ACTION REPORT
TO 2014 HOUSE OF DELEGATES REGARDING
2013 RESOLUTIONS

Those resolutions not receiving favorable action of the House of Delegates are omitted from this report. Action taken is in blue type after the RESOLVED(s) of each resolution.

Resolution No. 01 – 2013
Council Restructuring

RESOLVED, That the OSMA Council be comprised of 21 elected Councilor seats delineated as follows:

Geographic districts

Eight of the 21 Council seats represent 8 geographic districts that align approximately around physician referral patterns in the following contiguous counties.

1) District 1: Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland, Warren
2) District 2: Champaign, Clark, Darke, Greene, Miami, Montgomery, Preble
3) District 3: Allen, Auglaize, Crawford, Defiance, Hancock, Hardin, Henry, Logan, Marion, Mercer, Paulding, Seneca, Shelby, Van Wert, Wood, Wyandot
4) District 4: Erie, Fulton, Huron, Lucas, Ottawa, Putnam, Sandusky, Williams
5) District 5: Ashland, Cuyahoga, Geauga, Lake, Lorain, Medina, Wayne
6) District 6: Ashtabula, Columbiana, Holmes, Mahoning, Portage, Stark, Summit, Trumbull
7) District 7: Delaware, Fayette, Franklin, Knox, Licking, Madison, Morrow, Pickaway, Richland, Union
8) District 8: Athens, Belmont, Carroll, Coshocton, Fairfield, Gallia, Guernsey, Harrison, Hocking, Jackson, Jefferson, Lawrence, Meigs, Monroe, Morgan, Muskingum, Noble, Perry, Pike, Ross, Scioto, Tuscarawas, Vinton, Washington

At-large seats

Six of the 21 Council seats represent the various physician demographic or organizational needs to be determined by the Committee on Nominations. The committee shall then present these needs as they solicit and consider statewide nominations in developing a slate of candidates to number at least one more than the seats to be filled and to be elected at-large by the House of Delegates.

Officers

Four elected officers designated as president, president-elect, past president and treasurer as defined and authorized in Article VII of the OSMA Constitution and Chapter 5 of the Bylaws.

OMSS, MSS and RFS

The Organized Medical Staff Section, Medical Student Section and Resident and Fellows Section Councilors to be elected as authorized in Article VII of the OSMA Constitution and Chapters 4, 6 and 7 of the Bylaws; and, be it further

RESOLVED, That all elected Council members shall have the right to vote; and, be it further

RESOLVED, That the current ad hoc, non-voting seats on the OSMA Council that were

added in 2011 be eliminated; and, be it further

RESOLVED, That for purposes of transitioning to the new Council structure, the changes proposed in this resolution go into effect for Councilor elections at the 2014 House of Delegates meeting provided that for the 2014 councilor elections, ½ of the council seats will be elected for a one year term and ½ of the council seats will be elected for two year terms. Thereafter, all council seats, except the Medical Student Section and Resident and Fellows Section seat, will be elected for two year terms subject to a maximum of three terms as set forth in the OSMA Constitution and Bylaws Chapters 5 & 6. The Medical Student Section and Resident and Fellow Section councilors will be elected for one year terms subject to a maximum of three terms; and, be it further

RESOLVED, That for the 2014 transition year, odd numbered geographic district seats, three at large seats and the Resident and Fellows Section (RFS) and Medical Student Section (MSS) seats shall be elected for a one year term and the even numbered geographic district seats, three at large seats and the Organized Medical Staff Section (OMSS) seat will be elected for a two year term. In 2015, the odd numbered geographic districts seats and at large seats that were initially elected in 2014 for a 1 year term will be up for election again for election to a full two year term. Thereafter, ½ of the geographic district and at large elected council seats will be up for election each year alternating as described in this paragraph. The RFS and MSS seats will be up for election each year; and, be it further

RESOLVED, That the OSMA Bylaws be amended as follows to revise the composition and duties of the House of Delegates Committee on Nominations as stated in Chapter 5 of the Bylaws:

CHAPTER 5
NOMINATION AND ELECTION OF OFFICERS

Section 1. Committee on Nominations. Except for selections made in 2014 as stated in the next paragraph below, the Committee on Nominations shall consist of eight members including the OSMA President, the OSMA President-elect and six additional members appointed by the OSMA President and approved by the Council. The President shall appoint the chair of the Committee. The President and President-elect serve on the Committee on Nominations during his or her term of office. Other committee members shall serve not more than one, three-year term with two new members rotating on each year.

In 2014, the initial transition year to a newly structured Committee on Nominations, the OSMA President will appoint two members to the committee to serve one, three year term. The House of Delegates will elect four members, two to serve one, two year term and two to serve one, one year term. In 2015, the OSMA President will appoint two members to serve one, three year term. For all subsequent years, the OSMA President will appoint two individuals each year to serve one, three year term.

The Committee on Nominations shall report to the House of Delegates a ticket containing the name of one (1) or more members for each of the offices to be filled at that Annual Meeting, except that of President-Elect. Each nominee must have a majority vote of the Committee in order to be placed on the ticket for presentation to the House of Delegates except that the Committee shall accept the nominees named by the geographic councilor districts, the Organized Medical Staff Section, the Resident and Fellows Section and the Medical Student Section and the Committee shall not alter or add to these district or section nominations. Each

nominee for Councilor from a geographic district must be a resident of the Councilor District for which that nominee for Councilor is nominated. Six council seats, officers and Delegates and Alternate Delegates to the American Medical Association shall be elected at large. Each year the Committee on Nominations shall recommend nominees for three at large seats. The Committee on Nominations may recommend more than three candidates for the at large seats to be filled; however, not more than two at large delegates can reside or practice in the same Councilor geographic district. In the event that the House of Delegates nominates an at large candidate from the floor creating a situation where there are three at large candidates from the same geographic district and all three are among the top vote getters, the top two vote getters who are in the same geographic district will be elected, the lowest vote getter will be dropped and the candidate who is not from the same geographic district and who has the next highest number of votes will be elected.

