

TEXAS MEDICAL ASSOCIATION

HEALTHY VISION 2025

PUTTING THE
HEALTH BACK
INTO
Health Care

*TMA's advocacy agenda for
Texas physicians and
their patients*



**TEXAS MEDICAL
ASSOCIATION**

Physicians Caring for Texans

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PRESIDENT'S MESSAGE

As we enter 2019, patient care in Texas is at a critical crossroads. Let us choose the right path forward.

For starters, Texas still ranks 41st nationally in physicians per 100,000 population. Not enough of our health care dollars are going to health care. Corporations are pressing harder to dictate patient care decisions. Insurance company abuses create unnecessary barriers to patient care. Unqualified providers are trying to make dangerous medical decisions. Behavioral health and public health need much more of our attention. Too much of our state's population is uninsured. Infant and maternal mortality rates are alarming. We are losing our state's medical-school-trained doctors to residency programs in other states. And Medicare and Medicaid payments often don't even cover the cost of patient care.

Sure, it would be much easier to brag about our world-class medical schools and research institutions, our cutting edge treatments, the billions of dollars we provide in uncompensated care, our proven liability reforms that have stopped medical lawsuit abuse, and our thousands of dedicated and caring Texas physicians.

As a state, we collectively — public officials, physicians, other health care practitioners, taxpayers, business owners, parents — must assume responsibility for improving and protecting patient care for all Texans. We should neither take our health for granted, nor be blind to that which is curable through proper patient care or legislative reform.

In this, our fourth *Healthy Vision* document, the physicians of the Texas Medical Association share stories that illustrate these problems, and we outline our solutions. We look forward to working with the members of the Texas Legislature and the agencies that oversee and regulate health care to achieve our healthy vision for the people of this great state and for those of us who have dedicated our careers to caring for them.

Sincerely,

A handwritten signature in black ink that reads "Douglas W. Curran, MD". The signature is written in a cursive, professional style.

Douglas W. Curran, MD

President

Texas Medical Association

SECTION 1: LET DOCTORS BE DOCTORS

Stretched to the Limit

There came a moment when all the clicking on boxes, filling out forms, and waiting on hold was just too much for Houston internist Lisa Ehrlich, MD. The time and energy spent on all of these seemingly endless tasks meant she could not give nearly enough to her patients.

And after 19 years in private practice, with insurance companies and the government expecting her to care for 3,000-plus patients, she was burning out.

“I was really tired, exhausted,” Dr. Ehrlich said. “I did not want to go to work in the morning. ... I was stretched to the limit.”

On the outside, her practice looked like the model of success. She earned recognition from the Health Care Incentives Improvement Institute for diabetes care, asthma care, and for using health information technology. Vitals.com — an online physician rating system — regularly gave her its Patient’s Choice Award and Compassionate Doctor Recognition.

Dr. Ehrlich and her partner employed seven billing and clinical care staff, and could have used even more help. Meanwhile, payments were diminishing and electronic health records costs were exploding. “We were drowning,” she said.

“I was forced to begin limiting the time I spent with my patients and offload communications to my staff. I was spending more than half of my time on paperwork, haggling with insurance, and regulatory box checking.”

She worried that quality-improvement programs were doing little to keep her patients healthier or to hold costs down. She chafed at the forces that transformed the medical record — her

patients’ charts — from a clinical instrument into a tool to satisfy third-party payers and government regulators. She seethed at wasting time with prior authorization phone calls that took her away from her patients.

“We were, and still are, in a constant exercise that’s really designed to save the middleman money,” Dr. Ehrlich said. “It’s not for the care of the patient, and it’s not actually really saving money. It’s a tax on our practices. It’s a tax on us.”

In response, she staged her own revolution. Twenty-five years after graduating medical school, she eschewed joining forces with a big hospital system and instead reinvented her practice. Even though the personalized care model she implemented means she is accessible to her patients nearly 24/7, Dr. Ehrlich says she is happier — and saner. She’s still clicking and haggling, but on behalf of only 600 patients, all of whom she knows well.

“This arrangement has put the joy of practicing medicine and really caring for patients back in my life,” she said.

Her patients have a deeper, personal relationship with their very own physician, who is almost always on call. “This can be life-saving,” Dr. Ehrlich said, describing one case where her intimate knowledge of a patient’s medical history led her to arrange immediate treatment for necrotizing fasciitis — more commonly known as “flesh-eating bacteria.”

Or there’s the long-time patient who called her with unusual chest pains on Labor Day weekend. With his normal lab results and electrocardiogram, Dr. Ehrlich says, most emergency rooms



would have released him with no further work-up.

“But I just did not like the way he looked.”

Acting on instinct, she persuaded a cardiologist to perform an angiogram.

“He ended up having a 95-percent blockage of the left main artery, which we call the ‘widow maker,’” she said. “He was admitted immediately for bypass surgery and is a healthy survivor. In my old model, I would have had a 25-percent chance of being on call that day.”

The time physicians spend with their patients is the most satisfying and, obviously, the most productive part of their day. Unfortunately, research shows, most physicians spend far more precious minutes each day sitting at computer screens, filling out paperwork, or waiting on hold with insurance companies and pharmacies. This sad imbalance is one of the leading causes of medicine’s burnout epidemic. TMA offers numerous recommendations to reduce nonclinicians’ interference in the patient-physician relationship and to streamline bureaucratic processes. Physicians currently spend only about 17 minutes of every working hour in direct clinical face time with patients. With nearly 55,000 physicians actively practicing in the state, every minute we can shave from the paperwork burden effectively translates into a 1,100-doctor increase in Texas’ physician workforce.

HEALTH INSURANCE INTERFERENCE

Some of the most frequent, and most irritating, intrusions into physicians’ daily lives come from health insurance companies — commercial plans as well as Medicaid and Medicare managed care organizations. Their arbitrary denials of coverage, increasing demands for



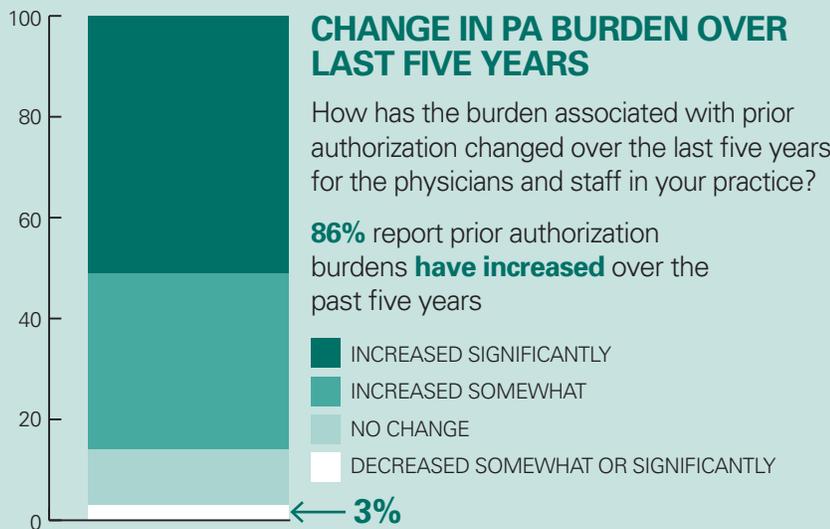
WIDESPREAD BURNOUT

Most physicians experience feelings of burnout

- SOMETIMES, OFTEN, ALWAYS FEEL BURNED OUT
- RARELY, NEVER FEEL BURNED OUT



Doctors say **EHR** and **loss of clinical autonomy** are the two factors they dislike most about medical practice.

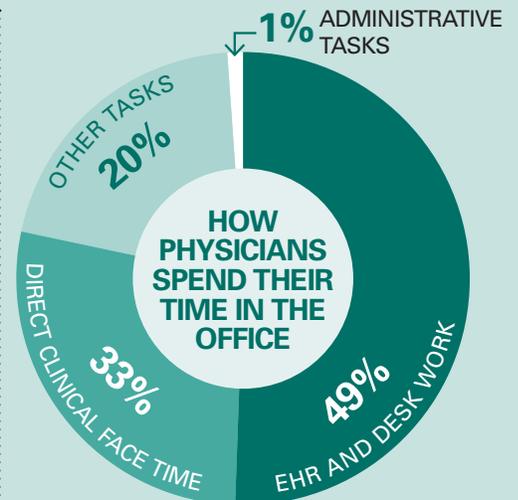


CHANGE IN PA BURDEN OVER LAST FIVE YEARS

How has the burden associated with prior authorization changed over the last five years for the physicians and staff in your practice?

86% report prior authorization burdens **have increased** over the past five years

- INCREASED SIGNIFICANTLY
- INCREASED SOMEWHAT
- NO CHANGE
- DECREASED SOMEWHAT OR SIGNIFICANTLY



HOW PHYSICIANS SPEND THEIR TIME IN THE OFFICE

Total sums over 100% because the Work Observation Method by Activity Timing platform allows recording of 2 tasks done in parallel. Multitasking results in overlapping time records, which are additive.

SOURCES: The Physicians Foundation 2018 Survey of America’s Physicians: Practice Patterns and Perspectives, conducted by Merritt Hawkins; “Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties.” *Annals of Internal Medicine*, 2016.

prior authorization for procedures, equipment, and medications, and seemingly random changes in pharmaceutical formularies combine to eat massive chunks of physicians' time and interfere in their ability to provide patients with the care they need.

TMA recommends that the Texas Legislature:

- Require that prior authorization reviews be performed by a Texas-licensed physician in the same or similar specialty as the physician submitting the request.
- Ensure that prior authorization approvals bind health plans to cover and pay for that service or medication and prohibit plans from denying coverage or payment after the fact based on a separate medical necessity decision.
- Require plans to automate the prior authorization process to reduce on-hold and waiting times.
- Require plans to eliminate prior authorization requirements for services, medical equipment, and medications that are routinely approved.

PRESCRIPTION DRUG MONITORING PROGRAM

Over the past several years, Texas significantly upgraded and improved the Prescription Drug Monitoring Program (PDMP) through which prescribers and pharmacies can look up a patient's history with opioids and other dangerous and addictive drugs. The PDMP is an important tool in the fight against addiction and overdoses. But it is still a very cumbersome and time consuming tool for physicians to use many times each day. Electronic integration will be a process, not an event. It will take some time to realize the full benefits; ultimately, this will give physicians access to important clinical information without additional work flow interruptions.

