

Healthy Vision

2020 SECOND
EDITION

*Caring for patients
in a time of change*



TEXAS MEDICAL
ASSOCIATION

Physicians Caring for Texans

VISION

To improve the health of all Texans.

MISSION

TMA supports Texas physicians by providing distinctive solutions to the challenges they encounter in the care of patients.

September 2014



Fellow Texans:

If you don't know where you're going, the old saying goes, you don't need a map. Any road will take you there.

But if you have a crystal clear vision of your destination, you need an equally detailed roadmap.

The physicians of this great state are committed to improving the health of all Texans. To get there, we must enhance the environment in which Texas physicians practice medicine. The current road may be filled with bumps and even dangerous curves, but the Texas Medical Association is dedicated to smoothing those bumps and straightening out those curves so that we can see

where we will travel. Our government must make it easier — not more difficult — for us to care for our patients.

This document, the second edition of our *Healthy Vision 2020*, articulates specifically and directly what we are asking of the Texas Legislature, the U.S. Congress, and state and federal regulators. The recommendations range from the simple (*Put ICD-10 on permanent hold*) to the complex (*Devise and enact a system for providing health care to low-income Texans with realistic payment to physicians, less stifling state bureaucracy, and no fraud-and-abuse witch hunts*) to the most fundamental (*Pass no laws or regulations that interfere with the patient-physician relationship*).

A strong, effective, and efficient health care system is critical for the physical health of Texans and the economic health of our state. We look forward to working with our elected officials, opinion leaders, and health care policy experts to make our healthy vision a reality for Texans. We invite you to read, share, question, and help us improve this roadmap.

On behalf of the 47,000-plus physician and medical student members and our millions of patients across the state,

Austin I. King, MD

President

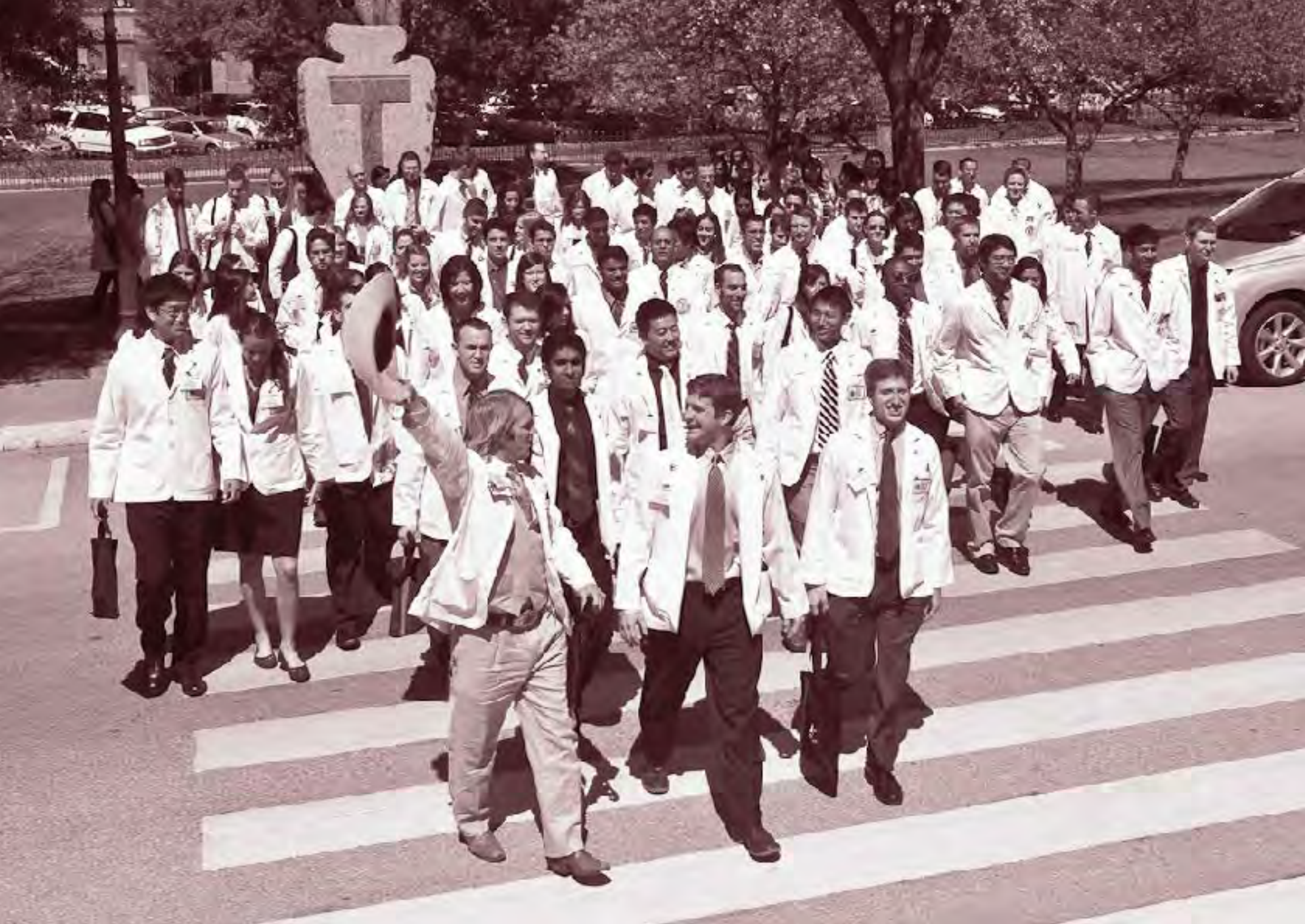
Texas Medical Association

TMA's Top 10 Recommendations

1. Increase Medicaid primary care physician payments on par with Medicare and extend higher payments to subspecialists and the Children's Health Insurance Program.
2. Devise and enact a system for providing health care to low-income Texans with realistic payment to physicians, less stifling state bureaucracy, and no fraud-and-abuse witch hunts.
3. Repeal the broken SGR formula. Enact a rational Medicare physician payment system that works and is backed by a fair, stable funding formula.
4. Increase funding for graduate medical education.
5. Protect Texas' landmark medical liability reforms.
6. Stop any efforts to expand scope of practice beyond that safely permitted by nonphysician practitioners' education, training, and skills.
7. Standardize Medicaid managed care administrative processes.
8. Ensure criteria used to measure physicians' performance are evidence-based, fair, and accurate, and truly evaluate quality and efficient care, not just cost.
9. Stop Recovery Audit Program bounty hunters.
10. Eliminate the adoption of ICD-10 coding system.

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Progress Made So Far

Thanks to the collective efforts of Texas' state and federal legislators, state agency leaders, organized medicine, and public health advocates, we accomplished many of the recommendations in the first edition of *TMA's Healthy Vision 2020*. Most of the results stem from actions of the Texas 2013 Legislature, while others are from federal laws and regulations.

Ensure an Adequate Health Care Workforce

- ✓ Restored much of the graduate medical education (GME) funding cuts from 2011.
- ✓ Created new incentive programs to grow GME, providing more money to train young physicians — family medicine residency program funding was doubled.
- ✓ Reinstated funding for Texas' physician loan repayment programs to ensure more physicians can practice in rural and underserved areas.
- ✓ Prohibited off-shore medical schools from buying up core clinical clerkship spots in Texas hospitals and displacing Texas medical students.
- ✓ Enacted a new law that firmly establishes the physician-led medical team, allows all involved to practice at their level of education and training, and places more authority and responsibility on the physician to supervise.
- ✓ Stopped scope of practice expansions beyond that safely permitted by nonphysician practitioners' education, training, and skills.

Protect Physicians' Independent Medical Judgment

- ✓ Preserved the primacy of the patient-physician relationship in the face of health system reform.
- ✓ No laws passed harming Texas' landmark legislation mandating protections for physicians' independent medical judgment in all employment scenarios.
- ✓ No laws passed requiring physicians to provide care that they believe is medically inappropriate or that violates their personal conscience and moral beliefs.

Promote Efficient and Effective New Models of Care

- ✓ Increased funding for mental health and substance abuse services to reduce waiting times for treatment, provide training for teachers and others, improve jail diversion, and to provide residential services for chronically homeless persons with behavioral illnesses.
- ✓ Restored funding that was cut in 2011 to women's health services and added more money to these programs to ensure low-income women receive timely care.
- ✓ Enacted several physician-driven, patient-centered medical home (PCMH) pilot projects, which provide financial incentives from both state and private payers, such as the pregnancy PCMH in Houston for Medicaid enrollees.
- ✓ Established a Maternal Mortality and Morbidity Review Task Force to identify causes of and remedies for pregnancy-related deaths and severe morbidity.

Repeal Harmful and Onerous State and Federal Regulations

- ✓ Delayed ICD-10 implementation until October 2015 to ensure systems are reliable and tested appropriately.
- ✓ Passed new laws that will create standardized prior authorization forms for prescription drugs and health care services for public and private payers.
- ✓ Streamlined the standards practices must follow in training staff on privacy laws and for notifying patients in the case of a breach of private information.

- ✓ Enacted a new law allowing patients to check in using the electronic strip on the back of their Texas driver licenses.
- ✓ Created a much more streamlined way of renewing physicians' state Controlled Substances Registration permit.
- ✓ Excluded the cost of vaccines from the state business tax for primary care physicians.

Invest in Prevention

- ✓ Passed new state laws to improve Texas' immunization policies. Childcare centers now must have a vaccination policy in place for their workers, and minor parents now can give consent for their own vaccines.
- ✓ Allocated more funding for the state's adult vaccination safety net.
- ✓ Aligned college meningitis immunization requirements with the recommendations of Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices while maintaining the current public health exemption process.
- ✓ Provided funding for proven interventions to reduce tobacco use, such as Texas' Quitline and education in schools.
- ✓ Retained the Fitnessgram program in Texas' public schools, which provides critical data to address the state's obesity epidemic.

Protect and Promote a Fair Civil Justice System

- ✓ Protected Texas' strong medical liability reform laws, including caps on noneconomic damages and protections for emergency services.
- ✓ Required the Texas Medical Board to focus efforts on quality-of-care issues.
- ✓ Stopped efforts to create new causes of actions against physicians and other health care providers who are delivering evidence-based and clinically appropriate care.
- ✓ Prevented federal preemption of state civil justice reforms.
- ✓ Maintained the integrity of the Texas Advance Directives Act, protecting physicians' freedom from exposure to medical liability suits.

Provide Appropriate State and Federal Funding for Physician Services

- ✓ Reversed cut that eliminated state coverage of Medicare deductible for patients dually eligible for Medicaid and Medicare.
- ✓ Required the Texas Health and Human Services Commission to reduce administrative hassles, ensure prompt payment of claims, streamline paperwork and credentialing requirements, and strengthen how Medicaid measures network adequacy.
- ✓ Improved due process and transparency, and expedited review for physicians accused of fraud and abuse in Medicaid by the Office of Inspector General.

Establish Fair and Transparent Markets for Patients, Employers, Taxpayers, and Physicians

- ✓ Passed new law that subjects companies and networks that sell, lease, or share physicians' privately contracted discounts, known as "silent PPOs," to Texas Department of Insurance (TDI) oversight and other regulations.
- ✓ Enacted a new law that ensures physicians will know if a health plan is applying their discounted contract rates under Medicaid managed care or the Children's Health Insurance Program to commercial products.
- ✓ Required health insurers to regularly report their medical loss ratios in a standardized format to TDI as well as to purchasers and enrollees upon request.
- ✓ Required insurers to notify patients that rescission of their policy is under consideration, and for what reason, before the actual cancellation occurs.
- ✓ Established tax incentives for businesses to provide health insurance for their employees.
- ✓ Allowed Texas' small businesses to challenge health insurance premium quotes, and required insurers to provide information to justify a premium increase.
- ✓ Protected TDI-Division of Workers' Compensation due process procedures and made certain physicians subjected to peer review are reviewed by professionals with the same training, education, and licensure.



What Health Care Means to Texas' Fiscal Health

Physicians play a critical role in our communities — maintaining and improving the health of patients. They are in charge of the care millions of patients receive in medical offices, clinics, hospitals, urgent care centers, emergency departments, and community centers across Texas. Most people recognize this role. What they may not know is the crucial role physicians play in improving the fiscal health of our communities.

Health care is a vital component of the Texas economy, generating tens of billions of dollars in revenue each year and providing hundreds of thousands of jobs. A March 2014 economic impact study by IMS Health, on behalf of American Medical Association (AMA) and state medical societies, puts dollar figures on exactly how much doctors' offices contribute to the Texas economy. That report found *Texas' 48,314 practicing physicians boost the state's economy by supporting 522,619 jobs and generating \$78.6 billion in economic activity.*

Texas office-based physicians generate significantly more economic output (i.e., medical and nonmedical sales revenues) than the legal industry; and produce more jobs than colleges, universities, and nursing homes combined. Texas physicians also compensate their employees better, who in turn are able to purchase goods and services.

In fact, physicians pay more in wages and benefits than higher education, legal, nursing, and home health industries combined.

Total Output, Jobs, Wages & Benefits, and State and Local Taxes Supported by Physicians in Texas, 2012		
Economic Measure	Total	Per Physician
Number of Physicians	48,314	-
Output	\$78.6 billion	\$1.63 million
Jobs	522,619	10.82
Wages & Benefits	\$43.1 billion	\$890,990
State and Local Taxes	\$2.5 billion	\$52,618

Source: *The Economic Impact of Physicians in Texas*, IMS Health, March 2014

“Physicians carry tremendous responsibility as skilled healers charged with safeguarding healthy communities, but their positive impact isn’t confined to the exam room. The study illustrates that physicians are strong economic drivers that are woven into their local communities by the economic growth, opportunity, and prosperity they generate.”

— AMA Past President Ardis Dee Hoven, MD

The IMS Health study concluded that, in Texas:

- **Economic output:** Office-based physicians created a total of \$78.6 billion in direct and indirect economic output in 2012. The output multiplier for office-based physicians in Texas is 2.01, meaning an additional \$1.01 of indirect output is generated in the state over and above each dollar of direct output created in the practice of medicine. Indirect output captures the value of revenues generated by other businesses as a result of the office-based physician industry, e.g., the sale of equipment to an office or the sale of laboratory services related to a physician visit.
- **Jobs:** Texas' office-based physicians supported 522,619 jobs in 2012. On average, each office-based physician supported 10.82 jobs, including his or her own. The jobs multiplier in Texas is 7.655, meaning that 7.66 additional jobs, above and beyond the clinical and administrative personnel who work in physician practices, were supported for each \$1 million of revenue a physician practice generated.
- **Wages and benefits:** Physician offices contributed \$43.0473 billion in direct and indirect wages and employee benefits in 2012. On average, each physician supported \$890,990 in total wages and benefits. This includes the payroll multiplier, which concludes that an additional 34 cents in wages and benefits was generated for every dollar of direct employee compensation within the industry.
- **Tax revenues:** Physician offices supported \$2.5422 billion in local and state tax revenues in the year 2012. The total tax contribution is computed by summing taxation on employee income, proprietor income, indirect business interactions, households, and corporations.

Across the country, the nation's 720,000 practicing physicians support 9.9 million jobs, generate \$1.6 trillion in economic activity, support \$775 billion in wages and benefits, and generate \$65.2 billion in state and local tax revenue.

A healthy and viable medical system is vital for continued economic development in our state. Without a healthy and educated workforce or ready access to high-quality medical care, Texas cannot attract new industries and employers.

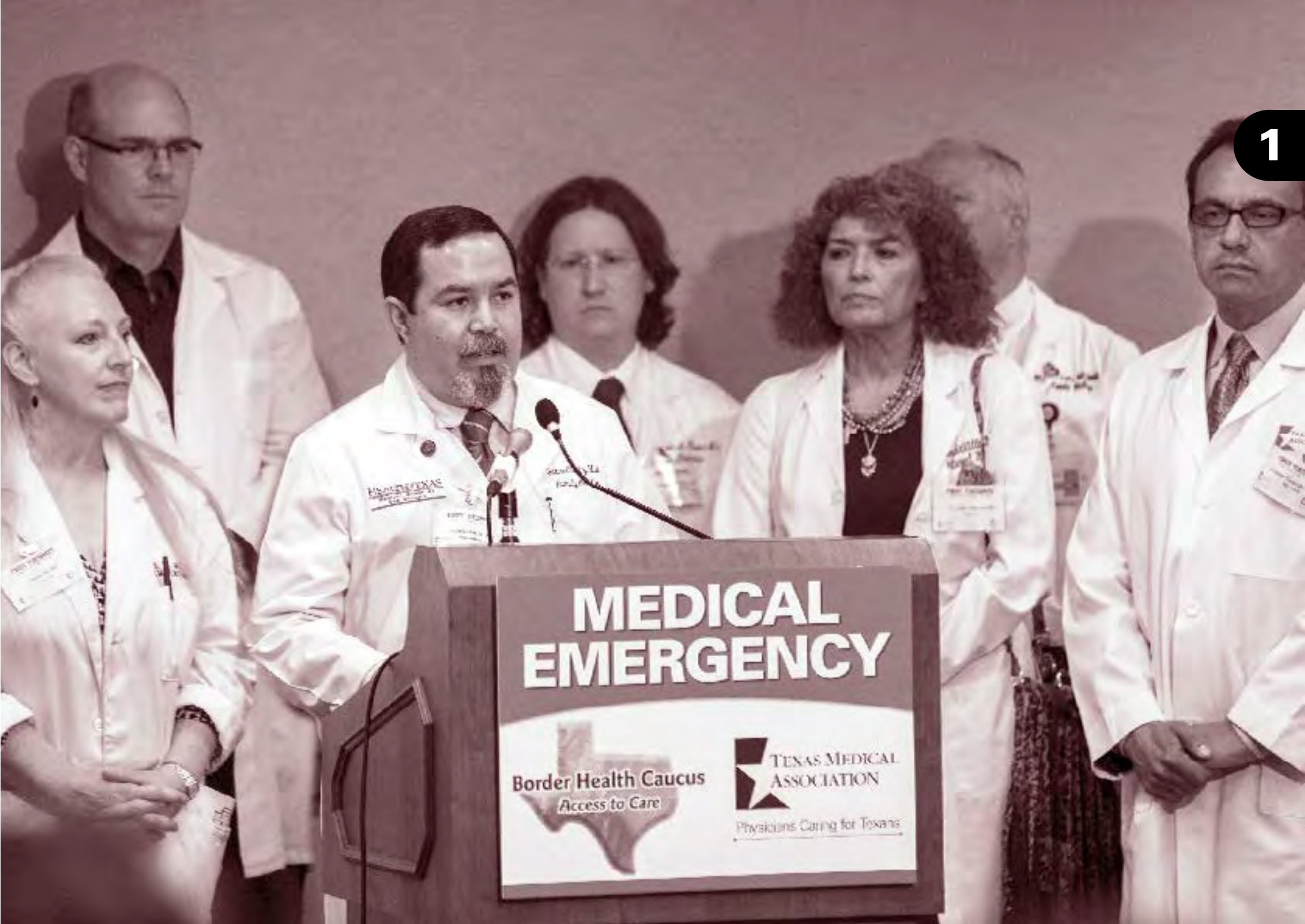
Total Output, Jobs, and Wages & Benefits by Industry in Texas, 2014

Industry	Output (\$ in millions)	Jobs	Wages & Benefits (\$ in millions)
Physicians	\$78,630.90	522,619	\$43,047.30
Higher Education	\$10,937.20	104,125	\$4,243.50
Nursing Home/ Residential Care Facilities	\$20,760.00	261,448	\$8,870.30
Legal Services	\$35,158.10	236,660	\$12,678.80
Home Health	\$21,933.70	361,448	\$9,152.60

Source: *The Economic Impact of Physicians in Texas*, IMS Health, March 2014

“The bottom line is that Texas’ physician practices, without a doubt, are good for the economic health of our communities and our state.”

— TMA Immediate Past President Stephen L. Brotherton, MD



MEDICAL EMERGENCY

Border Health Caucus
Access to Care

TEXAS MEDICAL ASSOCIATION
Physicians Caring for Texans

SECTION 1

Ensure an Adequate Health Care Workforce

Texas has a large, diverse, and growing population that is growing less healthy and more ethnically diverse, and needs more and better-coordinated health care services. Unfortunately, Texas — compared to other parts of the country — has significant shortages in most physician specialties and other health care professionals.¹ Although our 2003 liability reforms have helped to establish Texas as a good place to practice medicine and we have record numbers of physicians applying for licensure, the current supply won't keep up with the demand. Texas has unique challenges, with some of the nation's largest urban centers as well as the vast expanses of sparsely populated rural regions. We need to invest more in our medical schools and graduate medical education (GME) training programs. With the numerous shortages, we must focus on building physician-led teams that can safely meet the diverse and complex health care needs of the Texas population.

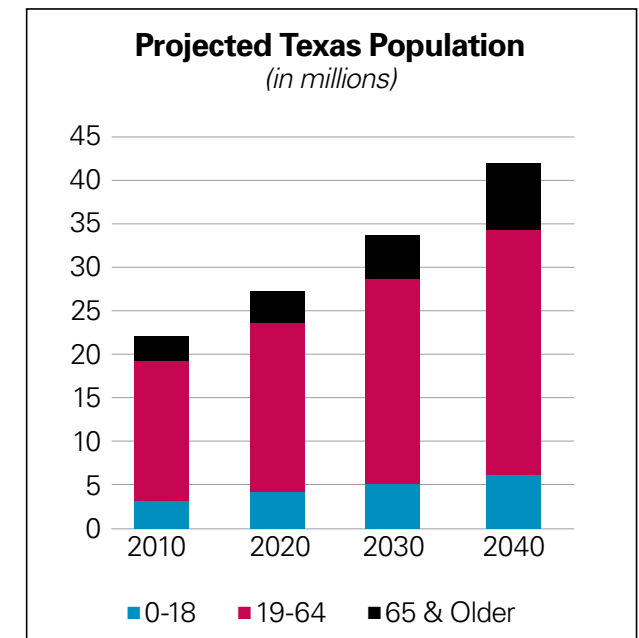
Meet the growing demand for medical care with clinically appropriate medical services

Texas' population is expected to boom from 25 million to almost 45 million by 2040.² This means not only more people who need medical care, but also a larger demand for more health care services from a growing populace of increasingly obese Texans and the generally sicker elderly residents.