All nominees shall meet qualifications set forth in the OSMA bylaws. Additionally, the Committee on Nominations shall determine candidate selection criteria for at large council positions that may include, but are not limited to, diversity, experience, engagement with organized medicine, experience with strategic planning, physician practice demographics, physician practice settings, current organizational needs, House of Delegates input, OSMA staff input and individual physician self-selection. The precise selection criteria may vary year to year to reflect the current needs of the OSMA. The Committee on Nominations makes the final determination about the selection criteria it will use in any given year and shall inform the House of Delegates of the selection criteria used. The Committee on Nominations shall also determine how best to solicit the candidates it will recommend to the House of Delegates.

. . .

Section 4. Nomination and Election of Councilors at the House of Delegates. Nominations for Councilors shall be made by the Committee on Nominations at the first session of the House of Delegates. However, for geographic district or section councilor seats, only those candidates may be nominated whose names have been filed with the Committee on Nominations through the office of the Executive Director by the caucus of that district's or section's Delegates prior to the opening of the House of Delegates. Compliance with the foregoing filing requirement may be waived or dispensed with by a vote of at least two-thirds (2/3) of the Delegates present at the opening session of such meeting **and, be it further**

. . . .

RESOLVED, that Article VII of the Constitution be amended to change the composition of the OSMA council as follows:

ARTICLE VII
THE COUNCIL

The Board of Trustees (referred to herein as "the Council") shall consist of one (1) Councilor from each geographical Councilor district, six (6) Councilors elected at large by the House of Delegates, one (1) member from the Organized Medical Staff Section, one (1) member from the Resident and Fellows Section, one (1) Student Member from the Medical Student Section and the other elected Officers of this Association. The Council shall be the executive body of the Association and shall have the complete custody and control of all funds and property of the Association and shall have and exercise full power and authority of the House of Delegates

between meetings of the House of Delegates.

ACTION: The OSMA Council approved in July 2013 a process for implementing Resolution 01-13 that included appointment of the Nominating Committee, including 4 provisional members of the committee to be elected at the 2014 HOD. The Nominating Committee began its work in the fall of 2013 and finalized a slate of candidates for the at-large Council seats in January. Information about the Nominating Committee, the at-large candidates and other changes to the nomination and election process is provided on the OSMA web site, and in handouts prepared for the District Meetings held in February and March 2014 and for the HOD.

Resolution No. 03 – 2013
Adoption of a New Mission Statement for the Ohio State Medical Association

RESOLVED, That the Ohio State Medical Association replace the current mission statement by adopting a new mission statement that states "The Ohio State Medical Association (OSMA) is a statewide organization dedicated to empowering physicians, residents and medical students to advocate on behalf of their patients and profession."

ACTION: Referred to Council – The OSMA Council convened a work group to consider whether and how to replace the current OSMA mission statement. Members of the work group were:

Jared Harwood, MD, PGY-2 OSU Orthopedic Surgery Residency Program (Chair)
Timothy McKnight, MD – Pediatrician, St. Luke's Medical Center, Westlake
Ryan Shapiro, MS-2 Wright State School of Medicine, Dayton
Alice Dachowski, MD – OSMA 9th District Councilor, Surgeon, Holzer Health System, Gallipolis
Sanjiv Lakhia, DO – TriHealth Physician Group, Cincinnati
Joy Mosser, MD – Central Ohio Skin Cancer, Columbus
Julie Tome, MD, MBA – ProMedica Physician Group, Toledo

The work group proposed to the OSMA Council the following new Mission, Vision and Strategic Priorities. These items were voted on and approved by Council at the September 28, 2013 Council Meeting:

OSMA Mission Statement

"The Ohio State Medical Association (OSMA) is dedicated to empowering physicians, residents and medical students to advocate on behalf of their patients and profession."

OSMA Strategic Priorities

- Empowering physicians to engage and educate patients on improving their health and the health of Ohio
- Leading physicians into the future through support in optimal practice models and in their role as the leader of the new health care systems
- Supporting the future of medicine by engaging medical students and residents and collaborating with other medical and health care organizations

OSMA Vision Statement

"Bringing physicians together for a healthier Ohio "

OSMA Values Statement

The OSMA values:

- The sanctity of the physician-patient relationship
- The role of physicians as the leader of the health care team
- Innovation that transforms health care delivery and improves the health of patients and the patient experience
- Access to high quality, affordable health care
- The role of patients in improving their health
- The future generation of physicians – medical students, residents, and fellows

Resolution No. 05 – 2013
New Education Loan Repayment Program for Ohio Physicians

RESOLVED, That our Ohio State Medical Association establish and support legislation creating a state-sponsored financial entity that incentivizes public and private financial institutions to participate in a medical education debt repayment program for all Ohio physicians working in underserved and/or academic settings. Provisions of such a program would include: (1) Eligibility for the program based on an application, which must be re-submitted annually to remain eligible; (2) The definition of "academic setting" must include some meaningful participation in medical student, resident, or fellow training; (3) A health professional shortage area (HPSA), as defined by the Health Resources and Service Administration, be considered to serve as the definition of "underserved;" (4) The loans of eligible physicians will be purchased by the financial institutions participating in the medical education debt repayment program and accrue interest at the rate of inflation with a cap of 50% of the current graduate/professional Federal Stafford loan interest rate; and (5) Eligible physicians will be offered extended repayment periods of at least 20 years.

