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2022 Annual Session

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES
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TexMed 2022
April 29-30, 2022

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2022 Annual Session
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Supplement

REPORT OF BOARD OF TRUSTEES

BOT Report 13 2022

Subject: Virtual Option for Delegates at Future Meetings (Resolution 105 2021)

Presented by: Rick W. Snyder II, MD, Chair, Board of Trustees

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Background
Due to the COVID-19 pandemic, the 2020 and 2021 meetings of the TMA House of Delegates were conducted virtually. This included the elections of TMA officers and the house business session.

At the 2021 house meeting, the Lone Star Caucus submitted Resolution 105, Virtual Option for Delegates at Future Meetings. The house adopted Resolution 105 as amended:

> **Resolution 105 – Virtual Option for Delegates at Future Meetings.** That (1) the TMA House of Delegates utilize virtual elections during House of Delegates meetings upon approval of the Board of Trustees; and (2) the TMA evaluate the feasibility of a virtual or hybrid option during the House of Delegates session for delegates to give testimony and vote on resolutions if unable to attend the meeting in person. **Adopted as amended.**

The resolution was referred to the TMA Board of Trustees and the TMA speakers. At its September meeting, the board referred Resolution 105 2021 to the Council on Constitution and Bylaws (C-CB), directing the council to evaluate how TMA will become compliant in implementing virtual elections and a virtual or hybrid option of the House of Delegates from a technical, financial, and parliamentary perspective.

Topic 1: Virtual or Hybrid Elections
The C-CB considered three possible methods of implementing the board's direction regarding virtual or hybrid elections at the house meeting:

- Option 1, continue with the currently available process – virtual ballots, cast in advance of the business meeting – as in the 2021 house elections.
- Option 2, switch to hybrid real-time elections, where virtual and in-person delegates cast ballots live at the outset of the house meeting; or
- Option 3, adopt limited virtual voting for when a delegate cannot attend, and no alternate is available.

Analysis of the three options is below.

Option 1: Currently Available Process (Virtual Advance Ballots)

Summary
Hold elections in the same manner as the 2021 elections, where the house meeting was opened to cast ballots virtually 15 days before the house business session.

This option would require the fewest logistical changes. TMA staff have already implemented this method of voting before. It would also not require bylaw changes, as the 2021 house adopted changes to the TMA Election Process to facilitate virtual elections consistent with the TMA Bylaws. If the board approves moving forward with this option as a regular method of holding elections though, the C-CB could evaluate whether bylaw amendments could improve the current process.

Considerations

- The inability to communicate election results with delegates in real time makes it more difficult to address vacancies arising during the elections. However, the 2021 house did adopt an amendment to the TMA Election Process to address such vacancies.
- Similarly, addressing runoffs could be more difficult than in a real-time election, as the additional rounds of balloting would require several days for voters to receive and return their ballots. Also, runoffs (or vacancies) that cannot be resolved virtually might need to be resolved in real time at the house business meeting, which could limit voting to delegates present at the in-person business meeting.
- This method does not allow for nominations from the floor (the American Institute of Parliamentarians, Standard Code of Parliamentary Procedure, notes that the inability to make nominations from the floor is an inherent disadvantage of voting by mail or voting electronically through the internet).
- The legal validity of elections conducted by mail or electronic message is less certain than for in-person elections. The statutory framework for corporate governance in Texas was passed in the 1950s, when corporate elections and meetings were generally conducted in person. In the ensuing decades, certain statutory provisions were amended to allow elections by mail, facsimile, and electronic message. However, many related provisions still retain language that contemplates corporate actions being taken at in-person meetings, resulting in conflicting statutory language.
- This option requires opening the house meeting in advance of the business session, which takes additional TMA delegate and staff time. As the meeting is ongoing while voting occurs, this also creates the potential for a quorum challenge. This could be addressed, though, by amendments to remove the bylaw requirement that elections be held at the business meeting. Also, for remote elections, the bylaw's quorum requirement could be amended to determine quorum based on ballots cast.
- The ability of delegates to vote virtually for officer elections may decrease in-person attendance at the house business session. TMA's contracts with the event site hotels presume a certain number of hotel room bookings and food service based on expected delegate attendance. Additionally, TMA's room rates, space allotments, and concessions will often reflect a tradeoff with the hotel based on the anticipated number of attendee bookings at the hotel. If in-person delegate attendance decreases, TMA may not be able to negotiate as favorable terms. Conversely though, delegates not attending in person would save on save on travel and hotel costs.
- Reduced in-person attendance could also result in there not being a quorum at the house business meeting. As set forth below, though recent meetings have exceeded quorum requirements, a reduction of 100 or more in-person attendees could make it difficult to reach and maintain a quorum:

	2017	**2018**	**2019**	**2020**	**2021**
Quorum	246	232	259	282	278
Delegates Present	408	420	416	408	399

- The estimated cost to implement this option would be comparably low. For the 2021 elections, delegates received an email link that allowed them to vote through the TMA website. TMA "owns" this process and would not have to go through an outside vendor to reinitiate it. The costs associated with this option would generally be associated with TMA staff time.

Option 2: Hybrid Real-Time Elections

Summary

Hold real-time elections in a manner similar to how they were conducted prior to the COVID-19 pandemic, except virtual delegates could vote concurrently with in-person delegates (i.e., through Lumi or an equivalent application).

This method would remove some of the previously discussed logistical challenges inherent to virtual ballots, such as addressing runoffs and vacancies that occur during the elections. It could be logistically challenging in other ways, though, particularly to resolve technical issues for both in-person and remote delegates.

Considerations

- Previous TMA attempts to hold other hybrid meetings have been challenging, with it being difficult to hear the virtual attendees. The TMA Bylaws and Texas statute require each person participating in the meeting to be able to communicate with all other persons participating in the meeting.
- Coordinating real-time election features – floor nominations, immediate run-offs – for in-person and virtual delegates could be difficult and time-consuming. It could also be logistically challenging to resolve technical issues for both in-person and remote delegates while the elections are being conducted in real time. This could also affect quorum, if a significant portion of the delegates participated virtually but then were unable to participate due to technical issues.
- To effectively live-stream audio and visual content from the event site may require TMA to purchase additional internet bandwidth from the event site.
- TMA would need to amend the TMA Election Process, which currently contemplates a house election as being either virtual or in-person.
- As with Option 1, it is less certain whether votes cast electronically are valid under the Texas statutes governing corporations.
- As with Option 1, there is the potential that the ability to participate in virtual elections would decrease delegate attendance at the in-person business session, which could result in decreased hotel bookings and difficulty reaching quorum for the business meeting.
- The estimated cost for voting software and software support personnel is $45,000-$55,000. This does not include the audio-visual costs associated with live recording and broadcasting.

Option 3: Limited Virtual Voting

Summary

Allow virtual voting, but only when delegates cannot attend, and no alternate delegate is available.

This could address the concern that virtual voting would lead to decreased in-person attendance by limiting virtual voting to instances when in-person attendance is not possible.

Considerations

- This option could be seen as inconsistent with Resolution 105, which does not discuss imposing criteria for virtual voting.
- TMA would need to develop standards for when virtual voting would be allowed, establish a framework for the review process, and determine who would conduct the review, and would need to amend the TMA Bylaws and TMA Election Process accordingly.
- Depending on voting method, virtual voters might not be able to vote for positions created by vacancies and runoffs, or make nominations from the floor.

- Many of the considerations discussed in Options 1 and 2 would still be applicable to this option, albeit on a (presumably) smaller scale.
- The estimated cost is uncertain, as it could depend on the method of virtual voting and the number of delegates who qualify for this option.

Topic 2: Hybrid Business Session

Summary

For a house meeting held in person, a hybrid option would allow physicians not attending in person to participate virtually in giving testimony and voting on resolutions.

Legal or parliamentary requirements would not prohibit a hybrid house meeting. The TMA Bylaws allow a meeting to be held with a combination of in-person or video-conferencing attendees, so long as each person participating in the meeting can communicate with all other persons participating in the meeting. Voting may also be done in person or by electronic message.

It is uncertain, though, if these requirements can be met in real-world application. Coordinating real-time parliamentary requirements – e.g., votes, motions, seconds – for in-person and virtual delegates could be challenging for the house speaker. Legal requirements, such as maintaining quorum and the ability of all members to communicate, could be complicated by technical outages or difficulties in communications between members attending in person and members attending virtually.

Considerations

- Coordinating real-time parliamentary requirements – e.g., votes, motions – for in-person and virtual delegates could be challenging for the speaker. It could be necessary to develop a process to alternate between recognizing in-person and virtual delegates, so that each group is equally able to participate in the parliamentary process. This could result in a longer house business session, which already usually takes two days.
- The TMA Bylaws and Texas statute require each person participating in the meeting to be able to communicate with all other persons participating in the meeting. It could be difficult to maintain a quorum, if a significant portion of the delegates participated virtually but then were unable to participate due to technical issues.
- Amendments would be needed to the provisions in the TMA House Standing Rules that currently address a house meeting as being either virtual or in-person.
- As with the virtual election options, the ability to participate virtually could decrease in-person delegate attendance, which would decrease hotel bookings and negatively affect TMA's negotiating leverage.
- The estimated cost of a hybrid business session could range from $100,000 to $500,000. Conducting a hybrid event at a hotel could be operationally and financially uncertain, as each hotel could differ on the technical challenges of setting up the necessary audio-visual equipment, and the cost of doing so. Moving to a ballot system that allows in-person and virtual voting would also require replacing TMA's current voting equipment. Effective live-streaming audio and visual content from the event site may require purchasing additional internet bandwidth from the hotel.

Topic 1 Conclusion

The board will continue to review and evaluate these processes to hear as many TMA member voices as possible, working hard to ensure all delegates have access to voting. The board looks forward to technology advances within the coming year that will give delegates who are unable to attend the house business meeting in person the ability to vote in a secure manner.

Topic 2 Conclusion

To assess the feasibility of a hybrid business meeting, your speakers will implement a hybrid Reference Committee on Financial and Organizational Affairs hearing during TexMed 2022. Reference committees shares similar features to a meeting of the house – e.g., a presiding officer and members testifying on resolutions – which would allow a preview of whether effective communication can be maintained in a hybrid format. Also, reference committees are prefatory and advisory in nature. Thus if the technical challenges of a hybrid format interfere with successful communication at a reference committee, there is an opportunity to revoice testimony at the subsequent house meeting.

References:

1. TMA Constitution and Bylaws
2. TMA Election Process
3. TMA 2021 House of Delegates Standing Rules, Special Circumstances
4. AMA Instructions to access virtual November 2021 Special Meeting of AMA HOD

REPORT OF BOARD OF TRUSTEES

BOT Report 14 2022

Subject: Investments

Presented by: Richard W. Snyder II, MD, Chair, Board of Trustees

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TMA and Separate Fund Investments

Members of the Texas Medical Association Board of Trustees also serve as trustees or as the board of trustees for two library funds, two student loan funds, The Physicians Benevolent Fund, and the TMA Special Funds Foundation. The investment portfolios for TMA, and for the funds for which members of the TMA Board of Trustees serve as trustees or as the board of trustees, are invested by the Board of Trustees by way of designated investment managers. The board acts on recommendations of its Finance Committee, which meets three times a year. The committee and the board review quarterly reports from TMA's investments monitor, The Quantitative Group at Graystone Consulting. The Quantitative Group is the investment monitor for TMA funds and all funds managed by TMA. The committee and the board review quarterly composite reports prepared by The Quantitative Group and presented by W. Joseph Sammons, The Quantitative Group senior vice president, and Ronald Kern, The Quantitative Group executive director. The board establishes investment performance objectives for the investment portfolios of TMA and six separate funds and sets policy for the mix of investment media (equities, fixed income, alternative mutual funds, and cash equivalents).

The Dec. 31, 2021, net assets of the funds managed by these investment managers were reported as follows: TMA, $42,367,272; Texas Medical Association Library, $3,466,961; Annie Lee Thompson Library Trust Fund, $4,782,859; May Owen Irrevocable Trust, $3,746,301; Dr. S.E. Thompson Scholarship Fund, $7,688,981; The Physicians Benevolent Fund, $5,810,485; and the Texas Medical Association Special Funds Foundation, $3,643,386.

Dec. 31, 2021, Investment Manager Performance Report

Since Dec. 31, 1993, the composite annualized performance for all equity investments has been 9.55% versus the equity composite index annualized rate of return of 10.15%. The one-year rate of return was 23.81% versus the equity composite index return of 23.75%. Equity investment allocation by manager is approximately 32% at Luther King Capital Management, 64% in iShares blended mutual funds, 2% in Dodge & Cox International Stock Fund, and 2% in the Invesco Developing Markets mutual fund.

The composite annualized performance for all fixed income investments has been 5.09% versus the Barclays Aggregate annualized return of 5.28% for the period of June 30, 1992, through Dec. 31, 2021. The one-year rate of return was -1.13% versus the index return of -1.54%. Fixed income investment allocation by manager is approximately 52% at Vaughn Nelson, 21% in the Metropolitan West Intermediate Bond Fund, 14% in the JP Morgan Strategic Income Bond Fund, and 13% in the FPA New Income Bond Fund.

Alternative mutual fund investments have experienced an annualized return of 9.63% versus the HFRI Fund of Funds Composite Index annualized return of 5.78% for the five-year period through Dec. 31, 2021. The one-year rate of return was 15.17% versus the benchmark return of 6.53%. Alternatives investment allocation by manager is 100% in the FPA Crescent Fund.

REPORT OF BOARD OF TRUSTEES

BOT Report 15 2022

Subject: Audit of 2020 Financial Statements and 2021-22 Operating Budgets

Presented by: Richard W. Snyder II, MD, Chair, Board of Trustees

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Audit of 2020 Financial Statements

The Audit of 2020 Financial Statements report was presented to the Texas Medical Association Board of Trustees at its May 13, 2021, meeting. Independent auditor Holtzman Partners, LLP, determined the consolidated financial statements "present fairly, in all material respects, the consolidated financial position of Texas Medical Association and Texas Medical Association Board Administered Organizations . . . in accordance with accounting principles generally accepted in the United States of America." Copies of the audit report are available in the association's offices for review by any TMA member.

The Audit of 2021 Financial Statements report by Holtzman Partners, LLP, will be completed and presented to the Board of Trustees at its 2022 spring meeting. The board will present the audit reports to the House of Delegates in 2023.

2021 Operating Budget

For 2021, operating income was $25,823,541 and operating expenses were $24,277,541. At year end, total actual operating income for the year was above budgeted operating income by $431,801 (1.70%). Total actual operating expenses were under budget by $1,169,199 (4.59%), resulting in an actual net operating surplus of $1,546,000. This actual net operating surplus exceeded the budgeted net operating deficit by $1,601,000. An unaudited report on 2021 operations is attached.

2021 Nonoperating Income and Expense

2021 nonoperating income includes TMA Surprise Billing Litigation Fund contributions of $55,100. Nonoperating expense includes legal fees of $427,760 for support of surprise billing litigation efforts, legal fees of $17,393 for settlement of contractual obligations, and loss on disposal of equipment of $42,202.

2021 Net Investment Gain

Net investment gain includes realized investment gains of $780,786 and unrealized gains on investments of $3,779,163.

2022 Operating Budget

In December 2021, the Board of Trustees approved a 2022 operating budget projecting an income of $26,298,440 and expenses of $26,298,440, with a 2022 capital expenditure budget of $445,000. The operating budget will be presented to the house by Board of Trustees Chair Richard W. Snyder II, MD. The board also approved direct financial support of related organizations in 2022 as follows: TEXPAC request for support totaling $472,610; TMA Alliance request for support totaling $125,000; TMA Foundation request for support totaling $115,000; and Association Management Services request for support totaling $1,118,600. Offsetting these expenses are projected 2022 Association Management Services fees totaling $1,070,700; corporate contributions of $225,000 to TEXPAC; and $15,000 in grant revenue received for TMA Foundation programming.

The 2022 expense budget of $26,298,440 represents an increase of $851,700 from the final 2021 expense budget of $25,446,740. Supporting this expense budget is a projected income budget of $26,298,440. This

represents an increase of $906,700 from the final 2021 income budget of $25,391,740. As a result, a break-even budget is projected for 2022.

The 2022 budgeting process included a review of all programmatic activities. TMA's relevance and value to its members were used as benchmarks for evaluating programs and determining which areas to expand or reduce. As containing expenses for approved programs becomes increasingly difficult, programmatic growth must be restrained or new sources of income identified. The 2022 Operating Budget adopted by the board is attached.

Texas Medical Association
Statement of Income and Expense by Program
For the Year Ending December 31, 2021

UNAUDITED

	Total	Building Fund	Operating Fund Budget Comparison			
			Actual	Budget	Variance	% Variance
Income						
Membership Recruitment & Retention	$ 16,753,150		$ 16,753,150	$ 15,675,000	$ 1,078,150	6.88%
Royalty Income	1,906,050		1,906,050	2,251,350	(345,300)	(15.34%)
Rental Income	1,817,545		1,817,545	1,803,960	13,585	0.75%
Related Organizations	1,310,915		1,310,915	1,210,860	100,055	8.26%
Marketing and Member Services	280,430		280,430	608,680	(328,250)	(53.93%)
Communications	753,987		753,987	858,700	(104,713)	(12.19%)
Legal	599		599	13,000	(12,401)	(95.39%)
Educational Programs	632,155		632,155	396,220	235,935	59.55%
Investment Income	477,663	94,870	382,793	402,000	(19,207)	(4.78%)
TexMed and Conferences	187,050		187,050	421,000	(233,950)	(55.57%)
Organizational Support Activities	1,315,518		1,315,518	1,333,320	(17,802)	(1.34%)
Medical Education	137,090		137,090	173,150	(36,060)	(20.83%)
Advocacy and Public Policy	73,850		73,850	70,000	3,850	5.50%
Public Health - Quality - Science	173,927		173,927	79,500	94,427	118.78%
Information Systems	23,400		23,400	19,000	4,400	23.16%
Boards, Councils, Committees	75,082		75,082	76,000	(918)	(1.21%)
Total Income	$ 25,918,411	$ 94,870	$ 25,823,541	$ 25,391,740	$ 431,801	1.70%
Expense						
Communications	$ 3,213,297		$ 3,213,297	$ 3,053,780	$ 159,517	5.22%
Organizational Support Activities	4,168,793		4,168,793	4,031,070	137,723	3.42%
Building Operations	2,308,045	78,591	2,229,454	2,627,660	(398,206)	(15.15%)
Related Organizations	1,657,551		1,657,551	1,755,950	(98,399)	(5.60%)
Legal	1,441,606		1,441,606	1,444,480	(2,874)	(0.20%)
Advocacy and Public Policy	1,954,639		1,954,639	2,103,840	(149,201)	(7.09%)
TexMed and Conferences	1,058,884		1,058,884	1,766,550	(707,666)	(40.06%)
Depreciation	1,116,563		1,116,563	1,187,300	(70,737)	(5.96%)
Health Policy - Regulation	815,629		815,629	877,550	(61,921)	(7.06%)
Information Systems	1,630,669		1,630,669	1,629,350	1,319	0.08%
Membership Recruitment & Retention	2,079,746		2,079,746	1,952,590	127,156	6.51%
Marketing and Member Services	654,146		654,146	744,190	(90,044)	(12.10%)
Public Health - Quality - Science	1,133,634		1,133,634	1,054,240	79,394	7.53%
Boards, Councils, Committees	256,454		256,454	462,950	(206,496)	(44.60%)
Medical Education	492,134		492,134	519,610	(27,476)	(5.29%)
Educational Programs	374,342		374,342	235,630	138,712	58.87%
Total Expense	$ 24,356,132	$ 78,591	$ 24,277,541	$ 25,446,740	$ (1,169,199)	(4.59%)
Net Operating Income (Loss)	$ 1,562,279	$ 16,279	$ 1,546,000	$ (55,000)	$ 1,601,000	
Non-Operating Income (Expense)						
TMA Surprise Billing Litigation Fund contributions	$ 55,100		$ 55,100			
Surprise Billing Litigation legal fees	(427,760)		(427,760)			
Contractual Obligations legal fees	(17,393)		(17,393)			
Loss on Disposal of Equipment	(42,202)		(42,202)			
Total Non-Operating Expense	(432,255)		(432,255)			
Investment Gain (Loss)						
Realized Investment Gain (Loss)	780,786	54,177	726,609			
Unrealized Gain (Loss) on Investments	3,779,163	751,976	3,027,187			
Net Investment Gain	4,559,949	806,153	3,753,796			
Net Income	$ 5,689,973	$ 822,432	$ 4,867,541			

Texas Medical Association
2022 Operating Budget

	2022 Budget	2021 Budget	Change $	Change %	% of Budget
Income					
Membership Recruitment and Retention	$ 16,500,000	$ 15,675,000	$825,000	5.3%	62.7%
Insurance Royalty Income	2,295,650	2,251,350	44,300	2.0%	8.7%
Building Operations	1,859,860	1,803,960	55,900	3.1%	7.1%
Related Organization Support	1,085,700	1,135,860	(50,160)	(4.4%)	4.2%
Organization and Support Activities	768,480	775,640	(7,160)	(0.9%)	2.9%
Communications	680,500	858,700	(178,200)	(20.8%)	2.6%
Member Experience	644,500	960,560	(316,060)	(32.9%)	2.5%
Education Center	617,500	396,220	221,280	55.8%	2.3%
Investment Income	420,000	402,000	18,000	4.5%	1.6%
Conference Management	408,600	421,000	(12,400)	(2.9%)	1.5%
Advocacy and Public Policy	295,000	145,000	150,000	103.4%	1.1%
Continuing Medical Education	211,400	173,150	38,250	22.1%	0.8%
Association Governance	201,000	151,000	50,000	33.1%	0.8%
Information Technology	179,900	229,300	(49,400)	(21.5%)	0.7%
Population Health	117,350	0	117,350		0.4%
Legal	13,000	13,000	0		0.1%
	$ 26,298,440	$ 25,391,740	$906,700	3.6%	
Expense					
Organization and Support Activities	$ 3,262,890	$ 3,351,090	$ (88,200)	(2.6%)	12.4%
Communications	3,228,720	3,360,910	(132,190)	(3.9%)	12.4%
Building Operations	2,607,740	2,627,660	(19,920)	(0.8%)	9.9%
Advocacy and Public Policy	2,351,360	2,387,110	(35,750)	(1.5%)	8.9%
Membership Recruitment and Retention	1,777,550	1,774,340	3,210	0.2%	6.7%
Association Governance	1,688,350	1,441,260	247,090	17.1%	6.4%
Legal	1,592,790	1,444,480	148,310	10.3%	6.1%
Information Technology	1,589,200	1,519,610	69,590	4.6%	6.0%
Related Organization Administration	1,583,610	1,641,530	(57,920)	(3.5%)	6.0%
Population Health	1,496,380	1,246,360	250,020	20.1%	5.7%
Health Policy - Regulation	1,253,530	1,162,930	90,600	7.8%	4.8%
Member Experience	996,840	800,700	196,140	24.5%	3.8%
Conference Management	979,320	938,340	40,980	4.4%	3.7%
Education Center	436,590	235,630	200,960	85.3%	1.7%
Continuing Medical Education	332,990	327,490	5,500	1.7%	1.3%
Non-Cash Depreciation Expense	1,120,580	1,187,300	(66,720)	(5.6%)	4.2%
	$ 26,298,440	$ 25,446,740	$ 851,700	3.3%	
Net Budget	$ 0	$ (55,000)	$ 55,000		

Supplement

REPORT FROM THE COUNCIL ON SOCIOECONOMICS

C-SE Report 7 2022

Subject: Resolution 106 – Creation of Ad Hoc Committee to Study and Make Recommendations Concerning Noncompete Agreements in Physician Employment Contracts

Introduced by: Rodney B. Young, MD, Chair, Council on Socioeconomics

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At TexMed 2021, the House of Delegates referred Resolution 106: Creation of Ad Hoc Committee to Study and Make Recommendations Concerning Noncompete Agreements in Physician Employment Contracts to the Council on Socioeconomics. It calls on the Texas Medical Association to:

(1) Study noncompete agreements in physician employment contracts and evaluate the impact of noncompete agreements on physicians and patients in Texas with a report made to TMA no later than TexMed 2022; and
(2) Assess whether means other than noncompete agreements might suffice to protect physician employers' legitimate interests with report made to TMA no later than TexMed 2022.

The Council on Socioeconomics formed a member workgroup that met with resolution authors to better understand their concerns. Although plans for discussion with the full council at the 2021 TMA Winter Conference were canceled due to COVID-19 concerns, subsequent meetings held Jan. 28 and March 8 were adequate for the council to reach its conclusion.

TMA Policy Addressing Noncompete Clauses

The Council considered TMA's policy and Board of Councilors' ethics opinion in this area:

- **185.020 Principles for Employment Contracts** says in part, "The need to protect quality patient care and the physician's exercise of independent medical judgment in providing that care to patients, both in the context of accountable care organizations and hospital physician employment efforts, is paramount." Also: "An employment arrangement with a physician should ensure that the patient's well-being is placed first."
- **265.001 Exclusive Contracts** says in part, "Exclusive contracts should never be used to circumvent medical staff bylaws as a mechanism to solve quality assurance problems."
- **60.004 Freedom of Choice** says in part, "Free and open competition of physicians and free choice of physicians for the primary benefit of patients is a goal which public and private policy should support."
- **115.015 Accountable Care Organizations** says in part, "ACOs and value-based payment models must not impose marketplace limiting agreements (e.g., covenants not to compete and exclusivity provisions) upon physicians or physician practices. Further, they must not interfere with the internal management of physician practices regarding covenants not to compete."
- **Covenants Not to Compete** says in full: "Covenants not to compete disrupt continuity of care, deprive the public of medical services, and restrict competition. The Board of Councilors discourages any agreement that restricts the right of a physician to practice medicine. Restrictive covenants are unethical if they are excessive in geographic scope or duration in the circumstances presented, or if they fail to make reasonable accommodation of a patient's choice of physician.

