

Supplement to Handbook

TexMed 2018

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TO THE HANDBOOK FOR DELEGATES
2018 Annual Session

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Replace 4-page Elections Charts with 4-page *Revised* Elections Charts;
Remove 2-page AMA Alternate Delegate candidate profile for Bryan G. Johnson, MD;
Remove 2-page AMA Alternate Delegate candidate profile for Richard W. McCallum, MD.

At Agendas Tab:
Replace Opening Session Agenda page with *Revised* Opening Session Agenda;
Replace Regular Session Agenda page with *Revised* Regular Session Agenda;
Replace 5-page Order of Business with 5-page *Revised* Order of Business.

At Financial and Organizational Affairs Tab:
Replace 2-page agenda with 2-page *Revised* agenda;
Replace SPKR Report 1-A-18 with *Revised* SPKR Report 1-A-18;
Replace BOT Report 12-A-18 with *Revised* BOT Report 12-A-18;
Replace Resolution 105-A-18 with *Revised* Resolution 105-A-18.

At Medical Education and Health Care Quality Tab:
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Insert Resolution 204-A-18 after Resolution 203-A-18;
Insert Resolution 205-A-18 after Resolution 204-A-18.

At Science and Public Health Tab:
Replace 2-page agenda with 2-page *Revised* agenda;
Insert Resolution 313-A-18 after Resolution 312-A-18;
Insert Resolution 314-A-18 after Resolution 313-A-18.

At Socioeconomics Tab:
Replace agenda with *Revised* agenda;
Insert PRES Report 1-A-18 before CHSO Report 1-A-18;
Insert CSE Report 3-A-18 after CSE Report 2-A-18;
Insert CSE Report 4-A-18 after CSE Report 3-A-18;
Insert CSE Report 5-A-18 after CSE Report 4-A-18;
Insert CSE Report 6-A-18 after CSE Report 5-A-18;
Insert CM-EMST Report 2-A-18 after CSE Report 6-A-18;
Insert CM-MHPC Report 2-A-18 before Resolution 401-A-18;
Insert Resolution 406-A-18 after Resolution 405-A-18.

Revised for Supplement

ELECTIONS
May 2018

OFFICERS

Office	Incumbent	Eligible for Election	Term of Position	Candidates Announced as of May 1
President-Elect	Douglas W. Curran	No	2018-19	David C. Fleeger* Travis
Speaker, House of Delegates	Susan M. Strate	Yes	2018-19	Susan M. Strate Wichita
Vice Speaker, House of Delegates	Arlo F. Weltge	Yes	2018-19	Arlo F. Weltge Harris
Three Trustees**	David N. Henkes Keith A. Bourgeois Richard W. Snyder	No Yes Yes	2018-21	Keith A. Bourgeois Harris Carrie de Moor Collin-Fannin Jayesh B. Shah Bexar Richard W. Snyder Dallas Joseph S. Valenti Denton
Board of Trustees Young Physician Member	Carrie de Moor	No	2018-20	Lindsay Botsford Harris

General officers listed serve one-year terms except trustee which is a three-year term.

House policy also provides that the names of candidates seeking election or reelection be distributed in advance. However, nominations will be accepted on the floor of the house whether or not prior notification of intent to seek election has been received or published.

If you wish to announce your candidacy or a candidate for election or reelection, please notify Ada Drozd, executive coordinator, Office of the EVP, at ada.drozd@texmed.org or (800) 880-1300, ext. 1540.

*Should Dr. Fleeger be elected president-elect, four trustees will be elected.

**Trustee positions are "at large," not slotted. TMA Bylaws provide that all nominees for trustee will be listed on a single ballot.

Revised for Supplement

COUNCILOR AND VICE COUNCILOR ELECTIONS
May 2018

COUNCILORS

Office	Incumbent	Eligible for Election	Term of Position	Candidates Announced as of May 1
District 1	Gilbert A. Handal	Yes	2018-21	Gilbert A. Handal
District 2	Vivek U. Rao	Yes	2018-21	Vivek U. Rao
District 4	Dan L. Locker	No	2018-21	Jane C. Rider
District 11	Charles M. Perricone	No	2018-21	Sheldon Y. Freeberg
District 14	Edward W. Tuthill	Yes	2018-21	Edward W. Tuthill

VICE COUNCILORS*

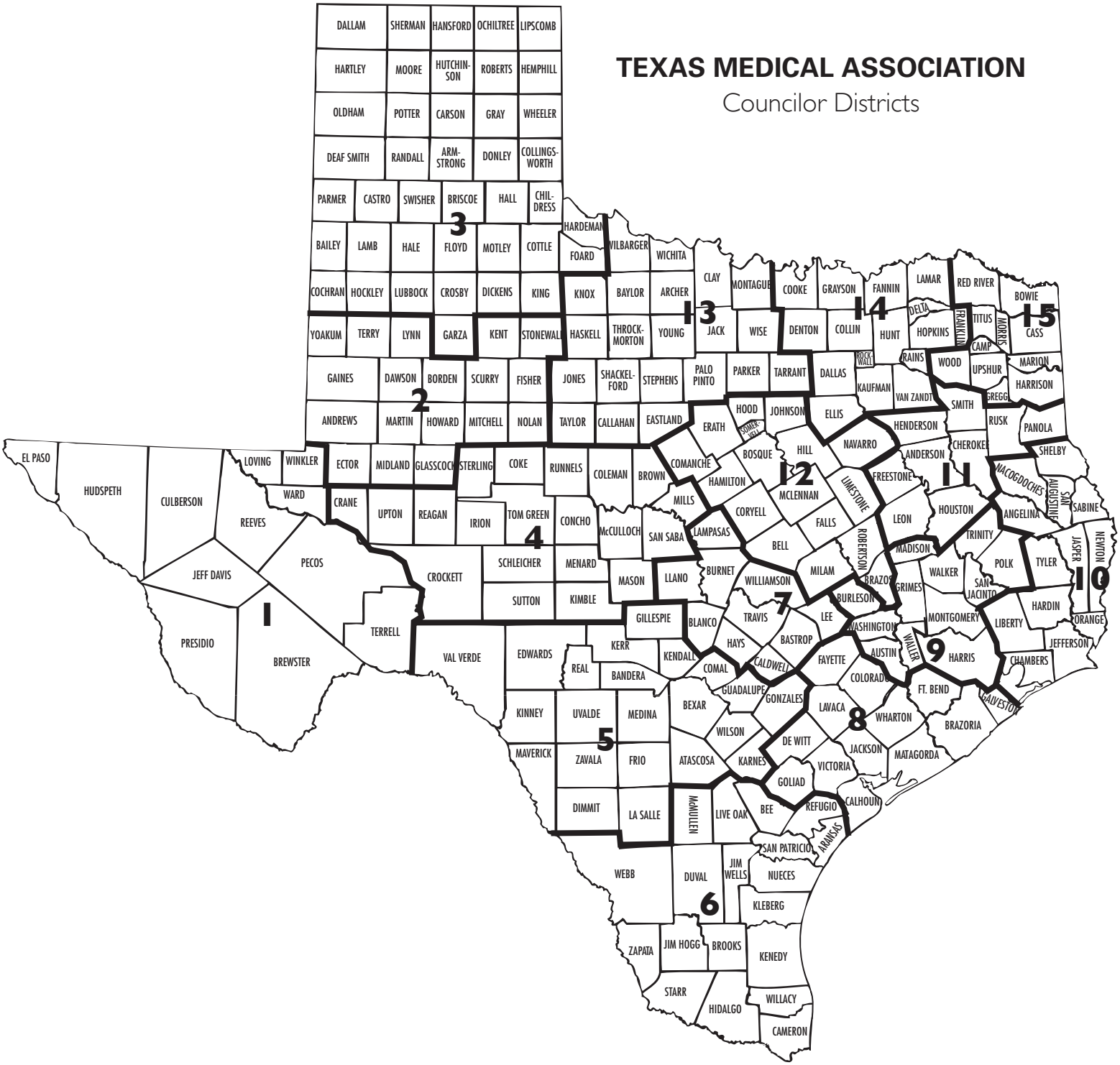
Office	Incumbent	Eligible for Election	Term of Position	Candidates Announced as of May 1
District 2	James W. Huston	Yes	2018-21	James W. Huston
District 4	Jane C. Rider	No	2018-21	
District 11	Sheldon Y. Freeberg	No	2018-21	
District 12	Vacant		2018-19	Alisa Marie D. Berger
District 14	Victor L. Vines	Yes	2018-21	Victor L. Vines

District elections are held for vice councilors and names are forwarded to the House of Delegates for confirmation. Terms are three years, unless filling an unexpired term. See map in this section for councilor districts.

*As provided in TMA Bylaws, nominations for vice councilor positions are determined by district elections and confirmed by the House of Delegates. Should you have a nomination for vice councilor, please notify Ann Arnett, assistant to the Board of Councilors, at ann.arnett@texmed.org or (800) 880-1300, ext. 1340.

TEXAS MEDICAL ASSOCIATION

Councilor Districts



Revised for Supplement

AMA DELEGATION ELECTIONS
May 2018

DELEGATES

Delegates	Incumbent	Eligible for Reelection	Term (2 Years) Jan. 1-Dec. 31	Candidates Announced as of May 1
1	Michelle A. Berger	Yes	2019-20	Michelle A. Berger
2	Brad G. Butler	Yes	2019-20	Brad G. Butler
3	David C. Fleeger	Yes	2019-20	David C. Fleeger
4	William H. Fleming III	Yes	2019-20	William H. Fleming III
5	Asa C. Lockhart	Yes	2019-20	Asa C. Lockhart
6	Kenneth L. Mattox	Yes	2019-20	Kenneth L. Mattox
7	Kevin H. McKinney	Yes	2019-20	Kevin H. McKinney
8	Larry E. Reaves	Yes	2019-20	Larry E. Reaves
9	Leslie H. Secrest	Yes	2019-20	Leslie H. Secrest
10	E. Linda Villarreal	Yes	2019-20	E. Linda Villarreal

ALTERNATE DELEGATES

Alternate Delegates	Incumbent	Eligible for Reelection	Term (2 Years) Jan. 1-Dec. 31	Candidates Announced as of May 1
1	Vacancy		2019-20	Laura Faye Gephart Alexander Kenton
2	G. Ray Callas	Yes	2019-20	G. Ray Callas
3	Gregory M. Fuller	Yes	2019-20	Gregory M. Fuller
4	William S. Gilmer	Yes	2019-20	William S. Gilmer
5	Cynthia A. Jumper	Yes	2019-20	Cynthia A. Jumper
6	Elizabeth Torres	Yes	2019-20	Elizabeth Torres
7	Roxanne M. Tyroch	Yes	2019-20	Roxanne M. Tyroch
8	Arlo F. Weltge	Yes	2019-20	Arlo F. Weltge
9	Habeeb M. Salameh*	No	2018-19	Theresa Phan
10	Jessie Ho*	No	2018-19	Faith Mason

Delegates and alternate delegates serve two-year terms, Jan. 1, 2019-Dec. 31, 2020; except that the terms for alternate delegate Places 9 and 10, which are designated for a resident and medical student, are May 19, 2018-May 18, 2019.

*Nominations are made by the Resident and Fellow Section and Medical Student Section.

Revised

TEXAS MEDICAL ASSOCIATION
2018 HOUSE OF DELEGATES ANNUAL SESSION

OPENING SESSION
Friday, May 18, 8 am, Expo Hall, Level 2, JW Marriott San Antonio Hill Country Resort and Spa
(The speakers may take items out of order.)

1. Call to Order
   Susan M. Strate, MD, Speaker
   Arlo F. Weltge, MD, Vice Speaker

2. Invocation
   Mark J. Kubala, MD, Past President

3. Report of Reference Committee on Credentials
   Leah H. Jacobson, MD, Chair

4. Approval of May 5-6, 2017 Minutes
   Michelle A. Berger, MD, Secretary/Treasurer

5. Address of Texas Medical Association Alliance President
   Karen Lairmore

6. Address of Texas Medical Association President
   Carlos J. Cardenas, MD

7. Board of Trustees Annual Association Finances Report
   David N. Henkes, MD, Chair

8. Section Awards
   Young Physician Section, Lindsay K. Botsford, MD, Chair
      Young at Heart
   Resident and Fellow Section, Habeeb M. Salameh, MD, Chair
      J.T. “Lamar” McNew, MD
   Medical Student Section, Jennifer E. Nordhauser, Chair
      C. Frank Webber, MD
      Student of the Year

9. American Medical Association Update
   David O. Barbe, MD, MHA, AMA President

10. Presentation by The Physicians Foundation
    Timothy B. Norbeck, CEO

11. Nominating Speeches
    President-Elect
    Trustees
    AMA Alternate Delegates

12. Recognition of TMA Past Presidents

13. Recognition of Outgoing Council and Committee Chairs

14. Acceptance of Handbook Items as Business of the House (see Order of Business)

15. Consideration of Late Reports and Resolutions

16. Moment of Silence for Deceased Physicians

17. Announcements

18. Recess for Reference Committee Hearings

Revised

TEXAS MEDICAL ASSOCIATION
2018 HOUSE OF DELEGATES ANNUAL SESSION

REGULAR SESSION
Saturday, May 19, 8:30 am, Expo Hall, Level 2, JW Marriott San Antonio Hill Country Resort and Spa
(The speakers may take items that are not time-specific out of order.)

1. Call to Order
   Susan M. Strate, MD, Speaker
   Arlo F. Weltge, MD, Vice Speaker

2. Report of Reference Committee on Credentials
   Leah H. Jacobson, MD, Chair

3. Announcements

4. Presentation of TMA-Established Organizations (video-taped)
   Texas Medical Liability Trust
      Robert D. Donohoe, President and CEO
   TEXPAC
      Robert J. Rogers, MD, Chair, Board of Directors
   Texas Medical Association Foundation
      Leslie H. Secrest, MD, President

5. Distinguished Service Award (9:15 am)
   Surendra K. Varma, MD, Lubbock

6. Initial Extractions from Reference Committee Reports

7. Elections (9:30 am)

8. Installation of TMA and TMAA Presidents (10:45 am)

9. Call for Reference Committee Reports

10. Adjourn

Revised for Supplement
Items in Supplement are in italics.