ACTION: Referred to Council. The Council took no action on this resolution, but directed staff to conduct further research into this topic including, but not limited to, the following:

- Collaboration with the Association of American Medical Colleges (AAMC) to determine which tenets of its existing 74 loan repayment and forgiveness programs may fit into an Ohio-based medical education loan repayment program.

- Collaboration with the American Academy of Family Physicians (AAFP) to identify and perhaps tap into existing funding resources available for physicians who wish to practice in underserved areas.

Resolution No. 06 – 2013
Crafting Innovative Ways of Funding Graduate Medical Education

RESOLVED, That our Ohio State Medical Association support legislation to convene a state based task force of key stakeholders, to include representatives from private business enterprises such as health insurance companies, private practice physicians, members of the

general public, and academic medical center employees to study current graduate medical education (GME) financing in Ohio and investigate creative alternatives for GME funding that rely less on federal resources.

ACTION: Referred to Council. The OSMA Council adopted this resolution.

The OSMA legislative team is working with the medical student section of the OSMA on this resolution to develop ideas for the legislation. Additionally, the OSMA has been invited to participate on the task force established by the Kasich Administration to discuss allocating Medicaid direct medical education dollars to reflect the Administration's priorities in primary care. Dr. Gary LeRoy and the OSMA Director of Legislation, Jeff Kasler, will serve on the task force.

Resolution No. 07 – 2013
Support for Physician led Patient-Centered Medical Home

RESOLVED, That the Ohio State Medical Association encourages the formation and ongoing support of physician led patient-centered medical homes by calling for insurance providers to (1) recognize and reimburse the staffing needed for a medical home and (2) increase reimbursements for primary care physicians.

ACTION: The OSMA continues to work with the Governor's Payment Reform Task Force to ensure both private and public payors implement more patient centered medical home (PCMH) type payment models. President-Elect Mary Wall, M.D., serves on the Task Force. Work continues in 2014 and a presentation will be made at the 2014 OSMA Practice Symposium from members of the Task Force.

Resolution No. 08 – 2013
Support for More Primary Care Physicians

RESOLVED, That the Ohio State Medical Association take steps to increase the number of medical students and residents going into primary care by calling for an increase in the number of residency positions in primary care.

ACTION: In September 2013, the OSMA Council approved the OSMA's new mission, vision and values statements, as well as a set of strategic priorities that include the following related to students and residents:

- Value Statement – The future generation of physicians – medical students, residents, and fellows
- Strategic Priority - Supporting the future of medicine by engaging medical students and residents and collaborating with other medical and health care organizations

While it is in the early stages, the OSMA is working on a plan for working with medical students, residents, and program directors to identify their needs and to develop strategies to address the issues they face, include limited funding and residency training.

Resolution No. 09 – 2013
Abolishing Loss of Chance

RESOLVED, That the Ohio State Medical Association make every effort to advocate to the Ohio General Assembly to abolish the "Loss of Chance" doctrine.

ACTION: The OSMA developed and had introduced a tort reform package (HB 276) that includes a provision to statutorily abolish the loss of chance doctrine. The bill has had 2 hearings in the House Judiciary Committee where the OSMA and OHA were the primary supporting witnesses. The bill is expected to have additional hearings throughout the spring.

Resolution No. 11 – 2013
Oppose the Criminalization of Medical Statements

RESOLVED, The Ohio State Medical Association (OSMA) opposes the criminalization of mistakes made by physicians in medical records, operative notes, and coding in the absence of any proven billing fraud.

ACTION: No specific action taken.

Resolution No. 12 – 2013
Advocating for Public Education for the Use of Appropriate Health Care Resources

RESOLVED, That the Ohio State Medical Association support public education initiatives addressing the effective and efficient use of health care resources.

ACTION: The Ohio State Medical Association (OSMA) had no applicable policy prior to this Resolution. The OSMA has implemented this new policy by supporting several American Medical Association (AMA) policies and initiatives related to health care expenditures, strategies to address rising health care costs, allocation of limited medical resources, medical necessity of diagnostic tests, and physician stewardship of health care resources. The OSMA is also engaged in discussions with the AMA regarding a national pre-diabetes screening initiative that could be done in conjunction with local YMCA and YWCA facilities.

Resolution No. 13 – 2013
Adolescent Pregnancies

RESOLVED, That the Ohio State Medical Association (OSMA) support initiatives to reduce the incidence of adolescent pregnancies.

ACTION: The Ohio State Medical Association (OSMA) fully supports the idea of reducing teenage pregnancies. The OSMA will look to engage local and statewide programs that will help the Association fully implement this policy.

Resolution No. 14 – 2013
The Obesity Epidemic and Patient Accountability

RESOLVED, That the Ohio State Medical Association work with appropriate agencies (i.e., Ohio Department of Health, Ohio Department of Insurance, hospital organizations etc.), through a work group or task force, to create model policy and programming that aims to:

1. Educate the public regarding the risks of obesity;
2. To incentivize the population to become accountable for their health; and

3. Design effective insurance incentive programs in a manner that encourages subscribers to adopt healthy lifestyle habits which decrease obesity.