Texas has long been challenged to produce or recruit enough physicians to keep up with our rapidly growing population. The sheer size of the state's population is the biggest driver of physician demand. The state's broad expanse and varied geography and demographics, plus the great attraction for others to move to Texas, result in an ever-increasing demand for physicians and other health care professionals. Over the past two decades, Texas has led the country in population growth.³

The convergence of a larger, increasingly aging, and increasingly obese population of Texans represents “a recipe for disaster.” In the United States, approximately 80 percent of all persons 65 and older have at least one chronic condition, and half have at least two.⁴ These patients take longer to treat, and the amount of services and care they require grows more and more complex. Diabetes, which causes excess morbidity, premature mortality, and increased health care costs, affects about 1.8 million adult Texans.⁵

As adults live longer, the prevalence of Alzheimer's disease also increases. An estimated 13 percent



Source: Texas State Data Center, March 2012

of those age 65 and older have Alzheimer's. The number doubles as people reach 85 and older. In Texas, about 340,000 Texans suffer from the disease.⁶

Texas is a state with significant shortages of physicians and other health care professionals. Several powerful trends are pushing those shortages to levels that will further threaten Texans' ability to access care, regardless of where they live or whether they have health insurance coverage. In addition to Texas' ethnic diversity and 1,254-mile shared border with Mexico, those trends include:

- High population growth: Texas added 8 million residents from 1990 to 2010 and is expected to add another 5 million by 2020;⁷
- More seniors: By 2020, more than 5.7 million Texas baby boomers become eligible for Medicare, the age group with the highest demand for primary and specialty care physician services;⁸
- High birth rate: Texas has the third-highest birth rate in the nation, increasing demand for obstetrical, pediatric, and neonatal physician services;⁹
- More chronic disease: Many Texans suffer from chronic diseases such as diabetes and hypertension, which frequently require more health care services; and
- High rates of poverty.

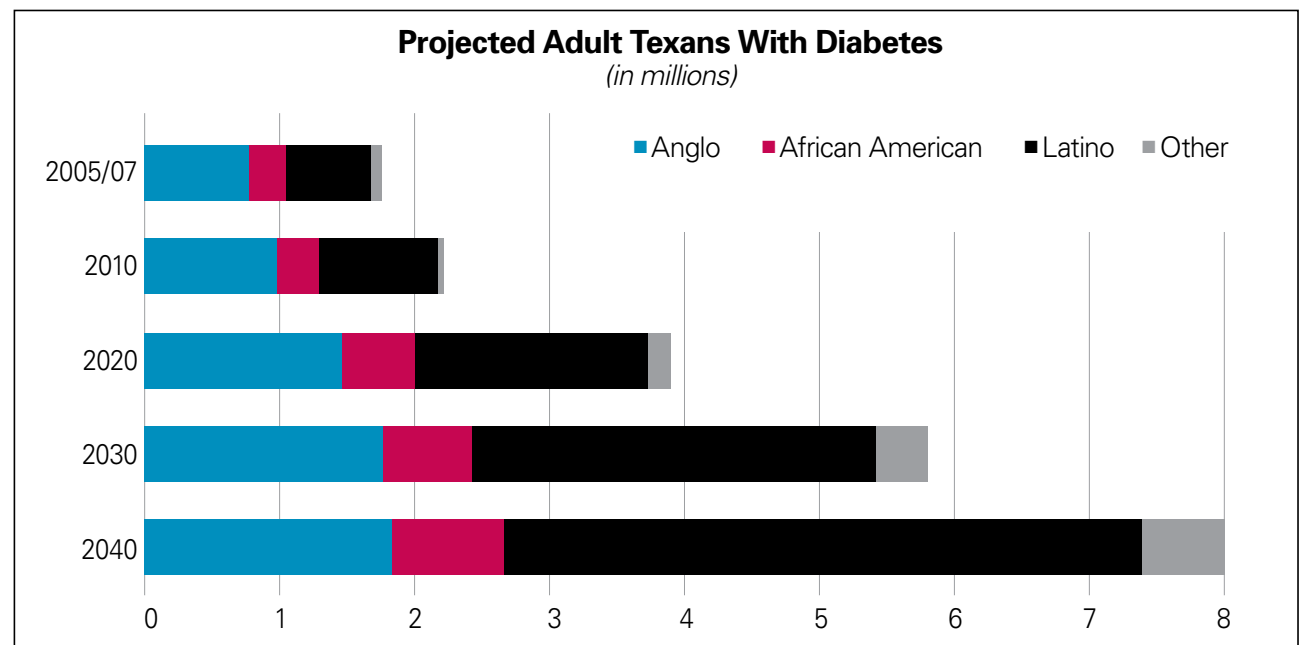
More and more Texans will experience health-related disparities because of poor health status and/or a lack of preventive health options or access to timely medical care. Health disparities include differences

in the occurrence or prevalence of a disease or a poor health condition. For example, the Texas Diabetes Council estimates that the number of adult Texans with diabetes will quadruple from the current 1.7 million to almost 8 million in 2040. This surge is strongly associated with population growths in Latinos and African-Americans, who have higher rates of diabetes.

People with diabetes and other chronic health conditions have complex care needs. Their physicians not only must treat the condition

itself, but also must lead a team of caregivers who rally all the resources to help prevent health complications and greater health care costs for the patient.

Physicians must be the backbone of such a complex system of care if it is to be high quality and cost-effective. Otherwise, the state's efforts to increase preventive care, improve medically necessary treatment for the chronically ill, and reduce inappropriate emergency department visits will falter. Physicians also play an important



Source: Office of the Texas State Demographer, 2010. Summary Report on Diabetes Projections in Texas, 2007-2040.

role in developing and partnering with the public health system. This partnership can enhance local coordination of care, disease surveillance, access, and health promotion.

Make sure enough physicians and other health care professionals are working in all parts of Texas

Texas has a shortage of both primary care physicians and other specialists. Texas ranks behind nearly every other state in the number of patient care physicians per capita and usually ranks last among the most populous states.¹⁰ To evaluate this shortage across specialties, we have devised a metric that compares the number of Texas physicians per 100,000 population with the U.S. average by specialty. We call this the “Texas Specialty Ratio.” The closer this ratio is to 100 percent for a given specialty, the closer Texas is to the national average.

- Texas has fewer physicians per capita than the national average for 36 out of 40 major medical specialty groups.
- Psychiatry, preventive medicine, and child/adolescent psychiatry are among the specialties with the lowest Texas Specialty Ratios.
- The four specialties with higher Texas Specialty Ratios are aerospace medicine, medical genetics, transplant surgery, and colon and rectal surgery.

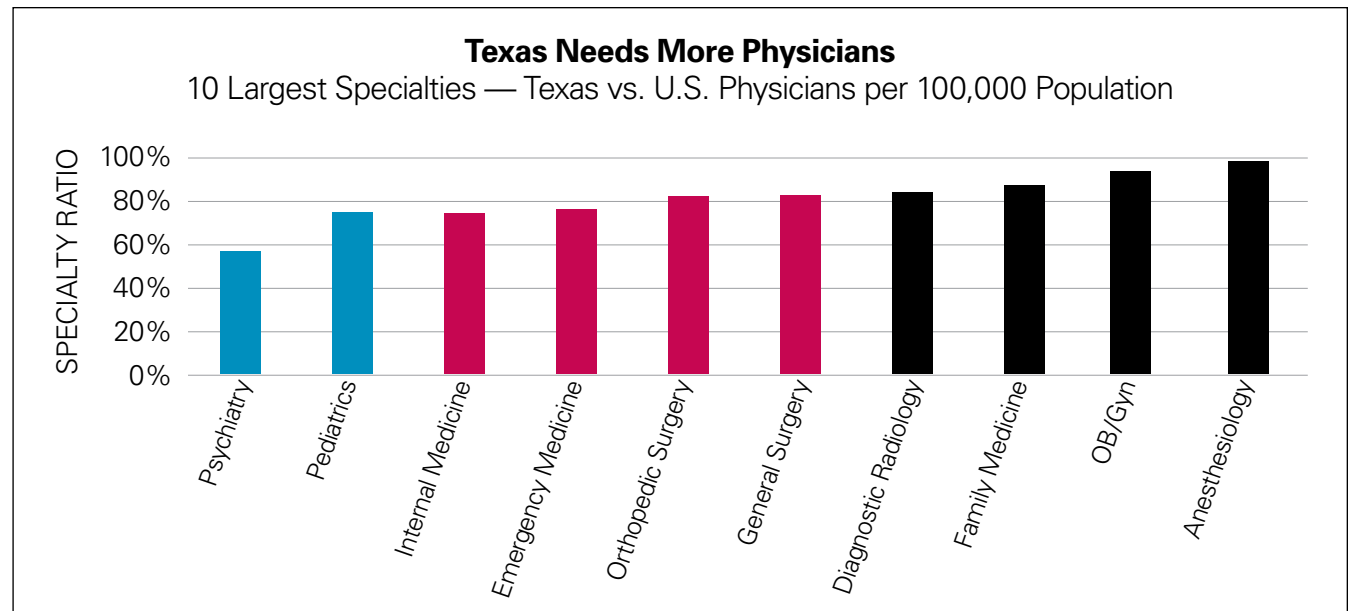
Texas ranks fourth among the six most-populous states in medical students and resident physicians

per capita.¹¹ Despite the ongoing success of our 2003 medical liability reforms, Texas continues to be overly dependent on other states and countries for supplying new physicians. Last year, 73 percent of newly licensed physicians graduated from medical schools outside of Texas.¹²

To meet future physician demands, Texas needs a stable, high-quality medical education system to produce homegrown physicians. We must provide a reasonable opportunity for Texas medical school graduates to obtain their residency training in the state without being forced to leave home. Multiple studies confirm that physicians who complete both medical school and residency training in the state are three times more likely to practice here.¹³

Because the human body is complex, the mastery of medical care is correspondingly complex, requiring a lengthy educational and training pipeline. After college, physicians traditionally complete a four-year medical school education, followed by specialty training in residency programs for three to eight additional years, depending on specialty.

Considering the significant challenges the state faces in meeting its health care workforce needs, state leaders must support a comprehensive health professions workforce analysis that includes all appropriate stakeholders and visualizes the needs of Texas for the short and long term.



Source: TMA calculations using AMA Physician Characteristics and Distribution in the United States, 2014 Edition

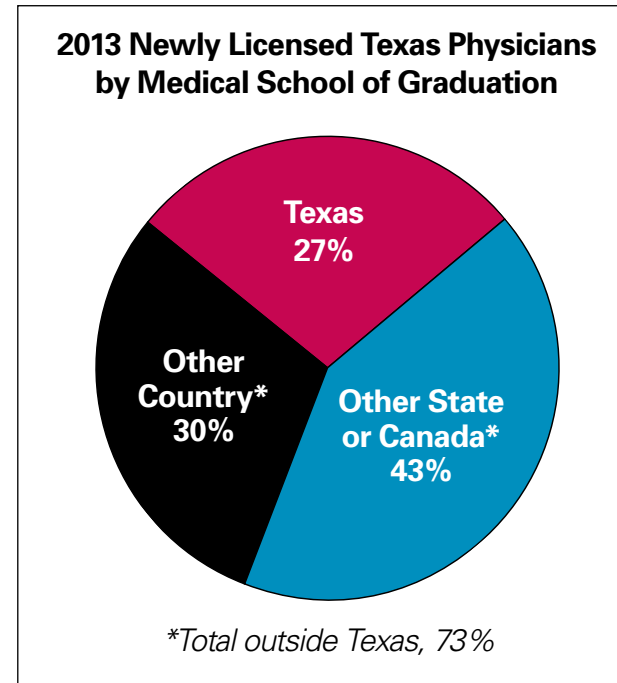
Ensure Texas medical school graduates remain in the state for specialty training

Texas is now educating the largest number of medical students in its history.¹⁴ These gains will be lost to us, however, if we do not create sufficient numbers of high-quality, entry-level residency training positions to incentivize these students to remain in the state for specialty training.

Many parts of the United States are in the midst of medical education building campaigns. Texas is among the leaders, having reached the nationally recommended 30-percent growth in medical school enrollments over the past decade. Following establishment of the three medical schools now under development and growth at other schools, the number of graduates is projected to peak at 2,000 by 2022.¹⁵

In 2013, almost half (49 percent) of Texas medical school graduates left the state for residency training.¹⁶ Texas invests \$176,000 in each medical student's four years of education.¹⁷ Texas physicians are concerned about the state's ability to protect that growing investment with enough GME positions to meet demand.

For 2013, there were 1,611 entry-level GME positions offered in Texas. By comparison, 1,587 students graduated from Texas medical schools in 2013. The Texas Higher Education Coordinating Board recommends a ratio of 1.1 entry-level GME positions for each Texas medical school graduate. To meet this goal, Texas would have needed 1,746 entry-level training positions in 2013, or 135 additional positions.



Source: Texas Medical Board, 2013, prepared by the Texas Medical Association

Texas needs continued and stable state support for both critical parts of a physician's education and training to help cultivate future generations of Texas physicians trained to deliver care in the evolving health care delivery systems, ensuring stable access to health care for all Texans.

Texas medical school graduates are projected to peak at 2,000 in 2022. This will mean an even greater demand for residency training positions to enable graduates to remain in the state. To achieve the 1.1-ratio goal after enrollments reach the peak, Texas will need to add 589 GME positions to the 2013 numbers.

Medical education is a public good and a tremendous economic asset to the state

- Academic health centers generate an additional \$1.30 in economic activity for every dollar spent.
- Texas ranks fifth among states in the total economic impact of academic health centers. These centers serve as major employers in their communities and impact 210,000 jobs. Many of these are filled by highly educated and skilled workers at higher salary levels.¹⁸
- Academic health centers have a major financial impact in every region they are located: Houston, Dallas, Bryan/College Station, Temple, Lubbock, El Paso, San Antonio, Fort Worth, and Tyler.

To successfully retain our own medical graduates for residency training and entry into practice, Texas must:

- Have an adequate number of training positions,
- Ensure residency programs have enough resources to provide high-quality training,
- Attract and retain well-qualified faculty,
- Evaluate the impact of the newly established GME expansion grant programs on GME capacity and retention of our medical school graduates for training, and
- Provide incentives for teaching hospitals to create new GME positions and maximize the potential for adding residency teaching at other hospitals that have not previously participated in residency training.

Texas must make sure that our medical school graduates are fully informed of the state's strong interest in retaining them for training and eventual practice.

Improve rural access to care

Physician shortages constitute a special problem in rural areas of the state. The continued urbanization of Texas exacerbates this long-standing problem. Approximately 12 percent of Texans live in rural counties, yet only 9 percent of primary care physicians practice there. In 2013, Texas had 52.3 primary care physicians per 100,000 population in rural areas versus 73 per 100,000 in urban areas.¹⁹ Physician shortages in rural areas not only hinder access to primary and specialty care, but they also serve as impediments to attracting new businesses to those areas, and ultimately lead to

diminished quality of life for residents and years of lost productivity. A number of factors hurt physicians' ability to open and sustain rural practices, including heavy concentrations of Medicare, Medicaid, and uninsured patients; professional isolation and lack of health care infrastructure; and high debt after medical school.

Physician practices in rural Texas contribute to the local economy in at least four critical ways.

1. They employ administrative and clinical staff to help care for patients. On average, a solo primary care physician in a rural area will employ three staff: a registered nurse, a medical technician or licensed vocational nurse, and a receptionist/billing clerk.
2. They contribute revenue to and generate additional employment at local hospitals through inpatient admissions and outpatient services.
3. They have a ripple effect on employment and economic activity such as pharmacies; physical, occupational, speech, and inhalation therapy; and medical equipment and device sales.
4. They generate essential tax revenues for their communities.

If rural physician practices and rural economies are to survive and thrive, physicians need incentives to practice in those areas, particularly if the state and federal governments fail to provide appropriate payments for Medicaid and Medicare services. Medical school programs with rural-focused curricula and residency training tracks increase the potential supply of primary care doctors in underserved areas as do loan forgiveness programs like the National Health Service Corps and the State's Physician Education Loan Repayment Program.



- ✓ Preserve and protect state support for undergraduate medical education and cultivate the future generation of Texas physicians, thus ensuring stable access to quality health care for all Texans.
- ✓ Support and develop new graduate medical education (GME) programs in the specialties that best reflect the state's health care needs. Support incentives for hospitals and other community-based agencies to develop residency programs in the specialties most needed.
- ✓ Direct the Texas Higher Education Coordinating Board to monitor the availability of GME training positions so that Texas can retain our graduates for residency training and beyond.
- ✓ Sponsor research that will identify and promote innovations in training family medicine residents for practice in Texas.
- ✓ Maintain and build on the current bonus payments for primary care physicians under Medicaid, and extend it to other specialties to ensure medical services are available throughout Texas, particularly in rural areas.



SECTION 2

Preserve Physicians' Independent Medical Judgment

The patient-physician relationship is unique in modern American life. Patients place their lives in their physicians' hands. Not only must they trust in their doctors' knowledge, experience, and skill, but they also must trust that their physician is acting in their best interest — neither motivated nor distracted by competing interests. In return, the physician is responsible for recommending and applying the most appropriate, science-based treatments for the patient's individual circumstances and medical conditions. All of these pressures are magnified during the often-emotional final days and weeks of a person's life.

Defend physicians' ethical responsibilities to patient

Evolving health care structures and financing are making it more and more challenging for physicians to navigate the intersection of professional ethics and economics.

Our health care system is constantly emphasizing lowering costs. So-called "quality-based measures" may give physicians perverse incentives to dismiss patients who do not (or cannot) meet target measures, and they may be asked to ration health care resources in ways that place employers' or Wall Street's needs above individual patient needs.

Furthermore, hospitals and other entities continue to look toward employing physicians so they can consolidate market share and capture the payment stream for physician and ancillary services. Physicians employed by hospitals and other practice models not owned and controlled by physicians could find their clinical autonomy threatened.

The recent controversies at the U.S. Department of Veterans Affairs show how unrealistic it can be to mandate appointment times with physicians without a concomitant increase in funding to hire or contract with enough primary care physicians to meet the demand.

The ability of physicians to act in their patients' best interests must not be compromised by outside — and sometimes competing — economic, political, and social pressures. Each patient encounter must be governed by the ethics of the medical profession, the integration and application of advancing medical knowledge, and the partnership with the patient in making good decisions for that patient's health. Yet lawmakers and other nonphysicians are ever more inclined to dictate the details of the interaction between physicians and patients. Physicians increasingly face nonphysicians' attempts to mandate what information, tests, procedures, and treatments they must — or must not — provide to their patients.

The practice of medicine is founded upon ethics that arise from the imperative to alleviate suffering and to care for patients. According to the American Medical Association Code of Medical Ethics,

"The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare."

Maintain restrictions on corporate control of the practice of medicine

In a changing and uncertain environment, many physicians will seek employment opportunities as a way to deal with unpredictable and oftentimes inadequate payment models and the increasingly overwhelming administrative burden of running their own practices. At the same time, hospital-controlled health care corporations and other nonphysician-owned businesses are trying to recruit physicians. In Texas, while only 7 percent of physicians report they are hospital employees, 34 percent report that their practices are at least partially owned by some nonphysician organization that is not bound to honor the professional and ethical standards that apply to licensed physicians.

It's critical that physicians' ability to make decisions in the best interest of their patients is not compromised — regardless of the business or practice arrangement. Some nonphysician businesses are trying to control physicians by requiring them to be bound by restrictive contracts. These are contracts that limit the physicians' ability to contract with other payers, limit to whom they can refer their patients, and direct how they should practice medicine.

Protecting the patient-physician relationship lies at the heart of Texas' long-standing legal doctrine banning the corporate practice of medicine. This commitment to patient-focused care has led to Texas becoming a global destination for health care.

Employment without protections is the corporate practice of medicine. Employment with protections is part of the practice of medicine.

At TMA's urging, the 2011 Texas Legislature passed groundbreaking laws that protected patients and their physicians' ability to exercise independent medical judgment from interference by a hospital administrator or corporate officer. At the same time, we preserved Texas' ban on the corporate practice of medicine with several carefully delineated expansions for physician employment. These included strong protections for physicians employed by or associated with hospital-controlled health care corporations, rural county hospital districts, large urban government-controlled hospital districts, and the newly established Texas health care collaboratives. Texas is the first state in the country to take this critical step of protecting clinical autonomy. These laws place responsibility for monitoring and ensuring enforcement of autonomy with the Texas Medical Board, which is the agency responsible for upholding the standards of medical practice in the state.

Over the course of the coming decade, patients and physicians will see many changes in the organization and delivery of medical services. New payment models are driving new practice arrangements. Many physicians will continue to practice independently, some will partner in small

to large groups, and others will join larger single or multispecialty groups. Payment models for physicians' services will continue to be a mix of global or capitated payments, fee-for-service, and salary.

Regardless of the practice arrangement, TMA and its member physicians remain committed to protecting the clinical autonomy of physicians and the primacy of the patient-physician relationship.

