 2.2 percent,
• Achieve or exceed dues revenue goal of $16.8 million, and
• Retain 94 percent of recruitable members.

Key Priorities
Of note is the ongoing engagement of the Committee on Membership in addressing TMA priorities and helping implement the recommendations of the November 2016 member survey.

Women in Medicine: Better serving the unique needs of women in medicine has been a priority of TMA. The association has hosted special programming and events, hosted tables at the TMA Foundation gala, and supported the efforts of county medical societies, many of which have strong Women in Medicine committees.

In 2018-19, a series of three Women in Medicine events held in conjunction with TMA conferences were at capacity and had a waitlist of those who wanted to attend. During the 2018 TMA Fall Conference event, the focus was on how TMA might enhance its activities to better serve and represent female physicians. Linda Villarreal, MD, vice chair of the TMA Board of Trustees, and Robin Rather, CEO of Collective Strength, guided the conversation.

Participants reviewed current TMA and other medical society policies on nondiscrimination. Participants made four recommendations for TMA to consider, including the need for member training and policy on inherent bias and creation of a women’s section within TMA. Additionally, participants discussed needed programming, advocacy, and services such as professional and leadership development; improving female representation within TMA; more point-of-entry and leadership opportunities for women; creation of implicit bias training; a campaign to address gender pay inequity; and creation of watchdog function at TMA to identify discrimination and propose direct action.

The Council on Socioeconomics was charged with looking at the recommendations and suggesting policy to the House of Delegates for action during TexMed 2019. The committee will recommend creation of a Women in Medicine Section at that time. Plans for 2019 include another series of events and help implementing any recommendations approved by the TMA Board of Trustees and the House of Delegates.
Image Campaign: Another research finding from the member survey was the need to boost physician image. Members of the committee expressed keen interest in this campaign to help boost physician image in a time when legislators, insurance companies, hospital administrators, and others are hoping to expand nonphysician practitioners’ scope of practice. The committee envisions ads that feature individual physicians, the role they play in their communities, their strong connection to their patients, and their everyday heroic acts. TMA, with the help of the committee, could solicit story ideas and physicians to highlight. The audience would be Texas patients and the general public. Another suggestion was to build on the success of the TMA Takeover Tuesdays, which feature a day in the life of a Texas physician by putting more advertising dollars behind it, increasing the frequency of the ads, and expanding the reach of the current program.

Additionally, Committee Chair Dr. Philip met with Steve Levine, vice president (VP), TMA Communications, on how TMA might mobilize physicians to become advocates for TMA and increase the reach of TMA messaging. Following this discussion, TMA launched TMA Leading Advocates to identify and recruit potential TMA champions to help spread TMA messages via social media. Dr. Philip has volunteered to work with the TMA Communications team to implement these ideas.

Professional and Leadership Development Track: TMA regularly fields calls from members who do not meet the age requirement to participate in the TMA Leadership College but would like to do so. TMA also has heard from physicians interested in Women in Medicine leadership development offerings. TMA recently received a request from a 100-percent membership large group to provide a comprehensive leadership program for its physicians.

The TMA Leadership College is a respected program and continues to be a sought-after experience by TMA membership; demand is expected to grow. The program has made admirable strides towards its goal of developing a strong pipeline of future leaders for organized medicine. To serve more physician members, their varied interests and needs, and a changing health care landscape, staff are researching ways to develop TMA’s leadership offerings to cover a continuum of career stages and leadership competencies.

To help meet increased demand, the TMA Young Physician Section and the TMA Leadership College Alumni under the supervision of the Committee on Membership hosted a Professional and Leadership Development Track during TexMed 2018. The target audience was young and female physicians, TMA Leadership College alumni, and other health care professionals in all areas of practice. The speakers and the subject matter for TexMed 2019 were chosen based on feedback from members:

- Managing Your Online Reputation, Steve Levine, VP of Communications, Texas Medical Association; and
- Intergenerational Team Communications, Amanda Veesart, PhD, RN, CNE, Texas Tech University Health Sciences Center School of Nursing

2019 Recruitment and Retention Campaigns

Annually, TMA membership development and marketing staff develop a marketing plan meant to help maintain the visibility of Texas Medical Association including its value, benefits, and services. Key recruitment and retention campaigns are noted here for your review.

Newly licensed: This campaign targets physicians for the year following licensure. It is primarily a print campaign due to the lack of email addresses for this population. Each first-class postcard contains a URL directing members to custom landing pages with more details and information on highlighted benefits. Edits to this campaign continue each year to refine messaging and reduce costs.
Texas Medicine Today: This campaign will provide nonmembers with a three-month trial subscription to TMA’s daily members-only e-newsletter. Each issue will arrive once a week and contain the top stories from the week prior, content marketing, and ads featuring TMA services, practice management consulting case studies, and a “join today” call to action. In the first quarter, the target will be former members. In the second quarter, the target will be those who have never been a member.

CME purchasers: TMA targets nonmembers who purchase CME in the TMA Education Center in this campaign. Emails offering a $125 credit toward the cost of their membership is offered. If the applicant chooses the auto-renew option, the credit is doubled to $250. In 2018, just over three percent of those targeted joined TMA. Most appear to be previous members.

Practice managers: The TMA membership field team suggested a monthly message to practice managers highlighting a service/product. They cited group practice visits that demonstrated more and more practice managers are tasked with payment of dues and deciding which memberships are important. The practices that were most knowledgeable about the benefits of TMA membership and were tapping into these benefits were more likely to renew. Monthly emails will be sent to practice managers highlighting a specific benefit or service. The email will target both current 100-percent membership group managers and large group managers in TMA’s targeted recruitment lists. Services to be highlighted are:

1. Compliance (HIPAA, Medicare Access and CHIP Reauthorization Act, DocbookMD secure messaging, Third Rock cyber security, and the like);
2. New practice/transition to independent practice (TMA services case study);
3. Coding and documentation (billing and coding hotline, Hassle Factor Log, TMA services case study);
4. Staff recruitment/management (TMA services case study);
5. Revenue cycle management/billing (Centers for Medicare & Medicaid Services Quality Payment Program, TMA services case study);
6. Nonphysician practitioners (general management, billing, delegation of duties/supervision);
7. Custom projects (strategic planning case study);
8. Customer service (Best Front Desk or Crash Course for First Time Managers – practice CME that serves as professional development);
9. TMA Insurance Trust and Texas Medical Liability Trust products and services;
10. Discounts: endorsed vendors, group discount program, Practice Management Consulting, career center;
11. TMA Knowledge Center; and
12. TMA white papers.

Targeting of potential members via various digital channels (Facebook ads, retargeting website visitors, and tracking user actions to identify those most likely to join) will supplement these efforts. Additionally, TMA membership development and marketing staff will continue focused in-the-field efforts to engage potential members and encourage renewal of TMA’s 100-percent membership group practices. Plans also include highlighting TMA legislative efforts in recruitment and retention messaging.
Acting upon a nomination by the Dallas County Medical Society, the Board of Councilors selected Don R. Read, MD, of Dallas to receive the association’s Distinguished Service Award. The award will be presented on Friday, May 17, 2019, at the opening session of the House of Delegates.

As a colon and rectal surgeon in Dallas for more than 40 years, Dr. Read is a fellow of the American College of Surgeons, the American Society of Colon and Rectal Surgeons, and the Texas Society of Colon and Rectal Surgeons. Upon graduating from Austin College in 1964, Dr. Read received his medical degree in 1968 from The University of Texas Medical Branch at Galveston.

Dr. Read has been a leader in medicine for decades, having joined TMA and DCMS in 1979. Dr. Read served in leadership capacities for both organizations, serving as president of DCMS in 2002 and as president of TMA in 2016-17. His other leadership roles include chair of the TMA Board of Trustees, founding chair of the TMA PracticeEdge Board of Managers, chair of TMA’s Patient-Physician Advocacy Committee, and president of the Texas Society of Colon and Rectal Surgeons. As one of the most respected physician leaders in the Dallas community, DCMS awarded Dr. Read with the Charles Max Cole, MD, Leadership Award in 2010.

Dr. Read exemplifies integrity, honesty, compassion, and servant leadership. He has provided exceptional and distinguished service to his patients, DCMS, and TMA.
Pursuant to Texas Medical Association Bylaw 5.217, the Board of Councilors may issue opinions on matters of medical ethics. Opinions the board adopts shall be reported to the TMA House of Delegates.

At TMA’s 2018 Fall Conference meeting, the board adopted the following opinions, replacing existing opinions on the same respective subjects.

**SEXUAL AND ROMANTIC RELATIONSHIPS AND MISCONDUCT.** Sexual contact that occurs concurrent with the patient-physician relationship constitutes sexual misconduct and is unethical. A physician must terminate the patient-physician relationship before initiating a dating, romantic, or sexual relationship with a patient. But even after a patient-physician relationship has been terminated, sexual or romantic relationships with former patients or even key third parties are fraught with potential harm to all involved because of the patient-physician relationship. Because of the risk of harm to both participants, sexual or romantic relationships with former patients or key third parties should always be approached with caution and are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the professional relationship. Key third parties include, but are not limited to, a patient’s spouse or partner, parent, guardian, or proxy. *AMA Principles of Medical Ethics I, II, IV* (Adopted February 2002; Amended September 2018)

**CHAPERONES DURING PHYSICAL EXAMS.** Although not legally required, from the standpoint of ethics and prudence, the protocol of having chaperones available on a consistent basis for patient examinations, where appropriate, is strongly encouraged. Physicians aim to respect the patient’s dignity and to make a positive effort to secure a comfortable and considerate atmosphere for the patient. Physicians may do this by actions including the following:

1. providing appropriate gowns and private facilities for undressing;
2. sensitive use of draping;
3. clear explanations on various components of the physical examination; and
4. establishing a policy that patients are free to make a request for a chaperone in each health care setting. This policy should be communicated to patients, either by means of a well-displayed notice or preferably through a conversation initiated by the intake nurse or the physician. The request by a patient to have a chaperone should be honored.

An authorized health professional should serve as a chaperone whenever possible. In their practices, physicians should establish clear expectations about respecting patient privacy and confidentiality to which chaperones must adhere. If a chaperone is provided, a separate opportunity for private conversation between the patient and the physician should be allowed. The physician should keep inquiries and history-taking, especially those of a sensitive nature, to a minimum during the course of the chaperoned examination. *AMA Principles of Medical Ethics I, IV* (Adopted May 2006; Amended September 2018)
GIFTS FROM PATIENTS. Gifts that patients offer to physicians are often an expression of appreciation and gratitude or a reflection of cultural tradition, and can enhance the patient-physician relationship.

Some gifts signal psychological needs that require the physician’s attention. Some patients may attempt to influence care or to secure preferential treatment through the offering of gifts or cash. Acceptance of such gifts is likely to damage the integrity of the patient-physician relationship.

There are no definitive rules to determine when a physician should or should not accept a gift. No fixed value determines the appropriateness or inappropriateness of a gift from a patient.

Physicians should be cautious if patients discuss gifts in the context of a will. Such discussions must not influence the patient’s medical care.

When deciding to accept a patient’s gift, a physician should:

1. Consider whether accepting the gift is in the patient’s best interest;
2. Understand that gifts given to secure preferential treatment compromise the physician’s ability to provide services in a fair manner;
3. Be sensitive to the gift’s value relative to the patient’s or the physician’s means and whether the physician would be comfortable if acceptance of the gift were known to colleagues or the public. Physicians should decline gifts that are disproportionately or inappropriately large relative to the patient’s or the physician’s means.
4. Consider declining a gift bequeathed after a patient’s death if the physician believes that its acceptance would present a significant hardship (financial or emotional) to the family.

The interaction of these various factors is complex and requires the physician to consider them sensitively. *AMA Principles of Medical Ethics I, II* (Adopted May 2005; Amended September 2018)

TERMINATION OF THE PATIENT-PHYSICIAN RELATIONSHIP. The patient-physician relationship is wholly voluntary in nature and therefore may be terminated by either party. However, physicians have an ethical obligation to support continuity of care for their patients. Thus, it is unethical for a physician to unilaterally terminate the patient-physician relationship without first providing an adequate medical attendant or reasonable notice under existing circumstances of the physician’s intent to terminate the professional relationship. *AMA Principles of Medical Ethics I, VI* (Adopted April 2003; Amended September 2018)

PATIENT DISCLOSURE. Physicians should sensitively and respectfully disclose all relevant medical information to patients. The quantity and specificity of this information should be tailored to meet the preferences and needs of individual patients. Physicians need not communicate all information at one time, but should assess the amount of information patients are capable of receiving at a given time and present the remainder when appropriate. *AMA Principles of Medical Ethics I, III, V, VIII* (Adopted February 2007; Affirmed without amendment September 2018)

At TMA’s 2018 Fall Conference meeting, the board also approved the deletion of the following current opinion:

ABANDONMENT. The unilateral severance by the physician of the patient-physician relationship without providing an adequate medical attendant or reasonable notice under existing
circumstances of the physician’s intent to terminate the patient-physician relationship is abandonment and is unethical. (Adopted April 2003)

At TMA’s 2019 Winter Conference meeting, the board adopted the following opinion, replacing the opinion entitled “DRUGS”:

**GENERIC PRESCRIPTIONS.** A physician must ensure the physician’s patient is dispensed the drugs and medications best suited for the patient’s individual needs by directing a pharmacist to dispense brand name products when it is medically necessary to do so. *AMA Principles of Medical Ethics I, II, VIII* (Amended January 2019)

At TMA’s 2019 Winter Conference meeting, the board adopted the following opinion, replacing the opinion entitled “PRESCRIPTIONS-ELECTRONIC”:

**FILLING PRESCRIPTIONS.** Patients have the right to have a prescription filled wherever they wish and physicians should respect the patient’s freedom of choice to the extent allowed by law. *AMA Principles of Medical Ethics I, IV, VI, VIII* (Amended January 2019)

At TMA’s 2019 Winter Conference meeting, the board adopted the following opinions, replacing existing opinions on the same respective subjects:

**IMPAIRED PHYSICIANS.** It is unethical for a physician to practice medicine while under the influence of a controlled substance, alcohol, or any other chemical agents that impair the ability to practice medicine.