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES
ORDER OF BUSINESS
2018 ANNUAL SESSION
May 18-19, 2018

Reference Committee Key:
Financial and Organizational Affairs = FOA
Medical Education and Health Care Quality = MEHCQ
Science and Public Health = SPH
Socioeconomics = SOCIO

REPORTS:	**REFERRED TO:**
1. Report of President	
1. Physician-Led Initiatives to Address Maternal Mortality and Morbidity	*SOCIO*
2. Reports of Speakers	
1. Transparency in Election in the House of Delegates (Resolution 109-A-17)	*FOA*
2. Election of TMA Board of Trustees Members, Filling Vacancies by Special Election (Resolution 101-A-17)	FOA
3. Reports of Board of Trustees	
1. TMA Leadership College	Informational
2. Disclosure of Affiliations	Informational
3. Hurricane Harvey Disaster Relief	Informational
4. TMAIT, TMFHQI, and TMLT	Informational
5. Pending Lawsuits Involving Texas Medical Association	Informational
6. Investments	Informational
7. TMA/THA Physician Medicaid Rate Improvement Task Force	Informational
8. Audit of 2016 Financial Statements and 2017-18 Operating Budgets	Informational
9. 2017-18 Board Officers and Committees	Informational
10. Medical Student and Resident Physician Loan Funds	Informational
11. Minority Scholarship Program	Informational
12. Sunset Review of TMA Standing Committees	*FOA*
13. Policy Review	FOA
14. TMA 2025	FOA
15. Amendments to Constitution and Bylaws Chapter 9, Councils	FOA
4. Report of Executive Vice President	
1. 2017-18 Update	Informational
5. Report of Interspecialty Society Committee (no report)	
6. Report of Committee on Membership	
1. Membership Development	Informational
7. Reports of Board of Councilors	
1. Distinguished Service Award — Surendra K. Varma, MD	Informational
2. Opinions of the Board of Councilors	Informational
3. County Medical Societies	Informational
4. Support of Evidence-Based Medicine (Resolution 107-A-17)	FOA
5. Emeritus Nominations	FOA
6. Honorary Nominations	FOA
7. Policy Review	FOA

8. Reports of Committee on Physician Health and Wellness
1. 2018 Goals; PHR Assistance Fund; Drug Screen Program — Informational
2. Continuing Medical Education Programs — Informational
3. Treatment Facilities; Medical Student and Resident Activities — Informational

9. Reports of Texas Delegation to the AMA
1. AMA House of Delegates Meetings in 2017 — Informational
2. AMA Membership, Representation, and Delegation Leadership — Informational
3. Texas Delegation Operating Procedure Changes — FOA

10. Report of International Medical Graduate Section
1. Displaced and Refugee Physicians in Texas and Potential TMA Outreach (Resolution 105-A-17) — Informational

11. Report of Medical Student Section
1. Medical Student Section Operating Procedures Update — FOA

12. Report of Resident and Fellow Section (no report)

13. Report of Young Physician Section (no report)

14. Reports of Council on Constitution and Bylaws
1. Amendments to the TMA Constitution — FOA
2. Election of TMA Board of Trustees Members, Filling Vacancies by Special Election (Resolution 101-A-17) — FOA

15. Reports of Council on Health Care Quality
1. Quality Update — Informational
2. Policy Review — MEHCQ

16. Report of Council on Health Promotion (no report)

17. Reports of Council on Health Service Organizations
1. Policy Review — SOCIO
2. Medical Staff Rights and Responsibilities Bill of Rights — SOCIO
3. Due Process Rights in Physician Contracts With Hospitals — SOCIO

18. Report of Council on Legislation (no report)

19. Reports of Council on Medical Education
1. Addressing Physician Mental Health Status Disclosures (Resolution 111-A-17) — Informational
2. Policy Review — MEHCQ
3. Aligning Future Graduate Medical Education Capacity With Target Enrollments of New Texas Medical Schools — MEHCQ
4. Physician Representation on Texas Higher Education Coordinating Board — MEHCQ

20. Reports of Committee on Continuing Education
1. TMA CME Program Update — Informational
2. Policy Review — MEHCQ

21. Reports of Committee on Physician Distribution and Health Care Access
1. Annual Physician Workforce Update — Informational
2. Policy Review — MEHCQ

22. Reports of Council on Practice Management Services
1. Reducing Errors in Pharmacy (Resolution 307-A-17) MEHCQ
2. HIT Policy Review and New Cyber Security Policy MEHCQ

23. Reports of Council on Science and Public Health
1. Rejection of Discrimination (Resolution 304-A-17) FOA
2. Addressing the Diaper Gap (Resolution 305-A-17) SPH
3. Vitamin D3 Supplementation (Resolution 320-A-17) SPH
4. Implementing a Sugar-Sweetened Beverage Tax in Texas (Resolution 312-A-17) SPH
5. Policy Review SPH
6. Physician Role in Increasing Vaccination for HPV SPH
7. Evidence-Based Management of Substance Use Disorders SPH
8. Improving EHR, HIE, and other HIT Products to Address Issues of Sex and Gender SPH

24. Report of Committee on Cancer
1. Policy Review SPH

25. Reports of Committee on Child and Adolescent Health
1. Policy Review SPH
2. Referred 2017 Resolutions Relating to Concussions and Head Injuries SPH

26. Report of Committee on Emergency Medical Services and Trauma
1. Committee Activities Update Informational
2. *Policy Review* *SOCIO*

27. Report of Committee on Infectious Diseases
1. Policy Review SPH

28. Report of Committee on Reproductive, Women's, and Perinatal Health
1. Evaluation and Management of Stillbirth SPH

29. Reports of Council on Socioeconomics
1. Policy Review SOCIO
2. Geographic Practice Cost Indices Policy SOCIO
3. *Transparency and Payments for Prior Authorizations (Resolution 406-A-17)* *SOCIO*
4. *Compensation of Physicians for Authorizations and Preauthorizations (Resolution 408-A-17)* *SOCIO*
5. *Clearer Language Regarding the Physician's Role in Providing Auxiliary Aid for Effective Communication Under Current Federal Laws (Resolution 411-A-17)* *SOCIO*
6. *Medicaid Work Requirements* *SOCIO*

30. Report of Committee on Medical Home and Primary Care
1. Committee Activities Update Informational
2. *Policy Review* *SOCIO*

31. Reports of Patient-Physician Advocacy Committee
1. Patient-Physician Advocacy Update Informational
2. Review of Policy 265.019 Disruptive Behavior Standard FOA

32. Report of Committee on Rural Health
1. Committee Activities Update Informational

33. Report of TEXPAC
1. TEXPAC March Primary Summary Report Informational

34. Report of Texas Medical Association Insurance Trust
1. Texas Medical Association Insurance Trust 2017 Annual Report — Informational

35. Report of Texas Medical Association Foundation
1. Texas Medical Association Foundation 2017 Annual Report — Informational

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

37. Report of TMF Health Quality Institute
1. TMF Health Quality Institute Annual Report — Informational

RESOLUTIONS: **REFERRED TO:**

101. Patient-Centered Medical Record Responsibilities — FOA
Webb-Zapata-Jim Hogg County Medical Society
102. Language Change in TMA Bylaws and Bexar County Medical Society Bylaws From — FOA
"Doctor of Osteopathy" to "Doctor of Osteopathic Medicine" — FOA
Bexar County Medical Society
103. Internet-Based Notification of Patients When a Physician Is Closing or Leaving a Practice — FOA
Travis County Medical Society
104. Clarification of Guidelines for Online Prescribers in Texas — FOA
Travis County Medical Society
105. Revision of Section 165.155 (a) of the Texas Occupations Code, Solicitation of Patients — FOA
Bexar County Medical Society
106. Creation of a TMA Ad Hoc Committee on the Power and Influence of the Texas Nonprofit Health Corporation/501(a) Organization — FOA
Bexar County Medical Society
107. Physician Protections When Reporting Violations of Non-profit Health Corporations — FOA
Harris County Medical Society
108. Inclusion of Medical Students in Good Samaritan Laws and Policies for Disaster Settings — FOA
Medical Student Section
109. Liability Exemptions for Volunteer Medical Health Workers — FOA
Harris County Medical Society
110. Medical Necessity Decisions Are the Practice of Medicine — FOA
Harris County Medical Society
201. Incorporating High-Value Care into Undergraduate and Graduate Medical Education in Texas — MEHCQ
Medical Student Section
202. Addressing Gender Bias in Undergraduate Medical Education with Implicit Bias Training — MEHCQ
Medical Student Section
203. Freedom from Maintenance of Certification — MEHCQ
Ori Z. Hampel, MD
204. Creating a Non-Profit Texas Board of Medical Specialties — MEHCQ
Smith County Medical Society
205. Graduate Associate Physicians — MEHCQ
International Medical Graduates Section
301. Synthetic Cannabis Educational Resources for Providers — SPH
Medical Student Section
302. Appropriate Physician Oversight of EMS Medical Practices — SPH
Travis County Medical Society
303. "Bathroom" Bills — SPH
Harris County Medical Society
304. Improving the LGBTQI+ Patient Health Care Experience — SPH
Medical Student Section

305. Addressing Food Deserts in Texas SPH
Medical Student Section
306. Addressing HB 3859 – A Misstep in the Protection of Foster Care Children SPH
Medical Student Section
307. Restriction of Provisions of HB 2561 to Schedule II Drugs SPH
Bexar County Medical Society
308. Texas Prescription Drug Monitoring Program Data Integration into EHR Technology SPH
Medical Student Section
309. Implementing Blood Glucose Screening in Texas Schools SPH
Medical Student Section
310. Community Health Workers and HPV Vaccination SPH
Medical Student Section
311. Encouraging Unstructured Playtime in School SPH
Medical Student Section
312. Identification Bracelets for Patients with Hearing Loss SPH
Tarrant County Medical Society
313. Raising the Minimum Purchase Age for All Guns to 21 SPH
Ryan Van Ramshorst, MD, Texas Pediatric Society
314. Extreme Risk Protection Order and Gun Violence SPH
Ryan Van Ramshorst, MD, Texas Pediatric Society
401. Physicians Allowed To Delegate Ability to Enter EHR Data SOCIO
McLennan County Medical Society
402. Opposition to Medicaid Work Requirements SOCIO
Ryan Van Ramshorst, MD, Texas Pediatric Society
403. Under-Reporting of Optometric Diabetic Eye Examinations to Treating Physicians SOCIO
Harris County Medical Society
404. Opposition to Pain Score as Contributor to Hospital Financial Incentives SOCIO
Medical Student Section
405. Compensation to Physicians for Authorizations and Preauthorizations SOCIO
Ori Z. Hampel, MD
406. Supporting the Reclassification of Complex Rehabilitation Technology SOCIO
Resident and Fellow Section

Revised for Supplement
Items in Supplement are in italics.

AGENDA
REFERENCE COMMITTEE ON FINANCIAL AND ORGANIZATIONAL AFFAIRS
Friday, May 18, 2018
JW Marriott San Antonio Hill Country Resort, Level 2, Cibolo Ballroom 6

1. *Speakers' Report 1 – Transparency in Election in the House of Delegates (Resolution 109-A-17)*

2. Speakers' Report 2 – Election of TMA Board of Trustees Members, Filling Vacancies by Special Election (Resolution 101-A-17)

3. Council on Constitution and Bylaws Report 2 – Election of TMA Board of Trustees Members, Filling Vacancies by Special Election (Resolution 101-A-17)

4. *Board of Trustees Report 12 – Sunset Review of TMA Standing Committees*

5. Board of Trustees Report 13 – Policy Review

6. Board of Trustees Report 14 – TMA 2025

7. Board of Trustees Report 15 – Amendments to Constitution and Bylaws Chapter 9, Councils

8. Board of Councilors Report 4 – Support of Evidence-Based Medicine (Resolution 107-A-17)

9. Board of Councilors Report 5 – Emeritus Nomination

10. Board of Councilors Report 6 – Honorary Nominations

11. Board of Councilors Report 7 – Policy Review

12. Texas Delegation to the AMA Report 3 – Texas Delegation Operating Procedure Changes

13. Medical Student Section Report 1 – Medical Student Section Operating Procedures Update

14. Council on Constitution and Bylaws Report 1 – Amendments to the TMA Constitution

15. Council on Science and Public Health Report 1 – Rejection of Discrimination (Resolution 304-A-17)

16. Patient-Physician Advocacy Committee Report 2 – Review of Policy 265.019 Disruptive Behavior Standard

17. Resolution 101 – Patient-Centered Medical Record Responsibilities (Webb-Zapata-Jim Hogg County Medical Society)

18. Resolution 102 – Language Change in TMA Bylaws and Bexar County Medical Society Bylaws from "Doctor of Osteopathy" to "Doctor of Osteopathic Medicine" (Bexar County Medical Society)

19. Resolution 103 – Internet-Based Notification of Patients When a Physician is Closing or Leaving a Practice (Travis County Medical Society)

20. Resolution 104 – Clarification of Guidelines for Online Prescribers in Texas (Travis County Medical Society)

21. *Resolution 105 – Revision of Section 165.155 (a) of the Texas Occupations Code, Solicitation of Patients (Bexar County Medical Society)*

22. Resolution 106 – Creation of a TMA Ad Hoc Committee on the Power and Influence of the Texas Non-Profit Health Corporation (NPHC)/501A Organization (Bexar County Medical Society)

23. Resolution 107 – Physician Protections When Reporting Violations of Non-profit Health Corporations (Harris County Medical Society)

24. Resolution 108 – Inclusion of Medical Students in Good Samaritan Laws and Policies for Disaster Settings (Medical Student Section)

25. Resolution 109 – Liability Exemptions for Volunteer Medical Health Workers (Harris County Medical Society)

26. Resolution 110 – Medical Necessity Decisions Are the Practice of Medicine (Harris County Medical Society)

Revised

REPORT OF SPEAKERS

SPKR Report 1-A-18

Subject: Transparency in Election in the House of Delegates (Resolution 109-A-17)

Presented by: Susan M. Strate, MD, Speaker

Referred to: Reference Committee on Financial and Organizational Affairs

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Resolution 109-A-17, Transparency in Election in the House of Delegates, from the Angelina County Medical Society, was referred to the TMA speakers with a report back to the House of Delegates at A-18. The resolution requests that:

(1) Vote counts of all secret ballots taken in the TMA House of Delegates be announced publicly in the house at the time each election result is announced; and

(2) Final vote counts of all secret ballots in the TMA House of Delegates be made public and made part of the official proceedings of the house.

Your speaker notes that individual house members already maintain the right to review all house election results. These results are available to any TMA member upon request on site after elections conclude, or following adjournment of the meeting by contacting TMA House of Delegates staff. However, members may not always be aware of this option. It is likely that members would benefit from efforts to increase clarity and transparency regarding TMA's balloting procedures and availability of voting results.

Announcing vote counts publicly could lead to considerable disruption in house proceedings. Prolonged discussions among house members regarding the counts and increased calls for vote confirmations are likely to occur, thereby impeding the business schedule and potentially fostering a contentious atmosphere. Members may feel undue concern when encountering a tight election, not having been accustomed with the reality that votes are sometimes exceedingly close, yet still valid. What's more, candidates themselves may not wish to have vote counts publicly displayed, and caucus members may feel that announcing the counts limits their ability to vote independently.

To increase awareness of current TMA election protocols, the TMA speakers of the house can provide members with a TMA Balloting Procedures resource document. Members also will continue to have access to specific election results. For these reasons, the TMA speakers recommend the following amendments to Resolution 109-A-17:

Recommendation 1: That ~~Vote counts of all secret ballots taken in the TMA House of Delegates be announced publicly in the house at the time each election result is announced;~~ a TMA Balloting Procedures resource document be posted on the TMA website and distributed at each annual session; and

Recommendation 2: Final vote counts of all secret ballots in the TMA House of Delegates continue to be made ~~public and made part of the official proceedings of the house.~~ available to any member upon request on site after elections conclude, or following adjournment of the meeting by contacting the TMA House of Delegates staff.

Recommendation 3: That Resolution 109-A-17 be adopted as amended.

Revised

REPORT OF BOARD OF TRUSTEES

BOT Report 12-A-18

Subject: Sunset Review of TMA Standing Committees

Presented by: David N. Henkes, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

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TMA Bylaws provide that standing committees of the association shall be discharged at the expiration of three years unless the parent council or board petitions the Board of Trustees. The House of Delegates then acts on the recommendations of the board.

At the 2016 Winter Conference, the Board of Trustees (BOT) approved a report detailing the findings and recommendations of a BOT Task Force on TMA Committee Sunset Review Process. The task force's report was in response to Resolution 106-A-15, TMA Sunset Review of Councils, Committees, and Sections, referred to the board for study.