TMA recommends that the Texas Legislature:

- Direct the Texas Board of Pharmacy to ensure that electronic health records manufacturers integrate an automatic PDMP look up into the systems they sell. This would streamline workflow in thousands of Texas physicians' offices and reduce time-consuming interruptions to check each patient's controlled substance prescription history manually.
- Expand physicians' authority to delegate PDMP searches to other members of the health care team.
- Limit the initial mandate to check the PDMP before writing a prescription to the following Schedule II drugs: opioids, benzodiazepines, barbiturates, and carisoprodol. (The mandate takes effect Sept. 1, 2019.)

PHARMACY INTERFERENCE

Claiming it is part of their role in fighting the opioid epidemic, pharmacies and pharmacy chains are instituting rigid limits on the type, amount, or dosage of analgesics they will provide a patient, regardless of the physician's prescription. Some are requiring vast amounts of patients' clinical information before filling a physician's valid prescription. These arbitrary limits and information requests frequently delay patient care. Fighting the limits and providing the requested medical records consume valuable time from a physician's day.

TMA recommends that the Texas Legislature:

- Preserve physicians' authority to prescribe appropriate medications without pharmacies interfering or overriding physicians' valid orders.

ELECTRONIC HEALTH RECORDS AND HEALTH INFORMATION EXCHANGES

Despite the decades-old promise to revolutionize health care, electronic health records (EHRs) remain expensive, cumbersome, time consuming, and extremely frustrating for many physicians. Research shows that physicians spend only 27 percent of their day on direct

Stunning Admission by Aetna Prompts Investigation

KPRC-TV—Houston, Feb. 11, 2018

clinical face time with patients, in large part because they spend nearly 50 percent of their time on electronic and old-fashioned paperwork. Numerous government and private payer programs intended to measure the quality of medical care physicians provide require volumes of data to be entered into — and later retrieved from — an EHR. Each of the programs has different rules, uses different metrics, and requires different data. Health information exchanges (HIEs) in Texas purport to enhance patient care by allowing physicians and providers to share data quickly and easily. Unfortunately, different brands of proprietary EHRs are unable to “talk” to each other, unless physician pay exorbitant fees to vendors. This barrier prevents meaningful data integration from a hospital, laboratory, or another physician into a patient’s electronic chart.

TMA recommends that the Texas Legislature:

- Align Medicaid quality requirements with other programs’, such as Medicare’s, to reduce confusion and complexity, and increase physician participation.
- Require EHR vendors to ensure their products will share data about reportable diseases directly with state and local public health agencies, and ensure those agencies have the technology to receive that data from the EHRs.
- Ensure HIEs integrate data seamlessly among physicians, hospitals, state registries, labs, and other stakeholders at no or low cost to physicians.
- Remove cost and hospital barriers that stand in the way of HIE integration between physicians and EHR vendors.
- Align all health information organizations in the state to create efficiencies for all participating stakeholders.
- Require bidirectional data sharing among health information organizations and physicians and providers that use EHRs.

MAINTENANCE OF CERTIFICATION

To renew their Texas medical license every two years, all physicians must complete at least 48 hours of continuing medical education. The vast majority of Texas physicians are voluntarily board-certified, passing a comprehensive examination after completing their residency. Certification for many is time-limited, and the certifying boards have instituted time-consuming and expensive processes for maintenance of certification (MOC), which many physicians believe offers little to no value to them or their patients. The 2017 Texas Legislature passed a law that prohibits the use of a physician’s MOC status as a requirement for doctors to obtain or renew a medical license, and bars health plans and most hospitals from requiring physicians to obtain MOC for credentialing or contracts. Many hospitals around the state have wrongly insisted that their old MOC requirements automatically remain in place despite passage of the new law.

TMA recommends that the Texas Legislature:

- Explicitly state that hospitals may not require MOC for staff privileges unless the physician members of the hospital’s medical staff affirmatively vote after Jan. 1, 2018, to do so, clarifying the 2017 law.

SECTION 2: PROTECT OUR LIABILITY REFORMS

Texas' 2003 medical liability reforms swiftly ended an epidemic of lawsuit abuse, brought thousands of sorely needed new physicians to Texas, and encouraged the state's shell-shocked physicians to return to caring for patients with high-risk diseases and injuries. The landmark legislation saved access to care across the state, particularly in rural Texas and the Rio Grande Valley, and in critical specialties like obstetrics/gynecology, emergency medicine, and neurosurgery. Under tort reform, the number of physicians practicing in Texas has grown even faster than our exploding population. Tort reform, however, is a never-ending political and legislative battleground in Texas. We cannot relax our guard against direct attacks on the 2003 law.

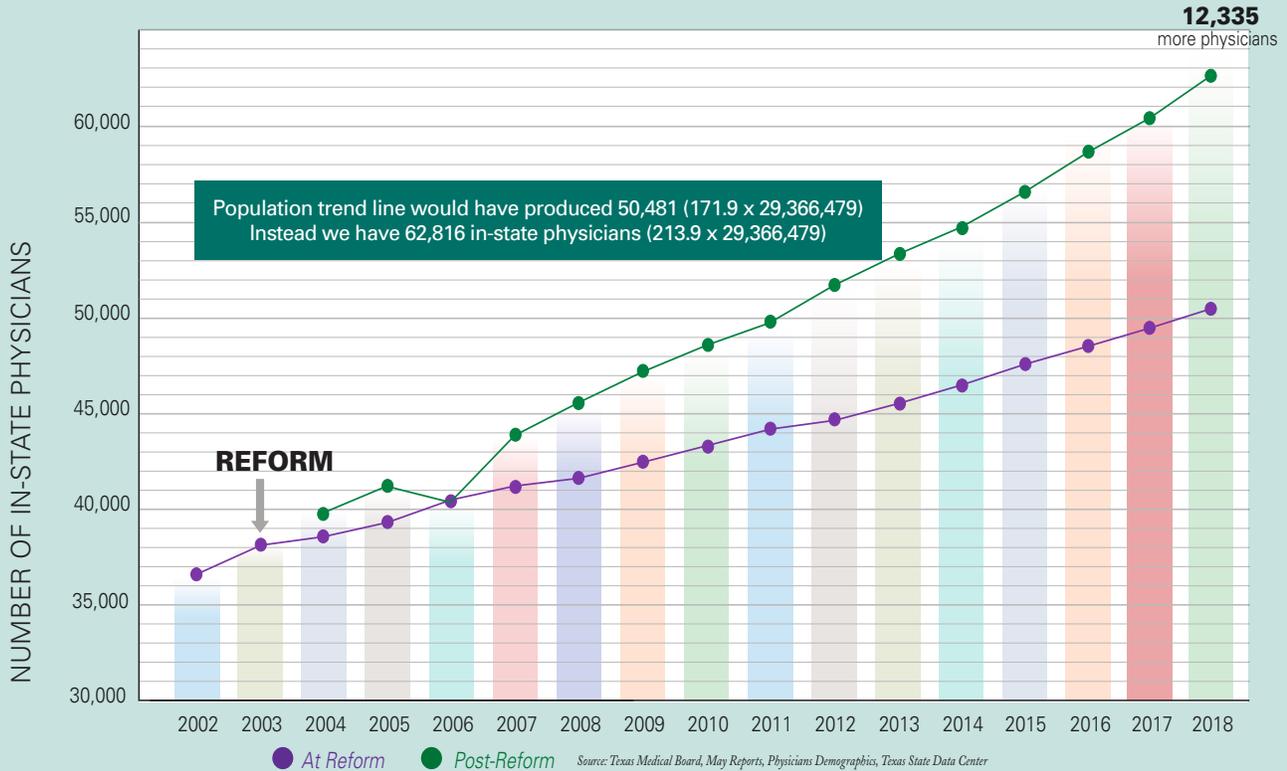
TMA recommends that the Texas Legislature:

- Protect the caps on noneconomic damages in medical liability cases but continue to allow unlimited economic damages.
- Maintain the special liability standard for emergency department services, obstetrical units, and emergency surgery.

SINCE TORT REFORM, PHYSICIAN GROWTH FAR EXCEEDS POPULATION GROWTH

IN-STATE PHYSICIANS PER CAPITA

Since 2003, Texas has added 12,335 more physicians with in-state licenses than can be accounted for by population growth.



In-State Physicians: <http://www.tmb.state.tx.us/dl/FE250965-55F1-D57F-56C8-F1E71EA768E2>
Population: <http://www.dhs.texas.gov/chs/popdat/si2018.shtml>

SOURCE: Texas Medical Board, May Reports, Physicians Demographics Texas State Data Center. The bottom line holds the 2003 physicians per capita number constant adjusting for population growth. The top line is the actual number of in-state active physicians. According to the Medical Group Management Association (MGMA) 2009 Cost Survey. National Data on Physician Patient Encounters, physicians, on average, see 3,967 patients each year. Multiple the delta 12,335 more physicians (62,816-50,481) x 3,967 patient visits = the opportunity for 48.9 million additional patient visits in 2018.

SECTION 3: HOLD HEALTH INSURERS ACCOUNTABLE

Let Me In, Let Me In

Beaumont anesthesiologist Ray Callas, MD, is tired of beating his head against the wall trying to get “in-network” with health insurance companies. And he’s tired of the surprise bills his patients receive when he can’t get in.

“If I’m out-of-network, but I’ve tried time and again to negotiate with networks and still can’t get in, I believe insurance should accept some of the responsibility for that bill,” he said.

And Dr. Callas is not an outlier.

TMA’s biennial physician survey shows 67 percent of physicians with no contracts who attempted to join a network received either no response or a “take it or leave it” offer. Thus, when physicians are not part of a network, it is generally because they either have no choice or no bargaining power.

And neither do their patients. Surveys show that as many as 60 percent of Americans have received a surprise bill from an out-of-network physician or provider. Many of them result from emergency medical care.

Especially in emergencies, it’s common for someone like Dr. Callas not to know if he’s in-network for the patient in front of him.

“My responsibility as a patient’s physician is to know the risks of administering anesthesia, not administering their personal insurance plan,” Dr. Callas said. “Frankly, educating patients regarding their insurance plan and what is and is not covered, and how to meet deductibles — that’s the responsibility of the plan. Don’t just hand them a 75-page booklet and tell them their benefits are described within.”

Narrow, inadequate networks can mean little or no access to critical services. The plans themselves determine how their networks are established and what physicians and providers will participate in those networks.

Physicians have a real and powerful incentive to be part of the insurance companies’ networks: Most believe they must contract with at least one commercial payer to have a financially viable practice.

Health plans, on the other hand, profit from skimpier networks.