Medical staffs have a right and an obligation to ensure that members of their medical staff are both mentally and physically able to practice in a competent manner and that drug testing for reasonable cause is within that purview. Drug testing based on adequate cause should only be undertaken when the medical staff has reasonable policies to ensure confidentiality, accuracy, and fairness. Random drug testing is not supportable in the absence of reasonable cause for testing. *AMA Principles of Medical Ethics I, II, IV* (Amended January 2019)

**INTERNET PRESCRIBING.** Although the development of telecommunications technology now makes it possible for physicians to prescribe medications by means of the internet, such prescription writing may not always be ethical. Connection with a patient through the internet has inherent limitations on communications and interactions with the patient that may not be present in a traditional office setting. However, there may be situations in which internet prescribing may be appropriate. A physician issuing a prescription to a patient seen remotely should be prudent in doing so by establishing the patient’s identity; confirming that remote services are appropriate for that patient’s individual situation and medical needs; evaluating the indication, appropriateness, and safety of the prescription in keeping with best practice guidelines and any formulary limitations that apply to the electronic interaction; and documenting the clinical evaluation and prescription. *AMA Principles of Medical Ethics I, IV, VI, IX* (Adopted February 2006; amended January 2019)

**DO-NOT-RESUSCITATE ORDERS.** When a patient suffers cardiac or respiratory arrest, attempts should be made to resuscitate the patient, except when cardiopulmonary resuscitation (CPR) is not in accord with the patient’s expressed desires or is clinically inappropriate.
All patients should be encouraged to express in advance their preferences regarding the extent of treatment after cardiopulmonary arrest, especially patients at substantial risk of such an event. During discussions regarding patients’ preferences, physicians should include a description of the procedures encompassed by CPR. Patients’ preferences should be documented as early as possible and should be revisited and revised as appropriate.

Advance directives stating patients’ refusals of CPR should be honored whether patients are in or out of the hospital. When patients refuse CPR, physicians should not permit their personal value judgments to obstruct implementation of the refusals.

If a patient lacks the ability to make or cannot communicate a decision regarding the use of CPR, a surrogate decision maker may make a decision based upon the previously expressed preferences of the patient. If such preferences are unknown, decisions should be made in accordance with the patient’s best interests. If no surrogate decision maker is available, a physician contemplating a “do-not-resuscitate” order (DNR) for a patient should consult another physician or a hospital ethics committee, if either is available.

If a patient (either directly or through an advance directive) or the patient’s surrogate requests resuscitation that the physician determines would not be medically effective, the physician should seek to resolve the conflict through a fair decision-making process, when time permits. In hospitals and other health care organizations, medical staffs or, in their absence, medical directors should adopt and disseminate policies regarding the form and function of DNR orders and a process for resolving conflicts.

Before placing a DNR order in a patient’s medical record, the physician or the facility’s personnel should inform the patient or, if the patient lacks appropriate capacity, the patient’s surrogate.

DNR orders and a patient’s advance refusal of CPR preclude only resuscitative efforts after cardiopulmonary arrest and should not influence other medically appropriate interventions, such as pharmacologic circulatory support and antibiotics, unless they also are specifically refused. (Amended January 2019)
REPORT OF BOARD OF COUNCILORS

Subject: County Medical Societies Constitution and Bylaws and Name Change

Presented by: Steven Petak, MD, Chair

1. **Nueces County Medical Society Constitution and Bylaws**
   The Board of Councilors approved amendments to the Nueces County Medical Society’s constitution and bylaws.

2. **Lamar-Delta County Medical Society Constitution and Bylaws**
   The Board of Councilors approved amendments to the Lamar-Delta County Medical Society’s constitution and bylaws.

3. **El Paso County Medical Society Constitution and Bylaws**
   The Board of Councilors approved amendments to the El Paso County Medical Society’s constitution and bylaws.

4. **Wichita-Archer-Baylor-Clay-Knox County Medical Society Name Change**
   The Board of Councilors approved the request from Wichita-Archer-Baylor-Clay-Knox County Medical Society to change its name to Wichita County Medical Society.

5. **Hill Country County Medical Society Constitution and Bylaws**
   The Board of Councilors approved amendments to the Hill Country County Medical Society’s constitution and bylaws.

6. **Bowie County Medical Society Constitution and Bylaws**
   The Board of Councilors approved amendments to the Bowie County Medical Society’s constitution and bylaws.
REPORT OF TEXAS DELEGATION TO THE AMA
TEXDEL Report 1-A-19

Subject: AMA House of Delegates Meetings in 2018
Presented by: David N. Henkes, MD, Chair

2018 ANNUAL MEETING
More than 100 Texas physicians, residents, medical students, and alliance members representing the Texas Medical Association, including various sections, and national specialty societies participated in the June 9-13 American Medical Association meeting in Chicago. The Texas delegation left the meeting with a clean sweep by all the candidates who ran for AMA office and with a positive reception for the three policy proposals TMA brought forward.

Elections
Sue Bailey, MD, was reelected to her fourth term as speaker of the house by acclamation. Shortly before the meeting concluded, Dr. Bailey announced she will run for AMA president-elect next year. Russel Kridel, MD, won his bid for a second, three-year term on the AMA Board of Trustees. Dr. Lockhart won his bid for reelection to another three-year term on the AMA Council on Medical Service; John Flores, MD, was elected to the governing council of the AMA Organized Medical Staff Section; Hilary Fairbrother, MD, won her race for chair-elect of the AMA Young Physicians Section and will ascend to the chair in June 2019; Emily Dewar of the McGovern Medical School at UTHealth in Houston was elected speaker of the AMA Medical Student Section; Aaron Wolbrueck from the University of North Texas Health Science Center at Fort Worth Texas College of Osteopathic Medicine was elected chair of Region 3 of the AMA Medical Student Section; and Texas A&M Health Science Center College of Medicine student Rebecca Haines won her race for Region 3 secretary/treasurer.

Policy
All three of the policy proposals Texas took to the meeting won support from the house. The delegates:
- Approved a Texas resolution asking AMA to support changes in U.S. Drug Enforcement Administration regulations so that psychiatrists can e-prescribe medications to a patient with whom the physician has established a valid telemedicine relationship,
- Called for further study of a Texas resolution asking AMA to push Medicare to improve access to complex rehabilitation technology for patients with chronic and disabling conditions, and
- Reacted to a joint resolution from Texas and Missouri by reaffirming AMA’s existing “prudent layperson” policy on health insurance companies’ payment for emergency medical services.

TMA Asks AMA to Stay Out of Affordable Care Act Suit
TMA leaders publicly objected to AMA’s decision to get involved in a high-profile federal lawsuit challenging the constitutionality of the Affordable Care Act (ACA).

Other Business of the House
Delegates addressed various other economic, legislative, and public health topics. The house:
- Celebrated the installation of Barbara L. McAneny, MD, as the new AMA president;
- Chose Patrice A. Harris, MD, as AMA president-elect;
• Called for expanding eligibility for Affordable Care Act premium tax credits to families earning up to 500 percent of the federal poverty level;
• Directed AMA to prepare a report on the effects of corporate investors acquiring a controlling interest in physician practices;
• Voted to oppose the sale of individual and small-group health insurance plans (other than short-term plans) that do not guarantee preexisting condition protections or cover essential health benefits;
• Said state licensing boards should require physicians to disclose a physical or mental health condition only when that condition “currently impairs” their judgment or ability to practice;
• Deemed that young people’s use of products containing any form of nicotine, including e-cigarettes, “is unsafe and can cause addiction,” and also said the federal government should require e-cigarette packages to display the products’ nicotine content and full list of ingredients;
• Supported evidence-based practices to reduce maternal morbidity and mortality in ethnic and racial minorities;
• Approved spending up to $1 million per year to establish an AMA center on health equity to address disparities in delivery and outcomes that affect patient populations that often lack political, social, or economic power;
• Voted to oppose the criminalization of self-induced abortion;
• Adopted policy stating that patients should have no cost-sharing responsibilities for all colorectal cancer screening including colonoscopies that involve biopsies or polypectomies;
• Said AMA should support full insurance coverage, with no cost sharing, of all prescription and over-the-counter contraceptives; and
• Adopted an ethics opinion saying physicians should encourage patients to participate in clinical trials, where applicable, rather than seek access to investigational therapy through the Food and Drug Administration’s expanded access program.

2018 INTERIM MEETING

About 100 Texas physicians, residents, and medical students representing the Texas Medical Association, including various sections, and national specialty societies participated in the Nov. 10-14 AMA meeting near Washington, D.C. Although the Texas delegation brought no action items to the meeting, Texans played prominent behind-the-scenes roles influencing policy decisions.

Elections

Five Texas students won election as regional representatives in the house. Ankita Brahmaroutu of Texas A&M Health was elected a regional delegate. Chosen as alternate regional delegates were Jonathan Eledge of The University of Texas Medical Branch at Galveston (UTMB Health) School of Medicine, Neha Ali of Texas A&M; Amanda Arreola of The University of Texas Rio Grande Valley (UTRGV) School of Medicine, and Joseph Camarano of UTMB Health. Two more Texans won similar positions through the Resident and Fellow Section. Ellia Ciammaichella, DO, of Houston, who is training in physical medicine and rehabilitation, was elected a delegate. San Antonio surgery resident Michael Metzner, MD, was elected an alternate.

Honors

Ray Callas, MD, received the AMA Medal of Valor for his work on behalf of patients and his community in the wake of Hurricane Harvey. The award recognizes physicians who demonstrate courage under extraordinary circumstances in nonwartime situations.

Francisco G. Cigarroa, MD, the former chancellor of The University of Texas System, received the AMA Foundation’s Award for Health Education. The foundation particularly cited his work overseeing the creation of The University of Texas at Austin Dell Medical School and UTRGV School of Medicine.
Greg Bernica, the longtime CEO of the Harris County Medical Society, received the AMA’s Medical Executive Lifetime Achievement Award. The award honors a medical association executive who has contributed substantially to the goals and ideals of the medical profession.

“Zero Tolerance” for Harassment
AMA delegates unanimously adopted an emergency resolution directing AMA to “immediately engage outside consultants to … implement new processes for the evaluation and adjudication of sexual and non-sexual harassment claims involving staff, members, or both.”

Texans Shine Brightly
Ray Callas, MD, persuaded the house to adopt an amendment based on a state law that TMA got passed that says that physicians seeking participation in managed network care be paid immediately if they are part of a group practice with an existing contract with the health plan. The Texans also helped to defeat resolutions that would have undermined Texas’ landmark 2003 medical liability reforms and the state’s successful mediation approach for patients who want to contest “surprise bills” for services from out-of-network physicians.

The AMA House:
• Declared e-cigarettes and vaping “an urgent public health epidemic” and “just days before the Food and Drug Administration (FDA) announced new restrictions” urged FDA to ban flavoring agents in tobacco products;
• Voted to support “gun violence restraining orders” and “red-flag” laws that would allow law enforcement personnel to confiscate firearms from people arrested or convicted of domestic violence or who have “demonstrated significant signs of potential violence”;
• Called for a ban on 3D-printed firearms and their digital blueprints;
• Adopted new AMA policy in support of insurance coverage for supplemental screening for patients with “dense breast” tissue, and calling for research on the risks and benefits of supplemental screening for women who have otherwise negative mammograms;
• Directed AMA to advocate for “the expansion of broadband and wireless connectivity to all rural and underserved areas” of the country;
• Once again rejected an AMA Council on Ethical and Judicial Affairs (CEJA) report establishing ethical guidelines for physicians to continually self-assess their professional competence, and a Council on Medical Education report on guidelines for assessing the competency of senior and late-career physicians;
• Continued the multiyear stalemate over whether AMA policy, which opposes physician-assisted suicide, should take a neutral stance on “medical aid in dying” in states that allow that for terminally ill people. Impassioned debate once again centered around the still-in-force CEJA ethics opinion that says “physician-assisted suicide is fundamentally incompatible with the physician’s role as healer”; and
• Adopted new AMA policy opposing government policies separating undocumented immigrant parents or guardians from their children, and opposing the medically inappropriate administration of psychotropic drugs to those children. But delegates voted to direct the AMA board to decide the organization’s position on U.S. policies that prohibit unaccompanied, undocumented minors access to the country.
As of Dec. 31, 2018, American Medical Association membership in Texas totaled 18,002 compared with 16,189 at year-end 2017, an increase of 1,813 members. The physician category (which includes non-dues-paying retired, exempt, and honorary in addition to dues-paying active physicians) saw an increase of 1,027 members for a total physician membership of 10,415; resident members increased by 1,050 for a total resident membership of 4,031; and student members decreased by 264 for a total student membership of 3,556.

**Representation in AMA**

With the increase in membership, the Texas Delegation to the AMA saw an increase of two elected delegates and alternate delegates to the AMA House of Delegates; 19 physician delegates now represent Texas. Numerous Texas physicians and medical students hold positions of leadership within the AMA organizational structure: Susan R. Bailey, MD, reelected to her fourth one-year term as speaker of the AMA House of Delegates; Gary W. Floyd, MD, reappointed to the AMA Council on Legislation; Asa Lockhart, MD, reelected to the AMA Council on Medical Service; Russell W.H. Kridel, MD, reelected to the AMA Board of Trustees and serving as board secretary; Lyle S. Thorstenson, MD, reappointed to the American Medical Association Political Action Committee and serving as chair; Michelle A. Berger, MD, appointed to the AMA Council on Long Range Planning; and Diana L. Fite, MD, appointed to the AMA House of Delegates Compensation Committee. Texans serving as ex officio members of the AMA House of Delegates are AMA past presidents J. James Rohack, MD, and Nancy W. Dickey, MD.