Upon review and deliberation of the issues raised in Resolution 106-A-15, the board discerned the need for greater collaboration of all parties involved in and affected by sunset recommendations. The board further recognized the importance of transparency of criteria and inclusive communication of process prior to sunset recommendations coming before the House of Delegates. The BOT task force report contained five recommendations:

1. That, as part of their appointment, council and committee members be provided with annual objectives and goals and how they align with TMA's overall strategic efforts.
2. That criteria for sunset review align with TMA strategic goals and objectives and that the criteria be communicated to councils and committees in a transparent and efficient manner at the beginning of each year with ongoing collaboration with the Board of Trustees as the year progresses.
3. That sunset review be accomplished as reasonably and efficiently as possible and that for any major change (discharge, reorganization), the Board of Trustees actively participate and collaborate with all affected councils or committees and, if necessary, seek external member input prior to forwarding recommendations to the House of Delegates.
4. That TMA provide (1) an orientation of council and committee chairs as to their roles and the association's organizational structure; and (2) a mechanism for better communication between council chairs and the Board of Trustees and between council chairs with each other.
5. That the Council on Constitution and Bylaws be asked to consider issues identified in this report in light of options for alternatives to standing committees such as use of subcommittees to allow organizational effectiveness and efficiency.

TMA's Council on Constitution and Bylaws Report 1-A-17 found that, as a supplement to TMA Bylaws, parliamentary procedure provides a good deal of direction concerning the functions of committees, subcommittees, and special groups. The council recommended adoption of the new *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* (AIP) to ensure TMA is following the most up-to-date parliamentary procedures (SPKR and CCB Joint Report 1-A-17, Adopted A-17).

In further response to these recommendations, an orientation video has been created and will be shared with all council and committee members and posted to the TMA website. It clearly describes the functions and work products expected of TMA councils and committees, as well as other general requirements including attendance. This video will discuss the TMA governance process, and the process of committee sunset review. The board also approved the use of a simple, one-page form for use by all councils to evaluate standing committees reporting to them.

Board of Trustees
The Interspecialty Society Committee provides its member societies and other specialty societies an entity to which legislative, social, economic, and professional concerns may be presented and transmitted to the House of Delegates or other appropriate bodies of the association. The committee has been recognized as the conduit for specialty concerns and offers specialty societies a voice within TMA.

The Committee on Membership provides physician-led guidance in the development of annual and long-term membership recruitment and retention programs. County society staff serve as consultants to the committee. The committee is instrumental in providing guidance on proposed marketing strategies, ideas for new and emerging membership segments, removing barriers to membership, a local physician view of TMA policies and procedures, and direction and assistance for local market activities. Its efforts contribute directly to membership recruitment and retention, which continues to increase every year, contributing to an annual dues revenue budget which now stands at $16.55 million, making up 63.3 percent of TMA's overall revenue budget. TMA membership is now 51,532 members strong.

Recommendation 1: Continue the Interspecialty Society Committee and Committee on Membership for three years.

Board of Councilors
The Committee on Physician Health and Wellness reports to the Board of Councilors. The Committee on Physician Health and Wellness (CPHW) has many duties. The duties include promoting healthy lifestyles in Texas physicians, reviewing rehabilitation provided to physicians with potentially impairing conditions, liaising with the Texas Medical Board (TMB) and Texas Physician Health Program (TXPHP), making recommendations to the Council on Legislation when there are needed changes in the laws, and providing education on physician health and wellness topics.

These duties are very important to TMA's 2020 goal of engaging in legislative, regulatory, and legal advocacy to improve the environment in which Texas physicians care for their patients.

These important duties have led to many accomplishments by CPHW over the years, including operation of a statewide drug screening program for physicians, production of numerous programs and brochures to educate physicians about wellness, stress and potentially impairing conditions, management of a Physician Health and Rehabilitation Fund to assist affected physicians, surveillance of activities involving physicians reported for suspected impaired conditions, and liaising with the TMB and TXPHP.

Recommendation 2: Continue the Committee on Physician Health and Wellness for three years.

Council on Medical Education
The Committee on Continuing Education serves a unique role both within and outside of TMA. Not only does the committee develop policy for consideration, but also it conducts research used by others within TMA and in the legislative arena. This research is not conducted by any other group in the state and fills a gap. Furthermore, the committee's work supports a uniform, national system of continuing medical education (CME) accreditation, helping to assure physicians, state legislators, CME providers, and the public that all CME programs are held to the same high standards, and enables Texas physicians to maintain their licenses and board certifications. The committee's work also has gained national recognition; TMA has been asked to provide services to other state medical societies that are struggling with their CME accreditor programs. The council agrees there is sufficient evidence to demonstrate the committee's effectiveness in fulfilling its charge over the past three years; not continuing the committee would have a devastating impact on accredited CME organizations and physicians in Texas.

The Committee on Physician Distribution and Health Care Access serves in a unique role of monitoring and reporting on dominant trends in the physician workforce and in other health professions, and identifying research on the state's workforce needs. Work of the committee has gained national and state

recognition, and the committee fills a gap in state workforce planning. The outcomes assist the Council on Medical Education in formulating policy recommendations on medical education and inform TMA's advocacy activities with both Congress and the Texas Legislature.

Recommendation 3: Continue the Committee on Continuing Education and Committee on Physician Distribution and Health Care Access for three years.

Council on Science and Public Health

Five standing committees report to the Council on Science and Public Health: Committee on Cancer, Committee on Child and Adolescent Health, Committee on Emergency Medical Services and Trauma, Committee on Infectious Diseases, and Committee on Reproductive, Women's, and Perinatal Health. Overall, the council commends each of the committees' activities and accomplishments. Each of the committees met the necessary meeting and attendance requirements. These committees submitted numerous reports to the House of Delegates, created physician education, worked closely with other committees, and advocated on numerous issues.

The Committee on Cancer has been focusing on educating Texas physicians and the public regarding updated information on cancer prevention and treatment. Targeted initiatives such as HPV vaccination and HCC education will have long-term effects on mitigating the risks of cancer on the residents of Texas. Efforts to address tobacco prevention and cessation have been included in CME opportunities, and collaboration with the advocacy efforts through the Texas Public Health Coalition forums.

The Committee on Child and Adolescent Health (CCAH) is an important advocate for pediatrics and child health in Texas. CCAH provides input and expertise regarding public health and its impact on child health. CCAH serves to review, advise, and advocate for legislative issues in Texas that impact child health and pediatrics. CCAH provides resources for TMA on pediatric issues, pediatric providers, immunization practices, and funding for pediatric care. The committee advocates for fragile populations involving children and provides input on the epidemiology of childhood illnesses such as influenza and Respiratory Syncytial Virus.

The Committee on Emergency Medical Services and Trauma's charge is to: (1) work with all parties in the formulation, initiation, and maintenance of community plans for emergency medical services leading to statewide coverage; (2) provide liaison between the Texas medical community and government agencies concerned with emergency medical care; (3) educate and inform Texas physicians on the developments in emergency medical services at national and state levels; (4) identify and review state health programs relating to emergency medical services, injury prevention, and trauma care; (5) participate in, and provide physician input to, these state health programs; (6) maintain liaison with government agencies devoted to preparation and execution of plans in the event of any occurrence of catastrophic proportions, and educate Texas physicians about plans for medical care in disaster situations; (7) study, evaluate, and make recommendations regarding trauma and related problems, including accidents and physical abuse resulting in trauma; and (8) study, evaluate, and make recommendations regarding the development and funding of a statewide trauma system.

The Committee on Infectious Diseases (CID) currently is engaged in a number of activities, working closely with other TMA committee members, Texas Department of State Health Services (DSHS), the Cancer Coalition, Texas Pediatric Society, and frontline providers on ways to improve HPV coverage in Texas. The group has examined ImmTrac functionality, advised on an infographic created by BeWise, explored options for advising providers on vaccine tracking using EHRs, and discussed opportunities to work with additional stakeholders including the Texas Parent Teachers Association and the Texas School Nurses Association. Identifying a deficiency of reliable, validated data on the rate of HPV vaccine uptake in children resulted in formation of an HPV data work group led by TMA's CID chair. The committee has identified a variety of activities to promote awareness of multidrug resistant organisms, including

highlighting issues during the national U.S. Antibiotic Awareness Week. The committee will continue to work with the (DSHS) to identify ways to collaborate to inform and assist physicians.

The committee continues to engage with stakeholders on infection control issues related to long-term care facilities. This includes working to prepare for implementation of CMS rule on vaccination, antimicrobial stewardship, and infection prevention and control, convening additional stakeholders meetings, and identifying opportunities to testify and advocate for statewide policy changes.

The committee continues to track other key infectious disease-related legislative topics. This includes raw milk, especially in light of recent outbreaks. In addition, the committee will review the TMA policy on needle exchange and will identify ways during the interim and legislative session to advocate for reduce HIV and HCV infection.

In addition to the charge given to the Committee on Reproductive, Women's and Perinatal Health (RWPH), the committee works in collaboration with TMA groups, state agencies, and other professional organizations to support priorities of the committee including (1) the Council on Science and Public Health workgroups on Zika and LGBT; (2) Texas Association of Obstetricians and Gynecologists and the Committee on Infectious Diseases on developing communication plans for physicians on CMV; (3) developing a report on evaluation and management of stillbirth; (4) Texas Pediatric Society to address newborn screening payment issues; and (5) Women's Health Advisory Committee. There is RWPH-member involvement in state activities including the Task Force on Maternal Mortality and Morbidity; Texas Collaborative for Healthy Mothers and Babies; Task Force on Domestic Violence; Newborn Screening Advisory Committee; Midwives Advisory Board of the Texas Department of Licensing and Regulation; and the Health and Human Services Commission's Perinatal Advisory Committee. RWPH collaborates with DSHS on work plans developed at the 2017 Maternal Mortality and Morbidity Forum.

Recommendation 4: Continue the Committee on Cancer, Committee on Child and Adolescent Health, Committee on Emergency Medical Services and Trauma, Committee on Infectious Diseases, Committee on Reproductive, Women's, and Perinatal Health for three years.

Council on Socioeconomics

Three standing committees report to the Council on Socioeconomics: Committee on Medical Home and Primary Care, Patient-Physician Advocacy Committee and Committee on Rural Health and the council recommends their continuation. All of these committees' duties are integral to TMA's 2020 goal of engaging in legislative, regulatory, and legal advocacy to improve the environment in which Texas physicians care for their patients. Additionally, they both contribute to TMA's 2020 goal of strengthening physicians' trusted leadership role.

The work of the Committee on Medical Home and Primary Care (CMHPC) has led to many accomplishments including ongoing contribution to content and focus of the annual Texas Primary Care and Health Home Summit. Members of the committee are part of the summit leadership team. CMHPC is currently drafting a report on the state of primary care in Texas similar to "The Primary Solution: Mending Texas' Fractured Health Care System." This report was created by the Primary Care Coalition several years ago to educate lawmakers and the public about the role of primary care in the health care delivery system. The report will focus on examining health care costs, promoting the medical home model, ensuring adequate payments for medical home providers, and what other states are doing to promote the patient-centered medical home. It will be integral to the continued development and modification of TMA regulatory and legislative efforts and TMA policy analysis.

The Committee on Rural Health (CRH) has focused on working with the law firm Kemp Smith to start the formation of a rural coalition that would help draw down USDA and other federal dollars to provide no-cost or low-cost loans to rural physicians and other rural providers. CRH also provides valuable feedback on numerous legislative and regulatory issues relating to rural health in Texas such as

telemedicine (including licensure for out-of-state psychiatrists for telemedicine services), the physician loan repayment program, the rural hospital closure crisis, health disparities in rural areas, and GME funding. Committee members have submitted multiple resolutions throughout the years to the TMA House of Delegates that directly impacted and improved rural physicians' practices. Members of CRH serve as liaisons with other rural health stakeholder groups including the Texas Organization of Rural and Community Hospitals and the State Office of Rural Health.

Recommendation 5: Continue the Committee on Medical Home and Primary Care and the Committee on Rural Health for three years.

The Patient-Physician Advocacy Committee (PPAC) continues to be involved with the Texas Medical Board to learn more about its processes and procedures and to offer input on improvements. The committee has, on various occasions, invited the board's executive director, general counsel, and medical director to its committee meetings to discuss a variety of concerns. The committee also provided input to TMA's efforts to address concerns regarding the TMB licensure and disciplinary process as part of the Texas Sunset Commission's scheduled review of licensing agencies.

PPAC also has reviewed several physician-specific cases over the years that have resulted in amicus briefs being submitted to the courts on behalf of TMA members. In the past few years, PPAC has reviewed several cases dealing with apparent shortcomings of the peer review process and with allegations that the peer review process can be used to hide dubious intentions of others. Recognizing what was becoming a trend and to continue the committee's discussion of the peer review process, PPAC further reviewed several academic works that described what some have termed "sham peer review."

Finally, the committee performed a sunset review of TMA's policy on sham peer review. The committee recommended retaining the policy, but determined that TMA could take on a more active role in fulfilling TMA's commitment against sham peer review as outlined in that policy. Recognizing that the committee alone lacked the resources to adequately evaluate the peer review process to determine whether more could be done to ensure a fair review process, the committee recommended to the Council on Socioeconomics that a task force or ad hoc committee be formed to further evaluate the issue.

In addition, PPAC discussed the committee's purposes and how the committee should move forward. The committee reviewed its purposes as stated in TMA's bylaws and found that the committee's charge does not accurately reflect the committee's recent work and focus. The committee proposes an amended charge to more accurately reflect the committee's work.

Recommendation 6: Amend the charge of the Patient-Physician Advocacy Committee in Section 10.532 of TMA Bylaws as follows:

> The committee shall ~~assess~~ evaluate the quality of medical and health care services in the State of Texas and recommend regulatory, legislative, and legal approaches to assure that the highest standard of quality medical care is available for all Texans. The committee shall assess the environments and circumstances in which physicians practice on both a case-by-case and a global basis to identify and advocate against barriers to a healthy environment for the practice of medicine. The committee shall serve as a source of advice on quality ~~assurance, utilization review, and other~~ ~~quality~~ and medical practice environment issues; develop and recommend policy; establish and maintain liaison with appropriate regulatory agencies and with groups with similar interests; and serve in an advocacy role for physicians and patients on issues related to quality ~~assurance, utilization review, and other forms of review~~ and medical practice environment.

Recommendation 7: Continue the Patient-Physician Advocacy Committee, as amended, for three years.

Revised

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 105
A-18

Subject: Revision of Section 165.155 (a) of the Texas Occupations Code, Solicitation of Patients

Introduced by: Bexar County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

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Whereas, Section 165.155 (a) of the Texas Occupations Code makes it a Class A misdemeanor if any 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; and

Whereas, It can be construed that when any physician advertises or gives group discounts; solicits and pays an individual to become a patient for research; or sends any type of favor or gift, offers a discount, or sends gift certificates for treatments to friends, past patients, or colleagues that have referred patients, that physician is committing a Class A misdemeanor; therefore be it

RESOLVED, 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.

Revised for Supplement
Items in Supplement are in italics.

