Texas Medical Association Overview

The Texas Medical Association (TMA), the nation’s largest and one of the oldest and most powerful state medical societies, speaks out for more than 47,000 physician and medical student members across the state in our commitment to improve the health of all Texans. In partnership with our 120 county medical societies, we have been helping Texas physicians set high professional and ethical standards since 1853.

TMA monitors state and national laws to ensure that physicians can practice their craft with a minimum amount of interference. We help doctors set up offices and file claims for payment. TMA is the physicians' partner in health education through programs like *Be-Wise Immunize* and the *Physicians Oncology Education Program*. TMA offers continuing medical education programs, has its own physicians' insurance, and publishes both a bi-monthly newsletter, *Action*, and a monthly health care magazine, *Texas Medicine*. Our website keeps membership informed of the latest medical news and special programs offered by TMA.

**Mission**: TMA supports Texas physicians by providing distinctive solutions to the challenges they encounter in the care of patients. In 2004, the Board of Trustees developed the following four goals and targeted strategies:

**GOAL 1. Viability**: Protect, improve, and strengthen the viability of medical practices in Texas.

*Strategies:*
1. Ensure Texas physicians receive timely and equitable payment for medical services provided.
2. Provide cost-effective solutions to improve all aspects of practice management operations.
3. Increase Texas physicians' understanding, adoption, and appropriate utilization of vital information technologies to support efficiency, efficacy, and quality-of-care measurement.

**GOAL 2. Environment**: Ensure continued success in legislative, regulatory, and legal interventions to enhance the statewide environment in which Texas physicians practice medicine.

*Strategies:*
1. Develop and implement public and private sector strategies promoting sustainable health care financing and delivery systems to improve access to health care.
2. Promote patient-centered, cost-efficient, and physician-directed systems of care.
3. Support a Texas-specific strategy to address growing physician demand.

**GOAL 3. Trusted Leader**: Strengthen physicians' trusted leadership roles within their communities.

*Strategies:*
1. Enhance the public image of TMA-member physicians.
2. Provide practice-based materials to improve effectiveness and awareness of public health initiatives through the patient-physician relationship.
3. Reinforce the physician's role as the leader of the health care team.
4. Uphold physician professionalism.

**GOAL 4. One Voice**: Enhance the powerful, effective, and unified voice of Texas medicine.

*Strategies:*
1. Ensure a powerful voice through growth in membership and member involvement and the ongoing financial health of the association.
2. Promote an effective voice through leadership development, active governance structures, and disciplined message development and dissemination.
3. Demonstrate a unified voice by strengthening relationships and strategic alliances within and without the federation of medicine.
Border Health Caucus Overview

Physician leaders from cities and county medical societies along the border and south Texas—including Brownsville, Corpus Christi, El Paso, Eagle Pass, Edinburg, Harlingen, Laredo, McAllen, Pharr, Rio Grande City, and San Antonio—united in 2001 to form the Border Health Caucus (BHC). Their mission is to ensure lawmakers in Austin and Washington, D.C., understand the unique health challenges facing the border region and improve access to care.

Since 2001, the BHC continues to be a strong voice for patients and their communities regarding health care policy and regulation. Here are a few of its accomplishments:

- **Medical liability reform day of awareness:** The caucus identified medical liability reform as its top priority in 2002 and organized a *Day of Awareness*. Physicians closed their offices to raise awareness of lawsuit abuse in Texas, which was forcing physicians to leave the state.

- **Passage of landmark liability reforms:** In 2003, the BHC joined the Texas Medical Association (TMA) in the fight to pass medical liability reform and Proposition 12. In conjunction with TMA, border physicians built a strong grassroots campaign that was critical in passing Proposition 12, which has become a nationally recognized model for medical liability reform.

- **Legislator Preceptor Program:** Physicians take legislators on a tour of the border’s health care infrastructure to help legislators better understand the forces affecting the health care system and patients (their constituents).

- **Annual Border Health Conference:** Each year since 2004, BHC physicians and health care experts from along the U.S.-Mexico border and south Texas take their concerns and solutions directly to Washington, D.C. The goal of the conference is to raise awareness of the many health care challenges along the border and to ask the U.S. Congress to:
  - Strengthen the border’s public health infrastructure
  - Eliminate health care disparities
  - Prevent chronic disease
  - Improve patients’ access to a physician by shoring up the health care workforce
  - Fix Medicare so it is sustainable and can better serve seniors, people with disabilities, and military families who depend on it for care.

- **First Tuesdays at the Capitol:** Each year, physicians spend time at the state capitol advocating for their patients and their profession.

- **Legislative tour of the valley:** The BHC has participated in the Rio Grande Valley Partnership’s legislative tour. The tour aims to educate legislators about the complex regional health care needs.

*Information accessed from the TMA website, [www.texmed.org](http://www.texmed.org), on June 6, 2013.*
Here’s something Congress can do to make an immediate, positive impact on health care: Eliminate costs and hassles that don’t add value to patient care. New regulations and mandates are bombarding physician practices seemingly every day. Last January, a new electronic format for claims and other electronic transactions (called “HIPAA 5010”) added costs to physician practices. The switch to the International Classification of Diseases and Related Health Problems version 10 (ICD-10) next year will require physicians to adopt an entirely new language to record all possible diagnoses and inpatient procedures, adding significant training costs.