Additional Texas physicians holding elected or appointed positions on AMA entities are:

- John T. Carlo, MD, Council on Science and Public Health;
- Jose M. de la Rosa, MD, chair-elect, Academic Physician Section;
- Hilary Fairbrother, MD, chair-elect, Young Physicians Section;
- John G. Flores, MD, member, Organized Medical Staff Section Governing Council;
- Robert T. Gunby, MD, president, Organization of State Medical Association Presidents;
- James Guo, MD, member, Organized Medical Staff Section;
- Lynne M. Kirk, MD, Council on Medical Education;
- Cynthia A Jumper, MD, Council on Medical Education;
- Susan Pike, MD, member-at-large, Integrated Physician Practice Section;
- Monique A. Spillman, MD, PhD, Council on Ethical and Judicial Affairs;
- Surendra K. Varma, MD, member, Academic Physician Section and section liaison to the Council on Medical Education; and
- Paul Wick, MD, immediate past chair and member, Senior Physicians Group Governing Council.

Texans serving as resident representatives are: Ellia Ciammaichella, DO, Houston, regional delegate, and Michael Metzner, MD, San Antonio, regional alternate delegate.

Texans serving as student representatives are: Emily Dewar, McGovern Medical School at UTHHealth, Houston, speaker, AMA Medical Student Section; Aaron Wolbrueck, University of North Texas Health...
Science Center at Fort Worth Texas College of Osteopathic Medicine, Region 3 chair; Rebecca Haines, Texas A&M College of Medicine, Region 3 secretary/treasurer; Ankita Brahmaroutu, Texas A&M, Region 3, delegation chair; and Joseph Camarano, The University of Texas Medical Branch at Galveston School of Medicine; Amanda Arreola, The University of Texas Rio Grande Valley School of Medicine; and Neha Ali, Texas A&M, as Region 3 alternate delegates.

In addition to the 19 delegates and alternate delegates representing the Texas Medical Association in the AMA House of Delegates in 2018, many other Texas physicians serve in the AMA house as specialty society delegates and alternate delegates:

- C. Bob Basu, MD, alternate delegate, American Society of Plastic Surgeons;
- Brittany Bickelhaupt, MD, alternate delegate, American Academy of Physical Medicine and Rehabilitation;
- Donna Bloodworth, MD, alternate delegate, American Academy of Pain Medicine;
- Sue Bornstein, MD, delegate, American College of Physicians;
- Tilden L. Childs III, MD, delegate, American College of Radiology;
- Ronald J. Crossno, MD, alternate delegate, American Academy of Hospice and Palliative Medicine;
- Gary Dennis, MD, alternate delegate, National Medical Association;
- Seema Desai, MD, alternate delegate, American Academy of Dermatology;
- John Early, MD, delegate, American Academy of Orthopaedic Surgeons;
- Hilary E. Fairbrother, MD, delegate, American College of Emergency Physicians;
- Melissa J. Garretson, MD, delegate, American Academy of Pediatrics;
- John N. Harrington, MD, delegate, American Society of Ophthalmic Plastic and Reconstructive Surgery;
- Lisa Hollier, MD, alternate delegate, American College of Obstetricians and Gynecologists;
- Lynne M. Kirk, MD, delegate, American College of Physicians;
- Robert C. Kramer, MD, alternate delegate, American Society for Surgery of the Hand;
- Keagan H. Lee, MD, alternate delegate, United States and Canadian Academy of Pathology;
- Jonathan D. Leffert, MD, delegate, American Association of Clinical Endocrinologists;
- David Lichtman, MD, delegate, American Society for Surgery of the Hand;
- Alnoor Malick, MD, alternate delegate, American Society of Allergy, Asthma and Immunology;
- Sealy Massingill, MD, delegate, American College of Obstetricians and Gynecologists;
- Daniel M. Meyer, MD, delegate, American Association for Thoracic Surgery;
- Vineet Mishra, MD, alternate delegate, American College of Phlebology;
- Hernando J. Ortega Jr., MD, MPH, delegate, Aerospace Medical Association;
- Ray D. Page, DO, PhD, delegate, American Society of Clinical Oncology;
- Harry Papaconstantinou, MD, alternate delegate, American Society of Colon and Rectal Surgeons;
- Mary Dale Peterson, MD, alternate delegate, American Society of Anesthesiologists;
- Carlos J. Puig, DO, delegate, International Society of Hair Restoration;
- Susan M. Strate, MD, delegate, College of American Pathologists; and
- Crystal C. Wright, MD, alternate delegate, American Society of Anesthesiologists.

2018 Officers

At the Texas Delegation’s Jan. 25, 2019, meeting, David N. Henkes, MD, was reelected chair; Michelle A. Berger, MD, and Gary W. Floyd, MD, were reelected co-vice chairs; and G. Ray Callas, MD, and Gregory M. Fuller, MD, were reelected as at-large members of the Delegate Review Committee.
Subject: International Medical Graduate Section Update

Presented by: Sejal S. Mehta, MD, Chair

The International Medical Graduate Section (IMG) was originally established by the House of Delegates (HOD) to promote diversity and integration of international medical graduates in Texas medicine. During the 2017 sunset review process, the Board of Trustees recommended continuing the IMG section for two years, with a report back to the HOD at the 2019 Annual Session with information on specific contributions of the IMG Section.

Beginning in 2017 the section decided to discontinue meeting during TMA Fall Conference due to low attendance. Instead, the section now meets at Winter Conference and TexMed. The section also implemented a mixer during Winter Conference. The section mixer has grown in attendance every year, and has become a popular section activity. Additionally, since these changes to the schedule, the section has seen a slight increase in meeting participation as well as a quorum at every meeting.

The section has taken a keen interest in advocacy initiatives including licensing issues related to unmatched international and U.S. medical graduates, as well as refugee and displaced medical graduates. To assist these physicians, who are also potential TMA members, the IMG Section created an online portal for non-licensed IMG physicians where they match with an IMG physician member to serve as a resource in navigating the licensing boards or for support to integrate into American society and within the family of medicine. Over 20 non-licensed physicians have utilized the site since it launched in May 2018.

The section also created an award that recognizes IMG physicians who have taken steps beyond their regular workday to improve the health of their community. The section announced the award in 2018 and accepted nominations through January 2019 for the inaugural award. The chair of the IMG Section will present the award at the Annual Session.

Future plans include a focus on increasing IMG membership, engagement, and meeting participation.
The TMA Council on Health Care Quality oversees and supports the direction for TMA activities on health care quality, including policy, advocacy, and education on quality improvement, patient safety, performance measurement, and clinical effectiveness. The council has been very active in a number of activities, summarized below.

**CMS Quality Payment Program**
Since the Medicare Access and CHIP Reauthorization Act (MACRA) was enacted in 2015, the council continues to have an ongoing focus on physician advocacy and education concerning the provisions of the law, specifically the Quality Payment Program (QPP), that affect practicing physicians in the areas of health care quality and performance measurement.

The QPP is a framework of integrated policies the Centers for Medicare & Medicaid Services (CMS) uses to implement the two payment tracks required by MACRA: the Merit-Based Incentive Payment System (MIPS) and advanced alternative payment models (APMs). The program undergoes annual updates through federal rulemaking that provide a comment period on proposed rules. As part of TMA’s ongoing advocacy and policy analysis, staff from the TMA MACRA Task Force, with input from the councils on Health Care Quality and Socioeconomics and the ad hoc Committee on Health Information Technology, composed a 58-page TMA comment letter recommending improvements to the policies governing the QPP. Additionally, the TMA MACRA Task Force contributed to a separate comment letter by the Physicians Advocacy Institute (PAI) and Healthsperien, a Washington, D.C.-based health care consulting firm, to amplify our recommendations.

While CMS approved several of our recommendations in whole or in part, it also adopted rules that demonstrate the QPP is advancing with more complex policies and rigorous performance measurement methodologies at a faster pace than TMA recommends. Additional concerns include data requirements for measures that are meaningful to physicians, lack of appropriate risk adjustment for quality and cost measures, disruptive upgrades to physicians’ electronic health records systems, and requiring practices to accept more risk than they can manage financially if they wish to earn bonus payments under the APM track, among others.

In 2019, CMS estimates that more physicians will continue to participate in MIPS than in APMs. The most favorable QPP policy continues to be the low-volume threshold, which decreases the percentage of physicians in small practices who have to participate in the program. However, the threshold exception does not exempt all physicians who continue to face administrative, technological, and financial challenges. In addition to the final rule, CMS’ recent publication of performance results for the first year of the QPP showed that small and rural practices scored lower than large practices. Although the published data were limited, the initial results validate TMA’s concerns that the budget neutrality requirement under MACRA would result in a very large shift of Medicare payments away from small and rural practices to large, mostly urban physician organizations and health care systems.

Of note, CMS has not published any data to date that show whether the QPP is meeting its aims as envisioned by MACRA and Congress, such as improving the care and population health of Medicare beneficiaries, lowering Medicare costs, and minimizing burden on practicing physicians.
Because we know the QPP program has an adverse impact on small and rural practices, and due to the complexity of the program along with annual changes that occur as a result of federal rulemaking, developing physician education and resources to help physicians learn about and stay abreast of program requirements is an ongoing priority of the council. For example, immediately after the final rule was published, TMA developed an on-demand webinar that offers free CME credit to help physicians prepare their practices and succeed in the 2019 QPP performance year.

Under the direction of the council, staff from the TMA MACRA Task Force will continue to participate in workgroups facilitated by PAI and Healthsperien to update and produce in-depth educational materials for the 2019 performance year that will help physicians and groups succeed in the QPP and avoid Medicare payment penalties.

In addition, TMA continues to offer a comprehensive array of education and resources to help physicians learn about and navigate the QPP. All information is located in the TMA MACRA Resource Center, including where to get MACRA CME at no cost, information about TMA’s MACRA readiness assessment and customized on-site assistance by TMA Practice Consulting, free access to a separate MACRA QPP Resource Center and physician education initiative located on the PAI website (created by Healthsperien and TMA), free QPP education and technical assistance by the TMF Health Quality Institute (TMF), a list of MACRA resource centers by national specialty societies, a list of federally funded initiatives that offer education and technical assistance to help physicians transition to MIPS or APMs at no or low cost, and TMA PracticeEdge services for physician-led accountable care organizations/APMs.

Lastly, the council will continue to provide physician education on MACRA and the QPP during its annual quality track at TexMed 2019 and offer CME credits at no cost to all attendees. All QPP education offerings, clinical tools, resources, and technical assistance are routinely promoted via TMA communication channels.

TMF Health Quality Institute

TMF is under a multiyear contract by CMS to serve as the state’s Quality Innovation Network-Quality Improvement Organization. TMF provides Texas physicians no-cost technical assistance and education on quality improvement and patient safety through the following networks: antibiotic stewardship, behavioral health, cardiovascular health and Million Hearts, Health for Life-Everyone with Diabetes Counts, immunizations, nursing home quality improvement, medication safety, quality improvement initiative, readmissions, and value-based improvement and outcomes.

Specific to the QPP, TMF also has a robust QPP network and works with physicians and clinicians to help them transition to MIPS and successfully advance through the program’s performance categories by providing technical assistance, education, outreach, and distribution of learning modules at no cost. At the council’s urging, TMA continues to collaborate with and promote services provided by TMF, connecting members to free assistance that helps them improve patient and quality outcomes, as well as navigate Medicare requirements to avoid payment penalties and maximize value-based payments.

TMF Physician Practice Quality Improvement Award Program

TMF established the Physician Practice Quality Improvement Award Program in 2012, and it has since expanded beyond Texas to include practices in Arkansas, Missouri, Oklahoma, and Puerto Rico. The award program is offered to physicians annually and is cosponsored by TMA, the Texas Osteopathic Medical Association, and others. The purpose of the award program is to recognize physician practices for their dedication and commitment to providing high-quality patient care and improving outcomes. The
council has been involved in the award program since its inception and ensures promotion of the program through TMA communication channels. The deadline for the current award program is May 31, 2019.

**Texas Alliance for Innovation on Maternal Health (AIM) Initiative**

A 2018 report by then-TMA President Carlos J. Cardenas, MD, *Physician-Led Initiatives to Address Maternal Mortality and Morbidity*, recommended that the council, along with the Council on Science and Public Health, develop CME programs on “quality-based initiatives with standardized protocols and best practices to improve prenatal, labor and delivery and postpartum health outcomes; and implementation of hospital-based quality improvement initiatives that reduce maternal mortality and morbidity, based on best practice and standardized protocols.”

As part of TMA’s ongoing promotion of, and education on, the Texas AIM Initiative and its AIM Maternal Safety Bundles, the council will include a presentation on the initiative during its quality track at TexMed 2019, with CME credit at no cost to all attendees.

In brief, the Texas AIM Initiative is a program hospitals and communities use to improve maternal safety through best practices. The AIM Maternal Safety Bundles is a collection of best practices, vetted by experts in the field to ensure their effectiveness, to improve maternal care and maternal health outcomes. Each bundle focuses on a specific maternal health and safety topic: obstetric hemorrhage, obstetric care for women with opioid use disorder, and severe hypertension in pregnancy. The overall goal of the initiative is to end preventable maternal death and severe maternal morbidity in Texas.