“Insurance companies with narrow networks shame physicians into looking like the bad guy for billing for services rendered but unpaid, when the truth is I’ve tried to get in-network but have been offered less than desirable or even fair terms,” Dr. Callas said. “What other profession is expected to provide services regardless of the terms?”



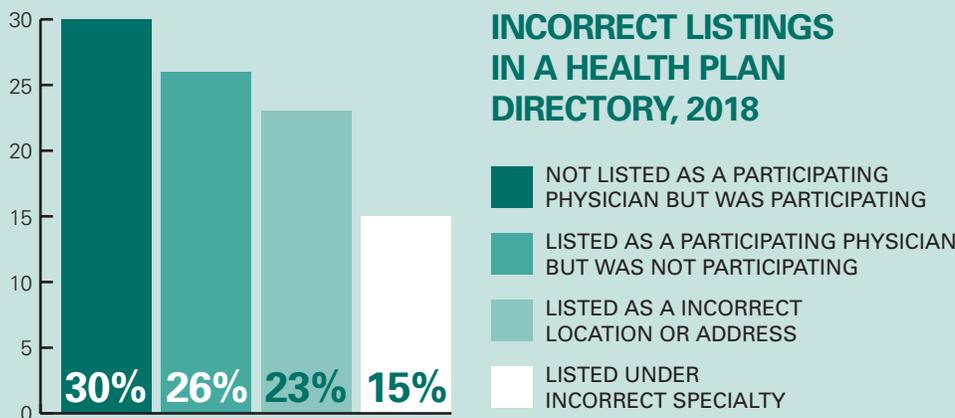
Austin Teacher Billed \$108,951 After St. David's Heart Attack Treatment

KXAN-TV— Austin, Aug. 28, 2018

Health insurance is supposed to protect you in case something goes terribly wrong, saving you from potential financial disaster. But the company selling it makes more money if you don't, or can't, use it. Insurance companies accomplish that by limiting the number of in-network physicians, hospitals, and providers; by publishing inaccurate network directories; by confusing patients about their coverage; and by constantly changing their rules and procedures. All of that makes patients pick up more of the tab they thought the insurance they bought would cover.

MAKE NETWORKS WORK FOR PATIENTS

Using narrow networks, or very limited lists of in-network physicians patients can see, is one scheme insurers use to maximize their profits; it transfers much of their financial liability to patients in the form of surprise bills. The health plans' notoriously inaccurate network directories add to patients' confusion. Texas' successful mediation program for balances of \$500 or more in certain out-of-network situations is helping to protect patients, but the state needs to do more to enforce strong network standards.



Of the 407 hospitals in Texas, **more than 300 do not have a single emergency physician in-network with at least one of three major plans.**

SOURCES: TMA 2018 Physician Survey; CPPP analysis of data posted online by Blue Cross Blue Shield of Texas, UnitedHealthcare, and Humana. Data are for providers at in-network hospitals that offer emergency room services, as reported by insurers.

TMA recommends that the Texas Legislature:

- Protect physicians' rights to set their charges and collect outstanding balances.
- Support the continued use of mediation for patients to resolve surprise bills.
- Require health plans to create and maintain adequate networks. Expressly authorize and require Texas Department of Insurance (TDI) to perform network examinations of preferred provider benefit plans on a routine basis. Augment the authority of the Office of Public Insurance Counsel (OPIC) to monitor network adequacy.
- Require health plans to provide accurate information on physicians' network status, updated in real time.

UNDO THE CONFUSION

Insurance companies frequently use jargon and complex small print to lay out what coverage patients have, or to announce changes in the terms of their plans. That makes it nearly impossible for patients to figure out what they have to pay.

TMA recommends that the Texas Legislature:

- Require health insurance companies and their agents to explain in plain language exactly what a patient's health plan will and won't cover, as well as the patients' financial responsibility, before they purchase a policy.
- Prohibit insurance plans and pharmacy benefit managers (PBMs) from switching patients' prescription drugs for non-medical reasons.
- Prohibit plans from terminating physician contracts without cause.

SECTION 4: ENHANCE PRACTICE VIABILITY

There Goes the Cavalry

One of the state's so-called money-saving budget moves is robbing Texans of their eyesight — all because a highly trained physician can no longer afford to see them.

Diabetes, uncontrolled, ravages its victims' bodies. It destroys their kidneys. It ruins their nerves and blood vessels. And it blinds them. A deadly combination of genetics, diet, and economics have made South Texas the epicenter of a diabetes epidemic.

Like a magnet, all of that drew a young Harvard-educated ophthalmologist to the lower Rio Grande Valley. Fresh out of fellowship at an institution that helped develop a drug that "was going to be a total game changer for diabetics," Victor H. Gonzalez, MD, turned down an offer to practice in Beverly Hills — and moved to McAllen.

"It struck me," Dr. Gonzalez recalled some 25 years later. "Here I have the opportunity to go somewhere, to bring Harvard to the Valley, in a sense, because the people from the Valley can't go to Harvard — they can't even go to Houston — and bring that type of intervention down here."

Dr. Gonzalez founded Valley Retina Institute (now part of Gulf Coast Eye Institute) in 1994. He not only treated patients for their diabetic retinopathy — the complication of diabetes that can lead to blindness — he also won funding for clinical trials on the promising new medicines he had studied at Harvard.

"We were receiving down here what eventually became the standard of care for the world, almost 15 years before the rest of the world got it," he said. "We had access to it because we had the research program, the protocols that gave us the opportunity to offer that to our population."

Still, Dr. Gonzalez found that running his practice was a financial juggling act. Given the Valley's poverty, very few of his patients were covered by private insurance. About 60 percent were both poor and elderly, covered by both Medicare and Medicaid; another 15 percent just by Medicaid, which pays about two-thirds of Medicare's rates; most of the rest are uninsured, "which we do a lot of free work for."

He made it work until 2012 because of the complex financing involving the bulk of his practice, the 60 percent covered by both Medicare and Medicaid — the "dual eligibles." Between the state and federal governments, caring for those patients earned Dr. Gonzalez a fee equal to Medicare's standard payment for office visits and procedures.

Then the state slashed its share, drastically. "All of a sudden the floor gets pulled out from under us, and for over 60 percent of the practice we get a 20-percent revenue cut," Dr. Gonzalez explained.

The juggling act got a whole lot more complex. As the practice sought out a more balanced mix of payers, it had to "significantly cut back" on free care. Then, in an attempt to further reduce costs, the state specifically targeted ophthalmology services and reduced what Medicaid pays for eye care. "It's just been a constant assault on us," he said.



Three of the institute's seven physicians left for greener pastures, and Dr. Gonzalez hasn't been able to recruit replacements. "Why would you want to come to a place when you ... can move somewhere else and get a 27-percent increase in revenue to see the same number of patients?"

All of that means the uninsured and dual-eligible diabetic patients — the ones that attracted Dr. Gonzalez to South Texas — have to wait longer for care.

"By the time we see them, the disease is much more advanced than it would have been if we would have had access to them earlier," he said. "The only new people I see now among Medicaid and the dual-eligible patients are emergencies, because that's all the room that I have. Any type of preventive work that's elective, I can't see them."

Emergency care, of course, is more expensive for the state. And Dr. Gonzalez says he can stabilize the disease process and recover lost eyesight for about 80 percent of the patients who can't get in to see him until they have an emergency. But, he adds, that is far below the promise of available treatments when they are instituted on time.

"There's a good 20 to 25 percent of them that I stabilize, but they've lost a lot of vision unnecessarily," he said. "Unless we can change this, we're going to revert back to where we were 20 years ago when I first showed up here, with a lot of people with very advanced disease, going blind."

Valley Doctors Rally Against Rate Cuts

Brownsville Herald, Mar. 31, 2012

In Texas, physicians' practices are small businesses, but big business. They create more than 670,000 jobs and generate almost \$118 billion in economic activity. [See Special Report: Texas Physicians Inject Billions into Lone Star State Economy, page 31.] Like any other business, physicians can provide life-saving care only when practice revenues exceed expenses. Low payments from public and commercial insurance plans, artificial restrictions on physicians' business activities, and increasing costs to comply with stifling government regulations and insurance company red tape combine to threaten the viability of many players in this critical sector of the Texas economy. TMA's recommendations for legislative action include fair payments for physician services, elimination of unnecessary regulations, and prohibition of outside entities' incessant interference in how physicians care for our patients.

PROTECT PRACTICE INCOME

Much of physicians' payments are controlled by government price-fixing, and physicians have little leverage in negotiating contracts with commercial insurers. Neither Medicare nor Medicaid payment rates have come anywhere near keeping up with the cost of running a practice. Physicians need appropriate pay for the life-saving, health-preserving services they provide, and relief from archaic laws that inhibit them from providing services their patients need.

TMA recommends that the Texas Legislature:

- Provide payments to physicians that at least meet the cost of caring for patients in the Medicaid program.
- Repeal payment cuts for services provided to vulnerable patients covered by both Medicaid and Medicare.
- Allow patients to obtain commonly prescribed medications from their physicians, on the spot.

LIMIT PRACTICE EXPENSES

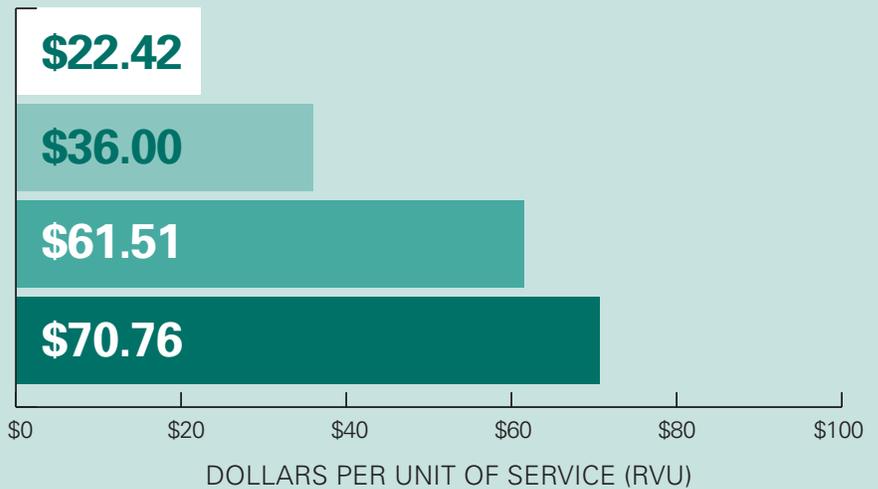
For most physicians, extra expenses come in the form of the lost time and added staff needed to respond to the multitude of unnecessary intrusions from government health programs and commercial insurance companies. [See Section 1: Let Doctors Be Doctors.] Like other small businesses, however, one age-old item looms large in the debit column: taxes. Recognizing the unique nature of health care when they rewrote the state’s business tax in 2006, legislators included exemptions for the free and under-paid care physicians provide to Medicaid, Medicare, the Children’s Health Insurance Program (CHIP), workers’ compensation, military, and charity care patients. Because physicians have contractual and ethical obligations to care for patients, often without regard to their own financial interests, their losses on unpaid and underpaid services are unavoidable and substantial.