Respect patients in their final days

Thanks to advancements in medicine and science, Texans are living longer. However, these blessings bring the challenges of care and treatment decisions in life's final stages. Advance directives allow patients to make their end-of-life treatment decisions known in the event they become incompetent or incapable of communication. Without advance directives, some of life's most difficult decisions are being thrust upon unprepared adult children, parents, or other loved ones. While some families are prepared to handle these difficult situations, others face significant challenges and uncertainty.

At each step, human beings are involved in both deciding on and providing treatment. We must respect the value of life and the moral conscience of those involved.

Texas physicians abide by the principle, "First, do no harm." For this reason, TMA supports the Texas

Advance Directives Act (TADA). Its aim is to allow patients to make their care preferences known before they need care, and to protect patients from unnecessary discomfort, pain, and suffering due to excessive medical intervention in the dying process. The time sometimes comes when all that can be done for a patient is to alleviate pain and suffering, and preserve the patient's dignity. For physicians, this is about medical ethics and providing medically appropriate care.

In 1997, then-Gov. George W. Bush signed TADA into law. It had unanimous support from physicians, nurses, hospitals, nursing homes, hospice care facilities, disability groups, and pro-life organizations. The law provides a balanced approach to addressing some of life's most difficult decisions.

TADA allows a patient to issue an out-of-hospital do-not-resuscitate (DNR) order, a medical power of attorney, or a directive for physicians and family members regarding the person's wishes to administer or withhold life-sustaining treatment in the event the person is in a terminal or irreversible condition and unable to make his or her wishes known. Additionally, when an attending physician disagrees with a health care or treatment decision made by or on behalf of a patient, the act provides for a process whereby an ethics or medical committee reviews the physician's request. The patient is given life-sustaining treatment during the process. If the ethics committee decides that

discontinuing lifesaving treatment is in the best interest of the patient, and the family disagrees with that decision, the hospital must continue treatment for 10 days to allow the family time to find a different facility for the dying patient.

Legislation has been introduced over the past four legislative sessions that would instead require indefinite treatment with no provision for the physician exercising ethics or moral judgment. TMA has opposed these proposals because they would prolong unnecessary — and often painful or even torturous — care that cannot prevent but can only prolong death. They would also require physicians, nurses, and other health care professionals to provide medically inappropriate care, even if that care violates medical ethics or the standard of care. They also would set a dangerous precedent for the legislature to mandate the provision of physician services and treatments that may be medically inappropriate, outside the standard of care, or unethical.

TMA RECOMMENDATIONS

- ✓ Pass no laws or regulations that violate the American Medical Association Principles of Medical Ethics or that permit a nonphysician-owned business to require physicians to practice medicine in a manner inconsistent with those principles.

- ✓ Pass no laws or regulations that interfere with the patient-physician relationship. Preserve the primacy of the patient-physician relationship in the face of health system reform.
- ✓ Support strong statutory provisions that protect independent medical judgment for physicians in *all* employment and contractual relationships.
- ✓ Oppose any legislation that would weaken or erode Texas' physician employment protections.
- ✓ Strengthen state laws to ensure that corporate entities cannot direct medical decisions to the detriment of patient care.
- ✓ Strengthen statutory provisions to protect physicians' due process rights and prohibit retaliation for patient advocacy in all employment and contractual relationships.
- ✓ Support legislation that protects the rights and moral conscience of physicians in serving their patients. Texas statute should not require physicians to provide care or counsel that they conclude is medically inappropriate, that violates their personal conscience and moral beliefs, or that does not protect their patients.
- ✓ Encourage or require all covered patients in state-directed programs or state-regulated health plans to enact advance directives to ensure patients' concerns and wishes are incorporated into their care.
- ✓ Support methods of resolving disagreements and conflict regarding medical treatments without litigation.



SECTION 3

Promote High-Quality, Effective, and Efficient Models of Care

Right Care, Right Person, Right Time, Right Place

No one worries about the spiraling cost of health care in the United States more than physicians. Our current health care delivery system does too little to coordinate care for patients with expensive-to-manage chronic conditions. Government and other payers are requiring physicians to invest in high-dollar health information technology (HIT) systems without ensuring that the investment translates into better patient care. We are responding to calls to measure a physician's effectiveness and efficiency, but government metrics imposed on physicians often are off-target. The way to save money in health care is not through ill-advised, random rationing of care, but rather through systems that ensure the right professionals provide the right care, at the right place, and at the right time.

Support physician-driven health care quality initiatives

Physicians are central to ensuring the provision of high-quality, effective, and efficient health care in Texas. The very notion of providing high-quality care is a fundamental principle of physician training, professionalism, and culture.

Today, the term “quality care” has taken on different meanings depending upon which stakeholder is discussing it — a health care policy expert, insurance company CEO, managed care organization executive, patient, or physician. Simply stated, quality is about ensuring the right care is delivered at the right time by the

right health care professionals. Unfortunately, our complex health care system, government regulations, and red tape make it increasingly more difficult to provide continuous and consistent care coordination.

Research has shown that quality in our U.S. health care system needs improvement. For example, a 2003 RAND study found many adults received recommended health care services only 55 percent of the time.²⁰ Misuse, underuse, and overuse of care are the three main areas that can result in patient harm and poor health care quality. With this knowledge, numerous quality improvement initiatives are under way throughout the U.S. health care system.

Physicians are actively striving to improve the quality of care they provide and promote health care innovations that lead to achieving the Triple Aim — better care, better health, and lower costs.



An initiative of the ABIM Foundation

TMA is one of five state medical associations chosen to participate in the American Board of Internal Medicine (ABIM) Foundation's *Choosing Wisely*® campaign. Since April 2012, around

60 national medical specialty societies have developed lists of “Things Physicians and Patients Should Question.” The lists are science-based recommendations that physicians have developed and vetted. The *Choosing Wisely* lists now include more than 300 recommendations regarding treatments, tests, and procedures that national medical specialty societies say are unnecessary or overused. TMA is helping physicians incorporate the program into daily practice.

Already, the Texas Institute of Health Care Quality and Efficiency recommended *Choosing Wisely* to the Texas Legislature for advancing the state’s version of health care reform passed in 2011. *Choosing Wisely* dovetails with one of the key values the institute is charged with upholding — making sure state quality initiatives are based on solid scientific evidence.

“When the American Academy of Neurology released their tips, I printed the suggestions out and taped them to my desk as a reminder.”

— Eddie Patton, MD, a Houston neurologist, uses the *Choosing Wisely* guidelines in his practice.

Promote the patient-centered medical home for every Texan

Consider that the costliest 1 percent of patients in the United State account for more than 20 percent of the nation’s health care spending. They are older patients with cancer, diabetes, heart disease, and other serious and chronic conditions. Many have multiple health problems and may not have relatives who can help with their care.

As public and private payers look for ways to reduce costs, improve patient outcomes, and ease barriers to access, they are turning to models of care that increase economic efficiencies and enhance patient care. One of these is the patient-centered medical home (PCMH). A PCMH is a primary care physician or physician-led team who ensures that patient care is assessable, coordinated, comprehensive, patient-centered, and culturally relevant. The physician or team directly provides, coordinates, or arranges health care or social support services as indicated by the patient’s individual medical needs and the best available medical evidence. The model uses a team-based approach, with the patient’s primary care physician leading the coordination of care. Trained teams and well-constructed electronic health records are keys to a successful PCMH.

TMA supports the use of the PCMH model in Medicare, Texas Medicaid, and commercial insurance plans. Given the budget constraints Texas faces and a growing population with unique health care needs, the PCMH offers the potential

for Medicaid cost savings as well as improved patient outcomes and physician and provider satisfaction.

In recent years, numerous states have implemented PCMH initiatives that engage both private and public payers. While each program design was unique and each measured success differently, the evidence indicates the model improves outcomes and reduces costs.

- The Patient-Centered Primary Care Collaborative published a literature review in January 2014. The authors reviewed 20 academic and industry-funded studies assessing how the PCMH model affected patient care, costs, utilization, and quality. According to the report, when primary care practices embrace the model, there are positive outcomes. Specifically, the literature review found that the PCMH:
 - Decreases the cost of care;
 - Reduces unnecessary or avoidable emergency department services, and hospital admissions and readmissions; and
 - Increases preventive health services, such as cancer screenings and immunizations.²¹
- A March 2014 study published in the *American Journal of Managed Care* found that the PCMH model “significantly reduced costs and utilization for the highest-risk [non-pediatric] patients” by decreasing inpatient hospital admissions.²²

Texas lawmakers have embraced the idea. In 2009, they directed Texas Medicaid to work with Medicaid HMOs to expand the PCMH model; they directed the Employee Retirement System (ERS) to test it for state employees in 2011. ERS implemented its first PCMH pilot in Austin. The model has been expanded to additional clinics in Houston, Tyler, and Lubbock that collectively cover more than 52,000 state employees. According to ERS, the PCMH has saved the system \$31 million since 2011 by reducing inappropriate emergency department visits and hospital readmissions.

A number of Medicaid HMOs, including Driscoll Children's Health Plan and Texas Children's Health Plan, are collaborating with physicians to implement the PCMH model in their networks.

In 2013, the legislature enacted a pilot pregnancy medical home for Medicaid enrollees in Houston. It is one of many outcomes-based initiatives Texas is testing to improve maternal and infant health. The pregnancy medical home pilot, led by a team of physicians in collaboration with certified nurse midwives, social workers, and other providers, integrates medical and social support services into a single location to improve the quality of care provided to pregnant women and their children. The results of the Texas pilot will be published in early 2015.

North Carolina, which initiated a similar pilot in 2011, has seen positive results. The state achieved

a 3-percent reduction in low-birth weight babies as well as modest declines in cesarean deliveries. Furthermore, the North Carolina pilot increased patient access to comprehensive medical care, resulting in more women receiving health screenings to identify factors that may lead to premature delivery, such as smoking or a prior preterm birth.²³

Promote physician-led health care teams

Texas needs more physicians and other health care professionals working in all parts of the state, especially in rural and border Texas. But the real gains in improving access to and coordination of patient care will come largely from solidifying and expanding the use of physician-led teams. Team-based care capitalizes on the efficiencies of having the right professional providing the right services to the right patient at the right time ... with overall direction and coordination in the hands of physicians.

In 2013, lawmakers bolstered this model by passing legislation that set up a more collaborative, delegated practice among physicians and advanced practice registered nurses (APRNs) or physician assistants (PAs). The new law reinforces the importance of physician-led medical care teams, recognizes the skills all practitioners bring to patient care, and allows the delegating/supervising physician greater flexibility to improve access to care and maintain quality of care. The new law recognizes that independent diagnosis and prescribing are the practice of medicine. Physicians may delegate, but they must supervise.

TMA believes that a physician-led team approach to care, with each member of the health care team providing care based on his or her education and training, is critical to ensuring that more Texans receive high-quality care. Team care requires cooperation and collaboration among all professionals, with a focus on quality, measureable outcomes, and efficient utilization of resources.

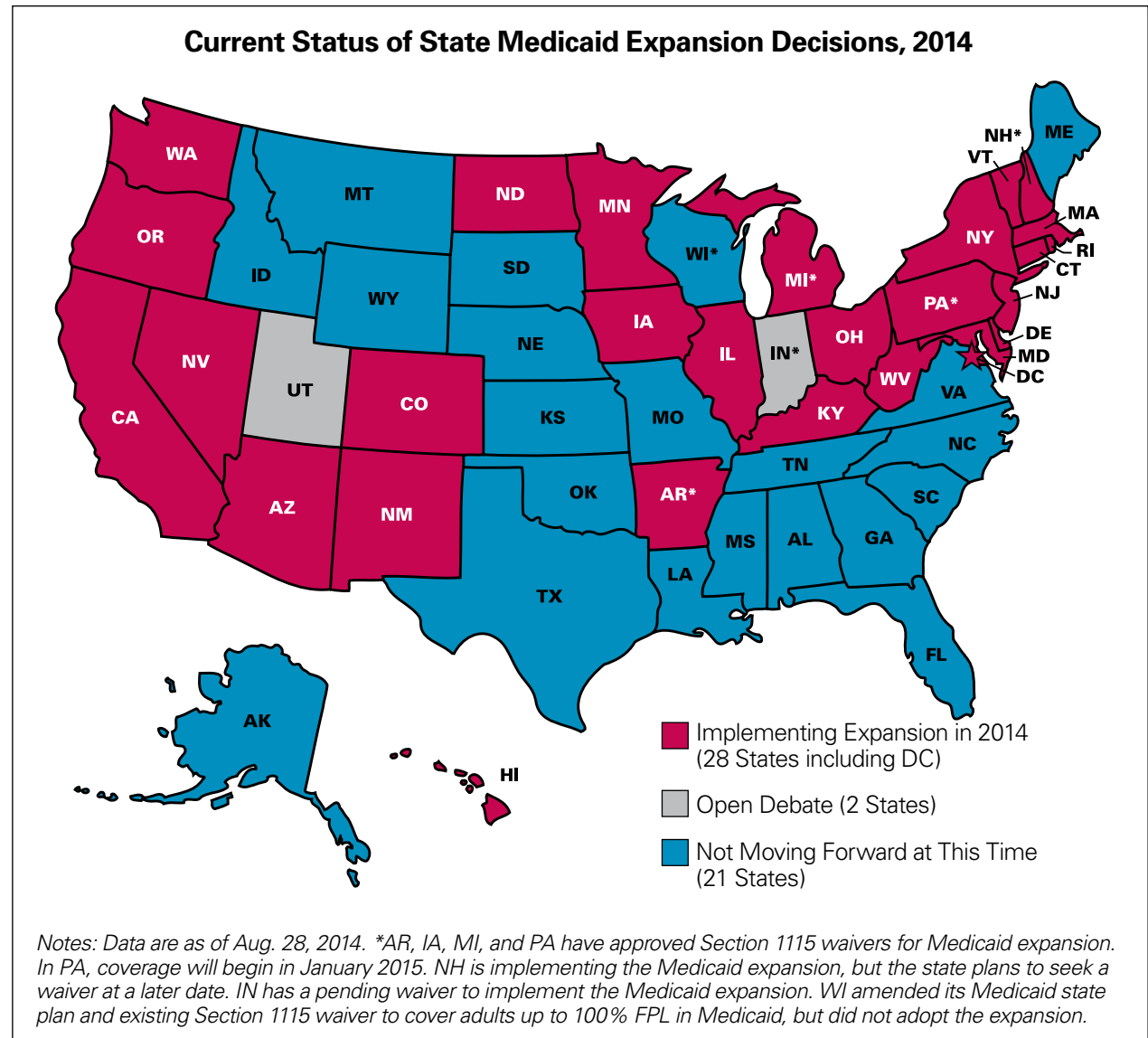
A small number of allied health professionals have spurred calls for Texas to grant them independent practice. Such an expansion in their scope of practice would likely increase costs and utilization, and could endanger the safety of our patients. The Texas Medical Practice Act was passed more than 130 years ago to protect Texans from people who called themselves "doctor" but who did not have the skills, training, or education to warrant such a title. The act, administered by the Texas Medical Board (TMB), clearly defines the practice of medicine and the educational qualifications necessary to diagnose, independently prescribe, and direct patient care — and to be held accountable for that care.

In the coming decade, integrating the talents of a diverse medical team under physician leadership will be one of the key challenges. Without physician direction, supervision, management, and coordination, medical care will trend toward even more fractured care, higher-than-necessary utilization, and creeping inefficiencies. This will lead to even higher costs, duplications of services, and lower-quality patient care. These inefficiencies in turn will hamper efforts to improve access to care.

On the other hand, some scope expansions are consistent with team care, are based on objective educational standards, and would improve patient care services. These should be carefully weighed and likely will involve regulatory oversight by TMB.

Improve health care coverage for low-income Texans

The Affordable Care Act (ACA) created two coverage options for uninsured patients with incomes up to 400 percent of the federal poverty level (FPL). One choice, which the U.S. Supreme Court made optional for states, was expanding Medicaid eligibility to 138 percent of FPL (\$16,104 for an individual or \$32,913 for a family of four in 2014).²⁴ The other was the new health insurance marketplaces, where patients go to buy private insurance. Texas is one of 21 states that chose not to expand Medicaid eligibility in 2014. As a result, more than 1 million uninsured Texans, mostly low-income adults, are left in what's called the "coverage gap," which means they make too much money to qualify for Texas Medicaid but not enough



Sources: Current status for each state is based on data from the Centers for Medicare & Medicaid Services and KCMU analysis of current state activity on Medicaid expansion.

to qualify for the marketplace premium tax credits. Few of these Texans have access to other affordable insurance options. Texas Medicaid eligibility for parents is about 20 percent of poverty — less than \$4,000 per year.

Most of these Texans work. In fact, 58 percent, more than 845,000, are currently working or have worked within the past year. Of the 42 percent who are not working, a majority (24 percent of Texans who could gain coverage under the coverage gap) are classified as “not in the workforce.” They include people with disabilities, college students, non-working spouses who care for children or a family member with a disability, and people who have left the workforce. The remaining 18 percent of Texans who could be helped are unemployed.²⁵ Although they work, few in the coverage gap have access to employer-sponsored coverage; if they do, they frequently forego coverage because of high costs.

Texas physicians want to ensure all Texans have access to coverage and, more important, have access to physicians and other health care providers. According to the Institute of Medicine, even when uninsured patients have access to safety net services, the lack of health insurance often results in delayed diagnoses and treatment of chronic diseases

or injuries, needless suffering, and even death.

That’s why TMA supports allowing state leaders to work with the Centers for Medicare & Medicaid Services (CMS) to develop a comprehensive solution that fits Texas’ unique health care needs. Several states have taken this step with some success, including Indiana, Arkansas, Iowa, Michigan, and Pennsylvania. (See adjacent chart.) TMA believes the Texas Legislature too can create an ingenious solution that works for the state and helps Texans in the coverage gap get affordable and timely care. Any Texas-style solution expanding access must:

- Draw down all available federal dollars to expand access to health care for poor Texans;
- Give Texas the flexibility to change the plan as our needs and circumstances change;
- Clear away Medicaid’s financial, administrative, and regulatory hurdles that are driving up costs and driving Texas physicians away from the program;
- Relieve local Texas taxpayers and Texans with insurance from the unfair and unnecessary burden of paying the entire cost of caring for their uninsured neighbors;

States Expanding Medicaid Programs

State	Programs Approved by Centers for Medicare & Medicaid Services
Arkansas <i>(In effect 9/27/13)</i>	Uses Medicaid funds to purchase private insurance coverage in the marketplace for newly eligible adults aged 19-64. Applies to parents with incomes between 17 and 138 percent of FPL and childless adults 0 to 138 percent of FPL.
Iowa <i>(In effect 1/1/14)</i>	Newly eligible adults with incomes below 100 percent of FPL will be eligible to receive coverage through the Iowa Health and Wellness Plan. Individuals with incomes between 100 and 133 percent of FPL will be eligible for premium assistance to purchase private insurance from the federally facilitated marketplace.
Michigan <i>(In effect 4/1/14)</i>	Covers newly eligible adults through Michigan’s existing Medicaid managed care delivery system, not through premium assistance. Will use existing Medicaid managed care organizations and prepaid inpatient health plans to serve the newly eligible population.
Pennsylvania <i>(Proposed effective date 1/1/15)</i>	Uses Medicaid funds to purchase private insurance coverage through the marketplace. For all newly eligible adults aged 21-64, parents between 33 and 138 percent of FPL, and childless adults between 0 and 138 percent of FPL.
State	Programs Pending CMS Approval
Indiana <i>(Public comment period ended 6/21/14)</i>	Expands the Healthy Indiana Plan (HIP), a 2008 pilot that combines health savings accounts with high-deductible plans sold on the private market. HIP was aimed at residents making too much to qualify for Medicaid. The new plan would extend HIP to as many as 500,000 people. Will be available to Indiana residents aged 19 to 64 earning up to 138 percent of the federal poverty level.

Source: Kaiser, 2014

- Provide Medicaid payments directly to physicians at least equal to those of Medicare payments; and
- Continue to improve due process of law for physicians and other providers in Texas as it relates to the Office of Inspector General.

Improve maternal and infant health

The March of Dimes gave Texas a “C” on its prematurity report card in 2013. The Texas Health and Human Services Commission reported 67 percent of hospital costs for newborns is for prematurity. Neonatal intensive care for an extremely preterm birth costs Medicaid an average of \$54,400 versus \$480 for a full-term baby. Babies born prematurely often suffer from chronic illnesses, such as asthma, and developmental delays or learning disabilities, all of which further increase health care costs as well as costs to the state’s

Births to Females Under 20 Years of Age, Percent by Race/Ethnicity, 2011

Mother’s Race/Ethnicity	Texas	United States
Non-Hispanic white	21%	39%
Non-Hispanic black	14%	24%
American Indian or Alaska Native	0%	2%
Asian or Pacific Islander	1%	2%
Hispanic	64%	33%

Source: U.S. Department of Health and Human Services, 2011

educational system. According to the Centers for Disease Control and Prevention (CDC), the leading cause of neurological disability in children is prematurity.

Improving birth outcomes not only enhances the lives of babies, mothers, and their families, but also can yield substantial savings, particularly to publicly financed programs such as Medicaid, which covers 53 percent of all Texas births.

Almost 60 percent of Texas women lack health insurance. Roughly 700,000 of these women are in the so-called “coverage gap” — earning too much for Medicaid (unless they are pregnant) but too little to qualify for subsidies to help buy private insurance on the federal exchange. Without coverage, uninsured women often forego needed care, particularly preventive care. Preventive health services are important for all patients, but especially for women, who require prenatal care during pregnancy and other types of preventive care, such as cancer screenings, high blood pressure checks, nutrition counseling, and birth control before and between pregnancies to ensure they and their babies are healthy.