> "A physician must not be subject to an action for violating a covenant not to compete for continuing to treat patients whom the physician believes will suffer harm if that physician's care must be discontinued to comply with the covenant not to compete.
>
> "Enforcement of restrictive covenants must not interrupt continuity of care for any patient. Every effort must be made to ensure a seamless transition."

AMA: Legislative Template: Covenants Not-to-Compete in Physician Contracts

To inform its understanding of noncompete agreements, the council referred to a very helpful American Medical Association resource titled "Legislative Template: Covenants Not-to-Compete in Physician Contracts." AMA developed this document in 2020 as a result of an AMA Board of Trustees Report, to "create a state restrictive covenant legislative template to assist state medical associations, national medical specialty societies and physician members as they navigate the sensitive intricacies of restrictive covenant policy at the state level."

As defined by AMA, "the term 'non-compete agreements' (subsequently referred to as 'non-competes') refers to agreements wherein a physician is prohibited from practicing medicine post-employment or contract within a geographic area for a specific period of time." The document further states, "Given strong opinions that AMA members have on physician non-competes, this Template does not recommend that the Federation adopt any legislative approach to non-competes, but it does provide legislative options based on how states so far have addressed various non-compete issues."

The AMA document recognizes growing interest and concerns by physicians regarding noncompete clauses, due in part to a growing number of employed physicians compared with independent practices owned by physicians. The council, like AMA, recognizes the divisiveness of the issue among physicians.

Some physicians may oppose noncompete clauses since their use could:

- Force practicing physicians to leave a community in which they established a patient population; and
- Negatively impact patient choice and access, threatening an established patient-physician relationship.

Proponents of noncompete clauses are often owners of a medical practice who seek a safety net as they commit time and resources to hire a new physician. Per the AMA document, "investment(s) might take the form of loans, recruitment costs, special training, relocation expenses, signing bonuses, etc. Employers may want to be able to recover the balance of these costs if a physician leaves employment before the employer has recouped its investment."

Acknowledging that some physicians seek to legislatively prohibit noncompete and other restrictive employment agreements, the AMA document refers to the Uniform Law Commission's Uniform Restrictive Employment Agreement Act.

In examining noncompete clause issues, the AMA document outlines how the legal system has considered and analyzed such employment clauses: "Because non-competes are a restraint of trade, courts have traditionally analyzed the validity of non-competes under the rule of reason, i.e., non-competes are enforceable only if they constitute a reasonable restraint of trade."

However, the document then acknowledges that existing case law cannot be used to determine or predict a ruling, given that "each case can vary greatly depending on the physician's specialty, the geographic

area involved, e.g., urban versus rural, hardship on the physician, the public policy issues raised, such as patient choice and patient access to care."

After acknowledging that it is problematic to use existing case law to predict a specific case's outcome, AMA cites four aspects courts often use to evaluate a noncompete clause dispute, i.e., whether:

(1) The noncompete protects a legitimate business interest (LBI);
(2) The noncompete is reasonable in terms of geographic scope and time;
(3) The scope of services covered by the noncompete is reasonable; and
(4) The noncompete is contrary to public policy.

AMA cites 31 states – Alabama (not applicable to physicians), Arkansas (not applicable to physicians), California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Louisiana, Maine, Massachusetts, Michigan, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Dakota, Oklahoma, Oregon, Rhode Island, South Dakota, Tennessee, Texas, Utah, Washington, West Virginia, and Wisconsin – that have laws that apply to noncompete clauses. Of these, 12 states have laws on noncompete clauses specific to a physician or health care professional: Colorado, Connecticut, Delaware, Florida, Indiana, Massachusetts, New Hampshire, Rhode Island, South Dakota, Tennessee, Texas, and West Virginia.

The AMA document then outlines four ways that state laws have prohibited the use and enforcement of noncompete clauses:

(1) Prohibit noncompete clauses with no explicit exceptions for recovery of damages or certain business transactions such as partnership dissolutions;
(2) Prohibit noncompete clauses with explicit exceptions for certain business transactions, e.g., partnership dissolutions and/or sale and purchase of the goodwill of a business;
(3) Prohibit noncompete clauses and explicitly permit recovery of damages;
(4) Prohibit noncompete clauses with explicit exceptions for recovery of damages and for certain business transactions, e.g., partnership dissolutions.

Following this section, the "Covenants Not-to-Compete in Physician Contracts" document highlights state law that allows for physician noncompete clauses with certain restrictions. The section "is designed to present options, based on existing state non-compete statutes, for Federation members who may be thinking about drafting non-compete legislative language that addresses certain non-compete issues without putting in place an outright ban, or imposing a ban with explicit caveats for specific business transactions and/or damages."

For those considering prohibiting noncompete clauses, AMA recommends considering laws that:

- Better identify LBI since, "courts will not enforce a non-compete unless the non-compete protects LBI";
- Address the duration of noncompete agreements by establishing a:
-
    - Fixed time limit on noncompete clauses;
    - Time duration of two years or less as reasonable;
    - Presumption that addresses the reasonableness or unreasonableness of a noncompete clause duration;
    - Presumption that a time duration be negotiated upon by all parties involved; and/or
    - Position that generally addresses the duration of a noncompete clause;

- Clearly define the geographic scope of noncompete clauses by either "specifying geographic limits in terms of cities, counties, or miles" or "addressing geographic limits through other, more general, means";
- Reevaluate the "similar business" or "like business" standard since, "some laws permit the enforcement of non-competes in various contexts so long as the applicable entity or former business associates conduct, or continue to conduct, a like or similar business";
- Further codify and define a reasonableness criterion, because "many states simply codify the common law requirement that the applicable geographic area be reasonable or not greater than necessary to protect the LBI at issue"; and
- Evaluate the "undue hardship" requirement, since "some states' courts consider the hardship that a non-compete would have on the individual involved when determining whether to enforce a non-compete." However, the AMA resource cautions that some statutes are "not always to the benefit of the affected individual."

AMA provides detailed information including citations to specific state law and case illustrations on various ways states address the liquidation of damages and address "buy-out" clauses. Further, the resource details state law regarding how to address or prohibit the recovery of damages.

Regarding "buy-out" language, the AMA document highlights that Texas and Indiana are the only states where "non-competes are enforceable only if the non-compete is accompanied by a reasonable buy-out provision." The Texas law was first enacted in 1983, with physician-specific provisions added in 1999, and last amended in 2009. Indiana enacted its law in March 2020. Texas courts have described this buy-out requirement as an "additional safeguard" granted to physicians by the Texas Legislature. Texas statute includes language stating, in part, that:

> A covenant not to compete relating to the practice of medicine is enforceable against a person licensed as a physician by the Texas Medical Board if such covenant complies with the following requirements:
>
> The covenant must provide for a buy-out of the covenant by the physician at a reasonable price or, at the option of either party, as determined by a mutually agreed upon arbitrator or, in the case of an inability to agree, an arbitrator of the court whose decision shall be binding on the parties.

Notably, Texas courts have decided entire noncompete clauses are void if they lack a required buy-out provision.

Regarding continuity-of-care issues, the AMA resource quotes the AMA Council on Ethical and Judicial Affairs Ethics Opinion 11.2.3.1. It acknowledges continuity-of-care concerns, stating in part, "Covenants not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care." The AMA resource highlights state law that addresses the patient-physician relationship. Included is a reference to Texas and Indiana, which "appear to be the only states making the enforcement of physician non-competes contingent on the employer or other entity providing specific information to both the departing physician and his or her patients." Furthermore, in Texas, "a non-compete cannot be enforced" unless it provides "that the physician will not be prohibited from providing continuing care and treatment to a specific patient or patients during an acute illness even after the contract or employment has been terminated."

From the Texas statute:

> (b) A covenant not to compete relating to the practice of medicine is enforceable against a person licensed as a physician by the Texas Medical Board if such covenant complies with the following requirements:
>
> (1) the covenant must:
>
> (A) not deny the physician access to a list of his patients whom he had seen or treated within one year of termination of the contract or employment;
>
> (B) provide access to medical records of the physician's patients upon authorization of the patient and any copies of medical records for a reasonable fee as established by the Texas Medical Board under Section 159.008, Occupations Code; and
>
> (C) provide that any access to a list of patients or to patients' medical records after termination of the contract or employment shall not require such list or records to be provided in a format different than that by which such records are maintained except by mutual consent of the parties to the contract;
>
> (2) the covenant must provide for a buy out of the covenant by the physician at a reasonable price or, at the option of either party, as determined by a mutually agreed upon arbitrator or, in the case of an inability to agree, an arbitrator of the court whose decision shall be binding on the parties; and
>
> (3) the covenant must provide that the physician will not be prohibited from providing continuing care and treatment to a specific patient or patients during the course of an acute illness even after the contract or employment has been terminated.

The noncompete resource by AMA then outlines noncompete laws addressing the patient-physician relationship after employment or contract termination, discussing how state laws impact a "physician's ability to continue to treat patients that he or she served while employed or contracted." Furthermore, the AMA resource discusses contract language and state law that prohibit a physician from soliciting a former employer's patients.

The document concludes with an acknowledgment that the template "does not cover all of the issues raised or implicated by state non-compete laws that might interest a Federation member. These issues include, but are not limited to: protection of trade secrets and other confidential business information; non-competes with respect to low-wage employees or independent contractors; consideration required to support a non-compete; advance notice of non-competes; franchises; ancillary; burden of proof in litigation; injunctions; choice of law; choice of forum; level of scrutiny; canons of construction; the Stark statute's provisions regarding non-competes; non-competes under the Conrad 30 program; third-party enforcement, etc."

Additional Background and Considerations Specific to Texas Law on Noncompete Clauses

As stated earlier, the physician-specific provisions of Texas' law on noncompete clauses have been in place since 1999. The law was last amended in 2009. The original physician-specific components of the law were heavily negotiated, with physicians on both sides of the issue at the time of its enactment.

Employer physicians wanted to be able to use noncompete clauses to protect their investments in recruiting physicians. Employee physicians would have preferred a blanket prohibition on noncompete clauses as applied to the practice of medicine. Texas' law was a compromise or middle ground reached to address concerns on both sides.

From the employed physician's perspective, the benefit of Texas' law on noncompete agreements (related to the practice of medicine) would likely be that it contains the previously mentioned continuity-of-patient-care provisions, including the buy-out provision.

These continuity-of-care provisions only apply to Texas-licensed physicians (and noncompete agreements related to the practice of medicine), so those who are not accustomed to drafting noncompete clauses falling within the Texas law may be unaware of these specific requirements. Out-of-state lawyers and management groups, for example, may forget to comply with these requirements when they draft noncompete clauses. Thus, not all noncompete agreements offered to Texas physicians satisfy Texas law or are enforceable.

From the employer physician's perspective, the benefit of Texas law is the continued ability to use noncompete agreements (if certain requirements are met) to protect their investments. Texas law also contains requirements for the court to reform the noncompete agreement if the limitations in scope of activity, duration, and geography are unreasonable.

TMA has been hearing more physicians express dissatisfaction with noncompete agreements lately, particularly in the context of hospital agreements. The language in some noncompete clauses also has become more onerous with the addition of nonsolicitation agreements. However, there are physicians who continue to value the use of noncompete agreements in their practices and use them for physician employees, as well as for other health professionals.

References:

1. Uniform Law Commission. About Us. www.uniformlaws.org/aboutulc/overview.
2. See e.g., *Valley Medical Specialists v. Farber*, 982 P.2d 1277, 1281 (Ariz. 1999).
3. *Novamed Surgery Ctr. of Tyler, L.P. v. Bochow*, 2013 Tex. App. LEXIS 7160 *; 2013 WL 2725544 (at p. 12).
4. Tex. Bus. & Comm. Code §15.50(b)(2). Note that this is an excerpt of a section of Texas law and is not the entire section.
5. See e.g., Gulf Coast Cardiology Group, P.A. v. Samman, 2002 Tex. App. LEXIS 5942 *; 2002 WL 1877175; *Novamed Surgery Ctr. of Tyler, L.P. v. Bochow*, 2013 Tex. App. LEXIS 7160 *; 2013 WL 2725544.
6. Tex. Bus. & Comm. Code §15.50(b)(3).
7. Tex. Bus. & Comm. Code §15.50(b).

REPORT OF COMMITTEE ON PHYSICIAN DISTRIBUTION AND HEALTH CARE ACCESS

CM-PDHCA Report 1 2022

Subject: Texas Physician Workforce Update for 2022

Presented by: Robert Emmick Jr., MD, Chair, Committee on Physician Distribution and Health Care Access

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This report represents the committee's annual physician workforce update to the House of Delegates for 2022 as directed by TMA Policy 185.001 Physician Workforce Texas. Results from the committee's research on the latest trends for the physician workforce are presented along with an analysis of the impact on access to medical care.

Committee Update on Physician Workforce Trends

To assess the status of the state's physician workforce, the committee looked at trends in Texas for three major areas: (1) physician workforce, (2) graduate medical education (GME), and (3) medical education. This report is organized around these three topics. The committee searched for the most recent data sources available in preparing this report.

Highlights of the Committee's Findings (see page references for details):

- Texas ranked No. 1 for state numerical population growth in the 2020 and 2021 U.S. Census Bureau enumerations (see page 5).
- Four of the top 10 fastest growing major metropolitan areas within the U.S. are in Texas (see page 5).
- An average of 850 people were added in Texas each day in the past year (see page 5).
- Texas' population is projected to grow from 29.5 million in 2021 to 35 million by 2030 (see page 5).
- To keep up with medical school enrollment growth and maintain the state's target ratio of 1.1 to 1 entry-level residency positions per Texas medical school graduate, 325 new entry-level residency positions are projected to be needed by 2027 (see page 9).

Current statistics show Texas reached historical numbers for the physician workforce, newly licensed physicians, number of residents and medical students, percentage of women enrolled at Texas medical schools, and funding for the state's Graduate Medical Education Expansion Grant Program, as shown below.

Historical Records

- Patient care physician workforce in active practice: 59,332, compared with 57,384 in 2019, and a ratio of 204.6 per 100,000 population, an increase from the ratio of 199.9 in 2019 (Current U.S. ratio is 247.5; see page 7).
- Medical license applications: 7,010 (see page 3)
- Newly licensed physicians: 5,304 (see page 3)
- Residents in training: 8,995, an increase of 30% over past decade (see page 9)
- Applicants to Texas medical schools: 7,359 (This total is for 14 of the state's 15 medical schools; see page 11 for an explanation.)
- Hispanic individuals who applied to Texas medical schools: 1,278, and Black/African American applicants: 722 (see page 11)
- Medical students: 8,635, an increase of 26% over past decade (see page 11)
- For the past three years, more women than men enrolled in Texas medical schools (see page 11).

- Additional funding through the state's Graduate Medical Education Expansion Grant program in 2022-23: $42 million in additional state appropriations for a total of $199 million to support about 1,300 residency positions (see page 9).

Positive Physician Workforce Trends

The number of Texas counties designated as primary care Health Professional Shortage Areas (HPSAs) declined by 29% since 2014, due to increased physician distribution (see page 7).

- The number of patient care physicians in Texas grew at a rate that was more than twice as fast as the population between 2010 and 2020. Primary care physicians in patient care increased at close to double the population growth rate (see page7).
- Texas' physician workforce has the second-lowest state percentage who are aged 60 and above (see page 7).
- Despite the pandemic, in 2020 and 2021 entry-level residency positions in Texas expanded at twice the rate seen earlier in the decade (see page 10).
- Texas ranks third with an 81% retention rate for physicians who completed both medical school and residency training in the state (page 12).
- Texas was highly successful in recruiting from outside of the state with more than three out of four of the newly licensed physicians (78%) graduating from medical schools outside of Texas (see page 4).

Other Trends

- Texas initiated a voluntary expedited medical licensing process as a result of its participation in the Interstate Medical Licensure Compact, which is expected to increase physicians seeking medical licensure in Texas (see page 6).
- During fiscal year (FY) 2021, the Texas Medical Board issued 813 emergency medical licenses, of which 333 (41%) were for telemedicine (see page 6).
- Six new medical schools have opened in Texas since 2016, and a new medical school is expected to open in Tyler in 2023 to increase the tally to 16, a tie with California for second place. New York leads with 17 medical schools (see page 11).
- The state's Physician Education Loan Repayment Program was forced to close to new applicants from Sept. 1, 2020, to Aug. 31, 2021, due to insufficient funding (see page 8).

Challenges to Texas Physician Workforce Development Efforts

- COVID-19 brought on unprecedented demands during the pandemic for physicians in specialties such as infectious diseases, public health, critical care medicine, emergency medicine, pulmonology, radiology, and pathology (see page 5). Physicians in all specialties were impacted in varying degrees.
- Physician shortages continue, as well as a maldistribution of physicians by geographic area and medical specialty:
    - Texas has 8.8% of the U.S. population but only 7.3% of U.S. active physicians.
    - Ratios of patient care physicians per 100,000 population remain among the lowest in the country (see page 8). Texas ranks 42nd for active physicians (all specialties), 47th for primary care physicians, and 46th for general surgeons.

Physician Workforce Development Goals

The committee developed the following goals for meeting future physician workforce needs:

- Increasing physicians educated and/or trained in the state who are retained or recruited back;
- Recruiting and retaining increased numbers of physicians from other states;
- Enhancing access to care for Texans living in areas with physician shortages and other access barriers, including increased use of telemedicine;

- Continuing to monitor the effects of the COVID-19 pandemic on the state's physician workforce as well as state assessments of public policies and market forces that strongly impacted physician practice; and
- Continuing to monitor the progress in meeting the state's physician needs, including pipelines that prepare physicians for practice.

In addition to recruiting more physicians, the committee will continue to identify ways to maximize the capacity of the existing physician workforce and health care systems for meeting patient care needs.

1. STATUS OF STATE'S PHYSICIAN WORKFORCE

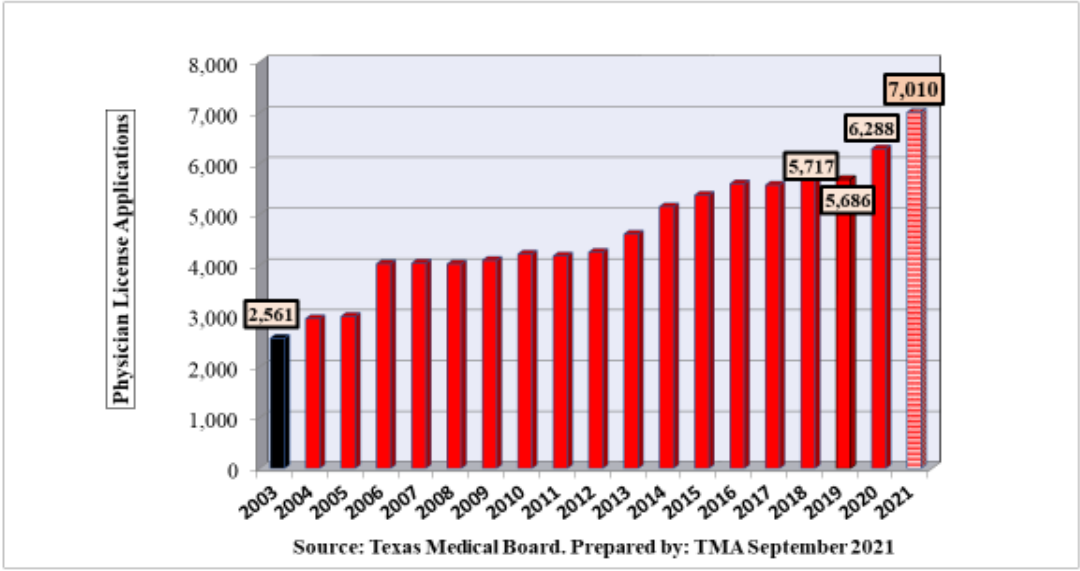
Newly Licensed Physicians in 2021

FINDING: More than 7,000 physicians applied for their first Texas medical license in 2021.

In evaluating the adequacy of the state's physician workforce, the committee looked at trends for the number of newly licensed physicians, population changes, changes in medical licensing laws, impact of the global pandemic on physician workforce demands and medical licensing, national rankings, projected physician workforce needs, and strategies for improving physician distribution and access.

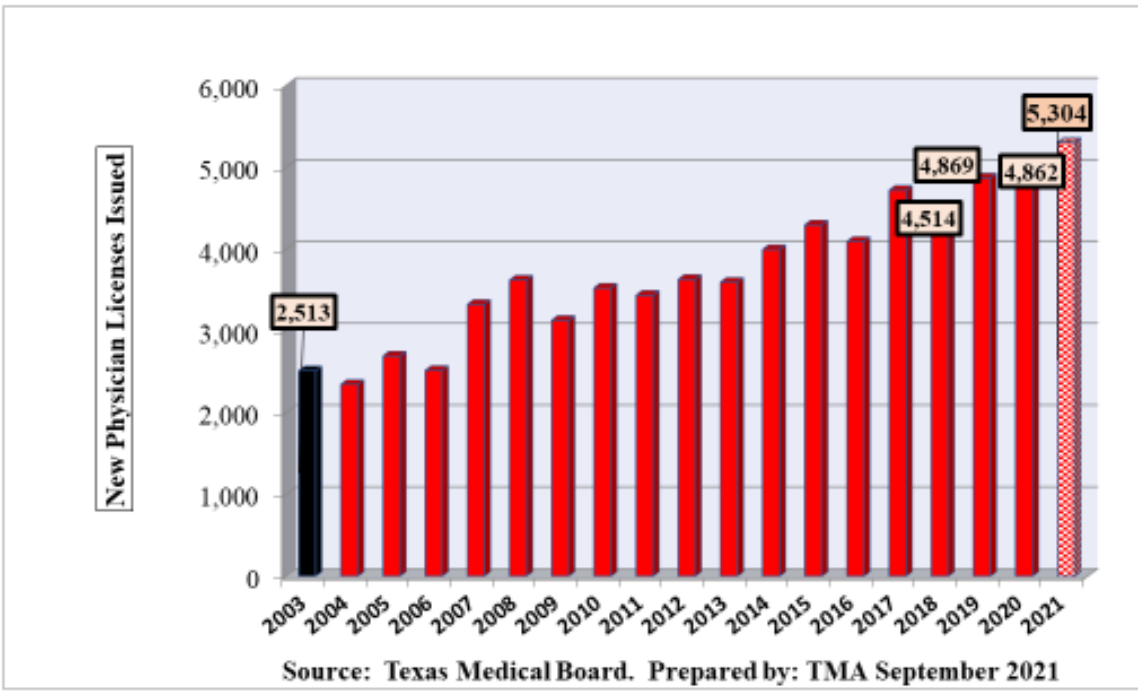
The Texas Medical Board received a record-breaking 7,010 medical license applications in FY 2021 (Sept. 1, 2020, to Aug. 31, 2021), as shown in Figure 1.

Figure 1: Texas Physician License Applications, Fiscal Years 2003-21



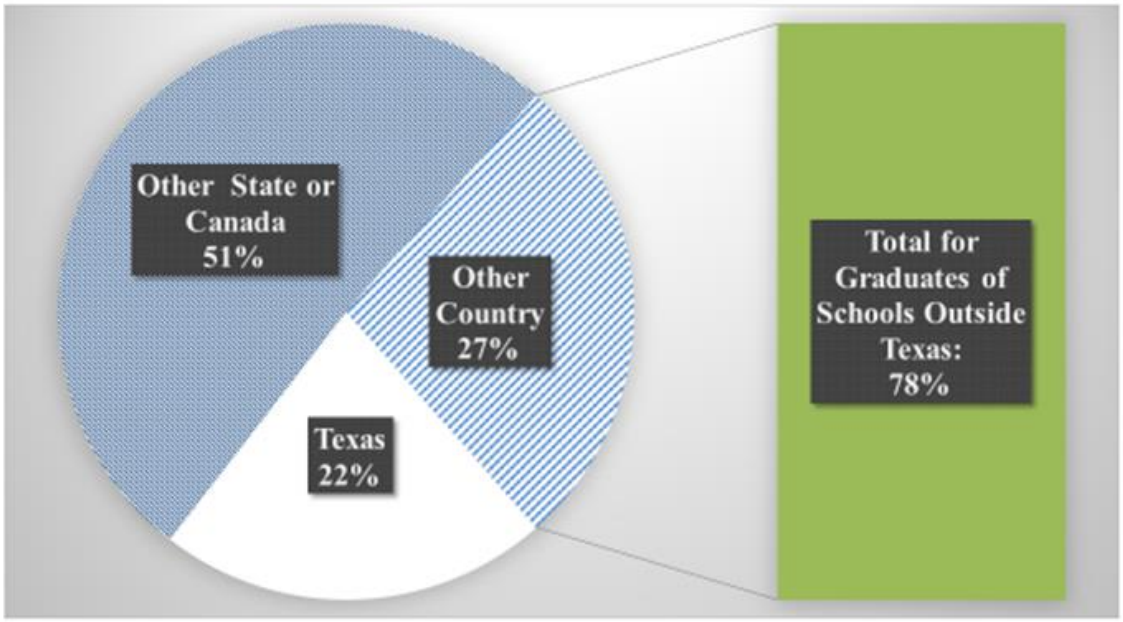
The board issued 5,304 new licenses in FY 2021, the highest number in the state's history (Figure 2). For context, 15 U.S. states and the District of Columbia have fewer than 5,300 total physicians. Of the new licenses, 5,210 were for patient care practices, 72 were for telemedicine, 21 were administrative, and one was for public health.