TMA recommends that the Texas Legislature:

- Ensure that any tax legislation that affects health care does not harm patient care or access by reducing or eliminating exemptions for charity and under-paid care.

**PHYSICIAN COST/
REVENUE COMPARISON**

- MULTISPECIALTY PRACTICE REVENUE
- MULTISPECIALTY PRACTICE COST
- MEDICARE PAY
- MEDICAID PAY



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

SECTION 5: MAKE MOTHERHOOD SAFE

It Didn't Have to Be

Eugene Hunt, MD, estimates he's attended the delivery of thousands — “three, four, five thousand?” — of infants in his 35 years of practice as a Dallas obstetrician.

Two “sad, sad, sad” cases stick in his mind. In one, the mother died just before going into labor; Dr. Hunt performed a cesarean section and saved the twins inside her body.

The other case has changed the way he monitors and cares for his patients weeks and months after they've taken their newborns home.

“You bet your boots,” Dr. Hunt said as he recounted the tragedy. “I have gone out and picked up patients from their homes and taken them to psych wards. I've brought them back to my office and called psychiatrists. The idea that one day after I talk to a lady she commits suicide is an experience that I can never ever forget.”

After a routine pregnancy and delivery, the lady — we'll call her Sharon — took home a “beautiful baby girl.” Some six to eight weeks later, she called Dr. Hunt to talk and shortly after showed up at his office.

“She seemingly looked fine, she didn't look all distraught,” he said. “She began telling me about some of the challenges of the baby and how the baby seems to cry a lot. ... She was overwhelmed, and it was kind of difficult.”

Dr. Hunt says he offered Sharon reassurance, telling her that her experience is common among new mothers and won't last. “A better day is coming,” he said.

Then the conversation turned in a way that Dr. Hunt unfortunately recognized only in hindsight.

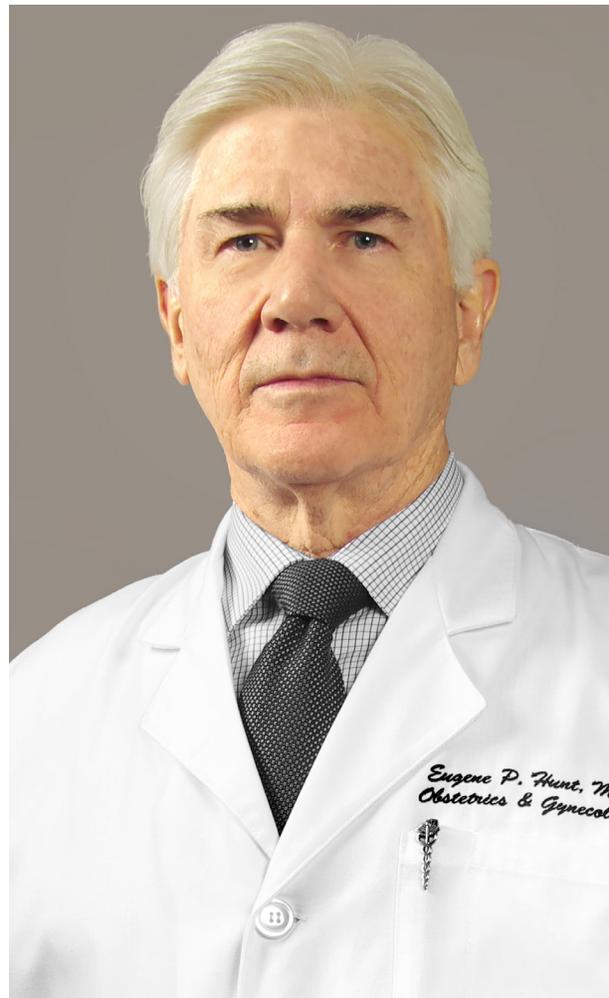
“She at one point made that little suggestion that someone, maybe family, had actually shot themselves. And then she said ‘I would never actually do anything like that.’ Forever, if anybody tells you they will never do something, you perk up.”

After more supportive conversation, he sent Sharon home, where her husband and mother were helping her care for the baby. Early the next morning, Dr. Hunt recounts, she put the infant in bed with her husband, walked to the garage, took a pistol from the glove compartment of her car, and shot herself.

Initially angry and disappointed at Sharon's suicide, Dr. Hunt says a conversation with a colleague helped him understand the catastrophe. “He was thinking from her perspective, ‘She is so overwhelmed, she is so distraught, and postpartum depression can certainly put her there.’”

Postpartum depression is not the “baby blues” that 50 to 60 percent of mothers experience in the first few months after delivering a baby. As many as one in seven new mothers acquire the serious psychiatric disorder known as postpartum depression. It's the tipping point where the physical, emotional, hormonal, and psychological changes surrounding pregnancy and birth gang up to create a dangerous mental illness in the mother.

“It is so overwhelming to the individual with the multitude of changes going on in every bit of their being that you've got to watch them,” Dr. Hunt said. “We must address every lady who has a baby, when we're discharging them from the hospital, we better talk about postpartum depression.”



It's recognized. This is real. And you can save lives when it's talked about properly."

Sharon's story is a regular reminder. "I had to wonder, what might I have said? What might I have done? This is part of the medical profession's burden when we have patients who do such things as this," he said. "What would have kept this tragedy from happening?"

Childbirth, one of life's greatest joys, can morph into tragedy when the infant's mother dies. Even one death is one too many. Thankfully, most maternal deaths — 80 percent in one state study — are preventable. And for every new mother who dies in Texas, another 50 to 100 experience serious, life-threatening conditions. Building on the work of state and national maternal health experts, Texas physicians propose a clinically proven list of interventions to counter this troubling trend. Physicians, hospitals, nurses, and other members of the health care team have rightly assumed responsibility to implement some of these recommendations. Others require action from the Texas Legislature — who, in foresight, already established the Texas Maternal Mortality and Morbidity Task Force — to ensure that at-risk mothers have the services and resources they need. Together, we can make sure it's safe to be a mom in Texas.

MORE ACCESS, LESS CONFUSION

Medicaid paid for 52 percent of all births in Texas in 2015, and most new moms' Medicaid coverage ends two months after they deliver their babies. A Texas Department of State Health Services (DSHS) study found that 382 Texas mothers died within a year of giving birth between 2012 and 2015. More than half of these deaths occurred later than two months after the baby was born. The top known causes of death in these cases included drug overdose, cardiac events, homicide, and suicide. Medicaid provides comprehensive care for eligible women from the time they find out they are pregnant until 60 days after delivery. When Medicaid pregnancy-related coverage ends, Texas automatically enrolls adult women into the Healthy Texas Women (HTW) program, which connects them with preventive health services, including contraceptive services and basic primary care. HTW provides coverage to low-income women of reproductive age before pregnancy, too. But it provides little or no treatment for acute or chronic conditions, leaving women with complex medical needs, such as diabetes, substance use disorder (SUD), or postpartum depression, without coverage for specialty care.

Low-income women ineligible for Medicaid may qualify for the Children's Health Insurance Program (CHIP) Perinatal Program (CHIP-P), which covers up to 20 prenatal visits, labor and delivery, and two postpartum visits. Women whose CHIP-P coverage ends can obtain preventive health care services via the Texas Family Planning Program. The underfunded Substance Use Disorder Services for Pregnant and Postpartum Women provides the services listed in its name but isn't integrated into a system that provides care for other medical services. Transitioning from one program to another is difficult and confusing, and only Medicaid provides comprehensive benefits. Women, families, physicians, and providers are often challenged in how to fully access needed services before, during, and after pregnancy.

TMA recommends that the Texas Legislature:

- Direct the Texas Health and Human Services Commission (HHSC) to pursue a federal demonstration waiver to increase access to comprehensive services for low-income women before, during, and after pregnancy, including substance use treatment and behavioral health care. Federal funds could provide more consistent and continuous coverage for women of childbearing age and eliminate some of the confusing maze of support systems. At a minimum,

the waiver should target high-risk women, including women with a prior preterm delivery or with a chronic medical condition that puts them at risk for pregnancy-related complications.

- Streamline and automate the transition from Medicaid to HTW for adolescents aging out of Medicaid and CHIP, and for CHIP-P enrollees to the Texas Family Planning Program.
- Ensure women receiving SUD treatment in a chemical dependency treatment program can easily and quickly obtain preventive, primary, and specialty care.
- Increase SUD treatment capacity by allocating dollars to promote and establish community-based treatment options.

MATERNAL SAFETY BEGINS WITH MOMS-TO-BE

Texas must embrace public and private efforts to increase awareness of the importance of community-based efforts that promote early entry into prenatal care and ensure essential follow-up care after delivery. In addition, the Maternal Mortality and Morbidity Task Force reported that black women had a 2.3-times higher rate of maternal death than white women. Any public health efforts must target this at-risk population to provide the best care for all Texas mothers.

TMA recommends that the Texas Legislature:

- Support a comprehensive public education program on the importance of prenatal care, and eliminate Medicaid eligibility barriers that stymie timely enrollment.
- Support common sense efforts to reduce risk factors associated with maternal death and disease, such as initiatives to reduce smoking before and during pregnancy.

WELL-SPACED PREGNANCIES ARE SAFER PREGNANCIES

In Texas, approximately half of pregnancies are unintended. Women whose pregnancies are unintended are more likely to have a short interval between pregnancies —18 months or less — which increases health risks to mother and child. Unintended pregnancies also increase Medicaid costs. Medicaid pays \$3.5 billion per year for pregnancy- and delivery-related services for mothers and infants in the first year of life. Long-acting reversible contraceptives (LARCs), such as implants and intrauterine devices, are 20 times more effective than other methods, yet the latest national data indicate less than 12 percent of women rely on LARCs. Three of Texas' disjointed women's health programs cover LARCs as a benefit, but usage among women who want them remains low. Many physicians, hospitals, and clinics do not offer same-day availability of LARCs because of low payment, logistical hurdles, and insufficient training on how and when to use them.