**TMA Value-Based Initiatives Workgroup**

In 2018, the Board of Trustees tasked the Council on Socioeconomics with convening a cross-divisional value-based payment workgroup with three primary goals: (1) respond to Resolution 403-A-17, adopted in May 2017, calling upon TMA to support the concept and implementation of community-based health care delivery models and to collaborate with the county medical societies to advocate for the adoption of such models; (2) survey Texas’ value-based payment landscape, particularly pertaining to models serving low-income, uninsured, or other vulnerable populations; and (3) develop TMA policy, education, and toolkits not only to spur formation of physician-led, community-based organizations but also to help physicians who serve low-income populations successfully transition their practices to participate in new payment arrangements. At TMA Fall and Winter conferences, Sue Bornstein, MD, trustee and chair of the TMA Value-Based Initiatives Workgroup, presented to the council the workgroup’s goals and work to date. Jeffrey Kahn, MD, serves on the workgroup and led discussions at each council on Health Care Quality meeting to solicit physician input.

**TexMed 2019 Quality Activities and Quality Track**

Through generous sponsorship from TMF, the council will again host quality activities at TexMed 2019: quality quick tips (mini-presentations) and a four-hour quality track with CME credits at no cost to attendees. Dr. Kahn will chair the quality track. Quality quick tips will provide a “best practices” exchange in the field of quality improvement. Ultimately, such a dialogue will meet the needs for improving patient care, safety, and satisfaction in practices across Texas.

The quality track will provide physicians with current information on changes in the health care landscape and their implications on quality and patient safety nationally and in Texas. The program will begin with a presentation on, and evaluation of, Medicare’s QPP. Speakers will address data on health care utilization and quality performance, value-based care initiatives and strategies, best practices to improve maternal health and end preventable maternal death and severe maternal morbidity across Texas, and practice strategies for successful participation in physician-led accountable care organizations and innovative health care delivery models.
In addition, the TexMed 2019 meeting app will provide physicians with quality and practice management resources, information about education and clinical tools on quality that they can use throughout the year to establish protocols and improve health care for their patients and to spur best practice discussions for their practice staff.

**CMS Qualified Entity**

In 2017, CMS approved UTHealth School of Public Health (UTSPH) in Houston establishing a “Qualified Entity” (QE) to research claims data by Medicare and other payers to evaluate physician performance and regional variations in Texas. Cecilia Ganduglia-Cazaban, MD, DrPH, codirector of the UTSPH Center for Health Care Research Data, routinely presents at council meetings to update members on the QE’s research progress. In March, the QE will launch its new The Health of Texas website and make research data accessible to physicians and the public. TMA will inform membership of the new website through TMA communication channels. Council member Marina C. George, MD, serves as a volunteer on the QE’s physician work group to provide physician input and guidance for the QE’s ongoing research. She will keep the council apprised of QE updates and solicit physician feedback, as needed.

**TMA Publications on Health Care Quality**

Council members regularly contribute to articles published in *Texas Medicine* on health care quality, stemming from topics discussed at its meetings. During 2018-19, several council members were interviewed for topics on MIPS performance feedback, TMA advocacy on the CMS-proposed rules for the Medicare physician fee schedule and QPP, and the 2019 Medicare and QPP final rule. Specific articles are, “The Results Are In: Physicians Finally See How They Fared in First Year of MIPS,” “Cornered: Proposed Medicare Fee Overhaul Could Box in Doctors,” and “Buying Time: Medicine’s Warnings Prompt CMS to Delay Dramatic Coding and Payment Changes.”

**New Council Subcommittee**

At 2019 TMA Winter Conference, the council approved the formation of a new subcommittee to evaluate quality programs and clinical metrics used by commercial health plans. The goal of the subcommittee is to establish stronger relationships around quality efforts and identify areas for improvement, collaboration, and education. In general, the subcommittee’s scope of work will include meeting with large employers to discuss relevant data needed for health care and value-based purchasing. It is anticipated that in late summer 2019, council members will meet with medical directors of commercial health plans to discuss quality programs, quality measures, outcomes, and performance improvement initiatives.
TMA’s 2018 CME Program
TMA’s 2018 CME program offered 352 CME activities, which reached 7,630 physicians and 1,140 nonphysician participants. In 2017, the CME Program offered 221 activities, which reached 8,923 physicians and 740 nonphysician learners.

Update on CME Providers in TMA’s Intrastate Accreditation Program
TMA’s current roster of CME-accredited organizations includes 53 entities. The breakdown for type of organization is as follows: 40 hospitals or hospital systems, 1 physician group, 3 state specialty societies, 1 state agency, 2 regional health education centers, 1 university student health center, 1 quality improvement organization, 1 hospice, 1 regional medical staff organization for emergency services, 1 county medical examiner’s office, and 1 regional advisory council in emergency preparedness.

2018 Texas CME Professional Development Conference
TMA offers an annual two-day conference for physicians and staff who plan and implement CME activities. The program provides updates on CME issues, trains CME providers to meet accreditation requirements, and provides networking opportunities for CME providers. The 2018 Texas CME Professional Development Conference was held June 13-15 at the Sheraton Austin at the Capitol, and was attended by 130 CME professionals. The conference focused on preparing CME professionals to address the new menu of criteria for accreditation with commendation, CME that counts for Maintenance of Certification (MOC), and CME in Merit-Based Incentive Payment System.

Dr. Larry Driver Appointed to ACCME Committee for Review and Recognition
Larry C. Driver, MD, chair of TMA’s Committee on Continuing Education, was elected to the Accreditation Council for Continuing Medical Education (ACMCE) Committee on Review and Recognition (CRR) for a three-year term beginning January 2019. The CRR is a volunteer committee comprising nine members; all members are nominated by ACCME-recognized accreditors and elected by the ACCME Board of Directors. The CRR is part of ACCME’s network of volunteers, which provides the foundation for the accreditation system. As a member of the CRR, Dr. Driver will be instrumental in formulating recommendations to the Board of Directors regarding the recognition status of state medical societies that wish to accredit intrastate providers of CME. The CRR also makes recommendations to the Board of Directors regarding recognition policy development.

CME in Support of MOC
The American Board of Ophthalmology was added to the list of member boards that collaborate with ACCME to increase the number and diversity of accredited CME activities that meet the requirements for MOC and streamline the process for accredited CME providers and physicians. Collaborations are in place with: American Board of Anesthesiology, American Board of Internal Medicine, American Board of Ophthalmology, American Board of Otolaryngology - Head and Neck Surgery, American Board of Pathology, and American Board of Pediatrics.

State Medical Boards Pilot
The ACCME is collaborating with the Tennessee Board of Medical Examiners and North Carolina Medical Board on a pilot program that will enable CME providers to report physician participation in accredited CME
to the state medical boards via ACCME’s Program and Activity Reporting System. The ACCME and the boards are engaging in this collaboration because they share the goal of reducing regulatory burdens on physician learners. If the pilot is successful, ACCME’s goal is to explore similar collaborations with other state boards.
The Committee on Physician Distribution and Health Care Access is charged with the responsibility of monitoring and reporting on the status of the state’s physician workforce (TMA Policy 185.001, Physician Workforce Texas). This report provides a summary of the committee’s latest assessments, findings, and activities for promoting greater access to medical care.

Committee Findings on Physician Workforce Trends
To assess the latest trends for the state’s physician workforce, the committee obtained physician supply data for 2018 from the Health Professions Resource Center at the Texas Department of Health Services. These data were added to the committee’s historical workforce files for assessments of shifts in historical trends as well as changes from the previous year.

In conducting these assessments, the committee learned:

- All pathways into the state’s physician workforce are continuing to grow at historically high levels:
  - Medical school enrollments, residents in training, and applications for medical licenses.
  - Three medical schools are in the development process through 2020, raising the composite class size to 2,247 in 2020. This will place additional pressures on clinical training sites for medical students in the state, which already are stretched.
  - The number of medical graduates is projected to have a net increase of 433 from 2018 to 2024. This increase will result in additional strain on residency program capacity and accelerate the need for more residency positions.

- Texas has led the nation in population growth since 2000. The state’s physician supply, however, is growing at an even faster rate than the state’s population and has done so for the past nine consecutive years – the longest growth period since the data have been collected.

- More women, 1,053, entered Texas medical schools in 2018 than any time in the state’s history, with the highest percentage of women ever among first-year enrollments, at 52.3 percent.

- Residents in training in the state have grown by 23 percent over the past decade to 7,953, and the number of programs increased 29 percent. This is a faster rate of growth than changes at the national level.

FINDING: Texas reached another historic peak in the number of new medical license applications received in Fiscal Year 2018. The annual number of applications more than doubled since the passage of the 2003 state tort reform laws.

New records continue to be set in the state for the number of new medical license applications, as reported by the Texas Medical Board. As shown in Figure 1, more than 5,700 medical license applications were received by the board in the state fiscal year that ended Aug. 31, 2018. The annual number of applications has more than doubled since tort reform laws were passed in 2003, from about 2,600 to 5,700.
The number of newly licensed physicians for Texas also is continuing to show strong growth, reaching 4,514 in Fiscal Year 2018, the second highest in the state’s history (Figure 2). This number was just 4 percent below the peak reached the prior year. The fact that applications came in at the highest rate ever in 2018 indicates physicians continue to have a strong interest in practicing medicine in Texas. Three out of four newly licensed physicians in the past year were graduates of medical schools outside of Texas, with 47.5 percent graduates of other U.S. states and 26.9 percent graduates of international medical schools.

Texas has attracted physicians to the state at a much higher rate since the 2003 state tort reform laws were passed. In the 15 years preceding tort reform, Texas averaged 1,325 newly licensed physicians each year. Since 2003, the average annual net increase is 1.5 times that amount, at 3,561. A cumulative total of more than 53,000 new physicians have been licensed in Texas since 2003.
**FINDING: Physician workforce continues to grow at a faster rate than the state’s population.**

About 80,000 physicians have a current Texas medical license. Of this number, 54,233 report a practice in direct patient care in the state. Physician supply has been growing at a steady rate for decades (Figure 3), and in the past 10 years, the annual growth in physician supply ranged from 3 to 5 percent.

As a basic indicator of general access to physician services, the committee tracks changes each year for the ratio of patient care physicians per 100,000 population. This ratio has shown steady growth over the past decade, rising from 158 in 2009 to 184.7 in 2018, as shown in Figure 4. The ratio only grows if the physician supply is increasing at a faster rate than the state’s population. Given the longstanding shortage of physicians in the state, this is a positive trend. Growth in the ratio is an extraordinary achievement when it is considered that Texas led the nation in population growth during this time period.

During the past nine years, the ratio of physicians per 100,000 population saw the longest sustained increase during the 28 years since these data have been collected. As shown in Figure 3 on the previous
page, the ratio grew for nine consecutive years. There was a slight decline in the ratio between 2008 and 2009 of less than 1 percent, but a quick rebound in 2010 and consistent growth thereafter.

The committee wanted to know more about how growth in the physician supply compared with the state’s robust population growth. It was learned that physician supply, both total supply (all specialties) and primary care, was growing at a much faster rate than the population (Figure 5). Total physician supply grew at two times the rate as the population during the past decade, and primary care physician supply also beat population growth, growing 1.6 times faster.

**Figure 5: Texas Physician Supply Growing Faster Than Population**

Comparison of % Change for Population and Physician Supply, 2009 to 2018

![Graph showing % change](image)

Although there are numerous positive trends for the state’s physician workforce, the committee recognizes that serious challenges remain. Much of the state continues to experience geographic and specialty maldistributions. For example, 34 of the state’s 254 counties do not have a family/general physician; 102 do not have an internist; 138 do not have a pediatrician; 157 (two-thirds) are without an OB/Gyn; and 176 counties (69 percent) do not have a psychiatrist. Texas ranks 41st in a ranking of states by patient care physicians (all specialties) per capita, 47th for primary care physicians per capita, and 48th for general surgeons per capita (2017).

TMA continues to advocate for various state policies to help improve geographic disparities in access to care. This includes a concentrated effort to restore the recent funding cut of $8.45 million to the State Physician Education Loan Repayment Program in the state’s 2020-21 biennial budget, as well as support for increasing the loan repayment amount. Other legislative bills such as House Bill 1065/Senate Bill 1084 would establish a new state grant program for the creation of rural training tracks.

In addition to efforts to expand the state’s physician supply, the committee also is looking for innovative programs to increase access to care in medically underserved areas. The committee joined forces with the Committee on Medical Home and Primary Care and the Committee on Rural Health to propose new TMA policies that promote greater implementation of Project ECHO (Extension for Community Healthcare Outcomes). See CM-PDHCA Report 1-A-19, Improving Access to Care for Medically Underserved Areas Through Project ECHO and the Child Psychiatry Access Project Model behind the Reference Committee on Medical Education and Health Care Quality tab in this handbook.

**FINDING: The Texas population is considerably more diverse than the state’s physician workforce.**

Currently, there is considerably more diversity among the Texas population than the physician workforce, as shown in the comparisons presented in Figure 6.
Figure 6: Comparison of Racial/Ethnic Diversity for Texas Physicians and Texas Population, 2018

Findings from a comparison of diversity among the Texas population and Texas physicians:

- 5 times more Hispanic Texans than Hispanic physicians,
- 2 times more African-American Texans than among physicians,
- 1.5 times more white Texas physicians than white Texans, and
- Women make up 50.3 percent of Texans, but only 34 percent of Texas physicians.

TMA has multiple policies in support of greater diversity within the physician workforce. The representation of women in Texas medicine has grown every year, in a stair-step pattern since these data have been collected starting in 1987. (Data are not available for some years, as noted in Figure 7.) The percentage of women in medicine has tripled since then, now representing about one-third of Texas physicians.

Figure 7: Percentage of Women in the Texas Physician Workforce
Selected Years During 1987-2018

Source: Health Professions Resource Center, DSHS.
Prepared by TMA
This steady pace of growth is expected to continue, based on the percentage of women in Texas medical schools and the number of women among newly licensed Texas physicians (45 percent). Women make up slightly more than half of the first-year medical students (52.3 percent) in 2018, the highest ever for Texas. It is difficult to predict whether women will remain the majority because the numbers fluctuated over the past two decades, ranging from 44.5 to 52.3 percent and averaging 47.9 percent, as shown in Figure 8, making it difficult to project what will happen in the future. Regardless of whether women remain the majority, women are expected to represent about one-half of entering students.