Texas has three programs that collectively serve as the preventive health safety net for low-income women — Texas Women’s Health Program (TWHP), Expanded Primary Health Care Program (EPHC), and family planning initiatives. Texas has the capacity to serve only about one-quarter of the women who qualify for these programs.

Reduce Texas’ maternal mortality rates

Texas statistics for maternal mortality more closely resemble a third-world country than a state with world-class medical care. About 12.3 percent of babies are born prematurely — higher than the U.S. rate of 11.7. Rates are highest among African-American women. The national goal is 9.6 percent by 2020.

Factors that contribute to poor maternal and infant health are lack of early prenatal care, diabetes, hypertension, and obesity. Too many Texas women must confront some or all of these challenges.

Texas has made progress in the past two legislative sessions improving outcomes on maternal illnesses and deaths. In 2011, the Texas Department of State Health Services (DSHS) and the March of Dimes launched the Healthy Texas Babies Initiative (HTBI), bringing together health and community leaders to develop state and local strategies to address Texas’ poor maternal and birth outcomes. Texas Medicaid, with strong support from TMA and the state’s two OB-Gyn specialty societies, implemented 2011 legislation to halt payment for non-medically necessary, elective inductions prior to the 39th week of gestation. The 2013 legislature established a Maternal Mortality and Morbidity Review Task Force to identify causes of and remedies for pregnancy-related deaths and severe morbidity. Lawmakers also reversed funding cuts enacted in 2011 to DSHS-administered women’s preventive health care, which left more than

200,000 women without access to these vital services.

More work remains. Increasing the number of women who enroll in the Texas Women's Health Program, EPHC, and family planning programs, as well as increasing the number of physicians and clinics who participate, will be essential to Texas' efforts to improve maternal health and birth outcomes.

Improve patient access to safe health care: Telemedicine

Texas has one of the fastest growing populations in the United States. This dramatic growth necessitates a robust health care workforce across the state. Currently, 32 Texas counties have no practicing physician. Some areas of the state have critical shortages of specialists. Physicians need tools such as telemedicine that can provide safe, high-quality, timely care to patients. Physicians, patients, and lawmakers should examine how to make telemedicine an effective tool that will improve access, decrease health care costs, and improve patient health. However, we must maintain safeguards to protect patients and ensure telemedicine complements the efforts of local health care providers.

Good telemedicine standard of care

TMA has long-standing policy — first adopted in the 1990s — in support of physicians and providers rendering safe, high-quality telemedical

services. TMB amended its telemedicine rules in 2010 to ensure medical services delivered this way observe the same standards of care as traditional medicine. Those rules, developed with input and support from TMA, academic health science centers, and health technology companies, require an established patient-physician relationship and state that an online or telephonic evaluation solely by questionnaire does not constitute an acceptable standard of care. A patient-physician relationship must begin with an initial face-to-face visit; a relationship cannot be established solely by a phone call, online questionnaire, or Internet “face-time” discussion.

If a traditional patient visit requires a physical examination of the patient, that same standard will apply to a telemedical visit. That is why a true telemedical service requires a local observer or presenter to perform the necessary physical non-virtual examination. Merely filling out a questionnaire or speaking over the phone provides subjective information only and can lead to incorrect diagnosis and treatment.

In the 2011 and 2013 legislative sessions, for-profit telemedicine and insurance companies pushed legislation that would allow them to provide telemedicine services in Texas without an established patient-physician relationship. Their efforts failed, but they are likely to try again in 2015. Their efforts thus far have focused solely on getting the health plan enrollees to pay more out of pocket for a telemedicine transaction, as

the health plan pays nothing for the service. TMA will continue to protect patient safety by ensuring anyone who provides telemedicine does so under TMB rules.

TMA strongly supports TMB's telemedicine rule regarding the initial face-to-face visit, the recognition of local coverage arrangements, and the necessity for an observer (licensed health care practitioner) for all new medical conditions. TMA will continue to fight for safe medical care delivery and oppose business models that do not meet appropriate standards of care.

Ensure equal pay and follow-up for after-hours care

Insurance companies generally don't pay physicians for the time they spend with patients over the telephone for after-hours care. TMA supports legislation that will allow physicians to bill patients for after-hours telephone consultations. This parity is critical to ensure patients can maintain continuity of care with their physician. Also, when telemedicine services are provided to patients, the telemedicine company needs to make certain that all treatment provided is communicated to the patient's local physicians to guarantee appropriate continuity of care or in case the patient needs follow-up care.

Current barriers to telemedicine services

Interstate licensing compact: Because telemedicine programs involve physicians

They are worth his patients' very lives. "[Using telemedicine] we have the opportunity to create all sorts of innovative engagements with patients on the remote end for the betterment of their care, to take care of at-risk populations who aren't cared for at all or so minimally that it costs everyone," says Dr. Kim. But the first step, he says, "is to establish a therapeutic relationship. To do that, I need a picture, and I need sound. Without both, I do not know how I would be able to render an assessment, opinion, or recommendation, including ... and especially ... the prescribing of medications. In my opinion, this is the minimum bar for telehealth care."

— To Thomas J. Kim, MD, pictures are worth more than a thousand words

treating patients remotely and often across state lines, physicians using telemedicine technology must comply with each state's licensing requirements. Recently, the Federation of State Medical Boards (FSMB) proposed an interstate medical licensure compact that would allow physicians to practice telemedicine in multiple states without having to go through each state's individual licensure application process. State boards would mutually agree to a common set of requirements to help streamline licensing and greatly reduce the hassle of a full licensure application evaluation. TMB recently decided to move forward on discussing the proposal.

Expedited credentialing: In 2011, CMS and the Joint Commission promulgated rules allowing hospitals using telemedicine to rely on credentialing conducted at the facility where the physician is located. However, some physicians report hospitals still frequently require complete credentialing, even when doctors in another geographic location deliver services only via telemedicine. TMA and the Texas Hospital Association are working with HHSC's Quality-Based Payment Advisory Committee to develop a uniform approach to telemedicine credentialing in line with CMS and Joint Commission regulations and state rules.

(TMA Recommendations on page 28)

A typical telemedical visit is conducted with a physician at a remote location using video and audio to connect to a patient who is accompanied by a licensed health care provider (acting as the local observer for the physician). The observer is able to take objective measurements, such as blood pressure, heart rate, and weight, that the physician needs to provide treatment safely.

Rx TMA RECOMMENDATIONS

- ✓ Advocate for the patient-centered medical home (PCMH) model and financial incentives from both state and private payers. Recognize the significant start-up costs for transforming a typical primary care, fee-for-service practice into a fully functional medical home.
- ✓ Support legislation allowing state leaders to work with the Centers for Medicare & Medicaid Services (CMS) in developing a comprehensive coverage solution for the unique health care needs of Texas.
- ✓ Institute incentives for physicians who find innovative solutions to save Medicaid costs without increasing the overall cost of care.
- ✓ Stop any efforts to expand scope of practice beyond that safely permitted by nonphysician practitioners' education, training, and skills.
- ✓ Enact only those changes to scope of practice laws that are based on objective educational standards, improve patient care services, protect patient safety, preserve the physician-led medical home, are consistent with team care, and have appropriate regulatory oversight by the Texas Medical Board (TMB).
- ✓ Pass legislation that strengthens TMB's regulatory oversight of nonphysician licensees who, by specific educational achievement, are granted authority to perform acts traditionally reserved for and defined as the practice of medicine.
- ✓ Increase funding for women's preventive health services to ensure all women in need can obtain services.
- ✓ Evaluate efficacy of Texas Health and Human Services Commission (HHSC) and Department of State Health Services (DSHS) patient, physician, and provider outreach for women's health programs as well as whether state-funded programs have sufficient physician and provider capacity.
- ✓ Continue collaborative, evidence-based efforts with physicians and other stakeholders that will reduce preventable preterm births, including implementing measures to ensure uninsured, low-income women have timely access to appropriate early preventive health care before, during, and between pregnancies.
- ✓ Intensify smoking cessation efforts for pregnant women.
- ✓ Support implementation of neonatal intensive care and maternal standards of care, both of which the HHSC Perinatal Advisory Council is developing.
- ✓ Ensure adequate resources for the Maternal Mortality and Morbidity Review Task Force as well as the Fetal, Infant, and Child Mortality Review Program.
- ✓ Identify the population of pregnant women at higher risk of a poor birth outcome due to abuse of alcohol, opioids, or other substance, and amplify educational and outreach efforts to physicians and patients regarding Medicaid substance abuse treatment resources.
- ✓ Invest funding in research to identify genetic, economic, and social factors contributing to higher rates of preterm births.
- ✓ Ensure telemedicine services are provided in accordance with TMB rules and accepted standards of care.
- ✓ Enact legislation that would require insurance companies to pay local physicians for after-hours telephone and telemedical consultations on the same basis as other physicians who may be working for a telemedical business and permit them to contract with patients for this added service.
- ✓ Require any telemedical service to be communicated to the patient's local physician to ensure continuity of care.
- ✓ Support an interstate compact for telemedicine licensing that ensures state sovereignty over the practice of medicine.
- ✓ Allow expedited credentialing at hospitals for distant-site physicians who provide telemedicine services to the facility.

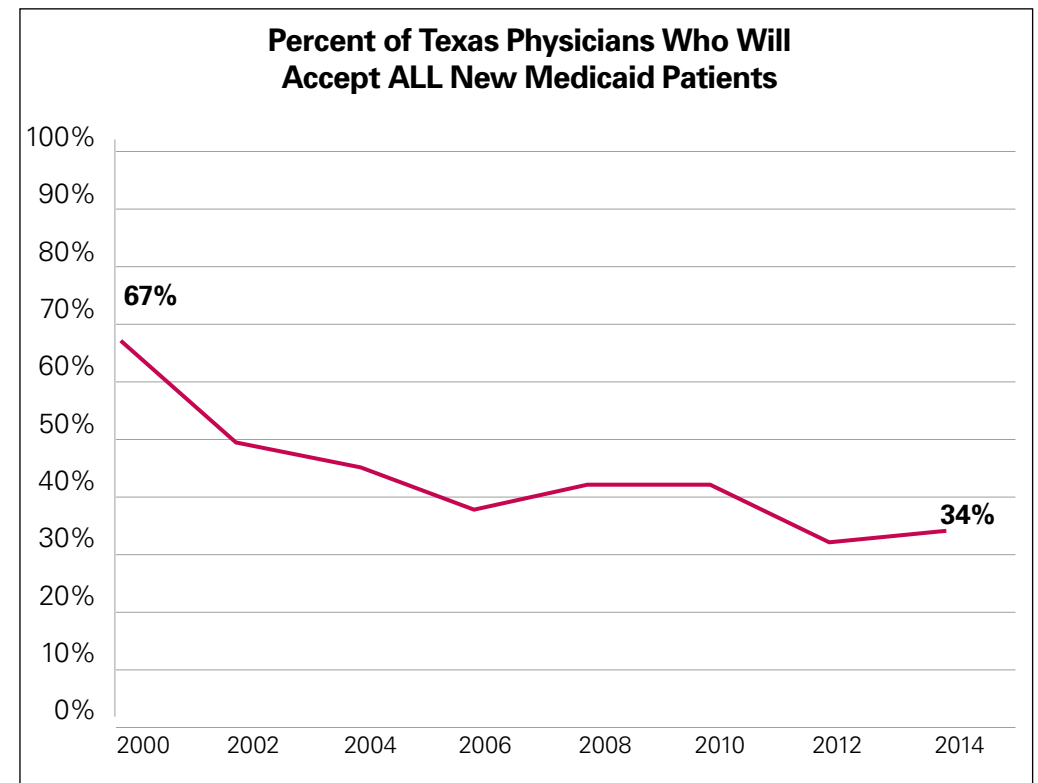


SECTION 4

Promote Government Efficiency and Accountability by Reducing Medicaid Red Tape

Texas physicians strongly support Medicaid. Without it, nearly 4 million poor and low-income Texans would lack health insurance, jeopardizing their health and well-being. Physicians want to take care of these patients, and they do so throughout the state. Unfortunately, red tape and bureaucratic hassles coupled with low pay are forcing many physicians to limit the number of new Medicaid patients they take — or to not take any at all. For more than a decade, physician participation rates have been in a free fall, plummeting 33 points in 14 years. In 2000, 67 percent of Texas physicians reported accepting all new Medicaid patients; today, only 34 percent do.

Physicians don't reach this decision easily. They want to provide prenatal care to pregnant women, medications for asthmatic children, and community services for seniors wishing to stay in their homes instead of a nursing facility. But after doctors care for a Medicaid patient, their office staff must then navigate the program's increasingly complex rules and bureaucratic regulations to get paid.



Source: 2014 TMA Physician Survey, Preliminary Results

Administrative hassles not only detract from a physician's ability to provide needed care, they also drive up overhead costs, ultimately making the meager Medicaid payments too low for many physicians to put up with the tangle of red tape.

Standardize Medicaid managed care administrative processes

Federal and state Medicaid laws and regulations are extremely complex. Physicians participating in Medicaid must comply with all of the requirements of the *Texas Medicaid Provider Procedures Manual*, which exceeds 1,800 pages, as well as all state and federal laws governing or regulating Medicaid. Physicians also must abide by additional requirements imposed by multiple Medicaid HMOs. Pediatricians practicing in Harlingen, for example, must be familiar with traditional Medicaid rules plus five different Medicaid HMO plans if they participate in all six products.

While all Texas Medicaid plans cover the same essential patient benefits and services, what it takes to receive approval to provide the care — or get paid for it — varies with each plan. For instance, one Medicaid HMO may require prior approval for therapy provided to children with disabilities;

another may not. Or each Medicaid HMO may require prior approval of the same service, but use different criteria to grant approval.

Many physicians who want to participate in Medicaid have found just signing up for the program daunting. They must complete a confusing application, submit it to the state, then hope their answers are correct because if not, the application is returned. Sometimes physicians' applications are lost, and they have to redo it. Physicians frequently spend months navigating the state's application process. Once Medicaid approves the application, physicians then must be credentialed by each Medicaid HMO they agree to contract with, even though the information each plan needs to complete the credentialing process is nearly identical to the original Medicaid application. All these time-consuming administrative issues serve as barriers for physicians who want to take care of Medicaid patients.

Improve Medicaid HMO physician networks

Perhaps the worst hassle of all is contending with inadequate Medicaid HMO physician networks. Contractually, state and federal governments require each plan to have an adequate number of primary care and subspecialty physicians to provide timely care for the patients in their networks. But in practice, this is not always the case. Patients and physicians frequently complain

that physicians and providers listed in HMO directories as accepting new Medicaid patients either are not accepting them at all or have excessive wait times for new patient appointments.

Primary care physicians say it is not uncommon to spend hours on the phone trying to find specialty care for a Medicaid patient. Too often, they resort to referring their patients to costly emergency departments to ensure their patients get the care they need.

Significant expansion of these networks will not happen until the government eliminates bureaucratic hassles and increases payment rates.

Simplify compliance with Medicaid fraud and abuse laws

For physicians, learning and complying with the *Texas Medicaid Provider Procedures Manual*, the Texas Administrative Code, state law, and federal statutes and regulations require a significant amount of time and staff resources. On top of the sheer volume of compliance obligations, physicians also must stay up to date with frequent changes and revisions. If physicians fail to strictly comply with all of Medicaid's requirements, they face stiff fines, penalties, sanctions, or other enforcement actions. This creates an impossible situation for physicians who want to care for Medicaid patients.

Medicaid rules should be clear and easy to understand so physicians can dedicate their

Medicaid administrative simplification progress made

Lawmakers in 2013 heard the plea for Medicaid administrative simplification, directing the Texas Health and Human Services Commission (HHSC) to address physician, provider, and patient complaints regarding Medicaid HMO operations. Two new laws require HHSC to reduce administrative hassles, ensure prompt payment of claims, streamline paperwork and credentialing requirements, and strengthen how Medicaid measures network adequacy.

One law established a workgroup to advise HHSC on creation of a Provider Protection Plan. The plan is required to address:

- Prompt payment of claims;
- Adequate and clearly defined provider network standards;
- Prompt credentialing processes; and
- Establishment of electronic means to submit claims, prior authorization requests, and claims appeals, and to obtain remittance advice and explanation of benefits.

Another new committee — the Statewide Medicaid Managed Care Advisory Committee — will advise HHSC on how best to expand the HMO model to new populations and services over the next several years. The committee, led by a TMA physician, also will identify ways to improve network adequacy, reduce HMO hassles, and increase quality, efficiency, and patient, physician and provider satisfaction.

time, talent, and staff resources to patient care, as opposed to administrative hassles, burdensome audits, and fear of fraud and abuse accusations. While TMA supports efforts to eliminate health care fraud, we also strongly support a fair process to define, detect, and prevent actual fraud. HHSC needs to make improvements that will reduce and streamline its red tape to prevent administrative errors in the first place. When HHSC identifies potential compliance problems (whether through an investigation or audit), steps should be taken to resolve them quickly. First, the problem and applicable standards must be communicated to the physician, so he or she has an opportunity to respond to allegations and, in the event an issue does exist, take corrective action.

Second, when allegations of potential fraud, abuse, and/or any overpayments arise, they should be supported by reliable evidence. Accordingly, investigations concerning the practice of medicine must include the expertise of medical practitioners with appropriate training and experience — particularly for questions of whether a service or treatment was medically necessary.

Third, when issues are accurately identified, they should be resolved in a timely manner, especially when the concerns are based on non-fraudulent violations. Timely resolution of non-fraudulent issues allows physicians to correct identified errors and keep their focus on patient care without the distraction of extensive litigation, looming demands, or nonpayment.

TMA believes the best way to reduce administrative and payment errors is through continued education and outreach from HHSC and Medicaid managed care plans. This step would help eliminate costly errors before they occur, saving physicians and their office staff time and money, and ultimately saving taxpayers money as well.

Physicians should be afforded adequate notice of the alleged issues or violations, calculation of overpayments (including extrapolation methodology), and proposed sanctions or penalties; the applicable timelines for responding to allegations; and the right to offer a meaningful response. If issues cannot be settled informally,

Texas laws and regulations should clarify the coordination of responsibilities, authority, and interaction among enforcement agencies. Eliminating redundancy would streamline operations, expedite investigations and recovery efforts, and provide physicians with clarity on the legal authority of each investigative agency and the applicable rules and processes.

physicians should be able to appeal the alleged violation and money in question to an independent third party and have that appeal heard in a timely manner.

Eliminate duplicate Medicaid audits and investigations that waste taxpayers' money

Physicians participating in Medicaid face audits and/or investigations from an array of state agencies or agency contractors. Duplication and overlap of investigations waste taxpayer money, valuable state resources, and time in Texas Medicaid. Seven different state agencies are involved in Medicaid audits and investigations, including the Office of the Attorney General (made up of the Medicaid Fraud Control Unit and the Civil Medicaid Fraud Division), the HHSC Office of Inspector General, managed care organizations (MCOs), MCO Special Investigative Units, and Recovery Audit Program contractors.

Physicians must know which agency is conducting the investigation, who has the authority to settle or resolve an issue, and whether they are being accused of an administrative violation, civil fraud, or criminal activity. Texas laws and regulations should clarify the coordination of responsibilities, authority, and interaction among enforcement agencies. Eliminating redundancy would streamline operations, expedite investigations and recovery efforts, and provide physicians with

clarity on the legal authority of each investigative agency and the applicable rules and processes.

Discard costly and burdensome data reporting programs

For more than a decade, Texas physicians who own ambulatory surgery centers (ASCs) or hospitals have had to collect and report data to the Texas Health Care Information Council (THCIC) that provide little or no benefit to patients. Data reporting laws and their subsequent regulations were intended to help patients make informed health care choices, a laudable goal. However, over the past 20 years, the THCIC data reporting program has failed to do this. It only collects physicians' billing information, which it turns around and sells to third parties, such as large hospital systems and commercial health insurance plans, who use it for marketing. THCIC has not shared any summary data with physicians so they can improve patient safety or quality outcomes. Plus, THCIC's data reporting requirements are expensive and time-consuming for physicians and their office staff to meet.

(TMA Recommendations on page 34)



TMA RECOMMENDATIONS

- ✓ Establish a centralized credentialing portal so physicians can apply to participate in all the Medicaid HMOs participating in the service area simultaneously.
- ✓ Integrate Medicaid/Medicaid HMO application and credentialing processes for physicians applying to the program for the first time.
- ✓ Improve coordination of benefits between Medicaid and Medicaid HMOs to prevent recoupment of money from physicians after services were provided in good faith.
- ✓ Require Medicaid HMOs to communicate clearly to physicians and patients the process for obtaining services when an in-network physician/provider cannot be found.
- ✓ Require the HMOs to establish a dedicated contact person for a physician to call to request assistance in arranging services not available in network.
- ✓ Establish a Texas Health and Human Services Commission (HHSC) ombudsman to oversee Medicaid HMO network adequacy, respond to patient and physician complaints, and enact physician recruitment initiatives.
- ✓ Establish a division within HHSC dedicated to recruiting new physicians to participate in Medicaid, and/or allow the HMOs to recruit physicians who are not enrolled in Medicaid but whose specialty is needed in the network.
- ✓ Monitor HMO network adequacy more stringently. Apply stiffer penalties for plans that fail to maintain adequate networks.
- ✓ Require the state to publish in-network and out-of-network utilization trends and data about patient/physician complaints.
- ✓ Protect 2013 legislation that improves due process for physicians who are confronted with a Medicaid fraud or overpayment accusation.
- ✓ Ensure physicians and providers have a meaningful opportunity to appeal allegations of Medicaid fraud and/or abuse to an independent third party.
- ✓ Eliminate redundant efforts and expenditure of state funds, employee time, and other resources involved in investigating alleged violations of Medicaid regulations.
- ✓ Ensure Texas laws and regulations clarify the coordination of responsibilities, authority, and interaction among enforcement agencies regarding the Medicaid program.
- ✓ Eliminate data collection programs, such as the Texas Health Care Information Council, that don't provide patients with useful information to make informed health care decisions.