TMA recommends that the Texas Legislature:

- Reduce red tape and payment barriers that are preventing widespread adoption of LARCs.
- Provide funding to make LARCs available immediately following delivery to women enrolled in CHIP-P.
- Increase teen access to contraceptive care by allowing adolescents to enroll in both CHIP and HTW (with parental consent).

GET THE NUMBERS RIGHT

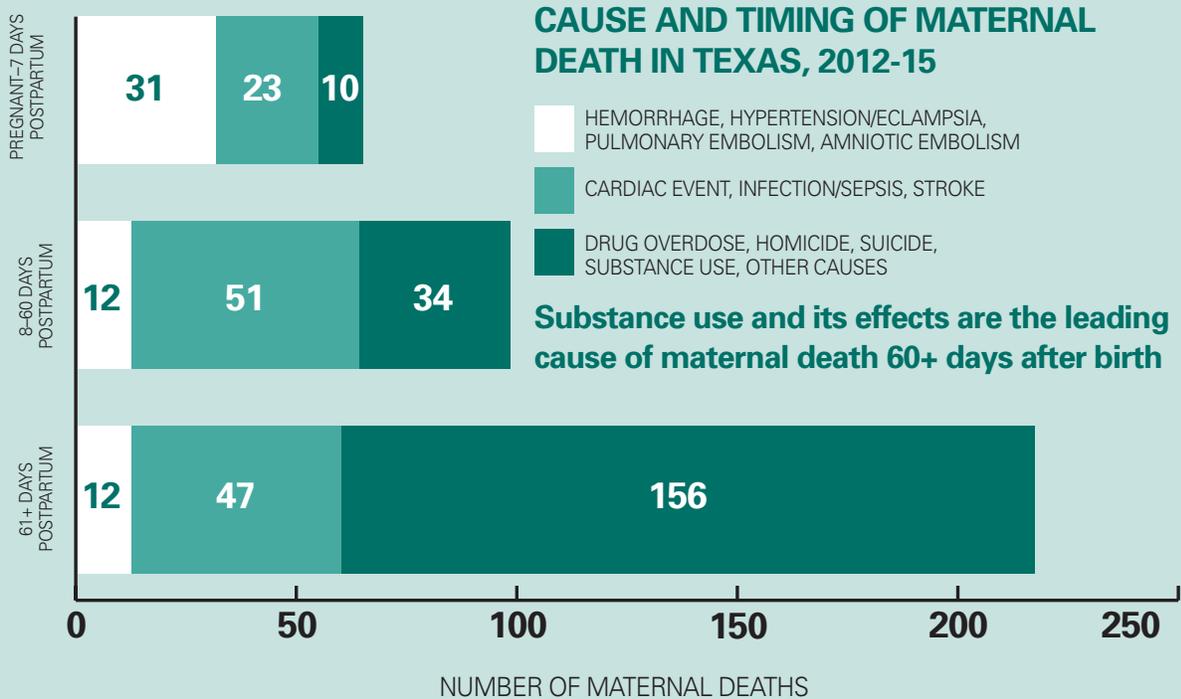
The lack of accurate data — including inaccurate and incomplete death certificates — has significantly complicated the state's quest to identify the root causes of Texas' maternal health problems. Meanwhile, physicians treating women before, during, or after their pregnancies frequently do not have access to their patients' complete social or medical history because the myriad of electronic health records (EHRs) in use are not interoperable. [See Section 1: Let Doctors Be Doctors, page 4.]

TMA recommends that the Texas Legislature:

- Support comprehensive efforts to improve the state’s surveillance of maternal mortality and ensure Texas’ maternal death records have accurate information on all of the factors associated with maternal deaths.
- Require improved interoperability among EHRs to eliminate barriers to the exchange of health information critical to providing quality maternal and postpartum care.

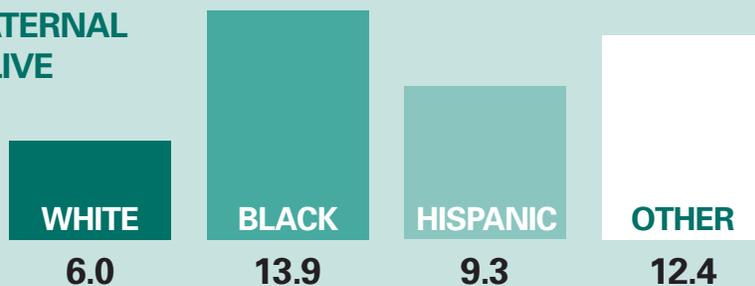
Most Pregnancy-Related Deaths Preventable, State Report Finds

Houston Chronicle, Aug. 24, 2018



PREGNANCY-RELATED MATERNAL DEATH RATE PER 100,000 LIVE BIRTHS IN TEXAS, 2012

Sources: Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report, September 2018; 2012 Death Files, 2011-2012 Live Birth and Fetal Death Files. Center for Health Statistics, DSHS

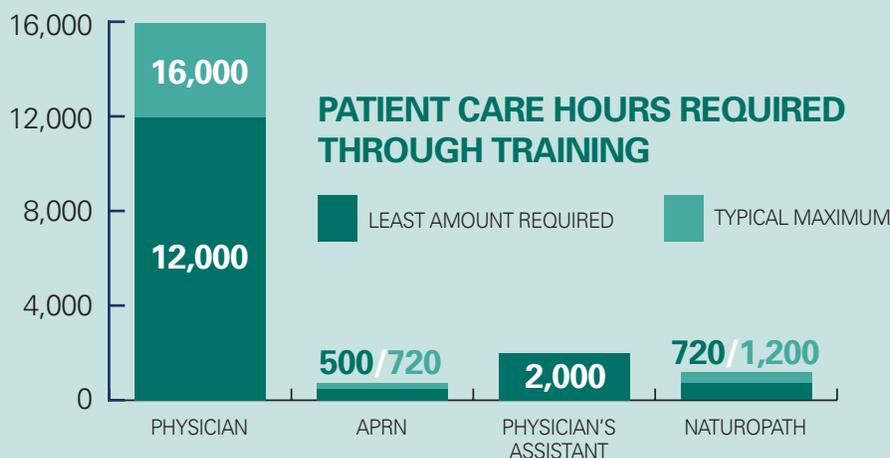


SECTION 6: FOCUS ON TEAMWORK AND PATIENT SAFETY

Texas needs more physicians and other health care professionals working in all parts of the state, especially in rural and border Texas. But the real gains in improving access to and coordination of patient care will come largely from solidifying and expanding the use of physician-led teams. Team-based care capitalizes on the efficiencies of having the right professional providing the right services to the right patient at the right time ... with overall direction and coordination in the hands of physicians. Unfortunately, nonphysician practitioners once again are asking lawmakers to expand their legal scope of practice beyond what their education, training, and skills safely allow. Advanced practice registered nurses (APRNs) want full practice authority. Pharmacists want to administer children's vaccines, prescribe some medications without a physician's directive, and perform some diagnostic testing. Chiropractors want to evaluate and treat disorders of the nervous system. And naturopaths, whose license was eliminated in Texas in the 1950s, want the state's stamp of approval on their activities once again.

TMA recommends that the Texas Legislature:

- Oppose any efforts to expand any health professionals' scope of practice beyond what is safely permitted by their education, training, and skills.
- Ensure any changes to scope-of-practice laws protect patient safety, are consistent with physician-led team-based care, are based on objective educational standards, and improve patient care.
- Require licensure and regulation by the Texas Medical Board (TMB) for any nonphysician practitioners who are qualified and seek authority to make a medical diagnosis and prescribe medications.
- Reject any attempt to adopt the APRN Compact multistate license, which would replace Texas scope-of-practice law with other states' laws and authorize patient care independent of a supervisory or collaborative relationship with a physician.
- Require structured clinical training for APRN students.



Source: American Medical Association
Scope of Practice Partnership

SECTION 7: INVEST IN PUBLIC HEALTH AND BEHAVIORAL HEALTH

The phrase “public health” elicits numerous images: first responders at a natural disaster, disease detectives peering through microscopes, posters, videos and flyers urging parents to vaccinate their children against deadly diseases, anti-smoking campaigns. Public health is all of this and more. It’s state and local government agencies, and individual physicians, working to detect, respond to, and prevent what’s bad for the health of Texans. Investments in public health have a proven ROI — like every dollar spent on childhood vaccination saves a minimum of \$10 in direct and indirect costs. In a classic example of “penny wise, but pound foolish,” though, public health budgets are constant targets for trimming. Failing to build and maintain our public health defenses definitely will cost Texas taxpayers far more in the long run.

DISASTER RESPONSE

Preparedness is the key to an effective response to any disaster — from a hurricane to a mass shooting. Planning, practicing, and knowing ahead of time what you’ll need to know onsite are essential. And each new disaster exposes shortcomings in the plan that need to be corrected before the next storm.

TMA recommends that the Texas Legislature:

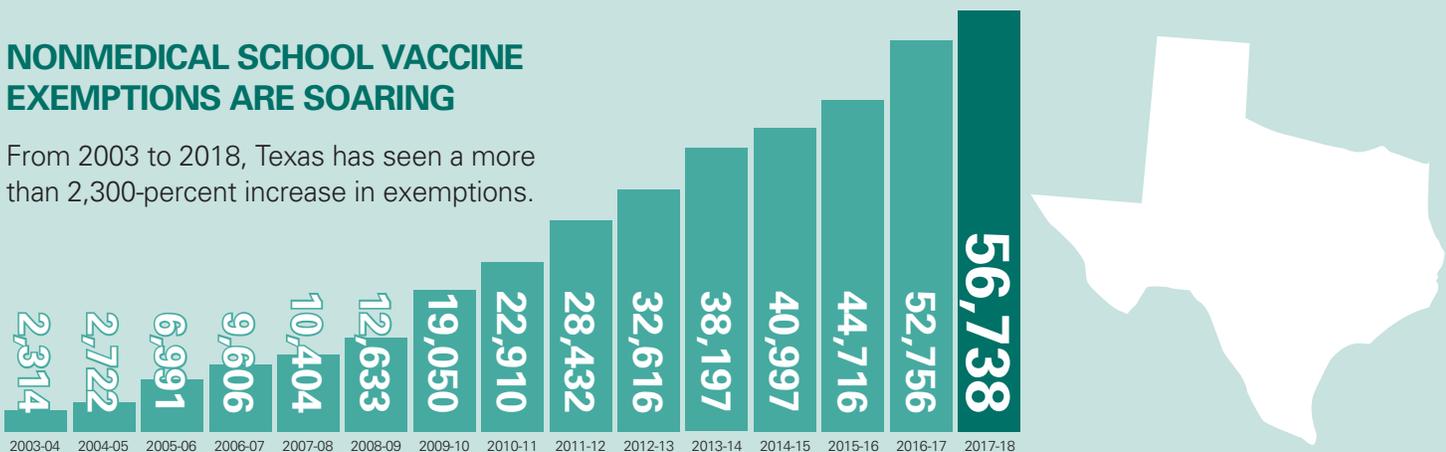
- Pass volunteer liability protections for physicians and institutions serving in disasters.
- Promote better access for first responders to vaccinations and to their vaccination records.
- Open the Adult Safety Net program to small and volunteer first responder organizations to ensure access to needed vaccines.