Figure 2: Number of Newly Licensed Texas Physicians, State Fiscal Years 2003-21



More than three out of four of the newly licensed physicians in the past year were graduates of medical schools outside of Texas, with 51% who graduated in other U.S. states or Canada and 27% in other countries (Figure 3). Texas medical school graduates represented 22%.

Figure 3: Newly Licensed Texas Physicians by Medical School of Graduation - Fiscal Year 2021



Source: Texas Medical Board. Prepared by TMA.

Texas Population Trends

FINDING: Texas is No. 1 in state numerical population growth in the nation, but the state's physician workforce is growing at a faster rate.

To frame the work of planning for physician workforce needs, the committee evaluated state demographic trends. Texas ranks No. 1 in state numerical population growth, continuing a trend that has lasted for decades.

Population gains for Texas between the 2010 and 2020 U.S. censuses:

- Four million people were added, an increase of 15.9%, for a total of 29 million (second most-populous state). For context, net growth for Texas was the same as the *current total population* of the state of Oklahoma. And, for comparison, the percentage increase was *double* the total U.S. growth rate of 7.4%.
- Dallas-Fort Worth-Arlington led the country in numerical population growth for major metropolitan areas.
- Nationally, only three major metropolitan areas increased by 1.2+ million (about 20%), and two were in Texas: Dallas-Fort Worth-Arlington and Houston-The Woodlands-Sugar Land. New York was the third area.
- Austin saw the biggest percentage increase (33%), and Texas had three other areas on the list of the top 10 fastest-growing major metropolitan areas: No. 5, Houston (20.3%); No. 6, Dallas-Fort Worth (20%); and No. 7, San Antonio (19.4%).

During the past year, amid the pandemic, population growth slowed across the country. The U.S. Census Bureau reported a yearly national growth rate of only 0.1% from 2020 to 2021 – the smallest annual population growth for the U.S. since the founding of the nation. Births and international in-migration were both down, and deaths were up. However, Texas still gained an average of 850 people per day, with a net annual rate of 1.1%, reaching a total of 29.5 million in 2021. Demographers forecast Texas' population will increase by 5.5 million to 35 million by 2030.

Impact of COVID-19 Pandemic on Texas Physicians and Learners

The COVID-19 pandemic has been widely disruptive to medical practice. In the first year, erratic supplies of personal protective equipment interrupted health care delivery. At times, state emergency policies put in place to maximize resources constrained physician practice, particularly the periodic suspensions of hospital-based surgeries and procedures. In response, some physicians were forced to curtail their practices and others decided to retire earlier than planned.

The pandemic had an uneven effect on physician demand by specialty. Demands periodically spiked to unprecedented levels for some specialties, including infectious diseases, public health, critical care, pulmonary medicine, emergency medicine, radiology, pathology, cardiology, neurology, and nephrology. Other specialties experienced more consistent demand, including anesthesiology, obstetrics, and oncology. Primary care physicians experienced more erratic patient flows as patient fears about the safety of medical care fluctuated. As each wave of the pandemic subsided, patient care volume generally returned to prepandemic levels.

To meet sharp spikes in staffing needs at Texas hospitals, the Texas Department of State Health Services (DSHS) periodically activated a state program to respond to emergency staffing requests from individual hospitals for physicians, nurses, respiratory therapists, and other high-demand health care professionals. This staffing was temporary, and requests were filled only after traditional hospital staffing methods were unsuccessful.

Disruptions carried into medical education and residency training. For extended periods, medical students were prevented from in-person participation in academic classes, clinical skills assessment programs with standardized patients, clinical clerkships, preceptorships, match ceremonies, and graduations. Most in-person learning environments have been restored, but residency program interviews are still limited to virtual formats.

Residents had differing experiences by specialty type. Some were temporarily reassigned from training programs to fill unmet clinical staffing needs during spikes in hospitalizations. Others, including surgical residents, struggled to meet training target numbers to enable on-time training completion.

In the first year of the pandemic, disruptions occurred at every stage of physician workforce development testing, including the Medical College Admissions Test for pre-med, the U.S. Medical Licensing Exam and Comprehensive Osteopathic Medical Licensing Exam for medical students and residents, and board certification exams for physicians. All testing formats have since been restored.

Emergency Medical Licenses
From March to October 2020, the Texas Medical Board issued 2,577 temporary medical licenses under the Texas Disaster Emergency Rule. A large majority were not issued to patient care physicians, but instead 87% (2,236 physicians) were for telemedicine practices. Since that time, the number of temporary emergency medical licenses issued has slowed, and the percentage issued for telemedicine practice was cut in half: In FY 2021, 813 emergency medical licenses were issued, of which 41% (333 physicians) were for telemedicine.

Special Medical Licensing Provisions During the COVID-19 Pandemic
In addition to the state's standing emergency policies, Gov. Greg Abbott issued special licensing provisions with the goal of maximizing the health professions workforce to meet spikes in demand. For retired physicians, this included an emergency provision that allowed those who converted to a retired or inactive medical license in the past four years to quickly reactive their license. The Texas Medical Board reports 52 physicians reactivated through this process from March 2020 to February 2022.

Support for Post-Pandemic Study of Hospital Staffing Shortages
Last year, the house adopted policy that asks the Texas Medical Board and the Statewide Health Coordinating Council at DSHS to conduct a post-pandemic study of the effectiveness of state emergency policies in responding to the spikes in hospital staffing needs. The goal is to identify needed changes in emergency preparedness policies to be better prepared for the next pandemic or other extended emergency event. The committee eagerly anticipates outcomes from the analysis to inform future policies.

New State Medical Licensing Law: Interstate Medical Licensure Compact
Effective March 1, 2022, physicians who are licensed in one of the 34 other states in the Interstate Medical Licensure Compact; are certified by a recognized board; have no licensing restrictions, as defined; and meet other compact requirements can qualify for voluntary, expedited medical licensing in Texas through the compact. It is estimated that 80% of U.S. physicians meet the criteria for licensure through the compact. Additional requirements include:

- Graduation from an accredited American medical school or certain international schools;
- Completion of residency from an accredited residency program; and
- Passage of each component of the recognized national medical licensing exams within three attempts.

Physicians going through the compact for licensing must have a designated principal licensing state and are subject to practice and enforcement requirements for each state in which they are licensed. The compact is expected to yield more newly licensed physicians for Texas, but it is not easy to predict how many. Some with plans to relocate to Texas may choose this expedited pathway. In addition, the compact

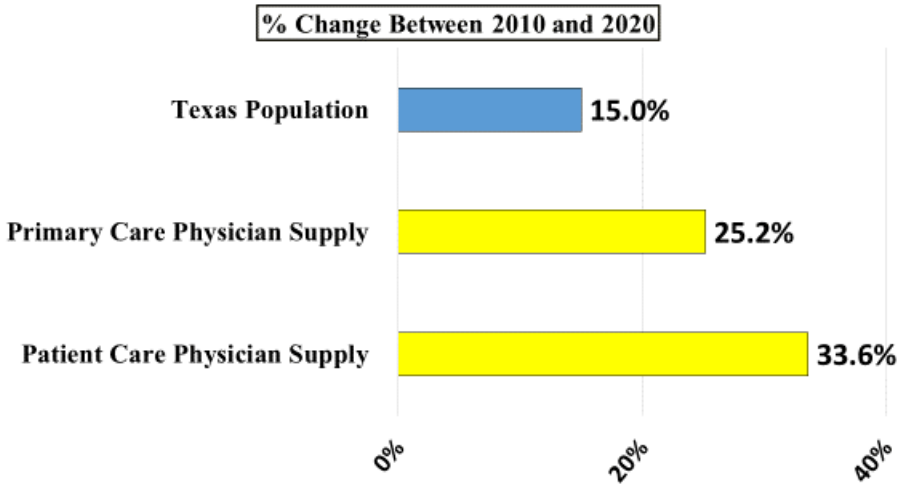
may accelerate the number of physicians in other states who provide telemedicine to patients in Texas. The committee will monitor the impact of the compact on the physician workforce.

Recent Physician Workforce Trends

Texas continues its steady growth of physicians, reaching a record number in 2020: 59,332 patient care physicians in active practice, compared with 57,384 in 2019. The ratio of patient care physicians per 100,000 population increased from 199.9 in 2019 to 204.6 in 2020. However, Texas' ratio still falls well below the U.S. ratio of 247.5.

Since 2010, the growth rate for physicians in Texas has consistently been greater than population gains. Patient care physicians (of all specialties) grew at more than double the rate of the state's population between 2010 and 2020. Primary care physicians in patient care increased at close to double the growth rate in population, as shown in Figure 4. Prior to 2010, there were years when population grew at a rate faster than physicians.

Figure 4: Texas Physician Supply Growing Faster Than Population
Comparison of % Change for Population and Physician Supply, 2010 and 2020



Sources: State Physician Workforce Data Report, 2011 and 2021
Association of American Medical Colleges - Prepared by: TMA

Compared to other states, Texas physicians have a lower percentage (29.4%) who are aged 60 and above. Utah has the lowest percentage in the nation, at 28.3%, as reported by the Association of American Medical Colleges, 2021. Texas has the second lowest ranking in the nation.

Drop in Primary Care Health Professional Shortage Area Designations

The committee conducted an in-depth study of Texas counties designated by the U.S. Department of Health and Human Services as HPSAs with the goal of formulating policies for improving access in areas with the most severe physician shortages. In a historical review, the committee made a surprising finding: The number of HPSA designations declined from 168 counties in 2014 to 119 in January 2022, ***a 29.2% drop***. The loss of HPSA designation meant there had been an increase in primary care physicians practicing in the 49 affected counties. (Note: Data for 2014 was selected for comparison because it was the most readily available historic HPSA information.)

When the committee compiled current data to assess the ratios of population-per-primary care physician for the 119 Texas counties designated as HPSAs in January 2022, several counties were found to no longer meet the HPSA criteria. These areas had ratios below the minimum ratio of 3,500 to 1 that is

required to qualify for HPSA designation. This indicates there may have been an even greater improvement in the distribution of primary care physicians in certain physician shortage areas than originally identified. The committee is continuing its in-depth analysis of HPSAs, and a more complete report is expected to be presented to the house in 2023.

National Rankings

Texas' physician supply is clearly growing. Yet when compared with other states, Texas' per-capita ranking remains lower. This results from the challenge of increasing the physician supply at the same rate as population for a state with a consistently high increase in population. Most other states either have a larger physician supply and/or recent growth or lower population gains. For example, 16 states lost population between the 2010 and 2020 U.S. censuses. And, for the first time in recorded history, between 2020 and 2021, California lost population. The following state rankings for ratios of physicians per 100,000 population for Texas demonstrate how Texas continues to lag other states in per-capita comparisons:

- 42nd for patient care physicians (all specialties);
- 47th for patient care primary care physicians; and
- 46th for general surgeons in patient care.

Although still ranked in the bottom quintile, this does represent an improvement for Texas. Since 2010, Texas rose from 46th to 42nd in the nation for patient care physicians (all specialties) per 100,000 population, according to the Association of American Medical Colleges' State Physician Workforce Data Reports for 2011 and 2021.

Projected Physician Workforce Trends

A study of future physician supply and demand for 2018 and 2032 for 35 medical specialties in Texas commissioned by the Health Professions Resource Center at DSHS in 2018 projected extensive physician shortages. Starting with an estimated total shortage of 6,218 physician full-time-equivalents (FTEs) for Texas in 2018, the need is predicted to grow to a total of 10,330 FTEs by 2032. Shortages are forecast to vary by specialty and geographic region, as shown in the following examples:

- General internal medicine is projected to have the greatest total numerical shortage of the 35 medical specialties in the study with an additional 2,607 FTEs needed from 2018 to 2032.
- Family medicine is projected to have the fastest growing shortage from 2018 to 2032, increasing from a shortage of 1,034 to 2,495 FTEs.
- By region, critical shortages are forecast for:
    - Psychiatry for all regions, but with less need in Central Texas;
    - Pediatrics in most regions except the Gulf Coast and Central Texas; and
    - Family medicine in most regions, except the Panhandle, North Texas, Central Texas, and South Texas.

Note: To aid in interpreting the predicted shortages, see a state regional map on the last page of the DSHS study referenced above, Texas Physician Supply and Demand Projections, 2018-2032, at https://www.dshs.state.tx.us/legislative/2020-Reports/TexasPhysicianSupplyDemandProjections-2018-2032.pdf. This study was prepared before the pandemic and does not reflect its impact, including the potential for an acceleration of physician retirements.

Strategies for Improving Physician Distribution and Access

State strategies are in place to improve the distribution of physicians in underserved areas. This includes various pipeline programs for medical students and residents, and loan repayment for physicians in practice. Of the various programs, the committee is particularly concerned about the status of the state's

Physician Education Loan Repayment Program. This program was closed to new applicants from Sept. 1, 2020, to Aug. 31, 2021, due to insufficient funding. Underserved communities value this program as a physician recruitment tool. Further, the program provides an opportunity for individual physicians to eliminate up to $180,000 in education-related debt. In the 2022-23 state budget, appropriations for this program were reduced by almost $1 million (3.2%) to a total of $28.9 million for the biennium.

The role of telemedicine in enhancing access to care was accelerated during the pandemic. TMA remains involved in promoting fair and equitable laws, regulations, and payment policies for telemedicine services. For areas with the most severe physician shortages that also lack the population base and infrastructure to support a physician's practice or a health care facility, telemedicine has become an even greater priority for improving access to medical care.

2. STATUS OF GME

The committee looked to its parent council, the Council on Medical Education, for an evaluation of the state's GME capacity. This included the projected need for training positions in the state to accommodate the growing number of medical school graduates.

Texas had a historic number of residents in 2020 with 8,995 at 737 residency programs, including 3,227 first-year residents. Total residents grew by 30% over the past decade, and Texas has a ratio of 32.2 residents per 100,000 population, ranking 27th among U.S. states. In comparison, the U.S. ratio is 43.8. Texas ranks fifth in the country for the retention of residents for practice, at 59% (based on training background for physicians in practice in Texas on Dec. 31, 2020, as reported by the Association of American Medical Colleges).

Texas has set a target ratio of 1.1 to 1 for first-year residency positions to medical graduates with the goal of retaining Texas medical graduates for in-state training and entry into practice. The state's target ratio was reached in 2018, and it has been maintained. Looking forward to 2027, the TMA Council on Medical Education projects Texas will need to add 325 entry-level GME positions to maintain the target 1.1-to-1 ratio.

State Support for Growing GME Capacity

Texas legislators have strongly supported achieving the 1.1-to-1 goal. In 2015, state legislators took steps to greatly expand what had been a small state GME expansion grant program. That year, the first-ever state GME permanent fund was established by legislators with $300 million in seed funding. This became the source for $11 million in annual funding for the grant program.

To demonstrate growing legislative support, funding for the state Graduate Medical Education Expansion Grant Program increased from $12.5 million in 2014 to $99.5 million per year for 2022 and 2023. This reflects an additional $42 million that was provided for the current biennial budget.

Since 2014, a cumulative total of $520.5 million has been appropriated for the state Graduate Medical Education Expansion Grant Program. This enabled the creation and continued support of a cumulative total of 465 first-year GME positions (Table 1).

Table 1: New First-Year GME Positions Created With State GME Expansion Grants, by Year Filled

2014	2015	2016	2017	2018	2019	2020	2021	**2022***	**2023***	***TOTAL***
25	63	71	78	0	38	115	20	**20**	**35**	***465***

**2022 and 2023 are subject to verification.*

Source: Texas Higher Education Coordinating Board. Prepared by: TMA.

Dependent on the availability of funding, the state Graduate Medical Education Expansion Grant program has a goal of providing sustained support for positions created through the program as residents progress to their second and third years of training. Grants of $75,000 each were allocated to support 1,278 residency positions in 2022 and 1,391 in 2023 (subject to verification), as shown in Table 2. A cumulative total of 5,451 positions has been supported since 2014.

Table 2: Total GME Positions (All Post-Graduate Years) Funded With State GME Expansion Grants, by Year Filled

2014	2015	2016	2017	2018	2019	2020	2021	**2022***	**2023***	***TOTAL***
25	125	278	458	583	702	895	1,107	**1,278**	**1,391**	***5,451***

**2022 and 2023 are subject to verification.*
Source: Texas Higher Education Coordinating Board. Prepared by: TMA.

Grant awards for 2022 are shown in Table 3 by type of residency program. Of the total 1,278 funded residency positions, 64% are in primary care, 16% in psychiatry, and almost 1% in a primary care/psychiatry combined program for a combined primary care/psychiatry total of 80%. Only 20% of funded positions were for nonprimary care specialties (excluding psychiatry).

Table 3: Number and Percentage GME Positions (Including All Post-Graduate Years) Funded With State GME Expansion Grants, 2022,* By Specialty Category

2022 State Grant Funding by Specialty Category	# Funded GME Positions	% Funded GME Positions
Primary Care	814	64%
Psychiatry	204	16%
Primary Care and Psychiatry (Medicine-Psychiatry)	4	<1%
Other Non-Primary Care Specialties	256	20%
TOTAL	***1,278***	***100%***

**2022 subject to verification.*
Source: Texas Higher Education Coordinating Board. Prepared by: TMA.

Despite the pandemic, Texas saw a spike in new residency positions. In the National Resident Matching Program, residency program sponsors offered a net addition of 161 first-year residency positions in 2020, and 146 in 2021. This level of growth was more than double what was seen earlier in the decade. The prior eight years saw an average yearly increase of only 71.

Little Change in Federal Funding for GME

Medicare provides the largest amount of financial support for residency training of any source by a large margin, and there has been little change since eligible residency positions were frozen 26 years ago. In December 2020, Congress authorized an additional $1.8 billion to fund 1,000 new Medicare-supported residency positions, at 200 a year ***nationwide*** over a five-year period beginning October 2022. The impact, however, may be negligible as the Centers for Medicare & Medicaid Services has proposed limiting the increase to a maximum of one residency position per facility. Other limited changes were made for rural training track programs and for teaching hospitals with exceptionally low Medicare GME payment caps.

3. STATUS OF MEDICAL EDUCATION

There are 15 medical schools in the state, 12 allopathic and three osteopathic. Twelve are public schools, and three are private. Texas has a historic number of medical students: 8,635. Over the past year, enrollments increased by 7.5% and by 26% over the past decade.

Six new medical schools have opened in Texas since 2016, and The University of Texas System is developing a new medical school in Tyler. This school will open in 2023 with an inaugural class of 40, raising the tally to 16. Texas will continue to rank second for total number of schools in a tie with California, following New York with 17.

Despite the recent growth, Texas ranks 36th in the number of medical students per capita in national state rankings, with a ratio of 29.2 medical students per 100,000 population. In comparison, the U.S. per-capita ratio is 37.9. Texas ranks second in the country for the percentage of medical students who ultimately practice in the state, at 59% (based on education information for physicians in practice in Texas on Dec. 31, 2020, Association of American Medical Colleges). California ranks first with a retention rate of 62.7%.

FINDING: Number of applicants to medical schools rose sharply in 2021.

The number of applicants to medical schools saw a sharp rise in the U.S. and Texas in 2021. For Texas, the number jumped by 21.7% (+1,313) to a total of 7,359. This yearly increase was about 10 times the average yearly increase of 130 reported for the previous five years (2016-20).

A greater number of underrepresented minority individuals also applied to Texas medical schools. The number of applicants doubled over the past decade, and spiked in the past year, as follows: Hispanic (+293 or 29.8% for a total of 1,278) and Black/African American (+237 or 48.9% for a total of 722). However, their numbers are small compared with other groups' numbers, and they remain underrepresented in medicine.

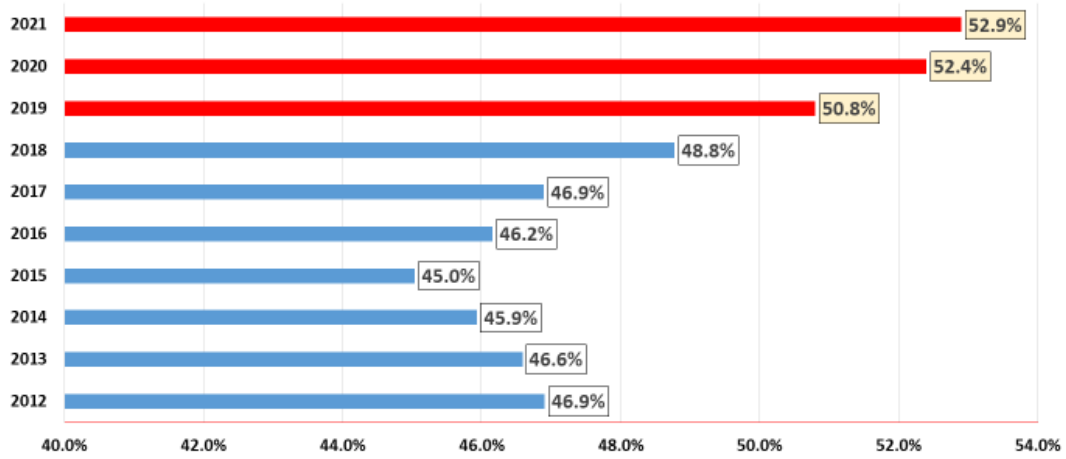
(Note: Applicant data in this section represent 14 of the state's 15 medical schools as reported by the Texas Medical and Dental School Application Service, excluding Texas Christian University School of Medicine. This school opened in 2019 with an inaugural class of 60 and it uses the application service offered by the Association of American Medical Colleges. Applicant data are not available from this source.)

TMA has policy (185.018) in support of expanded medical school enrollments and aligning GME capacity with these expansions to help retain graduates who want to train in the state and to prepare physicians in specialties most needed for Texas. There is policy (200.058) in support of a study of the projected need for more medical schools. And TMA has policies that support the increased enrollment of underrepresented minority individuals in Texas medical schools, including 185.012 and 185.027.

FINDING: More women are enrolled in Texas medical schools than men.

For the third year in a row, most total enrollees at Texas medical schools are women (52.9%) (Figure 5). This trend is projected to continue at least for the near future as more women applied to Texas medical schools (52%) than men and more women matriculated in 2020 (55%).

Figure 5: % Women Among Total Texas Medical School Enrollments, 2012-2021



Sources: Texas Higher Education Coordinating Board, University of the Incarnate Word Osteopathic Medical School, and Texas Christian University School of Medicine
Prepared by: Texas Medical Association

Enrollments for women fluctuate by year, but over the past decade, the percentage of men declined from 53% to 47%. A similar trend is occurring at the national level.

4. SUMMARY

Texas is doing an exceptional job in expanding the physician workforce, with a historic number of new physicians. Much of the growth is from physicians educated and trained outside of Texas, but Texas also has been successful in retaining 81% of physicians who completed both medical school and residency in the state – the third highest retention rate in the country. And of chief importance, since 2010 physician supply is consistently expanding at a rate that exceeds the state's population growth.

The impact of the pandemic on physician practices has been uneven. Although every physician has been forced to adjust, some faced unprecedented demands with abnormally long workdays and high levels of stress for extended periods, contributing to reports of physician burnout. Caseloads for other physician specialties have been mixed. The full effects on physicians' practices and the health care delivery system are unknown.

Most surprisingly, the committee unexpectedly discovered a 29% reduction in the number of primary care HPSA designations for Texas counties since 2014. This reflects an improved distribution of primary care physicians in the most underserved areas of the state – an important and little-known finding. Despite signs of improved physician numbers and distribution, the committee recognizes that physician shortages remain in many other areas. The committee is continuing its in-depth analysis of HPSAs, and a more complete report is expected to be presented to the house in 2023.

Although there has been strong growth in the number of Texas physicians, Texas has far fewer physicians per capita than other states. Rapid improvement per capita is not easily accomplished when facing consistently high increases in population. There is a continued need to expand physician recruitment efforts and to prepare more homegrown physicians. The committee was particularly concerned to learn about the suspension of new applications for the State Physician Education Loan Repayment Program from Sept. 1, 2020, to Aug. 31, 2021, because of insufficient funding. The benefits of this program are substantial for physician shortage areas and physicians with high debt loads. Adequate funding needs to become a state priority.

The committee will continue to monitor the state's physician workforce for future reporting in TMA's communication venues and to inform the development of TMA's advocacy efforts for the 2023 Texas legislative session.

Related TMA Policy:
Policy 185.001 Texas Physician Workforce
Policy 185.012 Physician Recruitment
Policy 185.018 Mitigating the Texas Physician Shortage
Policy 185.027 Renewed Efforts to Increase Racial/Ethnic Diversity Among the Texas Physician Workforce
Policy 200.058 Projected Need for More Medical Schools in Texas

Supplement

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Joint Report 9 2022

Subject: Creation of Ad Hoc Committee on Independent Physician Practices

Presented by: Bradford W. Holland, MD, Speaker, Texas Medical Association
John G. Flores, MD, Vice Speaker, Texas Medical Association
E. Linda Villarreal, MD, President, Texas Medical Association
Rick W. Snyder II, MD, Chair, Board of Trustees

The Texas Medical Association is wholly committed to the support and preservation of the physicians who are in independent private practice. TMA is concerned by the disturbing trend over the last many years showing a decline in the number of private practices, while the number of employed physicians has continued to increase. As independent and small-group physician-owners of practices compose the backbone of health care, especially throughout most of rural Texas, we cannot afford to lose this practice model to the changes wrought in the evermore complex health care industry.