FINDING: Three more medical schools are in development in the state.

When the TTUHSC Paul L. Foster School of Medicine opened in 2009 in El Paso, it was the first medical school in Texas in almost four decades. Since 2016, the number of medical schools in Texas increased by three, including the opening of two University of Texas allopathic schools in 2016. Both are small schools: Dell Medical School with 51 students and Rio Grande Valley Medical School in Edinburg with 55 students. In fall 2017, UIWSOM opened an osteopathic medical school in San Antonio with an inaugural class of 160 students. The combined growth from the three schools lifted the number of medical schools in the state from nine to 12 and added 265 students to the state’s 2018 composite medical school class size, raising the total to 2,013, the highest number ever in the state. Since then, three more medical schools have been announced for Texas for 2019-20, as shown in Table 1.
Table 1: Three New Medical Schools Under Development in Texas

<table>
<thead>
<tr>
<th>Medical School</th>
<th>Inaugural Class Size</th>
<th>Opening Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNTHSC/TCU MD School, Fort Worth</td>
<td>60</td>
<td>2019</td>
</tr>
<tr>
<td>University of Houston MD School, Houston</td>
<td>30</td>
<td>2020</td>
</tr>
<tr>
<td>Sam Houston State DO School, Conroe</td>
<td>150</td>
<td>“</td>
</tr>
</tbody>
</table>

Texas Christian University (TCU) and the University of North Texas Health Science Center at Fort Worth (UNTHSC) are jointly developing a new allopathic medical school in Fort Worth. The new school plans to admit 60 medical students in July, with 20 slots reserved for TCU students, and then build over time to a class size of 240. Philanthropic support has been secured to cover tuition for the first year. In partnership with Medical City Healthcare, a part of HCA Healthcare, TCU and UNTHSC are working to create 500 new residency positions at 14 hospitals in the Dallas/Fort Worth Metroplex over seven years.

University of Houston (UH) plans to open with 30 students in 2020 and add 30 more students each year from 2021 to 2023, to reach a peak class size of 120. Philanthropic support will cover tuition for all four years for the inaugural class and a portion of the second class. UH is collaborating with HCA Healthcare’s Gulf Coast Division to create 389 residency positions by 2025.

Sam Houston State University in Huntsville is developing an osteopathic medical school in Conroe, north of Houston, to open in 2020 with an inaugural class of 150. This will increase the number of medical schools in Texas to 15, the same number as California, and the second highest in the nation (including existing and proposed). New York leads with 17 medical schools.

The new schools will place additional pressure on the state’s capacity for clinical training and graduate medical education (GME). TMA’s Council on Medical Education is in support of a study by the Texas Higher Education Coordinating Board on the need for more medical schools in the state. The council is proposing new TMA policy in support of the study; see CME Report 4-A-19 Study of Projected Need for More Medical Schools, behind the Reference Committee on Medical Education and Health Care Quality in this handbook.

**FINDING:** Texas will continue to be challenged to expand GME capacity at the same rate as medical school enrollments with three new medical schools in development.

The number of residents training in the state is at historic levels, with 7,953 residents at 648 residency programs. Texas had an increase of 23 percent in the number of residents and 29 percent more residency programs over the past decade. The growth in Texas was greater than the increases at the national level.

From 2014 to 2017, 237 new GME positions were created in the state through state grants provided to residency programs by the Texas Higher Education Coordinating Board. The Texas Legislature authorized a total of $97 million to provide continued support for the newly created residency positions in the state budget for 2019-20. Monies were not available to create additional positions. The initial state budgets for 2020-21 proposed by both the House and the Senate (House Bill 1 and Senate Bill 1) are proposing an additional $60 million for the state’s GME Expansion Grant program, for a total of $157 million. This is to enable the state to maintain the current ratio of 1.1 to 1 and allow for the potential funding of an estimated 100 new GME positions.
Projected GME Needs
Texas reached the state’s GME goal of 1.1 entry-level training positions for each Texas medical school graduate in 2018. Last year, a total of 1,904 entry-level training positions were offered in the residency matches (1,863 allopathic and 41 osteopathic). In comparison, there were 1,734 Texas medical school graduates last year, resulting in a ratio of 1.1 to 1.

In looking forward, there is a need to add more entry-level residency positions to keep pace with the opening of the new medical schools and other projected enrollment growth. All three schools are expected to graduate their first class by 2024, adding a projected combined total of 433 graduates (a 25-percent increase) by that year. As shown in Table 2, unless additional residency positions are created, the state’s GME ratio will drop below 1.1 to 1 in 2019 and continue declining thereafter, resulting in a ratio of 0.88 to 1 by 2024, or a deficit of 263 entry-level residency positions in comparison to graduates.

Table 2: Comparison of Entry-Level Residency Positions and Medical School Graduates for Texas

<table>
<thead>
<tr>
<th>Actual Data for 2015-2018, Projected Data from 2019-2024</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic Year</td>
</tr>
<tr>
<td>Medical School Graduates</td>
</tr>
<tr>
<td>1,690</td>
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<tr>
<td>1st-Yr Residency Positions Offered</td>
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<tr>
<td>TOTAL 1st-Yr GME Positions Offered</td>
</tr>
<tr>
<td>1,730</td>
</tr>
<tr>
<td>Ratio of GME Positions to Graduates</td>
</tr>
<tr>
<td>1.02</td>
</tr>
<tr>
<td>NET DIFFERENCE:</td>
</tr>
<tr>
<td># Med Schl Grads and 1st-Yr. GME Pos.</td>
</tr>
<tr>
<td>40</td>
</tr>
</tbody>
</table>

Sources: National Resident Matching Program Main Residency Match®, 2015-2018; American Osteopathic Association; and University of North Texas Health Science Center. Prepared by TMA.

A 2017 state law requires new medical schools to formulate a plan to meet the GME needs of their future graduates. The three medical schools in development will be the first schools affected by this law, and TMA will monitor the law’s impact.

Texas Medical School Graduates Who Do Not Match to Residency Positions
Since 2014, the Council on Medical Education has worked with Texas medical schools to monitor the number of Texas medical school graduates who do not match to a residency position. An annual average of 37 Texas medical school graduates (2 percent) were unable to match to a residency position in the year of their medical school graduation during the years of 2014-2018. Only 13 of Texas’ 2017 medical school graduates were not able to match to a residency position in the second year after graduation. See Resolution 205-A-18, Study of Unmatched Candidates for U.S. Residency Programs.

Summary
The committee recognizes numerous positive trends in expanding the state’s physician workforce. All pipelines into the physician workforce are at the highest levels in the state’s history, and this high rate of growth has been sustained for several years. This includes the record-high number of physicians who are seeking medical licensure in the state. Physician shortages remain, however, as a result of geographic and specialty maldistributions.
During the 2019 Texas Legislative Session, TMA continues to advocate for various state policies to help improve access to care. This includes a concentrated effort to restore the recent funding cut of $8.45 million to the State Physician Education Loan Repayment Program in the state’s 2020-21 biennial budget, as well as support for legislative bills such as House Bill 1065/Senate Bill 1084, which would establish a new state grant program for the creation of rural training tracks.

In addition to efforts to expand the state’s physician supply, the committee also is looking for innovative programs to increase access to care in medically underserved areas including greater implementation of Project ECHO to improve access to specialty services in the state.

The committee will continue to report its findings on trends for the physician workforce and distribute this report among state policymakers in addition to TMA’s membership.
Subject: EMS and Trauma Activities Update

Presented by: Veer Vithalani, MD, Chair

Resolution 302: Appropriate Physician Oversight of EMS Medical Practices
At TexMed 2018, the House of Delegates referred Resolution 302 for additional discussion. The resolution called on TMA to determine appropriate physician oversight of emergency medical services (EMS) medical practices. There is evidence that errors in emergency settings such as emergency departments and emergency medical services can lead to poor outcomes for patients. One method of reducing these errors is to require physician staffing ratios per number of prehospital providers.

Proponents of the resolution contend that staffing ratios would create greater oversight for EMS systems and decrease the likelihood of critical errors. After discussion with the resolution author, committee members, and the Governor’s EMS and Trauma Advisory Council (GETAC) leadership, the committee determined that the resolution’s recommendation should be adopted as amended by the committee. The committee will submit a report to the house in May on its recommendations. In the meantime, it will continue to work with the author and other stakeholders to discuss.

Stroke and Trauma Facility Rulemaking
In September and October 2018, the committee coordinated TMA comments on draft revisions to the state’s stroke and trauma facility designation rules. The committee held three conference calls with specialty societies to ensure broad physician input on the association’s comments. Specialty societies engaged in the discussion included the Texas College of Emergency Physicians, Texas Society of Anesthesiologists, Texas Neurological Society, and the American Heart Association Southwest Affiliate.

TMA and specialty societies submitted a letter on the draft rules in October 2018 and will participate in the upcoming formal rulemaking process in 2019.

Trauma Funding and the Driver Responsibility Program
The Driver Responsibility Program (DRP) funds a majority of the state’s trauma system. The DRP collects surcharges from Texans who violate driving laws, including driving while intoxicated (DWI) and driving without a valid license or insurance. If an individual does not pay the fees within 105 days, his or her license is suspended.

Lawmakers of both parties agree that there are problems with the DRP but recognize that eliminating the program would greatly impact the state’s trauma system. Legislators filed several bills to change or eliminate the program. As of Feb. 1, 2019, no bills had received a committee hearing. While the committee supports efforts to ameliorate the impact of the program on low-income drivers, it opposes reductions in trauma funding. The committee will continue to work within a coalition of specialty societies and hospitals to protect funding for the program.

Travel Screening Guidelines
Historically, there has not been a standard list of travel screening questions used by hospital or clinic EMS. During the 2017 TMA Fall Conference, the committee determined the need for a collective list of these questions. The committee collected questions from members and shared the list with the TMA Committee on Infectious Diseases (CID). At the 2018 TexMed meeting, the committee collaborated with the CID and the Committee on Health Information Technology to research hospital emergency infectious disease screening protocols for patients who have traveled to foreign countries recently.
The committee will hold additional discussions this spring on whether or how to standardize the protocols and incorporate them into electronic health records.

Governor's EMS and Trauma Advisory Council

TMA staff closely track GETAC's activities, including participation in quarterly meetings. Robert Greenberg, MD, GETAC chair, is a consultant to the committee. Dr. Greenberg provided GETAC updates at the May and September committee meetings.
Subject: Medical Home and Primary Care Activities Update

Presented by: Anne Marie Ponce De Leon, MD, Chair

**Primary Care in Texas**

Over the past year, the committee collaborated with the state’s four primary care specialty societies to develop an educational document on the status of primary care in Texas. The societies include the Texas Academy of Family Physicians, Texas Pediatric Society, American College of Obstetricians and Gynecologists District XI (Texas)/Texas Association of Obstetricians and Gynecologists, and the Texas Chapter of the American College of Physicians.

The report provides an overview of primary care in Texas and its importance to a high-functioning health care delivery system, as well as statistics on the prevalence and distribution of primary care physicians in the state, their reimbursement, and the practice management challenges they face.

The report was distributed in late February and disseminated at the April First Tuesdays at the Capitol event in conjunction with student, resident, and physician visits to the Capitol.

**Project ECHO (Extension for Community Healthcare Outcomes)**

The committee has collaborated with the Committee on Physician Distribution and Health Care Access and the Committee on Rural Health to bolster efforts related to Project ECHO. Project ECHO was established by the University of New Mexico in 2003. It is a unique model that utilizes “hub-and-spoke” video conferencing to provide telemonitoring on best-practice specialty care by bringing together physician specialists at academic health centers (hubs) and community-based primary care physicians (spokes) in areas of physician shortage and medical underservice. See CM-PDHCA 1-A-19 in this handbook.
The Patient-Physician Advocacy Committee presents the following informational report regarding the committee’s recent activities.

**State Office of Administrative Hearings Issues**
The committee discussed challenges faced by physicians who are successful before the State Office of Administrative Hearings (SOAH). The committee received general information about SOAH procedures from an administrative law attorney. The committee also heard from an affected physician. The committee later reviewed draft bill language prepared by TMA staff to address concerns brought before the committee and recommended that the Council on Legislation consider proceeding with the draft bill, relating to overturning and vacating certain temporary suspensions or restrictions of an individual’s medical license by the Texas Medical Board (TMB).

**Texas Medical Board**
The committee invited Texas Medical Board representatives to its meetings to learn more about its processes and procedures and to offer improvements. The committee met with the board’s president, executive director, and general counsel on various occasions to discuss a variety of concerns, ranging from sunset issues to the need for a TMB form for lodging complaints against TMB-certified nonprofit health care corporations (formerly known as 5.01[a]s).

**Board Certification**
In a letter to the American Board of Medical Specialties (ABMS), the committee had encouraged ABMS and its member boards to adopt a safe harbor for minor licensure actions, so that if a physician agrees to certain actions by TMB, the physician can be more aware of the possible consequences of that agreement with respect to board certification. The committee was informed that, in response to its letter, ABMS had drafted a revised ABMS licensure policy that was being reviewed by the ABMS Committee on Certification and the Ethics and Professionalism Committee. If the draft policy continues to advance, the aforementioned ABMS committees will work together to create a draft for consideration by the ABMS Board of Directors.
REPORT OF INTERSPECIALTY SOCIETY COMMITTEE

Subject: Informational Update
Presented by: Jack Pierce, MD, Chair

As the 86th Texas Legislative Session begins, the Interspecialty Society Committee (ISC) is focused on discussing legislative issues that directly affect the many specialty societies that comprise the ISC.