IMMUNIZATIONS AND INFECTIOUS DISEASE

Vaccines are safe and effective. They prevent dangerous infections that can kill, maim, and readily spread to others. Through intensive immunization campaigns, we have eradicated smallpox from the planet and eliminated polio in the U.S. Other diseases, like measles, went away but came back — primarily among people who refuse vaccinations. The vast majority of Texans — including 86 percent of Republican primary voters — support strong

NONMEDICAL SCHOOL VACCINE EXEMPTIONS ARE SOARING

From 2003 to 2018, Texas has seen a more than 2,300-percent increase in exemptions.



immunization requirements for school children. And vaccinations aren't just for kids. Nearly 12,000 Texans died of influenza in the 2017-18 season, and about 75 percent of them were 65 or older. The flu shot doesn't provide perfect protection, but even among older people who live in long-term care facilities — where flu outbreaks are most common — the vaccine is 80-percent effective in preventing death from a flu complication.

TMA recommends that the Texas Legislature:

- Require public school campus-level reporting of vaccine exemption information.
- Reduce the number of children allowed into school provisionally when lacking full vaccination coverage.
- Protect and reform Adult Safety Net immunization funding.
- Improve outbreak reporting and response on flu and other infectious diseases in long-term care facilities.
- Improve surveillance and prevention of multi-drug resistant organism (MDRO) infections in long-term care facilities.
- Require long-term care facilities to maintain easily accessible information on the vaccine status of their patients and staff.

Texas Is the 2nd Fattest State for Children, New Study Determines

Houston Chronicle, Nov. 7, 2017

OBESITY

Obesity and being overweight contribute to diabetes, hypertension, heart disease, cancer, stroke, and maternal health problems. Unfortunately, Texas has a growing obesity crisis. One third of adult Texans were obese in 2017, up from 21.7 percent in 2000. In the 2016-17 school year, 18.5 percent of Texans age 10 to 17 were obese, the seventh highest rate in the nation. For most of us, the cause of obesity is simple: too much food and not enough activity. The cure: eat less and move more.

TMA recommends that the Texas Legislature:

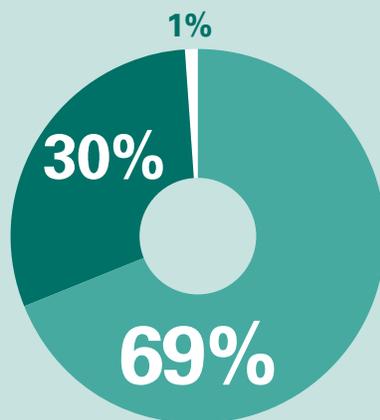
- Restore required credits in physical education for high school and middle school students.
- Place limits on using Supplemental Nutrition Assistance Program (SNAP) benefits to buy sugar-sweetened beverages and unhealthy foods.
- Allow SNAP benefits to be used at farmers' markets to purchase locally grown fruits and vegetables.

TOBACCO AND CANCER

Tobacco use is the No. 1 cause of preventable disease and premature death in Texas. Approximately 28,000 Texans die from smoking every year. We spend an estimated \$8.8 billion in annual direct health care costs attributable to tobacco use. Nearly 3 million Texas adults smoke cigarettes, and most smokers (95 percent) took their first puff well before the age of 21. Adolescent tobacco use leads to an increased risk of nicotine addiction. Continued use causes lung cancer, coronary heart disease, diabetes, other serious and costly chronic health conditions, and an early death.

TMA recommends that the Texas Legislature:

- Raise the minimum legal age for purchasing tobacco products to 21.
- Restore state funding for tobacco prevention and control programs and eliminate funding restrictions on statewide efforts to prevent tobacco usage.
- Ensure adequate funding for the Cancer Prevention and Research Institute (CPRIT) and the Texas Cancer Registry.



TEXANS OVERWHELMINGLY SUPPORT RAISING THE TOBACCO AGE TO 21



Tobacco use is the number one cause of preventable disease and premature death in Texas.

Source: ACS CAN Texas Cancer Poll, conducted by Public Opinion Strategies, Dec. 10-13, 2016

BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER

Behavioral and mental health have been an unintentional mainstay in the news for many months now, due to the increasing number of natural disasters, overdoses, and mass shootings. Those with substance use disorder (SUD) frequently also have a mental health illness or disorder. The physical devastation wrought by natural disasters leaves largely unattended emotional devastation in its wake. Although the 85th Legislature shined a bright light on mental health problems and made significant progress in understanding how to recognize them and provide options for treatment, more can be done. TMA's recommendations will help health care professionals, mental health professionals, and law enforcement make sure that people living with SUD and behavioral health problems get appropriate help when needed.

TMA recommends that the Texas Legislature:

- To combat the opioid epidemic and SUD, expand access to Medication Assisted Treatment (MAT), expand available options for safe disposal of unused medications, consider incentives for physicians to train and be certified in MAT, and improve HHSC coordination with local mental health authorities in rural areas and small towns.
- Utilize innovative telemedicine initiatives to expand the ability of primary care physicians to treat and manage behavioral health disorders.
- Increase funding for jail diversion programs for people with mental health conditions and SUD.
- Expand availability of public school-based counselors and mental health programs to improve school safety.

SECTION 8: BOOST ACCESS TO CARE

It's Going to Hurt All of Us

In a rural Texas town where one-third of the patients admitted to the local hospital have no insurance, Athens family physician Douglas Curran, MD, does all he can to keep women like Rose (not her real name) out of the hospital.

Rose is part of what Dr. Curran calls “this massive group of working poor who have no access to care.” She doesn’t make enough to afford private insurance. She makes too much to qualify for Medicaid.

“She’s one of the strategic breadwinners in the family,” he said. “So when she’s not working, they’re struggling just to buy food.”

Rose just can’t afford to get sick, says Dr. Curran. And Texas can’t afford for Rose to get sick either. Not Rose and not the men and women who tend our ranches, build our office towers and highways, or serve our meals — the 4.5 million Texans who put our state at the top of the nation’s list of uninsured residents.

“Right now, we have a state that’s really moving business-wise, a lot of things are happening,” he said. “If you keep people healthy, they’re producing, they’re generating, they’re keeping things going. But if that populace is not properly cared for and supported and empowered, then we’ll see the people that we really need to keep our business environment pristine begin to drift away. It’s going to hurt all of us.”

Dr. Curran was on call the night Rose was wheeled into the emergency room. She was short of breath, had “big swollen feet,” and the oxygen level in her blood was dangerously low. He drained 50 pounds of fluid from her body and released her on aspirin and three generic medications — “three, \$4 drugs” — to treat her congestive heart failure and high blood pressure.

Thankfully, Dr. Curran also was able to refer Rose for follow-up to a local, physician-run, volunteer clinic for the working poor.

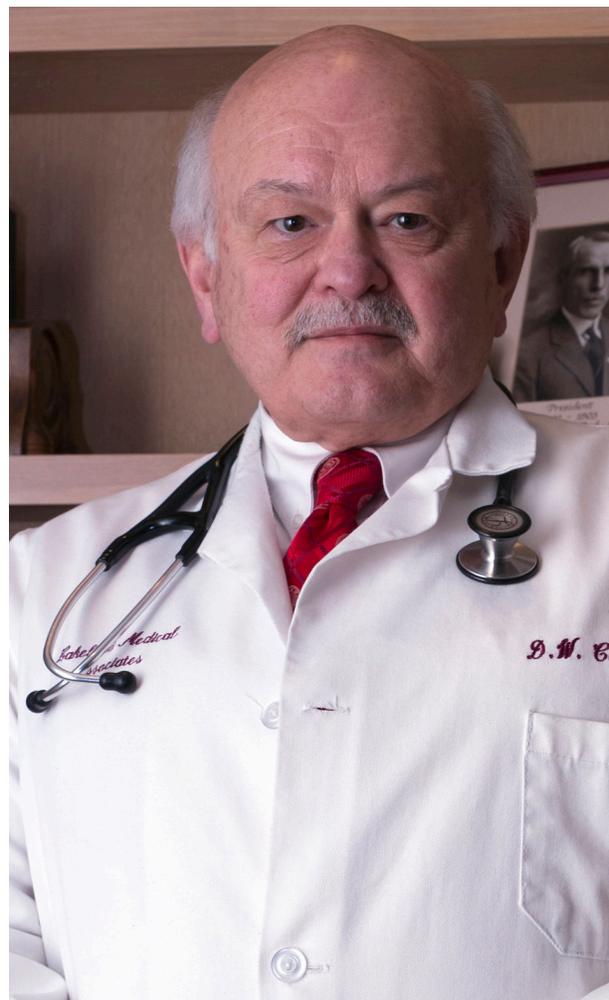
“We take care of the people who can pay a little bit there,” he said. “They pay \$15. It goes into the pot to keep the clinic going. The nurses are all volunteers. My wife’s an RN; she volunteers there a day a week. You do what you have to do.”

At the clinic, doctors and nurses can check Rose regularly to make sure the medicines are keeping her healthy — and to make sure the drugs’ side effects aren’t making her sicker. Without those check-ups, neither Dr. Curran nor any other physician could safely refill her prescriptions. Nor would they.

“Nobody’s going to refill those medicines, so she’ll re-accumulate that fluid, and she’ll be back in the hospital, and it costs \$25,000 to get her back to a stable state on those \$4 medications,” he said. “At the end of the day, that raises your insurance rates, my insurance rates, and everybody else’s insurance rates because she’s back in the highest cost place to get care there is (the emergency department).”

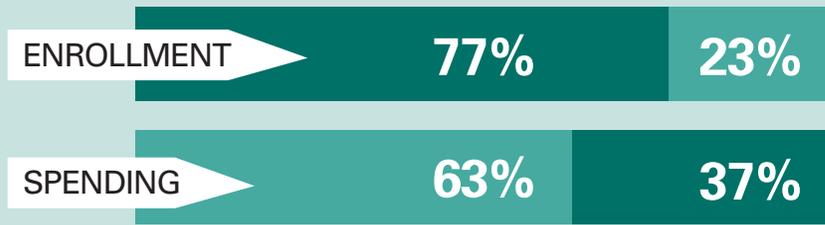
After passage of the Affordable Care Act in 2010, 33 states expanded eligibility for their Medicaid programs to include people like Rose. Texas did not, and all of the state’s top leaders remain strongly opposed to expansion.