ACTION: Referred to Council. Council adopted this resolution. The OSMA is working with the Department of Health on a comprehensive obesity initiative focused on preventing and reducing obesity during a child's first five years. It includes a variety of public awareness campaigns and could potentially look at various incentive programs in the future. The OSMA also remains an active member of the ODH's State Health Improvement Plan – Chronic Disease Workgroup.

Resolution No. 15 – 2013
Concussion Care

RESOLVED, That the Ohio State Medical Association (OSMA) advocate that all schools, teams at all levels of sport, referees, and coaches receive standardized training and education on the diagnosis of concussions, the long term impact of concussions, and the management of youth who have suffered a concussion; and, **be it further**

RESOLVED, That the Ohio State Medical Association encourage organized sports teams educate parents and guardians of their players on the diagnosis, treatment, and risks of concussions, as well as provide access to educational tools regarding concussion management; and, **be it further**

RESOLVED, That the Ohio State Medical Association recommend that any athlete who is suspected of having suffered a concussion be removed from play for that game and that day until formally cleared by a qualified healthcare provider; and, **be it further**

RESOLVED, That the Ohio State Medical Association encourage all athletes to pledge at the start of any training that they will report to the coaching staff any injury that raises the suspicion of having had a concussion; and, **be it further**

~~**RESOLVED**, That the Ohio State Medical Association encourage the use of a baseline neurologic test to be easily applied prior to a season so that youth with a suspected injury can be definitively assessed as impaired or defined as having recovered; and, **be it further**~~

RESOLVED, That the Ohio State Medical Association require that all youth who have suffered a concussion be cleared in writing by an appropriate healthcare physician before return to play.

ACTION: Referred to Council. The Council adopted this resolution as amended. In 2012-2013 the OSMA worked with a number of different organizations to pass legislation that puts in place many of the "Resolved" statements listed above. The law requires a child who suffers a concussion or other head injury during athletic competition to be medically cleared by a physician or a medical professional working under the supervision of a physician.

Resolution No. 16 – 2013
Maintenance of Certification and Licensure vs. Board Certification, Continuing Medical Education and Lifelong Commitment to Learning

RESOLVED, That the Ohio State Medical Association (OSMA) insists that lack of Specialty Board Certification does not restrict the ability of the physician to practice medicine in Ohio.

ACTION: No specific action taken.

Resolution No. 17 – 2013
Physicians Caring for Family Members

RESOLVED, That the Ohio State Medical Association (OSMA) support non-interference with appropriate patient care even when a patient or potential patient is a family member or significant other.

ACTION: No specific action taken.

Resolution No. 22 – 2013
Maintain Access to Continuing Medical Education

RESOLVED, That the Ohio State Medical Association investigate ways of streamlining the accreditation process and reducing the costs for granting American Medical Association (AMA) Category 1 Continuing Medical Education (CME) credit.

ACTION: The OSMA continually seeks ways to provide CME programs at reasonable rates.

Resolution No. 23 – 2013
Physician Assistants and Nurse Practitioners in the State of Ohio

RESOLVED, That the Ohio State Medical Association (OSMA) review the defined current scope of practice for physician assistants and nurse practitioners in Ohio to determine to what extent such licensees may indeed be practicing in a manner inconsistent with the physician assistant supervisory plans approved by the State Medical Board of Ohio, or the collaboration arrangements for nurse practitioners required by statute, and whether changes in such practices are warranted; and, **be it further**

RESOLVED, That the Ohio State Medical Association seek to protect patients' rights to be treated by a physician in lieu of the physician assistant or nurse practitioner, if such request is made.

ACTION: Referred to Council. The Council rejected this resolution based on existing OSMA policy and the OSMA's inability to investigate the activities of all allied practitioners. The OSMA does not have the ability to determine whether licensees are practicing in a manner inconsistent with the supervisory agreements required by the licensing boards. If a physician feels that an allied practitioner is acting outside of his or her scope, the physician may file a complaint with the board that licensed the allied practitioner and that board will begin an investigation to determine whether the allied practitioner is acting outside of his or her scope of practice.

Regarding the second Resolved, the OSMA will continue to advocate that patients should have the right to be treated by a physician, if that is their choice. Existing OSMA policy (below) provides that allied practitioners must have the appropriate experience, training and education and that a physician should always be the head of the healthcare team.

Amended Resolution 19 – 2007
State Medical Board Oversight

RESOLVED, That the Ohio State Medical Association reaffirms the principle that practitioners seeking to expand their scope of practice must have the appropriate experience, training and education to treat patients safely and that the physician should be the leader of the health care team.

Resolution No. 24 – 2013
Clear Identification of Degrees for Health Care Providers

RESOLVED, That our Ohio State Medical Association request that the Ohio State Medical Board and the Ohio State Board of Nursing discourage Physician Assistants and Nurse Practitioners from allowing patients to refer to them as "doctors," if they do not have a doctorate degree, and penalize them for allowing this misconception to be perpetuated.

ACTION: Referred to Council. Council adopted this resolution and directed staff to inform applicable boards of current regulations (see below) and OSMA policy, when appropriate.

Section 4731.41, Ohio Revised Code, prohibits a person from practicing medicine and surgery without a license issued by the Medical Board. Section 4731.34, Ohio Revised Code, provides that a person shall be regarded as practicing medicine and surgery when the persons uses the words or letters "Dr.," "Doctor," "M.D.," "physician," or any other title in connection with their name *in any way that represents the person as engaged in the practice of medicine and surgery*.