While all physicians faced unprecedented challenges to their practices' viability because of the economic and marketplace environment that existed prior to 2020, these challenges were further exacerbated by the global pandemic. Because of the unique structure of the private practice model, the independent physician has been affected by these challenges more directly and most likely, more severely. It is therefore emergent and imperative that the Texas Medical Association convene a special work group to immediately address the crisis faced by independent physician practices.

TMA therefore announces the formation of a TMA Ad Hoc Committee on Independent Physician Practices. The committee shall consist of 10-18 members.

The charge to this committee is to urgently hold hearings on identifying and enumerating the most critical threats to private practice in Texas, and to formulate viable policy, and procedural and economic solutions to reinvigorate independent physician practices.

The term of appointment to this committee shall be two years and may be eligible for renewal.

The staff and resources of the Texas Medical Association shall be available to assist this committee with its meetings and hearings, and TMA will provide the appropriate meeting space and resources to conduct its business. Staff assigned to this committee will be pulled from the Division of Member Experience.

The findings of this committee shall be presented yearly to the House of Delegates at its annual meeting, as well as to the Board of Trustees of TMA.

AGENDA
REFERENCE COMMITTEE ON FINANCIAL AND ORGANIZATIONAL AFFAIRS
Friday April 29, 2022

1. Speaker Report 1 2021 – Amending TMA Constitution Article V House of Delegates
2. *Board of Trustees Report 10 – New Council on Member Experience*
3. *Board of Trustees Report 12 – Texas Medical Liability Trust Governing Board*
4. *Board of Trustees Report 17 – Establishing the Standing Committee on Medicaid, CHIP, and the Uninsured*
5. *Board of Councilors Report 1 – Emeritus Nominations*
6. Board of Councilors Report 2 – Honorary Nominations
7. Texas Delegation to the AMA Report 3 – Amending the Texas Medical Association Bylaw 6.10
8. International Medical Graduate Section Report 1 – Amendment of International Medical Graduate Section Operating Procedures
9. Medical Student Section Report 1 – Amendment of Medical Student Section Operating Procedures
10. *Medical Student Section Report 2 – Amendment of Medical Student Section Operating Procedures*
11. Resident and Fellow Section Report 1 – Amendment of Resident and Fellow Section Operating Procedures
12. Young Physicians Section Report 1 – Amendment of Young Physician Section Operating Procedures
13. Women Physicians Section Report 1 – Amendment of Women Physician Section Operating Procedures
14. Council on Constitution and Bylaws Report 1 – Amendments to Bylaws for County Medical Society Annual Reporting Requirements
15. Council on Constitution and Bylaws Report 2 – Amendments to Bylaws to Require Association Membership to Serve in a TMA Position or as a Consultant
16. Council on Constitution and Bylaws Report 3 – Amendments to Bylaws to Allow Section Elections Before or Concurrent to their Business Meetings
17. Council on Constitution and Bylaws Report 4 – Amendments to Constitution and Bylaws to Create a Telemedicine Member Classification and Update Article III
18. Patient-Physician Advocacy Committee Report 2 – Sunset Policy Review
19. LGBTQ Health Section Report 1 – Amendment of LGBTQ Health Section Operating Procedures

20. Resolution 101 – Encouraging Participation in House of Delegates by Allowing Voting in Elections without Being Present at the HOD
21. Resolution 102 – Preserving the Viability of Independent Physician Practices
22. Resolution 103 – Treating Implicit Association Test Results as Confidential Medical Information
23. Resolution 104 – Improving the Appearance of the Texas Medical License
24. Resolution 105 – Free Speech Policy
25. Resolution 106 – Bullying in the Practice of Medicine
26. Resolution 107 – Supporting Diversity in Texas Medical Association Publications
27. Resolution 108 – Increasing Support for Doula Services to Address Perinatal Health Outcomes
28. Resolution 109 – Texas Medical Association Open Meetings and Board of Trustees Decisions
29. Resolution 110 – Protecting the Patient-Physician Relationship by Eliminating Lawsuits Filed by Uninvolved Parties
30. Resolution 111 – Interference in the Patient-Physician Relationship
31. Resolution 112 – Freedom of Medical Information Dissemination Between and From Physicians
32. Resolution 113 – Optimizing Individual Choice in End-of-Life Care
33. Resolution 114 – Duties of Physicians When Communicating in the Public Space
34. Resolution 115 – Opposition to Debt Litigation against Patients
35. Resolution 116 – Protecting Physicians' Ability to Provide Care in Dynamic Legal Environments
36. Resolution 117 – Ethical Guidance for Pediatric HIV

Supplement

REPORT OF BOARD OF TRUSTEES

BOT Report 10 2022

Subject: New Council on Member Experience

Presented by: Rick W. Snyder II, MD, Chair, Board of Trustees

Referred to: Reference Committee on Financial and Organizational Affairs

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The Texas Medical Association Board of Trustees recommends that the Council on Practice Management Services (C-PMS) and the Committee on Membership (CM-M) components unify to establish a Council on Member Experience (C-MX), and their individual components be discharged.

C-PMS and CM-M are frequently working on the same goals and objectives for the growth, engagement, and advancement of physicians with TMA. Considering this, the board, as well as council and committee leadership, feels it is best for C-PMS and CM-M to join forces as the Council on Member Experience to minimize duplication of efforts and to improve upon the experience for physicians in TMA. This will not only strengthen TMA's ability to support physicians in Texas but also will streamline discussions, offerings, and staff.

TMA Bylaws provide that the House of Delegates acts on the recommendation of the board to establish or discharge a council by a two-thirds majority vote.

Currently, the individual C-PMS and CM-M charges are as follows:

> C-PMS: The council shall oversee all association practice management services provided directly to physicians and their staff.
>
> CM-M: The committee shall provide guidance in the development of annual and long-term membership recruitment and retention programs. The committee shall coordinate with and be supportive of the membership activities of county medical societies and the American Medical Association.

The Council on Member Experience would be charged with recognizing and heightening TMA members' experience and engagement throughout the association, and better aligning TMA's offerings with the needs and wants of members. Its agenda would help guide coordinated development of relevant and timely member benefits, programs, and services for key interest groups and segments of TMA membership.

C-MX's focus and work would support the following TMA 2025 goals:

> **Practice Strength:** Protect and strengthen medical practices in Texas.
> Objective b. Provide cost-effective solutions to improve all aspects of practice management operations.
>
> **Healthy Environment:** Engage in legislative, regulatory, and legal advocacy to improve the environment in which Texas physicians care for their patients.
> Objective b. Advance patient-centered, cost-efficient, physician-directed systems of care.

Trusted Leader: Strengthen physicians' trusted leadership role.
Objective a. Enhance the public image of Texas physicians.
Objective d. Advance physician professionalism.

One Voice: Enhance the powerful, effective, and unified voice of Texas medicine
Objective a. Increase membership and member involvement to ensure the ongoing financial health and governance strength of the association.
Objective b. Leverage the effective voice of Texas medicine.
Objective c. Demonstrate a unified voice by strengthening relationships and strategic alliances.

Recommendation 1: Discharge the Council on Practice Management Services.

Recommendation 2: Discharge the Committee on Membership.

Recommendation 3: Establish a new Council on Member Experience.

Recommendation 4: Amend TMA Bylaws recognizing the Council on Member Experience, and removing the Council on Practice Management Services and the Committee on Membership, as follows in the attached, and renumber accordingly.

CHAPTER 1. MEMBERSHIP

[ ]

1.208 *Resident*. Physicians serving internships, residencies, and fellowships in hospitals located within the geographical boundaries of a county society, who are not in private practice, shall be eligible for resident membership in that county society. Resident membership shall cease with the completion of the internship, residency, or fellowship.

Resident members shall have all rights and privileges of membership except the right to vote and hold elective or appointive positions. However, resident members may serve as voting delegates or alternate delegates to the TMA House of Delegates, may be elected to the designated position on the association's AMA delegation, may be appointed to the designated member position on the Board of Trustees ~~and the Committee on Membership~~, and may serve as special appointees to councils and committees (see Sections 9.38 and 10.30). Resident members also may be granted voting privileges on committees of a county medical society, at the discretion of the county society. Resident members may be granted the right to vote and hold elective or appointive positions in a Section, if provided for in its operating procedures.

1.209 *Student*. Full-time students pursuing a course of study in a Texas medical school recognized by the Texas Medical Board that leads to the degree of Doctor of Medicine or Doctor of Osteopathy shall be eligible for student membership in the county society in which the medical school or satellite campus where they are enrolled is located. Student membership shall cease upon termination or change of enrollment status.

Student members shall have all the privileges of membership except the right to vote and hold elective or appointive positions. However, student members may serve as voting Medical Student Section delegates or alternate delegates, may be elected to the designated position on the association's AMA delegation, may be appointed to the designated member position on the Board of Trustees ~~and the Committee on Membership~~, and may serve as special appointees to councils and committees (see Sections 9.38 and 10.30). Student members also may be granted voting privileges on committees of a county medical society, at the discretion of the county society. Student members may be granted the right to vote and hold elective or appointive positions in a Section, if provided for in its operating procedures.

[ ]

CHAPTER 3. HOUSE OF DELEGATES

[ ]

3.258 *Establishment of new sections*. Through the Board of Trustees, the Council on Member Experience ~~Committee on Membership~~ may submit a report to the House of Delegates recommending creation of a section. County societies, existing House of Delegate sections, and voting members of the House of Delegates may submit resolutions resolving that a section be created. The report or resolution will contain a defined mission and criteria outlined in Section 3.261.

[ ]

CHAPTER 9. COUNCILS

[ ]

9.807 *Council on Member Experience*. The council shall plan and oversee programs to recognize and heighten TMA members' experience and engagement throughout the association, and to better align TMA's offerings with the needs and wants of members. It shall help guide coordinated development of relevant and timely member benefits, programs, and services for key interest groups and segments of TMA membership. ~~*Council on Practice Management Services*. The council shall oversee all association practice management services provided directly to physicians and their staff.~~

[ ]

CHAPTER 10. COMMITTEES

10.212 Membership

[ ]

b. *Term and tenure*. Except as provided in this subsection, the term of service shall be for three years, and the terms shall be staggered. Tenure of service shall not exceed two terms; serving as much as two years shall be considered a full term. Tenure for the Committee on Physician Health and Wellness shall be three terms. Term and tenure for members of the Interspecialty Society Committee shall be as stated in 3.226. ~~Term for the resident and student members on the Committee on Membership shall be one year; tenure shall be three terms.~~

[ ]

~~10.52 *Council on Practice Management Services*~~

~~10.521 *Committee on Health Information Technology*. The purpose of this committee shall be to (1) Promote the safe and effective use of technology that supports practice efficiency, quality improvement activities, and management of population health; (2) monitor and influence state and federal laws, regulations, and programs impacting physician and patient use of technology; (3) develop association policy related to health technology; (4) collaborate with other professional organizations and governmental agencies working on health technology issues and serve as the association's voice and advocate; and (5) oversee development of health information technology education and resources for physicians.~~

[ ]

10.54 *Council on Socioeconomics*

10.541 *Committee on Health Information Technology*. The purpose of this committee shall be to (1) promote the safe and effective use of technology that supports practice efficiency, quality improvement activities, and management of population health; (2) monitor and influence state and federal laws, regulations, and programs impacting physician and patient use of technology; (3) develop association policy related to health technology; (4) collaborate with other professional organizations and governmental

agencies working on health technology issues and serve as the association's voice and advocate; and (5) oversee development of health information technology education and resources for physicians.

[ ]

~~10.612 *Committee on Membership*. The committee shall be composed of members appointed to represent county medical societies and House of Delegate sections. One member shall be appointed from each of the eight component county societies with the largest number of members; three members shall be appointed to represent other county societies. The TMA president shall appoint a member from each of the House of Delegates sections.~~

~~The committee shall provide guidance in the development of annual and long-term membership recruitment and retention programs. The committee shall coordinate with and be supportive of the membership activities of county medical societies and the American Medical Association.~~

[ ]

CHAPTER 13. MEMBERSHIP DUES AND SPECIAL ASSESSMENTS

[ ]

13.60 Temporary waiver/reduction of dues

County societies may grant a temporary waiver or reduction of county society and association dues for physicians who the society believes are deserving due to financial hardship or disability. The waiver or reduction will apply only to a single annual dues period; additional waivers or reductions may be granted only after complete review. The association must be notified of each action, and the county society shall provide such information as required by the Council on Member Experience ~~Committee on Membership~~.

Supplement

REPORT OF BOARD OF TRUSTEES

BOT Report 12 2022

Subject: Texas Medical Liability Trust Governing Board

Presented by: Rick W. Snyder II, MD, Chair, Board of Trustees

Referred to: Financial and Organizational Affairs

The Texas Medical Liability Trust (TMLT) Governing Board annually makes nominations to the TMLT board. These nominations are, in turn, submitted to and approved by the TMA House of Delegates. TMLT policyholders are also given the opportunity to nominate other eligible candidates. These nominations also are reported to the House of Delegates.

Beginning with elections in 2007, places on the TMLT board are staggered so that only a portion of places are up for election each year. Each term is for three years, and board members may be reelected for two additional three-year terms for a maximum of nine years of service on the board. The following places are up for election in 2022:

- Place 4: Michelle Harden, MD, will fulfill her third term and board tenure at the end of 2022. The TMLT Governing Board recommends nominating Jamie Lynch, MD, orthopedics, San Antonio, for a three-year term beginning in 2023.
- Place 5: William Fleming III, MD, will fulfill his third term and board tenure at the end of 2022. The TMLT Governing Board recommends nominating Gary Sheppard, MD, internal medicine, Houston, for a three-year term beginning in 2023.
- Place 6: The first term of Luis Benavides, MD, will end at the end of 2022. Dr. Benavides will not be seeking additional terms, and therefore, the TMLT Governing Board recommends nominating Joe Valenti, MD, obstetrics and gynecology, Denton, for a three-year term beginning in 2023.

Recommendation: Approve Jamie Lynch, MD; Gary Sheppard, MD; and Joe Valenti, MD, as nominees of the Texas Medical Liability Trust (TMLT) Governing Board, to be placed before TMLT policyholders for election.

Supplement

REPORT OF THE BOARD OF TRUSTEES

BOT Report 17 2022

Subject: Establishing the Standing Committee on Medicaid, CHIP, and the Uninsured

Introduced by: Rick Snyder, MD, Chair, Board of Trustees

Referred to: Reference Committee on Financial and Organizational Affairs

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At TexMed 2019, the Texas Medical Association House of Delegates referred Council on Socioeconomics Report 4, Establishing the Standing Committee on Medicaid, CHIP and the Uninsured, to the Board of Trustees. The report recommended that (1) the Select Committee on Medicaid, CHIP, and the Uninsured be made a standing committee called the Committee on Medicaid, CHIP, and the Uninsured, reporting to the Council on Socioeconomics; (2) the number of members of the committee be set at 15 to allow broad representation to address the programs and activities of the committee; and (3) TMA Bylaws Chapter 10, Committees, Section 10.53 be amended to include a new subsection, 10.531, Committee on Medicaid, CHIP, and the Uninsured, and the remainder of the chapter be renumbered accordingly.

During the house discussion, considerable debate occurred regarding the composition and size of the new committee, ultimately resulting in referral to the board to bring back an alternative proposal. Subsequently, the board met with leaders from the council and select committee to develop a new plan. The special "pandemic" house meetings in 2020 and 2021 delayed action. The recommendations outlined below will fulfill the directive from the house.

Background

In 1999, the councils on Socioeconomics and Legislation jointly appointed an Ad Hoc Committee on Medicaid and Access to Care to develop TMA policy recommendations on Medicaid, CHIP, and the uninsured. At the time of its creation, Medicaid had become an increasingly important component of the state's health care delivery and financing system as well as state and federal efforts to reduce the uninsured. Neither parent council felt it had sufficient time or expertise to evaluate and track the program's unique policy and financing issues without sacrificing work on their other respective charges.

The councils charged the committee with the following:

- Identify and develop TMA regulatory and legislative policy relating to Medicaid, the Children's Health Insurance Program (CHIP), and the uninsured, including efforts to reduce the administrative complexity or "hassle factor."
- Monitor and respond to, as appropriate, state and federal regulatory and legislative issues pertaining to these programs as well as issues pertaining to safety-net providers and systems.
- Coordinate and collaborate with appropriate state agency officials to ensure the efficient and sensible implementation of legislation relating to Medicaid, CHIP and uninsured and develop TMA positions and/or policy as appropriate. The committee also should track the impact of legislative and budget decisions on the Medicaid physician network, patient access to services, and quality of care.
- Collaborate, as appropriate, with provider associations, consumer groups, Medicaid/CHIP managed care plans, and external research organizations to improve Medicaid and other publicly financed health care programs.

- Assist the association in its efforts to promote to employers, local governmental officials, state policymakers, and the public the economic value of Medicaid and CHIP to local communities and the state generally as well as the interdependence of Medicaid and CHIP and other public and private payers.
- Collaborate with county medical societies to track and assess innovative health coverage options.

In 2010, the councils rebranded the committee as the Select Committee on Medicaid, CHIP, and the Uninsured, keeping the same charges. Throughout its existence, the committee, in collaboration with its parent councils, has developed house-adopted policy relating to Medicaid and CHIP, developed TMA's Medicaid/CHIP legislative priorities, and worked closely with state agencies and stakeholder groups to implement new program initiatives. Major achievements include:

- Establishment of a strong working relationship with the Texas Health and Human Services Commission (HHSC) to resolve payment and administrative issues for physicians participating in Medicaid, CHIP, and/or state's women's health program, Healthy Texas Women. The committee meets with HHSC at least three times per year to provide input on HHSC policy initiatives, such as implementation of new Medicaid managed care network adequacy standards, value-based payment initiatives, and Medicaid and CHIP benefit revisions.
- Implementation of CHIP in Texas, including a child-specific benefit package and 12 months' continuous coverage.
- Development of TMA principles on Medicaid and CHIP legislative initiatives (Policy 190.023).
- Formulation of TMA principles and policy regarding Medicaid managed care (policies 190.014 and 190.019).
- Formulation of TMA policy supporting efforts to secure additional federal funds to provide health care coverage to the state's working poor (Policy 190.032).
- Development of TMA policy regarding opposing federal Medicaid block grants (Policy 190.036), opposing federal Medicaid work requirements (Policy 190.037), and opposing federal public charge rules (Policy 190.039).
- Implementation of Healthy Texas Women and its predecessors to provide low-income women access to preventive health care coverage, including contraception.
- Convening of the Medicaid Managed Care Summit, together with the Texas Association of Health Plans, Texas Hospital Association, and Texas Association of Community Health Plans, to identify regulatory and legislative opportunities to improve Medicaid.
- Enactment of legislation to simplify Medicaid managed care prior authorization requirements.
- Enactment of legislation to improve health care coverage for low-income children and postpartum women.

In 2022, the select committee also developed two policy reports for consideration by the House of Delegates, both of which were submitted under the auspices of the Council on Socioeconomics. These reports are C-SE Report 5 2022 Improving Coverage and Access for Breast and Cervical Cancer Treatment and C-SE Report 6 2022 Improving Patient's Physical Health by Addressing Oral Health.

The issues addressed by the select committee remain very high priorities for the association. Given the complexity of these programs, the association needs a policymaking body to develop and maintain expertise in Medicaid and indigent care policy, financing, and operations; to develop TMA policy and advocacy initiatives to improve care for low-income populations; to track state and federal initiatives related to these issues; and to collaborate closely with state agencies on regulatory efforts. There also is high member expectation that TMA will continue to prioritize improvements to Medicaid and CHIP, including reducing red tape for patients and physicians; developing innovative health care delivery and

alternative payment models designed to boost quality, health outcomes, and physicians; and pursuing innovative initiatives to reduce the state's alarmingly high rate of uninsured.

TMA Bylaws provide the following criteria for the establishment of standing committees of the association:

> 10.211 Criteria for establishing and method of continuation. Only the House of Delegates may establish standing committees. Prior to considering the establishment of a standing committee, the house shall ensure that the following procedures have been followed. The council recommending a committee must first submit to the Board of Trustees a description that includes (1) a specific purpose for the committee; (2) a specific program for the committee; (3) a specific expected result of the committee's activities; (4) a specific time limitation, not exceeding three years, for the committee's existence; (5) a specific cost estimate; and (6) the number of members to be appointed to the committee. The House of Delegates shall act on the recommendation of the Board of Trustees.

To ensure that the committee has diverse expertise from the physicians who care for each of the unique Medicaid populations – children; pregnant women; low-income parents; seniors; and children and adults with physical, intellectual, or behavioral disabilities – the board recommends retaining the diverse composition of the current committee, which is larger than most standing committees.

Typical TMA committee consists of nine to 15 physicians. However, Medicaid is not one program, but many, each with different populations and needs. Moreover, Texas has the highest rate of uninsured people in the country, the majority of whom are adults eligible for coverage if Texas pursued federal funds.

- Eighty percent of Medicaid patients are under age 21.
- Medicaid and CHIP together cover nearly 40% of all Texas children.
- Fifty-three percent of all Texas births are paid by Medicaid.
- Medicaid is largest source of behavioral health services in Texas.
- Ninety-five percent of Medicaid enrollees must enroll in a Medicaid managed care organization (MCO).

Moreover, the program plays a critical role in the financing of the state's health care safety net, medical education, and systems of care. Thus it is recommended that the committee's membership comprise 24 physicians to ensure sufficiently broad representation from primary and subspecialty care physicians who care for covered populations as well as the uninsured.

Because Texas requires 95% of Medicaid enrollees to join a Medicaid MCO, it also is recommended that Medicaid medical directors who are TMA members be named as consultants because they will bring unique and helpful insight into Medicaid/CHIP policymaking, quality improvement and population health initiatives, and delivery system reform while also providing much-needed input and perspective on opportunities to streamline and improve the program.

The TMA Bylaws provide an exception to expand the membership of a standing committee beyond nine members. Specifically, the bylaws state:

> 10.212 Membership
>
> a. Number of members. There shall be nine members of each standing committee, with the exception that, according to Section 10.211, the House of Delegates, acting upon recommendation of the Board of Trustees, may specify a greater or lesser number of members for certain committees.

There is precedent for establishing committees with membership broader than other standing committees. The Committee on Membership comprises 15 members drawn from county medical societies and sections; the Interspecialty Society Committee includes the delegates and alternate delegates from each of the 26 specialty societies represented within the TMA House of Delegates.

Recommendation 1: That the select committee on Medicaid, CHIP and the Uninsured be made a standing committee called the Committee on Medicaid, CHIP, and the Uninsured, reporting to the Council on Socioeconomics.

Recommendation 2: That the Texas Medical Association establish the number of members of the committee as 24 to allow broad primary and subspecialty physician representation to address the diverse populations served by Medicaid, CHIP, and safety-net programs.

Recommendation 3: That TMA Bylaws Chapter 10, Committees, Section 10.53 be amended to include a new subsection, 10.541, Committee on Medicaid, CHIP, and the Uninsured to read as follows, and the remainder of the chapter be renumbered accordingly:

> **10.541 Committee on Medicaid, CHIP, and the Uninsured** The committee shall (1) research and formulate association policy proposals on Medicaid, the Children's Health Insurance Program (CHIP), the uninsured, and other safety-net programs, including initiatives to improve the availability and affordability of health care coverage and insurance in the public and private sectors; (2) identify and develop TMA regulatory, legislative, and budget recommendations relating to Medicaid, CHIP, and uninsured, including physician-led efforts to improve health outcomes and quality, enhance access to care, constrain costs, and reduce administrative complexity; (3) closely monitor and engage, as appropriate, on implementation of state and federal regulatory and legislative initiatives related to these programs; (4) actively work with the Texas Health and Human Services Commission and the Medicaid managed care organizations in the design and implementation of physician-friendly value-based payment initiatives and population health measures to address social determinants of health; and (5) collaborate, as appropriate, with provider associations, consumer groups, and Medicaid and CHIP health plans to simplify program eligibility and enrollment; strengthen programmatic benefits and services; improve network adequacy and continuity of care; promote high-quality, timely, and appropriate patient care; and eliminate unnecessary or redundant paperwork and administrative requirements.

Related TMA Policy:
190.014 Medicaid Managed Care Guiding Principles
190.019 Medicaid and Medicaid Managed Care
190.023 Policy Principles for Medicaid and CHIP Legislative Initiatives
190.32 Medicaid Coverage and Reform

190.036 Opposition to Federal Medicaid Block Grants for Traditional Medicaid Populations
190.039 Opposition to New Federal Public Charge Definition

REPORT OF BOARD OF COUNCILORS

BOC Report 1 2022

Subject: Emeritus Nominations

Presented by: Alisa Berger, MD, Chair, Board of Councilors

Referred to: Reference Committee on Financial and Organizational Affairs

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The Texas Medical Association's House of Delegates, upon nomination by the county medical society to which the member belongs and approval by the Board of Councilors, may elect a member of the association who has rendered exceptional and distinguished service to scientific or organized medicine, or both, to the status of member Emeritus.

The Board of Councilors has approved the nominations of James S. Cox, MD; Betty J. Edwards, MD; Phillip G. Sutton, MD; Albert T. Gros, MD; James Cullington, MD; and Bruce A. Levy, MD, JD for Emeritus membership and recommends their election by the House of Delegates. A brief sketch for the nominees follows.