Dr. Curran supports finding ways to get more Texans insured, but he says his practice can’t afford to accept too many



TEXAS MEDICAID ENROLLMENT AND SPENDING BY CATEGORY

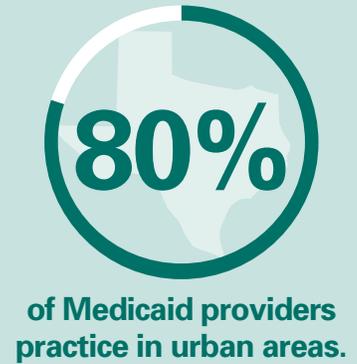
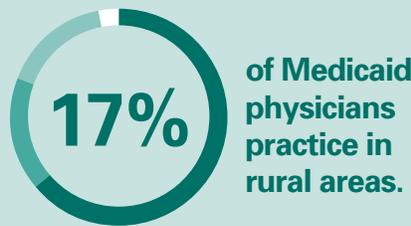
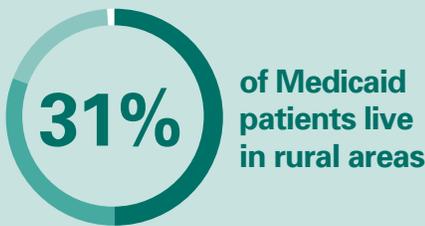
- ELDERLY AND PEOPLE WITH DISABILITIES
- ADULTS AND CHILDREN



Source: Kaiser Family Foundation

MEDICAID PATIENT AND PROVIDER LOCATIONS

- URBAN
- RURAL
- SUBURBAN
- UNKNOWN



Medicaid patients. With operating costs of \$41,000 a day for 17 family physicians, and Texas’ notoriously low payment rates for primary care services, Medicaid is a losing proposition.

“It’s not enough to pay my bills or to keep the lights on and to pay my employees,” he said. “A visit for a sore throat pays me about \$27, and it costs me about \$48 to see the patient in my office. I’d be better off [financially] giving a Medicaid patient 10 bucks and sending her to the emergency room.”

For more than a decade, Texas has held the title of “Uninsured Capital of the United States.” And for the first time in a decade, the number of children without health insurance increased in 2017, eroding Texas’ slow gains in coverage for children. The friction created when 17 percent of the population lacks health insurance threatens to slow our booming Texas economy. It increases costs to taxpayers and insured Texans, and heaps unpaid expenses onto physician practices and hospitals. It leaves 4.5 million uninsured men, women, and children wondering what they’ll do if they become seriously ill or injured. Meanwhile, Medicaid, CHIP, HTW, and other safety net programs struggle to meet their mandates. Terribly low payment rates, incessant bureaucratic hassles (for physicians and patients), and a confusing maze of not-well-connected delivery systems are primarily to blame. Patients end up seeking far too much primary care and routine care in emergency departments, the most expensive piece of our health care system. TMA’s prescription to enhance access to health care includes innovative coverage models for the working poor, competitive Medicaid payment rates, a revolution of simplicity and transparency for all of the state’s health programs, further investments in cost-effective ways to grow our physician workforce, and more progress on telemedicine.

New Medical Schools Won't Cure Texas Doctor Shortage

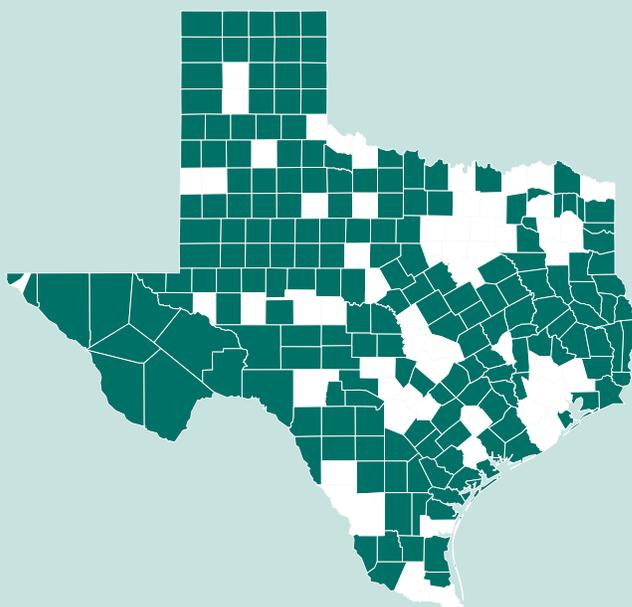
Houston Chronicle, Nov. 24, 2018

STRENGTHEN MEDICAID

Medicaid provides health insurance coverage for nearly 4 million Texans — two-thirds of them children. About two-thirds of Texas Medicaid spending, however, pays for care for adults with disabilities and seniors. The state contracts responsibility for nearly all of the program to managed care organizations (MCOs). Recent news reports have revealed extensive problems with some of the MCOs' management of care for extremely vulnerable patients. For physicians, Medicaid and CHIP are typically the lowest payers. They often do not cover the basic cost of providing care. Furthermore, Medicaid's mounds of paperwork saddle practices with extra costs without benefitting patient care. As a result, the Medicaid physician network has shriveled dramatically, harming patient care and contributing to higher costs for taxpayers. Physicians, hospitals, and MCOs have begun a collaboration to identify reforms that promise to improve patient care while decreasing Medicaid-related headaches and hassles.

TMA recommends that the Texas Legislature:

- Allocate funds to ensure competitive and appropriate Medicaid payments, prevent Medicaid payment rate cuts, and promote fair payment to match inflation and cost of practice increases.
- Reduce administrative burdens and bureaucracy surrounding physician participation in Medicaid and all other health benefit programs, reduce unnecessary prior authorization requirements, and integrate Medicaid and managed care enrollment and credentialing.
- Increase HHSC oversight, transparency, and accountability for Medicaid MCOs, including improved monitoring of MCO network adequacy.
- Support innovative Medicaid MCO/physician collaborations that reduce red tape and reward high-performing practices.



HEALTH PROFESSIONAL SHORTAGE AREAS IN TEXAS

- SHORTAGE AREA
- AREAS WITH ADEQUATE COVERAGE

CONTINUE TO EXPAND GRADUATE MEDICAL EDUCATION

Texas has led the nation in population growth for the past two decades, adding nearly half-a-million people a year over that time. All of these new Texans need a lot more doctors. The state currently has 12 medical schools — three of which opened since 2016 and have yet to produce a graduating class. Three more are scheduled to open by 2021. The annual number of graduating physicians will grow from about 1,800 in 2019, to more than 2,200 by 2024. But becoming a physician is a two-part process: four years of medical school, followed by three or more years in residency, or graduate medical education (GME). Texas retains 80 percent of physicians who complete medical school and residency in Texas, but a much smaller share of those who go out of state for GME (after Texas taxpayers spent about \$180,000 each to support their medical education). Thanks to strong, continued support from the Texas Legislature, the state has engaged in a steady expansion in the number of GME slots available. In 2018, Texas finally reached its goal of having 1.1 GME positions for every medical school graduate. A much larger investment will be needed to keep up with all the new medical schools and to keep as many new doctors in Texas as possible.

TMA recommends that the Texas Legislature:

- Fully fund GME to maintain the ratio of 1.1 entry-level residency positions for every Texas medical school graduate.

IMPROVE ACCESS TO CARE IN RURAL AREAS

Texas' physician shortage is particularly acute in our state's vast rural areas. Of Texas' 172 rural counties, 101 are designated as "Primary Care Health Professional Shortage Areas." Eighty-four rural Texas counties have five or fewer physicians; 24 counties have none. Ten rural Texas hospitals have closed permanently since the beginning of 2013.

TMA recommends that the Texas Legislature:

- Restore funding for the primary care Physician Education Loan Repayment Program and the Family Medicine Residency Program.
- Support the development of rural health GME tracks to produce more physicians for rural Texas.
- Provide other incentives for physicians to practice in rural and underserved areas, especially in primary care and other needed specialties.

BOOST TELEMEDICINE ACCESS AND PAYMENT

The 2017 Texas Legislature made tremendous progress, passing a law that defines telemedicine as a way to deliver health care, not a health care service. It also clarifies that the standard of care for a telemedicine visit is the same as when a physician sees a patient in person. With that framework in place, the state can now take steps to take better advantage of this technology.

TMA recommends that the Texas Legislature:

- Improve broadband access across Texas to accelerate telemedicine adoption and implementation.
- Support innovative uses and applications of telemedicine to promote continuity of care across all specialties.
- Require health plans to allow a patient's physician to utilize — and get paid for utilizing — telemedicine to provide a covered service, through a platform of the physician's choice.
- Ensure that patients' regular physicians can use telemedicine to treat their patients and not force them to go to an outside vendor for telemedicine services.

SECTION 9: DON'T LET CORPORATIONS PLAY DOCTOR

The Last Line of Defense

Physicians are the last line of defense between a patient and a corporation's bottom line, says Austin hospitalist Dieter Martin, MD.

Hospitalists are skilled in treating the numerous non-emergency circumstances they encounter while treating inpatients in a hospital. Emergency medicine physicians, meanwhile, are trained specifically to handle trauma and the rapid-fire assessment and treatment necessitated by emergencies. They aren't interchangeable.

"Memorizing the rules to basketball doesn't make me LeBron James," Dr. Martin said. "I can play basketball, but not like he does."

Compared to hospitalists, emergency physicians are like LeBron on the free agent market: expensive. And that cost differential, a lawsuit filed by Dr. Martin's group alleges, is why the company that contracts for both specialties' services mandated that hospitalists cover emergency room crises like cardiac arrest and mass casualties on overnight shifts.

These allegations have not been proven in court. But this kind of conduct is what doctors mean when they talk about the corporate practice of medicine: the usurpation by a nonphysician of a physician's diagnostic, treatment, prescribing, and referral authority and responsibility. It's the practice of medicine by corporations. Although illegal in Texas, it still happens frequently.

Consider the impact when administrators, rather than physicians, make critical medical decisions. Micromanagement of length-of-stay data, not a clinical assessment of a patient's recovery, determines when a patient should be discharged from a hospital — even if he or she isn't ready to go home yet, Dr. Martin said.