Accordingly, a person who uses the title "physician" or "doctor" in connection with his/her name in any way that represents the person as engaged in the practice of medicine and surgery is subject to prosecution for the unlicensed practice of medicine in violation of Section 4731.41, Ohio Revised Code. Violation of Section 4731.41, Ohio Revised Code, is a fifth degree felony for the first offense.

Resolution No. 27 – 2013
Establishing Standards for State Prescription Drug Monitoring Programs

RESOLVED, That our Ohio State Medical Association (OSMA) work with the Ohio State Board of Pharmacy to identify inefficiencies in Ohio Automating Rx Reporting System (OARRS) and solutions to these inefficiencies.~~; and, **be it further**~~

~~**RESOLVED**, That our Ohio State Medical Association work with the Ohio State Board of Pharmacy to establish Prescription Drug Monitoring Program (PDMP) standards describing an ideal PDMP system which may serve as a guide for all states in establishing or refining their own PDMP systems; and, **be it further**~~

~~**RESOLVED,** That our Ohio State Medical Association (OSMA) report these standards back to the OSMA annual meeting in 2014; and, **be it further**~~

~~**RESOLVED**, That a resolution be forwarded to the American Medical Association (AMA) House of Delegates and Medical Student Section to disseminate the Prescription Drug Monitoring Program (PDMP) standards developed by Ohio in 2013 to all states and encourage the AMA to increase interstate operability of PDMP systems.~~

ACTION: Referred to Council. Council amended and adopted resolution 27-2013 as shown.

The OSMA has worked with the Ohio State Board of Pharmacy since the inception of the Ohio Automated Rx Reporting System (OARRS). The OSMA is actively involved in the Governor's Cabinet Opiate Action Team (GCOAT). GCOAT has been charged with monitoring OARRS and creating metrics that determine whether educational activities about prescription drug abuse and practitioner's use of OARRS is working to lessen the prescription drug abuse epidemic in Ohio. As part of this group, inefficiencies with the OARRS system have been, and will continue to be, identified and changes will be made to OARRS to optimize the system's usability and reporting capabilities. At this point, it is unknown whether OARRS is an "ideal" system and whether it should serve as a guide for other states.

Resolution No. 29 – 2013
Filling the Funding Gap for Medicaid to Allow Reasonable Reimbursements

RESOLVED, That our Ohio State Medical Association supports expanding Ohio's Medicaid program under the Affordable Care Act, including the provision of additional state expenditures, if necessary, to ensure adequate funding; and, **be it further**

RESOLVED, That a sliding scale income based co-pay should be required for Medicaid services, where the minimum co-pay is a sum greater than zero.

ACTION: Referred to Council. Council adopted the resolution.

The governor opted to expand Medicaid to 138 percent of the poverty level (about $15,415 per year), as permitted by the federal Affordable Care Act. This measure would have provided access to health care coverage for roughly 275,000 previously uninsured Ohioans. The federal government would pay 100 percent of the cost for three years and then decrease coverage annually to 90 percent by 2020, where it would remain. The General Assembly rejected the proposal. The Governor then sought and was granted authority from the Controlling Board to accept federal expansion. Opponents filed a legal challenge that was heard and rejected by the Ohio Supreme Court. The OSMA participated in an amicus brief in support of allowing expansion to go forward.

Medicaid co-pays are listed here:
http://medicaid.ohio.gov/FOROHIOANS/AlreadyCovered/MedicaidCopays.aspx

Resolution No. 32 – 2013
Mandate Creation of Oversight Panel for Health Insurance Carriers

RESOLVED, That the Ohio State Medical Association give a high legislative priority toward the reintroduction and passage of a bill which mandates the "development of an independent healthcare panel, including physician representation, to oversee health insurance carrier practices and policies," for the protection of Ohio patients and to reduce the unfair burden of overcoming roadblocks to care currently placed on physicians.

ACTION: Because of the need to respond to the legislative agenda brought forth by individual members of the General Assembly – including 13 bills dealing with prescription drug abuse, 6 bills dealing with scope of practice expansions, and 73 additional legislative measures that the OSMA is following, there has been insufficient personnel resources to devote to this resolution at the present time.

Resolution No. 33 – 2013

Patient Steerage by Quality Measures

RESOLVED, That patient steerage by insurers to lower cost services must be based on established and verifiable national quality measures that are physician developed; and, **be it further**

RESOLVED, That economic comparisons of health care providers be transparent to all involved with no kickbacks to patients nor facilities be provided to encourage low bid services or their use; and, **be it further**

RESOLVED, That insurance carriers formally discuss at an appropriate peer level with patients and their ordering physician of any potential switch of testing or treating facility and consider medical decision making that may influence a physician's choice of a particular testing or treating facility for their patient; and, **be it further**

RESOLVED, that insurance carriers notify the originally scheduled imaging provider AND THE REFERRING PHYSICIAN AT LEAST 24 hours prior to any change in service venue. If a change in service venue occurs, they must contact the original servicing health care facility within the next business day, and, **be it further**

RESOLVED, That the Ohio State Medical Association will monitor insurance carriers' compliance with referrals based on quality indicators, will identify unethical insurance carrier practices, and will refer inappropriate economic steerage to the Ohio Department of Insurance**.**

ACTION: The OSMA has had discussions with Anthem and other carriers about referral policies. As part of the governor's Payment Reform Task Force the issue of cost and quality measures for referral has been discussed at length and built into the models that will be implemented over episodes of care.