SECTION 5

Repeal Harmful and Onerous Federal Regulations

Administrative costs in the U.S. private and public health care system amount to around \$361 billion annually — 14 percent of all health care expenditures. Insurers and government health programs, such as Medicare and Medicaid, require physicians and their patients to follow too many complex, nonsensical, and redundant policies, rules, and procedures. In fact, physicians and health care providers employ more billing and posting clerks than any other industry.²⁶

Since September 2011, physicians have had to comply with more than 100 new administrative mandates resulting from the Affordable Care Act (ACA). Unfortunately, the ACA was not the genesis of physician regulation, nor are these busy rulemakers limited to the federal government. The huge numbers of state and federal regulations and their haphazard nature place tremendous burdens on physicians' practices, most of which are small businesses. These rules insert the government between physicians and their patients, frequently do little to improve patient care, and divert physicians' time and energy away from their patients in the exam room.

Eliminate the adoption of ICD-10 coding system

Forced adoption of International Classification of Diseases, 10th revision (ICD-10), is an excellent

example of a costly regulation that will disrupt practice operations. ICD-10 is a 20-year-old boondoggle of a system that will help only health care researchers. All physicians, hospitals,

providers, and insurance companies must shift from ICD-9 to ICD-10 by Oct. 1, 2015.

The number of diagnostic codes that physicians will be required to use under ICD-10 will grow from 13,500 to 69,000. The number of inpatient procedure codes will soar from 4,000 to 71,000. For example, the new system has 480 codes for a fractured knee cap — up from a grand total of 2 in ICD-9. Switching to ICD-10 will mandate extensive revision of physicians' paper and electronic systems. Transition to the new system is expected to cost solo physicians up to \$226,000 each. The cost to a midsize practice with 10 physicians, six administrative staff, and one full-time coder ranges from \$213,000 to \$824,000; the cost for a large practice with 100 physicians and 10 full-time coders could reach up to \$8 million.

The ICD-10 mandate will create significant burdens on the practice of medicine with absolutely no direct benefit to individual patient care. It is a



Source: TMA's *Deadlines for Doctors*, a compilation of compliance requirements physicians have had to implement since 2011

huge weight to place on physicians when they face numerous other administrative hurdles, including implementing and achieving meaningful use of electronic health records (EHRs), meeting quality measures under Medicare's Physician Quality Reporting System (PQRS) and other programs, the impending creation of accountable care organizations in Medicare, and more. The timing of the transition could not be worse, as many physicians already are spending significant time and resources implementing complex EHRs in their practices.

ICD-10 is old technology developed during the 1980s and not designed to work in the current electronic world. A new version of the codes, ICD-11, could come as early as 2017. It is being designed for use with EHRs and the Internet, and should be more user-friendly than ICD-10.

After three deadline extensions, TMA is asking the Centers for Medicare & Medicaid Services (CMS) to delay ICD-10 permanently until ICD-11 or another appropriate replacement for ICD-9 is ready for widespread implementation.

Stop Recovery Audit Program bounty hunters

CMS hires several types of contractors to review and audit medical care delivered by doctors — Recovery Audit Program contractors (better known as RACs), zone program integrity contractors, Comprehensive Error Rate Testing contractors, and Medicare administrative contractors. It's confusing, burdensome, and expensive for physicians to defend their medical decisions with so many audit programs administered by multiple contractors — especially

when many of the RAC claims are erroneous. In fact, the U.S. Department of Health and Human Services' (HHS) Office of Medicare Hearings and Appeals recently announced it would no longer accept any physician or provider requests for administrative law judge review, the third level of administrative review in the Medicare appeals process. Citing a backlog of 357,000 cases, HHS said it would not accept new appeals for up to two years. RACs are costing physician practices time and money, and taking their time away from patient care.²⁷

Here are just a few of the problems with the Recovery Audit Program:

- RACs are essentially bounty hunters; they receive a healthy commission on every claim they deny.
- RACs don't have a medical license. Personnel with little to no expertise in medical care conduct the reviews, which helps explain why their "overpayment determinations" are being overturned at an alarming rate. Only physicians should be allowed to decide whether a physician service was medically necessary.
- RACs are not held accountable. According to CMS, the RAC loses 43 percent of the time when a physician or provider appeals an overpayment claim. Physicians should not bear the cost of legal and administrative fees to pursue appeals, especially when they win the appeal. RACs should be penalized for erroneous overpayment determinations and should be required to reimburse physicians for the costs incurred in defending against a recovery audit when the RAC loses the appeal.

- Extrapolations should not be allowed. RACs should not base their findings on a statistical sample of claims, which is not always an accurate assessment of a physician's coding and documentation. Instead, RACs should review claims on an individual basis.

Eliminate costly administrative and payment schemes

In addition to reducing costs of existing administrative requirements, TMA wants to prevent the government from placing new burdens on physician practices, such as electronic funds transfer (EFT) fees.

TMA became aware of certain companies that were acting as middlemen in EFT transactions. One company told physicians they must "act quickly" to "continue to receive payments" through EFT at a charge of 1.5 percent per claim.

The most scurrilous aspect of an EFT percentage fee is that the amount paid may increase greatly with no corresponding increase in the actual cost of funds transfer. For instance, at 1.5 percent, an EFT for a \$200 service would cost \$3, while an EFT for a \$10,000 surgery would be \$150. According to the U.S. Treasury, it costs the government "10.5 cents to issue an EFT payment." To charge even \$3 is an outrageous overcharge for an EFT. TMA opposes charging physicians percentage fees for using EFTs.²⁸

This is just one example of the many problems that, when taken together, plague physician practices and create administrative complexity and excess expenses.

(TMA Recommendations on page 38)



TMA RECOMMENDATIONS

- ✓ Require government agencies to consider the disruption that new regulations and penalties introduce into medical practices and refrain from introducing new hurdles.

ICD-10

- ✓ Put ICD-10 on permanent hold until ICD-11 or another appropriate replacement for ICD-9 is ready for widespread implementation.

Recovery Audit Program

- ✓ Direct Recovery Audit Program contractors (RACs) to focus only on practices with demonstrated inappropriate billing patterns and provide due process and fair procedures for physicians who are subject to a RAC audit.
- ✓ Create a threshold or safe harbor for physicians who are overpaid by a small amount to ensure they are not subject to fraud prosecution.

Administrative Simplification

- ✓ Oppose efforts to charge physicians fees for using electronic funds transfers (EFTs).
- ✓ Require, after an initial face-to-face encounter, the Centers for Medicare & Medicaid Services (CMS) to pay for patient phone and email consultations.
- ✓ Require health plans to have a standardized, electronic format by which physicians can obtain their entire fee schedule.
- ✓ Establish uniform and enforceable standards so insurers pay the required first-dollar coverage of preventive care.
- ✓ Update formats for electronic eligibility verification (270/271) to standardize all information required as a result of the Affordable Care Act (ACA).

- ✓ Repeal the ACA requirement that a prescription is necessary for health savings account or flexible savings account reimbursement for over-the-counter drugs.
- ✓ Eliminate the Clinical Laboratory Improvements Amendment (CLIA) certificate requirements for Centers for Disease Control and Prevention (CDC)-approved items sold over the counter, such as pregnancy tests.
- ✓ Eliminate the CLIA certificate requirements for physician-performed microscopy.
- ✓ Prohibit CMS from recovering overpayments from physicians after one year from date of service when CMS has committed a processing error and the physician has made no misrepresentation.

Medicare Advantage Plans

- ✓ Prohibit termination of physicians from Medicare Advantage (MA) networks within six months of the enrollment period to protect the rights of patients who chose a plan based on its published list of participating physicians.
- ✓ Reverse the new mandate that requires a physician ordering a referral from another physician to be enrolled in Medicare for the referred physician to be paid for his or her services.
- ✓ Require MA plans to pay physicians any bonus they would earn under CMS incentive programs, such as for e-prescribing, without regard to the MA plan contract with the physician.
- ✓ Prohibit MA plans from departing from the National Correct Coding Initiative code edits established by CMS.
- ✓ Mandate that MA plans abide by state insurance prompt pay laws.

Medicare Administrative Contractor

- ✓ Require all Medicare administrative contractors (MACs) to recognize all Medicare-enrolled physicians.
- ✓ Require CMS and its MACs to accept a death certificate as proof of the true date of death even if it differs from the date provided by the Social Security Administration.
- ✓ Require CMS to develop a standard Medicare enrollment contract letter for MACs to use that must be accepted by state Medicaid as proof of enrollment. The Texas Medicaid program will not accept the current MAC enrollment letter as proof of Medicare participation.
- ✓ Require MACs to track and post on their websites the current work/lag time for appeals of claims, claims processing, and enrollment processing.

Prior Authorizations

- ✓ Standardize an electronic process for submitting prior authorization requests to health plans, and radiology and pharmacy benefit managers (including a standard for attachments to those requests).
- ✓ Stop CMS from using or developing claim submission and payment rules that require non-standard coding for consultation and other services.



SECTION 6

Use Health Information Technology Wisely

As in nearly every other sphere of modern life, technology has delivered enormous improvements in medicine. Once-unimaginable diagnostic tools and treatments are now commonplace. Health information technology (HIT), properly implemented, has tremendous potential to advance quality of care, prevent certain types of medical errors, and streamline health care delivery. Recognizing this potential, the government and employers are pushing physicians and providers to adopt HIT quickly so they can better measure the “value” they receive for their health care dollar. Physicians themselves, of course, are motivated to provide the best possible care, which in modern times involves the use of various technologies, including HIT. In spite of the great potential, HIT needs significant work to make it more efficient and effective for patient care. Many physicians find they are clicking more but achieving less. Currently, it’s too expensive, too disruptive to patient care, and prevents physicians and providers from sharing patient data in a timely, secure manner.

Electronic Health Records

The American Recovery and Reinvestment Act (ARRA) of 2009 allocated more than \$90 million in grants to Texas to improve HIT across the state. Within ARRA is the Health Information Technology for Economic and Clinical Health Act (HITECH), which authorized incentives of up to \$63,750 per physician participating in Medicare or Medicaid to adopt electronic health records (EHRs) that meet meaningful use standards. These incentives

are particularly helpful, as the technology is very expensive; physicians — especially in solo and small group practices — frequently cite cost as a major barrier to EHR adoption.

In spite of the federal incentives, EHRs are still cost-prohibitive. Not all physicians are eligible for the incentives. The average EHR purchase initially costs at least \$40,000 per physician, not including productivity dips that hurt practice revenues.

Associated costs, such as EHR interfaces, patient portals, training, upgrades, and annual licensing fees go above the initial purchase cost and, in some cases, have not been fully anticipated. Sixty-three percent of Texas physicians whose practices are not implementing an EHR indicate it was cost-prohibitive to do so.²⁹

In addition to rolling out EHR systems, physicians have had to meet nearly 100 other mandates from HITECH and the Affordable Care Act, all of which impact physicians’ practices and do little to improve care quality.

One federal requirement physicians have worked hard and in good faith to meet are the goals for “meaningful use.” The program requires physicians to use EHRs to collect and track data on 14 different measures, most of which are focused on primary care. For instance, all physicians must record and report a patient’s weight — even for specialty care where this requirement isn’t useful, such as ophthalmology.

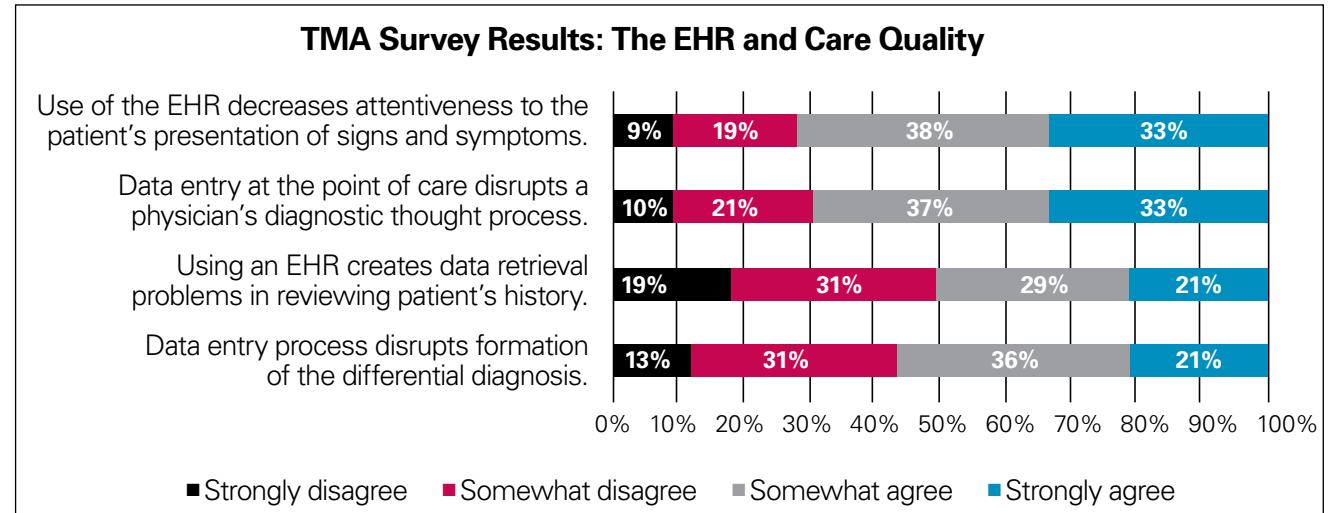
A recent RAND study found:

- EHRs had important effects on physician professional satisfaction, both positive and negative. The current state of EHR technology significantly worsened professional satisfaction in multiple ways. Poor EHR usability, time-consuming data entry, interference with face-to-face patient care, inefficient and less fulfilling work content, inability to exchange health information between EHR products,

and degradation of clinical documentation were prominent sources of professional dissatisfaction.

- Physicians approved of EHRs in concept, describing better ability to access patient information remotely as well as improvements in quality of care. Physicians, practice leaders, and other staff also noted the potential of EHRs to further improve both patient care and professional satisfaction in the future as EHR technology — especially user interfaces and health information exchange — improves.
- Excessive productivity quotas and limits on time spent with each patient are major sources of physician dissatisfaction. The cumulative pressures associated with workload were described as a “treadmill” and as being “relentless,” sentiments especially common among primary care physicians.
- Physicians describe the cumulative burden of rules and regulations as overwhelming, draining time and resources from patient care.

As more Texas physicians use EHRs, it is imperative that patient safety remain top of mind. Studies now indicate that using EHRs can introduce new types of errors. These errors can be caused by system use or misuse. Requiring a physician to rely on a system that is counterintuitive to his or her clinical training could result in adverse outcomes for patients. Even expert users find that EHRs require more physician time than paper records and can interrupt the patient-physician interaction in the exam room. More than 70 percent of the physicians responding to a recent TMA survey agreed that use of an EHR decreases attentiveness to the patient’s presentation



Source: 2014 TMA Physician Survey, Preliminary Results

of signs and symptoms.³⁰ Other physicians report that electronic records often lack or conceal critical information needed for patient care. Governments at all levels must carefully consider the unintended consequences that new regulations have on patient care.

Physicians who change practices or switch EHRs now find preserving the patient’s electronic health record either impossible or prohibitively expensive. TMA would like to see industry-wide changes preventing vendors from holding data hostage when physicians choose to change EHR vendors. TMA has asked the American Medical Association (AMA) to work at the federal level to achieve EHR data portability as part of the Office of the National Coordinator for HIT (ONC) standards for EHR product certification. AMA is also working to

improve transparency around proprietary data storage.

In spite of the problems, 68 percent of physicians in Texas use an EHR in their practice, and this number is expected to swell to 80 percent by 2018. As EHR use continues to expand, it is critical that federal and state governments strive to protect patients and their physicians in this evolving technological environment.

We must continue working toward developing a strong HIT infrastructure in Texas that supports physician workflow while enhancing the quality and cost-effectiveness of patient care. TMA further supports strong patient privacy protections and technical standards so that patients and physicians can trust the sharing of health care information across the care continuum.

Health Information Exchange

Health information exchanges (HIEs) are supposed to help physicians and providers share patient information quickly and securely. The ability to have the right information at the right time to enhance care quality is one of the greatest promises of digitized medicine. Unfortunately, it is very difficult and costly to map patient data across disparate proprietary EHR systems. Because of the cost, HIEs are prioritizing connections with large health care institutions that have significant amounts of patient data. Unfortunately, this approach is leaving many physicians out of the communication loop, unable to share patient information securely through an HIE. Many physicians still have to share patient information via secure fax machines.

HIEs must provide complete, timely, and relevant patient information as part of the physician's workflow, at the point of care, in a fully enabled electronic information system. Patients and their physicians must have confidence that the patient information shared is reliable, private, secure, and delivered in a manner that complies with HIPAA.

Most HIEs are in their infancy and need significant maturation before they are used ubiquitously. Until interfaces are standardized as to the minimum data set required, physicians and other health care providers should not be forced to use HIEs. Only when HIEs are well established, highly utilized, and deliver reliable patient information at a 99-percent rate of complete accuracy should they become integrated into physicians' and providers' practices.



TMA RECOMMENDATIONS

- ✓ Enact legislation and rules that provide positive incentives for physicians to acquire and maintain health information technology.
- ✓ Do not penalize physicians who choose not to participate in the federal Medicare meaningful use program.
- ✓ Help physicians preserve the patient medical record in an electronic format through better data transition requirements of proprietary EHR vendors.
- ✓ Establish patient safety, privacy, and quality of care as the guiding principles for all HIE efforts. Cost reduction and health care efficiency are the expected byproducts.
- ✓ Require regulatory agencies to align physician office technology requirements so they minimize the disruption to physician workflow and patient care.
- ✓ Encourage HIE participation through legislation that will hold physicians responsible only for their own actions or inactions in regard to a possible breach of protected health information provided to an HIE (and not for the negligence or bad behavior of others).
- ✓ Eliminate the tracking of and accounting for all disclosures of patient information (when an electronic health record is used) and return to the previous mandate to track disclosures that are NOT for treatment, payment, or "health care operations."
- ✓ Allow for the release of medical record copies in any reasonable format the health professional chooses.
- ✓ Eliminate federal mandates that compel physicians to engage in unnecessary activities and reporting.



SECTION 7

Establish Fair and Transparent Insurance Markets

From the giant Texas Medical Center to a solo practitioner in a tiny Panhandle crossroads, physicians' practices fuel the economic engines that grow Texas. The economic benefit of doctors' offices goes beyond the hundreds of thousands of direct jobs they support, including the quite-quantifiable ripple effect of those jobs and tax dollars through the local economy. It also takes in health care's obvious, but somewhat less tangible, contribution to Texas' continued economic development.

Physicians are small, midsize, and large employers. Solo practices often run on a shoestring, with only a nurse and one or two staff, while small or large groups use more support staff for medical and administrative functions. Regardless of practice size, physicians must be recognized as important businesses and employers who contribute billions of dollars to state and local economies. Physicians' practices must remain viable to continue providing jobs and quality patient care in rural and urban Texas.

The Affordable Care Act (ACA) requires most Americans to have health insurance. By April 1, 2014, enrollment through the health insurance exchange marketplaces topped 7 million nationally — more than 733,000 were Texans.

While Texas physicians want better access to coverage for their patients, they are frustrated by the confusion and administrative burdens imposed by the federal government's implementation of insurance exchanges. Some of the many questions physicians and their office staff must have answered include:

- How do I determine that my patient purchased insurance coverage through the marketplace?
- Is my patient covered by a private commercial plan, HMO or PPO product, or by a subsidized qualified health plan product?
- How do I determine if my patient has paid his or her premium?
- Is my patient in a 90-day grace period?

- Did my patient purchase a narrow network plan that could prevent him or her from seeing a specialist? Does my patient understand the limitations of the provider network that came with the level of coverage purchased?
- What is the impact to my practice when health plans require electronic funds transfers or virtual credit card payments?

While the ACA exchanges have brought about new insurance coverage opportunities for Texans, significant problems remain — and potential new ones are developing — with traditional health insurance companies and Texas' workers' compensation program.

Coverage differentiation needed on patient identification cards

Health insurers are providing a variety of insurance products inside and outside the ACA health insurance exchanges. These products include commercial HMOs, exclusive provider organizations (EPOs), and PPOs outside the exchange and qualified HMO and PPO plans inside the exchange, some of which are purchased with federal premium subsidies. Physicians' office staff need to be able to determine and distinguish via the patient's identification card if the coverage is a private commercial plan, an exchange plan, or a subsidized exchange plan.

Physicians need to know this information to collect accurate copays and deductibles, as they

can differ in commercial versus exchange plans. More important, they need this information when discussing treatment options with their patients, especially if a patient's care spans several weeks or months. This becomes further complicated for patients in a subsidized exchange plan because they have a 90-day grace period to make their premium payments.