Hospitals are paid for patient stays based on diagnostic codes determined by physicians. But "it is not uncommon for hospitals to tack on additional costs based on lab results, like if labs indicate something like malnutrition," explained Dr. Martin. "That's not why the patient came to the hospital, and [it] will be coincidentally resolved during the regular course of treatment, but hospitals bill for it, which ultimately costs the patient more."

Or imagine the relief you feel when your grandmother is finally ready to be discharged and her physician says she can continue to convalesce at home. Not so fast, says the hospital, insisting instead that she be referred to a rehab facility of the hospital's choosing — and possibly ownership.

"It's not really an arm's length relationship," says Dr. Martin. "It's more like hands around a doctor's neck."

The more hospital-dependent medical specialists are, the more leveraged they are because the hospital essentially has a monopoly on their workplace. Emergency room physicians and anesthesiologists are most frequently caught in this cross-fire. Physicians, and their patients, have little opportunity to push back against hospital dictates.

When physicians do object, and contracts are threatened, they have few options: acquiesce or find themselves out of work. In a city like Austin, with only two hospital systems, finding other work can be challenging. Forcing physicians to another state or town, or into early retirement, only exacerbates our ongoing physician shortage.

When physicians talk about "clinical autonomy," they mean white coats, not grey suits, should make patient-care decisions. Physicians are ethically and morally bound to put their patients first. Corporations have other responsibilities.



The sanctity of the patient-physician relationship is absolute. Patients trust their physicians to do what is best for their individual circumstances; physicians know that each patient is special and unique and requires their undivided attention. Everyone knows the physician's credo: Responsibility to the patient is paramount. And despite the pervasiveness and ambiguity of endless regulations, day in and day out, physicians live and honor that rule. But the corporations that manage the business end of health care exist to make money. That unflinching focus on the bottom line — and persecution of those who report unethical incursions — has the potential to significantly and adversely impact patient care. TMA has several recommendations to reinforce our state's ban on the corporate practice of medicine, or infringement upon the physician's clinical judgment and paramount responsibility to the patient. Physicians are ethically and morally bound to put their patients first. Corporations have other responsibilities.

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of respondents said they had seen physicians lose employment, contracts, or hospital privileges raising concerns about hospital regulatory compliance or patient care quality.

HOSPITALS INTERFERING IN PHYSICIANS' CLINICAL AUTONOMY

Source: TMA 2018 Physician Survey



of respondents said they feared losing their independence in clinical decision-making.

PROTECT EMPLOYED PHYSICIANS' CLINICAL AUTONOMY

Texas' ban on the corporate practice of medicine prohibits the employment of a physician by non-physicians in most circumstances. State law does, however, allow physicians to be employed by nonprofit health organizations "incorporated and directed by physicians licensed by the Texas Medical Board (TMB)." The medical board is also tasked with approving and certifying all nonprofit health organizations. An April 2017 TMB report

listed 550 active organizations, the largest of which are closely aligned with big hospital systems and employ several thousand physicians. As these nonprofit health organizations multiply and grow, so do their opportunities to control physicians' clinical decisions.

TMA recommends that the Texas Legislature:

- Protect physicians' independent medical judgment and clinical autonomy when lay control can interfere with best practice.
- Ensure that transparent due process provisions are included in all contracts, and that physicians employed by lay owned or run entities have a fair discipline or termination "for cause" process.
- Prohibit retaliation against employed physicians for reporting quality of care concerns or advocating for patient safety and the quality of medical or hospital care.
- Establish a more robust process at the TMB for receiving and investigating complaints against nonprofit health organizations.
- Prohibit hospitals from requiring or incentivizing employed physicians to make referrals to hospital-affiliated entities and professionals as a condition of employment.
- Pass no legislation that allows the government or corporate entities to dictate care that prevents physicians from exercising their moral or ethical conscience, or from providing medically appropriate care.

TEXAS MEDICAL BOARD SUNSET

Despite a complete Sunset review in 2016 and little disagreement over recommendations to improve the TMB, renewal of the agency and the Medical Practice Act became collateral damage in the battles between the Texas Senate and House of Representatives that marked the end of the 2017 regular legislative session. When lawmakers revisited TMB Sunset in the July-August special session, they decided to renew the agency for just two years and made no changes to TMB operations or the Medical Practice Act. TMB Sunset is back on the agenda for the 2019 legislature.

TMA recommends that the Texas Legislature:

- Renew the TMB and the Medical Practice Act for a full 12-year Sunset cycle.
- Ensure fair TMB disciplinary and appeals processes.
- Provide the overworked agency with more resources for licensing and oversight/enforcement.

VALUE PATIENT AUTONOMY

Perhaps no decision we make is more personal, difficult, or profound as choosing how we wish to spend our final days. Physicians encourage all Texans to think this through carefully — and discuss their decisions with family and loved ones — long before they enter a hospital or nursing home with a terminal illness. Texas physicians abide by the principle, "First, do no harm." For this reason, TMA supports the Texas Advance Directives Act as signed into law by then-Gov. George W. Bush. Its aim is to allow patients to make their care preferences known before they need care, and to protect patients from unnecessary discomfort, pain, and suffering due to excessive medical intervention in the dying process.

TMA recommends that the Texas Legislature:

- Support patients' right to make their own end-of-life care decisions and prohibit them from being overridden by a surrogate.
- Oppose attempts to legalize physician-assisted suicide.
- Protect physician moral conscience and continue to shield from liability physicians who seek to resolve end-of-life disputes via a medical ethics committee.
- Oppose changes to the medical power of attorney form that would permit the use of co-agents.

SECTION 10: LIFT THE FEDERAL REGULATORY BURDEN

TMA focuses most of its advocacy activities on the Texas Legislature and state agencies and courts. Because the federal government plays such an outsize role in health care policy and programs, however, TMA also conducts extensive advocacy with the U.S. Congress and federal regulatory agencies. As on the state level, much of TMA's work in Washington is intended to ensure physicians receive fair payment for the medical services they provide to patients, and to win relief from onerous government regulations.

KEEP WHAT'S GOOD; FIX WHAT'S BROKEN

Given the split partisan control of the 116th Congress, most experts expect little or no major health care legislation to pass. TMA, however, will continue to push for repeal of unfair or illogical provisions in the Affordable Care Act (ACA) and other health care laws, while supporting those parts of the ACA that improve patients' access to quality care.

TMA recommends that the U.S. Congress:

- Repeal the moratorium on physician-owned hospitals.
- Repeal the prohibition on physician joint ownership of diagnostic laboratories.
- Allow physicians to contract directly for services with Medicare beneficiaries.
- Maintain insurance coverage for patients with pre-existing conditions.
- Maintain essential health benefit requirements.
- Impose no federal caps on state Medicaid funding.
- Increase or eliminate the Medicare GME funding cap, and increase GME capacity for primary care, and in rural and underserved areas.
- Relax restrictions on self-referral for physicians serving rural, medically underserved, and economically depressed areas.

CUT FEDERAL RED TAPE

TMA's primary federal objective in the near future will be to obtain continued regulatory relief from the Department of Health and Human Services (HHS), the Centers for Medicare & Medicaid Services (CMS), and other administrative agencies.

TMA recommends that federal agencies:

- Ensure appropriate pay for Medicare services provided.
- Enact extensive reforms to Medicare's Quality Payment Program (QPP), eliminating all penalties, reducing QPP's overwhelming administrative and technology burdens, and using fair and clinically appropriate quality metrics.
- Further reduce QPP's administrative requirements for small and rural practices.
- Hold electronic health record (EHR) vendors more accountable for interoperability and data submission errors.
- Develop appropriate risk requirements for physicians participating in Medicare's advanced alternative payment model (APM) tracks.
- Streamline Medicare and Medicare Advantage enrollment and credentialing.
- Reduce federal administrative burdens and bureaucracy surrounding participation in Medicaid.
- Help Texas implement cost-reducing, quality-improving Accountable Care Organizations (ACOs) in the Medicaid program.
- Modernize and streamline enrollment, access to service, eligibility verification, medical records management, billing, and appropriate payment in the Veterans Choice Program.

SPECIAL REPORT: TEXAS PHYSICIANS INJECT BILLIONS INTO LONE STAR STATE ECONOMY

Physicians add opportunity, growth, and prosperity to the Texas economy by creating more than 670,000 jobs and generating nearly \$120 billion in economic activity, according to a 2018 economic impact analysis prepared by the IQVIA consulting firm.

The study quantifies the boost that 51,333 active Texas patient care physicians provide to the state’s economy, producing a ripple effect that is felt statewide. It measures physicians’ impact using four key economic indicators:

- **JOBS:** Physicians support 670,172 jobs in Texas —13.1 jobs for each physician on average.
- **ECONOMIC ACTIVITY:** Physicians generate \$117.9 billion in economic output, comprising 7.3 percent of the Texas economy. Each physician generates \$2.3 million for the local and state economy on average.
- **WAGES AND BENEFITS:** Physicians contribute \$55.4 billion in total wages and benefits paid to workers across Texas, empowering a high-quality, sustainable, professional workforce. Each physician contributes \$1.1 million to workers’ wages and benefits on average.
- **STATE AND LOCAL TAX REVENUE:** Physicians’ contribution to the Texas economy generates \$3.5 billion in state and local tax revenue — translating to \$68,599 in tax revenue for each physician on average — helping to pay for schools, roads, criminal justice system, and health care services for all Texans.

The IQVIA analysis found that every dollar applied to physician services in Texas generates an additional \$2.13 in other business activity. An additional 7.66 jobs, above and beyond the clinical and administrative personnel that work inside physician practices, are supported for each \$1 million of revenue generated by a practice. In addition, Texas physicians generate more economic output, produce more jobs, and pay more in wages and benefits than higher education, nursing and community care facilities, legal services, and home health.



JOBS	670,172
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Direct jobs	246,714
Indirect jobs	423,458
Average jobs supported by each physician.....	13.1



ECONOMIC ACTIVITY	\$117.9 BILLION
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Direct economic output.....	\$55.2 billion
Indirect economic output	\$62.7 billion
Percent of total GSP/GDP ²	7.3%
Average economic output generated by each physician.....	\$2.3 million



WAGES AND BENEFITS	\$55.4 BILLION
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Direct wages and benefits	\$34.0 billion
Indirect wages and benefits.....	\$21.4 billion
Average jobs supported by each physician.....	\$1.1 million



STATE AND LOCAL TAX REVENUE	\$3.5 BILLION
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Average state and local tax revenue generated by each physician	\$68,599



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