The Texas Pediatric Society discussed concerns on immigration and the separation of children from parents/guardians at the U.S.-Texas border.

The Texas Allergy, Asthma and Immunology Society is sponsoring bills requiring food allergy posters to be posted in restaurants and to be available online for free. These issues also are being presented to the House of Delegates through Resolution 304-A-19.

The Texas Society of Anesthesiologists is concerned about rules published in the Texas Registry allowing nurses to be exempt from telemedicine and Prescription Management Program regulations.

The Texas Dermatological Society is concerned about med spa regulation compliance; the Texas Pediatric Society desires more funding for prenatal testing to keep Texas in compliance with federal regulations; and the Texas Society of Pathologists is anticipating the refiling of the Beacon Labs bill from previous legislative sessions.

Delegates and Alternate Delegates in Attendance of the ISC January 26, 2019 meeting:

- Sarah Avery, MD – Texas Radiological Society
- Louise H. Bethea, MD – Texas Allergy, Asthma and Immunology Society
- Tilden Childs, MD – Texas Radiological Society
- Charles Cowles, Jr., MD – Texas Society of Anesthesiologists
- Troy T Fiesinger, MD – Texas Academy of Family Physicians
- Allen Flack, MD – Texas Society Pathologists
- Michael Graves, MD – Texas Dermatological Society
- Charleta Guillery, MD – Texas Pediatric Society
- Jeffrey B. Kahn, MD – Texas Association of Otolaryngology
- Heidi Knowles, MD – Texas College of Emergency Physicians
- Megan Kressin, MD – Texas Society of Pathologists
- Pradeep Kumar, MD – Texas Society of Gastroenterology and Endoscopy
- Richard L. Noel, MD – Texas Society of Psychiatric Physicians
- Stacey Norrell, MD – Texas Society of Anesthesiologists
- Debra Pratt, MD – Texas Society of Medical Oncology
- Jack W. Pierce, MD – Texas Ophthalmological Association
- C.M. Schade, MD, PhD – Texas Pediatric Society
- Ryan Van Ramshorst, MD – Texas Pediatric Society
- Stanley Wang, MD – Texas Chapter of American College of Cardiology
The Medical Student Section (MSS) was established by the House of Delegates (HOD) to shape the future of medicine in Texas by active medical student involvement in the affairs of the various Texas county medical societies, the Texas Medical Association, and the American Medical Association. Its purpose is to foster dialogue between individuals and organizations within medicine, promote and aid in programs which may serve to unify and give direction to health-related activities at all levels of education, and provide a good and useful service to medical students in Texas.

Membership
Medical student membership reached an all-time high in the association. As of Dec. 31, 2018, student membership in the TMA was 6,673, a 584-student increase over the same time in 2017. These numbers include eight of the 12 medical school chapters who joined TMA at 100 percent membership. TMA is anticipating medical school growth within Texas to reach 15 schools by 2020.

Leadership
With the continued addition of new medical schools in Texas, the section has seen tremendous growth in student participation and interest in leadership positions. In 2018, this was even more evident when over 115 students applied for approximately 60 TMA board, council, and committee positions available. Additionally, several Texas students served at the national level including:

- AMA-MSS Speaker, Emily Dewar (McGovern Medical School);
- Region 3 Chair, Aaron Wolbrueck (University of North Texas Health Science Center at Fort Worth);
- Region 3 Secretary/Treasurer, Rebecca Haines (Texas A&M College of Medicine);
- Region 3 Delegate, Ankita Brahmaratou (Texas A&M College of Medicine)
- Region 3 Alternate Delegates, Joseph Camarano (The University of Texas Medical Branch at Galveston), Amanda Arreola (The University of Texas Rio Grande Valley), Jonathan Eledge (UTMB), and Neha Ali (Texas A&M);
- Student Representative on the AMA Minority Affairs Section Governing Council, Luis E. Seija (Texas A&M); and
- Medical Student Section Councilor and Representative, Luis E. Seija.

Along with positions listed above, several students from Texas also were appointed or elected to leadership positions in various American Medical Association-MSS Standing Committees, as well as other state and national specialty societies.

During the MSS Business Meeting at TexMed 2018, the section recognized eight members to be part of the Leadership Honor Society which recognizes fourth-year medical students who have actively participated in Texas organized medicine.

Finally, Texas Gov. Greg Abbott appointed Jane Gilmore as student regent for the Texas Tech University System Board of Regents for the 2018-19 school year.

Advocacy
MSS Delegates from across the state collaborated to write and submit 12 resolutions to the House of Delegates at 2018 Annual Session. Of these resolutions, six were adopted or adopted as amended. Resolution topics included opposition to pain score as a contributing factor to hospital financial incentives, prescription drug monitoring, and creation of a synthetic cannabis educational resource for providers, among others. The MSS also updated its bylaws, which the House adopted at the 2018 meeting.

Section leaders also worked with TMA staff to develop an advocacy internship program which will give students an opportunity to work closely with TMA advocacy staff on policy and legislative priorities by attending hearings and briefings, participating in meetings, and gaining a basic understanding of government function on a variety of health-related issues.

Awards

The MSS Executive Council recognized The University of Texas Medical Branch at Galveston as the 2018 Chapter of the Year and Sinan Ali Bana, Texas A&M University, as Student of the Year. Stephen L. Brotherton, MD, Fort Worth, was selected as the recipient of the 2018 C. Frank Webber, MD, Award for providing outstanding service to the TMA Medical Student Section. These awards were officially presented at the 2018 Annual Session.

Chapter Service

Multiple chapters participated in one or more of TMA’s outreach programs: Walk with a Doc, Be Wise – Immunize℠, and Hard Hats for Little Heads. Two chapters, UT Health San Antonio and Texas Tech University Health Sciences Center-Lubbock, were awarded the Service Project of the Year award by the TMA-MSS Executive Council. The service projects recognized for these awards were, Head Start Physicals for School Children (UTHSCSA) and Anti-Human Trafficking Alliance (TTUHSC-Lubbock).

Multiple grants were awarded by the TMA Foundation to chapters for the work they have implemented within their communities, including:

- Alliance Refugee Wellness Fair (Baylor University);
- Aggie Health Project: Hepatitis C (Texas A&M);
- Carnaval de Salud: United to Serve Health Fair (UT Southwestern Medical School);
- Community Health Day (Baylor University);
- HOPE Health Fair (UTMB); and
- Implementing a Smoking Cessation Program in a Dallas Homeless Population (UT Southwestern)

The foundation also awarded the Paul L. Foster School of Medicine the 2019 John P. McGovern Champion of Health Award for providing health care to El Paso County’s uninsured population through the school’s medical student run clinic.
The Resident and Fellow Section (RFS) was established by the House of Delegates to encourage participation in shaping the future of medicine in Texas by active involvement in Texas county medical societies, the Texas Medical Association, and the American Medical Association. Its purpose is to foster dialogue between individuals and organizations within medicine; promote and aid in programs which may serve to unify and give direction to health-related activities at all levels of education; and provide a good and useful service to residents and fellows in Texas.

Section Activities
The RFS meets three times annually in conjunction with all TMA meetings. During Winter and Fall Conferences, the RFS has joint meetings with the Young Physician Section (YPS). These joint meetings continue to be well received and attended. Additionally, the RFS and YPS host a mixer at all three conferences that are very popular.

During its meeting at TexMed 2018, elections were held for RFS Executive Council positions and the following residents were elected for a term of one year:

- Chair-Elect, Arindam Sarkar, MD
- Secretary, Carla Khalaf McStay, MD
- TMA Delegates: Fatma Ahmed, MD; Michael Dakkah, DO; Dara Grieger, MD; and Jaya Kasaraneni, MD
- TMA Alternate Delegates: Steven Blake Baker, MD; Patrick Crowley, DO; Collin Juergens, MD; and Sujan Reddy, MD.

The section meeting at the 2018 Fall Conference featured a presentation on integrated leadership for hospital and health care systems and was presented by J. James Rohack, MD, a TMA past president.

During the 2018 Winter Conference meeting, the section held discussions on supporting resolutions introduced by section members. The section also held elections, and Kayla Riggs, MD, was elected to be the Board of Trustees resident representative. Theresa Phan, MD, was elected to be the resident AMA alternate delegate on the TMA delegation.

During the AMA RFS meeting at AMA’s 2018 Interim Meeting, Ellia Ciammaichella, MD, was elected to be a delegate and Michael John Metzner, MD, was elected to be an alternate delegate.

Planned activities
The section plans to continue conducting joint meetings with the YPS. Future plans include focusing on increasing Texas resident attendance and participation at meetings.
The Texas Medical Association Young Physician Section (YPS) met in conjunction with the Resident and Fellow Section (RFS) twice in the course of 2018-19, at the TMA Fall and Winter Conferences. Joint meetings with the RFS continue to be well-received and attended. The fall meeting featured a presentation on integrated leadership for hospital and health care systems by James Rohack, MD. During the winter meeting, new AMA-YPS delegates were elected to one-year terms:

- Gates Colbert, MD (re-elected)
- Matthew Brooker, DO (re-elected)
- Laura Faye Gephart, MD (re-elected)
- Marcial Oquendo, MD

The remaining members of the Executive Council are listed below along with applicable terms:

**Officers (one-year terms):**
- Chair: Jessica Best, MD
- Chair-Elect: Gates Colbert, MD
- Immediate Past Chair: Lindsay Botsford, MD

**TMA Delegates (two-year staggered terms):**
- Anna Allred, MD (2017-19)
- Jessica Best, MD (2017-19)
- Clay Cessna, DO (2018-20)
- Gates Colbert, MD (2017-19)
- Jennifer Liedtke, MD (2018-20)
- Sachin Mehta, MD (2018-20)

**TMA Alternate Delegates (two-year staggered terms):**
- Andy Chen, MD (2018-2020)
- Sara Woodward Dyrstad, MD (2018-20)
- William Fox, MD (2018-20)
- Samuel Mathis, MD (2018-20)
- Paraag Kumar, MD (2017-19)
- Jimmy Widmer, MD (2018-20)

In 2019, the section plans to continue conducting joint meetings with the RFS and hopes to increase member participation in section meetings.
The Texas Medical Association Insurance Trust (TMAIT) operates under the authority of an eight-member board composed of five trustees appointed by TMA and three trustees elected by the Trust’s subscribers. The five appointed trustees include the executive vice president of TMA and a member of the TMA’s Young Physician Section. During 2018, the trustees met in person in January, May, and September in conjunction with TMA conferences and the House of Delegates meeting. In addition, the trustees held their annual three-day planning session in August.

The Board of Trustees is assisted by the TMAIT Advisory Committee, made up of nine TMA physicians and a TMA Alliance member appointed by the trustees to review claims and underwriting decisions appealed by the membership. The advisory committee, which includes a variety of medical specialists, provides a member the opportunity for a panel of his or her peers to review insurance carrier decisions concerning underwriting and claim matters. The advisory committee is one of the principal strengths of TMAIT, as it gives each member a forum for further consideration of decisions that affect insurance coverage.

To expand the insurance market for the trust and our members, TMAIT in 2000 established its own insurance agency, TMAIT Financial Services, Inc., to assist those members who feel they need to shop for coverage. Through the agency, we are able to offer a TMA member any insurance plan available on the open market.

TMAIT maintains a 21-person staff at TMA’s Austin headquarters. TMAIT staff are involved in every phase of the program: marketing, enrollment, billing, and claims assistance. With direct access to all membership information, TMAIT staff can supply an immediate response to a member’s inquiry about insurance benefits. Staff are assisted by actuarial, legal, financial, tax, and technology advisors who offer advice on a broad range of technical issues. Staff serve as a liaison between the membership and the insurance carriers, and provide a member service generally not available to an individual purchasing coverage through the commercial insurance market.

The TMAIT life, business overhead, and long-term disability (LTD) plans are underwritten by Prudential Insurance Company of America. The health insurance plans are underwritten by Blue Cross and Blue Shield of Texas. In addition to providing financial security, the insurers are important members of the TMAIT administrative team. Working in partnership with the trustees, the advisory committee, and TMAIT staff, the insurers provide TMAIT the high level of insurance expertise and administrative assistance required to operate a cost-effective, state-of-the-art insurance program. TMAIT staff communicate throughout each day with our insurance representatives; this close contact allows TMAIT to provide first-class service to its membership.

Through the combined resources of TMAIT and the agency, we are able to offer TMA members access to an extremely broad range of insurance products – from the cost-effective group insurance plans offered through the trust to individual insurance products tailored to specific needs.

2018 Financial Results
Overall, the insurance program experienced a gain of about $5 million in 2018 compared with a gain of about $10 million in 2017. The results by plan, with comparative information for 2018, are presented below.
• The life insurance plan gained about $500,000 for 2018 compared with a gain of about $2.7 million in 2017. There were 23 death claims in 2018 compared with 20 in 2017. The total payments in 2018 were $4.6 million compared with $2.4 million paid in 2017.

• The business overhead plan gained about $675,000 during 2018 compared with a gain of about $125,000 during 2017.

• The LTD plan gained $3.5 million in 2018 compared with a $7.2 million gain in 2017. For the second year in a row, only eight new claims were incurred in 2018.

• In 2018, the health plans produced a loss of about $250,000 compared with a loss of $600,000 in 2017. In both years, the loss was expected as a result of the trustees’ decision to subsidize rates and reduce the impact of the high cost of health insurance on plan participants.

In years like 2018 in which the experience is favorable, gains are credited to the Trust’s Premium Stabilization Funds (PSFs), which provide added security and stability for the insurance program. At the close of the 2018 policy year (Oct. 31, 2018), the insurance program had a combined PSF balance of $83 million.

2018 Program Initiatives and Accomplishments

TMAIT launched an online enrollment platform for trust products with our long-standing partner, Prudential Insurance Company of America. This online platform expands members’ choice of how they can interact with TMAIT and provides them with the convenience of online access to participate in our products.