Impact of the 90-day ACA grace period

Under the ACA, people who buy a subsidized plan on the exchange also have the benefit of a 90-day grace period to bring premium payments current when they are in arrears. The federal government requires insurance companies to cover services for the first 30 days of the grace period. After the remaining 60 days, insurance companies may retroactively terminate the insurance policy if the insured person doesn't make premium payments. This means that insurance companies may demand physician payments for services be returned even if the physician followed all the rules and requirements in providing care to the patient. When this happens, the physician is forced to seek payment directly from the patient, which is expensive, disruptive, and usually not successful, as care has already been rendered. In some cases, the physician has already dispensed expensive medications to the patient, resulting in a direct, out-of-pocket cost to the practice. TMA is asking the Centers for Medicare & Medicaid Services to require insurers who sell health plans on the ACA exchange to provide immediate notice when patients enter the 90-day grace period.

When customers of any small business receive services or goods and intentionally do not pay for them, the cost of those items increases significantly for all the customers who do pay. Those same free market principles impact physician practices: The grace period may increase charges for those patients who do pay for the medical services they receive.

Impact of narrow networks on access to care

Some health plans sold through the ACA health insurance exchanges use "narrow networks," that is, they limit the doctors and hospitals their patients can use. Go to Doctor A or Hospital A, and the plan will pay all or most of the bill. Go to Doctor B or Hospital B, and the patient will have to pay all or most of the bill. Narrow networks could mean some newly insured people are no longer covered when they see their former physician or go to their local hospital. A narrow network may mean physicians and hospitals with the appropriate expertise and resources for patients with rare or complex health problems may be available only with much larger out-of-pocket costs than the patient anticipated when purchasing his or her health insurance.³¹

Narrow networks have become increasingly popular, growing from 15 percent of the insurance plans that employers offered in 2007 to 23 percent in 2012.³²

Often, health plans advertise they have physicians, hospitals, and health care providers contracted to provide services, making it appear they have robust networks. This can be misleading to patients when the entire advertised network is not available when they need care. Patients who purchase coverage with a low premium discover they are required to use a limited or narrow network of physicians. In some cases, patients will end up paying more out-of-pocket costs even when they choose to see a physician inside the larger network but who is not part of the limited network. Health insurers should be required to disclose network limitations up front and in their marketing information so patients understand their out-of-pocket costs may be more when they actually need health care.

Improving health plans' communications about narrow networks would allow physicians and their staff to spend less time trying to explain the limitations of the insurance plan to the patient and more time focusing on patient care.

Preserve the proprietary nature of negotiated rates in physician contracts

Under the guise of "transparency" and "decreasing the cost of health care" at the federal and state levels, there is much discussion about making the physician's proprietary negotiated contract rates with health plans publicly available and allowing persons who are not parties to the contract to use those rates.

To promote market competition, businesses in general are not required to share their contract rates with the public or with those who are not parties to the contract. This same free market principle also should apply to physicians' practices.

In health care, a "gag clause" was once an insurance company contract provision that prevented physicians from discussing all medical care options with their patients. Today, it is a loaded term some groups use to portray a barrier to consumers seeking health care price information. These groups are proponents of increased "price transparency" and use "gag clauses" to describe contract details between insurers and physician groups or hospital systems. The gag clauses are actually contractual provisions to prevent the parties to the contract from disclosing their negotiated fees to anyone outside the contract. When we buy groceries, we are not privy to the discount Walmart or H-E-B negotiated and paid its suppliers for their inventory. These prices are not publicly disclosed, even to the stores' customers.

Gag clauses do prohibit sharing of proprietary contract information to parties who are not health plan members or who are not a party to the contract between the health plan and physician or provider. Unfortunately, third-party administrators in Texas and other states have been pushing recently to require health plans, physicians, providers, or the state to disclose proprietary negotiated rates to the public.

In reality, gag clauses do not prohibit health plans from sharing contract payment information with their own members for determining out-of-pocket payments. In fact, Texas' Senate Bill 1731 passed in 2007 requires health plans to provide actual payment information to their enrollees when requested. Texas insurers have invested many millions of dollars into transparency tools that disclose estimated insurer payments and out-of-pocket payments for many services — none of which is prevented by any physician contract term.

Virtual credit cards/electronic funds transfers — administratively simple but for whom?

Health plans today rarely use paper checks to pay physicians. Instead they are using electronic payment methods, such as virtual credit cards (VCCs) and electronic funds transfers (EFTs). While physicians want health plans to simplify their administrative process to ensure timely payment, they don't want it to come at an additional cost. Unfortunately, VCCs and EFTs do add more cost to physician practices and serve only to benefit the health plan.

The American Medical Association (AMA) released a white paper on the impact of these two payment options on physician practices, which stated:

- **Virtual credit card payments** are a valid electronic alternative to paper checks, but they come with a cost to the physician practice. Just like credit card payments, VCC payments are

subject to interchange and transaction fees. Those interchange fees can run as high as 5 percent for these corporate "card not present" transactions. Physicians are often unaware of these high fees when accepting VCC payments.

Unlike traditional credit card payments received from patients, the processing fees for VCCs do not come with corresponding benefits. Patient credit cards ensure physician payment by shifting patient debt collection responsibility to the credit card companies. This helps eliminate the risk of bad debt that plagues physicians' practices. VCCs do not offer risk reduction for physicians but instead carry increased processing charges. Meanwhile, credit card companies often offer health plans up to a 1.75-percent rebate for paying physician and provider claims with VCCs.

- **Electronic funds transfers** are similar to direct deposit offered by many employers. Automated clearinghouse (ACH) EFT is a funds transfer tool in which payment is processed over the ACH Network, a payment system implemented by the National Automated Clearing House Association. Unlike percentage-based interchange fees associated with VCCs, ACH EFT payments are subject only to a standard transaction fee (approximately 34 cents) regardless of payment amount. As shown in AMA's table on the next page the difference in processing fees can have a substantial impact on physician payment. As

of Jan. 1, 2014, the U.S. Department of Health and Human Services required all health plans to use ACH EFT to pay physicians that request and register for this payment method.

Plans, however, may require other payment methods, such as VCC, within their contracts with physicians to avoid using ACH EFT.³³

Although EFTs may seem to be a better alternative than VCC, EFT payments are not without their downside. A health plan may stipulate that if the physician accepts payment through an EFT, he or she has to accept the amount of the EFT as “acceptance as payment in full.” This notation impacts the physician’s ability to appeal an incorrect payment from the health plan or collect any additional amounts due from the patient, if applicable. (For more on EFT problems, see Section 5: Repeal Harmful and Onerous Federal Regulations.)

Workers’ Compensation

Texas employers expect their employees’ work-related injuries to be treated appropriately and efficiently. Injured workers should be able to receive clinically appropriate and affordable health care quickly and without having to travel too far. Treatment for injured workers must be clearly defined, fair, easy to understand, accountable, and easily accessible.

Health Care Standard ACH EFT Versus Virtual Credit Card		
	ACH EFT	Virtual Credit Card
Physician Contracted Fee	\$5,000.00	\$5,000.00
Processing Costs	\$ 0.34	\$250.10*
Total Payment	\$ 4,999.66	\$ 4,749.50

*Calculated using 5-percent interchange fee plus \$0.10 transaction fee

Source: American Medical Association, May 2014

Acknowledging that physician participation is crucial to the success of the workers’ compensation system, the Texas Department of Insurance-Division of Workers’ Compensation (TDI-DWC) has taken steps to reduce and stabilize costs, and improve injured workers’ access to quality care and return-to-work outcomes while minimizing administrative complexities. These steps include the adoption of:

- Fair fee guidelines for professional services, inpatient and outpatient hospital services, and ambulatory surgical center services;
- Science-based treatment and return-to-work guidelines for non-network claims;
- Certification and monitoring of workers’ compensation health care networks;
- Rules to streamline dispute resolution; and
- Rules to streamline preauthorization requests.

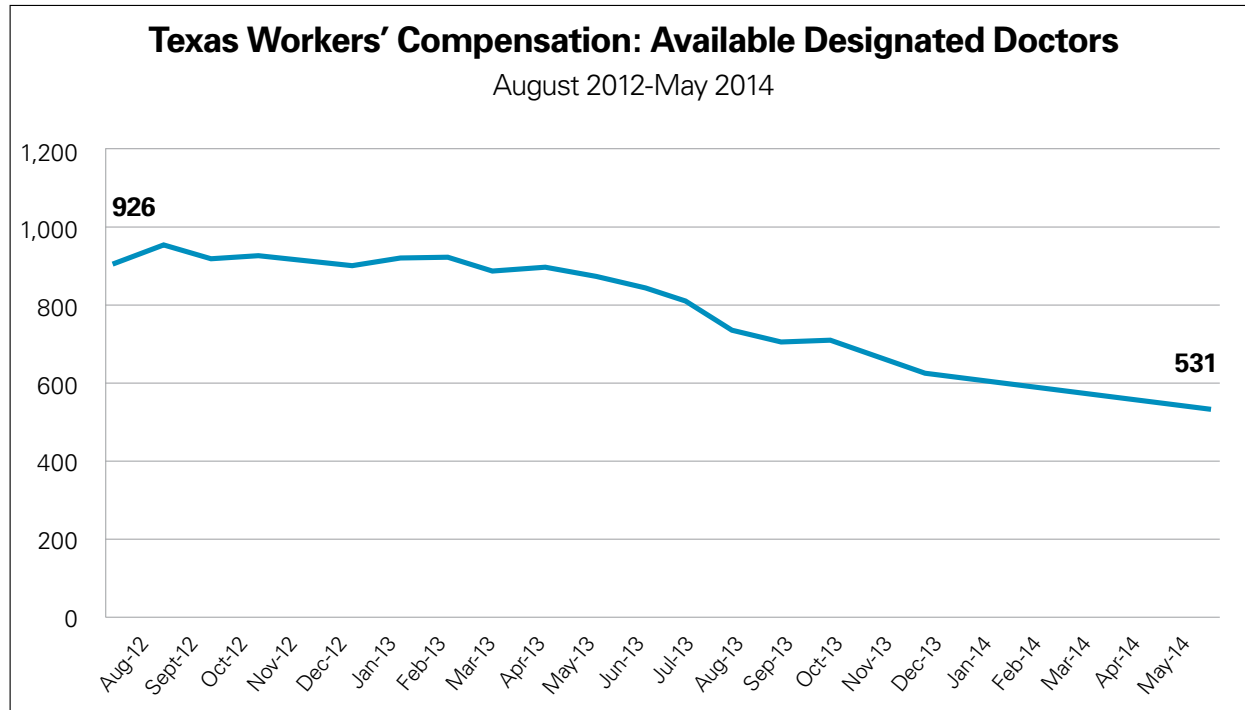
Despite these improvements, barriers still exist that prevent physicians from treating injured workers. One area is in DWC’s designated doctor program.

Designated doctors make recommendations about an injured employee’s medical condition or help resolve disputes about a work-related injury or occupational illness. In the past two years, physician participation has dropped dramatically due to changes in state law in 2011. Doctors were previously allowed to schedule as many as five designated doctor exams when they traveled to locations away from their practice. Now, they can schedule only one exam. The time away from a physician’s office to perform only one designated doctor examination is usually cost-prohibitive.

Insurance companies also frequently question the medical necessity of care physicians provide

to injured workers. These determinations are being made by nonphysicians who don't have the training or expertise to reach such conclusions. TMA continues to advocate for actual peer-to-peer reviews of medical necessity for surgical procedures.

It is critical that actual physicians, not other health care professionals without the equivalent medical training, review physician recommendations for treatment.



Source: Texas Department of Insurance-Division of Workers' Compensation

Rx TMA RECOMMENDATIONS

- ✓ Require health plans to clearly differentiate on their enrollee ID cards when the patient bought coverage through the Affordable Care Act exchange and whether the coverage is a subsidized exchange plan.
- ✓ Require any insurance product (sold inside or outside the health insurance exchange) that uses a “narrow” or “limited network” to publicly disclose this network structure up front as well as any corresponding limitations to consumers and physicians.
- ✓ Prohibit health plans from imposing “acceptance as payment in full” notations on any electronic funds transfer or checks that are deposited without knowledge of the notation.
- ✓ Recognize the private nature of contracting by keeping physicians’ negotiated contract rates with health plans proprietary.
- ✓ Eliminate barriers to physician participation in the Texas workers’ compensation system.
- ✓ Ensure that peer reviews of physicians in the workers’ compensation system are performed by physicians, not by providers without equivalent or appropriate training and education.



SECTION 8

Provide Appropriate Funding for Physician Services

For decades, physicians have given away their services for free to patients who could not afford to pay. However, today's health care market makes this very difficult. Medicare and Medicaid, which now cover 36 percent of all health care spending in the United States, often pay physicians less than it costs them to provide their services. Commercial insurance companies' payment rates, computed largely as a percentage of Medicare, have followed the government-run programs into the basement. Simultaneous increases in paperwork, compliance, reporting, and technology have driven annual practice expenses to more than \$500,000 per physician. The squeeze leaves many physicians struggling to keep their practices open, let alone provide charity care. State and federal leaders must realize that cutting physicians' payments is not an effective tool for controlling health care costs, and often exacerbates the cost of care by limiting access to efficient outpatient care. Without physicians, no health care delivery system can be effective.

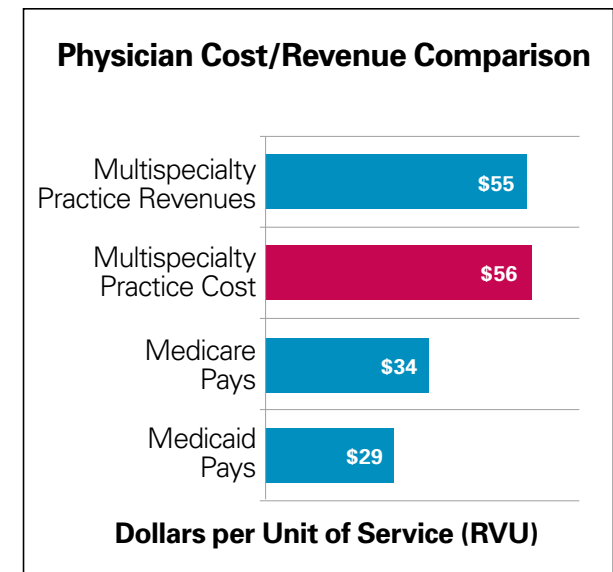
Recognize and cover physicians' cost of providing care

Physicians' practice costs — like any other business' operating costs — continue to march upward. While the rate of increase has slowed slightly in the past several years, physicians face growing demands to cover the salaries and benefits of their professional and office staff,

purchase new clinical and practice management equipment, buy liability insurance, update software, and pay rent and utilities.

The Medical Group Management Association's (MGMA's) data show that, for 2012, most physician groups were operating on razor-thin margins or at a loss. MGMA each year compares physicians' office costs with revenue in dollars per unit

of service. To simplify the accounting for the thousands of different types of services physicians provide, each unit of work is measured in relative value units or RVUs. This is a Medicare measure of the units of service produced. One unit of work is approximately the value of the simplest office visit for a new patient. In 2012, physician-owned multispecialty groups brought in an average of \$55 per unit of work while spending \$56 to keep their clinics open, for an operating loss of \$1 per unit of work. Family practice groups brought in less, \$52 per unit of work, but their costs were \$54, for a median operating loss of \$2 per unit of work.



Sources: Medical Group Management Association; Centers for Medicare & Medicaid Services; Texas Health and Human Services Commission

To stay open, any business must collect enough revenues to cover costs. Especially for patients covered by government insurance programs, this isn't happening for physicians. MGMA data show that Medicare pays only 61 percent of physicians' average costs. Medicaid payments per unit of work vary, but for most services, Medicaid covers less than half of the average cost to provide the services.

The U.S. Government Accountability Office also evaluated physicians' Medicaid payments against managed care and private insurers for evaluation and management services (E&M) physicians provide to patients in their office and emergency departments. They found Texas' Medicaid payments were 50 percent lower than private insurance for E&M office services and 85 percent lower for emergency services.

Physician practices are often forced to limit services to Medicare and Medicaid patients if they cannot make up the losses elsewhere. Physicians in a number of Texas communities, particularly those in rural and South Texas, say they are facing dire circumstances.

Ensure competitive Medicaid and CHIP payments for physicians

Physicians want to take care of Texans who rely on Medicaid coverage for their care. Unfortunately because of the red tape and bureaucratic hassles coupled with low payment rates, many physicians

struggle to continue to see their Medicaid patients. (See Section 4: Promote Government Efficiency and Accountability by Reducing Medicaid Red Tape for details.)

Medicaid is a state- and federally funded health care program that provides low-income patients access to essential health care services. For every dollar Texas invests in Medicaid, the federal government contributes another \$1.40. Without Medicaid, millions more Texans would be uninsured: As of June 2014, Medicaid covered nearly 3.8 million Texans. To qualify, patients must have a low income, but being poor doesn't always mean a patient will qualify for the program. For example, low-income childless adults are not eligible in Texas even if their income meets the state's Medicaid income requirements. Most Medicaid recipients in Texas are children, pregnant women, or disabled.

Texas allocated \$56 billion in all funds to Texas Medicaid for budget years 2014-15; the state's share was \$22.1 billion, and the federal government paid \$33.9 billion. While most enrollees (75 percent) are pregnant women and children, they account for only about 40 percent of the program's costs. Seniors and patients with disabilities make up the other 25 percent of the patient population but account for 60 percent of the costs. In 2013, the Texas Legislature enacted numerous reforms to reduce total Medicaid expenditures by \$961 million, including authorizing further expansion of Medicaid HMOs,

improving birth outcomes, and restructuring the medical transportation program.

The Children's Health Insurance Program (CHIP) provides health insurance to low-income children who do not qualify for Medicaid. Like Medicaid, the costs are shared between the state and federal government: In 2014, the federal government paid 70 percent of Texas' CHIP costs. The Affordable Care Act (ACA) reauthorized CHIP through 2019 and approved funding for the program through September 2015. Pending continued funding, beginning in federal fiscal year 2016, the ACA will increase the CHIP federal matching amount another 23 percent, meaning Texas' cost-sharing would drop from 30 percent to 7 percent. As of April 2014, some 500,000 low-income children were enrolled. To qualify, a family of four may not earn more than \$47,700 (in 2014).

For physicians, Medicaid and CHIP are typically the lowest payers. They often do not cover the basic cost of providing the service. On average, Medicaid pays 73 percent of Medicare and about 50 percent of commercial insurance payments. In 2010 and 2011, the state cut already-meager physician payments another 2 percent.

Recognizing the inadequacy of Medicaid payments and the need to pay better to expand access to care, the ACA gave primary care physicians a temporary reprieve from low Medicaid rates. The act increased Medicaid payments to Medicare parity for primary care services provided by

eligible physicians from Jan. 1, 2014, to Dec. 31, 2015. The federal government provided 100 percent of the funding to pay for the higher rates. CHIP services were excluded from the rate increase as were subspecialists.

Without action by Congress — or the Texas Legislature — the higher payments will soon expire. As federal action appears unlikely, Texas lawmakers should invest the necessary resources to improve appropriate and timely access to medical services for Medicaid patients not only by maintaining higher payments for primary care physicians, but also by ensuring competitive physician payment rates for subspecialists and the CHIP program.

If lawmakers cut physicians' payments further or fail to invest in a robust physician network, millions of Medicaid recipients will have an enrollment card but fewer physicians caring for them, driving patients to use more costly emergency departments.

Repeal the dual-eligible payment cut

During the 82nd Texas Legislature, lawmakers made a number of funding cuts without knowing their complete impact, creating a medical emergency for thousands of dual-eligible Texans and the physicians who care for them. "Dual-eligible" patients are low-income seniors and people with disabilities who qualify for both Medicare and Medicaid. In Texas, there are approximately 465,000 dual-eligible patients, who are among the sickest and most vulnerable people in our state.

When physicians provide treatment to dual-eligible patients, Medicare pays the physician 80 percent. Medicaid used to then pay the remaining 20 percent coinsurance for the patient. Medicare also requires patients to pay an annual deductible — \$147 in 2014 — which Medicaid used to pay because the patients are so poor. Beginning Jan. 1, 2012, Texas Medicaid quit covering the Medicare deductible. It also decided to pay physicians and providers no more than the amount Medicaid pays for the same service, which, in most instances, eliminated payment of the patient's coinsurance. The Texas Legislature in 2012 subsequently reinstated full payment of the annual deductible for dual-eligible patients. Yet, the patients' physicians still face a cut of 20 percent for the coinsurance amount.

Example: Established dual-eligible patient visits physician office for routine visit; Medicare deductible has been met. Physician bills Medicare CPT Code 99213. Medicare allowable is \$69.61. Medicare pays \$55.69 (80 percent of the allowable). Physician bills Medicaid for the remaining 20 percent. Medicaid allowable is \$33.27, so no coinsurance will be paid. Under the old policy, Medicaid would have paid an additional \$13.92, so that physician's entire payment equaled Medicare's \$69.61 allowable. This is essentially a 20-percent payment cut, and is less than what a physician receives for treating any other Medicare patient.

The dual-eligible payment cut unfairly penalizes physicians who provide care for the poorest and

often sickest and frailest Medicare patients. The policy change hit particularly hard practices in rural and inner-city Texas, along the Mexico border, and many of those serving nursing home residents. Physicians in these settings serve a disproportionate number of dual-eligible patients. In addition, the cut is forcing physicians to limit how many dual-eligible patients they are willing to treat, to restrict their Medicaid participation, and to forego practicing in communities that most need them.

Don't tax sickness

Saving lives should not be taxed like other services. Taxing patient care is bad medicine. People don't choose to be sick. Health care is a unique business activity and should not be subject to a traditional business activity tax.