Summary of Qualifications

James S. Cox, MD, FAAFP, FACEP

The Tarrant County Medical Society nominated James S. Cox, MD, for Emeritus status. Dr. Cox graduated from Tulane University Medical School in 1975 and completed his residency in family practice at John Peter Smith Hospital in Fort Worth. The residency program is affiliated with The University of Texas Health Science Center community health department in Dallas.

Dr. Cox received his board certification from both the American Board of Family Practice and the American Board of Emergency Medicine. He has held numerous leadership positions, including chief of staff at Lakeland Medical Center and vice chief of staff at both Henderson County Memorial Hospital and the emergency division at Harris Methodist Fort Worth. He is heavily involved in organized medicine, including as a 44-year member of TMA and as a member of the Texas Academy of Family Physicians and of the Texas College of Emergency Physicians.

Dr. Cox has received many honors, such as the Albert Nelson Marquis Lifetime Achievement Award, the American Medical Association's Physician's Recognition Award, and the Tarrant CMS Humanitarian Award. He started collecting similar awards early in his youth, including the Outstanding Young Man of America and several Boy Scouts of America awards.

Betty J. Edwards, MD

Betty J. Edwards, MD, was nominated by the Harris County Medical Society for Emeritus status. Dr. Edwards earned her medical degree at The University of Texas Medical Branch (UTMB) School of Medicine in Galveston, where she also performed her residency in obstetrics and gynecology. She obtained her board certification from the American Board of Obstetrics and Gynecology.

Dr. Edwards has held many positions in academia, including her current role as a clinical professor at UTMB Galveston, which she has held since 2003. She is past president of the Houston Academy of Medicine, a nonprofit that provides community health education, and has exemplified consummate

leadership and distinguished service to organized medicine. She has also served on multiple TMA committees and the Harris CMS public health committee.

She has been a member of TMA and Harris CMS for approximately 42 years. She is also a member of many professional medical organizations, including the American College of Obstetricians and Gynecologists, the American Association of Physicians and Surgeons, and the Royal Society of Medicine.

Phillip G. Sutton, MD, FACS

The Harris County Medical Society also nominated Phillip G. Sutton, MD, to Emeritus status. He has been a member of TMA and Harris CMS for approximately 43 years. He graduated from medical school at The University of Texas Medical Branch School of Medicine in Galveston and completed his residency at The University of Texas Health Science Center at San Antonio.

He is involved in many professional organizations, including as a fellow of both the American College of Surgeons and the Aust Surgical Society. He is also past president of the Houston Academy of Medicine, a nonprofit that provides community health education, and has exemplified consummate leadership and distinguished service to organized medicine. In his professional career, he has held many high positions, including chief of surgery and president of medical staff.

Albert T. Gros, MD

Albert T. Gros, MD, was nominated by the Travis County Medical Society (CMS) for Emeritus status. Dr. Gros is board certified by the American Board of Obstetrics and Gynecology and has been practicing medicine for over 40 years. He received his medical degree from the Baylor College of Medicine and completed his residency at Baylor-affiliated hospitals.

Dr. Gros is an American College of Obstetrics and Gynecology fellow and Texas Association of Obstetricians and Gynecologists member. Prior to his retirement, he had privileges at multiple hospitals, including South Austin Hospital, Brackenridge Hospital, Seton Medical Center, and St. David's Medical Center.

Dr. Gros has been actively involved in his county medical society, with TMA, and in his community. For example, Dr. Gros is member of the Travis CMS delegation to TMA and previously chaired TMA's Council on Legislation and served on Travis CMS's Board of Ethics and the Central Texas Medical Foundation board.

Dr. Gros has been a TMA member for approximately 39 years.

James Cullington, MD, FACS

The Travis County Medical Society also nominated James Cullington, MD, to Emeritus status. He has been a member of TMA and Travis CMS for approximately 41 years. He earned his medical degree from The University of Texas Medical Branch in Galveston and completed an internship and specialty training with Walter Reed General Hospital, then finished his specialty training at Fitzsimons Army Medical Center in Denver, Colo. He received his board certifications from both the American Board of General Surgery and the American Board of Plastic Surgery.

He has been very active in Travis CMS, including as a member of its Medical Legislation and Mediation Committee and its Membership and Public Relations Committee. Dr. Cullington also has served as a delegate to TMA and has been a member of TMA's Interspecialty Society Committee.

In addition to Travis CMS and TMA, Dr. Cullington has been involved in other medical organizations, including the American Society of Plastic Surgeons, Texas Society of Plastic Surgeons, American College of Surgeons, and Austin Society of Plastic and Reconstructive Surgeons. He also contributed to the medical community through many scientific publications and teaching.

Bruce A. Levy, MD, JD

Travis County Medical Society also nominated Bruce Levy, MD, JD, to Emeritus status. Dr. Levy has been a TMA and Travis CMS member for approximately 42 years. He graduated from Hahnemann Medical College and Hospital in Pennsylvania with a medical degree and completed his post-graduate medical training at Hahnemann as well as at the University of Washington School of Medicine in Seattle, Wash. He went on to also earn his juris doctorate from the University of Houston Law School. He received his board certification from the American College of Anesthesiologists and American Board of Anesthesiologists.

Dr. Levy has received many honors, including most recently the W. Neal Kocurek Health Advocacy Award, which is given annually by the Austin People's Community Clinic to a community leader who demonstrates exceptional advocacy in the interest of equitable health care, and the Marcel Patterson Leadership Award, Texas Society of Gastroenterology and Endoscopy (the first time this award was given for a second time to the same physician).

He has been very involved in Travis CMS and TMA activities, including as a member of Travis CMS' Physician Wellness Committee and chair of its Mediation Committee and Board of Ethics, and as a member of TMA's Committee on CME. He has also been an executive board member of Travis CMS.

Recommendation: The TMA Board of Councilors recommends that the House of Delegates vote to approve James S. Cox, MD; Betty J. Edwards, MD; Phillip G. Sutton, MD; Albert T. Gros, MD; James Cullington, MD; and Bruce A. Levy, MD, JD, to Emeritus member status.

Supplement

REPORT OF TMA MEDICAL STUDENT SECTION

MSS Report 2 2022

Subject: Amendment of Medical Student Section Operating Procedures

Presented by: Ryan Wealther, Chair, Medical Student Section

Referred to: Reference Committee on Financial and Organizational Affairs

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The Medical Student Section would like to change its rules and policies to ensure they align with how the section currently functions.

Recommendation: Amend the Medical Student Section's Rules and Policies as follows:

RULES AND POLICIES
OF THE
MEDICAL STUDENT SECTION

R1.10 MSS BUSINESS MEETING.

R1.11 Purpose. The purpose of the meeting shall be to hear reports regarding TMA, section, and chapter business; elect members of the Executive Council; discuss opportunities for section member involvement in TMA and AMA; ~~and~~ approve recommendations concerning internal policy, and adopt resolutions for submission to the House of Delegates of TMA.

R1.12 Notice. Notice of the date, time, and location of a section meeting shall be sent to chapters and members of the Executive Council prior to the meeting. Prior to the meeting, agenda packets shall be distributed to members of the Executive Council.

R1.13 Resolutions. Any medical student member may submit resolutions to the Medical Student Section. All resolutions must follow the process specified by the TMA delegation co-chairs to be considered as business. ~~All resolutions must be received prior to the business meeting to be included on the agenda by a deadline at set by the current Executive Council.~~

Resolutions not received in accordance with this process ~~by that deadline~~ shall be considered as nonconforming ~~late~~ resolutions. Authors of nonconforming ~~late~~ resolutions shall substantiate that the resolutions pertain to issues or events which have arisen after the deadline or are emergent in nature. Such resolutions shall be considered at the discretion of the TMA delegation co-chairs. ~~require a two-thirds affirmative vote of the section to be accepted as business to be acted upon by the section.~~

Resolutions approved for consideration as business shall require a majority vote of the MSS chapter delegates for adoption. Adopted resolutions shall be listed in the TMA-MSS Digest of Actions, which shall serve to show a history of resolutions submitted by the MSS to the TMA House of Delegates.

~~Resolutions requesting change to TMA policy shall require a majority vote of the section before being submitted to the TMA House of Delegates on behalf of the Medical Student Section.~~

~~Resolutions requesting forwarding to the AMA by the Texas Delegation will only be considered if the MSS member of the Texas Delegation has been notified prior to the meeting at which the item will be considered. Authors of such resolutions may be required to demonstrate that a search for relevant AMA policy has been performed. Such items will require a two-thirds majority of votes as provided in Operating Procedure Section 3.10 in order to retain the clause asking for forwarding.~~

R2.10 EXECUTIVE COUNCIL.

R2.11 Responsibilities.

R2.111 The chair shall be the principal officer of the section and shall, as far as practical, ~~visit the~~ engage with various ~~areas of the state in the interest~~ chapters of the Medical Student Section. The chair shall serve as an advisor to the section's delegates and alternate delegates to the TMA House of Delegates and preside at the TMA-MSS Chapter Presidents Meeting.

R2.112 The vice chair shall serve as parliamentarian of the section ~~and as chair of the Programming/Social Issue Task Force~~. The vice chair also shall monitor the section's operating procedures, and report violations and changes that need to be addressed.

R2.113 The reporter shall record the minutes of all section and Executive Council meetings, and must submit these records to the Section Coordinator within 1 month of each TMA meeting. The reporter shall monitor TMA and AMA electronic communications for the section, and assist chapters in increasing access to and promoting awareness and usage of electronic communications to enhance section goals and activities.

R2.114 The TMA delegation co-chairs shall report delegate activities at each meeting of the section and Executive Council, coordinate activities of chapter delegates and alternate delegates including delegate caucuses and making reference committee assignments. The co-chairs shall give testimony at TMA meetings as necessary. The co-chairs shall coordinate the MSS resolution writing process and serve as co-chairs of the Resolution ~~Writing Task Force~~ Review Committee. The co-chairs shall ~~submit a report to~~ work with the Section Coordinator to submit a report within 1 month of TexMed detailing TMA-MSS activities during each meeting.

R2.115 The AMA delegation co-chairs shall report delegate activities at each meeting of the section and Executive Council. The co-chairs shall coordinate activities of the AMA-MSS delegates and alternate delegates. The co-chairs shall ~~submit a report to~~ work with the Section Coordinator to submit a report within 1 month of the AMA Annual and Interim Meetings detailing AMA/TMA-MSS activities during each meeting. The AMA delegation co-chairs shall serve as the TMA-MSS' liaisons to Region 3 AMA-MSS leadership.

R2.116 The student serving as an alternate delegate on the Texas Delegation to the AMA shall represent the section at delegation meetings and collaborate with fellow TMA-MSS members who serve as region delegates and region alternate delegates to the AMA House of Delegates. The student will work with the Region 3 AMA-MSS region delegation chair and the AMA-MSS General Council section delegate and/or section alternate delegate to ensure they are integrated and ready to serve at the AMA Annual House of Delegates meeting immediately following their selection to this role. The student is responsible for reporting back to the section on the progress or outcome of student-authored or student-relevant resolutions and providing a report to the Texas Delegation at each Delegation meeting. This report should focus not only on resolutions to be submitted to the AMA House of Delegates by the AMA-MSS Assembly, but also on other information of importance to TMA and TMA students such as, but not limited to, reporting names of students that were elected to the AMA MSS governing council and region delegate positions.

R2.117 The TMA student member of the TMA Board of Trustees shall represent the section at TMA Board of Trustees meetings. The student serves for one year to manage business and financial affairs of the association, implement policies of the TMA House of Delegates, establish interim policy of the association between meetings of the House of Delegates, monitor program activities of association councils and committees, and provide the MSS perspective on major TMA decisions in the Board of Trustees. The student representative is responsible for reporting back to the Executive Council and the section on Board of Trustees' initiatives related to the MSS.

R2.118 The Executive Council may appoint task forces as needed.

R2.12 Elections.

R2.121 Eligibility. All candidates must be members of the Texas Medical Association. A medical student shall not be eligible for any Executive Council office if he or she will graduate from medical school before or during the term of office, excluding AMA delegation co-chair if their graduation dates fall within two months prior to the end of their respective terms. This exclusion shall not apply to the immediate past chair.

R2.122 Candidate Qualifications. All candidates for positions on the Executive Council must have attended at least one section meeting prior to election. ~~Provided sufficient candidates meet this requirement, a~~ Additional qualifications for the following positions apply:

Those seeking position as section chair shall have past or current service as a member of the MSS Executive Council.

Those seeking positions as TMA delegation co-chairs shall have past or current service as a delegate or alternate delegate to the TMA House of Delegates.

Those seeking positions as AMA delegation co-chairs shall have past or current service as a chapter delegate or alternate delegate to the AMA-MSS Assembly meeting.

In the event that no candidates for a position meet these qualifications, the MSS may suspend these requirements to allow a candidate who would not otherwise qualify.

R2.123 Procedures. Prior to the elections, all candidates shall submit a statement of intent, curriculum vitae - not to exceed two pages - and a headshot to the section coordinator, prior to a date set by the current Executive Council, to be included in agenda packets for the section meeting. Any information submitted later than the preset date prior to elections will not be included in the agenda packets.

Nominations may be accepted from the floor for each position until candidate speeches begin for that respective position. Nominees from the floor may not disseminate any campaign materials other than a curriculum vitae, not exceeding two pages, and a statement of intent.

Election materials including but not limited to buttons, pins, badges, stickers, signs, banners, and other such gadgets and trinkets are prohibited.

When necessary, these procedures may be suspended by a two-thirds vote of present MSS members.

R3.10 CHAPTER GOVERNING BOARDS. Each chapter shall have a governing board composed of students in good standing ~~who are elected by popular vote~~. The students must be members of their respective county medical society and the Texas Medical Association.

R3.11 Composition and terms. Officers comprising each chapter governing board shall be the president, vice president, treasurer, TMA delegate, TMA alternate delegate, AMA delegate, AMA alternate delegate, and TEXPAC representative.

Chapters may have additional officers ~~Additional officers may be elected~~ to meet the needs of the chapter. These additional officers shall serve as non-voting ~~nonvoting~~ members of the chapter's governing board unless the chapter's constitution requires otherwise. Governing board members and any additional chapter officers shall serve one year terms beginning and ending as determined by the chapter.

No chapter shall have ~~elect~~ two individuals serving in ~~to~~ the same position on the governing board.

R3.12 Duties. Duties of chapter governing board members include, but are not limited to:

R3.121 The president shall serve as the principal officer of the chapter and preside at meetings of the chapter and the governing board. The president shall serve as the chapter representative to TMA-MSS chapter presidents meetings.

R3.123 The vice president shall assist the chapter president in the performance of the president's duties. The vice president shall serve as parliamentarian at all chapter and governing board meetings and is responsible for overseeing all chapter programming. ~~The vice president shall serve as the chapter representative to the section's Programming/Social Issue Task Force.~~ In the event of a vacancy in the office of president, the vice president shall assume the duties of the president; at the next

regularly scheduled meeting of the chapter an election shall be held to elect a vice president.

R3.124 The treasurer shall manage all chapter finances and shall be responsible for recommending to the governing board disbursement of chapter funds in a manner that complies with TMA and section finance policies. The treasurer shall approve member reimbursement requests and serve as liaison to the section coordinator for chapter financial matters.

R3.125 The TMA delegate shall be responsible for attending and voting at TMA House of Delegates meetings, and reporting actions taken by the TMA House of Delegates and informing the chapter of developments at the state level. The TMA delegate will also vote on MSS resolutions that are to be forwarded to the TMA House of Delegates. ~~The TMA delegate shall serve as a chapter representative to the section's Legislative Task Force.~~

R3.126 The TMA alternate delegate shall assist the TMA delegate in the performance of the delegate's duties. As provided in TMA Bylaws, if the TMA delegate is unable to attend or vote during a session of the TMA House of Delegates, the TMA alternate delegate shall be seated and vote during the delegate's absence.

R3.127 The AMA-MSS delegate shall be responsible for attending and voting at AMA Medical Student Section meetings, and reporting actions taken by the AMA and informing the chapter of developments at the national level. The AMA-MSS delegate shall also be responsible for coordinating any and all chapter testimony prior to sessions of the AMA-MSS Assembly.

R3.128 The AMA-MSS alternate delegate shall assist the chapter AMA-MSS delegate in the performance of the delegate's duties. If the AMA-MSS delegate is unable to attend or vote during a session of the AMA-MSS Assembly, the AMA-MSS alternate delegate shall assume the AMA-MSS delegate's duties during his or her absence.

R3.129 The TEXPAC representative shall serve as the chapter's representative to TEXPAC. This position will represent the chapter at all TEXPAC meetings and inform the chapter of developments at the state level.

R4.10 CHAPTERS WITH MULTIPLE CAMPUSES. Satellite campuses of a Texas medical school shall not be able to form a separate TMA-MSS chapter recognized by TMA. However, a satellite campus may establish a chapter branch organizational body by agreement of the campus and its associated chapter's governing board. The organizational body shall exist to enable the satellite campus the ability to participate in chapter programming events and assist the chapter in conducting its business.

Chapters with multiple campuses shall have one, and only one, TMA delegate and alternate delegate to the TMA House of Delegates.

The chapter governing board shall have discretion to seek appointment of a local chapter advisor for its satellite campuses.

R5.10 RECALL OF CHAPTER OFFICERS. To recall a TMA-MSS chapter officer, a meeting must be called of the chapter's governing board. Notice of the meeting shall be given to the chapter advisor and

the officer at least 15 days, but no more than 30 days prior to the date of the meeting. The complaint must be made before the governing board with the chapter advisor and officer attending. If the matter cannot be resolved at this level, the governing board may request that the officer be recalled before the chapter membership. For the officer to be recalled, the matter may go before the chapter membership at the next regular chapter meeting. The officer shall be recalled if two-thirds of the chapter members present and in good standing vote to remove the officer. An emergency meeting may not be called specifically for an officer recall vote.

If an officer is recalled, the officer may appeal the decision to the TMA-MSS Executive Council at its next regularly scheduled meeting. Notice shall be provided to the chapter governing board and one member of the board must attend the meeting. The decision of the TMA-MSS Executive Council shall be final and no further appeals may be made.

R6.10 CAUCUSES. Prior to a TMA House of Delegates meeting, notice of the caucus meeting schedule shall be sent to all TMA delegates and alternate delegates, and Executive Council members. Prior to a TMA House of Delegates meeting, the TMA delegation co-chairs shall notify TMA delegates and TMA alternate delegates of reference committee assignments and, if available, shall send an agenda for the caucus.

TMA delegates and alternate delegates are encouraged to attend their respective county society handbook review meetings. TMA delegates and alternate delegates shall attend reference committee meetings, testify on issues before the reference committee, and shall present a brief summary on the recommendations of the reference committee to the section's caucus meetings.

~~R6.10 TASK FORCES. The Executive Council may appoint task forces as needed.~~

R7.10 TMA COUNCIL AND COMMITTEE REPRESENTATIVE APPOINTMENTS. The Executive Council shall recommend to the TMA president names of student representatives and alternate student representatives for consideration as appointees to association boards, councils, and committees.

Applications for positions on boards, councils, and committees shall be made available to student members each year at or before the TMA Winter Conference. Deadline for applications shall be published on the application. The Executive Council shall meet before the conclusion of the TMA Annual Session to make recommendations for appointments. A member who holds a position on the Executive Council shall not be considered for appointment. Students who are recommended for appointment shall receive notification after the annual session.

A medical student shall not be eligible for appointment as a student representative or alternate representative on a board, council, or committee if he or she will graduate from medical school before or during the term of the appointment.

Student representatives and alternate representatives to association boards, councils, and committees shall serve one-year terms, beginning at the conclusion of the annual session at which they were appointed, and ending at the conclusion of the following annual session. Any appointed student representative or alternate representative may apply to serve additional one year terms for the same or a different committee.

Student representatives and alternate representatives to TMA boards, councils, and committees shall be responsible for providing a brief report of meetings to the section coordinator after that meeting. Failure to do so may result in removal from the position. Student representatives and alternate

representatives to TMA boards, councils, and committees should attend at least two out of three TMA conferences per year. Failure to do so may result in removal from the position.

R8.10 ACTIVITIES AT AMA-MSS MEETINGS. The AMA delegation co-chairs shall preside at all Texas medical student caucuses at AMA-MSS meetings. The Texas complement of medical students to AMA meetings (see Section 8.10) shall focus efforts on presenting Texas resolutions to the AMA-MSS; evaluating and voting on all AMA-MSS resolutions and reports; and campaigning for Texas candidates running for AMA-MSS offices.

The AMA delegation co-chairs shall ~~be responsible for~~ work with AMA-MSS Region 3 in coordinating research and evaluation of AMA-MSS resolutions and reports. At least one week prior to AMA-MSS meetings, the delegation co-chairs shall assign resolutions and reports to each AMA-MSS delegate and his or her chapter for evaluation and report to the MSS caucus.

R9.10 CANDIDATES FOR AMA-MSS OFFICE. All Texas candidates for AMA-MSS Assembly Governing Council positions, for the student position on the AMA Board of Trustees, or for other national positions appointed by the Governing Council outside of committee leadership positions ~~the positions of Region Delegate and Alternate Delegate to the AMA HOD~~ desiring TMA-MSS support must submit a statement of intent and curriculum vitae to the TMA-MSS Executive Council at least three weeks prior to the submission deadline for the materials candidates are required to submit to AMA ~~TexMed (for Annual Meeting elections or the Fall Conference (for Interim Meeting elections)~~.

The Executive Council shall provide a recommendation of which candidate(s) should receive TMA-MSS support prior to the TMA-MSS business meeting. If there are multiple candidates from Texas for a position, or if there is a single Texas candidate and a member of the Executive Council requests to discuss whether to recommend the candidate, the chair shall call a special meeting of the Executive Council to determine its recommendation(s). A request to discuss whether to recommend a single Texas candidate must be made to the chair within seven days of the chair notifying the Executive Council that the candidate is the only Texas candidate seeking TMA-MSS support..

TMA-MSS support includes official state support, a letter of support, provision of campaign materials, and coordination of campaign efforts by the Texas complement to the AMA-MSS.

For the positions of region delegate and alternate delegate to the AMA House of Delegates, the TMA-MSS will not formally support any candidates. All candidates for the positions of region delegate and alternate delegate to the AMA House of Delegates are required to submit application paperwork to the section coordinator within five business days of submitting it to AMA if they wish to seek funding from the TMA-MSS. If candidates run from the floor and win their election, they must notify the section coordinator within five business days of the conclusion of the AMA-MSS business meeting.

R10.10 SECTION FINANCES.

R10.11 Funding. The TMA Board of Trustees (BOT) provides funding to the Medical Student Section to enhance chapter programming and encourage member participation at TMA and AMA meetings. As with any funds provided through the TMA budgetary process, funds are utilized within specific guidelines and all expenditures must be documented. Availability is on an annual basis. Funds not utilized during the fiscal year (Jan. 1 through Dec. 31) are not carried over for use in the following year, the exception being funds earned through AMA Outreach Awards.

R10.12. AMA Outreach Awards. The AMA Outreach Program is a peer-to-peer recruitment program. MSS program participants earn funds for travel to AMA meetings by recruiting new AMA medical student members. Funds are awarded to chapters through the Texas Medical Association, and are administered by the section coordinator. Except where specified, the same financial policies and reimbursement guidelines in effect for funds provided by the BOT will apply to AMA Outreach funds.

Funds awarded through the AMA Outreach Program are typically distributed in January or early February for that year. In the event that an award check from the AMA Outreach Award program arrives prior to Jan 1, chapters may not use more than 10 percent of the award to fund December travel and activities. In addition, because AMA Outreach funds are an award, unused funds will carry over to the next calendar year.

R10.13. Annual Distribution of Funds. Each January, the section coordinator will designate a portion of the funds provided by the BOT for use by each chapter. Funds will be allocated in such a manner as to optimize both chapter programming and student participation in TMA meetings.

The following guidelines are for use in determining appropriate designation of TMA funds:

Each chapter is to be given a base amount for travel to TMA meetings and a base amount for TMA programming. Any chapter with multiple campuses is to be given ~~an~~ additional ~~50 percent of the base amount~~ funding for TMA travel for each additional campus.

Annually, physicians make donations to a student "scholarship" fund to aid student travel to TMA meetings. Each chapter will receive a percentage of any funds donated by physicians for student travel to TMA meetings. The percentage received will be determined by the section coordinator, and will be deposited into each chapter's TMA Travel Account.

Disputes regarding fund designation will be resolved by the Executive Council.

R10.14 Management of Funds. Once funds have been allocated, they will be managed by the section coordinator, in conjunction with the MSS chapter treasurers, utilizing three separate accounts for each chapter. The first account will be for funds allocated for chapter programming (Chapter Programming Account). The second account will be for funds designated to assist with travel to TMA meetings (TMA Travel Account). The third account will be reserved for AMA Outreach funds earned by the chapter (AMA Outreach Account).

It is recommended that chapter officers engage in long-range planning for travel to TMA and AMA meetings. TMA generally has three meetings annually: Winter Conference (January/February), TexMed (April/May), and Fall Conference (September). AMA generally has four ~~three~~ meetings annually: Annual Meeting (June), Interim Meeting (November), ~~and the~~ Medical Student Advocacy ~~and Region~~ Conference (March ~~spring~~), and Region Conferences (January/February).