AGENDA
REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HEALTH CARE QUALITY
Friday, May 18, 2018
JW Marriott San Antonio Hill Country Resort, Level 2, Cibolo Ballroom 8

1. Council on Health Care Quality Report 2 – Policy Review

2. Council on Medical Education Report 2 – Policy Review

3. Council on Medical Education Report 3 – Aligning Future Graduate Medical Education Capacity With Target Enrollments of New Texas Medical Schools

4. Council on Medical Education Report 4 – Physician Representation on Texas High Education Coordinating Board

5. Committee on Continuing Education Report 2 – Policy Review

6. Committee on Physician Distribution and Health Care Access Report 2 – Policy Review

7. Council on Practice Management Services Report 1 – Reducing Errors in Pharmacy (Resolution 307-A-17)

8. Council on Practice Management Services Report 2 – HIT Policy Review and New Cyber Security Policy

9. Resolution 201 – Incorporating High-Value Care into Undergraduate and Graduate Medical Education in Texas (Medical Student Section)

10. Resolution 202 – Addressing Gender Bias in Undergraduate Medical Education with Implicit Bias Training (Medical Student Section)

11. Resolution 203 – Freedom from Maintenance of Certification (Ori Z. Hampel, MD)

12. *Resolution 204 – Creating a Non-Profit Texas Board of Medical Specialties (Smith County Medical Society)*

13. *Resolution 205 – Graduate Associate Physicians (International Medical Graduate Section)*

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 204
A-18

Subject: Creating a Nonprofit Texas Board of Medical Specialties

Introduced by: Smith County Medical Society

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

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Whereas, The maintenance of board certification for Texas physicians through the American Board of Medical Specialties has proven time-consuming, expensive, and of no demonstrated value to the delivery of quality care; and

Whereas, Excess time and costs have driven many physicians to give up their board certification; and

Whereas, Many physicians do not see the value in the certification, and most patients do not see it as a true quality indicator; and

Whereas, Most of the hurdles to maintain certification have little to do with our actual medical practices; and

Whereas, Most physicians are licensed only to practice in Texas; thus there is no need to have a national organization located outside of Texas to determine who qualifies as a "board certified" practitioner; and

Whereas, Other Texas-based professions have Texas-based organizations to certify the accomplishment of specialization (e.g., the Texas Board of Legal Specialization is the only governing board authorized to certify attorneys in legal specialty areas in Texas); and

Whereas, The goal of the Texas Board of Medical Specialties would be to certify the clinical skill and knowledge development of Texas physician specialists with a focus on developing lifetime learning of the clinical information that will improve patient care; and

Whereas, It is time for Texas physicians to take back the criteria for certifying the quality of Texas physicians; therefore be it

RESOLVED, That the Texas Medical Association cause to be created a TMA-endorsed 501(c)(3) nonprofit Texas Board of Medical Specialties to serve the purpose of certifying physicians practicing in Texas.

Fiscal Note: Start-up costs of $500,000 to $1 million

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 205
A-18

Subject: Graduate Associate Physicians

Introduced by: International Medical Graduates Section

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

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Whereas, The Association of American Medical Colleges projects the country's growing physician shortage may be as high as 121,000 by the year 2030; and

Whereas, U.S. medical school graduates and international medical graduates (IMGs) who are eligible to apply for graduate medical education in the United States have completed four years of medical education, and IMGs also hold degrees from their respective medical schools. In addition, IMGs must undergo a credentialing process by the Educational Commission for Foreign Medical Graduates (ECFMG) that includes a review of their educational background; passage of the same exams as U.S. graduates: United States Medical Licensing Exam Steps I and II-Clinical Knowledge and Clinical Skills; and passage of an English language proficiency exam; and

Whereas, IMGs typically bring with them a wealth of training, clinical, research, and teaching experience; and

Whereas, Many U.S. medical school graduates and ECFMG-certified IMGs are unable to obtain a residency position each year because of the limited number of available slots; and

Whereas, In 2018 at the national level, 30,232 first-year residency positions were available for 43,909 total applicants to the National Resident Matching Program (NRMP) Main Match; and

Whereas, In recent years, thousands of physicians have been unable to match to residency positions. In the 2018 NRMP, only 1,171 positions were offered in the post-match process in comparison with 8,063 applicants who did not match during the main match, including 1,078 U.S. medical school seniors and 5,280 IMGs (note that this excludes the American Osteopathic Association DO Match statistics); and

Whereas, The more years that pass during which a physician is unable to be matched, the more diminished the chances are that a match will occur at all, meaning four years of medical school for U.S. graduates and perhaps additional years of training for IMGs may be forfeited; and

Whereas, A large number of U.S. medical graduates and IMGs with specific U.S. legal status may be available to provide medical care with appropriate supervision; and

Whereas, TMA has a policy that has lost its relevance in light of advanced practice registered nurses providing patient care with as little as 700 hours of training in comparison with medical graduates with an estimated 15,000 hours of medical education who are not able to provide medical care; and

Whereas, Reevaluation is needed concerning TMA's 2015 policy statement 30.036 New Licensing Category for Assistant Physicians from the Committee on Physician Distribution and Health Care Access, which reads that TMA opposes the creation of special licensing pathways for physicians who have not

completed a year of residency training, recognizing primary care as encompassing specialties that require the completion of a full residency training process in the relevant specialties, and opposes lower standards of licensing for physicians and other health professions in medically underserved areas; and

Whereas, A state licensing category of graduate associate physician should be established in Texas to allow U.S. medical school graduates and ECFMG-certified international medical graduates with specific U.S. legal status to provide medical care under the supervision of licensed physicians. Supervising physicians should be practicing in a specialty for which there is an inadequate supply in the state, be in good standing, and have a minimum of five years of post-residency patient care experience; and

Whereas, The professional experience gained while working as graduate associate physicians may be beneficial to these physicians in future applications for residency positions; therefore be it

RESOLVED, That the Texas Medical Association delete TMA Policy 30.036 New Licensing Category for Assistant Physicians; and be it further

RESOLVED, That the Texas Medical Association draft a legislative bill and advocate for its passage during the 2019 Texas legislative session to establish a licensing program for qualified U.S. medical school graduates and ECFMG-certified international medical graduates with specific U.S. legal status who have not entered residency training due to a shortage of residency positions. The licensee would be limited to medical care provided under the supervision of a physician in a specialty for which there is a physician shortage, be in good standing, and have a minimum of five years of post-residency patient care experience.

Related TMA Policy:
30.036 New Licensing Category for Assistant Physicians: The Texas Medical Association opposes the creation of special licensing pathways for physicians who have not completed a year of residency training. Further, TMA recognizes primary care as encompassing specialties that require the completion of a full residency training process in the relevant specialties. TMA opposes lower standards of licensing for physicians and other health professions in medically underserved areas (CM-PDHCA Rep. 2-A-15).

Sources:
1. Physician Supply and Demand Through 2030: Key Findings, Association of American Medical Colleges, 2018.
2. National Resident Matching Program Advance Data Tables 2018 Main Residency Match®, Washington, DC, www.nrmp.org.

Revised for Supplement
Items in Supplement are in italics.

AGENDA
REFERENCE COMMITTEE ON SCIENCE AND PUBLIC HEALTH
Friday, May 18, 2018
JW Marriott San Antonio Hill Country Resort, Level 2, Cibolo Ballroom 5

1. Council on Science and Public Health Report 2 –Addressing the Diaper Gap (Resolution 305-A-17)

2. Council on Science and Public Health Report 3 – Vitamin D3 Supplementation (Resolution 320-A-17)

3. Council on Science and Public Health Report 4 – Implementing a Sugar-Sweetened Beverage Tax in Texas (Resolution 312-A-17)

4. Council on Science and Public Health Report 5 – Policy Review

5. Council on Science and Public Health Report 6 – Physician Role in Increasing Vaccination for HPV

6. Council on Science and Public Health Report 7 – Evidence-Based Management of Substance Use Disorders

7. Council on Science and Public Health Report 8 – Improving Electronic Health Records, Health Information Exchange and other Health Information Technology Products to Address Issues of Sex and Gender

8. Committee on Cancer Report 1 – Policy Review

9. Committee on Child and Adolescent Health Report 1 – Policy Review

10. Committee on Child and Adolescent Health Report 2 – Referred 2017 Resolutions Relating to Concussions and Head Injuries

11. Committee on Infectious Diseases Report 1 – Policy Review

12. Committee on Reproductive, Women's, and Perinatal Health Report 1 – Evaluation and Management of Stillbirth

13. Resolution 301 – Synthetic Cannabis Educational Resources for Providers (Medical Student Section)

14. Resolution 302 – Appropriate Physician Oversight of EMS Medical Practices (Travis County Medical Society)

15. Resolution 303 – "Bathroom" Bills (Harris County Medical Society)

16. Resolution 304 – Improving the LGBTQI+ Patient Health Care Experience (Medical Student Section)

17. Resolution 305 – Addressing Food Deserts in Texas (Medical Student Section)

18. Resolution 306 – Addressing HB 3859 – A Misstep in the Protection of Foster Care Children (Medical Student Section)

19. Resolution 307 – Restriction of Provisions of HB 2561 to Schedule II Drugs (Bexar County Medical Society)

20. Resolution 308 – Texas Prescription Drug Monitoring Program Data Integration into Electronic Health Record Technology (Medical Student Section)

21. Resolution 309 – Implementing Blood Glucose Screening in Texas Schools (Medical Student Section)

22. Resolution 310 – Community Health Workers and HPV Vaccination (Medical Student Section)

23. Resolution 311 – Encouraging Unstructured Playtime in School (Medical Student Section)

24. Resolution 312 – Identification Bracelets for Patients with Hearing Loss (Tarrant County Medical Society)

25. *Resolution 313 – Raising the Minimum Purchase Age for All Guns to 21 (Ryan Van Ramshorst, MD, Texas Pediatric Society)*

26. *Resolution 314 – Extreme Risk Protection Order and Gun Violence (Ryan Van Ramshorst, MD, Texas Pediatric Society)*

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 313
A-18

Subject: Raising the Minimum Purchase Age for All Guns to 21

Introduced by: Ryan Van Ramshorst, MD, Texas Pediatric Society

Referred to: Reference Committee on Science and Public Health

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Whereas, Gun violence is a public health threat to children; and

Whereas, While mass shootings always command our attention, children remain at risk for suicide, homicide, and unintentional injury from guns every day; and

Whereas, Firearm-related deaths are the third leading cause of death overall among U.S. children aged 1 to 17 years; and

Whereas, The minimum purchase age for handguns is 21; therefore be it

RESOLVED, That the Texas Medical Association support federal and state bills that raise the purchase age for all guns to be in line with the current minimum age for handguns, which is 21 years.

Related TMA Policy:
260.015 Firearms: Firearm use and gun control are highly controversial issues in Texas and the United States. The Texas Medical Association supports (1) the primary prevention of firearm morbidity and mortality through educating Texans about gun safety and responsible gun ownership; (2) the Texas Hunter Education and certification program developed by the Texas Department of Parks and Wildlife; (3) physicians in the clinical setting providing anticipatory guidance on responsible gun use in an informational, nonjudgmental manner, while respecting parental decision-making; (4) strict enforcement of federal and state gun control laws and mandated penalties for crimes committed with a firearm, including illegal possession; and (5) the use of trigger locks and locked gun cabinets to help prevent unintentional discharge (Res. 28S, p 176, A-93; Substitute CPH Rep. 3-A-08).

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 314
A-18

Subject: Extreme Risk Protection Orders and Gun Violence

Introduced by: Ryan Van Ramshorst, MD, Texas Pediatric Society

Referred to: Reference Committee on Science and Public Health

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Whereas, Gun violence is a public health threat; and

Whereas, Mental illness, domestic violence, and substance abuse are often factors that increase risk for gun violence; and

Whereas, Texas prohibits firearm possession by domestic violence misdemeanants but does not require securing firearms or ammunition from domestic abusers who have become prohibited from possessing firearms or ammunition under federal or state law; and

Whereas, Extreme risk protection orders provide a mechanism for family, household members, or law enforcement to petition a court to remove guns temporarily from people at proven risk of harming themselves or others; therefore be it

RESOLVED, That the Texas Medical Association advocate for legislation permitting extreme risk protection orders in Texas.

Related TMA Policy:
260.015 Firearms: Firearm use and gun control are highly controversial issues in Texas and the United States. The Texas Medical Association supports (1) the primary prevention of firearm morbidity and mortality through educating Texans about gun safety and responsible gun ownership; (2) the Texas Hunter Education and certification program developed by the Texas Department of Parks and Wildlife; (3) physicians in the clinical setting providing anticipatory guidance on responsible gun use in an informational, nonjudgmental manner, while respecting parental decision-making; (4) strict enforcement of federal and state gun control laws and mandated penalties for crimes committed with a firearm, including illegal possession; and (5) the use of trigger locks and locked gun cabinets to help prevent unintentional discharge (Res. 28S, p 176, A-93; Substitute CPH Rep. 3-A-08).

Revised for Supplement
Items in Supplement are in italics.

AGENDA
REFERENCE COMMITTEE ON SOCIOECONOMICS
Friday, May 18, 2018
JW Marriott San Antonio Hill Country Resort, Level 2, Cibolo Ballroom 7

1. *President's Report 1 – Physician-Led Initiatives to Address Maternal Mortality and Morbidity*

2. Council on Health Service Organizations Report 1 – Policy Review

3. Council on Health Service Organizations Report 2 – Medical Staff Rights and Responsibilities Bill of Rights

4. Council on Health Service Organizations Report 3 – Due Process Rights in Physician Contracts With Hospitals

5. Council on Socioeconomics Report 1 – Policy Review

6. Council on Socioeconomics Report 2 – Geographic Practice Cost Indices Policy

7. *Council on Socioeconomics Report 3 – Transparency and Payments for Prior Authorizations (Resolution 406-A-17)*

8. *Council on Socioeconomics Report 4 – Compensation of Physicians for Authorizations and Preauthorizations (Resolution 408-A-17)*

9. *Council on Socioeconomics Report 5 – Clearer Language Regarding the Physician's Role in Providing Auxiliary Aid for Effective Communication Under Current Federal Laws (Resolution 411-A-17)*

10. *Council on Socioeconomics Report 6 – Medicaid Work Requirements*

11. *Committee on Emergency Medical Services and Trauma Report 2 – Policy Review*

12. *Committee on Medical Home and Primary Care Report 2 – Policy Review*

13. Resolution 401 – Physicians Allowed To Delegate Ability to Enter EHR Data (McLennan County Medical Society)

14. Resolution 402 – Opposition to Medicaid Work Requirements (Ryan Van Ramshorst, MD, Texas Pediatric Society)

15. Resolution 403 – Under-Reporting of Optometric Diabetic Eye Examinations to Treating Physicians (Harris County Medical Society)

16. Resolution 404 – Opposition to Pain Score as Contributor to Hospital Financial Incentives (Medical Student Section)

17. Resolution 405 – Compensation to Physicians for Authorizations and Preauthorizations (Ori Z. Hampel, MD)

18. *Resolution 406 – Supporting the Reclassification of Complex Rehabilitation Technology (Resident and Fellow Section)*

REPORT OF TMA PRESIDENT

PRES Report 1-A-18

Subject: Physician-Led Initiatives to Address Maternal Mortality and Morbidity

Presented by: Carlos J. Cardenas, MD, President

Referred to: Reference Committee on Socioeconomics

In September 2017, the Texas Medical Association and the Texas Department of State Health Services (DSHS) hosted a Maternal Health Forum. Based on the interest in and need for solutions to issues identified at this forum, TMA President Carlos J. Cardenas, MD, established the TMA Maternal Health Congress to develop and frame TMA's policy and advocacy on maternal health for the 86th legislative session. The congress consisted of members of TMA's Council on Science and Public Health, Council on Legislation, and Select Committee on Medicaid, CHIP, and the Uninsured, along with numerous statewide physician experts representing multiple specialties.

On March 24, 2018, the TMA Maternal Health Congress began with 2.75 hours of continuing medical education (CME) programming on maternal mortality and morbidity (MMM) in Texas. More than 80 state health care leaders and TMA physician leaders attended the congress. TMA has created a maternal health website with links to videos of each of the CME presentations at www.texmed.org/MHCongress/.

Presenters identified poor access to health care; limited availability of reproductive health services; and benefit limitations of Medicaid, the Children's Health Insurance Program-Perinatal (CHIP-P), Healthy Texas Women (HTW), and the Family Planning Program (FPP) as contributors to Texas having unacceptable levels of MMM. In addition to access barriers, speakers commented on potential inaccuracies in the reporting of maternal mortality in Texas' death registry system and the impact on MMM of chronic underlying health conditions including hypertension, obesity, diabetes, and substance use among women of reproductive age.