Two new trust products were introduced in 2018: TMA Member Critical Illness and TMA Member Accident Insurance plans. These plans are underwritten by Prudential.

TMAIT leveraged in-house data to target our marketing to specific member segments. This allowed us to make our marketing messages more relevant to the members who received them. This approach resulted an increase in all key online metrics and an increase in sales leads over the previous year.

For the second year in a row, TMAIT was recognized by the Professional Insurance and Marketing Association (PIMA) for excellence in marketing at the 2018 Marketing Methods Competition. PIMA convenes the leaders and leading companies in affinity benefits distribution and direct marketing. TMAIT was awarded the Gold Award for New Media and the Best of PIMA for Excellence in Marketing.

Based on input we received from the membership, we replaced the LTD Loyalty program (in effect since Nov. 1, 2016), which provides a 25-percent premium discount for all LTD participants who are aged 50 or over and have been insured 10 or more years, with a 25-percent premium reduction for all participants aged 50 and over, effective Nov. 1, 2018.

2019 Initiatives

TMAIT will launch a new website that will support our segmentation strategy so members who interact with TMAIT online will have a more relevant and valuable experience.

Our online enrollment platform will be enhanced so that members will be able to apply for TMA Member Life Insurance and have a decision in minutes. Our launch version will enable members to apply quickly for up to $500,000 of coverage and receive a decision in minutes.

During 2018, TMAIT staff and their consultants followed the developing Association Health Plan (AHP) Executive Order. On June 19, 2018, the U.S. Department of Labor issued a final rule designed to facilitate
creation of an ERISA-compliant multi-employer welfare plan (MEWA) under significantly less restrictive requirements related to rating rules and essential health benefits. Even though it has been nearly one year since the final rule was issued, almost everything about new AHPs remains unclear. At this time, the staff and the advisors believe it is best to table any discussion of a TMAIT-created MEWA until the ongoing uncertainty is resolved. We can revisit this issue at any time if circumstances change.

The Affordable Care Act (ACA) has prevented new enrollment in the association group health plans since Nov. 1, 2013. Fortunately, the ACA allowed us to “grandfather” coverage for members who began participation prior to that date. While operating on a closed-group basis presents significant challenges, those plans remain financially viable and continue to provide the same quality coverage as they have in the past. The association group health plans and the assistance we provide in securing coverage in the individual and small-group markets have allowed our staff to maintain a high level of expertise in the health insurance business. This places TMAIT and the agency in a great position to respond to any changes that may arise from any changes to the ACA or expansion of AHPs.
 Funds Raised and New Fund Established in 2018
The TMA Foundation raised more than $2 million in 2018, the third highest amount in its history.
Included in this total is a generous gift from Roberto J. Bayardo, MD, Houston, to establish his second
trust within the TMAF Family of Funds: the Medical Student Scholarship and Grant Trust Fund of Dr.
Roberto J. and Agniela (Annie) M. Bayardo. This new fund has two purposes: (a) to support TMAF’s
Medical Student Community Leadership Grant program, and (b) to enable TMA county medical societies
to apply for a matching medical student scholarship administered through the society’s own scholarship
program.

Grants Support 2018 Programs
The generosity of donors, plus investment earnings from endowments, enabled TMAF to grant more than
$670,000 to support programs primarily carried out in 2018.

Included among these grants is support for 10 TMA health improvement, quality-of-care, and science
initiatives; 12 county medical society, and alliance and medical student chapter health improvement and
scholarship initiatives; and TMAF’s Champion of Health Award.

This means that for every $1 TMA provides in support of TMAF, the foundation and donors provide TMA a
six-fold benefit in community health improvement and positive physician image.

TMA programs:

- Be Wise – Immunize℠,
- Hard Hats for Little Heads,
- Walk With a Doc Texas,
- Ernest and Sarah Butler Awards for Excellence in Science Teaching,
- Minority Scholarship Program,
- University of Health Forums,
- HPV social media campaign,
- History of Medicine traveling exhibits,
- Call Your Doctor First pilot program, and
- Texas Two Step: How to Save a Life CPR training event.

County medical society/alliance/medical student programs (2018 Medical Community Grant
programs):

- Drive Thru, Prevent Flu/Lamar Delta County Medical Society,
- Texas BookShare/Bell County Medical Society Alliance,
- Project Access Tarrant County/Tarrant County Medical Society,
- Alliance Refugee Wellness Fair/Baylor College of Medicine TMA Medical Student Chapter,
- Aggie Health Project: Hepatitis C/Texas A&M Health Science Center TMA Medical Student Chapter,
• HOPE Health Fair/The University of Texas Medical Branch TMA Medical Student Chapter,
• Implementing a Smoking Cessation Program in a Dallas Homeless Population/UT Southwestern TMA Medical Student Chapter
• Immunization Collaboration of Tarrant County/Tarrant County Medical Society Alliance Foundation,
• Carnaval de Salud: United to Serve Health Fair/UT Southwestern TMA Medical Student Chapter, and
• Community Health Day/Baylor College of Medicine TMA Medical Student Chapter.

John P. McGovern Champion of Health Award:
• Heal the City Free Clinic, Alan Keister, MD, Amarillo, and
• The Kind Clinic by Texas Health Action, Austin.

TMAF Family of Funds grants: TMAF’s Family of Funds was launched as an umbrella for TMAF funds and endowments that support the charitable health improvement and education goals of TMA and TMAA members, and the related efforts of TMA county medical societies and TMA alliance and medical student chapters.

• The TMAF Hispanic Nursing Scholarship Trust Fund of Dr. Roberto J. and Agniela (Annie) M. Bayardo supported $31,600 in grants for seven scholarships awarded by the Harris County Medical Society Alliance and the Travis County Medical Society Alliance.

Additional TMAF achievements:
• Raised nearly $395,000 through the 2018 gala, thanks to generous sponsors, more than 550 guests, and the efforts of the TMA Foundation Board of Trustees. Top sponsors were H-E-B; Pfizer, Inc.; and Texas Medical Liability Trust.
• Added expertise to its board of trustees with new members David Fleeger, MD, Austin, TMA president-elect; Curtis Eric Grey, MD, Athens; and Debra Pitts, Tyler; and TMA section representatives Arindam Sarkar, MD, Houston, Resident and Physician Section; Shannon Hancher, MD, Bellaire, Young Physician Section; and Sinan Bana, Medical Student Section.
• Approved grants for TMA’s 2019 health improvement, quality-of-care, science, and education initiatives as well as Family of Medicine community programs. See Attachment A.
• Twenty-one individuals became new or upgraded Major Donors; each were recognized at 2019 TMA Winter Conference, and their names will be added or moved up on the Major Donor displays at the TMA building. This brings the total number of Major Donors to 241 as of Dec. 31, 2018. Major Donor status begins at $10,000 in cumulative donations with additional levels for subsequent increased giving; see Attachment B.
• Presented the 2018 TMAF John P. McGovern Champion of Health Award; grants of $5,000 and $2,500 were presented for winning programs that improve student health and nutrition.

TMAF’s 26th Gala on Friday, May 17, 2019
TMA Foundation’s 26th annual gala, BIG & BRIGHT, celebrates the Texas State Fair of the 1930s and ’40s on Friday, May 17, at the Hilton Anatole Dallas during TexMed. Dr. Samuel and Cheryl Chantilis, Dallas, are Host City chairs and Metroplex co-chairs are Drs. Sejal and Saumil Mehta from Allen; Drs. Leena and Nick Shroff of Plano; Lisa and John Queralt, MD, Fort Worth; and Joseph Valenti, MD, Denton. The lead sponsor for the event is H-E-B. Confirmed sponsors at the $30,000-$2,000 level as of March 20, 2019, are H-E-B; Pfizer, Inc.; Drs. Nick and Leena Shroff; Texas Medical Liability Trust; Baylor Scott & White Health; Cook Children’s Health Care System; Texas Health Resources; Radiology Associates of North Texas, PA; TMA Insurance Trust; UnitedHealthcare; Dallas County Medical Society; DFW Fertility Associates/Cheryl and Sam Chantilis, MD; HeartPlace; Prudential; Steward Health Care; Texas MedClinic; University of North Texas Health Science Center; UT Health San Antonio Long
School of Medicine; Anesthesia Partners of Dallas; Austin Geriatric Specialists PA; Bell County Medical Society; Bexar County Medical Society; Dr. A. Clay Cessna and Mr. Jeffrey Harrison in honor of Celia Ann Jones; Collin-Fannin County Medical Society; Dallas Nephrology Associates; Frost Bank; Harris County Medical Society/Houston Academy of Medicine; Jackson Walker LLP; Luther King Capital Management; MD Medical Group; The Quantitative Group at Graystone Consulting; Dr. Steve and Sharon Robinson; Rudd & Wisdom, Inc.; Texas Institute for Surgery; Texas Scottish Rite Hospital for Children provided by Guy F. Stovall Jr., Trustee; TEXPAC; TMF Health Quality Institute; Travis County Medical Society; Texas Tech University Health Science Center School of Medicine Dean; The University of Texas Medical Branch; Vaughan Nelson Investment Management; an anonymous donor; Deborah A. Fuller, MD, and Lee Ann Pearse, MD, and Mr. Einar Vagnes; and Regina Rogers; Texas Indo American Physicians Society, Northeast Chapter; Texas Indo American Physicians Society, Southwest Chapter; TMA International Medical Group Section; TMA; and Abbott.

In the predinner receptions, guests will have the opportunity to enjoy retro games plus a silent auction. In the ballroom, guests may bid in the live auction and donate to the Make-A-Difference drive, which supports TMA’s Hard Hats for Little Heads.

The event is the single largest fundraising effort of TMAF and makes TMA health improvement, science, and quality-of-care programs possible.

Through April 30, regular individual tickets are $250 each and special VIP access tickets are $300; after April 30 these increase to $275 and $325 respectively. Individuals may sponsor a table of eight for $2,200. For more information and to purchase tickets, contact TMA Foundation at (800) 880-1300, ext. 1466, or (512) 370-1466.

Be Wise – Immunize is a service mark of the Texas Medical Association.
Attachment A

TMA GRANTS – In support of TMA’s public health and science priorities

TMA’s Be Wise – Immunize (BWI): BWI is a public health initiative that promotes the importance, safety, and effectiveness of vaccinations. The program combines education for physicians and patients with hands-on vaccination clinics (sponsored by physicians, TMA Alliance members, and medical students) to increase Texas’ vaccination rates. Since its beginning in 2004, Be Wise – Immunize has provided nearly 360,000 vaccinations to Texas children, adolescents and adults. The program supports TMA and TMA Alliance (TMAA) members with grants to fund local shot clinics aimed at Texas’ underserved and uninsured populations.

TMA’s Hard Hats for Little Heads (HHLH): HHLH encourages exercise and fitness and helps prevent life-altering or fatal brain injuries in Texas children. Since inception in 1994, more than 320,000 free helmets have been given to youths aged 14 and younger at community events such as bicycle safety rodeos and health fairs. TMA and TMAA members educate parents and their children about the importance of wearing a properly fitted helmet when bicycling, inline skating, skateboarding or riding a scooter.

TMA’s Ernest and Sarah Butler Awards for Excellence in Science Teaching: TMA is committed to elevating the importance of science in our modern society by recognizing and rewarding outstanding science teachers in elementary and junior and senior high schools. Since 1990, TMA has helped increase science literacy by providing cash awards to winning teachers and their schools to enhance their science curriculum.

TMA’s Minority Scholarship Program (MSP): Established in 1998, TMA’s MSP was designed as a unique means to fill a gap brought about by the Hopwood ruling barring public medical schools from offering minority-specific scholarships. In Texas, minority groups underrepresented with regard to population-to-physician ratios are Hispanic, African-American, and Native American. Annually, a qualified student entering each of Texas’ medical schools is selected to receive a $10,000 scholarship.

Walk With a Doc Texas (WWAD): WWAD engages physicians and their patients and the community in healthy physical activity to reverse the consequences of a sedentary lifestyle, especially obesity. Sixty-four TMA physician members are leading walks in 2019 that engage patients in walking with them at least once a month for 12 months. Participants enjoy a healthy snack and a brief health-related presentation before each 45-90 minute walk.

Distinguished Speaker Series (DSS): DSS is a forum for public health educators, physicians, community leaders, researchers, and thought leaders to share ideas, research, and policy options with public policy decisionmakers, lawmakers, and health stakeholders in Texas. The forum permits an opportunity to disseminate evidence, information, and expert opinions about the relationship between public health and Texans’ well-being, safety, and economic opportunity. DSS reinforces the importance of population health policy as a leading statewide priority and empowers stakeholders to advocate for evidence-based approaches to public health threats.

NEW! History of Medicine Banner Program: This program will enable TMA’s History of Medicine Committee to offer its seven exhibit banner sets to schools, libraries, and other venues that educate the public on a range of health and medical subjects, enhance the image of physicians, and encourage the pursuit of research and science education. The banners promote TMA’s patient health advocacy goals through education and historical content. With TMAF support, the recent museum exhibit, “Deep Roots: Botanical Medicine From Plants to Prescriptions,” will be added to the catalog of banners available.

Texas Two Step CPR: This initiative established by Texas medical students, the Texas College of Emergency Physicians, and HealthCorps provided skills training to community participants in hands-only CPR. The program expanded in 2018 to replicate the event on a national level. The project has trained more than 27,800 individuals on how to save lives with hands-only CPR.
Drive Thru, Prevent Flu/Lamar Delta County Medical Society. The Paris-Lamar County Health District partners with the Lamar-Delta County Medical Society and other community groups to provide an efficient method for 400 citizens, aged 18 or older, to receive the influenza vaccine. The “drive-thru” shot clinic is an easy-access option to both the elderly and a vast majority of the rural community who find it difficult to visit a regular, walk-in clinic.