Specific maximum allocations shall be established and budgeted for each meeting. In addition, each chapter treasurer shall contact the section coordinator for an exact balance of its chapter's TMA and AMA Outreach Accounts prior to engaging in the planning process.

R10.15 Reimbursement Guidelines. Reimbursement guidelines, established in accordance with TMA policy, will be reviewed annually, and if necessary, updated by the Executive Council**.** Original receipts or documentation must be provided for all reimbursable expenditures.

Reimbursement is contingent on participation in MSS conference activities. At an AMA-MSS Assembly meeting, a student must attend all TMA-MSS caucus meetings, the Region 3 caucus meetings, and one of the following: the AMA-MSS Assembly or the AMA-MSS Conference Social Project. At TMA conferences, a student must attend the MSS business meeting and one other conference meeting (council, committee, or student task force meeting). Any exception to this policy will be reviewed by the Executive Council on an individual basis.

In the event there is a dispute between a student member and the chapter regarding the use, misuse, or abuse of chapter funds, the member will be allowed due process. The member shall request, in writing, a hearing at which no less than two-thirds of the chapter's governing board and the chapter advisor shall be present. This hearing must be held within 15 days from receipt of the member's notification. The governing board must notify the member of its decision in writing within 7 days of the hearing. If the decision of the chapter governing board does not meet the satisfaction of the member, the member may appeal that decision to the TMA-MSS Executive Council within 30 days of the decision. The TMA-MSS Executive Council shall have 30 days to render a written decision to the member.

Currently, several chapters have independent sources of funding that are not subject to TMA financial policies and reimbursement guidelines. Any expenditures not considered reimbursable by TMA, may be expended from the individual chapter's other sources in accordance with that chapter's policies and guidelines. Because AMA Outreach funds (AMA travel) are for all chapter members, the funds are administered by TMA, and must adhere to TMA guidelines.

R10.151 Travel. TMA funds are to be used for travel and lodging only, and are for member travel only. Members are encouraged to carpool to out-of-town meetings. Where appropriate, members are to share hotel rooms when meeting schedules necessitate an ~~on~~ overnight stay. For travel via personal vehicle, mileage is reimbursed at the current IRS-allowed rate for one vehicle per chapter per meeting. Commuting to local meetings is not considered a reimbursable expenditure. For travel by air, coach (with baggage) airfare rate is reimbursable. If, however, the cost of airfare compared to that of travel by personal vehicle is greater for the same number of persons, then personal vehicles should be utilized. Individual chapters have the responsibility of setting a maximum reimbursable amount for air travel. ~~Chapters shall notify the section coordinator of this amount at least three weeks prior to travel; reimbursement shall be made accordingly.~~

R10.152 Lodging. Lodging will be reimbursed only when a member has official TMA business on the day before and after the night reimbursement for lodging is requested. If, however, it is necessary to stay overnight after official business is completed that day and reimbursement is desired, prior approval must be obtained from the section coordinator.

~~Maximum reimbursable amounts (including taxes) for lodging based on double occupancy will be based upon the hotel rate at which the convention is being held. In the event that lodging must be obtained at an off-site location, reimbursement will be no greater than that which would have been provided at the official convention~~

~~hotel. These rates, however, are subject to change if the Executive Council designates a "host" hotel with a lower rate, and members choose, instead, to stay at another hotel. In that case, members will be reimbursed for the rate charged by the host hotel.~~

R10.153 Miscellaneous travel expenditures. Parking garage fees, road tolls, and taxi and bus fares are reimbursable expenses only when a receipt is presented. Meals, ~~telephone calls,~~ rental cars, and alcohol are not reimbursable expenses.

R10.154 Reimbursement for spouses and significant others. For spouses and significant others traveling with student members to TMA or AMA conferences, the student member may take advantage of special negotiated conference travel rates. However, only the member may receive the appropriate portion of reimbursement based on the arrangements made by the chapter prior to travel. Spouses and significant others are responsible for any and all travel expenses incurred.

~~R10.155 Cash advance guidelines. The following guidelines apply to cash advances (usually dispersed by TMA check) for meeting and programming expenditures:~~

~~1. Cash advances will be made on a case-by-case basis.~~

~~2. Requests for cash advances must be made in writing and submitted to the section coordinator at least 30 days prior to the date that funds are needed.~~

~~3. Requests for cash advances must include an explanation of the nature and necessity of the expenditure, as well as an estimated amount for the expenditure.~~

~~4. Cash advances must be approved by the section coordinator and Department/Division Director.~~

~~5. Approved cash advances will be sent directly to the member requesting the advance.~~

~~6. Receipts and documentation of the expenditure, along with reimbursement to TMA for advanced funds not utilized, are due to TMA within 30 days of the date of the expenditure. Failure to comply with this policy may result in deduction of the cash advance from chapter funds, and possible suspension of future cash advances.~~

~~7. In the event that a person receiving a cash advance to attend a meeting does not attend the meeting, the advanced funds must be returned to TMA within 30 days of the meeting for which the advance was given.~~

R10.156 Reimbursement procedures. To be reimbursed for expenditures, the following procedures must be completed:

1. A reimbursement request/expense form must be completed and submitted by the traveler, along with all applicable receipts/documentation, to the chapter treasurer for approval. ~~The traveler must include his or her social security number on the form.~~ Forms may be

obtained from the section coordinator. Failure to submit properly completed forms could result in a 30-day delay (or more) in processing travel reimbursement requests.

2. The chapter treasurer is to approve and sign (not fill out) the reimbursement request forms submitted by chapter members. The treasurer shall then submit the forms to the chapter president for approval ~~and signature~~.

3. Approved reimbursement request/expense forms are then submitted by the chapter treasurer to the section coordinator for processing. Reimbursement checks will be sent directly to the traveler.

4. A combined chapter reimbursement request/expense form should be submitted for any and all expenses totaling $10 or less. Receipts should be submitted to the chapter treasurer, who will then complete the form and approve it. Reimbursement funds will be sent to the chapter treasurer to disburse the funds accordingly.

5. All reimbursement request/expense forms must be submitted (postmark date) to the section coordinator no later than 30 days after the date of the expenditure, with the following exception: the deadline for submitting forms for any meeting occurring after November 10 will be December 15~~0~~ of the same year. This exception is necessary to ensure that reimbursements are made within the correct fiscal year. Any forms received after the stated deadline will not be processed or paid.

6. In the event that the chapter treasurer is unavailable, the chapter president may submit reimbursement forms after two members of the chapter governing board have approved the expenditure.

APPENDIX

History of Student Involvement in the Texas Medical Association

When the Texas Medical Association Medical Student Section Operating Procedures were approved by the TMA House of Delegates in November 1976, there were 56 initial student members. At that time, the Section's Operating Procedures recommended that students be nominated to serve on Association councils and committees, but the practice did not take effect until a year later when John M. Smith, Jr., MD, then TMA President, encouraged their participation. With the active support of the TMA leadership, and some diligent work by the early student members, the MSS membership grew at an astonishing rate. By the end of 1983, membership had grown to more than 3,700 members.

Having achieved the initial goal of increasing student membership in the federation, attention was then focused on additional goals. Foremost was the desire to establish well-defined roots, while continuing to increase membership. Furthermore, the Section sought to provide higher quality services to members, more in depth communication, greater continuity of leadership, and a more significant contribution to the federation.

To achieve these goals, the Medical Student Section worked closely with the TMA Councils on Medical Education and Constitution and Bylaws to revise its Operating Procedures, incorporating two important changes: to establish one Chapter of the TMA/MSS at each of the seven allopathic medical schools in the state, and to increase the number of voting delegates from the Section to the TMA House of Delegates from one to seven. These two changes were approved unanimously by the House of Delegates at the 1981 Interim Session with the provision that the Section referring to the increased number of Delegates become effective following approval of the necessary constitutional amendments.

Following the establishment of Chapters, the Executive Council drafted model Chapter operating procedures and a series of recommendations for the development of the local Chapters. Each school then formally adopted its own operating procedures in accordance with the TMA Constitution and Bylaws and the operating procedures of the TMA Medical Student Section. Each Chapter's operating procedures were officially accepted and approved by the MSS Executive Council, TMA Board of Councilors and TMA House of Delegates at Annual Session 1982. In 1992, the TMA-MSS Chapter of the Texas College of Osteopathic Medicine was formally approved by the House of Delegates. In 2001 the Texas Medical Association House of Delegates approved a special student appointee to the TMA Board of Trustees.

Recent years have seen an expansion of medical schools in Texas, ushering in an era of increased activity and organization of the TMA-MSS. In 2022, the TMA-MSS has more than 4,800 members belonging to 15 chapters. During the COVID-19 pandemic, medical student members aided county medical societies and TMA in battling the pandemic. Wherever Texas physicians care for patients, medical students will be there alongside them bringing their passion for patient care.

AGENDA
REFERENCE COMMITTEE ON SCIENCE AND PUBLIC HEALTH
Friday April 29, 2022

1. *Board of Trustees Report 11 – Addressing Racism in Medicine*

2. Council on Science and Public Health Report 1 – Sunset Policy Review

3. Council on Science and Public Health Report 2 – Improving Physician Access to Immigrant Detention Facilities

4. Council on Science and Public Health Report 3 – Public Health and Health Care Protections While Incarcerated

5. Council on Science and Public Health Report 4 – Resolution 305 Supporting an opt-Out Organ, Eye, and Tissue Donation System in Texas (Tabled Res 319 2020)

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

7. Committee on Child and Adolescent Health Report 2 – Recommendations for Updating Texas Medical Association Teenage Sexual Health Guidelines, Resolution 304, and Supporting Comprehensive Sexuality Education Reform, Resolution 329

8. Committee on Infectious Disease Report 1 – Sunset Policy Review

9. Committee on Infectious Disease Report 2 – TMA Immunization Policy

10. Committee on Reproductive, Women's, and Perinatal Health Report 1 – Sunset Policy Review

11. Joint Report 2 – Res. 351 2021 Support of a Statewide Contact Tracing App

12. Joint Report 5 – Designating Texas Hospitals as Sensitive Locations, Resolution 303 (Tabled Res 315 2020)

13. Joint Report 6 – Recommendations for Advocating for the Improvement of Access to Mental Health Services Among Minority Teens, Resolution 302 (Tabled Res 311 2021)

14. Joint Report 7 – Resolution 313 2021: Elimination of Human Abuse and Persecution (Tabled Res 302 2020)

15. Resolution 301 – Ensuring that Health-Related Public Policies Are Scientifically Based and Physician Driven

16. Resolution 302 – Advocating for the Diagnosis, Treatment and Follow-up Documentation of Eradication to Prevent Helicobacter Pylori from Leading to Gastric Cancer

17. Resolution 303 – Reducing Processed Foods and Increasing Whole Foods in School Meals

18. Resolution 304 – Disaggregation of Data Within the AAPI Ethnic Community and Respective Subgroups

19. Resolution 305 – Creation of Standards through Consensus for Future Public Health Emergency Preparedness

20. Resolution 306 – Declassifying Testosterone as a Controlled Substance

21. Resolution 307 – Personal Autonomy for Individual Vaccination

22. Resolution 308 – Personal Autonomy for Physician Vaccination

23. Resolution 309 – Asking the State Board of Education to Update Sexual Health Education Guidelines in Texas K-12 Public Schools

24. Resolution 310 – Hepatitis B Screening and Treatment Among AAPI Community

25. Resolution 311 – Gun Safety Education in Schools

26. Resolution 312 – Hemp-Derived THC Product Safety Regulation

27. Resolution 313 – Corneal Donor Deferral Criteria

28. Resolution 314 – Strengthening TMA Policy on the Implementation of Syringe Services Programs

29. Resolution 315 – Mental Healthcare Among AAPI Community

30. Resolution 316 – Addressing Suicide Risk In Youth

31. Resolution 317 – Banning Conversion Therapy in the State of Texas

32. Resolution 318 – Supporting Transgender Youth Participation in Sports

33. Resolution 319 – Improving the Efficiency of the TxEVER System

34. Resolution 320 – Addressing the Impact of Abortion Restrictions in Texas

35. Resolution 321 – Recognizing People With Disabilities as a Health Disparity Population

36. Resolution 322 – Increasing Autonomy of Adolescent Pediatric Cancer Patients

37. Resolution 323 – Psychiatric Services for Pediatric Patients

38. Resolution 324 – Encourage Equitable Access to Medication for Opioid Use Disorder

39. *Resolution 325 – Medical Homes for Political Asylum Seekers*

Supplement

REPORT OF BOARD OF TRUSTEES

BOT Report 11 2022

Subject: Addressing Racism in Medicine

Presented by: Rick W. Snyder II, MD, Chair, Board of Trustees

Referred to: Reference Committee on Science and Public Health

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During the past year, the United States has experienced a resurgence in awareness of the role racism plays in our nation. Following the death of George Floyd, many associations, corporations, and institutions began to confront the issue of institutional racism. Many organizations have broadened their discussion to include the topics of equity, diversity, inclusion, and racism. Health care organizations have begun to discuss these issues as a public health crisis. The role of racism in health care, and more specifically in the practice of medicine in Texas, is a growing interest among members of our association.

In April 2021, the Texas Medical Association Board of Trustees formed a special task force on Equity, Diversity, Inclusion, and Racism to inform the board and provide recommendations for future work. The specific charge of the task force is to study, report, and recommend actions to mitigate the effects of racism, inequality, and lack of diversity and inclusion in two primary areas:

1. The effects of the lack of equality, diversity, and inclusion, and the presence of racism, in the health care setting on the public health of patients in Texas and what role physicians can play to mitigate disparities, inequities, and other related concerns.
2. The establishment of a code of conduct for internal use within the House of Delegates; TMA councils, committees, and task forces; and all other member experiences with TMA.

At the 2021 TMA House of Delegates annual session, the house adopted the following four resolutions, which were then assigned to the board for implementation. The board assigned them to the task force:

- Resolution 205 – Skin of Color Representation in Medical Education and Research;
- Resolution 330 – In Support of Reevaluating the Use of Race in Estimated Glomerular Filtration;
- Resolution 331 – Support for Increasing Digital Access; and
- Resolution 339 – Support for the Texas Department of State Health Services Efforts to Address Racial and Ethnic Disparities in Health.

Further, the house referred the following three resolutions for study to the board for report back with recommendations at TexMed 2022. The board then referred these resolutions to the task force, with a report back at the board's March meeting:

- Resolution 334 – Racism as a Public Health Issue;
- Resolution 345 – TMA Statement on the Health Impact of Racism; and
- Resolution 354 – Addressing Race in Medicine.

TMA Task Force on Diversity, Equity, Inclusion, and Racism

The task force was assembled in late October 2021 and began meeting in November 2021 to discuss, deliberate, and prepare this report for TexMed 2022 with recommendations for the creation of new house policy.

Members of the task force held numerous meetings with thoughtful, passionate, insightful, and pragmatic discourse. Several members noted the active work of their specialty societies and the American Medical Association. To best capture the entirety of the task force's charge and work product, the word "racism" was dropped and substituted with the word "justice." For convenience, the task force renamed itself the "JEDI" Task Force, and that language will be used going forward in this report.

The TMA JEDI Task Force understood the vast nature of the charge and decided to begin by reviewing all of the resolutions against existing TMA policy on diversity, equity, inclusion, and racism. The four adopted resolutions (205, 330, 331, and 339) were supported and added to the TMA policy compendium as follows:

- Resolution 205 is TMA Policy 200.065 Skin of Color Representation in Medical Education and Research.
- Resolution 330 is TMA Policy 260.124 Reevaluating the Use of Race in Estimated Glomerular Filtration Rate.
- Resolution 331 is TMA Policy 275.007 Support for Increasing Digital Access.
- Resolution 339 is TMA Policy 260.126 Support for the Texas Department of State Health Services Efforts to Address Racial and Ethnic Disparities in Health.

During this review, it was clear that TMA had no existing policy on racism. Resolutions 334, 345, and 354 required study and recommendations by the task force and called for policy development on racism and for TMA to make an official statement on racism. The JEDI Task Force made these three resolutions the initial scope of its work and formed three subcommittees to study and make recommendations for each resolution, and those recommendations are described later in this report. To improve clarity, the task force decided to combine the subcommittee reports on 334, 345, and 354 into this single report and offer six recommendations for policy consideration.

The second charge called for the JEDI Task Force to establish a code of conduct for internal use within the House of Delegates and other organizational bodies within TMA. The task force worked with the TMA Office of General Counsel to evaluate the existing code of conduct policies and potentially expand the authority of the Board of Councilors to address such matters.

Based on house and board feedback from the initial work, the JEDI Task Force is committed to meeting throughout 2022 and into 2023 to focus on additional opportunities within its scope. To carry out this charge, the board approved extending the time frame of the task force for an additional year.

The JEDI Task Force acknowledges the timely and essential opportunity TMA leadership has provided to work in the space of health equity and racism and commits to the production of robust, evidence-based work products to assist our members.

Resolution 334 – Racism as a Public Health Issue

Resolution 334 by the Medical Student Section was referred to the JEDI Task Force for study and report back at TexMed 2022. The specific language of the resolution states:

RESOLVED, That our Texas Medical Association acknowledge that systemic and structural racism within the health care system has caused and continues to cause health inequity that harms marginalized communities; and be it further

RESOLVED, That TMA recognize racism, in its systemic, cultural, interpersonal, and other forms, poses a threat to public health, the advancement of health equity, and the delivery of appropriate medical care; and be it further

RESOLVED, That TMA support resource development for health care institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, physicians, providers, and populations.

The resolution authors made the following select points:

- Institutional racism is defined as policies, rules, practices, and the like that have become a usual part of the way an organization or society works and that result in and support a continued unfair advantage to some people and unfair or harmful treatment of others based on race.
- After controlling for socioeconomic differences, race and ethnicity remain predictors of the quality of health care patients receive, and individuals from racial minority groups consistently experience worse health outcomes.

TMA Work Related to Racism

The impact of racism on health has been well documented in research and recognized by organized medicine. TMA has worked in the space of nondiscrimination, diversity, and inclusion through policy development, advocacy, and support of underrepresented Texas physicians and their patients. TMA has a strong, established policy rejecting discrimination (see Related TMA Policy) as well as a policy on addressing cancer health disparities, recognizing "racial/ethnic, socioeconomic, and geographic cancer health disparities as public health issues." However, racial-related disparities are not isolated to cancer patients.

Racism is an indisputable part of American history, including the history of Texas medicine. TMA has created prior work in this space, as demonstrated by "Courage and Determination: A History of African American Physicians," which maps out the racism and adversity met and overcome by both Black physicians and patients through history.

In the past, Black physicians were denied the ability to fully practice medicine or join medical associations, just as Black patients have historically been denied equal medical care and treatment. In TMA's building lobby, there is an automated display showing the timeline of when new special interest sections were created, including the Lone Star Medical Association for Black physicians, sections for international medical graduate physicians and women physicians, and the LGBTQ Health Section – all in direct response to the changing cultural environment and the need to include physicians who have been previously excluded.

As TMA moves forward in working in this space of diversity, equity, inclusion, and justice, the association's overall vision to "improve the health of all Texans" should be a central and resonating priority. This priority must be explicitly embedded in TMA's strategic planning process and communications.

National Specialty Organizations' Policies on Racism and Racism as a Public Health Issue

The JEDI Task Force recognizes the extensive work previously done in this space by organized medicine groups. The task force was determined not to ingeminate prior work or blindly accept other societies' conclusions. The task force has compiled, compared, and discussed the policies on racism and racism as a public health issue from the following select national health organizations:

• American Medical Association;
• American Public Health Association;
• American Academy of Pediatrics;
• American Academy of Family Physicians;
• American College of Physicians;
• American College of Emergency Physicians;
• American College of Cardiology;
• American College of Obstetricians and Gynecologists; and
• Society for Adolescent Health and Medicine.

During its deliberations, the JEDI Task Force agreed with Resolution 334 and the charge to TMA: to acknowledge the impact of racism on health and support policy, resource development, and advocacy to mitigate the effects of racism on health. A statement on racism and future policy development work is recommended and can be found in the recommendation section of this report. Should the house adopt this statement, the TMA Board of Trustees will work with the JEDI Task Force and appropriate councils to undertake a strategic commitment to address and mitigate the impact racism has on medical and residency training, the practice of medicine, and the health outcomes of our patients.

Resolution 345 – TMA Statement on the Health Impact of Racism

Resolution 345 by the Harris County Medical Society was referred to the JEDI Task Force for study and report back at TexMed 2022. The specific language of the resolution states:

> RESOLVED, That the Texas Medical Association develop an Official Statement on Racism; and be it further
>
> RESOLVED, That comprehensive policy be developed to support the statement and ensure that anti-racism and health equity strategies are prioritized for inclusion in organizational, educational, and advocacy activities; and be it further
>
> RESOLVED, that TMA support identifying racism as a public health emergency.

Harris County Medical Society authored Resolution 345 and made the following points as part of the resolution.

- African Americans experience the highest rates of mortality from heart disease, cancer, cerebrovascular disease, pregnancy-related conditions, and HIV/AIDS among all U.S. racial or ethnic groups.
- The social determinants of health, defined simply as the environmental and structural impacts of where one is born, educated, lives, and works, have significant impact on health and well-being.
- A history of structural or institutional racism, defined as differential access to the goods, services, and opportunities of society based on race, has resulted in shortened life expectancies and 10 times lower household net worth for non-Hispanic Black people in comparison with non-Hispanic white people.

- Multiple organizations including the American Medical Association, the American Academy of Family Physicians, and the American College of Obstetricians and Gynecologists have published official statements on racism.

Background

In its discussion and study of Resolution 345, the task force realized the serious and urgent nature that racism has on health. In our comprehensive review of existing TMA policy on health equity, anti-discrimination, and inclusion, we found no policy explicitly dealing with racism. We also examined national specialty society statements on racism, which are included in the appendix of this report.

TMA's vision statement is to "improve the health of all Texans." To fully achieve this vision, TMA must have an official statement on racism. Moreover, TMA's mission statement, "TMA stands up for Texas physicians by providing distinctive solutions to the challenges they encounter in the care of patients," further supports the need for comprehensive policy development on racism and its impact on patient health outcomes. To remain relevant to both physicians and patients, TMA must undertake a deeper understanding of the culture within medicine and fully represent a more diverse physician workforce and patient populations.

Future policy development on racism will require an enduring, long-term strategic and organizational commitment. Social determinants of health are far beyond the physicians' control but directly impact clinical practice. Striking a balance on advocacy priorities includes attention to scope of practice, prior authorizations, and issues that directly affect social determinants of health like Medicaid expansion.

The COVID-19 pandemic has dramatically demonstrated unequal access to health care and adverse health outcomes for many low-income communities of color. Studies have shown that while COVID-19 may be an equal opportunity disease, African Americans and Hispanics face significantly higher mortality rates in Texas. Unfortunately, social determinant inequities frequently relegate health care to a lower priority for the patient due to more immediate living concerns.[6]

To ensure the future success of TMA in its charge, the JEDI Task Force recommends formal Board of Trustees and TMA leadership strategic planning that includes a meaningful discussion of the issues defined in this report. The work of this task force and the policies adopted by the house must be embedded into our membership experience to maintain our relevance for the next generation of physicians. We must engage in the national-, specialty-, and state-society conversations and policy work that recognize the harmful effect all forms of racism have on our members and the health of our patients.

To fully represent and advocate on behalf of our 56,000 members, data are needed to understand how physicians feel on issues of social advocacy and legislative priorities. The task force recommends that TMA conduct a membership survey to understand the member expectations of TMA better. Future research will be essential in developing future communications, targeted programming, and effective advocacy.

Discussion and Recommendations

During its deliberations, the JEDI Task Force agreed with Resolution 345 and its charge to develop an official statement on racism. As outlined above, in response to Resolution 334, the task force agreed to author an official statement on racism, specifically in recommendation 1.

Resolution 345 also calls for a comprehensive policy on anti-racism and health equity strategies for inclusion in TMA's organizational, educational, and advocacy activities. The JEDI Task Force views attention to anti-racism and evidenced-based strategies for addressing health disparities as fundamental to

policy development and advocacy. Organizational, cultural, and leadership commitment to anti-racism and health equity should be guiding principles for TMA.

Lastly, the task force did not recommend the adoption of the language calling racism a "public health emergency" as called for in Resolution 345. The word "emergency" was thoughtfully debated. The word "emergency" means sudden and usually unexpected, requiring immediate attention. However, the task force favors a longer-term strategic and organizational commitment to addressing racism in medicine. Thus the task force recommended substituting the words "serious" and "urgent" and also included the terms "unacceptable" and "crises" to provide additional gravity to the problem.

Resolution 354 Addressing Race in Medicine

Resolution 354, authored by the Medical Student Section, was referred to the JEDI Task Force for study and report back at TexMed 2022. The specific language of the resolution states:

> RESOLVED, That our Texas Medical Association support the development of curriculum in Texas medical schools that addresses the history of race in medicine and its present-day effects for minority groups including but not limited to Black, Latinx, Indigenous (American Indians and Alaska Natives, Native Hawaiians/Pacific Islanders), and Asian populations; and be it further
>
> RESOLVED, That TMA encourage all members to participate in a continuing medical education program that addresses the history of race in medicine and its present-day effects for minority groups including but not limited to Black, Latinx, Indigenous (American Indians and Alaska Natives, Native Hawaiians/Pacific Islanders), and Asian populations; and be it further
>
> RESOLVED, That TMA create a Committee for Minority Health and Issues to address health disparities among minorities in Texas.