David Lakey, MD, chief medical officer of the UT System and chair of the TMA Council on Science and Public Health, led a panel discussion to consider 36 physician and health leader proposals for improving MMM rates that were submitted in response to TMA's request. The majority of proposals addressed factors identified as barriers to care for women while other proposals addressed quality improvement initiatives, prevention and treatment of behavioral health disorders, and improvements to state health programs for women of reproductive age. A full description of the proposals is on the maternal health webpage.

Texas Maternal Mortality and Morbidity and Health Coverage

Maternal mortality and maternal morbidity are key reflections of overall women's health and access to timely health services before, during, and after pregnancy. Even with the recent state corrections to inaccuracies in the maternal death data from 2012, Texas' data paints a troubling picture: Texas has a high rate of maternal mortality relative to many states and developed countries. Among African-American women, the data are even more alarming. A July 2016 report from Texas' Maternal Mortality and Morbidity Task Force described the most dramatic increase in MMM occurring among black women, who account for 28.8 percent of maternal deaths but only 11.4 percent of Texas births.

Texas' rate of maternal morbidity — severe complications following birth — also have increased dramatically. Nationally, while 700 to 900 maternal-related deaths occur each year, researchers conservatively estimate another 35,000-45,000 women will suffer from a severe maternal complication.

In Texas, most deaths occurred 42 days or more after delivery, the same timeframe in which low-income women lose pregnancy-related Medicaid or other coverage. Texas still leads the nation in the number of people who lack health insurance.

Many assume Texas Medicaid covers all low-income and poor women. In reality, to qualify for Medicaid, a woman must have limited income ***and*** qualify based on pregnancy, disability, or extremely limited resources. Working-age, healthy adult women who earn more than $250 per month do not qualify. Pregnancy-related Medicaid coverage ends 60 days postpartum regardless of post-delivery complications. As a result, low-income Texas women must maneuver through federal, state, and locally funded health programs. Preventive care — including annual exams and contraception— and basic primary care can be obtained via the state's women's preventive health programs, but access and availability varies considerably across the state. Moreover, the demand for services far exceeds capacity. For women needing specialty care, including treatment for substance use disorders (SUDs), the picture is even more dire. DSHS estimates only 9 percent of all Medicaid enrollees, including pregnant women, with a substance use disorder are able to obtain treatment. In 2015, the agency had funding to provide SUD treatment to fewer than 600 indigent pregnant women despite this being a priority population.

For low-income immigrant women, Medicaid is unavailable, except in emergency situations. If a low-income immigrant woman is pregnant, she can enroll in CHIP-P, which covers limited prenatal visits, delivery, and two postpartum visits. CHIP-P does not cover treatment of acute or chronic conditions unrelated to the delivery, including treatment for asthma, heart disease, and mental health and substance use disorders. CHIP-P covers care to support the fetus and not the mother. For those covered by CHIP-P, there is no automatic enrollment into Medicaid if income status or eligibility changes (for a detailed overview of women's health care programs, go to www.texmed.org/MHCongress/.

Adult women with an income between 100 percent and 400 percent of the federal poverty level qualify for federal subsidies for coverage purchased via the federal health care marketplace, though affordability of policies purchased there is an increasing concern.

Overview of Proposals and Testimony

Members of the Maternal Health Congress received testimony on each of the 36 proposals and organized them into five areas: (1) access to care, (2) behavioral health prevention and treatment, (3) access to long-acting reversible contraceptives, (4) quality improvement initiatives, and (5) public health programming.

(1) Access to care

Half of the 36 proposals urged TMA to ardently pursue reforms that increase health care coverage for women. Nineteen percent of adult Texas women lack health care coverage, three points higher than the overall statewide average. Rates are higher among women of color, low-income women, and immigrants. Uninsured women are less likely to receive preventive primary and specialty care they need to be healthy, foregoing everything from annual well-woman exams and high blood pressure screenings to behavioral health care and prescription medications.

The lack of regular medical care means uninsured (and underinsured) women tend to have poorer health outcomes, which is borne out in Texas by high rates of MMM. Late entry to prenatal care has been independently linked to increased rates of maternal mortality and severe maternal morbidity According to the Maternal Mortality and Morbidity Task Force and DSHS Joint Biennial Report, July 2016, 60 percent of maternal deaths occur between six weeks post-delivery and one year following delivery. One important

barrier for postpartum care to low-income women is lack of Medicaid coverage. Fifty-three percent of Texas births are paid by Medicaid, but Medicaid coverage for these low-income pregnant women ends 60 days postpartum with no exception. When this happens, women no longer have access to comprehensive coverage to manage and treat pregnancy-related complications.

Federal law allows states to extend coverage to no-disabled, working-age adults earning less than 138 percent of poverty ($16,753 per year for an individual; $34,638 for a family of four), with 90 percent of the costs paid by the federal government. The law also gives states some flexibility to customize their programs to meet their own residents' needs, such as tailoring benefits or requiring copayments. The law does not allow states to narrow eligibility to include only certain populations. However, the current administration may be willing to accommodate a request to cover only low-income adult women or other subset populations.

Existing TMA policy 190.032 Medicaid Coverage and Reform, adopted in 2013, supports the use of federal funds to develop a Texas-designed program to provide health insurance to eligible low-income adults with incomes below 138 percent of poverty. To date, 33 states have done so, and several others have submitted proposals to the Centers for Medicare & Medicaid Service for review.

Participants in the congress readily acknowledge that Texas' legislative and budgetary environment in 2019 will make it challenging for TMA to make progress towards implementing existing policy for all low-income adults. But bipartisan support to address Texas' maternal health crisis might be an opportunity to at least improve coverage for women of reproductive age. There was widespread testimony in support of undertaking all available options to substantially reduce rates of MMM. Motherless households can present dire long-term consequences for children, families, and the state's economy. Several testifiers spoke to the detrimental impact of adverse childhood events — such as the loss or disability of a mother — to the long-term health of families and communities.

Extending coverage not only would improve women's health but also is fiscally sound policy because Texas uses general revenue dollars to pay for services that could be covered by federal dollars. As just one example, Texas could mitigate a significant portion of its Child Protective Services (CPS) costs by investing in appropriate substance use disorder treatment for pregnant and postpartum women. Estimates show that two-thirds of CPS interventions stem from SUDs among parents.

TMA will continue to promote legislative private-public solutions to achieve universal health care coverage consistent with existing TMA policy.

(2) Behavioral health

According to the most recent data compiled by the Texas Maternal Mortality and Morbidity Task Force, drug overdoses are the leading cause of maternal death during and after pregnancy, with most deaths occurring after the 60-day postpartum period. In the majority of cases, a combination of drugs was used, though opioids were detected in 58 percent of cases. For women enrolled in Medicaid, substance use disorder treatment is available as well as treatment for co-occurring mental health conditions. Because services are not uniformly available statewide and capacity at existing facilities is limited, few eligible women actually receive the services despite pregnant women being a priority population. When pregnancy-related Medicaid ends, adult enrollees are automatically enrolled in Healthy Texas Women, but HTW covers only basic depression treatment. Specialty care is not covered. Other services like counseling or therapy also are not included under HTW. The Family Planning Program does not provide mental health screening or treatment. Pregnant and postpartum women ineligible for Medicaid do have access to Texas' publicly funded SUD treatment, but there are limitations on what services are available and narrow eligibility criteria.

To prioritize access to SUD treatment for pregnant and postpartum women, reduce maternal mortality and morbidity from SUD, and enhance SUD treatment, testimony emphasized that treatment should cover all pregnant women and postpartum women regardless of their drug of choice or method of use, and include accommodations for mothers and babies to stay together. Addressing diagnosis and treatment of SUD without stigma and with the goal of maintaining the mother-baby dyad is imperative.

Mental health conditions such as maternal depression also affect health outcomes for pregnant and postpartum women. These women may experience a mental health condition alone or in addition to a SUD. Co-occurring disorders require proper diagnosis and treatment. The Texas Maternal Mortality and Morbidity Task Force reports that suicide is one of the top reasons for maternal death after seven days postpartum.

TMA will continue to advocate that pregnant and postpartum women be prioritized for treatment of a substance use disorder. Part of that advocacy effort is to ensure the availability of support services for children, eliminating any possibility that child care is a barrier to the mother's participation in treatment. In addition, TMA will explore and advance opportunities such as Project Echo and others that promote telemedicine and telehealth solutions to increase access to treatment for pregnant and postpartum women with substance use disorders.

TMA will encourage the American College of Obstetricians and Gynecologists (ACOG) to support physician screening of patients by identifying payment codes for screening and providing information on evidence-based approaches developed by the U.S. Substance Abuse and Mental Health Services Administration to identify and support patients with a substance use disorder.

(3) Long-acting reversible contraceptives

In Texas approximately half of pregnancies are unplanned. Increasing women's ability to plan and space their pregnancies leads to lower abortion rates, improved infant and maternal health, educational and economic opportunities for women and their families, and cost savings for the state. Women who plan pregnancies are more likely to get prenatal care early, have healthier pregnancies, and reduce their risk of having babies born too early or too small. Additionally, women whose pregnancies are unintended are more likely to have a short interval between pregnancies —18 months or less — significantly increasing health risks for both women and infants.

Besides the impact to women and families, unintended pregnancies increase Medicaid costs. The Texas Health and Human Services Commission (HHSC) reports that in 2015 Medicaid paid for 52 percent of all births in Texas, at a cost of $3.5 billion per year for pregnancy- and delivery-related services for moms and infants in the first year of life.

Continued reductions in the number of unplanned pregnancies must be a key component of Texas' efforts to improve maternal health. At the congress, physicians urged TMA to undertake advocacy and educational initiatives to increase women's access to long-acting reversible contraceptives (LARCs), such as implants and intrauterine devices, which are 20 times more effective than other methods. While Texas Medicaid, Healthy Texas Women, and the Family Planning Program do cover LARCs as a benefit, physicians testified their usage among women who want LARCs still remains low, despite legislative guidance to HHSC to increase availability through policy and educational initiatives. Many physicians, hospitals, and clinics do not offer same-day availability of LARCs for women because of low payment, logistical hurdles, and insufficient training on how and when to use LARCs.

TMA's policy 260.075 Preventive Health Care for Texas Women promotes availability of long-acting reversible contraceptives to women. TMA will convene an expert panel of physicians, hospital

administrators, nurses, LARC manufacturers, and state agency officials to identify and resolve barriers preventing widespread availability of LARCs to low-income women.

(4) Quality improvement initiatives

Three proposals called for more consistency in implementing guidelines, standardized protocols, evidence, and other proven resources to reduce maternal mortality and morbidity. Several resources and tools were discussed, including ACOG and the national Alliance for Innovation on Maternal Health (AIM) Maternal Safety Bundles; the Association of Women's Health Obstetric and Neonatal Nurses safety bundles; and toolkits developed by the California Maternal Quality Care Collaborative, which provide important patient safety advances for the health of the mother and child.

Congress attendees discussed making use of the AIM bundles voluntary but readily available to hospital medical staff leaders. In particular, several testifiers said the AIM Maternal Safety Bundles for Obstetric Hemorrhage and for Severe Hypertension in Pregnancy should be prioritized. Women with cardiovascular risk in pregnancy and those who develop hypertension and preeclampsia with a targeted follow-up strategy also should be prioritized. There was widespread support for the development and implementation of quality-based initiatives with standardized protocols and best practices to improve prenatal, labor and delivery, and postpartum health outcomes.

(5) Public Health Interventions

Thirteen proposals submitted called for a range of public health activities to prevent or address maternal mortality and morbidity. These proposals addressed physician training and education, public awareness, improving current benefits and resources of state public health programs for women, and identifying chronic conditions associated with MMM.

State and local public health agencies have a key role in monitoring, and assessing public health and an important component of that role is the analysis of maternal health data. Maternal death records and other data must be accurate to enable the state to assess maternal health status and to identify populations at risk. These data are then used to inform the public on how to prevent adverse health events and to develop interventions to improve health status for women of reproductive age.

Discussion supported proposals that called for better surveillance of maternal mortality and improving physician access to the health records of women of reproductive age, especially those at higher risk of poor maternal health outcomes. They noted that physicians often do not have access to the patient's complete social or medical history. Not infrequently, physicians use an electronic health record, but health information exchange systems do not support interoperability, so physicians cannot access all of a woman's health records. Further, the state's limited health coverage prevents or complicates a physician's ability to provide optimal follow-up care. Several testifiers focused on the importance of quality and accuracy of death records. Suggestions for improving the records included partnering with DSHS to train physicians in their use and working with hospitals to ensure death summaries are captured accurately as part of the review of maternal deaths.

A member of the Texas Maternal Mortality and Morbidity Task Force proposed that TMA engage physicians in understanding the implicit racial bias that may influence care provided to some pregnant women, and black women in particular. TMA will work with others to convene a physician focus group to assess physician bias as a strategy to reduce health disparities. National models are not available, and this provides an opportunity for TMA to facilitate Texas' leadership in this area.

There also was testimony in support of TMA's role in promoting public awareness, such as through the Texas Medical Association Foundation providing seed grants to TMA members, residents, and medical students. These grants could support research and quality projects related to maternal mortality and

morbidity; implement best practice guidelines for perinatal and postpartum care; support local awareness activities such as a "march for mothers"; and increase the public's awareness of the importance of early entry into prenatal care, follow-up postpartum care, and the warning signs of postpartum mood disorders.

Physicians spoke in support improving provider networks and quality of current public women's health programs including Healthy Texas Women and the Family Planning Program; supporting payment for screening, brief intervention, and referral to treatment for substance use disorders; and ensuring HTW and FPP provide additional health benefits for women at greater health risk. Offering women who smoke access to counseling and education to support smoking cessation would be an example.

TMA must advocate for the enhancement of the state's public health programs for women of reproductive age and ensure these state programs address the prevention and management of chronic diseases that have an impact on maternal health. This includes a focus on evidence-based disease prevention services such as screening for substance use and smoking cessation programs, as well as appropriate support services such as transportation and support for models of maternal medical homes.

Conclusion

The TMA Maternal Health Congress provided a unique opportunity for TMA members and allied organizations to articulate a compelling case for Texas to invest much-needed resources towards substantially improving the health for women of childbearing age. Texas must do a much better job providing physicians, hospitals, and communities with accurate, timely, and reliable data on women's health — data that can be used to design effective policy and programmatic interventions.

Pregnancy is a brief period in most women's lives. To ensure healthy birth outcomes, Texas women must have access to appropriate preventive, primary, and specialty care across their reproductive lifespans if the state is going to reduce unacceptable levels of maternal mortality and morbidity. As one testifier said, the death — or grievous illness or injury — of any mother is one too many. Let's get to work.

Recommendation 1: That the Texas Medical Association pursue legislation authorizing the Texas Health and Human Services Commission to: (a) submit a federal Medicaid 1115 demonstration waiver requesting approval to design and implement a tailored health benefits program for eligible uninsured women of childbearing age that provides 12 months' continuous coverage for preventive, primary, and specialty care coverage, including behavioral health services, to women before, during and after pregnancy; (b) ensure adolescents aging out of the Children's Health Insurance Program (CHIP) are seamlessly enrolled into Healthy Texas Women; (c) ensure women losing CHIP-Perinatal are seamlessly connected to the Family Planning Program to avoid gaps in preventive health care; and (d) implement initiatives that improve early-entry prenatal care, including a statewide campaign on the importance of prenatal care during the first trimester, expediting Medicaid eligibility and enrollment for pregnant women, promoting use of telemedicine for routine prenatal care, and reforming the Medicaid transportation program to ensure pregnant women with young children can travel with their children to obtain preventive services.