Recognizing the unique nature of health care when they rewrote the state's business tax in 2006, legislators included exclusions for the free and under-reimbursed care physicians provide to Medicaid, Medicare, CHIP, workers' compensation, military, and charity care patients. In 2013, they added the purchase price of vaccines to the exclusions. Because physicians have contractual and ethical obligations to care for patients, often without regard to their own financial interests, their losses on unpaid and underpaid services are unavoidable and substantial. Those exclusions merit recognition.

Federal law and hospital staff agreements require physicians to provide care to patients in emergency settings regardless of ability to pay. Texas physicians deliver more than \$2 billion per year in a hidden tax via free charity care. No other profession is required by law to give away its products or services for free.

Medicaid and CHIP payments to Texas physicians cover less than half the cost of providing care. The average Texas physician provides more than \$72,000 per year in undercompensated care to Medicaid and CHIP patients (much more in some specialties, in rural Texas, and along the Mexico border). Tax increases add to the cost of caring for these patients, and force more physicians to limit participation in these government programs.

Texas physicians pay their fair share in business and personal taxes. They also pay such additional state taxes as an inflated licensing fee, a professional fee, an Office of Patient Protection fee, and additional license surcharges imposed over the years by the legislature. These fees are in addition to the sales taxes physicians pay on the supplies and equipment they use to care for patients, and the property taxes they pay on all business property and equipment they use for patient care.

Texas should not place additional taxes on caring for the sick.

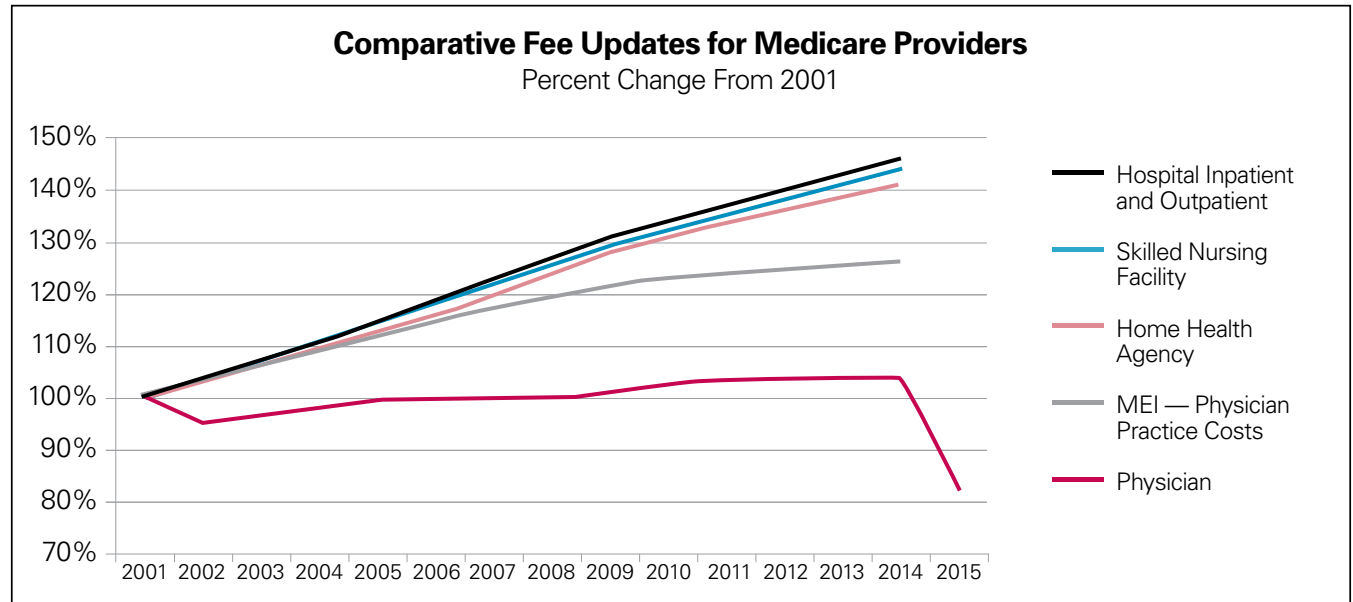
Stop the Medicare Meltdown — Repeal the SGR, fix the sequester, remove the penalties, and stop adding administrative cost

Over the last decade, nothing has so regularly and completely vexed and frustrated physicians more than the annual showdown with Congress to stop double-digit cuts to Medicare payments to physicians.

Medicare patients and military families are never out of danger. Year after year, the specter of congressional action or inaction threatens to jeopardize health care services for Medicare patients. And, because TRICARE rates for military families are based on Medicare, they're in danger, too.

This is because federal law requires Medicare payments to physicians be modified annually using the Sustainable Growth Rate (SGR) formula. Because of flaws in how the formula was designed, the corresponding result has mandated physician rate cuts every year for the past 13 years. Only short-term congressional fixes have stopped the cuts.

In 2014, Congress came closer than ever to passing legislation that would repeal the SGR permanently. The bill had strong bipartisan support and addressed many of the policy issues surrounding Medicare, but in the end, Congress lacked the willpower to cover the costs of the legislation. Instead, Congress voted for the 17th time to put another patch on the



Source: Centers for Medicare & Medicaid Services, 2014

problem. Physicians now face the threat of another major payment cut on April 1, 2015.

This cut is on top of a 2-percent sequestration cut that began in 2013 as required by the Budget Control Act of 2011. And physicians face multiple other cuts that will whittle away their payments over the next several years due to new ACA requirements.

Compounding this, most commercial insurers pay physicians based on a percentage of the Medicare rate. Since Medicare payments have been essentially unchanged over the last 13 years, this double hit has meant a flat-lining of physician payment rates and now threatens the viability of many physician practices. It makes investment in new clinical equipment and health information technology increasingly more difficult.

This decade-long and continued uncertainty is forcing a growing number of physicians to make the difficult decision to opt out of Medicare, to limit the number of Medicare patients they treat, or retire early. The 2012 Survey of Texas Physicians indicates that 51 percent of Texas physicians have, will, or are considering opting out of the Medicare program altogether.³⁴

Medicare patients today often can't get in to see their physicians as quickly as needed. This forces Medicare patients to put off care until they are sicker or end up using the hospital's emergency department. Sending Medicare patients to the

emergency room is counterproductive to the goal set by Congress and the White House to keep health care costs down by encouraging all Americans to have a "medical home."

Medicare patients should feel anything but secure about the future of their health care. Physicians are key to delivering health care services and are the foundation of the Medicare program. Without a robust network of physicians to care for the millions of patients dependent on Medicare, the program will not work.

We all recognize the value that hospitals, nursing homes, home health services, durable medical equipment vendors, and other health care providers give to Medicare patients. However, over the past decade, they all have received annual payment increases, while physicians have not.

Congress must repeal the flawed SGR formula permanently and replace it with a rational Medicare physician payment system that works and is backed by a fair, stable funding formula. Congress should create a bipartisan subcommittee to develop a comprehensive list of viable pay-fors to cover the cost.

Replace harmful restrictions with realistic quality-based incentives

TMA believes the patient-physician relationship must be preserved regardless of patients' health conditions, ethnicity, economic circumstances,

The SGR Threat: Year by Year

Year	Scheduled Cut	Actual Change	Cost* (in billions)
2003	-4.4%	1.4%	\$54.0
2004	-4.5%	1.5%	\$0.2 (2004 & 2005)
2005	-3.3%	1.5%	
2006	-4.4%	0.2%	\$-0.4
2007	-5.0%	0.5%	\$3.1
2008 (Jan.-June)	-10.1%	0.0%	\$6.4
2008 (July-Dec.)	-10.6%	0.0%	\$9.4 (includes 2009)
2009	n/a†	1.1%	
2010 (Jan.-Feb.)	-21.3%	0.0%	\$2.0
2010 (March)	-21.3%	0.0%	\$1.0
2010 (April-May)	-21.3%	0.0%	\$2.0
2010 (June-Nov.)	-21.3%	2.0%	\$6.0
2010 (Dec.)	-21.3%	0.0%	\$1.0
2011	-25.0%	0.0%	\$14.9
2012 (Jan.-Feb.)	-27.4%	0.0%	\$3.6
2012 (March-Dec.)	-27.4%	0.0%	\$18.0
2013	-26.5%	0.0%	\$25.2
<i>Total spent on SGR patches: \$153.7</i>			
<i>Cost of proposed SGR repeal and replacement legislation: \$138#</i>			

*All cost scores are 10-year Congressional Budget Office (CBO) estimates.

†Not applicable; the last 2008 legislation included the 2009 delay.
#Feb. 27, 2014, CBO score of the SGR Repeal and Medicare Provider Payment Modernization Act of 2014.

Sources: Congressional Research Service, American Medical Association, Texas Medical Association

demographics, or treatment compliance patterns. Unfortunately, many pay-for-performance strategies, commonly referred to as “value-based payment models,” that intend to contain health costs could undermine this relationship. These strategies have proliferated in both commercial and government health programs. The ACA encourages payment based solely on outcomes and mandates pay adjustments for all physicians. This often selectively penalizes physicians who treat disadvantaged patients.

Value-based payment models that do not risk-adjust properly for patients’ health status and those that rely solely on claims data for evaluation of care will likely hurt the patient-physician relationship. This is particularly true if patient risk factors, chronic conditions, compliance, health disparities, and culturally competent care are not factored into the physician’s performance profile. For example, many physicians are rated on how many of their patients obtain screening mammograms or colonoscopies at appropriate times; those ratings, and their payments, are hurt if a patient chooses not to get the tests the doctor ordered. Other examples of physicians’ quality rating measurements being directly impacted by patient choice or other factors include medication compliance, routine screening exams, weight management, and tobacco cessation.

Physicians also are finding the transition to value-based payment models cost-prohibitive due to: 1) the expansion of these “quality” programs; 2) the

vast number of quality measures; 3) the difficulty of deciphering which measures are important; and 4) interpreting quality-data reports in a meaningful way for their practices. The overwhelming number of uncoordinated quality measurement and reporting initiatives across multiple insurance companies must be addressed.

To help physicians transition to value-based payment systems, TMA is asking insurance companies and government payers for transparent methodology and program policies, standardized and valid quality measures, and streamlined quality reporting and evaluation processes. These systems must comply with a set of principles adopted by both TMA and the American Medical Association that:

1. Ensure quality of care,
2. Foster the patient-physician relationship,
3. Offer voluntary physician participation,
4. Use accurate data and fair reporting, and
5. Provide fair and equitable program incentives.³⁵

Repeal the Independent Payment Advisory Board

Replacing the SGR and removing administrative penalties will be meaningless unless Congress also repeals the Independent Payment Advisory Board (IPAB). Leaving both in place would create cruel and unusual double jeopardy for physicians who want to care for senior citizens and military families. The ACA created a 15-member IPAB designated to recommend measures to reduce Medicare spending if costs exceed targeted growth rates.

The ACA prohibits the panel from recommending changes to eligibility, coverage, or other factors that drive utilization of health care services. This means the board will have only one option — cut payments. And through 2019, hospitals, Medicare Advantage plans, Medicare prescription drug plans, and health care professionals other than physicians are exempt. This means the board has only one option — cut Medicare payments to physicians. Cuts the board recommends will automatically take effect, unless Congress acts to suspend them.

As we’ve seen with the SGR, it’s obvious that cuts the IPAB enacts will devastate Medicare beneficiaries’ ability to find physicians to care for them. The issue of Medicare spending for 3.2 million Texans is too important to be left in the hands of an unaccountable board that makes decisions based solely on cost.

Allow Medicare beneficiaries to contract directly with physicians for care

Growing bureaucratic burdens, inadequate payment rates that haven’t kept pace with the rising costs of providing care, annual threats of pay cuts, and full patient schedules combine to make it increasingly difficult for physicians to continue seeing Medicare patients. While most will keep their longtime patients after they become eligible for Medicare, a growing number of physicians have been forced to stop seeing new Medicare patients.

Currently, seniors who want to see a doctor who does not accept their Medicare insurance must pay

for their care entirely out of their own pocket. As baby boomers come of Medicare age, we will need to change some of Medicare's inflexible rules to ensure patients have access to physicians. One way to accomplish this is to allow Medicare patients to see any physician of their choice. Physicians should be allowed to enter into direct contracts with Medicare patients, even when they opt out of formal Medicare participation.

The Medicare Patient Empowerment Act would allow seniors to use their current Medicare coverage to see a doctor who is not accepting Medicare. It would strengthen patient choice and access to physicians. It would ensure that seniors can see any doctor they choose and still use the Medicare benefits for which they have paid, without having to change their Medicare plan. The act would allow Medicare patients and their physicians to enter into private contracts without penalty to either party.

TMA RECOMMENDATIONS

- ✓ Increase Medicaid primary care physician payments on par with Medicare and extend higher payments to subspecialists and the Children's Health Insurance Program.
- ✓ Devise and enact a system for providing health care to low-income Texans with realistic payment to physicians, less stifling state bureaucracy, and no fraud-and-abuse witch hunts.
- ✓ Repeal the dual-eligible budget cut.
- ✓ Protect tax law provisions that acknowledge physicians' unique roles in caring for all patients — this includes physicians who provide charity care.
- ✓ Prohibit tax auditors from accessing patient's private medical records.
- ✓ Repeal the broken Sustainable Growth Rate (SGR) formula. Enact a rational Medicare physician payment system that works and is backed by a fair, stable funding formula.
- ✓ Fix the broken SGR formula before giving additional payment increases to any other provider in Medicare.
- ✓ Accompany increases in compliance or reporting burdens with payment increases, not penalties.
- ✓ Revise Medicare's value-based purchasing program so it does not penalize physicians for providing services to chronically ill or disadvantaged patients, and does not punish them when patients cannot comply or choose not to comply with orders or recommendations for testing and treatment. Both cost and quality measures need to be risk-adjusted to account for the effects of poverty, poor educational attainment, and cultural differences.
- ✓ Ensure criteria used to measure physicians' performance are evidence-based, fair and accurate, and truly evaluate quality and efficiency of care, not just cost.
- ✓ Simplify Medicare quality reporting by using transparent methodology and consistent, standardized measures and reporting processes across all physician reporting programs.
- ✓ Repeal the Independent Payment Advisory Board.
- ✓ Pass the Medicare Patient Empowerment Act, giving physicians the ability to contract directly for any and all Medicare services.



SECTION 9

Promote Good Health; Save Taxpayers' Dollars

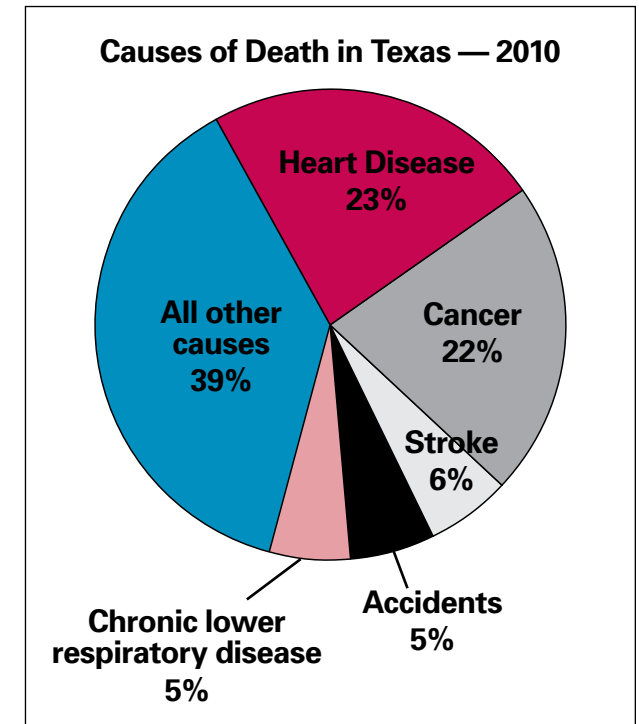
One of the keys to maintaining health lies in physicians helping patients take responsibility for their own health. Competent, compassionate medical care — delivered with professionalism, state-of-the-art clinical knowledge, and patient respect — helps patients assume responsibility. Conversely, patients have a duty to make informed, healthy decisions and share in the consequences of their decisions.

Over the past century, public health interventions such as pasteurization, vaccinations, safe drinking water, and seatbelts have reduced — and in some cases eliminated — illness and death. Each occurrence of preventable infectious or chronic disease is costly to Texas' government, taxpayers, business, our economy, and our patients.

Many of the health and wellness issues people face depend on the decisions they make and the social and environmental factors they are exposed to throughout their lifetime. Four out of 10 Texas adults report having at least one factor — high cholesterol, obesity, high blood pressure, a sedentary lifestyle, or a smoking habit — that puts them at high risk of developing a chronic disease.

Reduce barriers to healthy eating and physical activity

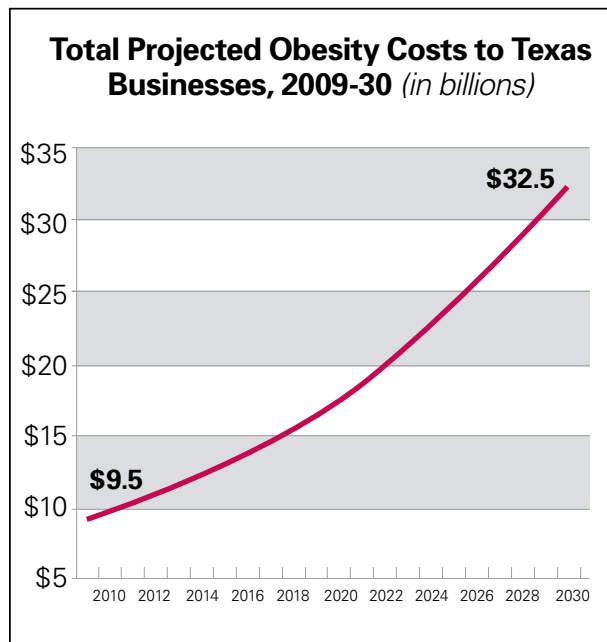
Obesity and being overweight contribute to diabetes, hypertension, heart disease, cancer, and stroke. Unfortunately, Texas has a growing obesity crisis. Thirty-seven percent of Texas adults are overweight, while 29 percent are obese³⁶ — placing Texas among the 20 states with the highest obesity rates. During the past three decades, obesity rates in children have more than tripled. Today, 32 percent of Texas children (aged 10-17) are obese. This not only increases their risk of being overweight or obese as adults, it also puts them at greater risk for chronic disease and other lifelong health problems as well as a shorter lifespan. A child who is overweight at age 12 has a 75-percent chance of being overweight or obese as an adult.



Source: Texas Department of State Health Services, 2010

Many of the leading causes of death and disability in Texas and the United States today are preventable. We need to better educate Texans so they can live healthier lives.

Improved physical health in students has been linked to academic success. Conversely, children with obesity are more prone to absences and lower grades. In the United States, students who are physically active at least 60 minutes on most days, play on at least one sports team, or watch fewer than three hours of television per day consistently earn “mostly A’s.” Unfortunately, the physical health of our students has been further compromised by the Texas Legislature’s action to reduce health education requirements.



Source: Texas Comptroller of Public Accounts, July 2011

The obesity epidemic, and the ever-younger age groups it strikes, threatens Texas’ physical and fiscal health. Texas’ continually expanding waistline correlates with increased health care costs. Obesity is responsible for 27 percent of the growth in health care spending. Treating obese patients costs 37 percent more than treating normal-weight patients. And over the course of a patient’s lifetime, the per-person costs of obesity appear to be the same as the costs for smoking.³⁷

The rise in overweight and obesity also is affecting the bottom line of Texas employers. In 2009, the Texas Comptroller’s Office found that obesity costs Texas businesses an estimated \$9.5 billion due to higher employee insurance costs, absenteeism, and other effects. Left unchecked, obesity could cost employers \$32.5 billion annually by 2030.³⁸

TMA recognizes there is no single solution to preventing or addressing the negative impacts of obesity. Physicians, communities, parents, schools, and workplaces must pursue multiple, scientifically proven approaches. Each must identify potential barriers to implementing local approaches for dealing with this growing crisis. Our legislative leaders can also play an important role by creating and promoting good health care policy that improves the health of Texans.

Texas Public Health Coalition

TMA created the Texas Public Health Coalition in 2007. It consists of 30 organizations dedicated to advancing core public health principles at the state and community levels. The coalition represents the voice of the Texas health care community on matters that impact the public most, and ensures policymakers have the tools they need to make wise and balanced public health policy. Its three primary goals are to improve Texas’ vaccination rates, reduce tobacco use, and curb Texas’ obesity epidemic.

Tackle the ills of smoking and tobacco use

While tobacco use is decreasing, Texas still continues to have higher rates of death attributable to smoking — 273 per 100,000, which is 10 percent greater than the national average of 248.5 per 100,000.³⁹ A major way to decrease smoking-attributable illnesses and deaths is by preventing minors and young adults from ever taking up the tobacco habit. More than two out of three of Texas’ adult smokers started smoking regularly at age 18 or younger, and 85 percent started at age 21 or younger.⁴⁰ The Centers for Disease Control and Prevention (CDC) estimates about 23,000 Texas minors start smoking each year.

Smoking during pregnancy is of particular concern to physicians because of the increased risk of preterm births; it’s a factor in 20 to 30 percent of low-birth weight births. And while the percent of women who smoke during pregnancy has declined significantly, the highest rates are among teenagers (16.7 percent) and women aged 20-24 (18.6 percent).⁴¹

While cigarettes, cigars, and smokeless tobacco (chewing tobacco and snuff) are the most widely used tobacco products, some new products are attracting the interest of minors. Electronic cigarettes or “e-cigarettes” are widely accessible and growing in popularity. Several states have already passed legislation to include e-cigarettes

in nonsmoking laws or to restrict the sale of e-cigarettes to minors.⁴² TMA is calling on lawmakers to restrict the purchase of e-cigarettes by minors, adopt appropriate regulations for e-cigarettes, and ensure the current smoking prohibitions include e-cigarettes. Physicians are concerned that the use of e-cigarettes by minors could be a pathway to future tobacco use and nicotine addiction.