Discussion

In its deliberations, the task force acknowledged the importance of physician and trainee education on the various ways racism can impact their patients' care and health outcomes. Such a multifaceted effort requires physicians to commit to continuous learning on racism and health equity throughout their careers, from medical school into their practice. While the Liaison Committee on Medical Education requires an active curriculum in cultural competence and health care disparities, it does not require explicit content on racism and its impact on the health of society. The Texas Medical Board also does not require physician education on the health care impact of culturally insensitive bias.

The task force recognizes that TMA does not have the authority to mandate medical school curricular content nor the manner of instruction. However, the task force fully supports this type of education to improve the health of all Texans.

After careful discussion, the JEDI Task Force agrees with the first two resolves of Resolution 354 and the request to TMA to support the development of a curriculum in Texas medical schools addressing the history of race in medicine and its present-day effects on historically marginalized ethnic groups. The task force also supports the request to TMA that members be encouraged to participate in CME that addresses the same topics. However, the task force would like to point out that the verbiage of the resolves in the resolution does appear to conflate racial and ethnic groups. Both race and ethnicity are social constructs, but the two terms are not interchangeable. Race is indicative of one's outward, phenotypic appearance and cannot be easily hidden. Ethnicity is indicative of culture in a particular geographic region. Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or other Pacific Islander are the standardized racial categories used by U.S. Census Bureau.[10]

The Task Force disagrees with creating a Committee for Minority Health and Issues as it believes the expertise to address health disparities among historically marginalized ethnic groups in Texas can be accessed by leveraging already existing TMA councils and committees in addition to the future work of the JEDI Task Force. The task force agrees that the lens of diversity, equity, inclusion, and justice should be applied to all levels of TMA's work.

Consideration of racism and health equity issues will always be germane to future comprehensive policy work and meaningful advocacy for our patients.

Code of Conduct

The board approved the JEDI Task Force's plan to establish a code of conduct for internal use within the House of Delegates and within TMA. The task force worked with the TMA Office of General Counsel to evaluate the existing code of conduct policies and potentially expand the authority of the Board of Councilors to address such matters. The board approved the JEDI Task Force's plan to obtain input from the TMA board, councils, and committees, and house delegation caucuses. The board discussed the possibility of conducting a forum at the 2023 TMA Winter Conference to allow the opportunity for leaders to provide additional input on the draft code of conduct, with the potential for final approval from the House of Delegates at TexMed 2023.

Recommendations

After thoughtful and considerable deliberation and discussion, the TMA Board of Trustees recommends the adoption of the following in lieu of adopting resolutions 334, 345, and 354.

Recommendation 1: That the Texas Medical Association recognize that racism is one of many social determinants of health that has a profound impact on the health of our patients and the practice of medicine in Texas.

Recommendation 2: That TMA recognize that implicit and explicit biases exist in medicine and that evidence-based strategies to address these biases are necessary to improve our understanding and treatment of all patients.

Recommendation 3: That our TMA acknowledge that racism, in its systemic, cultural, interpersonal, and other forms, is unacceptable, and is a crisis that creates a serious and urgent threat to public health.

Recommendation 4: That TMA commit to anti-discrimination, inclusion, and health equity as essential principles for future policy development, physician education, and advocacy on behalf of our members and our patients.

Recommendation 5: That the Task Force on Justice, Equity, Diversity, and Inclusion collaborate with the Council on Medical Education to survey Texas medical schools to identify the current curriculum being taught to students to address the history and impact of race in medicine and its role in perpetuating health disparities, with a written summary of the findings produced as a deliverable.

Recommendation 6: That the Task Force on Justice, Equity, Diversity, and Inclusion research materials to create a Texas-physician-tailored resource webpage that addresses marginalized and at-risk population bias, cultural sensitivity training, treatment bias, and the promotion of evidence-based practices for combating health care disparities that emerge.

Related TMA Policy:
50.012 Addressing Cancer Health Disparities
60.008 Rejection of Discrimination

References:

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Task Force on Equity, Diversity, Inclusion, and Racism
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Ronald Rodriguez, MD, PhD
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Appendix A: Select National Specialty Organizations' Policies on Racism and Racism as a Public Health Issue

American Medical Association

- Racism as a Public Health Threat H-65.952
- Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions H-65.951
- Racial Essentialism in Medicine D-350.981
- Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984
- Policing Reform H-65.954
- Health Plan Initiatives Addressing Social Determinants of Health H-165.822

American Public Health Association

- Racism is an ongoing public health crisis that needs our attention now
  "Racism is a longstanding systemic structure in this country that must be dismantled, through brutally honest conversations, policy changes and practices. Racism attacks people's physical and mental health. And racism is an ongoing public health crisis that needs our attention now! We see discrimination every day in all aspects of life, including housing, education, the criminal justice system and employment. And it is amplified during this pandemic as communities of color face inequities in everything from a greater burden of COVID-19 cases to less access to testing, treatment and care."
- Analysis: Declarations of Racism as a Public Health Crisis
  - Harris County Commission
  - Dallas County Commissioners
  - San Antonio City Council
  - Austin City Council
- Racial Equity & Public Health fact sheet
- Letter from APHA to the House of Representatives in support of H.R. 1280, the George Floyd Justice in Policing Act of 2021 (PDF)
- Letter to President-Elect Joe Biden urging swift repeal of ban on trainings that address racial and sex stereotyping (PDF)
- What Is Racism?

American Academy of Pediatrics

- The Impact of Racism on Child and Adolescent Health
  "The American Academy of Pediatrics is committed to addressing the factors that affect child and adolescent health with a focus on issues that may leave some children more vulnerable than others. Racism is a social determinant of health that has a profound impact on the health status of children, adolescents, emerging adults, and their families. Although progress has been made toward racial equality and equity, the evidence to support the continued negative impact of racism on health and well-being through implicit and explicit biases, institutional structures, and interpersonal relationships is clear. The objective of this policy statement is to provide an evidence-based document focused on the role of racism in child and adolescent development and health outcomes. By acknowledging the role of racism in child and adolescent health, pediatricians and other pediatric health professionals will be able to proactively engage in strategies to optimize clinical care, workforce development, professional education, systems engagement, and research in a manner designed to reduce the health

effects of structural, personally mediated, and internalized racism and improve the health and well-being of all children, adolescents, emerging adults, and their families."

- Poverty and Child Health in the United States
- Race, Ethnicity, and Socioeconomic Status in Research on Child Health
- Immunizing Against Hate: Overcoming Asian American and Pacific Islander Racism

American Academy of Family Physicians

- AAFP Policy Statement on Institutional Racism in the Health Care System
  "The AAFP opposes all forms of institutional racism and supports family physicians to actively work to dismantle racist and discriminatory practices and policies in their organizations and communities."
- AAFP Statement Condemning All Forms of Racism

American College of Physicians

- **Where ACP stands**:
  "The American College of Physicians is committed to combatting racial disparities that affect health and health care. This includes fighting the prejudice at the root of the problem, as well as the discrimination, inequities, violence and hate crimes that result from that prejudice. Racial disparities, discrimination, harassment and violence are public health issues. Evidence-based solutions are needed to combat the stressors that disproportionately harm racial and ethnic communities."

- **Policies:**
  - The American College of Physicians' Commitment to Being an Anti-Racist, Diverse, Equitable, and Inclusive Organization 2020
  - Racism and Health in the United States: A Policy Statement from the American College of Physicians 2020
  - Position Statement on Recognizing Hate Crimes as a Public Health Issue 2017

- **Policy and Position Papers:**
  - A Comprehensive Policy Framework to Understand and Address Disparities and Discrimination in Health and Health Care (2021)
  - Understanding and Addressing Disparities and Discrimination in Education and in the Physician Workforce (2021)
  - Understanding and Addressing Disparities and Discrimination Affecting the Health and Health Care of Persons and Populations at Highest Risk (2021)
  - Understanding and Addressing Disparities and Discrimination in Law Enforcement and Criminal Justice Affecting the Health of At-Risk Persons and Populations (2021)
  - President's Messages, Videos, and Advocacy Efforts

American College of Emergency Physicians

- ACEP Policy Statement on Non-Discrimination and Harassment
  The American College of Emergency Physicians (ACEP) acknowledges that implicit and explicit biases, attitudes, or stereotypes affect our understanding, actions, and decisions. These factors are further magnified in the emergency department where cognitive load, rapid and abbreviated interactions, and high stress can leave patients and staff vulnerable to pre-conceived notions and biases. In order to reduce biases and improve health equity, it is crucial to be mindful of their pervasiveness and to employ critical reflection, training, and education geared to address and disarm them. ACEP advocates for the respect and dignity of each individual, opposes all forms of discrimination and harassment, and supports anti-discrimination and anti-harassment practices

protected by local, state, or federal law. Discrimination and harassment may be based on, but are not limited to, an individual's race, age, religion, creed, color, ancestry, citizenship, national or ethnic origin, language preference, immigration status, disability, medical condition, military, or veteran status, social or socioeconomic status or condition, sex, gender identity or expression, or sexual orientation.

- ACEP Racial Inequities Response

American College of Cardiology

- ACC Denouncement of Racism
- ACC Diversity and Inclusion principles
- ACCs Commitment to Diversity and Inclusion
- A Message from the ACC Diversity and Inclusion Task Force
- Health Equity Resource Center
- Anti-Racism Resource Center

American Psychology Association

- 'We Are Living in a Racism Pandemic,' Says APA President

  "We are living in a racism pandemic, which is taking a heavy psychological toll on our African American citizens. The health consequences are dire. Racism is associated with a host of psychological consequences, including depression, anxiety and other serious, sometimes debilitating conditions, including post-traumatic stress disorder and substance use disorders. Moreover, the stress caused by racism can contribute to the development of cardiovascular and other physical diseases."
- Racism, bias, and discrimination resources
- Perceived Racism May Impact Black Americans' Mental Health
- APA apologizes for longstanding contributions to systemic racism
- Guidelines, Policy Statements and Resolutions

American College of Obstetricians and Gynecologists

- Joint Statement: Collective Action Addressing Racism
- Commitment on Changing Racism

Society of Adolescent Health and Medicine

- SAHM Urges Organizations and Health Professionals to Address Racism - Press Release
- Promoting Equity and Inclusion in Adolescent Medicine - Advocacy Activity
- SAHM Anti-Racism Toolkit

Supplement

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 325
2022

Subject: Medical Homes for Political Asylum Seekers

Introduced by: Domalapalli Maneesh Kumar, D.O., Ph.D., FAAP

Referred to: Reference Committee on Science and Public Health

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Whereas, There is a lack of a sustained and systematic method to efficiently provide quality health care for international political refugees while they await resolution of their asylum status; and

Whereas, Political refugees often have been suffering from harsh conditions in their abandoned country, requiring a more coordinated course of treatment; and

Whereas, While their status is pending, Afghan and Ukrainian political asylum seekers are not eligible for government health care coverage such as Medicaid, Medicare or the ACA Marketplace plans which creates the need for this emergency resolution; and

Whereas, The lack of coverage forces community refugee agencies independently to reach out to their contacts within the local medical community to provide charity care; and

Whereas, Political refugees are forced to accept a patchwork of services that depend on local circumstances and the resources of local medical organizations; therefore be it

RESOLVED, That the Texas Medical Association work with the Texas Legislature to develop a state program that provides medical homes for Afghan and Ukrainian political asylum seekers until their asylum status is approved and they have governmental heath care coverage; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association submit a similar resolution to the AMA House of Delegates that addresses this as a national problem.

AGENDA
REFERENCE COMMITTEE ON SOCIOECONOMICS
Friday April 29, 2022

1. *Board of Trustees Report 16 – Enactment of a Policy Framework on Health Insurance Design*

2. Council on Socioeconomics Report 1 – Sunset Policy Review

3. Council on Socioeconomics Report 2 – Adoption of Principles of Physician Value-Based Decisionmaking in Medical Practice and Professionalism

4. Council on Socioeconomics Report 3 – Resolution 107 2021 Utilization Review, Medical Necessity Determination, Prior Authorization Decisions

5. Council on Socioeconomics Report 4 – Res. 405 2021 – Ensuring Medical Practice Viability Through Reallocation of Insurance Savings During the COVID-19 Pandemic Care

6. Council on Socioeconomics Report 5 – Improving Coverage and Access for Breast and Cervical Cancer Treatment

7. Council on Socioeconomics Report 6 – Improving Patient's Physical Health by Addressing Oral Health

8. Committee on Health Information Technology 1 – Sunset Policy Review

9. Committee on Health Information Technology 2 – Amend Texas Medical Association Policy 118.002

10. Committee on Health Information Technology 3 – New Policy; Diagnosis Codes on Prescriptions

11. Committee on Health Information Technology 4 – Unique Patient Identifier, New Policy

12. Joint Report 1 – Paid Sick Leave

13. Joint Report 3 – Paid Parental Leave (Res. 430 2021)

14. Joint Report 4 – Ensuring That Telehealth Coverage Does Not Discourage Use of Local Physicians

15. Joint Report 8 – Augmented Intelligence in Health Care, Resolution 421 2021

16. Resolution 401 – COVID-19 Economic Injury Disaster Loan (EIDL) Forgiveness for Physician Groups of Five or Less

17. Resolution 402 – Study the Creation of a Physician Sponsored and Administered Health Insurance Program in the State of Texas

18. Resolution 403 – Disclosure of Prescription Drug Prices

19. Resolution 404 – Pharmacies Adhering to Patient Wishes to Transfer Prescriptions

20. Resolution 405 – Compensation to Physicians for Authorizations and Pre-authorizations

21. Resolution 406 – Improving Medicaid Access with Reasonable Payment for Physician Services

22. Resolution 407 – Telemedicine Evaluation and Management Services Equivalence

23. Resolution 408 – Federal Funding to Expand Medicaid and Improve Access to Care

24. Resolution 409 – Geographic Practice Cost Index (GPCI) Values in Texas

25. Resolution 410 – Fair Compensation for Physician Services Rendered to Medicare and Medicaid Dual Eligible Patients

26. Resolution 411 – State of Texas Should Pay the Cost of Electronic Prescription of Controlled Substances and Compensate for Time Spent Engaging the Texas Prescription Monitoring Program

27. Resolution 412 – Supporting the Use of Artificial Intelligence for Preventative and Early Detection Health

28. Resolution 413 – Support the Auto-Enrollment of Former Foster Care Children into Qualifying Healthcare Programs

29. Resolution 414 – Eradicating Gender Discrimination in Reimbursement

30. Resolution 415 – Amend TMA Policy 245.023 Equal Pay for Equal Work

31. Resolution 416 – Hospital Transfer Diversion Mitigation and EMTALA Preservation

32. Resolution 417 – Increasing Medicaid Reimbursement Rates for Physicians Practicing in Health Professional Shortage Areas

33. Resolution 418 – Medicaid Hearing, Vision, and Dental Coverage

34. Resolution 419 – Payment for Physicians Who Practice Street Medicine

35. Resolution 420 – Creation of a Self-Funded Physician Institute for Public Health and Healthcare Policy Education

36. Resolution 421 – Strengthening Protections Against Government Interference in the Practice of Medicine

37. Resolution 422 – Texas Health and Human Services audit policy is preventing Physicians' Right of Due Process

38. Resolution 423 – Mandating Price Transparency in Hospitals

39. Resolution 424 – Site Neutral Payment Policies

Supplement

REPORT OF THE BOARD OF TRUSTEES

BOT Report 16 2022

Subject: Enactment of a Policy Framework on Health Insurance Design

Introduced by: Rick Snyder, MD, Chair, Board of Trustees

Referred to: Reference Committee on Socioeconomics

In February 2021, the Texas Medical Association Board of Trustees established the Task Force on Health Care Coverage, charged with identifying short- and long-range solutions and strategic collaborations to achieve organized medicine's objectives for making health care more accessible, affordable, equitable, quality-focused, and patient-centered.

During the 2021 legislative session, the task force's work contributed to the enactment of important legislation relating to coverage, costs, and quality, including legislation to establish a new all-payer claims database and improve health care coverage for postpartum women and children.

During the legislative interim, the task force subdivided into three workgroups:

- Workgroup 1: Accountable Care Delivery Systems;
- Workgroup 2: Private and Public Sector Coverage Solutions; and
- Workgroup 3: Health Care Affordability, Outcomes, and Equity.

Each workgroup developed a plan to guide its work during the legislative interim, but in light of the delta and omicron COVID-19 surges, the co-chairs of each workgroup suspended most calls during the late fall and winter to allow members to focus on their patients, families, and personal health. However, in recent weeks, workgroup calls have resumed, and each is eager to move forward with recommendations to fulfill their respective charges. To that end, the Board of Trustees recently approved reauthorizing the task force for another year.

The long-range goals on which the workgroups will focus are :

- Advance physician-led strategies to constrain health care costs via improved population health, promotion of collaborative care models, and reductions in administrative waste;
- Promote legislative and regulatory initiatives to decrease rates of uninsured and underinsured using both private- and public-sector strategies to increase health care coverage;
- Pursue regulatory strategies to reduce health care insurance premiums and costs for both patients and payers;
- Promote physician-led, value-based payment initiatives among private and public payers;
- Broaden the state's safety-net system by implementing community-based accountable care initiatives inclusive of all practices and entities committed to serving low-wealth communities;
- Collaborate with state agencies; health care payers, including the Employees Retirement System of Texas and Teacher Retirement System of Texas; employers; and community-based hospitals and health systems to reimagine health care delivery using accountable care models; and
- Increase utilization of high-value primary care services and interventions, the bedrock of cost-effective health systems.

This report presents initial recommendations from the task force, which focused its initial efforts on reviewing TMA policy to identify potential gaps relating to the affordability and quality of private health insurance products, particularly unregulated "alternative benefit plans" (ABPs), and to develop recommendations to improve accountability and transparency of these products.

Discussion

TMA has extensive policy addressing health insurance, health care coverage, and health system reform (see Appendix 2 – TMA Policy for list of policies). Yet, like an old house onto which new rooms have been added over the years, these policies often lack consistency and a cohesive policy objective, potentially leading to inadvertent mixed messages to TMA members and policymakers. In other cases, policies contradict each other. For example, TMA Policy 145.003 Mandated Coverage, reaffirmed in 2013, calls for TMA to support "a moratorium on mandated coverage until a more comprehensive understanding of its impact on health care costs can be achieved," while Policy 260.029 Preventive Medicine, reaffirmed in 2014, supports mandated coverage for clinically effective preventive health services.

Moreover, many policies originated during the Clinton administration or in response to the Affordable Care Act. While policies have subsequently been reaffirmed in the intervening years, several policies may no longer accurately reflect physicians' rapidly changing or nuanced views on health insurance design and benefits or TMA's efforts to promote health plan accountability. Take, for instance, the debate over the sale of "catastrophic-only" health plans versus plans with more comprehensive coverage. TMA policy supports legislation allowing insurers to "sell no-frills, catastrophic group insurance not subject to state-mandated benefits, premium taxes, risk pool assessments, and other costly regulations." However, TMA policy also supports health plan regulation, including TMA's hard-won patient protections on network adequacy, prompt payment, independent utilization reviews, expedited credentialing, preventive health care services, and so forth.

According to the Texas Department of Insurance (TDI), alternative benefit plans, also referred to as alternative health benefit plans, are ones that "may not be regulated by the state, and they don't have to follow federal Affordable Care Act (ACA) rules." Examples of ABPs include short-term benefit plans, limited-benefit plans, and health-sharing ministries, among others, though TDI – and TMA – does not include direct primary care in the definition. In 2021, lawmakers introduced legislation to establish two new types of alternative health plans, the "Farm Bureau bill" and the Texas Mutual Health Plan. Statutorily, neither will be considered in the business of insurance and will be exempt from many state regulations, though the Farm Bureau bill does require compliance with some consumer and physician protections, including the surprise billing law (see Appendix 1 for a summary of both bills).
The Farm Bureau plan exempts coverage of preexisting conditions for the first six months and requires the plan to clearly disclose this limitation, while the Texas Mutual Health plan is not required to cover them. However, issuers of the plans can choose to incorporate such coverage and other consumer protections. Supporters argue the plans will provide employers and patients more affordable health insurance options, a very worthy goal. However, opponents raised concerns about the potential for patients to buy a product that provides limited value.

Given TMA's conflicting policies on health plan benefit design and concerns raised by the task force about the potential impact of the bills on patients and physicians, the Council on Legislation remained neutral. Yet, in the end, the lack of clear TMA policy meant both bills passed without the benefit of TMA's expertise.

No doubt, any discussion of health insurance design necessitates a discussion of tradeoffs between affordability and coverage. Health plans with better benefits cost more, making them out of reach for many low-income Texans. This, in turn, contributes to higher rates of uninsured. Likewise, more people can afford no-frills and/or high-deductible health plans, which provide protection from medical bankruptcy in the event of a catastrophic illness or injury but often at the expense of higher out-of-pocket costs for routine services.

According to the Kaiser Family Foundation, in 2020, "nearly half (46%) of insured adults report difficulty affording their out-of-pocket costs, and one in four (27%) report difficulty affording their deductible." To cope with these costs, many patients resort to delaying or skipping services or medications, potentially increasing costs elsewhere. Additionally, while these plans are affordable on their face, they may inadvertently contribute to health inequality because they do not provide coverage for routine, preventive, and primary care. That is why some employers pay the deductible on behalf of employees with lower incomes or exempt vital services from deductibles, including preventive and primary care and vital medications, so that employees do not skip essential health care services.

The proliferation of very-high-deductible plans also undermines TMA efforts to promote and strengthen primary care and contributes to financial uncertainty for physicians in all specialties. When patients skip outpatient care to avoid paying high out-of-pocket costs, if they do get sick and cannot meet the deductible, physicians may end up with more uncompensated care, a cost many practices cannot absorb in today's tight fiscal environment. Additionally, these plans may present a "moral hazard" wherein physicians can recommend a treatment regimen, but their patients have no means to follow it because the high deductible leaves them effectively uninsured.

Any health plan benefit design ultimately requires tradeoffs – decisions well-informed patients should be able to evaluate for themselves. In the 13 years since enactment of the Affordable Care Act, physicians and patients have come to expect at least minimum guardrails to prevent the sale of "junk" health plans, yet TMA policy does not clearly reflect this concern. The task force acknowledges that TMA policy cannot address every contingency because of the dynamic nature of the state and national health care landscape. Moreover, policy quickly becomes stale due to these rapid changes. However, the task force also believes TMA would benefit from a methodical, comprehensive review of its health insurance-related policies to develop a more consistent and organized policy framework that reflects the needs of patients and physicians. While TMA conducts a sunset review of all policies at least once every 10 years, related policies are not usually assessed at the same time, meaning the reviewing council may not have the full picture of other related policies.

Such a task will take time and would be best conducted by a cross-council initiative, either under the auspices of the board, another TMA policymaking body, or the task force. In the meantime, the task force also believes TMA should establish a policy framework that will inform TMA's regulatory and legislative advocacy initiatives regarding alternative and high-deductible health benefit plans.

Recommendation 1: That Texas Medical Association House of Delegates authorize the Board of Trustees to convene a cross-council ad hoc workgroup to conduct a methodical, comprehensive review of the association's health insurance-related policies with the goal of developing a consistent, cohesive policy framework and objectives that reflect the needs of patients and physicians. By engaging multiple councils in the review at the same time, the association will benefit from input from diverse perspectives.

Recommendation 2: That the recommendations generated from the review be submitted for consideration at the 2023 House of Delegates.

Recommendation 3: That the House of Delegates adopt a framework for evaluating health insurance and benefit design to aid the association's legislative and regulatory advocacy relating to alternative benefit plans during the 2022 legislative interim and 2023 legislative session as follows:

Framework for Evaluating Health Insurance Benefit Design

In the evaluation of legislative or regulatory initiatives regarding refining or establishing new private health insurance options, particularly existing and new alternative benefit plans, TMA should:

- Advocate vigorously in favor of state and federal protections for people with preexisting conditions.
- Support development of health insurance plans that balance affordability with meaningful coverage, including minimum health benefits, excluded from the annual deductible, that will help foster, promote, and maintain enrollees' good health and address health disparities, and that cover:
    - Clinically effective preventive health care and wellness services;
    - Primary care;
    - Outpatient services;
    - Prescription drugs for the prevention or treatment of chronic disease or conditions;
    - Chronic disease management; and
    - Diagnostic and laboratory services.
- Evaluate the merits of each newly proposed mandated benefit for state-regulated health plans based on objective, published data documenting its efficacy and cost-effectiveness. TMA also should consider the proposal's potential to address health disparities.
- Advocate that all alternative health benefit plans adhere to state-mandated consumer and provider protections, including network adequacy standards, prompt payment, mental health parity, independent review of utilization denials, and gold-carding requirements.
- Support robust, easy-to-understand written disclosure requirements for all issuers of alternative health benefit plans regarding exemptions from or limitations on patient, physician, and provider protections, including exclusion of coverage for preexisting conditions.
- Advocate that alternative benefit plans that are not regulated by the Texas Department of Insurance as the business of insurance clearly indicate the lack of regulation on the enrollee's health plan identification card and provide a link to the plan's website describing what standards govern the plan.
- Encourage lawmakers and employers to develop tiered health insurance products that offer sliding-scale deductibles and cost sharing based on an enrollee's ability to pay.
- Support requiring all alternative benefit plans to register with the Texas Department of Insurance to provide regulators, lawmakers, and the public insight as to their prevalence and utilization.
- Require alternative benefit plans to provide consumers a dispute resolution resource and notify them where to file complaints.
- Require alternative benefit plans to report data to the state's all-payer claims database.