Recommendation 2: That the Texas Medical Association develop a continuing medical education program for physicians that covers: (1) information on publicly funded support services for women with substance use disorders (SUDs); (2) guidelines for the prescribing of opioids and pain management; (3) efforts to better connect SUD treatment physicians and providers with women's health physicians and providers to ensure women undergoing treatment for these disorders are able to obtain preventive health care services, and (4) diagnosis and treatment of behavioral health issues such as anxiety and depression.

Recommendation 3: That the Texas Medical Association develop legislation to: (1) allocate sufficient state resources to resolve red tape and payment barriers preventing widespread adoption of long-acting

reversible contraceptives (LARCs), including ensuring the state pays physicians, hospitals, and clinics their full LARC acquisition costs so women can obtain a LARC according to clinical best practice; (2) ensure availability of LARCs immediately following delivery to women enrolled in the Children's Health Insurance Program (CHIP)-Perinatal; and (3) remove roadblocks preventing teens from simultaneously enrolling in CHIP and Healthy Texas Women to obtain contraceptive services with parental consent.

Recommendation 4: That the Texas Medical Association develop a continuing medical education program, in partnership with the American College of Obstetricians and Gynecologists District XI (Texas Chapter), Texas Association of Obstetricians and Gynecologists, and Texas Academy of Family Physicians, designed to increase patients' and physicians' awareness of long-acting reversible contraceptives as the most effective form of contraception.

Recommendation 5: That the Texas Medical Association develop continuing medical education programs on: (1) quality-based initiatives with standardized protocols and best practices to improve prenatal, labor and delivery and postpartum health outcomes; and (2) implementation of hospital-based quality improvement initiatives that reduce maternal mortality and morbidity, based on best practice and standardized protocols.

Recommendation 6: That the Texas Medical Association introduce legislation to improve the quality of health data records for women of reproductive age to support patient health, the quality of maternal death records, and the exchange of health information for women of reproductive age. The legislation should encompass: (a) support of comprehensive efforts to improve the state's surveillance of maternal mortality and ensuring Texas' maternal death records have accurate information on the factors associated with maternal deaths; (b) mandates to the Texas Department of State Health Services to develop training and educational materials for physicians and other medical certifiers to accurately report maternal deaths; and (c) mandates to electronic health record systems to improve the interoperability of health records, including resolution of barriers that are preventing the exchange of health information critical to providing quality maternal and postpartum care.

Recommendation 7: That the Texas Medical Association develop a public campaign to increase awareness of the importance of early and timely maternal health care and promote existing community-based efforts.

Fiscal Note: $30,000

Sources:

1. Nearly Dying In Childbirth: Why Preventable Complications Are Growing In U.S., National Public Radio, Dec. 22, 2017.
2. Health Insurance Coverage and Health — What the Recent Evidence Tells Us, Benjamin D. Sommers, MD, PhD; Atul A. Gawande, MD, MPH; and Katherine Baicker, PhD, *New England Journal of Medicine*, August 2017.
3. Texas Maternal Mortality and Morbidity Task Force, 2016.
4. Texas HHSC, Medicaid and CHIP: An Overview, February 2017.

Supplement

REPORT OF COUNCIL ON SOCIOECONOMICS

CSE Report 3-A-18

Subject: Transparency and Payments for Prior Authorizations (Resolution 406-A-17)

Presented by: John T. Carlo, MD, Chair

Referred: Reference Committee on Socioeconomics

Background

In May 2017, the TMA House of Delegates referred Resolution 406, Transparency and Payments for Prior Authorizations, to the Council on Socioeconomics.

The resolution as proposed requires the Council on Socioeconomics to review the following:

- 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 since 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 Authorization 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 to mandate that 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.

Managed care contracts between a payer and a physician contain specific information covering the obligations and duties to which a physician has agreed. Some obligations may be clearly defined, such as the promise to provide medical services to patients in exchange for listings in provider manuals and payment. Others may require further investigation by the physician, such as not being allowed to charge for services considered integral to or a component of other services provided. The policies and procedures included in managed care contracts encompass a wide range of topics, all of which affect the physician's practice. There may be policies and procedures specifying which services are covered, how the managed care organization will pay for those services, and how the physician can bill the plan enrollee. Some managed care contracts prohibit the physician from charging both the payer and the patient for the administrative costs associated with obtaining prior authorization approval. If the patient is out-of-network, then the physician has no contractual relationship with the plan.

Shifting the costs associated with prior authorizations to patients could disrupt the patient-physician relationship. If patients are unwilling or unable to pay the physician for prior authorization administrative costs, they could elect to forgo necessary medical care.

The 85th Texas Legislature in Regular Session passed S.B. 680 last year, providing a more standardized process for physician exception requests to step therapy drug protocols. Prior to this new law, the only real protection related to step therapy protocols was a prohibition on health plans adding a step therapy protocol mid-plan year.

Under current Texas law there already exist notice and disclosure requirements of certain information such as health benefit plan prescription drug formularies and step therapy protocols.

In January 2017, the American Medical Association and a coalition of 16 other organizations representing patients, physicians, medical groups, hospitals, and pharmacists released a set of 21 principles related to prior authorization and utilization management reform. The principles cover clinical validity, continuity of care, transparency and fairness, timely access and administrative efficiency, and alternatives and exemptions. They provide a roadmap to guide long-overdue reform of utilization management requirements like prior-authorization and step-therapy requirements. Although TMA was not part of the initial coalition developing the 21 principles, the Association did sign-on in support of the principles.

Electronic Prior Authorization (ePA) is the transmission of information requesting coverage of a specific medication for a specific patient via fax, telephone or web portals between a physician and a claims payer. The standardization of electronic prior authorization is a process integrated into a physician's electronic health record (EHR) and used for medications. Advantages to ePA include workflow efficiencies, standardization, and faster access to medications by patients. Not only do EHR vendors need to be equipped to offer ePA but also health plans and benefit managers must be able to support it. Some companies already offer ePA technology at no cost, and advocacy to make ePA free for physicians is ongoing.

At the 2016 AMA Annual Meeting, the House of Delegates adopted Council on Medical Service Report 7-A-16 Prior Authorization Simplification and Standardization. In addition, the AMA Board of Trustees asked the Council on Medical Service to provide a report on this topic at the 2017 AMA Annual Meeting. The final adopted recommendations in the 2017 AMA report address and support the concerns outlined in TMA Resolution 406. Members of the Texas Delegation to the AMA were instrumental in the development of the 2017 adopted recommendations.

Summary

The overwhelming number of medical services requiring prior authorization has created not only an administrative burden on physician practices but also potential barriers to patients getting medically necessary tests and treatment. The time-consuming processes and associated costs with prior authorization are diverting valuable resources away from direct patient care. Requiring health plans, third-party payers, benefit managers, and utilization review entities to disclose their statistics regarding prior authorization approvals and denials will help educate patients on why medically necessary care ordered by their physician cannot always be delivered in a timely manner.

Recommendation 1: The council recommends that TMA policy 235.034 be amended as follows:

235.034 **Authorizations Initiated by Third-Party Payers<u>, Benefit Managers, and Utilization Review Entities</u>**: The Texas Medical Association supports policy <u>and legislation</u> that <u>(1)</u> third-party payers<u>, benefit managers, and utilization review entities</u> 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<u>; (2) third-party payers, benefit managers, and utilization review entities should disclose all prior authorization requirements</u>

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).

Recommendation 2: The council recommends adopting new TMA policy on standardized electronic prior authorization transactions:

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.

Recommendation 3: That Council on Socioeconomics Report 3-A-18 be adopted in lieu of Resolution 406-A-17.

Related TMA Policy:
120.003 Health System Reform Managed Care: To provide a basic framework for association policies and activities in health system reform, the Texas Medical Association: ... (4) supports genuine relief from red-tape hassles and excessive administrative costs of health care; … (7) supports the right of a physician organization to negotiate at the federal or state level for payment of physician services, quality and utilization review, professional liability reform, and to reduce the hassle and cost of regulation; … (Second Supplemental BOT, p 36P-36S, A-93; amended CSE Rep. 6-A-03; reaffirmed CSE Rep. 1-A-13).

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

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

145.024 Medical Decision Makers Licensed in Texas: The Texas Medical Association will (1) support legislation that would amend the Texas Insurance Code to require utilization review agents to be supervised by physicians licensed to practice medicine in the State of Texas and all denials of care based on medical necessity to be made by physicians licensed to practice medicine in the State of Texas and in the same or similar specialty as the treating physician seeking authorization of medical care; and (2) work

to amend the Medical Practice Act to clearly include the supervision of persons performing pre-certification or preauthorization based on medical necessity as the practice of medicine; and include any denial of pre-certification or pre-authorization of medical services based on a determination of medical necessity as the practice of medicine (Amended CL Rep. 1-A-08; amended CSE Rep. 5-A-16).

REPORT OF COUNCIL ON SOCIOECONOMICS

CSE Report 4-A-18

Subject: Compensation of Physicians for Authorizations and Preauthorizations (Resolution 408-A-17)

Presented by: John T. Carlo, MD, Chair

Referred to: Reference Committee on Socioeconomics

The 2017 House of Delegates referred Resolution 408 to the Council on Socioeconomics for study and report back at TexMed 2018. The resolution requested the following:

> 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 specified 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 requests contained in the resolution would require rewriting existing federal and state laws that address:

- 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.

There also are concerns about the significant state and federal legislative changes required to implement this resolution. Additionally, legislative activity required to modify existing Texas prompt payment law would open up the possibility of changes to other parts of the law currently favorable to physicians.

Current Procedural Terminology (CPT) is a standardized code set used to report medical procedures and services performed by physicians. The code set is used by entities such as health insurance companies, government payers, and accreditation organizations. All electronic financial and administrative transactions require the use of CPT codes. Physicians who refrain from submitting electronic claims are not required to use any of the standardized code sets. Physicians who elect to establish a cash-only-based

practice are not contracted with any health plans and/or networks. They also do not need to use CPT codes because they do not submit claims to health plans and/or networks. With the movement toward bundled payment methodology, physicians may contract directly with health plans for payment. The services included in those bundled payments cannot be defined by one single code set. The physician may agree contractually to an arrangement that requires data reporting outside the scope of the established code sets and therefore would not be subject to The Health Insurance Portability and Accountability Act of 1996 (HIPAA) reporting requirements.

The use of CPT as a tool to calculate the billable minutes is a modification of CPT. As such it would require review by the American Medical Association, which holds copyright in CPT, and use or reprinting of CPT in any product or publication requires a license.

Existing TMA policy on authorizations initiated by third-party payers, policy 235.034 says, "The TMA supports policy that third-party payers 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."

Recommendation: That Resolution 408-A-17 not be adopted.

Supplement

REPORT OF COUNCIL ON SOCIOECONOMICS

CSE Report 5-A-18

Subject: Clearer Language Regarding the Physician's Role in Providing Auxiliary Aid for Effective Communication Under Current Federal Laws (Resolution 411-A-17)

Presented by: John T. Carlo, MD, Chair

Referred to: Reference Committee on Socioeconomics

Background

In May 2017, the TMA House of Delegates referred Resolution 411, Clearer Language Regarding the Physician's Role in Providing Auxiliary Aid for Effective Communication Under Current Federal Laws to the Council on Socioeconomics (CSE). The resolution requested that:

- TMA advocate with interested parties to support clarification of current federal laws in regards to what constitutes effective communication towards patients with interpretative needs;
- TMA support the creation of clearer guidelines with the Americans With Disabilities Act (ADA) for what is considered undue burden and recognize that negative resolution flow be a consideration;
- TMA support measures to provide smaller practices that have limited resources and availability of interpretive services with better legal protections and accessibility to qualified medial interpreters; and
- The Texas Delegation to the American Medical Association bring this resolution to the AMA House of Delegates.

Interpreters for Hearing-Impaired Patients

In 2013, the house asked CSE to review the issue of insurance coverage for the cost of interpreters for hearing-impaired patients. The Americans With Disabilities Act of 1992 (ADA) prohibits discrimination against people based upon their disability or perceived disability, or for advocating for a person with a disability. This includes charging the patient for the cost of a qualified interpreter, if necessary.

Currently, only Texas Medicaid pays physicians for the cost of a qualified interpreter and only in limited situations. It is important to note that under Title III of the ADA, physicians, not the hearing impaired person, choose the interpreter, if one is necessary. A physician "need not accept and pay for the services of a sign-language interpreter who is unilaterally retained by the family of a deaf patient, when the doctor has had no opportunity to make his own arrangements."

Existing TMA policy 90.002 American with Disabilities states: The Texas Medical Association supports seeking a change in the American Disabilities Act to permit public sector funding of interpretation services for the deaf (Res. 28R, p195, I-93; reaffirmed CM-R Rep. 3-A-03; reaffirmed CSE Rep. 2-A-14).

Limited English Proficiency (LEP) Background

A LEP person is an individual "whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English." The prohibition of discrimination against LEP persons began with the Civil Rights Act of 1964. Since then the issue has been reviewed by the Supreme Court and has been a subject of multiple executive orders. Section 1557 of the Affordable Care Act (ACA) prohibits certain entities that administer "health programs and activities" from discriminating

again individuals based on race, color, national origin, sex, or disability. Although Section 1557 does not mention discrimination again individuals based on language, the rules follow a long-established precedent interpreting a prohibition on national origin discrimination to require entities to take reasonable steps to provide meaningful access to individuals with LEP.

The U.S. Department of Health and Human Services (HHS) issued final rules implementing Section 1557 on May 18, 2016. The rules, found in Title 45 Code of Federal Regulations Part 92, lay out an important compliance framework for physicians and health care providers regarding all types of discrimination, including discrimination against LEP persons. This framework includes factors to help entities determine the reasonable steps they must take to provide meaningful access to LEP person, required notices entities must make available, and assurances that entities must make when applying for federal financial assistance. Most physicians will find themselves subject to Section 1557, which means a physician is obligated to take reasonable steps to provide meaningful access to services and programs to eligible LEP persons. Enforcement of Section 1557 rules include informal means such as "requiring covered entities to keep records and submit compliance reports to the Office of Civil Rights, conducting compliance reviews, and complaint investigation, and providing technical assistance and guidance." If informal means of enforcing the ADA provisions do not bring about compliance, HHS is authorized to enforce compliance by "suspension of, termination of, or refusal to grant or continue Federal assistance, or by referral to the Department of Justice with a recommendation to bring proceedings to enforce any rights of the United States."

An article in the December 2016 issue of *Texas Medicine* focused on physicians' concerns about the cost of complying with these requirements.

Existing Policy

TMA already maintains policy related to the issue of payment for interpreting services. The following statement was adopted at the 2017 meeting of the House of Delegates: 235.037 Public and Private Sector Funding of Interpretation Services for Limited English Speakers and American Sign Language: The Texas Medical Association will: (1) advocate with interested parties to support expanded reimbursement from Medicaid, the Children's Health Insurance Program, and other public sector insurers, as well as private sector coverage for interpretive series; (2) support expanded legislation that might arise concerning reimbursement for interpretive services for both American Sign Language and limited English speakers; and (3) advocate for increased access to qualified medical interpretive services for physicians (Res. 410-A-17).

Recommendation: That Resolution 411-A-17 not be adopted.

Related TMA Policy:

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

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

235.037 Public and Private Sector Funding of Interpretation Services for Limited English Speakers and American Sign Language: The Texas Medical Association will: (1) advocate with interested parties to support expanded reimbursement from Medicaid, the Children's Health Insurance Program, and other public sector insurers, as well as private sector coverage for interpretive series; (2) support expanded legislation that might arise concerning reimbursement for interpretive services for both American Sign

Language and limited English speakers; and (3) advocate for increased access to qualified medical interpretive services for physicians (Res. 410-A-17).