Substitute Resolution No. 34 – 2013
Patient Satisfaction Surveys not Valid as Reimbursement Criteria

RESOLVED, That when quality criteria are used as a measure to determine reimbursement for physician services, that only those quality parameters be used that are in the direct control of the physician, such as tests or treatment ordered, or appropriate patient education performed; and, be it further

RESOLVED, That if or when subjective quality criteria are utilized, such as patient satisfaction surveys, that such information should be used only as an adjunctive and not a determinative measure of physician quality for the purpose of physician reimbursement; and **be it further**

RESOLVED, That the Ohio Delegation to the American Medical Association (AMA) take this resolution to the AMA Annual Meeting.

ACTION: As a result of the OSMA physician satisfaction survey conducted in 2013, the OSMA is working with representatives from different hospital systems to discuss appropriate strategies to collectively approach government officials and other payors to develop more appropriate patient satisfaction scoring if such scoring is used as a factor in patient reimbursement.

The AMA adopted the following policy in 2013:

D-385.958 Patient Satisfaction Surveys and Quality Parameters as Criteria for Physician Payment

Our AMA will work with the Centers for Medicare & Medicaid Services (CMS) and non-government payers to ensure that (1) subjective criteria, such as patient satisfaction surveys, be used only as an adjunctive and not a determinative measure of physician quality for the purpose of physician payment; and (2) physician payment determination, when incorporating quality parameters, only consider measures that are under the direct control of the physician. (Res. 102, A-13; Reaffirmed: Res. 806, I-13)

Resolution No. 36 – 2013
Peer Review by Specialists with Knowledge of the Situation under Review

RESOLVED, That our Ohio State Medical Association (OSMA) take the position that, at the request of the treating physician, any reviews for medical necessity requiring physician phone calls should be conducted by physicians who are in the same specialty as the treating physician or who have the clinical expertise to make an informed review of the request; and, **be it further**

RESOLVED, that our OSMA insist that the review for medical necessity process be timely, courteous, and respectful of the treating physician's work schedule.

ACTION: No specific action

Resolution No. 37 – 2013 – External Affairs, Regulatory Affairs
Recovery Audit Contractor Audits

RESOLVED, That the Ohio State Medical Association encourage physicians to judge healthcare companies based on the presumption of innocence; and, **be it further**

RESOLVED, That the OSMA work to give the Ohio Department of Insurance (ODI) the right to review the conduct of the Recovery Audit Contractor auditor. The OSMA will encourage ODI to be diligent in its monitoring of their behavior, and if found overly aggressive without proof of fraud, can find the auditor liable for the cost of the audit; and, **be it further**

RESOLVED, That the Ohio State Medical Association will insist on clear and indisputable evidence of deliberate malfeasance and fraud before punitive damages are brought on healthcare providers who work within a maze of regulations to provide needed health care to their patients.

ACTION: Referred to Council. The OSMA Council rejected this resolution.

RAC audit terms and RAC auditor performance is not typically under the regulatory authority of the Ohio Department of Insurance or other state regulatory entity. It would fall to a federal agency.

Resolution No. 38 – 2013
Elimination of "Gotcha" Criteria for Recovery Audit Contractors

RESOLVED, That our Ohio State Medical Association take the position that clerical issues which have nothing to do with medical necessity or standard of care should not be used

to deny a hospital admission; and, **be it further**

RESOLVED, That the Ohio Delegation to the American Medical Association (AMA) take this resolution to the AMA annual meeting.

ACTION: Referred to Council. The OSMA Council adopted this resolution. The AMA already has policy regarding RAC Audits so the Ohio Delegation did not submit this resolution. AMA policy is as follows:

D-320.991 Creating a Fair and Balanced Medicare and Medicaid RAC Program

1. Our AMA will continue to monitor Medicare and Medicaid Recovery Audit Contractor (RAC) practices and recovery statistics and continue to encourage the Centers for Medicare and Medicaid Services (CMS) to adopt new regulations which will impose penalties against RACs for abusive practices.

2. Our AMA will continue to encourage CMS to adopt new regulations which require physician review of all medical necessity cases in post-payment audits, as medical necessity is quintessentially a physician determination and judgment.

3. Our AMA will assist states by providing recommendations regarding state implementation of Medicaid RAC rules and regulations in order to lessen confusion among physicians and to ensure that states properly balance the interest in overpayment and underpayment audit corrections for Recovery Contractors.

4. Our AMA will petition CMS to amend CMS' rules governing the use of extrapolation in the RAC audit process, so that the amended CMS rules conform to Section 1893 of the Social Security Act Subsection (f) (3) - Limitation on Use of Extrapolation; and insists that the amended rules state that when an RAC initially contacts a physician, the RAC is not permitted to use extrapolation to determine overpayment amounts to be recovered from that physician by recoupment, offset, or otherwise, unless (as per Section 1893 of the Social Security Act) the Secretary of Health and Human Services has already determined, before the RAC audit, either that (a) previous, routine pre- or post-payment audits of the physician's claims by the Medicare Administrative Contractor have found a sustained or high level of previous payment errors, or that (b) documented educational intervention has failed to correct those payment errors.

5. Our AMA, in coordination with other stakeholders such as the American Hospital Association, will seek to influence Congress to eliminate the current RAC system and ask CMS to consolidate its audit systems into a more balanced, transparent, and fair system, which does not increase administrative burdens on physicians.