Appendix 1
2021 Alternative Health Benefit Plan Legislation

House Bill 3752 – Texas Mutual Insurance Plans

House Bill 3752 allows the Texas Mutual Insurance Company to expand its offerings beyond traditional workers' compensation insurance by acquiring or establishing subsidiaries authorized to offer (1) accident or health insurance coverage in accordance with the current insurance code, or (2) "alternative health benefit coverage" plans. New subsidiaries may not begin offering products prior to Sept. 1, 2023.

The alternative benefit coverage plans may be offered to employers with 250 or fewer employees and individuals. As stipulated within the legislation, any subsidiary offering an alternative health benefit plan will not be subject to state insurance law or regulation, including prompt payment, network adequacy, or mandated benefit requirements, or sold through an insurance company. However, the law specifies that these new plans must "place emphasis on" eight key principles: (1) expanding health insurance competition, (2) adopting innovative strategies to improve health care quality while also lowering costs, (3) ensuring "adequacy" of benefits and access to care for people with preexisting health conditions, (4) preventing discrimination against people with preexisting conditions, (5) leveraging federal tax credits to increase affordability, (6) establishing transparent cost information for purchasers, (7) reducing rate of medical debt for consumers and uncompensated care for physicians and providers, and (8) ensuring equitable costs regardless of gender or against pregnancy. However, the Texas Department of Insurance may not establish rules. As an alternative health benefit plan, the new product also will be exempt from Affordable Care Act regulations.

By Sept. 1, 2022, Texas Mutual must submit a legislative report explaining how any anticipated new health benefit plans will comply with the legislatively required principles.

House Bill 3924 – Farm Bureau Plan

Rep. Tom Oliverson, MD/Sen. Drew Springer
Legislation effective date: Sept. 1, 2021
TMA position: neutral

Note: *As adopted by the House, HB 3924 authorized nonprofit agricultural organizations, i.e. the Farm Bureau, to offer a health benefit plan. However, the Senate attached an amendment that expanded the legislation to require certain insurers to provide notice on balance billing prohibitions and to address out-of-network payment issues. This summary pertains only to the new health benefit plan.*

As authorized by the legislation, on or after Sept. 1, 2021, the Farm Bureau or its affiliate may offer "nonprofit agricultural organization health benefits" to its members and their families that are explicitly exempt from most state insurance laws and regulations, including prompt payment, network adequacy, and mandated benefits. The bill allows the new plan to include a waiting period of six months or less for people with preexisting conditions, defined as "a condition present before the effective date of an individual's enrollment." Furthermore, individuals applying for the coverage must be provided written notice that the product is not an insurance policy or regulated as an insurance entity in this state. Before enrolling in the coverage, the individual must sign and return the notice, a copy of which must be maintained throughout the person's enrollment in the plan and must be made available to the individual upon request. There is no provision requiring the Farm Bureau to include on the health benefit coverage card that the plan may include a waiting period and is not subject to most state health insurance regulation, potentially making it difficult for physicians to differentiate this plan from others.

Appendix 2 – TMA Policy

Primary Care and Preventive Services
260.029 Preventive Medicine
255.004 Patient-Centered Medical Home

Coverage
- 110.009 Health Care Coverage
- 190.032 Medicaid Coverage and Reform

Affordability
- 95.041 Ensuring Patient Access to Affordable Prescription Medications
- 110.002 Cost Effectiveness
- 110.003 Private Individualized Medical Care
- 110.006 Health Plan
- 110.007 Cost Containment
- 110.008 Health Care Costs as Tax Deductible
- 115.016 “A Modest Proposal” to Save our Health Care System
- 120.002 Health System Reform Cost Control
- 145.003 Mandated Coverage
- 145.031 Requirement for Medical Insurance Companies to Provide Online Real-Time Insurance Claim

Adjudication
- 240.001 Geographic Practice Cost Indices (GPCIs)

Social Determinants of Health
- 265.030. Social Determinants of Health

Health and Insurance Plans
- 145.032 Improving Network Adequacy in Health Insurance Plans
- 145.038 Minimum Standards for Interstate Sale of Health Insurance Products
- 120.001 Health Care Reform
- 120.010 Principles for Evaluating Health System Reform
- 145.009 Individual Responsibility for Health Care
- 145.016 Small Employer Health Care Benefit Dscrepancies
- 180.024 Conflict Between Physician Ethics and Health Plan Business Practices
- 235.045 Contracted Health Plans Must Apply the Same Level of Benefits Concerning Patient Responsibility

Other Relevant TMA Policy: Specific Payment Models
265.017 Pay-for-Performance Principles and Guidelines
115.015 Accountable Care Organizations and Value-Based Care Models
115.021 Principles for Community-Based Accountable Care Organizations

Note: *Italicized portions below represent ideas important to the discussion. *Indicates the entire policy is regarded as important to the discussion.*

Primary Care and Preventative Services

260.029 Preventive Medicine

The primary reason to invest in prevention is to promote health, extend life, improve functioning, and prevent suffering. Preventive interventions should be used whenever they produce more health benefit than alternative services. This includes assisting physicians in incorporating disease prevention and health promotion in individual patient and community care.

The Texas Medical Association *supports universal access to clinical preventive services for all Americans* and believes that clinical preventive services of proven effectiveness, delivered in a cost-efficient manner, should be included in insurance benefits.

TMA acknowledges that a portion of morbidity and mortality in this country is related to unhealthy lifestyle choices and endorses efforts to educate, motivate, and encourage individuals to choose behaviors conducive to good health. TMA also acknowledges that the environment of individuals, including workplace, home, community, and socioeconomic status, influence conditions for taking responsibility for health (Council on Public Health, p 107, and Council on Scientific Affairs, p 128, A-94; reaffirmed CSA Rep. 6-A-04; amended CSPH Rep. 2-A-14).

255.004 Patient-Centered Medical Home

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

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

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

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

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

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

Quality and safety are hallmarks of the medical home, meaning (1) practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process

driven by a compassionate, robust partnership among physicians, patients, and the patients' families; (2) evidence-based medicine and clinical decision-support tools guide decision making; (3) physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement; (4) patients actively participate in decision-making, and feedback is sought to ensure patients' expectations are being met; (5) information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication; (6) practices go through a voluntary recognition process by an appropriate nongovernmental entity to demonstrate they have the capabilities to provide patient-centered services consistent with the medical home model; and (7) patients and families participate in quality improvement activities at the practice level.

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

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. It should (1) reflect the value of patient-centered care management work by physicians and nonphysician staff that falls outside of the face-to-face visit; (2) *pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources;* (3) support adoption and use of health information technology for quality improvement; (4) support provision of enhanced communication access such as secure e-mail and telephone consultation; (5) recognize the value of physician work associated with remote monitoring of clinical data using technology; (6) *allow for separate fee-for-service payments for face-to-face visits* (payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits); and (7) recognize case mix differences in the patient population being treated within the practice (SC-MCU Rep. 1-A-08; reaffirmed CM-MHPC Rep. 2-A-18).

Coverage

110.009 Health Care Coverage*

The Texas Medical Association supports tax law reforms which (1) increase the tax-preferenced insurance and spending choices available to patients; (2) encourage individuals to buy insurance and set aside funds for medical needs; (3) provide subsidies to those who are most in need; and (4) encourage personal responsibility and participation of patients in the financing and benefit design decisions that ultimately determine their health benefit coverage. TMA supports efforts to develop viable policies that can improve the provision of care for the uninsured population. If federal standards are relaxed or revised to allow risk rating and coverage exclusions for preexisting conditions, the State of Texas should act immediately to create a new high-risk health insurance pool to provide insurance coverage for individuals who cannot otherwise secure it (CSE Rep. 6-I-01; amended CSE Rep. 8-A-11; amended CSE Rep. 5-A-17).

190.032 Medicaid Coverage and Reform*

It is the vision of the Texas Medical Association to improve the health of all Texans. Too many Texans, too many of our patients, cannot afford the health care they need. This hurts their health, the economic growth and prosperity of our state, and taxpayers all across Texas.

We currently have a tremendously cost-effective opportunity to improve access to health care for these Texans. Unfortunately, that federal offer comes in the form of expanding before reforming our Medicaid program to cover the working poor.

Medicaid provides essential health services for millions of Texans. But many parts of the current Texas Medicaid system are broken. It offers the promise of coverage without adequate funding to ensure access to care. It is fraught with exasperating, unyielding red tape. Its overzealous "fraud inspectors" are getting in the way of taking care of patients. Physicians should not accept the option of simply expanding that broken program.

On the other hand, we cannot reject the federal government's offer to help us care for the working poor of Texas. Physicians need to take this money and use it for our people, our patients.

We must look beyond the federal government's expansion solution to design a remedy that works for Texas and for Texans. The people of this state are ingenious and innovative problem-solvers. We are confident that state leaders and lawmakers with input from employers, physicians, taxpayers, and others can design a comprehensive solution that:

Draws down all available federal dollars to expand access to health care for poor Texans;

Gives Texas the flexibility to change the plan as our needs and circumstances change;

Clears away Medicaid's financial, administrative, and regulatory hurdles that are driving up costs and driving Texas physicians away from the program;

Relieves local Texas taxpayers and Texans with insurance from the unfair and unnecessary burden of paying the entire cost of caring for their uninsured neighbors;

Provides Medicaid payments directly to physicians for patient care equal to at least those of Medicare payments; and

Continues to uphold and improve due process of law for physicians in the State of Texas as it relates to the Office of Inspector General.

The Texas Medical Association calls on the American Medical Association to advocate for Medicaid payments to all physicians for patient care to be at least equal to Medicare payments (Amended BOT/COL/CSE/SC-MCU Joint Rep. 3-A-13, reaffirmed CM-RH Rep 1 2020).

Affordability

95.041 Ensuring Patient Access to Affordable Prescription Medications*****

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

support measures that increase price transparency for generic and brand-name prescription drugs. (Substitute Res. 405-A-16 and Res. 409-A-16).

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

110.003 Private Individualized Medical Care
The Texas Medical Association reaffirms its position that *private, individualized medical care and free enterprise insurance mechanisms which involve a specific degree of direct patient responsibility within and allow pluralistic, free choice options* offer the highest quality of medical care at the lowest possible cost (CSE, p 144, A-93; reaffirmed CSE Rep. 6-A-03; reaffirmed CSE Rep. 1-A-13).

110.006 Health Plan*
The Texas Medical Association supports a health plan that contains methods to address health care costs generated by undocumented persons (Supplemental Board of Trustees, p 48, A-94; reaffirmed CSE Rep. 3-A-04; amended CSE Rep. 2-A-14).

110.007 Cost Containment
Members of the Texas Medical Association are encouraged to voluntarily evaluate their practice patterns to further reduce and improve utilization of expensive hospital and ambulatory services and to control costs. *Insurance companies and fiscal intermediaries are encouraged to support cost containment and cost-effective care by recommending use of the least expensive setting in which a procedure can be performed safely and effectively. Third party payers' payment should cover not only professional services, but also all other practice expenses. Duplicate laboratory procedures and tests should be eliminated* (Council on Socioeconomics, p 177, I-94; amended CSE Rep. 1-A-10, amended C-SE Rep 2 2020).

110.008 Health Care Costs as Tax Deductible*
The Texas Medical Association is committed to a national legislative initiative promoting health care costs as a tax deductible item regardless of whether the cost is incurred by an employer or an individual (Amended Res. 29I, p 148, A-98; reaffirmed CSE Rep. 1-A-08; reaffirmed CSE Rep. 1-A-18).

115.016 "A Modest Proposal" to Save our Health Care System
The Texas Medical Association through its membership and leadership position in medicine, strives to *change the cost curve by stopping the enlarging bureaucracies and the unfunded mandates*, and by asking the federal government to consider the imposed cost on physicians when making clinical recommendations and changes to providing health care (Res. 404-A-11; reaffirmed CSE Rep. 2 2021).

120.002 Health System Reform Cost Control
The Texas Medical Association emphasizes health system reform with *cost control reform measures that protect the freedom of access and the quality of medical care to patients and leaves government in the subordinate position* and role of taxation and funding (Res. 28Z, p 179D, A-93; reaffirmed CSE Rep. 6-A-03; reaffirmed CSE Rep. 1-A-13).

145.003 Mandated Coverage*
The Texas Medical Association supports a moratorium on mandated coverage until a more comprehensive understanding of its impact on health care costs can be achieved (CSE, p 143, A-93; reaffirmed CSE Rep. 6-A-03; reaffirmed CSE Rep. 1-A-13).

145.031 Requirement for Medical Insurance Companies to Provide Online Real-Time Insurance Claim*
The Texas Medical Association supports medical insurance companies providing online real-time adjudication of medical insurance claims to include verification of insurance eligibility for beneficiaries, as well as real-time verification of current deductible amounts, copay fees, and benefits schedules for all covered office and hospital outpatient and inpatient services. TMA will urge legislators to change state law to require the provision of such real-time claim adjudication by medical insurance companies and will urge Congress to change federal law to require provision of such real-time claims adjudication by medical insurance companies (Res. 407-A-14).

Adjudication
240.001 Geographic Practice Cost Indices (GPCIs)
The Texas Medical Association supports the collection and evaluation of the most current valid and reliable data and its use in *calculating accurate geographic practice cost indices and in determining geographic payment areas.* Variation between geographic payment areas should be minimized and equitable access to medical care services should not be diminished by geographic practice cost indices that are unreasonably low in rural areas (Supplemental CSE p 162, A-90; reaffirmed CSE Rep. 5-I-01; amended CSE Rep. 8-A-11; reaffirmed CSE Rep 2 2021).

Social Determinants of Health
265.030. Social Determinants of Health*
The Texas Medical Association will (1) educate physicians about the social determinants of health for the purpose of assisting physicians to better understand their impact on patient health outcomes and wellbeing; (2) educate state and federal policy makers, business leaders, and governmental and commercial payors about the influence of social determinants of health on overall health care quality and health care costs; (3) collaborate with innovative public and private partnerships to address social determinants of health and advocate for their adoption by state policy makers; and (4) advocate that governmental and commercial payors modify existing performance and quality programs reflect the higher expected health care utilization and cost of population at greater risk of exposure to social determinants of health and appropriately risk adjust physician compensation to reflect these higher costs. (Res. 316-A-19).

Health and Insurance Plans
145.032 Improving Network Adequacy in Health Insurance Plans*
Following is Texas Medical Association policy on improving network adequacy in health insurance plans:

Allow Consumers to Purchase the Product They Demand. TMA supports legislation that will require all state-regulated insurers offering preferred provider benefit plans to offer, for purchase, additional coverage to settle claims for labor and delivery, emergency care, and any subsequent admission to the hospital at the preferred level of coverage. This should apply to individual, small group, and large group coverage.

Protect and Keep Old and New Consumer Protections. TMA should advocate to ensure Texas consumers continue to receive the advantage of Texas Department of Insurance HMO emergency care/inadequate network protections and the new PPO/PPBP rules that credit all payments for out-of-network care in emergencies (or where the network is inadequate) to a consumer's in-network deductible and out-of-pocket maximum. Also, the PPO/PPBP regulations, which provide guidance to insurers that usual and customary charges must be used to settle claims where the network is inadequate, should also remain unchanged.

Authorize the Office of Public Insurance Counsel to Monitor Networks. TMA should support legislation that seeks to augment the Office of Public Insurance Counsel's (OPIC's) authority to monitor network adequacy in the HMO and PPO/PPBP lines of insurance business. OPIC should be granted statutory authority to file complaints with the Texas Department of Insurance (TDI) TDI upon OPIC's discovery of an inadequate network or other violation of network adequacy laws or regulations. OPIC currently issues HMO report cards for use by consumers. These report cards should be required to contain an evaluation of HMO network adequacy, and OPIC should be charged with the duty to develop and issue report cards for PPO/PPBP plans that include an evaluation of those networks.

Authorize the Office of Public Insurance Counsel to Intervene in Access Plan Filings and Network Adequacy Waiver Filings. TMA should support legislation that will require HMOs and insurers to provide a copy of any such filings to the Office of Public Insurance Counsel (OPIC) and permit OPIC to oppose Texas Department of Insurance approval of any filed access plan requests if OPIC finds the access plans or waiver applications unacceptable.

Stabilize Networks. The network directories that consumers depend on are notoriously inaccurate. TMA should support legislation that will stabilize the networks the insurers market by restricting without cause terminations of physicians and providers. The legislation should prohibit insurers from exercising without cause termination clauses within the first six calendar months and last three calendar months of each year. TMA should support legislation that will authorize the Office of Public Insurance Counsel to file complaints with the Texas Department of Insurance on inaccurate HMO and PPO/PPBP directories (CSE Rep. 2-A-15; reaffirmed BOT Rep. 12-A-16).

145.038 Minimum Standards for Interstate Sale of Health Insurance Products*

The Texas Medical Association supports, at a minimum, the following standards related to interstate sale of health insurance products sold in Texas, should such a policy be approved at the federal level: (1) products with in-network/out-of-network distinctions must meet Texas network adequacy standards; (2) products must adhere to Texas prompt pay requirements; (3) each company or HMO must meet minimum financial solvency standards required in Texas; and (4) the jurisdiction for all legal challenges is determined by the location where the care is given. TMA will seek establishment of minimum federal standards that do not weaken any states' requirements on network adequacy, tort, and other insurance plan regulations (Res. 405-A-17).

120.001 Health Care Reform

The Texas Medical Association weighs heavily in its evaluation of health care reform proposals the following concepts:

Make health insurance benefits part of the gross wage of employees and allow tax credits for premiums on individual tax returns so that employees, rather than employers, bear the **cost** of waste and reap the benefits of prudence;

Allow individuals who are otherwise uninsured the same tax credit incentive as the above to purchase health insurance;

Make tax credits refundable for low income families;

Allow insurers to sell no-frills, catastrophic group insurance not subject to state-mandated benefits, premium taxes, risk pool assessments, and other costly regulations;
Allow each employee or individual to choose a health insurance policy tailored to individual and family needs;

Limit favorable tax treatment for health insurance to catastrophic policies;

Allow each employee to choose between wages and health insurance coverage so that employees who choose less expensive coverage will have more take home pay;

Establish tax credits for deposits to individual Health Savings Accounts from which individuals would use their own money to pay small medical expenses without penalty;

Allow private insurers to repackage Medicare benefits and establish diverse policies tailored to the different needs of Medicare beneficiaries;

Give the elderly and future elderly and their employers tax incentives to self insure through Health Savings Accounts;

Allow Medicare patients to negotiate outside Medicare for more fair prices to both patient and physician;

Allow Medicaid patients to draw on an account, negotiate prices, and add their own money, if necessary, in order to purchase certain types of medical services – particularly prenatal care;

Encourage hospitals to negotiate a preadmission package price with patients, particularly on elective cases, and to make their bills understandable;
Allow patients to avoid the costly effects of the tort system through voluntary contract;

Establish and support not-for-profit endowed family health clinics in local communities to care for the office visits of the poor, with all physicians volunteering a portion of their time to support these clinics.
Health System Reform Quality Improvement Organization: Under health system reform, the quality improvement organization should be retained as an essential, local base for patient-focused quality assurance activities, and the scope of QIO review should be expanded beyond Medicare to include patients treated under private sector health plans

Health System Reform Establishment of National Health Board: The Texas Medical Association opposes establishment of a national health board under health system reform and supports continued oversight of health services through state and local agencies.

Health System Reform and Fee for Service Options: *Under any health system reform plan, managed care organizations should be required to offer an out-of-network benefit.* The Texas Medical Association opposes cuts in the Medicare and Medicaid programs to finance any health system reform plans. In addition, TMA voted to take appropriate actions to *assure that rural physicians are not excluded from physician networks.*

Health System Reform Public Health Funding: The Texas Medical Association endorses inclusion of public health funding and plans to meet public health needs in any health system reform proposals.

Health System Reform: The emphasis of Health Access America should be an incremental approach based on a defined set of AMA priorities. Any proposals for health system reform must address economic, demographic, and regional differences in the health care needs of the states. TMA voted to seek an incremental approach to directed-by-patient care needs and guided by a set of priorities that includes but is not limited to insurance reform, ERISA reform, tort reform, antitrust relief, opposition to Medicare and Medicaid cuts, and support for the Patient Protection Act.

Prompt Access to Benefits: Waiting periods to receive health care coverage in any insurance program in Texas should be eliminated.

Managed Care and Fee for Service: The Texas Medical Association opposes present and proposed managed health care plans that place third party business contracts and other intermediaries between the patient and the physician. *TMA believes that medical care for American citizens can best be provided by reinstituting a simple fee for service contract between the patient and the physician with due respect for the patient's ability to pay, directly or through their individual insurance. In addition, TMA believes that insurance companies should be directed to offer individuals affordable, transportable, community-rated health care plans using appropriate actuarial data to provide coverage for preexisting conditions at equitable rates which ideally should cover high end or catastrophic health care costs* (Council on Socioeconomics, p 150, I-92; amended CSE Rep. 3-A-04; amended CSE Rep. 3-A-14).

120.010 Principles for Evaluating Health System Reform

The Texas Medical Association will use the following principles as evaluation criteria in examining all national health system reform proposals. These principles are not ranked in order of importance; all are viewed as high priorities.

- Promote portable and continuous health care coverage for all Americans using an affordable mix of public and private payer systems.
- Promote patient safety as a top priority for reform, recognizing an effective mix of initiatives that combine evidence-based accountability standards, committed financial resources, and rewards for performance that incentivize and ensure patient safety.
- Adopt physician-developed, evidence-based tools for use in scientifically valid quality/patient safety initiatives that incentivize the physician-led health care delivery team, and include comparative effectiveness research used only to help those in patient-physician relationships choose the best care for patients.
- Preserve patient and physician choice and the integrity of the patient-physician relationship.
- *Incorporate physician-developed, evidence-based measures and preventive health and wellness initiatives into any new or expanded health benefits package as a means to promote healthier citizens.*
- Recognize and support the role of safety-net and public health systems in delivering essential health care services within our communities, to include essential prevention and health promotion public health services.
- Support the development of a well-funded, nationwide emergency and trauma care system that provides appropriate emergency and trauma care for all Americans.
- Support public policy that fosters ethical and effective end-of-life care decisions, to include *requiring all Medicare patients to have an advance directive that a Medicare enrollee can discuss as part of a covered Medicare visit with a physician.*

- Provide sustainable financing mechanisms that ensure the aforementioned affordable mix of services, and create personal responsibility among all stakeholders for financing and appropriate utilization of the system.
- Invest needed resources to expand the physician-led workforce to meet the health care needs of a growing and increasingly diverse and aging population.
- Provide financial and technological support to implement physician-led, patient-centered medical homes for all Americans, including increased funding and compensation for services provided by primary care physicians and the services provided by non-primary care, specialist physicians as part *of the patient-centered medical home continuum.*
- *Through public policy enactments, require accountability and transparency among health insurers to disclose how their premium dollars are spent, eliminate preexisting condition exclusions, simplify administrative processes, and observe fair and competitive market practices.*
- Reform the national tort system to prevent non-meritorious lawsuits, keeping Texas reforms in place as enacted by the Texas Legislature and constitutionally affirmed by Texas voters.
- Initiate a true cost of practice methodology that provides for annual updates in the Medicare Fee Schedule as determined by a credible, practice expense-based, medical economic index.
- Provide incentives that support the universal adoption of interoperable health information technology that supports physician workflow, increases practice efficiency, is safe for patients, and enhances quality of care.
- Require payers to have a standard, transparent contract with physicians that cannot be sold or leased for any other payer purposes without the express, written consent of the contracted physician.
- Support efforts to make health care financing and delivery decision making more of a professionally advised function, with appropriate standard setting, payment policy, and delivery system decisions fashioned by physician-led deliberative bodies as authorized legislatively (SC-HSR Rep. 1-A-09; amended CSE Rep. 2-A-19).

145.009 Individual Responsibility for Health Care

The Texas Medical Association encourages employers, employee groups, and other public policy advocates to work together to design and introduce *innovative and cost-effective mechanisms to finance health insurance coverage that could be owned and selected by individuals, flexible for each individual's and family's needs, and available as part of or as an alternative to traditional employer-sponsored health plans.* TMA is committed to working with business and government to preserve the private sector and to *establish an insurance market that is understandable and affordable,* as well as portable for individuals (Amended Res. 29X, p 161B, A-98; reaffirmed CSE Rep. 1-A-08; reaffirmed CSE Rep. 1-A-18).

145.016 Small Employer Health Care Benefit Discrepancies

Eligibility for extended health care benefits for employees of small employers should be on par with employees who work for large employers. The Texas Medical Association supports changes in COBRA that would afford small employers the same extended health care coverage benefits for their employees as the large employers (Res. 413-A-02; reaffirmed CSE Rep. 1-A-13).

180.024 Conflict Between Physician Ethics and Health Plan Business Practices

The Texas Medical Association continues to support health insurance business practices reforms in the Texas Legislature and continues to advocate for high standards of ethical practice by all physicians. TMA calls upon the Texas Medical Board to continue to *study the potential conflicts of ethical and financial interests imposed on physicians as part of health plans' business practices* (Res. 29AA, p 168D, A-97; amended CSE Rep. 1-A-08; reaffirmed CSE Rep. 1-A-18).

235.045 Contracted Health Plans Must Apply the Same Level of Benefits Concerning Patient Responsibility

Health plans in a binding contract with a physician must apply the same level of benefits concerning patient responsibility (copay, coinsurance) regardless of the contracted physician or provider rendering the service (Res. 414 2021).