It’s time for Congress and government agencies to consider the disruption that new regulations and penalties introduce into medical practices and refrain from introducing new hurdles.

Medicare’s required Physician Quality Reporting System pays a bonus at first but imposes penalties beginning in 2015. New state and federal privacy laws introduce more paperwork, and severe penalties for noncompliance. Stepped-up state and federal “fraud” detection has resulted in monumental compliance programs that further increase the cost of running a practice. These changes have limited documented evidence they will improve care or reduce fraud or protect privacy but absolute and complete assurance they will increase the cost of doing business in medicine.

All of those bureaucratic hassles come against the backdrop of the never-ending payment uncertainty due to the annual, cliff-hanger battle over Medicare payment cuts imposed by the Sustainable Growth Rate (SGR) formula. Frustrated physicians are dropping out of the program; last year only 58 percent of Texas physicians accepted all new Medicare patients, down from 78 percent in 2000.

**Put ICD-10 on permanent hold**  
*(HR 1701 by Poe; Coburn amendment to S 954)*

ICD-10 adoption, which will mandate extensive revision of physicians’ paper and electronic systems, is a costly regulation that will create significant burdens on the practice of medicine with no direct benefit to individual patient care. The mandatory Oct. 1, 2014, transition to the new system will cost solo physicians as much as $83,000 each, and group practices of up to 10 doctors as much as $250,000. And the punishment for noncompliance is severe: no payment for any medical services provided.
Support physician ownership of hospitals
(HR 2027 by Sam Johnson)

One of the Patient Protection and Accountable Care Act's (PPACA's) sections inhibits physicians' legal rights to own or invest in hospitals and other facilities that provide their patients high-quality care. Section 6001 prohibits new doctor investment in hospitals that take care of Medicare patients; no physician-owned hospitals may start nor may current ones expand.

Congress should focus not on who owns the medical facility but on the quality of the facility and appropriateness of patient care. Physician-owned hospitals receive the highest quality ratings and have better outcomes, shorter hospital stays, and much higher patient satisfaction scores than nonphysician-owned hospitals.

Stop the Medicare Meltdown — repeal the SGR

Without a robust network of physicians to care for the millions of patients dependent on Medicare, the program will not work. As bad as today's numbers are, half of all Texas physicians are considering opting out of Medicare altogether. This is because federal law requires Medicare payments to physicians to be modified annually using the SGR. Because of flaws in how it was designed, the formula has mandated physician fee cuts every year for more than decade.

However, momentum is building in Congress to overturn Medicare's flawed payment formula and replace it with a new one. The new payment system discussed by Congress would pay physicians based on quality measures. Physicians agree, their patients deserve quality care — and providing high-quality care is the goal of most physicians. However, as Congress debates this concept, we believe Medicare must develop an objective standard of quality measurements — one based on evidence-based science — and not one based on bureaucratic, arbitrary data points. Physicians must clearly understand the quality measurements enforced, have access to timely comparative data, and have the ability to control patient variables. Physicians shouldn't be penalized because they care for a sicker, poorer Medicare population or because they work in rural Texas. The new payment model must pay all physicians fairly, regardless of specialty and practice type.

It's critical that the SGR's replacement not continue to threaten the viability of physicians' practices or add new bureaucratic hassles to caring for Medicare patients.

Repeal the IPAB
(S 351 by Cornyn; HR 351 by Roe)

PPACA created the 15-member Independent Payment Advisory Board (IPAB) to recommend measures to reduce Medicare spending. The panel cannot recommend changes to eligibility, coverage, or other factors that drive utilization of health care services. This means the board will have only one option — cut payments. And through 2019, hospitals, Medicare Advantage plans, Medicare prescription drug plans, and health care professionals other than physicians are exempt. This means the board really will have only one option — cut Medicare payments to physicians.

Allow Medicare beneficiaries to contract directly with physicians for care
(HR 1310 by Price; S 236 by Murkowski)

As baby boomers come of Medicare age, we must change some of Medicare's inflexible rules to ensure patients have access to a physician. One way to accomplish this is to allow Medicare patients to see any physician of their choice. The Medicare Patient Empowerment Act would allow seniors to use their current Medicare coverage to see a doctor who is not accepting Medicare. It would strengthen patient choice and access to physicians.

Protect state medical liability reforms
(HR 1473 by Phil Gingery and Henry Cuellar)

This bill would clarify that the federal health reform laws passed in 2010 were not meant to establish medical standards of care for physicians and other providers. This bill would protect the ability of states to determine their own liability laws as appropriate for their citizens.

Texas has gained more than 10,000 new physicians above the expected baseline to take care of Texas patients as a result of its tort reform. Many of these new physicians practice high-risk specialties such as emergency medicine, neurosurgery, pediatric intensive care, and pediatric infectious disease. Twenty-seven rural Texas counties have added at least one obstetrician since the passage of Texas' medical liability reform, including nine counties that previously had none. Sick and injured Texans now have more physicians and more timely access to medical care when needed.