6. Our AMA will: (A) seek to influence CMS and Congress to require that a physician, and not a lower level provider, review and approve any RAC claim against physicians or physician-decision making, (B) seek to influence CMS and Congress to allow physicians to be paid any denied claim if appropriate services are rendered, and (C) seek the enactment of fines, penalties and the recovery of costs incurred in defending against RACs whenever an appeal against them is won in order to discourage inappropriate and illegitimate audit work by RACs.

7. Our AMA will advocate for penalties and interest to be imposed on the auditor and payable to the physician when a RAC audit or appeal for a claim has been found in favor of the physician. (Res. 215, I-11; Appended: Res. 209, A-13; Appended: Res. 229, A-13; Appended: Res. 216, I-

13; Reaffirmed: Res. 223, I-13)

Resolution No. 39 – 2013
Audit Overpayments

RESOLVED, That the Ohio State Medical Association (OSMA) work to ensure that insurance companies can only seek reimbursement for medical claims within one year unless fraud or misrepresentation is present; and, **be it further**

RESOLVED, That the Ohio State Medical Association work to ensure that insurance companies must accept claims within one year of provision of service without penalty; and, **be it further**

RESOLVED, That when interest is charged to the physician on overpayment of a given claim, then the Ohio State Medical Association work so that the physician can charge and be paid an equivalent interest rate on underpayment of claims; and, **be it further**

RESOLVED, That the Ohio State Medical Association will support health care providers who have acted in good faith in providing services with a valid contract.

ACTION: The OSMA's focus this past year has been to work with the administration and payors to address ACA implementation challenges. The issue of timely payment and payment terms has been discussed but no specific movement has occurred yet legislatively.

Resolution No. 40 – 2013
Ohio Department of Job and Family Service Medicaid Relative Value Scale Payment Modifier

RESOLVED, That the Ohio State Medical Association make every effort to eliminate the use of an adjustment modifier in setting Relative Value Scale (RVS) payment rates by the Ohio Department of Job and Family Services; and, **be it further**

RESOLVED, That Ohio delegation to the American Medical Association advocate the elimination of the use of an adjustment modifier in setting Relative Value Scale (RVS) payment rate for national educational consideration at its next meeting.

ACTION: Referred to Council. The OSMA Council rejected this resolution.

According to ODJFS staff, Ohio Medicaid prices new codes off the CMS payment file, an RVU-based methodology which takes into account physician work expense, practice expense and malpractice expense, each multiplied by the single Ohio geographic practice cost index adjuster. The total is then summed and multiplied by the annual conversion factor. Medicaid then prices any particular code at the average of its code group - e.g., E&M, medicine, etc. Additional payment adjusters could include prenatal care, after-hours care, Holzer Clinic adjustment, physician assistant provider, facility/non-facility pricing, professional/technical splits, multiple surgery pricing, and, soon, multiple procedure pricing for imaging and therapies. While this current methodology might create inequitable reimbursement in some cases, it is the opinion of staff that eliminating all modifiers or creating an alternate payment methodology will also create or result in some inequalities as well.

Resolution No. 41 – 2013 (partial)
Identifying Chemicals Used by the Oil and Gas Industry as Part of Hydraulic Fracturing

RESOLVED, That the Ohio State Medical Association advocate for provisions in Ohio state law that would allow doctors, first responders, emergency agencies, and the Local Emergency Planning Commission in each county to obtain the needed information on all chemicals located at an oil or gas exploration well pad, including hydraulic fracturing.

ACTION: No specific action taken.

Resolution No. 41 – 2013 (partial) – Assigned to Government Affairs
Identifying Chemicals Used by the Oil and Gas Industry as Part of Hydraulic Fracturing

The referred section is:

These provisions would include:

1) Require the company managing/owning the well pad to report all chemicals to be present on each hydraulic fracturing well pad for any use to the Local Emergency Planning Commission (LEPC)[4] in the county or counties in which a pad is located, before the chemicals arrive on the well pad[5].

2) Require that when identifying the chemicals to be sent to the pad, the exact chemical name and Chemical Abstracts System number for every chemical including "trade secret" chemicals would be divulged to the LEPC along with the address and exact Global Positioning Systems coordinates of the well pad to which they were going.

3) Allow physicians, veterinarians, ambulance personnel, and other first responders to apply to the LEPC when they have a need to know what chemicals were used at a specific well in order to treat a patient, or respond to an emergency involving a patient or the public.

4) Have a significant fine for each chemical found on a well pad when inspected that is not on the list in the possession of the LEPC of the county or counties in which the well pad is located. A larger fine would be assessed for each unlisted chemical found at a well pad which has had an accident (fire, explosion etc) or incident requiring fire fighters or Hazmat personnel, ambulance personnel or the services of the LEPC.

ACTION: Referred to Council. The Council accepted the staff recommendations as follows:

The OSMA government relations staff previously weighed in on fracking-related legislation passed in 2012. In fact, members of Senate leadership at the time asked the OSMA to provide insight on the legislation, specifically on provisions that outlined a physician's ability to access chemical information or "trade secrets," if a patient's or the public's health situation warranted such access.

In response, the OSMA government relations staff offered at that time – and maintains today – that the legislation does not place any "gag order" on physicians and does not inhibit the accessing of chemical-related information, if a patient's or the public's health warrants that access.

In addition, the U.S. EPA recently found that Ohio's existing fracking laws that allow oil and gas companies to shield information about chemicals from emergency management officials and first responders violate federal law.

OSMA government relations will monitor any new developments involving fracking-related legislation.