265.022 Improving Patient Care Quality by Decreasing Communication Errors from Language Barriers: The Texas Medical Association recognizes that residents should be informed about laws and regulations on the use in clinical practice of medical translators, interpreters, and other communication services for patients who are deaf, hearing impaired, or with limited English proficiency. Because policies differ among institutions, each training site should educate residents on site-specific policies including orientation on the availability of such services and how and when such services should be utilized. Further, residents should be provided the broader education needed, including information on the potential liability risk, to ensure compliance with laws and regulations on the use of translator, interpreter, and other communication methods when the resident completes training and enters medical practice. (CME Rep. 2-A-13).

Related AMA Policy:

Interpreters For Physician Visits D-90.999. Our AMA continues to monitor enforcement of those provisions of the ADA to assure physician offices are not subjected to undue burdens in their efforts to assure effective communication with hearing disabled patients. (BOT Rep. 15, I-98; Reaffirmation I-03; Modified: BOT Rep. 28, A-13; Reaffirmation A-14)

Language Interpreters D-385.978. Our AMA will: (1) continue to work to obtain federal funding for medial interpreter services; (2) redouble its efforts to remove the financial burden of medical interpretive services from physicians; (3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement; (4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and (5) work with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense. (Res. 907, I-03; Reaffirmed in lieu of Res. 722, A07; Reaffirmation A-09; Reaffirmation A-10; Reaffirmed: CMS Rep.5, A-11; Reaffirmed in lieu of Res. 110, A013; Reaffirmation A-17)

Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924. AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care; (2) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with our without an interpreter who is competent and culturally sensitive; (3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital, and other electronic or telecommunication services with the understanding, however, of these tools' limitations — to aid LEP patients' involvement in meaningful decisions about their care; and (4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements. (BOT Rep. 8, I-02; Reaffirmation I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation A-09; Reaffirmed: CMS Rep.5, A-11; Reaffirmed in lieu of Res. 110, A-13; Reaffirmation A-17)

Discrimination Against Physicians by Health Care Plans H-285.985. Our AMA: … (3) will support passage of federal legislation to clarify the Americans With Disabilities Act to assure that coverage for interpreters for the hearing impaired be provided for by all health benefit plans. Such legislation should also clarify that physicians practicing in an office setting should not incur the costs for qualified

interpreters or auxiliary aids for patients with hearing loss unless the medical judgement of the treating physician reasonably supports such a need.; (BOT Rep. 18, I-93; Appended by BOT Rep. 28, A-98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed in lieu of Res. 110, A-13)

Availability and Payment for Medical Interpreters Services in Medical Practices H-385.929. It is the policy of our AMA to: (1) the fullest extent appropriate, to actively oppose the inappropriate extension of the OCR LEP guidelines to physicians in private practice; and (2) continue our proactive, ongoing efforts to correct the problem imposed on physicians in private practice by the OCR language interpretation requirements. (BOT Rep. 25, I-01; Reaffirmation I-03; Reaffirmed: Res. 907, I-03; Reaffirmation A-09; Reaffirmation A-17)

REPORT OF COUNCIL ON SOCIOECONOMICS

CSE Report 6-A-18

Subject: Medicaid Work Requirements

Presented by: John T. Carlo, MD, Chair

Referred to: Reference Committee on Socioeconomics

Background

On Jan. 11, 2018, the Centers for Medicare & Medicaid Services (CMS) issued new policy guidance allowing states to obtain federal waivers to require certain working-age adult Medicaid enrollees to work in exchange for keeping their Medicaid benefits. CMS issued the guidance at the behest of 10 states that argued that implementing work requirements would make people healthier and more self-reliant.

In anticipation that Texas also would eventually request a waiver, the TMA Select Committee on Medicaid, CHIP and the Uninsured, which reports to the council, reviewed the guidance at its winter meeting.

Federal law gives the secretary of the U.S. Department of Health and Human Services broad discretion to waive some provisions of the Social Security Act as long as the waiver promotes the objectives of the Medicaid program. Many national Medicaid experts question the legality of the policy decision, noting that all other administrations — Republican and Democratic — have concluded that imposing such a requirement would be inconsistent with Medicaid's statutory mission to provide health care to eligible low-income people. Already, one lawsuit challenging the policy has been filed. Nevertheless, CMS is moving ahead. Within days of its announcement, it had approved waivers submitted by Kentucky, Indiana, and Arkansas and is reviewing some half-dozen others.

According to the guidance, states may not impose work requirements on pregnant women, people with disabilities, seniors, or the medically frail. Patients undergoing treatment for opioid or other substance use disorders must be given "reasonable accommodations," though CMS does not define what that means. The guidance goes on to encourage, but not require, states to broadly define "work" to include activities such as attending school or vocational training, caring for a child or parent, or volunteering, particularly because many Medicaid enrollees live in communities with high unemployment rates. Most of the state waivers submitted thus far include some exceptions, but there is considerable variation.

In announcing the new guidance, CMS Administrator Seema Verma said the intent of the new policy is to "make a positive and lasting difference in the health and wellness of our beneficiaries" — a goal everyone shares. Indeed, some studies confirm that people who work or who are otherwise engaged in meaningful community activities are happier and healthier. Yet the new policy belies the fact that the vast majority of working-age Medicaid patients already work and perpetuates a stereotype that people who are poor do not.

Moreover, the waivers approved thus far reveal that states will be allowed to suspend or deny Medicaid coverage for patients who fail to submit timely documentation of gainful employment or who do not work the minimum number of required hours. Indeed, under Arkansas' recently approved waiver, which will take effect in June, failure to submit proof of compliance could mean loss of Medicaid for up to nine months. In other words, states will be using onerous paperwork as a deterrent to Medicaid enrollment,

which will undermine the very health and well-being of the people the policy purports to help. After all, without coverage, chronically ill people will get sicker, not healthier.

TMA Select Committee members expressed strong support for any and all constructive initiatives to help low-income people obtain gainful employment or engage in other community activities. Yet of the low-income people who do not work, many face significant barriers to doing so, including low literacy level, lack of job training, poor health, or unreliable transportation. If Texas wants to encourage more Medicaid enrollees to work, it should help people overcome these barriers. Washington State, for example, helps people locate affordable housing and identifies employers who will work with people with a prior criminal history, another barrier to employment.

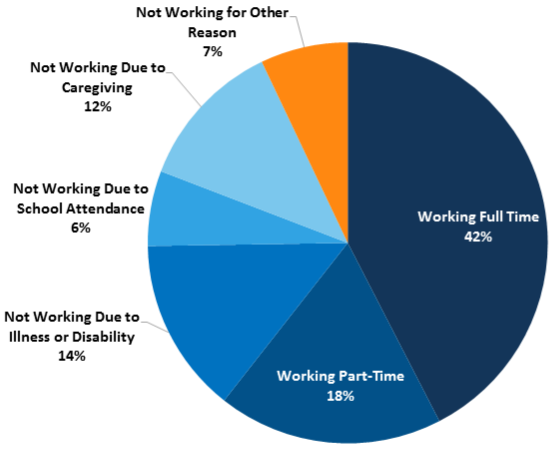
At the same time, the committee argued vigorously against any waiver imposing mandatory Medicaid work requirements, saying that organized medicine must not be a part of any effort to undermine health care coverage for low-income people by ensnarling them in red tape. TMA must work to improve coverage and eliminate burdensome paperwork.

Work Status of Adult Medicaid Enrollees

According to the Kaiser Family Foundation, 80 percent of adult Medicaid enrollees without a disability either work, live in a household with a working adult, attend school, or care for a child or relative. Of those who do not work, many face barriers to employment such as chronic illnesses, behavioral health disorders, inadequate job skills, or prior criminal history.

Figure 1

Work Status and Reason for Not Working Among Non-SSI, Nonelderly Medicaid Adults, 2016



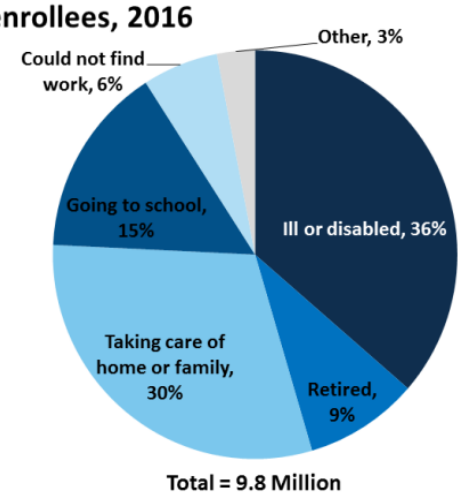
Total = 24.6 million

Notes: "Not Working for Other Reason" includes retired, could not find work, or other reason. Working Full-Time is based on total number of hours worked per week (at least 35 hours). Full-time workers may be simultaneously working more than one-job.
Source: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

THE HENRY J. KAISER FAMILY FOUNDATION

Figure 6

Main reasons for not working among non-SSI, adult Medicaid enrollees, 2016



NOTE: Includes nonelderly adults who do not receive Supplemental Security Income (SSI).
SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

Because the majority of Medicaid patients work or live in a family where someone does, it is reasonable to ask why establishing a Medicaid work requirement would be problematic. But recent analyses of other programs where work is mandatory — Temporary Assistance for Needy Families and Supplemental Nutrition Assistance Program — show that such a policy would be deleterious to employed and unemployed low-income people alike.

For Medicaid enrollees who do work, irregular work hours may mean they will be unable to satisfy minimum weekly or monthly work requirements, potentially jeopardizing their health care coverage. In the states with approved Medicaid work requirements, working Medicaid patients must verify their work status as frequently as every two months, creating a lot of new paperwork for them and the state. For patients with behavioral health disorders or intellectual disabilities — or even just working multiple jobs — keeping up with the red tape will prove burdensome. In some communities, lack of access to reliable, fast internet service may impede patients' ability to complete paperwork electronically. Many people will fall through the cracks.

While people who qualify for federal Supplemental Security Income based on disability are exempt from any mandatory work requirement, rigid federal disability qualifications mean many people with chronic illnesses or conditions, such as cancer, depression, or multiple sclerosis, do not qualify for disability. Their ability to work, even a bit, results in their denial of disability status. Thus, someone in precarious health still could be required to work under the new guidance.

Lifetime Limits for Adult Medicaid Enrollees

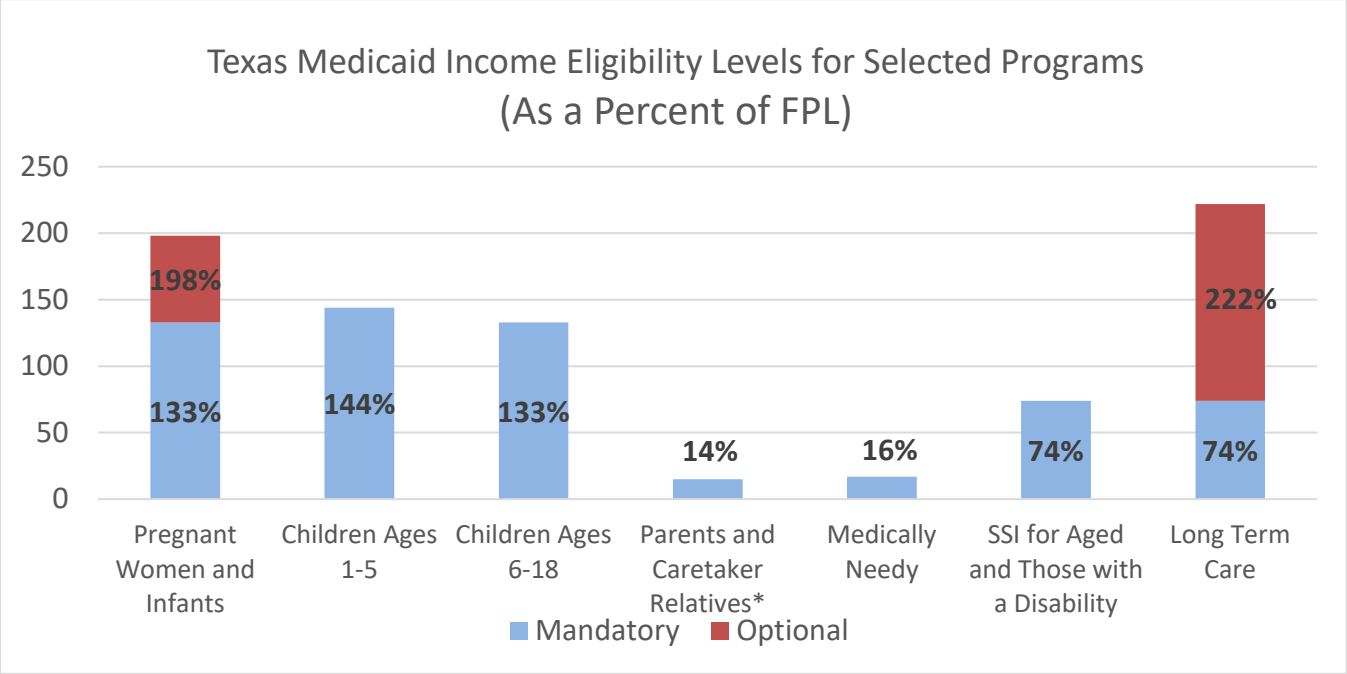
In addition to work requirements, CMS also is evaluating requests to impose lifetime limits on adults enrolled in Medicaid. Two states — Arizona and Kansas — recently submitted waiver requests to allow them to restrict Medicaid coverage to a maximum of five years and three years, respectively, even though for most low-income workers there is no other viable source of health care coverage absent Medicaid. According to the Census Bureau, nationally, 11 percent of the uninsured work in full or part time jobs, but for employers where health insurance is not offered or where it is not affordable. An arbitrary time limit would result in people enrolling in Medicaid when they need it, but dropping it when they don't, perversely increasing Medicaid costs. Moreover, it would punish people who have chronic health conditions or illnesses, such as diabetes or asthma, which will not end when Medicaid eligibility does.

While it too soon to say whether CMS will approve such requests, the committee felt it is important for the association to be on record against a policy that ill harm low-income patients and increase uncompensated care.

And as physicians well know, people who lose Medicaid still will need medical care. Many will turn to emergency departments for services, thus increasing uncompensated care for physicians and hospitals.

How Would the Medicaid Work Requirements Affect Texas?

CMS' new guidance applies primarily to states that expanded Medicaid to working-age parents and childless adults. Because Texas has not exercised that option, the waiver would apply to fewer than 200,000 Texans, though to ones who also are extremely vulnerable — very poor parents and former foster children under age 26. Currently, 147,000 poor parents are enrolled in Texas Medicaid. To qualify, parents must earn less than $320 per month, meaning a mother working part time at minimum wage — $7.25 per hour — earns too much to qualify (though Texas has the option to use federal Medicaid funds to extend coverage up to 138 percent of the federal poverty level using a private-sector strategy).



*In 2018, federal poverty level is $12,140 for an individual and $20,780 for a family of 3
Source: TX HHSC

If implemented, a waiver would require the state to establish new bureaucratic infrastructure to certify patients' compliance, likely with a high price tag. Kentucky estimates building the information technology system necessary to verify its Medicaid enrollees' work status will cost $170 million.

Furthermore, it should be noted that if Texas ever were to expand Medicaid consistent with TMA policy (policy 190.032), the intent of such coverage would be to benefit the working poor. As noted above, many low-income workers lack health insurance because their employer does not provide it or they cannot afford it. Imposing a bureaucracy that then could be used to deny coverage because a patient didn't submit the right paperwork at the right time – or could not work a minimum number of hours - would be contrary to TMA's goals.