Immunization Collaboration of Tarrant County (ICTC)/Tarrant County Medical Society Alliance Foundation. With a membership of more than 35 organizations, this program provides (1) low-cost vaccine events that help more than 7,000 eligible children and adults annually to receive required vaccines for kindergarten, seventh grade, and college school registrations; (2) vaccine education for parents, the community, and health care workers and providers through website and social media channels so ICTC becomes a go-to source for information about the importance and safety of immunizations; and (3) vaccine advocacy collaboration with TMA and The Immunization Partnership leading to science-based vaccine policies.

NEW! Texas BookShare/Bell County Medical Society Alliance. The Texas BookShare literacy program is a partnership with Texas Medical Association Alliance, Bell County Medical Alliance, Give More HUGS, and Baylor Scott & White Health. The program promotes early literacy and health and wellness during well check-up visits for children at six Baylor Scott & White Health clinics that serve low-income communities. Physicians prescribe books to promote language development and healthy habits for a better future, and to help every child read.

Project Access Tarrant County/Tarrant County Medical Society. Project Access Tarrant County (PATC) is a community collaboration that provides compassionate specialty care for Tarrant County’s uninsured. A network of volunteer TMA member physicians collaborate with hospitals, ancillary service providers, charitable community clinics, and other providers to serve the target population of the uninsured working poor. To date, PATC has enrolled more than 1,300 patients and has provided more than $11.5 million in donated care that this population otherwise would have been unable to obtain.

TMA MEDICAL STUDENT CHAPTERS – Medical Student Community Leadership Grants

Alliance Refugee Wellness Fair/Baylor College of Medicine. This annual event addresses health care disparities in the underserved refugee population that has resettled in Harris County by providing direct medical and preventive health services, education about health and well-being, and resources for greater access to medical care. In partnership with several area not-for-profit refugee resettlement agencies, this initiative provides refugees with culturally competent resources to navigate the Harris Health System.

Aggie Health Project: Hepatitis C/Texas A&M Health Science Center College of Medicine. In conjunction with Martha’s Clinic, Texas A&M’s student-run free clinic, this initiative aims to add hepatitis C to current health maintenance screenings and, when applicable, appropriate referral to community partners for the homeless and indigent of the city of Temple and Bell County. The addition of this screening addresses a disparity in available preventive services, creating opportunities for care and cure.

NEW! Carnaval de Salud: United to Serve Health Fair/UT Southwestern Medical Center (UTSW) TMA Medical Student Chapter. Established in 2004, Carnaval de Salud was created to organize services that cater to the health care and education needs of the local underserved community. The UTSW Medical Center students promote community wellness by providing free health screenings and creating engaging activities that entertain and deliver health information, introducing children to the general functions of the human body and connecting families to local resources.

NEW! Community Health Day/Baylor College of Medicine (BCM) TMA Medical Student Chapter. Community Health Day is a student-organized health fair held in the Sunnyside community in southeast Houston, a socioeconomically and medically underserved urban neighborhood. Each year, nearly all of BCM’s student organizations conduct health screenings, improve health literacy, and provide social resources to families and individuals with limited access to primary and specialty health care and other social services.
**Attachment A (continued)**

**HOPE Health Fair/The University of Texas Medical Branch (UTMB).** This collaborative event will provide vaccines, health screenings, and a meal to homeless and uninsured individuals in Galveston. The UTMB TMA Medical Student Chapter, Family Medicine Interest Group, and Gold Humanism Honor Society work with St. Vincent’s Student Run Clinic to host the second annual HOPE (Helping Others Through Partnered Empowerment) Health Fair. Last year, more than 200 vaccines were provided to this community, and in 2019, HOPE expects to serve at least 250 individuals.

**NEW! Implementing a Smoking Cessation Program in a Dallas Homeless Population/UT Southwestern (UTSW).** Medical students from UTSW are addressing tobacco use by homeless people at a local shelter, Union Gospel Mission, by implementing support groups, pharmacotherapy, and health education. This program is an immersive educational opportunity for medical students in preventive and community medicine who build a future commitment to these communities by interacting with vulnerable populations and gaining knowledge about health disparities and cultural competency.
TMA Foundation Major Donors

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Pon Satitpunwaycha, MD

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Dr. Dale and Mrs. Mertie L. Wood

*Deceased
TMAA Report 1-A-19

Subject: TMA Alliance Activities and Accomplishments

Presented by: Sunshine Moore, President

PUBLIC HEALTH OUTREACH

The TMA Alliance (TMAA), partnering with community organizations including local health departments and immunization coalitions, has contributed to 360,000 immunizations administered to Texas children since the inception of the Be Wise – ImmunizeSM program in October 2004.

As a major participant in the Hard Hats for Little Heads program, TMAA helped give away nearly 30,000 helmets to Texas children in 2018. Since 1994, TMA and TMAA have distributed more than 320,000 helmets.

Walk With a Doc events are now held in 41 communities across the state. In 2018, 63 walking events were held. County alliances participate in the promotion and logistics for these events.

County alliances also customize local programs to address health care issues in their communities, such as health care literacy and book share programs, sex trafficking awareness, and opioid abuse. Members also hold health and book fairs, Jump-A-Thons, and provide coats and shoes to underprivileged children. In addition, county alliances conduct a wide variety of fund raisers for medical and allied health professional scholarships.

LEGISLATION/POLITICAL ACTION

First Tuesdays at the Capitol continues to be a premier program that brings more than 1,000 physicians, alliance members, and medical students to Austin every legislative session. The 2019 First Tuesdays is already surpassing attendance levels for past sessions. A new program was added to First Tuesdays for members who didn’t have scheduled meetings and/or were new to grassroots advocacy by Patty Loose, First Tuesdays at the Capitol chair and past TMAA president (2015-16). It’s called the Advocacy Ambassador program and it has been a huge hit. Each First Tuesday, more than 50 people join teams and conduct meet and greets at the Capitol. Each team is led by an Alliance member.

Plans are underway to initiate and implement “First Tuesdays in the District” after the 2019 session. Every month, Alliance members will schedule coffee, lunch, or dinner visits with local legislators and their staff with TMA and TMAA members. The program will encourage more TMA and TMAA engagement in advocacy.

Alliance members continue to support TEXPAC with approximately 400 members. Initiatives are underway to double TEXPAC/Alliance membership in 2019.

TMA FOUNDATION

TMA Alliance leaders were instrumental in key TMA Foundation achievements including the gala held in San Antonio. Neha and Jayesh Shah, MD, and Gigi and Sheldon Gross, MD, of San Antonio co-chaired the event. Members that participated on the gala event committee included Anna Allred, MD; Shannon Hancher, MD; Jennifer Lewis; Shania Sheppard, MD; Angie Donahue; Monica Lee, MD; Jenny Shepherd; and Jennifer Zaragoza. Many other TMAA members rolled up their sleeves and assisted with
event and auction set up and numerous county alliance chapters contributed manpower, funds, and raffle items to support the annual benefit event.

Four Alliance chapters received community health improvement grants to launch and/or enhance their programs. Lubbock Anti-Sex Trafficking Project/Lubbock County Medical Society raises awareness about the problem of human sex trafficking of minors in Texas. Immunization Collaboration of Tarrant County (ICTC)/Tarrant County Medical Society Alliance Foundation provides low-cost vaccine events to ensure eligible children and adults receive required vaccines for kindergarten, 7th grade, and college with more than 7,000 served. The collaboration also provides vaccine education for parents, community, health care workers, and providers through website and social media channels so that ICTC becomes a go-to source for information about the importance and safety of immunizations. Texas BookShare/Bell County Medical Society Alliance is a new program, and is a partnership with TMAA, Bell County Medical Alliance, Give More HUGS, and Baylor Scott & White Health. Texas BookShare promotes early literacy and health and wellness during well check visits for children at six Baylor Scott & White Health clinics which serve low-income communities. Physicians will prescribe books to promote language development, healthy habits, and that help every child in Texas read.

The TMAA official family holiday sharing card was repeated in 2018, raising $2,885. Currently, Angela Donahue and Debbie Pitts represent TMAA as members of the TMA Foundation Board of Trustees. Hundreds of TMA Alliance members and their spouses are donors to the foundation, helping to make signature programs such as Hard Hats for Little Heads, Be Wise – Immunize, and Walk With a Doc Texas possible.
TMF Health Quality Institute has worked with Texas physicians for more than 46 years to help improve the health of Texans and health care in our communities.

TMF is recognized for our expertise and successes in delivering measurable improvements in the quality and delivery of health care, which derives from the strength of our relationship with Texas physicians.

As the Centers for Medicare & Medicaid Services (CMS) Quality Innovation Network Quality Improvement Organization (QIN-QIO) for Texas, Arkansas, Missouri, Oklahoma, and Puerto Rico, TMF is contracted to conduct various health care initiatives. These initiatives include improving cardiac health; reducing disparities in diabetes care; increasing screening and awareness of chronic kidney disease; improving rapid recognition and proper self-management of chronic obstructive pulmonary disease (COPD) exacerbation thereby reducing COPD emergency department utilization and subsequent inpatient hospital admissions; improving prevention efforts through meaningful use of health information technology; reducing harm in nursing homes; enhancing the coordination of care for patients to reduce unnecessary hospital readmissions; improving drug safety practices; promoting appropriate use of antimicrobials (including antibiotics); ensuring that eligible clinicians can easily comply with Merit-Based Incentive Payment System (MIPS) requirements and smoothly transition into Alternative Payment Models; assisting providers with quality reporting; improving immunization rates; increasing screening of depression and alcohol use disorders; and supporting the Transforming Clinical Practice Initiative.

Our QIN-QIO contract also provides new guidance on patient and family engagement in the patient’s health care. Through classes and various other outreach efforts, TMF is empowering patients and their family caregivers to be more confident participants in their health care. They are encouraged to be more open, informative, and helpful to their physicians to get the best care and to be more inquisitive about the self-management of their health.

In our ongoing efforts to engage patients, caregivers, physicians, health care providers, advocates and other stakeholders in a collaborative community, TMF continues to enhance our online Learning and Action Networks, which now include more than 26,000 U.S. and international users. These networks provide a forum for positive interaction, learning, sharing of resources, and best practices.

TMF is helping to improve health care in our communities through a variety of other state and federal contracts. We are increasing vaccines for children across Texas, training community health workers on chronic disease, and providing various health care facilities with data to help them self-audit to stay in compliance with Medicare regulations. Since TMF began working to promote childhood immunizations more than 10 years ago, we have successfully managed and completed more than 37,000 provider site reviews in multiple states. Through the CMS Civil Money Penalty (CMP) Reinvestment Program, TMF is collaborating with others to help drive large-scale national improvements in quality of care and life across skilled nursing facilities. Separately, TMF was awarded a CMP contract to improve oral hygiene for nursing home residents in Texas and Oklahoma. TMF received an additional CMP contract focused on educating staff in Texas nursing homes about the signs and symptoms of sepsis as well as evidence-based treatments for optimal resident outcomes.
TMF also is providing support for small medical practices in the CMS Quality Payment Program. Through this program, TMF provides Texas practices with technical assistance and services. This technical assistance brings direct support to thousands of MIPS-eligible clinicians in small practices with 15 or fewer clinicians, including small practices in rural locations, Health Professional Shortage Areas, and Medically Underserved Areas. The direct technical assistance is free to all MIPS-eligible clinicians and delivers support for up to a five-year period. TMF is also supporting physicians who are part of this program in Arkansas, Colorado, Kansas, Louisiana, Mississippi, Missouri, Oklahoma, and Puerto Rico.

We are honored to be partnered with the Texas Medical Association and the Texas Osteopathic Medical Association (TOMA) in offering the Texas Physician Practice Quality Improvement Award Program. The awards recognize Texas practices for their dedication and commitment to providing high-quality patient care. Please visit https://award.tmf.org/ for information about this noncompetitive recognition program. We are grateful to TMA and TOMA for their foresight in setting up TMF Health Quality Institute. Together, we are in the best position to help Texas physicians and their patients realize outstanding health care in an ever-changing health care environment.
REPORT OF COMMITTEE ON RURAL HEALTH

CM-RH Report 2-A-19

Subject: Rural Health Activities Update

Introduced by: Sandra D. Dickerson, MD, Chair

In addition to the report on expanding availability of broadband internet access to rural Texas and collaboration with the Committee on Physician Distribution and Health Care Access about Project ECHO, the Committee on Rural Health also has worked on:

Texas Department of Agriculture - Rural Policy Plan
Committee staff participated in a workgroup to draft the State Office of Rural Health’s Rural Policy Plan. The office, housed at the Texas Department of Agriculture, submitted its report to the Texas Legislature in December 2018. Other stakeholders who participated in drafting the report included the Texas Nurses Association, Texas Association of Rural Health Clinics, Texas Organization of Rural & Community Hospitals, the AgriSafe Network, Texas Rural Health Association, and the Texas Dental Association.

The plan, vetted by the committee last year, contains many TMA-backed proposals, including promoting use of telemedicine, focus on the rural health care workforce shortage, and broadband access.

Texas Rural Funders Collaborative
The committee, led by Dr. Sandra Dickerson, Dr. Lucia Williams, and Alison Mohr Boleware, is participating in the Texas Rural Funders Collaborative. The collaborative is a group of stakeholders that are collectively interested in improving rural Texas. Some stakeholders are philanthropic funders, while others work for state agencies, university systems, or private associations. While the collaborative’s mission is broader than rural health, it is focused on ways to strengthen health care availability and quality in rural counties.

In September 2018, Dr. Williams participated in a roundtable to provide real-world physician perspective on the collaborative’s rural health priority issues: strengthening rural hospitals, expanding telemedicine and telehealth, and improving broadband availability. Committee staff will continue to monitor the collaborative’s efforts.