Resolution No. 42 – 2013
Electronic Health Records Surveillance

RESOLVED, That our Ohio State Medical Association (OSMA) undertake surveillance of the use of electronic health records (EHR) by the physicians of Ohio to develop strategies for successful use of these systems to improve the care of our patients and our colleagues; and, be it further

RESOLVED, That the surveillance of EHR use in Ohio include physicians in private practice, academia, and those who are employed, with attention to, but not exclusively, time spent completing the EHR, confidence in coding, the use of scribes, and quality of life issues before and after EHR; and, be it further

RESOLVED, That our OSMA report the results of their surveillance activities on the use and impact of electronic health records on Ohio physicians at least annually.

ACTION: In July 2013, the OSMA launched the Health Information Technology Solutions (HIT Solutions) program, which is an updated version of the Electronic Health Record Standards of Excellence (EHR SOE) program, in order to offer OSMA members assistance with electronic health records and health information technology. In launching the new program, the OSMA created partnership opportunities with EHR vendors, updated the EHR preferred terms and conditions, and partnered with Agil IT, an information technology company specializing in health care, to support member needs and provide EHR mediation when necessary.

In 2014, the OSMA will launch the next phase of the program which will focus on creating partnerships with companies that offer products and services that physician practices would use along with an EHR system. By working closely with member practices that utilize the HIT Solutions program, the OSMA is able to identify trends and adjust the program accordingly or add benefits and services as needed.

The OSMA relies on other Ohio entities, such as CliniSync and HealthBridge to report on activities related to the use and impact of EHRs.

Resolution No. 43 – 2013
Webcam Patient Encounters

RESOLVED, That Ohio State Medical Association meet with WellPoint and ensure that WellPoint is completely aware of and acting within the boundaries of the regulatory rules in the state of Ohio in relationship to telemedicine to ensure appropriate patient care for the people of Ohio.

ACTION: The OSMA met with WellPoint to ensure that they were aware of Ohio rules on the topic of telemedicine.

Resolution No. 44 – 2013
Guidelines for Personal Electronic Device Medical Applications

RESOLVED, That the Ohio State Medical Association ask the American Medical Association to review and make any recommendations as deemed appropriate on the subject of personal electronic device applications (PED apps) which are intended to be marketed for use by the general public to ensure that reasonable guidelines and systems of control are in place to assure demonstrated product safety and efficacy and to protect patients' use of such apps in the absence of physician oversight.

ACTION: The following is the official AMA Action based on the resolution that was taken by the Ohio Delegation:

D-480.975 Guidelines for Mobile Medical Applications and Devices

Our AMA will prepare a report on the appropriate indications, guidelines and certification processes necessary to assure the efficacy and safety of mobile medical applications and devices developed for smartphones and other personal electronic devices that may be used by physicians, allied health professionals, caregivers and patients. (Res. 704, A-13)

Resolution No. 45 – 2013
OSMA Policy Sunset Report

ACTION: The OSMA policy compendium was updated to reflect the actions adopted in Resolution 45 – 2013 and posted on the OSMA web site. Due to its length, the text of Resolution 45 – 2013 is omitted from this report, but can be viewed at www.osma.org under annual meeting archives.

Resolution No. 46 – 2013
Medicare Conditions of Participation

RESOLVED, That the Ohio State Medical Association (OSMA) support the AMA proposed language to CMS as follows:

- Each hospital should have an organized and individual medical staff that is distinct to that hospital. This requirement is needed to protect local medical staff self-governance and oversight, support care coordination and peer review activities, and ensure that the distinct clinical needs of each hospital and its community are met.
- A member of the medical staff should be included on the hospital governing body, unless prohibited by law or otherwise made infeasible by state or local law governing the manner in which governing body members are selected. The CMS conditions of participation require that the medical staff be responsible for the quality of medical care provided to patients by the hospital. While non-physician governing body members such as civic leaders, corporate executives, attorneys, etc. bring relevant expertise to the overall management of the hospital, they are not equipped to evaluate and guide patient care at the facility. When included on the governing body, medical staff members bring this clinical perspective to the activities of the governing body, improving and enriching the policies promulgated by the governing body by offering a clinical perspective.
- Direct consultation of the manner proposed by CMS is not an adequate

substitution for medical staff representation on a hospital's governing body. At a minimum, CMS should strengthen its proposed language concerning consultation to require direct medical staff participation in hospital governance activities, even if that does not entail a vote; and, **be it further**

RESOLVED, Individual physician members of the OSMA House of Delegates are encouraged to submit comments, drawing from the AMA' s letter, to CMS electronically by 5:00 p.m. Eastern time on Monday**,** April 8 at http://www.regulations.gov/#!submitComment;D=CMS-2013-0019-0001. (This URL is available on www.OSMA.org; OSMA Communities. Click on the link to cut and paste or place own comment).

ACTION: The OSMA signed on to the AMA comments to CMS.

Resolution No. 47 – 2013
Protection of Employed Physicians' Rights

RESOLVED, That the OSMA will monitor and respond as appropriate to situations causing a negative impact on patients or physicians as a direct result of physician employment.

ACTION: The OSMA monitors most situations causing a negative impact by tracking incoming e-mails/calls, reviewing posts on the OSMA Community, conducting surveys, and bringing issues to the OSMA Council. The OSMA has created a task force of employed physicians that meets regularly to discuss the employed environment. The organization is also in the process of developing solutions for employed physicians that would mirror the Preferred Partner Program.