It also must be pointed out that by not exercising its option to use federal Medicaid funds to extend health care coverage to the working poor as authorized by the Affordable Care Act, Texas actually perversely

discourages very poor parents with chronic illnesses or conditions from working since by doing so they will then earn too much to remain eligible for Medicaid.

Thus far, only a handful of Texas lawmakers have expressed interest in pursuing a federal waiver to implement a Medicaid work requirement. But as other states submit waivers, it undoubtedly will pique legislators' interest. Of the 10 waivers submitted to CMS thus far, five are from states that like Texas chose not cover low-income adults using Medicaid funds. They are seeking waivers to impose work requirements on even the poorest parents.

Conclusions

Based on the Select Committee's review, the council believes implementation of any Medicaid waiver that would increase programmatic bureaucracy while also undermining health care coverage for low-income Texans would be antithetical to TMA's mission to improve the health of all Texans.

Depriving low-income people of health care will undermine the very health and well-being of the people the waivers purport to help. People who lose Medicaid still will need medical care, but few will be able to pay. And high out-of-pocket costs will impede people with chronic conditions from continuing their medications and treatment. Depriving poor parents of health care coverage also would have the unintended effect of increasing poverty, not moderating it. Medical debt is a key contributor to families' financial strife. Instead of using their limited discretionary dollars to save for a rainy day, many families instead will become saddled with medical debt that may take years to pay off. For physicians, such a policy also would contribute to higher uncompensated care costs.

The adoption of punitive Medicaid work requirements in lieu of more constructive strategies to help people find and keep jobs will not only jeopardize low-income patients' access to care but also increase paperwork and uncompensated care for physicians. Several approved waivers require patients to obtain physician attestation of their disability or illness every few months. If patients are locked out of coverage for some portion of the year, it will result in cost-shifting to physicians and hospitals. In rural and border communities, cost-shifting could be significant because those communities have more Medicaid enrollees and higher unemployment rates.

Support for any lifetime Medicaid limits also would punitively affect poor and low-income Texans access to health care while imposing hardships on physicians by increasing uncompensated care.

For all these reasons, the council recommends TMA not support any Medicaid waiver to implement mandatory work requirements or to impose life time Medicaid limits. Instead, the association should work with the legislature, state agencies, and CMS to find constructive strategies to help patients overcome barriers to work or meaningful community engagement.

Recommendation 1: That the Texas Medical Association oppose any federal Medicaid waiver seeking to impose mandatory work requirements, but instead collaborate with lawmakers, the Texas Health and Human Services Commission, and the Centers for Medicare & Medicaid Services to support constructive measures to help Medicaid enrolled and eligible patients overcome barriers that prevent them from working or engaging in other meaningful community activities.

Recommendation 2: That the Texas Medical Association oppose efforts to impose lifetime limits on adult Medicaid enrollees.

Recommendation 3: That the Texas Medical Association oppose any policy or regulation that punitively limits access to affordable health care for Medicaid-eligible patients.

Sources:

1. Centers for Medicare & Medicaid Services. Memo to state Medicaid directors RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries. Jan. 11, 2018. www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf.
2. Kaiser Family Foundation. Medicaid and Work Requirements: New Guidance, State Waiver Details and Key Issues. MaryBeth Musumeci, Rachael Garfield, and Robin Rodowizc. Jan. 16, 2018. www.kff.org/medicaid/issue-brief/medicaid-and-work-requirements-new-guidance-state-waiver-details-and-key-issues/
3. Texas Medicaid and CHIP in Perspective, 11th edition

Supplement

REPORT OF COMMITTEE ON EMERGENCY MEDICAL SERVICES AND TRAUMA

CM-EMST Report 2-A-18

Subject: Policy Review

Presented by: Veer Vithalani, MD, Chair

Referred to: Reference Committee on Socioeconomics

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

The committee recommends retaining the following policies:

100.022 **Emergency Psychiatric Services**: The Texas Medical Association advocates additional funding to sustain and expand recent state investments to redesign mental health crisis services as well as to expand the availability of community-based mental health care, including prevention and early intervention strategies (CM-EMS Rep. 1-A-08).

100.023 **Holding Admitted Patients in Crowded Emergency Departments**: The Texas Medical Association will work with hospitals and health care organizations to develop appropriate mechanisms to facilitate availability of inpatient beds, which would include a workable plan to achieve prompt transfer of admitted patients to inpatient units during "full capacity periods" in the emergency department (ED), when the number of patients needing evaluation or treatment in the ED is equal to or exceeds the ED treatment space capacity (Res. 203-A-08).

100.025 **Access to Emergency Care in Texas**: The Texas Medical Association will seek to establish a Texas bipartisan commission to examine, address, and support issues related to access to emergency care in Texas, or a coalition of organizations to address the current crisis (Res. 205-A-08).

100.026 **Emergency Department On-Call Physicians**: The Texas Medical Association will work with health care organizations and governmental agencies to ensure adequate emergency department on-call specialist access; maintain current liability protection for treatment of emergency medical conditions; and ensure appropriate physician compensation, given existing and special hospital funding for emergency services (Amended Res. 206-A-08).

Recommendation 1: Retain.

The committee further recommends amending policy 100.024 Regulation of Free-Standing Emergency Departments.

In 2009, the Texas Medical Association in partnership with the Texas College of Emergency Physicians, supported enactment of House Bill 1357 establishing the minimum statutory requirements for free-standing emergency departments. Since the Texas legislature enacted the law, there is no longer a need for TMA to pursue legislation regulating these facilities.

However, the committee continues to strongly favor Texas' current statutory framework and recommends policy as follows:

100.024 **Regulation of Free-Standing Emergency Departments:** The Texas Medical Association supports Texas' statutory framework ~~legislation~~ regulating the operation of free-standing emergency departments (FSED) that stipulates, among other provisions, that an FSED must ~~would include~~ (1) provide medical screening and stabilization services for all patients seeking emergency services; (2) be staffed with physicians, nurses, and other necessary staff with specialty training or experience in managing catastrophic illnesses or life-threatening injuries, including training in advanced cardiac life support, advanced trauma life support, and pediatric advanced life support; (3) ~~a requirement to~~ be open 24 hours a day, seven days a week, every day of the year~~,~~; (4) maintain full-time coverage by a physician(s) either board certified in emergency medicine or otherwise qualified to provide emergency medical care; and ~~a minimum requirement for life support equipment and training for both adults and pediatric patients, set forth minimum standards for licensed personnel staffing the emergency departments, and~~ (5) be certified ~~require certification~~ by the Joint Commission or other such independent accreditation body. TMA will continue to collaborate with the Texas College of Emergency Physicians to review and comment on any ~~regarding~~ proposed FSED-related legislation or regulation and will oppose any proposal ~~proposed regulations~~ that is onerous or goes against TMA policy (Amended Res. 204-A-08).

Recommendation 2: Retain as amended.

The committee recommends deletion of the following policy as it is considered redundant (see policy 100.024):

100.021 **Free-standing Emergency Departments**: The Texas Medical Association advocates legislation establishing minimum operating criteria and regulatory framework for free-standing emergency departments (FSEDs). At a minimum, the legislation should specify that FSEDs must:

Have and maintain equipment and supplies suitable for provision of emergency care services, including 1) equipment needed for the evaluation or resuscitation of critically injured patients, 2) appropriate diagnostic laboratory and radiological equipment, and 3) other essential equipment as determined by the state via rules.

Be open to receive patients 24 hours a day, seven days a week.

Have a referral, transmission, or admission agreement with a licensed hospital with an emergency room before the facility accepts any patient for treatment or diagnosis. The legislation should direct the state to establish via rulemaking the appropriate maximum mileage allowed to transport the patient from the FSED to the admitting hospital.

Maintain full time coverage by a physician(s) either board certified in emergency medicine or otherwise qualified to provide emergency medical care.

Be staffed with physicians, nurses, and other necessary staff with specialty training or experience in managing catastrophic illnesses or life-threatening injuries, including training in advanced cardiac life support, advanced trauma life support, and pediatric advanced life support.

Adhere to the minimum architectural, sanitary, hygiene, privacy, and medical record standards as defined by the state via rules.

Maintain an internal pharmacy capable of dispensing medications and controlled substances that are necessary for the prompt and medically appropriate treatment of those conditions that regularly present at a traditional hospital-based emergency room.

Be capable of accepting ambulance traffic.

Be accredited by the Joint Commission or other independent accrediting body (CM-EMS Rep. 1-A-08).

Recommendation 3: Delete.

Supplement

REPORT OF COMMITTEE ON MEDICAL HOME AND PRIMARY CARE

CM-MHPC Report 2-A-18

Subject: Policy Review

Presented by: Lindsay Botsford, MD, Chair

Referred to: Reference Committee on Socioeconomics

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

The committee recommends retaining the following policy:

255.004 **Patient-Centered Medical Home**: A patient centered medical home (PCMH) is a primary care physician or team who ensures that patient care is accessible, coordinated, comprehensive, patient-centered, and culturally relevant through the direct provision, coordination, or arrangement of health care or social support services as indicated by the patient's individual medical needs and the best-available medical evidence.

Principles of a patient centered medical home (as articulated by AAFP, the American College of Physicians, Association of American Physicians, and American Osteopathic Association) are as follows.

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact and continuous and comprehensive care;

Physician-directed medical practice - the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation - the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, acute care, chronic care, preventive services, and end-of-life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it, in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home, meaning (1) practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership among physicians, patients, and the patients' families; (2) evidence-based medicine and clinical decision-support tools guide decision making; (3) physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement

and improvement; (4) patients actively participate in decision-making, and feedback is sought to ensure patients' expectations are being met; (5) information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication; (6) practices go through a voluntary recognition process by an appropriate nongovernmental entity to demonstrate they have the capabilities to provide patient-centered services consistent with the medical home model; and (7) patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours, and new options for communication among patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. It should (1) reflect the value of patient-centered care management work by physicians and nonphysician staff that falls outside of the face-to-face visit; (2) pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources; (3) support adoption and use of health information technology for quality improvement; (4) support provision of enhanced communication access such as secure e-mail and telephone consultation; (5) recognize the value of physician work associated with remote monitoring of clinical data using technology; (6) allow for separate fee-for-service payments for face-to-face visits (payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits); and (7) recognize case mix differences in the patient population being treated within the practice (SC-MCU Rep. 1-A-08).

Recommendation: Retain.

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 406
A-18

Subject: Supporting the Reclassification of Complex Rehabilitation Technology

Introduced by: Resident and Fellow Section

Referred to: Reference Committee on Socioeconomics

Whereas, Complex rehabilitation technology (CRT) products are medically necessary devices individually configured to meet a person's unique needs, such as custom manual and powered wheelchairs, adaptive seating systems, alternative positioning systems, and other mobility devices; and

Whereas, The primary end users of CRT equipment are individuals with substantially disabling and chronic conditions resulting in long-term disabilities, necessitating the use of properly fitted CRT for maximum independence in mobility and activities of daily living and leisure; and

Whereas, The Centers for Medicare & Medicaid Services (CMS) currently classifies CRT under the broad category of durable medical equipment (DME) and does not assign it a distinct payment category under the Medicare program; and

Whereas, The current classification system does not provide the ability to distinguish technological differences between CRT and other DME and often results in limited access to CRT; and

Whereas, Congress and CMS have recognized the benefit of a separate classification for "complex rehabilitation power wheelchairs" and related accessories for individuals with "complex chronic conditions that are substantially disabling or life threatening [and] have a high risk of hospitalization or other significant adverse health outcomes" within the Medicare Improvements for Patients and Providers Act of 2008; and

Whereas, The Medicare program is commonly the model other payers use to establish their own coverage and pricing policies; and

Whereas, The current system allows nontrained providers to prescribe DME, which often results in improperly fitted CRT; and

Whereas, In reclassifying CRT, additional requirements could be implemented such as limiting CRT prescribers to CRT-trained providers to ensure properly fitted CRT; and

Whereas, DME typically is furnished for use in the home, but CRT is frequently required for optimal transition from a skilled nursing facility or other long-term care facility to a home or a community setting; and

Whereas, An individual requiring a stay at a long-term care facility under Medicare Part A will not be provided DME under Medicare Part B during the stay, and many long-term care facilities do not provide CRT due to cost or lack of expertise with CRT configuration; and

Whereas, Limited access to CRT puts an individual at risk for reduced independence and greater susceptibility to illness. The inability to independently reposition and care for oneself can lead to preventable diseases such as pressure ulcers, resulting in extended institutionalization, increased morbidity and mortality, increased readmission rates, and increased medical costs; therefore be it

RESOLVED, That the Texas Medical Association support the Centers for Medicare & Medicaid Services reclassifying complex rehabilitation technology equipment into its own distinct payment category under the Medicare program to improve access to individuals with substantially disabling and chronic conditions.

Related TMA Policy:

90.001 Funding of Services for Disabled Persons: The Texas Medical Association endorses the preservation and continued funding of programs that encourage physical and economic independence of disabled individuals, specifically programs in physical restoration, vocational rehabilitation and independent living (Council on Medical Education, p 90, A-92; reaffirmed CM-R Rep. 2-A-02; reaffirmed CME Rep. 1-A-12).

270.002 Rehabilitation Services: The Texas Medical Association supports increased funding and legislative action for rehabilitation services to be provided in all Medicaid, managed care, or other carrier basic benefit packages, and that benefits include acute and subacute rehabilitation, home care, outpatient rehabilitation, and durable medical equipment for physically challenged patients (Committee on Rehabilitation, p 140, A-93; reaffirmed CSE Rep. 1-A-05; reaffirmed CSE Rep. 1-A-15).

270.003 Rehabilitation Services in Managed Care Programs: Rehabilitation services should be required in benefits of managed care programs, Medicaid, and any other insurance carriers in order to meet the needs of the disabled population (Committee on Rehabilitation, p 170, I-94; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14).

Related AMA Policy:

Durable Medical Equipment Requirements H-330.945

Our AMA will: (1) continue to seek legislation to prohibit unsolicited contacts by durable medical equipment suppliers that recommend medically unnecessary durable medical equipment to Medicare beneficiaries; (2) affirm the concept that members of a physician-led interprofessional health care team be enabled to perform delegated medical duties, including ordering durable medical equipment, that they are capable of performing according to their education, training and licensure and at the discretion of the physician team leader; (3) advocate that the initiators of orders for durable medical equipment should be a physician, or a nurse practitioner or physician assistant supervised by a physician within their care team, consistent with state scope of practice laws; and (4) reaffirm the concept that physicians are ultimately responsible for the medical needs of their patients.

Protect Medicare Beneficiary Access to Complex Rehabilitation Wheelchairs D-330.907

Our AMA strongly encourages the Centers for Medicare and Medicaid Services (CMS) to refrain from implementing policies on January 1, 2016 that would curtail access to complex rehabilitation technology (CRT) wheelchairs and accessories by applying competitively bid prices to these specialized devices. In the event that CMS does not refrain from implementing policies limiting access to CRT wheelchairs, our AMA will encourage Congress to support legislation (e.g. H.R. 3229) that would provide a technical correction to federal law to clarify that CMS cannot apply Medicare competitive bidding pricing to CRT wheelchairs.

Sources:

1. Salzberg, C. A., D. W. Byrne, et al. A new pressure ulcer risk assessment scale for individuals with spinal cord injury. *Am J Phys Med Rehabil* 75(2): 96-104, 1996.
2. Pressure Ulcer Prevention and Treatment Following Spinal Cord Injury: A Clinical Practice Guidelines for Health-Care Professionals. Consortium for Spinal Cord Medicine, 2014.

Relevant pending legislation:

Ensuring Access to Quality Complex Rehab Technology Act of 2017 (H.R.750).