Tobacco use comes with a high consequential price tag; it’s estimated to be more than \$20 billion every year, including \$75 billion in direct health care expenditures, almost \$5 billion in decreased workplace productivity, and \$7.9 billion in premature death.⁴³ The American Cancer Society estimates Texas could save \$207 million over five years by implementing comprehensive smoke-free legislation. Savings are achieved from fewer heart attacks, strokes, and lung cancer, and from decreased pregnancy complications associated with tobacco use.⁴⁴

Texas has yet to enact any sort of statewide smoke-free legislation. TMA will continue its support of this legislation and local efforts to make Texas smoke free and to fund important state tobacco cessation programs.

The Toll of Tobacco in Texas	
High school students who smoke	14.1% (212,000)
Male high school students who use smokeless or spit tobacco	13.9% (females use much less)
Kids (under 18) who become new daily smokers each year	23,000
Packs of cigarettes bought or smoked by kids each year	62.4 million
Adults in Texas who smoke	18.2% (3,471,300)

Source: *Tobacco-Free Kids*, June 2014

Improve vaccination rates to control infectious diseases

Vaccinations are one of the safest and most cost-effective ways to prevent infectious diseases. While Texas has worked to vaccinate more young children, coverage rates for this age group are not improving in Texas or the United States. In fact, overall rates may actually be declining. Much of this is due to parental decisions not to vaccinate their children, exposing entire communities to potential outbreaks. Properly vaccinating all children born in the United States would prevent an estimated 20 million cases of disease during their lifetime and 42,000 premature deaths. For every dollar spent on childhood vaccination, we save a minimum of \$10 in direct and indirect costs, such as avoiding hospitalization, lost work time, disability, and disease outbreak investigations.

But vaccinating our children is not enough. Adult immunization also prevents infectious diseases, and vaccination rates for this population are significantly lower than rates for children. Bacterial pneumonia was the leading factor in more than 20 percent of the 1.4 million potentially preventable hospitalizations of Texas adults (2006-11), with hospital charges totaling more than \$9.6 billion. Routine vaccination of older and high-risk adults for bacterial pneumonia has been shown to decrease these preventable hospitalizations. Adult vaccinations also protect infants and people who cannot be vaccinated. Recent outbreaks of pertussis, measles, and influenza underscore the importance of improving Texas' adult vaccination rates.

Infectious disease knows no border

Infectious diseases can easily be reintroduced to Texas' unvaccinated communities, as illustrated in 2013, when a person traveling to Asia returned with the measles and interacted with a vaccine-hesitant community. In a matter of weeks, 20 additional people were infected. In total, 27 measles cases were reported in 2013, the highest annual case count in more than 20 years. This added unnecessary burdens on the local health care system and translated into significant and unnecessary costs to local, state, and federal taxpayers.

TMA's top concern during the 2014 Central American immigration crisis was to ensure

children and their guardians received timely and needed medical aid. Physicians from El Paso to Brownsville volunteered their time and effort so the Central Americans received appropriate preventive screenings before they traveled into the United States. These actions not only protected the immigrants from further sickness, it also protected Texans from infectious diseases, especially because of the disturbing trend in Texas not to vaccinate. Many serious infectious diseases are preventable. That's why the state and federal government has a vested interest in ensuring all persons are properly vaccinated.

A robust vaccination registry saves lives and money

Texas' immunization registry, ImmTrac, is opt-in; individuals must inform the state they want their vaccination information in the registry. To protect Texans against preventable diseases, it's imperative for the state to have an efficient and robust registry. This means 1) increasing the public's awareness of ImmTrac; 2) making it easier for individuals and physicians to register; 3) maintaining individual information in the registry throughout adulthood (unless an individual opts out); and 4) using de-identified data in ImmTrac to enable parents, public health officials, and physicians to assess vaccination coverage in their communities and schools. It's important to monitor areas with high vaccination exemption rates to determine if exemptions are contributing to ongoing disease outbreaks in Texas.

Vaccination Works in the United States		
Infectious Disease	Pre-Vaccination, Annual Cases, U.S.	With Current Vaccination
Haemophilus Influenza type b (Hib)	Pre-1985: 20,000 children infected with meningitis and pneumonia each year	<55 cases/year*
Rubella (German measles)	1965: 12.5 million cases	4 cases (2011)*
Measles	Pre-1963: 3 million cases; 500 deaths/year	Median of 69 cases/year (2001-12)* 159 cases (Jan.-Aug. 2013)*
Polio	1952: 21,000 people paralyzed	162 cases (1980-92)* No cases since 1992
Pertussis	Early 1940s: 175,000 average/year; 8,000 deaths/year	24,231 cases; 9 deaths* (provisional 2013 data)
Diphtheria	1920s: 100,000-200,000 cases/year	No cases (2004-08)*

Sources: Compiled from National Network for Immunization Information, and *Centers for Disease Control and Prevention.

TMA improves vaccination rates in local communities

TMA launched Be Wise — ImmunizeSM in 2004 to improve Texas' childhood vaccinations rates through action, education, and outreach. TMA physicians, medical students, and the TMA Alliance create awareness about the importance of vaccinations in their communities through educational and free and low-cost vaccination clinics. The program also now includes adolescent and adult vaccination outreach. Be Wise — Immunize has administered more than 250,000 vaccinations since its inception. The program is funded through a grant from the TMA Foundation. H-E-B and TMF Health Quality Institute provided major support for the Be Wise — Immunize program in 2013 and 2014.

Be Wise — Immunize is a service mark of the Texas Medical Association.

Texas is one of only 18 states that allow an individual or a parent of a child to exempt themselves from a required school or work vaccination solely for a personal belief.⁴⁵ Most states only allow vaccination exemptions based on medical contraindications or religious reasons. Local health departments, school districts, and parents should have access to vaccine-exemption information to better plan and implement vaccination efforts in those areas of the state at risk of vaccine-preventable diseases.

Increase Texas funding for mental health

A recent study estimates that Texas spends more than \$13 billion each year on mental health care. About one in four adults is affected by mental illness each year, and almost half of all adults are expected to be affected by mental illness during their lifetime.

Mental illness and substance abuse hurt the Texas economy through lost earning potential and the costs of treating coexisting conditions, disability payments, homelessness, and incarceration. More than 8 percent of Texas adults report current depression, and 5.2 percent report serious psychological distress.

Each year, the CDC estimates that 13-20 percent of U.S. children experience a mental disorder.⁴⁶ In 2011, almost 30 percent of Texas high school students (and 36.9 percent of female students)

reported they felt sad or hopeless almost every day for at least two weeks. Suicide is one of the 10 leading causes of death for all Texans under age 65 years and is the second leading cause of death for those aged 15-34 years (2010).

Substance use disorders and addictions to alcohol and legal and illegal substances are often associated with mental illness. People with untreated mental illness are often unable to make healthy decisions, making them more likely to practice high-risk behaviors such as alcohol, tobacco, and illicit drug use. This often contributes to the development of the serious chronic health conditions associated with those behaviors. They also are more likely to practice behaviors that put them at greater risk of contracting diseases such as HIV, hepatitis, and sexually transmitted infections. According to the Substance Abuse and Mental Health Services Administration, more than 500,000 Texans aged 12 or older per year in 2008-12 reported they were dependent on or abused illicit drugs — 41,000 received treatment for their illicit drug use during this time.

Texas public officials have recognized that people with mental illnesses are disproportionately residing in Texas prisons and jails. In 2012, nearly 20 percent of the adult offenders in Texas state prisons, on parole, or on probation were former patients of Texas' mental health system.⁴⁷

A Texan with serious mental illness is eight times more likely to be in a jail than in a hospital or treatment program, at a cost to the state of \$50,000 per year.

TMA is working to promote and support jail diversion programs in many communities so those with mental illnesses charged with nonviolent crimes have access to community-based support services and treatment. There is growing evidence these are cost-effective strategies in reducing local and state criminal justice system costs.

Reduce avoidable injuries and death

Preventing deaths and disability from motor vehicle accidents is essential. Distracted driving has become a major concern in Texas. In 2013, one out of every five motor vehicle crashes in Texas involved distracted driving, which includes texting, talking on the phone, or performing another task while driving. The Texas Department of Transportation reports that in 2013, almost 20,000 Texans were seriously injured in a crash caused by distracted driving.

TMA strongly supports a statewide ban on texting while driving to ensure the safety of all Texans, particularly young Texans.

Protect Texans' health and reduce taxpayer costs through clean air and water

Texas physicians have long recognized the impact of our environment on Texans' physical health. Physicians often are on the front lines of responding to environmental health events or disasters. A wide range of environmental factors cause death, disability, and disease, and affect our quality of life. Many of these are beyond our control. However, man-made problems of concern — including inadequate sanitation and exposure to hazardous substances in our air, water, soil, and food — require vigilance to ensure public health is protected.

Clean air and water are key components of a healthy environment and a healthy population. Many factors influence our air quality and our health. Medical science indicates that too much ground-level ozone over time has negative effects on vulnerable patients, especially those with cardiovascular diseases, asthma, or other respiratory conditions.⁴⁸ Coal-fired plants emit dozens of hazardous air pollutants, including sulfur dioxide, dioxins, and mercury. These can cause heart and lung diseases, and can damage the brain, eyes, and skin.

Technology exists to reduce air pollution and stimulate energy savings. Texas needs to take action to establish an energy policy that will clean up the air and encourage nonpolluting, renewable

energy sources. Additionally, Texas needs to evaluate and promote energy conservation measures for homes, businesses, and public buildings to decrease energy consumption and reduce the emission of toxins that harm our patients' health. As such, TMA supports policies calling for retrofitting coal plants to improve emissions.

Maintaining a healthy water supply is essential to the future of Texas. Water pollution is a growing concern to Texas physicians, particularly the effects of toxic elements like methyl mercury on high-risk populations. The public should have access to information about the chemicals to which they have been exposed that could harm their health. The expansion of hydraulic fracturing ("fracking") has had a tremendous impact on the Texas economy, but concerns are increasing from physicians caring for persons living near fracking areas, and for those employed in the industry. There is a lack of information and research on the chemicals used and the potential health effects of these chemicals on the environment and the population. TMA supports more detailed disclosure of chemicals used in hydraulic fracturing.

TMA has called for the Texas Commission on Environmental Quality to ensure clean air and water for the health of Texans while still meeting the state's energy needs.

TMA RECOMMENDATIONS

Obesity

- ✓ Reinstating the one-half health education credit requirement for a student to graduate from high school.
- ✓ Increasing state funding for science-based community programming on healthy eating and physical activity.
- ✓ Implementing science-based recommendations that will improve the quality and quantity of health education, nutrition, physical education, and physical activity in schools.
- ✓ Enacting science-based policies that address healthy environments and obesity as they relate to physical activity and increased access to affordable and healthy foods.

Tobacco Use

- ✓ Enacting regulation of electronic cigarettes and associated products that includes:
 - Restricting their sale to minors,
 - Including these in smoking prohibition legislation and local policies,
 - Providing school-based education for children on the hazards of electronic cigarettes,
 - Assessing the feasibility of taxing electronic cigarettes and associated products to decrease the use of these products, and
 - Encouraging the U.S. Food and Drug Administration to assess the marketing of electronic cigarettes to minors.

- ✓ Maintaining funding for the Texas Quitline and the state's smoking cessation program and requiring monitoring of electronic cigarette use.
- ✓ Making Texas smoke free and encouraging cities throughout the state to adopt uniform policies for smoke-free public places, workplaces, restaurants, and bars.

Immunizations

- ✓ Increasing vaccination funding for Texas' adult population.
- ✓ Studying the aggregated impact of personal belief immunization exemptions on the health of Texas' communities.
- ✓ Enabling parents, physicians, and public health officials to have access to vaccination exemption information for local schools.
- ✓ Changing ImmTrac requirements to ensure that after parents have opted their child(ren) into the registry, the records remain until the individual opts out on their own.

Mental Health

- ✓ Funding the development of the state's behavioral health workforce including expansion of residency slots in psychiatry.
- ✓ Increasing funding for state and local mental health initiatives including support for jail diversion.

- ✓ Increasing state funding for treatment of higher risk populations such as pregnant women in need of treatment for alcohol or other substance abuse.

Distracted Driving

- ✓ Banning texting while driving statewide.

Environmental Health

- ✓ Ensuring the Texas Commission on Environmental Quality has input from physicians or other public health experts on the health consequences of ozone-producing emissions and the safety of the contents in hydraulic fracturing before the commission.
- ✓ Requiring the disclosure of chemicals used in hydraulic fracturing and studying the long-term impact of their use.



SECTION 10

Protect and Promote a Fair Civil Justice System

In our generation, Texas has taken no more important step to strengthen our health care delivery system than passing the 2003 medical liability reforms. The 2003 law swiftly ended an epidemic of lawsuit abuse, brought thousands of sorely needed new physicians to Texas, and encouraged the state's shell-shocked physicians to return to caring for patients with high-risk diseases and injuries. Tort reform, however, is a never-ending political and legislative battleground in Texas. We cannot relax our guard against direct attacks on the 2003 law, attempts to weaken the Texas Medical Board, or cynical schemes to turn any individual's final days into a lawyer's playground.

Preserve Texas' landmark liability reforms

In 2003, the Texas Legislature passed sweeping liability reforms to combat health care lawsuit abuse, reverse skyrocketing professional liability insurance premiums, and ensure Texans' access to high-quality medical care. The centerpiece of those reforms was a \$750,000 stacked cap on noneconomic damages assessed against physicians and health care facilities (hospital system, nursing home, and such) in a liability judgment. There is no cap on medical expenses, lost wages, or other economic damages. Texas voters then approved

Proposition 12, a constitutional amendment that ratified the legislature's authority to adopt these important reforms.

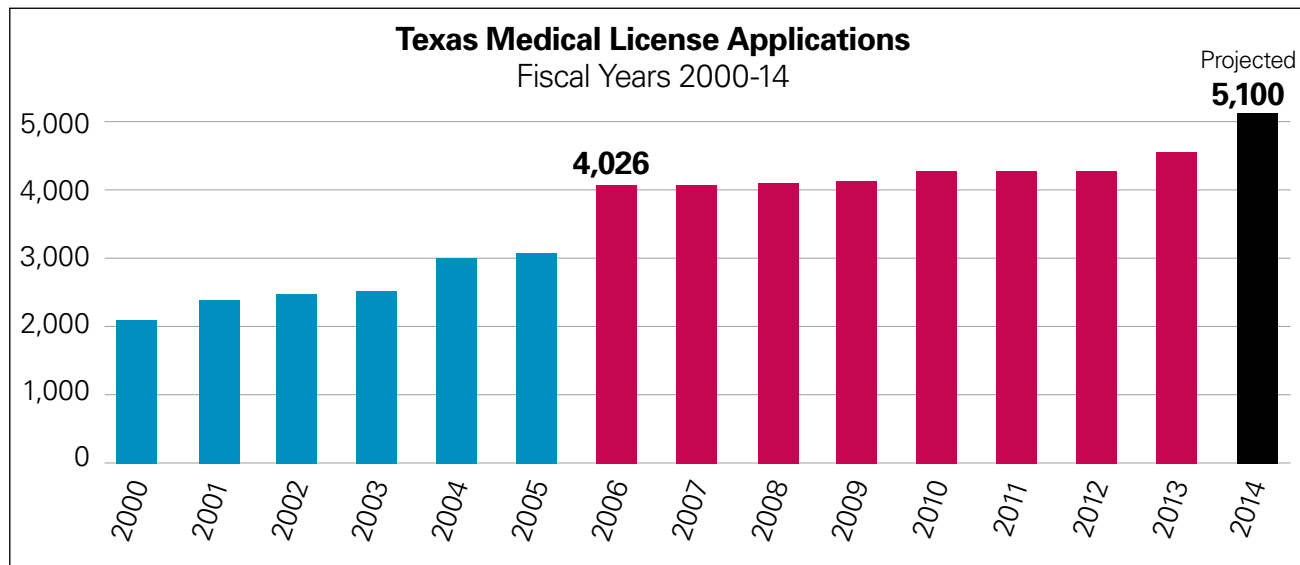
The reforms have worked. They've lived up to their promise. Sick and injured Texans have more physicians to deliver the care they need, particularly in high-risk specialties like emergency medicine, obstetrics, neurosurgery, and pediatric intensive care. Physicians also have benefited from lower liability insurance rates and fewer non-meritorious lawsuit filings.

Because of liability reform, good physicians continue to flock to Texas from other states. A stable liability climate — not the norm in most states — along with a fast-growing population and the need for more physicians has helped to fuel this increase. In the latter part of the decade following the 2003 reforms, the annual number of newly licensed physicians was about 70-percent higher than it was in the early years of the decade. Since 2008, Texas has ranked second nationally in percentage physician growth and in attracting the most physicians who treat patients. This trend looks to continue for years to come.

Using the most conservative figure available, Texas added enough direct patient care physicians since 2003 to provide 26 million more patient visits in 2014 than likely would have occurred without liability reform.

According to the Texas Alliance for Patient Access, the ranks of rural obstetricians have grown nearly three times faster than the state's rural population since 2003. Thirty-two rural counties have added at least one obstetrician. Fifteen rural counties that lacked a cardiologist now have one. Eleven counties have added their first general surgeon.

Fifty counties that had no emergency medicine physician now do. Forty of those counties are rural.



Source: Texas Medical Board

“I honestly do not believe I would still be in medicine today if not for Proposition 12.”

— Family medicine physician, 37,
Nueces County

While Texas leads the nation in medical liability reform legislation, some groups would like to see the law weakened or destroyed. Ever since 2003, adversaries and disingenuous front groups have tried to discredit the reforms with aggressive media outreach and misleading “research.” Each session, bills are introduced that attempt to create

new causes of action or would weaken, roll back, or eliminate key elements of the reforms, such as lifting the caps on noneconomic damages and protections for emergency services.

Improve funding for the Texas Medical Board

Texas continues to set new records for the number of medical license applications submitted to the Texas Medical Board (TMB) for processing. In 2013, TMB received its highest-ever number of applications at 4,610.⁴⁹ At press time, TMB was headed for a record 5,100 applications for 2014. This is good news for Texas patients and for Texas’ economy.

TMA surveyed⁵⁰ Texas physicians in 2013 — 10 years after medical liability reform — to ascertain the impact of the reforms on patient care. The findings indicated that:

- Texas’ liability climate was one of the top three reasons newly located physicians decided to practice in Texas (39 percent).
- The professional liability climate was “important” or “very important” in 63 percent of physicians’ decision to practice in Texas.
- Compared with 2003, almost three-quarters (72 percent) of physicians who have attempted to recruit new physicians to their practice, hospital, or community have found it easier to do so. Eighty percent were overwhelmingly successful in their attempts to recruit “high-risk” specialists such as obstetricians, neurosurgeons, pediatric subspecialists, and trauma surgeons.
- Physicians who were practicing in Texas then are now providing new or renewed services to their patients (13 percent).
- Physicians are accepting more high-risk patients (36 percent).
- If the 2003 Texas medical liability reforms were repealed by the Texas Legislature or nullified by federal law, 42 percent most likely would reduce or eliminate high-risk procedures. Younger physicians more likely would reduce or eliminate high-risk procedures. Older physicians more likely would retire early.

With the phenomenal growth in physicians practicing in Texas, it is critical that TMB has the resources needed to process new physician applications in a timely manner, as well as keep up with new legislative mandates to protect patients and improve efficiencies for physicians' practices.

As a key part of the 2003 medical liability reforms, the legislature enhanced the board's enforcement capabilities and imposed a surcharge on physicians' licenses to pay for staffing and infrastructure improvements. TMA supported the surcharge then and continues to do so today.

TMB, on average, collects in excess of \$70 million each biennium from physicians and others who it licenses. Licensure fees make up more than 50 percent of the revenue. TMB also collects another \$31 million from physicians in an occupation tax. The board receives approximately one-third of the total revenue for operations. In fiscal 2014-15, the board's appropriation was \$23.2 million.⁵¹ The remaining funds collected by the board go to the state's general revenue fund.

Lawmakers should direct physicians' licensure fees to the board so it can better accomplish its mission, particularly since the actual number of licensees has exceeded the anticipated number in the budget for the past several sessions.

Oppose federal preemption of state civil justice reforms

For decades, even before Texas passed our landmark medical liability reforms in 2003, organized medicine has pushed the U.S. Congress to enact national liability reforms based on the Texas and California tort models.

TMA supports the enactment of fair federal medical liability reforms because we know the very positive effects of the 2003 Texas reforms.

On the other hand, TMA and other state medical societies have been extremely diligent in ensuring that any national legislation under consideration — including pushes for federal tort reform — doesn't reverse or supersede strong laws already on the books in state capitals around the country.

TMA RECOMMENDATIONS

- ✓ Protect Texas' existing medical liability reform laws, including caps on noneconomic damages and protections for emergency services.
- ✓ Stop efforts to create new causes of actions against physicians and other health care providers who are delivering science-based and clinically appropriate care.
- ✓ Maintain the integrity of the Texas Advance Directives Act, free from exposure to medical liability suits. Do not yield to forces that seek to introduce litigious strategies into one of the hardest moments any family or physician faces.
- ✓ Require all revenue derived from physicians' licensure fees be used to fund the fixed and variable costs associated with the Texas Medical Board's operations.
- ✓ Oppose federal preemption of state civil justice reforms.

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